The magazine for dental professionals working in Scotland
August/September 2010

Scottish Dental magazine

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Welcome

Editor's desk

with Bruce Oxley

Taxing changes

When the new NHS regulations and terms of service came out at the beginning of July it appeared, at first glance, to be a fairly benign legislative change.

The 2010 regulations consolidate previous regulations and amendments made since 1996, as well as increasing the protection of patients and NHS resources.

However, the paragraphs relating to dental bodies corporates (DBC) will have made worrying reading for many dentists who have set up as limited companies in recent years.

The regulations clearly state that these dentists will no longer be eligible for practice improvement grants and training allowances. The Scottish Government pointed out that the regulations don't bar individual dentists from joining the first part of the list. But, if incorporated dentists did this, they would lose any tax benefits they currently enjoy from trading as a limited company.

At best, this is an unfortunate result of the law of unintended consequences and that when the BDA meets the SGHD this month, it will all be ironed out.

However, the cynical-minded out there might think that this is simply a way for the Government to claw back tax from dentists who have been forced to dissolve their limited companies.■

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August/September 2010

CONTACT CLAIRE WALSH AT: clairewalshbds@aol.com

Biting back

with Claire Walsh

Lack of consistency

Why do health boards vary on guidance?

Consistency – of alginate, of glass ionomer – is critical in dentistry, but consistency of approach can be hard to find these days.

Take decontamination – the Scottish Dental Clinical Excellence Programme (SDCEP) issued guidance in 2007 for cleaning instruments. The next level of guidance, relating to the next stage of decontamination (sterilisation of instruments), is due soon, and may well be published by the time you read this. HTMor-05 doesn't apply up here, so the inconsistencies in that particular document aren't our problem, thankfully.

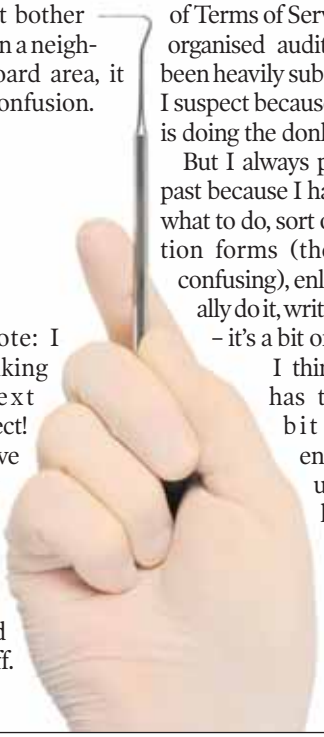
These days, you buy something and it's already been superseded, and it's the same with publications. Three years is a long time, but then has anything new been discovered in the interim, which would render the guidance obsolete? Not that I am aware of, and SDCEP has issued updates to other guidance, so I am sure that, had there been a seismic shift in thinking, we would know about it.

So, if we are all agreed that the guidance we have is appropriate and correct, then why do health boards vary their requirements for decontamination? I realised this only last week and I find it bewildering.

"If we are all agreed that the guidance we have is appropriate and correct, then why do health boards vary their requirements for decontamination?"

Practices can request NES training from trained infection-control nurses, which will still be free to NHS practices, unlike other courses which are now chargeable, so we can be thankful for small mercies. I attended in the past and rate it very highly – the nurses are knowledgeable and very down to earth, and, to my mind, are speaking from the horse's mouth – the bible according to NES and SDCEP. Surely the health boards should all be singing from the same hymn sheet? The moral of the tale seems to be: don't bother asking your mate in a neighbouring health board area, it can only lead to confusion.

On another note: I hope you're thinking about your next clinical audit project! The new regs have changed the start of the audit year to 1 August, as opposed to April, so everyone has to get organised and stop putting it off.



I can't make my mind up what I think of clinical audit. I have always (grudgingly) completed the required 15 hours in three years, but I hear loads of others haven't bothered, in spite of vague threats of being in breach of Terms of Service. The mass-organised audits have always been heavily subscribed, mainly I suspect because someone else is doing the donkey work.

But I always put it off in the past because I had to figure out what to do, sort out the application forms (they are utterly confusing), enlist others, actually do it, write it up, blah blah – it's a bit of a palaver.

I think the process has to be made a bit easier, to encourage higher uptake. But at least we are still paid an allowance to do it, unlike our chums in England! ■

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1 year, 6 issue subscriptions: UK £48; overseas £65; students £25. Back issues: £5, subject to availability.

 ISSN 2042-9762

Scottish Dental magazine
is published by
connect publications
Studio 2001, Mile End, Paisley PA1 1JS
Tel: 0141 561 0300
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www.scottishdentalmag.co.uk

"We can now ensure that we tick all the boxes when it comes to patient care...so that nothing is overlooked." PAGE 18

A team approach to fighting oral cancer

CANCER REFERRALS

Dentists are at the vanguard of Scotland's fight against oral cancer, with half of all patients at specialist oncology centres referred by the professionals.

And it's a fight that medical experts can win if the signs of cancer are spotted early on as Dr John Devine, Oral Cancer Maxillofacial Surgeon at Glasgow's Southern General Hospital, explained: "Although the incidence of oral cancer is relatively small compared with other cancers, if it is not treated early enough then it has a high mortality rate.

"It's a particularly nasty disease as it can affect the lips, tongue, gums and other areas of the mouth or back of the throat. While we can treat these areas, the removal of affected tissue or bone can lead to severe problems with patient's ability to speak, eat and swallow. And a worrying trend is the number of younger people presenting with the symptoms in what used to be a cancer of the old."

Oral cancer is a serious issue in Scotland as its incidence here is twice that of England, with an average of 500 new cases each year. Specialists cite a clear association of the disease with social deprivation and with sustained alcohol and tobacco use a main contributing factor.

Although about 85 per cent of oral cancer patients are over 50 years old, there has been an increase in younger people getting the disease – and once the diagnosis has been made, a staggering 50 per cent of patients will not live beyond five years.

As a former dentist himself, Dr Devine said that dentists do a great job for referring patients with suspicious oral cancer symptoms and the modern multi-disciplined team (MDT) approach adopted by hospitals throughout the UK helps to provide an effective treatment pathway for their patients to recover from this disease.

He said: "Our multi-disciplined team makes sure that all aspects of the patient's care is organised well in advance and that none of their physical or psychological needs are missed out."

For an insight into the multi-disciplined team approach to treating oral cancer patients, turn to page 18.

"It's a particularly nasty disease as it can affect the lips, tongue, gums and other areas of the mouth or back of the throat"

Dr John Devine

Protection scheme to be launched

The General Dental Council (GDC) is advising dental professionals in Scotland to keep up to date with developments concerning the Scottish Government's Protecting Vulnerable Groups Scheme (PVGS) which will be rolled out over the next four years.

The new membership scheme, which goes live on 30 November 2010, is to replace and improve upon the current disclosure arrangements for people who work with vulnerable groups such as children and protected adults.

Under the Protection of Vulnerable Groups (PVG) (Scotland) Act 2007, the delivery of dental care is a "regulated activity", so all dental professionals will need to register with the scheme.

The GDC understands it will have a legal obligation to share information about GDC registrants with the PVGS, but is currently waiting for confirmation on what information this will involve.

As regards receiving information about its registrants from the PVGS, the GDC has already decided that such information should not result in automatic erasure from the GDC Register, but should be considered as an allegation of impaired fitness to practise through the usual channels.

The GDC is looking carefully at how the PVGS will affect registrants and what role the Council will play.

For more information, visit www.scotland.gov.uk/pvglegislation

Leading clinicians descend on Glasgow

CONFERENCE

More than 3,000 of the world's leading dental clinicians and implant specialists will meet in Glasgow at the Scottish Exhibition and Conference Centre in October to discuss some of the most important issues and dilemmas they face in daily practice.

The city is hosting the 19th annual scientific congress of the European Association for Osseointegration (EAO) from 6-9 October and will focus on controversies in implant dentistry and how to be able to respond to them with knowledge based on scientific evidence.

The congress will also include parallel sessions, master classes, a poster presentation, EAO research prize competitions in clinical and basic research, and a series of courses.

A trade exhibition also runs throughout the conference and advance bookings already indicate that it is likely to be the biggest ever organised by the EAO.

EAO scientific chairman and chairman elect Paul Stone said: "We have a truly outstanding scientific programme with an educational faculty of clinicians and scientists from around the globe, as well as nearly 500 abstracts submitted for the clinical and research competitions, making this one of the leading forums for implant dentistry in the world."

For more details and registration information, visit www.eao.org

Scottish schools feature high in tables

The 2011 university league tables have been published with Dundee and Glasgow Dental Schools featuring prominently on all three lists.

Glasgow was ranked third overall in the dentistry sector of *The Times* Good University Guide behind Manchester and Sheffield but ahead of Dundee in sixth.

However, in *The Guardian's* University Guide and the Complete University Guide published in *The Independent*, Dundee finished ahead of Glasgow, ranking second and fifth respectively. Glasgow was placed sixth on *The Guardian* list and seventh on *The Independent's*.

Professor Jeremy Bagg, head of Glasgow Dental School said: "If you look at the percentage differences between schools, they are extremely small. From a PR and recruitment perspective it is clearly good to be near the top, but in reality the positions need to be taken with a pinch of salt."

"In reality the league table positions need to be taken with a pinch of salt"

Jeremy Bagg

Profession braces itself for cuts

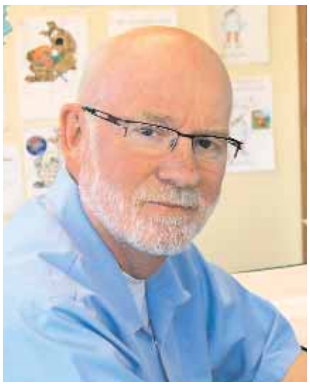
PAY CIRCULAR

The salaried service in Scotland will face increased pressures over recruitment and retention of staff in light of the recent NHS pay circular, according to the chairman of the Scottish Accredited Rep Committee.

Jackie Morrison, who is also a community dentist in Lanarkshire, says that dentists in the salaried service are fully aware of the problems facing the NHS in the current economic climate but that patient care is in danger of being compromised.

He said: "In Scotland's salaried primary care we treat some of the most vulnerable patients in the community.

"Many parts of Scotland already experience difficulties recruiting and retaining dentists. Where these difficulties exist, they adversely affect our ability to provide care to our patients, which include those with severe learning difficulties, mental health problems, anxious and phobic patients and vulnerable children.



"In Scotland's salaried primary care we treat some of the most vulnerable patients in the community"

Jackie Morrison

"We fully appreciate the pressures facing public finances and the restraints that they make necessary. In Scotland however, salaried services face a particularly difficult situation, because, unlike our counterparts in England, with whom we compete for recruits, we are yet to have implemented the new contract that we have been campaigning for."

The recent NHS pay circular for salaried dentists, which has been backdated to April, essentially gives staff a 1 per cent increase, with expectations of a zero per cent award next year.

This comes on the back of the announcement in March of a 0.9 per cent increase to item of service fees for independent contractor dentists, which was denounced by Robert Kinloch, chairman of the Scottish Dental Practice Committee, as a major disappointment that simply amounted to a pay cut.

Health Minister Nicola Sturgeon has also indicated recently that there will be no cuts to frontline dental clinical staff in the health service. However, the concern is that clerical and administrative staff could then take the brunt of any cost cutting that may be enforced on the sector.

'Sign up' urges LDC chair

LOCAL DENTAL COMMITTEES

The chairman of the Conference of Scottish Local Dental Committees (LDC) has urged dentists throughout Scotland to remember to pay the mandate to support dentists working on their behalf.

Tony Coia, a GDP from Dalmuir and member of the Greater Glasgow and Agyll & Clyde LDC, believes many dentists who move practices or relocate often forget to sign the mandate when they get their new list number.

Only 275 out of 647 dentists (42.5 per cent) within the Glasgow LDC area have signed the mandate to date, a figure which Tony says is quite typical for the larger board areas.

The voluntary 0.2 per cent contribution goes directly to the Scottish Dental Fund, which was set up to reimburse those dentists, at British Dental Guild rate, who give up their time to represent the profession on various committees and even in negotiations with Scottish Government.

Tony said: "I think it's essential for dentists to sign the mandate. These are ordinary practitioners who have taken it upon themselves to get involved in dental politics on the profession's behalf and these people need supported.

"If dentists don't support their colleagues in this endeavour then they will be compromised in their ability to negotiate on their behalf.

"You can't moan about what happens to you if you are not willing to take part in the process."

New regulations put Scottish dentists at 'unfair disadvantage'

Changes to how dentists are registered could have serious implications

REGULATIONS

The new NHS regulations for dentists, which include changes to how dentists and Dental Bodies Corporates (DBC) are registered with the health service, could put many dentists at a severe disadvantage compared to colleagues in the rest of the UK.

Stephen Neville, partner with Glasgow-based chartered accountants Martin Aitken and Company, claims that the new regulations mean dentists who operate as limited companies stand to lose out on training allowances and practice improvement grants as a result.

In order to keep these allowances they would have to join the list as an individual and therefore lose the tax benefits that go along with trading as a limited company.

Stephen said: "Dentists in Scotland would have to practise as individuals or groups of individuals, rather than through the more desirable company route, in order to keep these benefits. That means they will lose out on the tax cuts announced – tax cuts which NHS dentists across other parts of the UK can still take advantage of without these penalties.

"I'm sure this is an unintended consequence of the SNP's plans to reform NHS dentistry regulations in Scotland, but in order that Scottish dentists are allowed to continue practising on a level playing field with their counterparts in the rest of the UK, the Scottish Parliament must review this situation by restoring improvement grants and other allowances for small dental practice companies."

When challenged on this, the Scottish Government said: "These new regulations do not stipulate that dentists who join dental lists as individuals must dissolve any companies they have formed.

"Dentists who have formed companies can continue to join the first part of the dental list as individual contractors without affecting the status of the company. It is not mandatory that DBCs join the first part of the dental list. A company that is a DBC can also now join the first part of the list and in doing so can then provide General Dental Services (GDS).

"Dentists in Scotland would have to practise as individuals or groups of individuals, rather than through the more desirable company route"

Stephen Neville

"A dentist on the first part of the list and a company on the first part of the list cannot provide the same general dental services to a patient as a patient can only register with one listed provider of GDS."

However, Andrew Lamb, National Director for the BDA in Scotland, also raised concerns about the new regulations. He said: "The new regulations introduced in July 2010 incorporate numerous amendments made to regulations introduced in 1996 as well as some new developments. This includes significant changes to the listing arrangements.

"As DBCs can, for the first time, choose to be listed with an NHS Board, the BDA is concerned about the consequences this has on the employment status of practitioners working within a practice owned by a DBC that has selected to be listed.

"This is just one of several concerns the BDA has about the impact the new regulations has on dentists, whether intended or not. We will be raising these issues with the SGHD."

International recognition

SYMPOSIUM REVIEW

Glasgow played host to one of the largest events in the oral health calendar – the 18th International Symposium on Dental Hygiene – in July, attracting 1,100 attendees from 36 countries to the Scottish Exhibition & Conference Centre.

The symposium was organised by the British Society of Dental Hygiene & Therapy (BSDHT) on behalf of the International Federation of Dental Hygienists (IFDH). The three-day conference offered a wide range of presentations and workshops as well as a fair amount of typical Scottish hospitality.

Margie Taylor, Chief Dental Officer for Scotland, welcomed the delegates to the Symposium and took the opportunity to outline the success of the Childsmile programme.

Miss Taylor said: "I am very pleased to welcome experts in oral hygiene and delegates from around the world to Scotland for this vitally important event. Sharing knowledge and experiences allows us all to develop as professionals and introduce new ideas."

"Sharing knowledge and experiences allows us all to develop as professionals and introduce new ideas"

Margie Taylor

On the Friday and Saturday there was a choice of presentations and workshop sessions offering nearly 13 hours of CPD.

But it wasn't all work as the Friday night saw some famous Scottish hospitality at the Symposium Gala Dinner where 800 guests were treated to a chieftain haggis being piped in the banqueting hall of the Swallow Hotel.

"I think the acceptable standard is actually slightly below what some of the authorities are suggesting we aspire to." ROUND TABLE, PAGE 22

Costs under review

The revenue costs involved with decontamination have long been a source of concern for dentists. Is there light at the end of the tunnel?

Rumours circulating within the profession that the decontamination requirements are to be scaled back have been denied by the Scottish Government.

However, a spokesman for the SNP administration has admitted that the requirements are under constant review, with the revenue costs currently being looked at in greater detail.

With the revenue costs widely acknowledged to be anything up to £30,000 a year for single-handed practices and £50,000 for multiple-chair practices, any scaling back of the requirements that would impact on this would no doubt be welcomed by practitioners.

A spokesman for the British Dental Association revealed that they have submitted a list of issues to the Government and they are awaiting a response from them. He said: "A number of specific decontamination requirements in Scotland vary from the standards for England set out in HTM 01-05 including testing of equipment, water quality and instrument wrapping and storage. These can impact on the amount of time available for patient care and practice finance.

An autoclave print out common to many Scottish surgeries

"The BDA has set out its concerns on these three issues to the Scottish Government, and they have been referred to the appropriate bodies to determine whether the Scottish standards should remain or be modified to follow those set in England. We look forward to hearing the results of those deliberations."

However, a spokesman from the Scottish Government said: "There are no plans to change the standards for decontamination in Scotland. We are committed to protecting the safety of dental patients and staff. It is essential that appropriate measures are in place to promote good practice in the sterilisation of reusable surgical instruments and equipment.

"We regularly review the evidence and currently we are concentrating on the revenue costs to assess if they are commensurate with the risks involved."

Implant specialists to run the rule over practitioners' cases at Falkirk event

STUDY CLUB

A cohort of leading dental implant specialists will be on hand to give their advice on specific cases to practitioners at a unique, one-off event in Falkirk.

In a change to its regular study club evenings, The Association of Dental Implantology UK (ADI) will run a one-off Treatment Planning Evening on Thursday 2 September at the Macdonald Inchyra Grange Hotel, in Polmont, near Falkirk.

ADI committee member and Scotland representative David Offord explained: "We have assembled a fantastic faculty of senior Scottish implant dentists and technologists to chair eight treatment planning tables.

"There will be five members to each table and each one has 15 minutes in which to present their case and receive advice and feedback from the chair and fellow delegates.

"By breaking into small groups it encourages a more open discussion, and members will discover that they are not alone in finding aspects of implant dentistry challenging."

At the end of the session, each of the chairmen will give a brief summary of the planning problems they have been addressing, and David will conclude the evening by summarising the three most common problems and solutions.

For further information visit www.adi.org.uk or call the ADI office on 020 8487 5555. The next study club at Perth Royal Infirmary will be on 4 November, featuring Dr Francis Nohl.

IN BRIEF

DCPS SOUGHT TO SIT ON GDC'S FITNESS TO PRACTISE PANEL

The General Dental Council (GDC) is seeking dental care professionals for its Fitness to Practise panel to consider cases where a registrant's fitness to practise may be impaired, as well as applications for restoration to the registers and appeals against registration decisions.

The deadline for dentists has passed, but dental care professionals such as nurses, technicians, hygienists and therapists have until 3 September to apply for the roles, which are central to the GDC's work in protecting patients.

Members given training and expenses are expected to sit on the panel for around 20 days a year.

For more information visit http://www.gdcpanellists.com

HAVE YOUR SAY ON ADVERTISING GUIDELINES

The General Dental Council (GDC) is urging dental professionals, other healthcare professionals and members of the public to have their say on the draft version of a guidance document about advertising.

The GDC wants to provide more detailed information on what is expected of dental professionals regarding advertising, using specialist titles and information displayed on websites.

The consultation, which is open to everyone, can be found on www.gdc-uk.org and will run between 8 July and 1 October 2010.

Svirplis censured for deficient performance

A Lithuanian dentist practising in Dumfries has been ordered to work under supervision by the General Dental Council (GDC), following a string of clinical failures.

The Professional Conduct Committee found that Egidijus Svirplis, who qualified in Kaunas in 1998, came up short in his treatment of five patients between March 2006 and April 2008. This included failing to carry out or record basic periodontal examinations at initial patient visits, failing to take radiographs of diagnostic value prior to treatment and proposing an out of date technique for the provision of bridges.

Mr Svirplis underwent an assessment by the National Clinical Assessment Service (NCAS) in April 2009 and they found his performance to be inconsistent in nine areas. NCAS sampled a number of patients and found his practice to be satisfactory in some areas but poor in others. They also found that his performance was poor in terms of keeping up to date and that he had not, at that time, met the GDC's CPD requirements.

Despite the GDC committee finding that his professional performance was deficient, it ruled that it was remediable and noted the steps Mr Svirplis had taken in order to remedy those failings.

However, it was found that the process was not complete and he was ordered to work under clinical supervision for the next 12 months in order to provide evidence that his professional performance has improved and is being maintained to an appropriate standard.

Horn struck off

GDC | protecting patients, regulating the dental team

MISCONDUCT

A German dentist from the Canary Islands has been struck off by the General Dental Council (GDC) for admitting a series of offences including smoking marijuana, carrying out inappropriate and unprofessional prescribing practices as well as failing to have up-to-date indemnity cover.

Hans-Jurgen Joachim Horn, whose registered address was given as Los Gigantes on Tenerife, was employed at a practice in Penicuik between August 2006 and March 2008, and then on Portobello High Street in Edinburgh from 3 June to 11 November 2008.

Mr Horn, who qualified from Nuremburg in 2002, didn't attend the GDC hearing on 22 June and was struck off in his absence.

The Professional Conduct Committee heard that in November 2008 Mr Horn admitted to his employer that he regularly used marijuana and intended to continue to use the drug. When asked to give an assurance that he would stop, he refused.

Mr Horn was also found guilty of prescribing painkillers and antibiotics to his former dental nurse, himself and another patient on several occasions without maintaining proper records and recording the frequency or duration of the drugs. The final charge related to a period between October 2006 and September 2007 when he failed to hold appropriate professional indemnity cover.

The committee found that Mr Horn had "breached several of the fundamental tenets of the profession by his misconduct". The GDC determination also stated that: "Mr Horn has continued to show, through his recent email correspondence, an unprofessional and inappropriate attitude to his professional life and how aspects of his private life impact upon that."

In striking him off the register, the committee concluded: "The overall conduct and attitude of Mr Horn shows a level of intransigence, recklessness and irresponsibility that would leave the public at risk and would undermine public confidence in the profession and in the regulatory process if he was not erased from the register."

McCanny allowed to work under supervision

A dentist from South Queensferry has been allowed to continue practising under conditions after appearing in front of the General Dental Council's (GDC) Interim Orders Committee.

Brendan Joseph McCanny appeared in front of the committee on 25 June where an early review into 18-month conditions imposed on 13 May was carried out. The amended conditions, which run until 12 November next year, state that he must undertake audits of his record keeping – including the taking of medical histories – radiography and dental claims every three months.

Mr McCanny was also told he must identify an appropriate colleague who will be available to verify the adequacy and accuracy of the audits. This individual is to be approved by the GDC and must be prepared to review his conditions, observe his clinical practice and report back to the council every three months as to his fitness to practice.

Mr McCanny was also informed that he must inform the GDC of any new professional appointments he accepts and inform his employers or prospective employers that his registration is subject to such conditions.

GDC under fire over ORE exam

REGISTRATION

An ex-pat Scotsman whose wife failed the General Dental Council's (GDC) Overseas Registration Exam (ORE) in the bungled April diet, has called into question the validity and robustness of the entrance qualification.

As reported in the last issue of *Scottish Dental*, the council admitted a privacy breach when it emailed another candidate's results out to every other candidate who took the exam in the April sitting. This error was then compounded when the email sent out to apologise for the mistake, openly copied the email addresses of all recipients, as opposed to 'blind' copying them.

Kevin McPherson, an IT analyst originally from Elgin, has set up a campaign blog highlighting what he sees as a catalogue of errors in the administration of the ORE. His wife, who qualified in the Philippines, has been practising in the US for the past seven years and had planned to move back to the UK to set up in practice.

Even after the email blunder, the couple say they had accepted the results and were making plans to re-sit. However, they then claimed that they received a number of emails from other candidates listing errors, inconsistencies and concerns about the April diet as well as previous sittings.

These included one candidate who claimed his results changed from the first email sent out by the GDC in April, to the second email, and another who claimed that she was convinced she had failed the exam – saying she could only answer 20 out of 154 questions – and yet she was told she had passed.

"That is what got me thinking about looking into this in more detail," said Kevin. "As far as I am concerned there are potential public health concerns here."

They also recount the story of another candidate who claims to have fought a 14-month legal battle to get her paper released by the GDC, after which she discovered she should have passed when she was initially told she had failed.

The couple admit that the claims are wholly anecdotal at this point but they have lodged a complaint and an appeal, which has been turned down by the GDC.

A spokeswoman for the GDC said that they recognise there was a "poor standard of service" in the April diet and they have carried out an internal investigation. They have also reported their error to the Information Commissioner's Office.

She said: "Previous diets have generated complaints and the council has addressed them in line with its ORE Complaints policy. There are unsuccessful candidates who appear to believe themselves unjustly treated by the GDC and who are unable to accept that their complaint has been addressed. The council is aware these complaints are gaining a wider currency.

"The council remains focussed on providing a robust test of knowledge and skill in order to protect the public, by ensuring that only dentists with appropriate knowledge and skill are put on to the register."

The London venue for this year's show

Dentistry on show

The UK's largest dental exhibition, the BDTA Dental Showcase which is being held at ExCeL in London's Docklands from 14-16 October, looks set to attract over 13,000 visitors and more than 320 exhibitors this year.

The theme of this year's Showcase is "Innovation, Education and Integration" which emphasises the need to keep up to date with products, services and business practices to help deliver customer satisfaction and to gain valuable knowledge to develop the dentistry of the future.

The exhibition will feature complimentary seminars plus other lectures designed to give an insight into the latest innovations in dentistry and which contribute to verifiable CPD.

Tony Reed, BDTA executive director, said: "Innovation drives dentistry forward and we are delighted to be hosting feature lectures at this year's event to highlight new developments."

www.dentalshowcase.com

Implant symposium

An implant symposium marking 30 years of osseointegration in the UK and Ireland will take place in London in September.

The Nobel Biocare event will feature a panel of internationally renowned speakers addressing an eclectic range of topics of clinical interest.

The Symposium will be held at the Royal Institute of British Architects on 3-4 September with a gala dinner on the Friday night to be held at the nearby Langham Hotel on Portland Place.

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Orthodontist heads west for his latest practice venture

NEW PRACTICE

Livingston is the base for Dr Samir Sayegh's newest orthodontic practice

With four orthodontic practices under his belt already, Samir Sayegh wanted something special for his newest venture, which also happens to be the first dedicated orthodontic practice in West Lothian.

After opening two practices in Edinburgh, one in Kirkcaldy and one in Musselburgh, East Lothian, Dr Sayegh identified Livingston as the ideal base for his latest practice.

Converting newly built office or retail units into high spec dental practices has grown in popularity in recent years, with practitioners looking for a blank canvass to create their ideal practice. In this vein Dr Sayegh hired Arc Project Management to find the premises and they identified a recently built cluster of seven retail units in the West Lothian town, deciding on the fourth unit in the block.

With an open shell to work with, Arc designed and built a split-level state-of-the-art practice complete with biometric locks for the staff only areas and lights that are activated by a person's body heat.

Dr Sayegh explained: "It is a very modern practice, we have disabled access for patients and staff, three brand-new surgeries downstairs complete with digital x-ray machines and upstairs is fully fitted for staff convenience and administrative work. I'm delighted with the result and the practice is functioning very well."

The reception area and waiting room has been designed to create an atrium feeling, with the first floor office and staff areas set back and visible as soon as patients walk into the practice. This 'double-height' area was designed to create a feeling of space and to make it feel much bigger than it actually is.

Dr Sayegh completed his undergraduate degree from Edinburgh in 1978 and gained his speciality in orthodontics from the Royal College of Physicians and Surgeons of Glasgow in 1984.

Above: The view at reception

Scottish practice's aid helps African school's oral health

Equipment and supplies from a Scottish dental practice has been sent over 3,500 miles away to help improve the oral health of students at an African boarding school.

Whitemoss Dental Practice in East Kilbride donated tooth-brushes, toothpaste and cups to a charity based in the northern Ghanaian region of Kpandai.

The unusual connection came about after Chloe Smith, a patient at Whitemoss and cousin of the practice's receptionist Claire McLaughan, mentioned that she was heading out to Ghana. Claire arranged for the practice to donate the equipment and Chloe, loaded up with supplies, headed out for Kpandai in June.

Her destination was the Kpandai Girls Academy which was set up and is run by the Scottish charity Let Us Shine Africa. Chloe said: "They absolutely loved brushing their teeth. When they were in their villages they used chewing sticks to clean their teeth but they really took to the brushes and toothpaste in the school."

Fife team's mission

ROMANIAN VISIT

Volunteers from NHS Tayside and NHS Fife's dental services gave Romanian children something to smile about this summer after travelling to the poverty stricken countryside to help provide dental care.

The team, which included Senior Dental Officer Gillian Elliott, Dental Therapist Lynn McAllister, Dental Nurse Fiona Thompson, and James Leiper, an engineer from NHS Fife, was part of VisionRomania, a charity which provides care for deprived children in the country.

They were all shocked at the conditions the children lived in, many coming from homes in remote rural villages in the west of the country and living in conditions of extreme poverty with no electricity or running water.

Gillian said the situation was compounded by the country's lack of free medical or dental treatment. She explained: "As a single dental appointment costs the equivalent of 20 hours salary, treatment is a luxury for many people who have to suffer pain and infection with no prospect of treatment."

Working with translators, the team were able to gain the trust of the children and carry out a range of vital treatments including extractions, fillings and fitting stainless steel crowns.

They brought their own equipment to ensure high standards of hygiene, but had to forgo the usual dental chair and make do with a hospital bed and a portable light instead!

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Dental team success

After hours of gruelling effort, three Scottish dentists claimed the coveted first medical team prize in the 2010 Highland Cross – a unique 50-mile event combining the rigours of a mountain marathon and a cycling time trial across Scotland from the west to the east coast.

The three dentists included Roshan Fernandez, who runs Gentle Dental Care in Dunfermline, Colwyn Jones, a consultant in dental public health for NHS Health Scotland based in Edinburgh, and Rashmi Shah from Queens Road Dental Practice in Aberdeen.

The mountain marathon starts at sea level near the beautiful Eilean Donan Castle in Morvich and climbs to over 1,000 feet through some of the most remote and mountainous terrain in Scotland. After the running, the competitors have to jump onto their bikes to cycle the remaining thirty miles to the town of Beauly and the finishing line.

Colwyn was first team member to finish in a time of 4 hours 43 minutes. He said, "Initially the conditions were good for running; cloudy but later it got very warm. The sun broke through and you had to pace yourself carefully to avoid dehydration and overheating. However, it was a great day and we all finished safely."

Photo: Ann MacDonald

Above: Dentists on the run: Roshan Fernandez, Colwyn Jones and Rashmi Shah

Rashmi finished just less than a minute later. He said: "Conditions were tough and most people were slightly slower than usual, so I was very pleased with my time." Roshan, who is still recovering from a motorcycle accident, came in faster than expected as the third member, to help the team clinch the title.

The Highland Cross has raised over £2.7 million for local charities since 1983 and it is still possible to pledge support and donate at www.justgiving.com/Roshan-Fernandez

SCOTTISH HEALTH AWARDS

Dentists, dental nurses, dental therapists and other members of the dental team are being encouraged to nominate their colleagues for the Scottish Health Awards.

This year's ceremony will take place at the Corn Exchange in Edinburgh on 11 November and will recognise the contribution of Scotland's most committed and caring NHS workers.

The categories include awards for doctors/dentists, nurses, therapists, managers and volunteers, as well as a dedicated award for the 'Top Team'. Nominations are sought for NHS workers who go the extra mile and genuinely make a difference in their patients' lives with their loyalty and devotion to the cause.

The closing date for nominations is 5pm on 6 September. Visit www.scottishhealthawards.com

A team approach to treating oral cancer has huge benefits for patients, reports Tim Power

A look at the big

It's 7.50am on a Friday at the Southern General Hospital in Glasgow and the meeting room on the fifth floor of the neurology block is already busy with about 20 people pouring themselves coffee and tea and helping themselves to the odd Danish pastry.

But it's not the free breakfast they have come for – although the caffeine will help them remain alert over the next two hours as they review and discuss treatment plans of new patients that have been diagnosed with oral cancer.

They are members of the hospital's Oral Cancer Maxillofacial/Head & Neck Multi-Disciplinary Team (MDT), which consists of representatives from a dozen different clinical and healthcare specialist departments.

As the room is plunged into darkness and the projector lights up the screen, the next two hours are spent listening to individual patient cases, reviewing their CT scans and discussing treatment plans and post-surgery requirements.

CT scans flicker back and forward on the screen showing the three dimensional layers of cancer growth eating away at flesh and bone. While the surgeons describe the extent of the disease in detailed medical terms, they also discuss the patients in individual terms and explain how their medical and personal circumstances have shaped the proposed treatment plans.

Many of the patients are elderly and frail and suffering from other conditions that may contraindicate surgery or even radiology treatment. Some live alone, so the Macmillan Nurses, who play a key role in the treatment, have to consider bringing in community care so they can be looked after at home.

Sometimes, a resigned hush momentarily fills the room as even members of the non-surgical MDT can see that a cancer is so far advanced and there is little hope of treating the patient. It's now the turn of the palliative care nurses to suggest how they can help the patient manage their symptoms and remain at home in comfort and dignity.

Then there's the case of a cancer patient who has said: "No more, doctor". After three operations another cancer has been diagnosed and he believes he can't take any more. The surgeons know they have to operate, but for the time being they agree to respect the patient's wishes and let him build up his health before attempting to persuade him of the need for more treatment again.

All these patients have come under the care of the Southern General's Oral Cancer Maxillofacial/Head & Neck MDT from referrals from dentists and doctors.

In Glasgow, when patients are referred, they attend a consultation with Dr John Devine, Maxillofacial Head & Neck Surgeon, or one of his four fellow consultants at the Southern General's Maxillofacial Department, to assess their condition.

If cancer is suspected, each patient

PHOTOGRAPHY BY MIKE WILKINSON

picture

"The most important part of the meeting is where we discuss the treatment plans"

Dr John Devine

will have a biopsy, a CT scan and a general health check to assess whether they are fit enough to undergo any treatment that is recommended.

Once the results are known, they are prepared for discussion at the Friday morning meeting which, in addition to the clinical teams involved, such as surgeons, pathologists, oncologists, radiologists and maxillofacial prosthetics, also includes clinical and ward nurses and specialist Macmillan Cancer Support Head & Neck nurses. The Macmillan

Continued »

MAXILLOFACIAL PROSTHETIC TEAM

Barbara Thomson is part of the team that replaces what is lost by surgery

Advanced oral cancer tends to be treated by surgery rather than radiology or chemotherapy because of the localised nature of the disease and the difficulty of accessing its occurrence in the mouth, jaw or skull.

Surgical resections often create large defects accompanied by dysfunction and disfigurement that can adversely affect speech, swallowing, control of saliva, and mastication. If these cosmetic and functional impairments are not corrected or minimised, the patient may be unable to resume a normal life.

This is the job of the specialist Maxillofacial Prosthetic Team, part of the MDT which helps to plan and 'fix' the results of reconstructive surgery.

Maxillofacial Prosthetic Technologist Barbara Thomson modestly summed up their work as simply "replacing anything that has been removed by surgery".

However, the work itself is far from simple. It involves an advanced understanding of physiology and skeletal structure as well as the ability to interpret CT scans to create 3D computer models of the patient's skull and soft tissues.

This not only helps surgeons to understand the extent of the cancer and plan their resections, but is essential for the technologist to develop suitable prosthetics to fill or cover up the extent of the surgery and alleviate any problems with breathing, speaking or eating.

In the case of complex surgery, a life-size three-dimensional plastic model will be created so that the surgeon can plan the treatment in detail.

After surgery the two most common ways of dealing with the void created by the removal of tissue is a 'flap', a skin graft from the arm, leg of buttocks, or an obturator, which is a silicone 'bung' and associated denture to fill the void created by surgery and replace lost teeth.

In severe cancer cases patients might lose some of their nose or even their eyes and surrounding area so the team is skilled in creating life-like prosthetics, even down to matching skin texture and hand painting the pattern of the iris on an artificial eye.

The team spends a great deal of time with the patients to ensure that the individually crafted prosthetic is to their liking and can be used with a minimal amount of fuss.

Maxillofacial Prosthetic Consultant Fraser Walker is always impressed with the resilience of the patients throughout this traumatic experience. He said: "Their lives change forever after that first appointment with the consultant. In many cases patients can't speak, eat or breathe properly after surgery, so it is wonderful that our prosthetics can help them achieve the simple things we take for granted and give them the ability, dignity and confidence to carry on with their lives.

MACMILLAN CANCER SUPPORT NURSES

Even if people suspected it, Janice Brown knows to have your fears confirmed that you have cancer can come as a severe psychological shock to most people.

She is one of two specialist Macmillan Cancer Support Head & Neck Nurses who play a key role in the multi-disciplined oral cancer team, providing help and support throughout the patients' treatment and beyond.

Janice explained: "People can be devastated to hear that they have cancer, so it is important that we are there when they are first told to help cushion the blow."

Their role is to meet with the patient and their family and answer all the questions they might have about the disease and the possible treatments.

Once the treatment plan has been decided then the nurses visit the patients at home to provide another opportunity to talk about the treatment and their individual care needs.

It's an emotionally demanding job as they develop a close relationship with a patient and their family, but for Janice it's a privileged role to have.

"It's very rewarding to know that you are helping people through this traumatic period in their life," she said.

WE ARE MACMILLAN. CANCER SUPPORT

Continued »

nurses play a key role in supporting the patient from the time of diagnosis, through cancer treatment, and during the long period of rehabilitation.

And there are specialists present in nutrition, diet, speech therapy, dental hygiene and occupational therapy to address post-surgery issues such as difficulties in eating or speaking and adapting to any prosthetics.

Dr Devine said that these Friday meetings are crucial to understanding the needs of the patients and preparing to support them on and after their treatment journey.

"The most important part of the meeting is where we discuss the treatment plans and everyone has a say about the support they can offer the patients.

"We've certainly learned a lot about working together over the years and we are always finding new ways to help the patients through their treatment.

"That's what is so exciting about these meetings – you really get a feel for the dedication of everyone in the room trying to do the very best for our patients.

"I've never worked with a more dedicated bunch of people," added Dr Devine.

Chairing the Friday meeting discussions and keeping everyone to the strict two-hour timetable is Dr David Houghton, Consultant

ENT/Head & Neck Surgeon, who said this MDT approach has really enhanced patient care.

He said: "We can now ensure that we tick all the boxes when it comes to patient care. By having all the pathologists, surgeons, radiographers and ancillary and paramedical staff in the one room, everyone gets a formal presentation of each patient, and the opportunity to input into the proposed treatment plans so that nothing is overlooked.

"I think dentists are doing an excellent job of referring their patients to us and we ensure that they are not left out of the process"

Dr David Houghton

"I think dentists are doing an excellent job of referring their patients to us and we ensure that they are not left out of the process as we will always send them a letter outlining the treatment plan we have devised."

The benefits of the MDT to patient care are enormous, not just in the quality of their treatment, but also in the logistics and emotional support they receive. Everything is under one roof at the hospital's Maxillofacial Department and the process is well co-ordinated so that patients benefit from seeing the same specialists and don't have to wait long between appointments.

Since the majority of oral cancer treatment involves surgery, the MDT is very conscious of the need to provide ongoing support after the operation to ensure that patients can get back to a normal as life as possible.

Dr Houghton explained: "We have to balance the amount of surgery required to remove the area affected by cancer, with the residual function of the patient.

"In the last 10 years there has been a greater focus on how the patient will function after surgery, and this is very much at the front of our minds when we devise our treatment plans.

"Our aim is to provide the best treatment and after-care for oral cancer patients in the world – that's not being arrogant – it's what we truly aim for," he added. ■

TYPES OF HEAD AND NECK CANCER

Head and neck cancers*, of which oral cancer is just one, affects just under 8,000 people in the UK each year. Of these cases, about:

- 1650 occur in the pharynx
- 1400 occur in the mouth
- 1250 occur in the tongue.
- 500 occur in the nose and the paranasal sinuses
- 500 occur in the salivary glands
- 480 occur in the eye
- 360 occur in the lip
- 240 occur in the nasopharynx.

*Does not include cancers of the thyroid gland, larynx (voicebox) and ocular melanoma.

Source: Macmillan Cancer Support

Dental Protection

PHOTOGRAPHY BY MIKE WILKINSON

Professional

Hugh Harvie and Kevin Lewis from Dental Protection, the UK's leading provider of indemnity for the dental team, hosted the latest *Scottish Dental* round table evening

Despite covering topics as diverse as dental education, the commercialisation of dentistry and the problems surrounding decontamination, those attending the latest round table evening kept coming back to one element that seemed to neatly underpin the whole debate: professionalism.

There was unanimous agreement that in order to survive the various slings and arrows that come your way through a typical dental career, the one thing that will stand you in good stead is a commitment to professionalism in all its forms.

With two dental school deans in attendance, Kevin Lewis, Dental Director of Dental Protection Ltd (DPL), opened the evening by talking about education, both undergraduate and postgraduate. He remarked that DPL often see people who have "slipped out of the profession" by not attending courses and meetings, and having regular contact with their colleagues and peers. They then head off on a short course on something as complex as implants and start working beyond their competence without realising it.

Professor Bill Saunders, Dean of Dundee and Aberdeen Dental Schools, responded by saying: "What we are really talking about in many ways is professionalism in its widest remit. We try very hard, and it is difficult, to teach professionalism, to try to understand what is meant by professionalism and how indemnity and so on fits into this. Overall I think we have still got a lot of work to do but sometimes when you go into these cases, it's not as a result of their experiences as an undergraduate, it's their experiences when they leave."

He said he felt the new generation of dental students don't seem to have the same level of commitment as previous generations: "I know that when rotary endodontics first came up, I spent hours in the lab playing around with blocks and extracted teeth, and learned how to do it. There doesn't seem to be that attitude these days. Come five o'clock they all want to disappear and go off and play golf or whatever."

Kevin Lewis agreed by saying that the young people coming into the profession seem to be of a different world and these generational issues do create different problems dento-legally. But, he also argued that: "You are taking in a much richer crop of academic people, I mean I probably wouldn't get into a dental school today."

Professor Jeremy Bagg, Head of Glasgow Dental School, remarked that he was offered a place at Edinburgh to read dentistry if he achieved two D grades at A-Level. "And now if you haven't got straight As you haven't got much chance of getting into Dundee or Glasgow," he said. "In a sense if dental students are not successful in their education at university, it is actually us who have failed, because we get the absolute cream of the crop."

Returning to Professor Saunders' point, Charles Ormond, Falkirk-based GDP and Vice Dean of the FGDP, said that younger dentists want different things. He said: "They want instant gratification, they also want a better work-life balance, which is why they

"In a sense if students are not successful, it is actually us who have failed because we get the absolute cream of the crop"

Professor Jeremy Bagg

opinions

don't sit all night with their blocks. They are a different breed probably from what, looking around the table, we were."

Professor Saunders agreed with Charles Ormond's assertion but also pointed to the fact that the dental students are "the best students in the university". He continued: "Sometimes they ask us: 'Why am I still here working in a clinic when the whole of the law faculty has graduated?' And maybe sometimes we are a bit hard on them. But one of my worst jobs, I think, is standing up in front of the first years when they first arrive and saying: 'Welcome to Dundee, this is a great place but don't let me catch you doing this, this and this, because professionalism starts now'. And it's tough for an 18-year-old."

The discussion then turned towards the pressures placed on dentists and the temptations to see dentistry as a way to make money ahead of patient care. Kevin Lewis pointed out that today's UK dental graduates are statistically much more likely to be sued during their career than a graduating medic, lawyer, accountant or architect. "But they are all coming from the same generation, so other factors must be at work here," he said.

"I think it has got a lot more difficult for the new graduate," Charles Ormond replied. "In my day we were brought up on this concept that you had to make somebody dentally fit. That gave you a goal to go for and it was an easier remit to work to, whereas it has got more difficult for them in some of the things that they are being asked to do."

Professor Bagg then highlighted the way dental outreach training gives undergraduates valuable clinical experience. He explained that he believed it was a great way for them to develop confidence and their clinical skills, in a real world environment. Professor Saunders agreed and noted the success not just of the local

Continued »

MEET THE PANEL

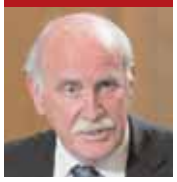
Charles Ormond
General Dental Practitioner in Falkirk and Vice Dean of the FGDP

Helen Kaney
Dento-Legal Adviser for Dental Protection based in Edinburgh

Andrew Lamb
National Director for the BDA in Scotland

Professor Bill Saunders
Dean of Dundee and Aberdeen Dental Schools

Hugh Harvie
Head of Dental Services, Scotland for Dental Protection



Professor Jeremy Bagg
Head of Glasgow Dental School

Kevin Lewis
Dental Director of Dental Protection

Yann Maidment
GDP from Edinburgh

Christina McNiven
Marketing Project Manager for Dental Protection

Bruce Oxley
Editor of *Scottish Dental* magazine

Continued »

outreach but the distance outreach his students were undertaking in Inverness and Aberdeen. Yann Maidment, private GDP from Edinburgh, then said: "This goes right back to when we were talking about professionalism. Outreach is where they are going to learn the soft skills of how to apply things as well as professionalism. Yes, you can learn the clinical skills in a dental school, but are they going to be able to apply it in a proper fashion? That's where the outreach fits in I think."

The question of competence was then touched upon with Professor Saunders saying that there is a need to challenge the idea that you are a competent dentist on qualification: "We need to say to students 'You might never be competent to do this' and therefore you must know that you are not competent to do it and refer it to someone who is competent. I think this is already being seen in practice in Scotland because of the number of referrals we now have to secondary care. It is shooting up."

Andrew Lamb, National Director for the BDA in Scotland, then posed the question as to what we are training dentists to be in the future? With dentistry becoming more and more complex he asked: "Is the general practitioner going to be a gatekeeper and farm people off in different directions for example to hygienists, therapists or specialists and do very little hands-on dentistry? Or are they going to be more oral physicians, making judgements about the risk of oral disease developing?"

Professor Bagg replied by saying: "I don't think the profession knows at all where it is going in terms of what the roles of all these people are going to be. I think a lot of it comes down to how dentists are remunerated."

Above: Kevin Lewis addresses his fellow dental colleagues at the round table

"We started off talking about professionalism and dentists who behave professionally will not go beyond their competence"

Andrew Lamb

Hugh Harvie then asked the group what their thoughts were in relation to the growing commercialisation of dentistry, in particular dentists responding to commercial pressures by embarking on courses of treatment or techniques that they have little knowledge or experience of.

Andrew Lamb replied: "We started off talking about professionalism and if the dentists behave professionally they will not go beyond their competence. I think that's the important thing."

Kevin Lewis said that as dentistry is continually evolving, every generation of dentists has no doubt ended up doing things that they weren't taught at dental school. "Some dentists will become competent to carry out these procedures but others will not," he said. "Education can teach people how to learn and apply new skills and knowledge responsibly, but competence and ethical responsibility go hand in hand. If treatment isn't necessary in the first place, the fact that you can do it outstandingly well is irrelevant."

Yann Maidment responded by saying that it can be difficult for dentists to know where their competencies lie and when to refer and seek advice. He argued that if you have given your best dental advice and the patient still wants the other option, do you let them walk away to another dentist or do you try and find a way to meet their desires? He said: "This is how as a profession we can get people to come and see us because of what they want and hopefully guide them towards what they need as well."

Hugh Harvie then spoke about how he has seen, over a number of years, a rise in complaints associated with over-ambitious treatment plans and not matching the patients' expectations.

"The expectations of patients are now so high and in some cases they are completely unrealistic," said Professor Saunders. He went on to argue that his medical colleagues don't have anything like the amount of problems facing dentists in this regard. He said: "If you have a total hip replacement and it still gives you a bit of pain afterwards, that's life. If you do a root canal treatment and the patients still gets pain, you get sued."

Charles Ormond argued that dentists might set themselves up for a fall in some respects as medical doctors will cite the odds and statistics for success and failure, while dentists rarely give out the failure rates for their treatments. When they do it is often only after a failure, which can then come across as the dentist making excuses.

Helen Kaney, dento-legal adviser for Dental Protection based in Edinburgh, said: "And that's what patients think sometimes, that when you explain that to them afterwards, they think it's an excuse. This is a known factor with patients proceeding with complaints and claims."

Inevitably if you bring a group of dentists together the conversation

will at some stage come round to the thorny issue of decontamination, and this evening was no different. However, with Professor Bagg at the table there was an opportunity for the other guests to quiz the microbiologist who has been a member of the group that has been producing guidance documents on the subject for the Scottish Dental Clinical Effectiveness Programme (SDCEP).

Professor Saunders raised the issue of the ongoing costs of single-use instruments and central sterilisation at the main hospital in Dundee. He explained that he can use up to £70 worth of sterilised instruments for one case. "It's crazy," he said. "How can you expect an NHS dentist to do a decent job of molar root canal treatment when he's having to fork out that sort of money before he even starts?"

Andrew Lamb agreed by saying: "It's the revenue costs of running the LDUs that will be far more taxing for dentists than the money that is required for the capital. It is the revenue costs that are really going to hit the practices in the long term."

Professor Bagg responded by saying: "In terms of endodontic instruments, I accept that the costs are big. Andrew Smith and I have published three papers where we have looked at visual contamination, we've looked at blood contamination and we've done work with a physical chemist in London looking at protein contamination. You cannot clean these instruments.

"If you can't clean it properly, you cannot sterilise it. So I have absolutely no problem with the science or the evidence behind saying that these instruments should be single use."

He went on to explain that he believes it is about finding a balance and assessing risk. He spoke about the advantages of getting decontamination procedures out of the surgery but he questioned the suggestion that you need four rooms in order to undertake decontamination successfully. He then highlighted the Scottish survey on decontamination that he was involved with and said: "There were a lot of practices that were trying very hard, but there were a large number of dental nurses that were working their socks off to do the wrong thing, because they hadn't been told how to do it properly."

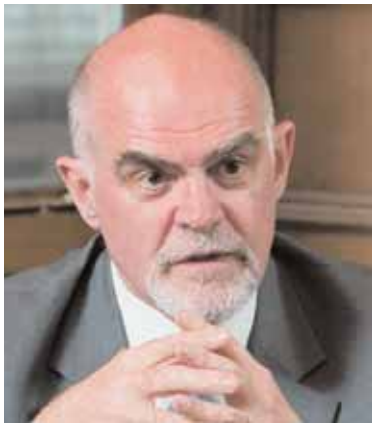
Yann Maidment, who has been running an LDU in his practice for the past eight months, said: "It has to have someone on it all the time or it will slip back. It has to be managed, there has to be a management system that returns to it, and the people doing the job know it is going to be returning at regular intervals. Or you will start to find bits of cement on your probes."

The conversation then returned to the revenue costs with the agreement being that while the capital money available to dentists was welcomed, it is the revenue costs that are the real worry. Professor Bagg then highlighted the fact that there are fundamental differences of opinion between the experts. He asserts that instruments need to be 'sterilised' but not 'sterile at point of use', while he has colleagues who believe they need to be sterilised and also sterile at point of use. In order to satisfy the latter you need to be wrapping all instruments before sterilisation and working with a vacuum autoclave as well as contending with all the running costs that involves.

He said: "I would be perfectly happy having dentistry performed on me with instruments that have been sterilised in a non-vacuum autoclave and appropriately stored under aseptic conditions. You have a fairly rapid turnaround of dental instruments in general practice and I would much rather that the instruments were sterilised properly, unwrapped in a non-vacuum autoclave, than to go down the vacuum route and having people not doing the testing and having packaged instruments coming out of autoclaves that might not be working properly.

"If you take the vacuum autoclaves out of the equation, it would make a huge difference to the revenue costs."

Professor Bagg also explained that it is very difficult to prove that an infection is, or has been in the past, transmitted to patients in a dental setting. He said: "It's easy to see MRSA on a surgical ward because it presents in the form of post-operative infections. You do microbiological cultures, undertake typing of the organism, show commonality and you know you've got an outbreak. But with something like hepatitis C it could be 25 years before the patient develops symptoms and trying to pin the source of infection down to a single dental appointment is virtually impossible."



"They are a different breed probably from what, looking around the table, we were"
Charles Ormond

"I know that when rotary endodontics first came up, I spent hours in the lab playing around with blocks and extracted teeth, and learned how to do it"
Professor Bill Saunders

Andrew Lamb then asked if the focus on vCJD that followed the Glennie technical requirements has made things more difficult for decontamination to gain full acceptance amongst the profession.

Professor Bagg said: "The Government hadn't taken any serious interest in instrument decontamination since the Nuffield review in 1959. Concerns were raised with the emergence of prion diseases and suddenly a transition to gold standard procedures was expected in a short period of time."

He explained that he had hoped that revised decontamination procedures would have been introduced more gradually over a longer period of time: "By dealing with some of the straightforward issues, it didn't need to cost a lot of money to get us to a quality standard where we could say to the public that we are confident they can go to the dentist safely.

"Yes it is always great to be gold standard, but if risk-benefit analysis is considered, I think the acceptable standard is actually slightly below what some of the authorities are suggesting we aspire to." ■

With thanks to Dental Protection Ltd and the Apex Waterloo Place Hotel, in Edinburgh.

As the deadline for paying GDC fees for DCPs approaches, Hew Mathewson, former President of the GDC, looks at how the registration scheme is performing

Tick talk

The requirement for dental care professionals (DCPs) to be registered with the General Dental Council (GDC) is still only a recent introduction and, as the deadline for paying the annual retention fee approaches, it is a good time to look at the mechanics of the scheme and the benefits of registration as well as some of the difficulties that can arise.

One of the key questions general practitioners face is whether to pay the £96 fee on behalf of their employees. While it isn't a huge sum of money, we are in a difficult economic climate, with many private practices less busy than they would like and many NHS practices finding patients somewhat reluctant to sign up for some of the more expensive courses of treatment. Add to that the fact that practitioners haven't had a significant pay rise for a number of years – and that this year's pay rise has to be paid for with efficiency savings – and it is easy to see that it is an outgoing even small practices with just three or four registrants will want to consider carefully.

The matter is generally settled for those in the salaried services or those working directly for the NHS or in a dental school, as they pay the retention fee themselves and are responsible for ensuring it is done. For the rest, I believe a slight majority of employers do currently pick up this bill, many understandably requiring their employees – be they nurses, hygienists, therapists, technicians or orthodontic therapists – to undertake to pay back the appropriate proportion of the fee if they leave within 12 months.

"One of the key questions is whether to pay the £96 fee on behalf of their employees"
Hew Mathewson

Whatever your decision, those practitioners who don't pay their employees' retention fee must remember that they are still responsible for making sure that this has been done and that their registration remains 'live'.

It is a responsibility that stretches beyond the practice boundaries too. Dentists need to check, for example, that those people who are contracted to supply them with laboratory work are also registered. And the same goes for work that is sent abroad, especially if it is to a country outside the EU. The GDC has issued guidelines for this and dentists need to make sure they follow those guide-

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lines carefully and are fully aware of the implications. While you may have done the groundwork when the requirement first came into being a few years ago, these are checks that need to be carried out on an ongoing basis.

Trainees, of course, don't need to be registered at all – but they do need to be 'in training'. This may seem obvious to most, but there have been cases where staff have been taken on in April and not enrolled in a course until September the following year, a full 18 months. While this may be financially beneficial to the practitioner, it is, sadly, not acceptable, as trainees must be enrolled as soon as is practical. Active, forward movement in the pursuit of learning is the key here.

To cope with any delays between appointment and the start of a course, my suggestion is that dentists commence the training of new staff immediately – with a formal induction to the practice or the premises. They should then be enrolled in the first suitable course and, in the meantime, advised to keep a logbook recording their day-to-day learning. In this way, if challenged, dentists can show that the individual was a student engaged in the learning process. Besides, all that note-taking will pay off when the trainee finally comes to sit his or her exams.

No practitioner who wants to stay in business would offer to pay the fees of the self-employed – but employment status can be riven with complications. One area of confusion that I come across regularly is the status of dental hygienists who are considered by the dentist – and who consider themselves – to be self-employed. They might work for two three practices, run a car on the business and be paid gross.

But be warned, unless that hygienist is sitting at home on Monday morning waiting for the phone to ring from any number of potential employers, Her Majesty's Revenue & Customs will consider them to be employed by each dentist they work for. The result? A hefty tax and National Insurance bill presented to each dentist in relation to their hygienist employee – whether or not that person has been paying tax. So unless, most unusually, you have a letter from the HMRC to the contrary, you should treat your regular hygienist as an employee.

More than half the money the GDC spends is in investigating and pursuing fitness-to-practice accusations against dentists

Any discussion of retention fees tends quickly to turn to the differential between the cost of registering as a DCP and that of registering as a dentist, currently standing at £438, and I want to take the opportunity to address this.

There is no question that the GDC tries its utmost to set the annual retention fee such that it reflects the costs of registering DCPs and dentists. Currently, more than half the money the GDC spends is in investigating and pursuing fitness-to-practice accusations against dentists. This is the biggest single reason for the fees being set as they are – dentists, it must be said, have an uncanny knack of getting themselves into trouble.

Generally, problems arise when dentists have done a less than satisfactory job and misled the patient about it. Less frequently, they may be subjected to fraud allegations against the NHS, or accusations they have sexually molested a patient. Often it is simply something silly they have done in their private lives.

"One area of confusion is the status of dental hygienists who are considered by the dentist – and who consider themselves – to be self-employed"
Hew Mathewson

It was thought when we registered the approximately 65,000 DCPs that they would get into trouble at about the same rate as dentists – the idea being to adjust the fee as time went on – but this simply hasn't happened. While a few are getting in trouble, often for making false declarations at first registration, or not admitting to criminal convictions on reregistration, the rate is well below that of dentists.

I hesitate to speculate on why this is the case, and instead point out what is known: that once a dentist is in some kind of trouble, a great many of them fail to seek help until it is too late, thus damaging their own case. Dentists have 21 days to reply to an accusation, but many frequently don't pick up the phone to their protection agency, the Medical and Dental Defence Union of Scotland, (MDDUS) until day 20 – it should, of course, have been done on day one.

This very common occurrence perhaps has something to do with the personal nature of the job – dentists are, after all, working intimately with people they have often come to know well, and to have this work criticised is a very personal thing. I believe many dentists, when faced with such criticism, are deeply upset and, quite wrongly as it happens, ashamed to share the details with a peer, even if that peer is paid to help – but, believe me, the MDDUS's advisers have heard it all.

So dentists would do well to remember, should disaster loom or an allegation be made – however unreasonable or seemingly ridiculous – that contacting a professional adviser from the start will ultimately be in their best interest. The MDDUS is there to help, not hinder, you – and there is surely no worse start to defending a complaint than to be chased up over it.

Of course, it would be better all round if dentists stayed out of trouble altogether and, as part of this series of articles, I will in future issues be highlighting the 10 key things dentists should avoid in order to stay trouble-free – so watch this space. ■

Hew Mathewson is a general practitioner in Edinburgh, a special adviser to the MDDUS and a former President of the General Dental Council

Ian Wilson's remarkable training clinic and charity in Africa is bringing much-needed dental care to some of the continent's poorest people, writes Richard Goslan

The waiting room

By his own admission, Ian Wilson didn't stand out from his fellow graduates in the class of '87, the year he qualified in dentistry from Edinburgh University.

"I'm an ordinary guy, I wasn't the best in my class, I wasn't a high flier," he said.

But what he has gone on to achieve in the profession can only be described as extraordinary.

That's because after working for about five years as a dental associate at a number of NHS practices in the UK, Ian travelled to Africa, where his eyes were opened to the impact he could have using his skills in the developing world.

Initially, he volunteered with a Christian mission organisation called Mercy Ships, which takes crews of volunteers to different ports to provide expertise in various fields, including medicine, sanitation, agriculture – and dentistry.

"That was a great opportunity to see what impact I could make personally into the lives of people in the developing world," said Ian. "That was how the ball got rolling."

Over the next 10 years, Ian volunteered for dentistry projects across Africa, including Nigeria, Togo, Ghana, the Ivory Coast and Kenya, but on his return to the UK, he found himself left with a niggling question mark about the long-term impact his work was having.

"I was wondering what difference at the grassroots level I was making on these communities," he said. "My photographs looked good, I was

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"My photographs looked good, I was coming back with great stories, I'd taken a load of teeth out and done some fillings, but what was going on after I'd left? Invariably I'd always feel there was bit of a vacuum"

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coming back with great stories, I'd taken a load of teeth out and done some fillings, but what was going on after I'd left? Invariably I'd always feel there was bit of a vacuum, but I wasn't sure how to do anything about that."

Ian's answer came in a chance encounter with a woman called Andie, who was working on a project to help vulnerable people in rural Tanzania. A year-and-a-half later, they were married and had a shared vision to set up a sustainable charitable project in that country.

"We had relationships here, friendships and good relations with the government in Tanzania, so in 2002 we came back out to establish a new dental clinic for another non-governmental organisation. It was run on a commercial basis, but had the opportunity to reinvest the profits into the local community," said Ian.

"For the first two years of our contract we did that, but in 2004 we felt that it was better and more productive, in terms of our work with the government and our work with the poor, to develop our own charity. So in 2004, we established Bridge2Aid (B2A) Tanzania and also the Hope Dental Centre, which is the hub of our operations here."

Ian and Andie set up the Hope Dental Centre in Mwanza, the second-largest city in Tanzania, which sits on the southern shore of Lake Victoria.

"This is probably the best clinical facility I've ever worked in, thanks to the generosity of the dental trade and the profession"

Below: Ian and his Hope Dental Centre team are training local dentists and providing essential treatment for communities

"This is probably the best clinical facility I've ever worked in, thanks to the generosity of the dental trade and the profession, which have donated materials and equipment," said Ian. "We've also had great support from our team, including Mark Topley and his wife Jo, who have been with us since 2005."

All of the profits go towards funding their Bridge2Aid charity's projects in both providing dental care to those who either can't afford it or normally don't have access to it, as well as to other community development projects.

Ian explained: "We are committed to helping the Maskini community, who are regarded as the 'untouchables' of society here, because they may have been affected by leprosy and have some form of physical disability. We've been involved in changing the infrastructure, or even the accommodation, where the Maskini have been living."

The Hope Dental Centre also provides the training base for Tanzanian clinical officers who can take their skills to the rural areas of the country, where three quarters of the population live, but where they have no access to any form of dentistry, or even pain relief.

"All they need is someone who is trained to take their tooth out and get them out of pain," said Ian. "Not fillings, not expensive stuff that needs expensive equipment, just simple emergency pain relief.

"You and I take it for granted that if we have an emergency, we'll get an appointment either that day or within the next two or three days. Here in Africa, most people don't have a phone, they don't know where the dentist is, they don't know what their duties are, and they can end up on a journey of maybe two or three days to find a dentist who can just get them out of pain."

For training, Bridge2Aid relies on volunteer dentists travelling to Tanzania as part of the charity's Dental Volunteer Programme (DVP).

"Taking part in a DVP is a life-changing experience," said Ian. "For two weeks – even if it's only two weeks out of your entire career – you can go and train somebody. That person will always remember where you came from and that you learned their name and you trained them to help their community – you can't put a value on that."

Bridge2Aid has trained more than 120 clinical officers in the region. If you consider how many people they then have the potential of providing emergency dentistry to, the numbers are remarkable.

Ian said: "You can't compare

the figures for the UK and the developing world. In the UK, there might be one dentist for every 1,500-2,000 people. In the developing nations of Africa, that ratio is more likely to be one dentist for every 350,000 to 400,000 people.

"The local clinical officers who have attended the training programme can then provide better care for their own communities. Conservatively, that has provided access to dental treatment for somewhere in the realms of 1.5 million people in rural Tanzania."

Volunteer dentists from the UK pay their own way to Mwanza, and spend six full days working one-to-one with local clinical officers in a rural village environment, although with the weekend free there is always the chance to go on safari nearby.

"The teaching is intensive, but the volunteers are not just here to pull teeth out – they are training people so that when they get back on the plane to go home, they are leaving an investment, sharing their own skills with another clinician in the developing world," said Ian.

The difference between simply throwing money at a problem and sharing your expertise is huge, he added.

"It's a valid criticism of charities that they can end up throwing money into a black hole. People rightly want to know that if they give money to charity it's being used well.

"The programme has answered my questions about leaving a vacuum and we've already seen the impact the training has had on the standard and availability of dentistry here."

Ian's goal is to reach a point where the Hope Dental Centre and Bridge2Aid are staffed and run entirely by locals.

"Ultimately we're building a team which one day will carry on the work, without me being here, because I'm not here for ever," he said.

"You can't talk about sustainability unless one day you're willing to hand over to the Tanzanian team and we're in that process."

Despite all his other responsibilities, Ian makes sure he still spends three days a week doing dentistry. The rest of his time goes into developing and promoting the charity's work, and raising awareness of the impact people can make by getting involved.

"I want to be able to look back in 20 or 30 years' time and have the reunion, see how a small idea mushroomed and people took it on board in their own way, with their own style, and maybe developed a programme which is bigger than what I'm doing," he reflected.

"That would allow me to sit back and think 'my goodness, I made a difference'." ■

For more information, visit www.bridge2aid.org and www.hopedentalcentre.com, go to www.facebook.com/bridge2aid

The adventure begins

There are many decisions to make when first embarking on a dental career, but one of the most vital involves choosing the best indemnity, says Dental Protection

By the time you read this article, more than 120 newly qualified dentists will have passed their final examinations in Scottish dental schools. The graduating dentists will have celebrated the results in time honoured fashion, accepted the congratulations and good wishes of family and friends and enjoyed the graduation ceremonials and the celebratory lunches and dinners. Dental Protection offers them a warm welcome to the profession and wishes them all every success in the future!

Part and parcel of the process of moving from student life to being a registered dentist are the many decisions which have to be made and which can have a big impact on a future career. It starts with choosing an area to work and going for interviews as part of the Vocational Dental Practitioner Training Scheme or GPT Scheme. Then there is wondering how you got on at interview, the excitement of getting that first job, meeting the practice owner and staff at the new practice, arranging accommodation or transport, and organising a well-earned holiday before starting "real" work. It's an exciting time so enjoy the experience.

Before starting in practice there are two essential things that must be done:

- Ensuring that registration with the GDC has been completed and that your name is on the Dentists Register
- Ensuring that indemnity is in place before starting in practice.

Choosing an indemnity provider is particularly important and deciding to join Dental Protection is a decision that every dentist can make with confidence. Dental Protection is the largest of the UK indemnity organisations and provides access to the knowledge and experience of the largest team of dento-legal advisers in the world, let alone the UK. It can draw upon its wide international experience to provide local support through its office in Edinburgh or (if you are moving south) its two other UK offices.

If you are venturing further afield, we even have offices as far away as Australia and New Zealand. Staffed by experienced dento-legal advisers, you can be assured of accessing advice, assistance and support in those early days in practice.

The journey continues

Dental Protection has members throughout Scotland and the Edinburgh office provides access to effective local advisory and support services. We are very much aware of the pressures on dental practitioners and we strive to provide a high-quality and accessible service for our members as part of our commitment to the dental team.

Fairness is an underlying principle running throughout Dental Protection and nowhere is this more obvious than in our subscription rates. Because of the lower levels of claims for compensation in Scotland and fewer complaints to the GDC, Dental Protection has been able to hold the same subscription rates for 2010 as for 2009. A comparison of subscription rates confirms that Dental Protection offers the most competitive subscription with no "tie in" for any period of time.

"Choosing an indemnity provider is particularly important and deciding to join Dental Protection is a decision that every dentist can make with confidence"

One important development introduced by Dental Protection in 2009 was DPLXtra which is a practice-based package providing access to a range of advisory and support services for all members of the dental team. Not only do members benefit from reduced subscriptions, but practice managers can access information about employment issues, both online and by telephone from Croner Consulting. This package has proved very popular with all members of the dental team.

Our next flagship event, in Edinburgh on 9 November, is intended to improve your understanding of what happens when a complaint is made to the GDC, the stages in the process and the preparation for a hearing and the possible outcomes. We are all aware of the increasing numbers of complaints to GDC, so this event will provide invaluable insight and guidance on how to avoid the pitfalls which might lead to a complaint.

Membership of Dental Protection is available to all members of the dental team, including dentists and DCPs. If you are not already benefiting from the services provided by Dental Protection use the contacts below to find out more. ■

Dental Protection Membership Department T: 0845 718 7187
E: membership@mps.org.uk

THE EDUCATIONAL ROUTE

We are very conscious of the needs of our Scottish members and during the last twelve months Dental Protection has held a number of events at various locations throughout Scotland.

The next flagship event has been organised in association with the British Dental Association, in Edinburgh on Friday 9 November at the Assembly Hall in Edinburgh. We will take a "behind the scenes" look at the Fitness to Practice process when a complaint is made to the GDC. Speakers include:

- Alison Lockyer, chair of the GDC
- Jason Leitch, chair of Conduct and Health Committee, GDC
- Philip Blakebrough, head of Fitness to Practice, GDC
- John Gibson, member of the Fitness to Practice Panel
- Chris Morris, Hempsons Solicitors
- Stephen Henderson, dento-legal adviser.

For more information, go to www.dentalprotection.org/uk/newsandevents

Anas Sarwar talks about his transition from the treatment room as an NHS dentist to walking the corridors of power in Westminster as the MP for Central Glasgow – a role for which he has big ambitions

A question of politics

PHOTOGRAPHY BY MIKE WILKINSON

A career in politics might not seem like the logical next step for a newly qualified NHS dentist. But after spending time with new Glasgow Central MP Anas Sarwar, the motivation for going into both professions is obvious.

Glasgow-born Sarwar is only 27, and one of the youngest MPs to be elected to the Westminster Parliament in May.

But, despite his relative youth, he is a seasoned political campaigner, having spent his mid-to-late teens on the hustings alongside his father Mohammad Sarwar, the first Muslim MP in Britain.

Despite some rough times for his father during his own political career, Anas wasn't put off from becoming part of the political process. And many hours spent knocking on doors and communicating with people from all cultures and backgrounds have given Sarwar a strong desire to make a difference in peoples' lives.

Educated at Hutcheson's Grammar near his Pollokshields home, he joined the local Labour party at the age of 16, with a keen sense of social justice at the forefront of his reasons for doing so.

After leaving school, he enrolled in dentistry at Glasgow University in 2000, citing a family friend as one of the guiding influences in that decision.

Anas said: "I had some good role models as a young man and one of those was a friend of the family – who happened to be a dentist. I've always been drawn towards public service, and I saw dentistry as a part of that. I liked the idea of working with people. I've always thought of myself as a people person and enjoy the interaction that comes with being a dentist.

"It's nice to be able to put someone at ease who is a bit nervous about treatment – it was one of the things that I really enjoyed about being in general practice, seeing a patient from consultation to treatment and being able to see, not only a change from a dental perspective, but also their personal confidence to undergo treatment in the future."

His formal training took place at Glasgow Dental School on Sauchiehall Street in the centre of Glasgow. Following graduation in 2005, Anas's first and only practice was Bidwell and Associates in Paisley – where he worked until 2009.

Despite positive experiences of the education process, as a politician, Anas is acutely aware of the challenges facing establishments as budgets come under increasing pressure.

He said: "My training was good. But, I think the people involved there now would point to big changes in the money available to them and drops in staffing levels. I think that's a great shame and the challenge, in the current economic climate, is how to continue to invest in dentistry, especially when you consider there is a shortage of NHS dentists across the UK. One of the ways to overcome that is to invest in dental hospitals and dental practices."

Despite no longer working in the industry, he retains a keen interest in

issues affecting the profession – hardly surprising when you consider his wife Furheen is still a practising NHS dentist.

Anas however, doesn't see the jobs of dentist and politician being fundamentally different: "I've always been passionate about the political process. I firmly believe in the principals of social justice and equality, regardless of age, race or social background. And the only way to affect change is to be a part of the political process.

"Inside dentistry, many of the things that I am passionate about are evident. For example, access to adequate health care, of which dentistry is a huge part, is something that should be available to all – no matter what your income or background is. Access to work, education, healthcare – and to dentistry – these are the things I believe everyone should have the opportunity to enjoy."

Anas Sarwar is one of two dentists at Westminster, the other being Sir Paul Beresford, who has been elected as the chair of the all-party parliamentary group (APPG) for dentistry.

So, as a dentist himself, the question inevitably arises of the possibility of a secretarial or ministerial brief at some time in this area. Would the MP for Glasgow Central like to wield some influence over the future of dentistry in the UK if he got the chance?

"I'll always take a natural interest in this subject, but I didn't go into politics with a single issue in mind. People ask me why I went into it at all when there is a shortage of dentists, but the answer is always the same, public service is where I think my future lies.

"The answer is always the same, public service is where I think my future lies"

"Obviously as my wife is still a dentist, so I am aware of the challenges facing the profession. Registration is one of course, and the other is access – particularly in rural areas.

"To address both, we have to invest in training and make sure that we have quality institutions, with more dentists coming through the system. We need to encourage graduates, and existing dentists to work in the NHS – and provide the incentives to do that. And we have to put incentives in place in rural areas where access to dentistry is a problem."

To campaign as part of his father's election team is one thing, but to be front of house is a completely different experience. It brings with it all the exposure – wanted and unwanted – public figures in the UK now

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take as par for the course.

It's a big challenge to meet the expectations the young MP has created. As one of the 232 new MPs at the last General Election, he knows he's taken on a very big responsibility – but it's one that he is relishing.

He said: "I've only been at Westminster for a few weeks and it is a steep learning curve. There is a lot to understand and you have to hit the ground running, so you have to pick things up as you go. At the moment I'm still getting my constituency office together and the people who will work with me, so it's very hectic and very exciting at the same time."

While he can, of course, always turn to his father for advice, Anas Sarwar is very much his own man: "My father is always there for me, but to be honest he never steered me in the direction of politics. Neither of my parents did. They were just supportive of me whatever I did, and happy for me if I was successful at it.

"At the end of the day, I'm a Glasgow boy, born and bred and it's a place I love. I wouldn't want to live anywhere else in the world. To get the chance to represent some of the people in this great city is an enormous privilege and something I am extremely proud of. I'm working my socks off to repay the trust people have put in me."

Politics is, of course, notoriously fickle. And in the ever-changing political landscape of the UK it's difficult to predict the next five or 10 years. So if it all ended tomorrow for Anas Sarwar MP, would he be ready to throw himself back into the rigours of general practice?

"As long as I am an MP I will give it my 100 per cent commitment, but if that was to change, I would have no hesitation in returning to dentistry. I think it offers a great career, and can be a rewarding one financially. But equally as important, it gives the opportunity to make a difference in someone's life." ■

One of the surgeries featuring the Takara Belmont Voyager II chair

Raja Mahesh was looking for the perfect solution to equip his new Glenrothes orthodontic practice. Here, he explains how it was done

'Built-in' ideas are a success

Setting up his new orthodontic practice in Glenrothes meant that Raja Mahesh needed to find suitable premises in a central location.

The orthodontist wanted a suitable base for his specialist orthodontic practice in the Fife new town, and after much searching, found the property in October 2009.

Mahesh, who was runner up in the 'Against the Odds' competition conducted by the British Orthodontic Society in 2009, said: "There were other premises, but none as centrally located as these. I paid a premium to the landlord to take the property off the market until my NHS grant application and bank loan were processed, and signed the lease in January."

After meeting with a number of dental practice fitters, and visiting other premises fitted out by them, Mahesh chose SAS Shopfitters to carry out the work on his new practice.

"The designs were drawn up by the architect, based on my own specifications, and SAS undertook the project to make it a reality. Dereck from SAS held several site meetings – at least twice a week, to go over the project and went out of his way to incorporate any alterations that I had thought of during the construction work. Collin, the site foreman and all the boys were brilliant – always keen to listen to my ideas and expectations and willing to undertake them readily.

"The practice passed its NHS inspection without a glitch"

Raja Mahesh

"The work was all completed within five weeks – on schedule, as promised – and the practice passed its NHS inspection without a glitch," he added.

Wright Cottrell provided all the dental equipment, including Takara Belmont Voyager II chairs, Dolby Medical equipped the LDU and the orthodontic computer software was provided by Do-IT.

Mahesh came to the UK from India in 1995, and worked for four years in various hospital posts in oral & maxillo-facial surgery and orthodontics.

He completed a Fellowship in Dental Surgery (FDSRCS Eng) before starting specialist training in orthodontics at the Edinburgh Dental institute and Victoria Hospital, Kirkcaldy in 2000. He obtained his MSc in Orthodontics in 2002, becoming the first person to achieve a distinction in the 10 years that the course had been offered by the University of Edinburgh.

A year later, he obtained Membership in Orthodontics (MOrth) from the Royal College of Surgeons of Edinburgh.

Mahesh worked in several specialist practices in the Lothians for five years, before setting up his own practices in Bathgate and Glenrothes. The Community Dental Service in Glenrothes helped out by renting him premises while he searched for his own.

He said: "We've set up a two-surgery practice on the ground floor, with a separate LDU, reception/waiting room and office. The store room, with compressor and suction units is isolated outside the surgery – thereby reducing noise in the surgery – and there's a staff room, x-ray/oral hygiene room, disabled toilet and a small lab.

"The entire practice has been designed on a 'built-in approach', whereby everything from the computer monitor to the wall cupboards have been built into the wall – helping to give the surgeries a nice, clean look. TV monitors have been mounted on the ceiling above the patient's head-rest, to enable the younger patients to relax during their treatment.

"The whole place is well lit, with daylight streaming through 16 windows. The windows also serve to carry the practice logos and photographs of beautiful smiles!"

Mahesh is assisted at M-Brace Orthodontics by practice manager Jan and orthodontic nurses Shirley and Lyndsey. They all welcomed MSP Tricia Marwick to the official opening of the practice, which took place on 22 June and was very well attended. ■

The reception area at M-Brace Orthodontics

In the second part of his article on anaesthetic injections, Bruce Hogan looks at risk factors and potential complications

No hard feelings

Trismus

When administering an IDB, the needle should be advanced slowly. If bone is contacted too firmly, a microscopic barb can be created at the end of the needle that then tears the tissue as the needle is withdrawn.

Haematoma

Patients taking warfarin are at particular risk of haematomas. There is anecdotal evidence of airway compromise as a result of massive deep haematomas in such patients.

In 2005, Brewer wrote an article on this subject and indicated that local

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"The National Patient Safety Agency gives a list of treatments where the INR does not need to be checked and a list of treatments where it should be checked. Local anaesthesia is on neither list!"

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anaesthesia was a procedure that required no check of INR prior to its administration. He made no distinction between infiltration and block anaesthesia. However, Perry and colleagues in 2007 described both infiltration and block anaesthesia as potentially invasive along with treatments such as extraction. They advised an INR check of less than 3.0 before performing an IDB and advised that the IDB be given cautiously with an aspirating syringe.

The latest poster guidance from the National Patient Safety Agency (2009) gives a list of treatments where the INR does not need to be checked and a list of treatments where it should be checked as less than 4.0 within 72 hours beforehand. Local anaesthesia is on neither list! However, on the poster's flow chart, there are recommendations that for those treatments where the INR needs to be checked, the local anaesthetic used should contain a vasoconstrictor; that, where possible, an infiltration, intraligamentary or mental block should be given and an IDB should only be given if there is no alternative and should be administered slowly using an aspirating technique.

This all leaves me unsure as to whether routine restorative dentistry under IDB anaesthesia does or does not require a pre-op check of the INR. Could someone reading this article please advise?

Overdose

Given that roughly 5 to 7.5 cartridges of the commonly available dental local anaesthetic agents can be given safely to a healthy adult, overdose by this mechanism should be very rare indeed. Care should be taken in patients with chronic cardiac, renal or hepatic disease and in children where the maximum doses should be halved.

"Systemic toxicity is much more likely to occur as a result of a rapid intravenous/intravascular injection"

Systemic toxicity is much more likely to occur as a result of a rapid intravenous/intravascular injection, especially of a local anaesthetic containing adrenaline. The patient tends to turn very pale, feels anxious and nauseous and is aware of an unpleasant tachycardia. This can be a stressful experience for both the dentist and the patient. It is important that the patient is not labelled 'allergic' to local anaesthetic as a result of an intravascular injection. Prevention of this problem should be possible by using an aspirating syringe, advancing the needle through the tissues slowly and by injecting slowly. My experience is that the Astra aspirating syringe used with the so-called self-aspirating anaesthetic cartridges is the best

aspirating system. Forced into an alternative when there was an acute shortage of local anaesthetic a few years ago, I have found that the genuine Aspiject syringe used with conventional cartridges is also very good. I find other 'own-brand' copies of this syringe are unreliable in my hands.

If a positive aspirate does occur (and it is usually but not exclusively with an IDB), then it is clearly necessary to move the tip of the needle until aspiration is negative before injecting. Sometimes the vessel moves with the needle initially and so it may be necessary to move the needle a fair distance before aspiration is negative. Repeated positive aspirates result in a band of pink solution at the top of the cartridge which can then make it impossible to decide on whether the ensuing aspirates are positive or negative. In this situation, it may be necessary to switch to a new cartridge and start again, especially if treating a medically compromised patient.

Unfortunately, it is possible to get a false negative aspirate and produce an overdose reaction despite good technique. This is probably because the lumen of the needle is apposed to the wall of the vessel. For this reason, and given that dentistry is hard enough without unexpected medical emergencies, I now routinely use a non-adrenaline containing local anaesthetic agent for my IDBs. Until I could no longer get supplies of it, I used 'Citanest' with felypressin. Now I use 3 per cent plain mepivacaine ('Scandonest'). This has a low pKa which should theoretically facilitate entry into nerve cells, and the lack of vasoconstrictor should result in a more rapid resolution of lip and tongue numbness, especially useful in children. I have never experienced any problems associated with inadequate duration of anaesthesia of this agent. Inadvertent intravascular injection of this agent appears to give no problems other than failure of anaesthesia.

"It is possible to get a false negative aspirate and produce an overdose reaction despite good technique"

Consideration should be given to avoiding an adrenaline-containing local anaesthetic on patients with unstable angina, uncontrolled arrhythmias or a recent (less than one month) history of myocardial infarction.

Drug interactions

These almost always occur at the higher end of the maximum allowable local anaesthetic doses and there is unlikely to be a problem as long as no more than two cartridges are used. It has recently been recommended that a drug history be taken at the beginning of each patient visit.

At the doses used in dentistry, it is unlikely that the local anaesthetic agent itself will cause a drug interaction. Rather, it is the adrenaline component that has to be considered. (There is no documentation of felypressin interacting with other drugs). Additionally, systemic absorption of adrenaline and thus a drug interaction is very limited unless an intravas-

Continued »

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cular injection occurs.

Cognisance is required if a patient is taking one of the following: non-selective beta-blockers – e.g. propranolol, sotalol, nadolol (can cause unchecked alpha effects including life-threatening rise in blood pressure); non-potassium sparing diuretics – e.g. furosemide, bendroflumethiazide (can cause hypokalaemia and arrhythmias); tricyclic antidepressants – e.g. amitriptyline, imipramine (can cause adrenaline toxicity); atomoxetine used to treat ADHD (similar risks to tricyclics); dopaminergics – e.g. entacapone (can cause adrenaline toxicity); serotonin and noradrenaline reuptake inhibitors – e.g. duloxetine, venlafaxine and phenothiazines – e.g. chlorpromazine (may produce severe prolonged hypotension or hypertension). An adrenaline-containing local anaesthetic should not be used in a patient who has taken a drug with sympathomimetic properties – e.g. cocaine, cannabis, amphetamines within the last 24 hours.

Needle fracture

A recent article in *Dental Update* shows that this is more than a theoretical consideration even in the modern era of disposable needles. Fracture usually occurs at the hub of a narrow/30 gauge needle. Prevention of this problem includes making sure the injection is administered painlessly so that there is no risk of sudden patient movement. One should avoid repeated use of the same needle; avoid pre-bending the needle; always withdraw a needle along its long axis; only move a needle medially or laterally within the tissue if its tip is just below the surface and never insert a needle right up to its hub. This suggests that a short needle should not be used for an IDB. A haemostat should always be handy at the chairside just in case a needle ever fractures.

Allergy

Allergy to modern amide dental local anaesthetic agents is extremely rare. The most likely allergen is the metabisulphite antioxidant preservative agent which is only required in vasoconstrictor-containing anaesthetics. Thus, in an emergency, a plain local anaesthetic can be given.

Many patients who say they are allergic to local anaesthetic give a history that suggests a previous intravascular injection. Past reports to the CSM suggestive of genuine allergy have included facial swelling, breathlessness and skin rash. Patients giving this sort of history should be referred for patch testing or equivalent. For patients who are latex allergic, it is now possible to get latex-free local anaesthetic cartridges (e.g. Septanest and Citanest).

Some patients appear to be supersensitive to the adrenaline component of dental local anaesthetics and experience prolonged tachycardia in response to these drugs even when there has been no apparent intravascular injection. A plain local anaesthetic should be used in such patients.

Intra-arterial injection

This is less common than an intravenous injection and can usually be avoided by moving the needle if undue resistance to injection is felt and by injecting slowly. Intra-arterial injection may produce discomfort and a localised area of skin blanching. In its more extreme form, it may cause visual disturbances, hearing disturbances and hemiparesis of the body.

Osteonecrosis

An adrenaline-containing local anaesthetic should not be used on a patient who has received head and neck radiotherapy due to the risk of osteoradionecrosis.

Recently it has been suggested that an adrenaline-containing local anaesthetic should not be used by the intraligamentary route in a patient who has received bisphosphonates. The latest Greater Glasgow and Clyde bisphosphonate protocol does not make mention of this, although this is a rapidly evolving area.

"An adrenaline-containing local anaesthetic should not be used on a patient who has received head and neck radiotherapy"

Prolonged impairment of sensation

This is more likely to affect the lingual nerve than the inferior alveolar nerve possibly due to structural differences between the two. I am not aware of other branches of the trigeminal nerve being disrupted by dental local anaesthetics (e.g. mental nerve).

Prolonged impairment of sensation is more likely the more concentrated the anaesthetic agent. Thus, the risk is about 1 in 1.2 million injections for two per cent and three per cent solutions and one in 400,000 injections for

four per cent solutions. As articaine is supplied as a four per cent solution, and as there is no evidence that articaine is superior to other solutions when it comes to block injections, articaine should not be used for an IDB.

Aside from neurotoxicity of the anaesthetic agent, nerve damage can also arise from direct needle trauma. If significant resistance is felt during injection, the needle should be moved until normal resistance is felt. Similarly, if a patient feels an 'electric shock' sensation during an injection, the needle should be moved slightly before continuing. A note should be made of this occurrence in the clinical records. Having said that, only 15 per cent of patients who experience an electric shock sensation subsequently suffer prolonged impairment and 57 per cent of patients suffering from prolonged impairment had no

"Only 15 per cent of patients who experience an electric shock sensation suffer prolonged impairment"

'electric shock'. About 80 per cent of cases of prolonged impairment of sensation resolve within two weeks and almost all resolve within eight weeks. Impairment beyond eight weeks is likely to be permanent.

It has been estimated that every dentist, during a career, will have at least one patient who experiences permanent nerve damage following an IDB and that there is no way to prevent it happening or to treat it if it does.

Needlestick injury

The reader is referred to other texts for this important issue. Written protocols are essential and consideration should be given to needle guards, Ultra Safety Plus syringes and the dentist having sole responsibility for assembling and dismantling the syringe.

Cardiac patients

An adrenaline-containing local anaesthetic should not be used on a patient with unstable angina, an uncontrolled arrhythmia or with a history of a myocardial infarction within the last month.

Medicolegal considerations

The gold standard for record keeping as it relates to use of local anaesthetic should include the following:

- Site/ sites of injections
- Type of injection – infiltration/block etc
- Agent used and concentration
- Quantity used – ml or number/concentration of cartridge(s)

Batch number

- Record any difficulties and how they were managed
- Record if local anaesthetic not used

When referring a patient to a hygienist, a clear prescription should be provided for any local anaesthetic to be used and this should be signed by the dentist. ■

Acknowledgements:
The author would like to thank Lesley Smith for her advice on bisphosphonates and Andrew Hadden for his help with medicolegal considerations.

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Minimise risks

Management of patients receiving bisphosphonates by Stephen Jacobs

A current hot topic in general dentistry and, in particular, any type of surgical dentistry, including simple extractions, is in the management and care of patients who are undergoing therapy with a group of drugs called bisphosphonates.

Bisphosphonates are a drug group that can be immensely beneficial to patients with osteoporosis and many other serious medical problems. However, it has become apparent that certain dental treatments, including extractions, implant surgery and any form of dento-alveolar surgery, can be more risky in these patients where a type of osteonecrosis may ensue.

Bisphosphonate osteonecrosis of the jaw, or BON as it is commonly known, is a severe osteonecrosis that is painful, debilitating and virtually untreatable. Dentists must know and understand how to minimise these risks.

As someone who has seen a case of BON and heard about many others, including seeing photographs, from colleagues in their work in maxillo-facial units, believe me, it is something that I hope all my colleagues in practice never have to deal with.

The problem is that many of our medical colleagues, especially general practitioners, are not fully aware of the issue and, to make matters worse, bisphosphonates are being much more commonly prescribed.

For example, in my referral practice, I do not go more than a week or two without seeing a female patient, referred for implants, who is on alendronic acid, and, literally millions of women in the United States are on 'Fosamax'.

When I do speak with a patient's medical practitioner about this, they are usually very interested and grateful that I have alerted them to the issue and ask me for further information.

The Association of Dental Implantology (ADI) recently commissioned a white paper from Professor Jon Suzuki in the United States for distribution to our members and publication on the ADI website. Below is the guidance found within our paper.

Guidance

- Patients on intravenous (IV) bisphosphonates are at the highest risk of developing bisphosphonate - associated osteonecrosis (BON), particularly if they have been receiving IV treatment for more than six months. Elective dental implant treatment cannot be recommended for these patients. If treatment is required, this should be undertaken in a hospital environment with intravenous antibiotic therapy and full aseptic technique being considered as appropriate.
- Patients on IV bisphosphonates for less than six months should be at low risk of developing problems in relation to non-surgical periodontal and restorative care. However, surgical treatment, e.g. extractions, should only be undertaken if absolutely necessary and should be approached cautiously and conservatively. If possible, a single intervention should be undertaken and an interval of two months left to verify acceptable healing before considering further surgical intervention.
- Patients on oral bisphosphonates treatment for three years or less probably have only a slightly increased risk of developing BON. As such, elective dental therapies including extractions and dental implants are not contraindicated. The patient should, however, be informed of the risk and appropriate consent obtained.
- Patients on oral bisphosphonates treatment for more than three years are at an increased risk of developing BON and this risk may increase with the duration of bisphosphonates therapy and other co-factors such as smoking. Therefore, surgical treatment, e.g. extractions, should be approached extremely cautiously and conservatively. If possible, a single intervention should be undertaken and an interval of two months left to verify acceptable healing before considering further surgical intervention.
- All patients on bisphosphonates treatment should rinse for one minute using a chlorohexidine aqueous solution 0.2% prior to dental treatment and to continue rinsing twice daily for 14 days after treatment.
- All patients on bisphosphonates treatment should be prescribed systemic antibiotics for one to two days prior to any dental procedures which involve trauma to bone, e.g. extractions, implant placement and periodontal surgery.
- All patients on bisphosphonates treatment should be encouraged to attend for regular dental assessment and maintenance. The importance of ensuring a high standard of oral hygiene and good diet should be emphasised to reduce the need for possible future dental surgical intervention. Patients who smoke should also be encouraged to cease.

Final thoughts

Some patients receive IV bisphosphonates as infrequently as twice yearly and often forget to reveal this in their routine medical history questionnaire. Dental practitioners should be aware of this factor and be very careful when verbally confirming the medical status of the patient.

Further, there is no evidence in the literature that ceasing drug therapy or taking a 'drug holiday' reduces the risks of BON, due to the extremely long half-life of these drugs.

Therefore, the education of our patients, together with their medical practitioners, is of paramount importance. In many cases, courses of dental treatment, including extractions, implant treatment and periodontal surgery, can be carried out prior to the commencement of drug therapy, or before the critical time of taking the drugs has elapsed. ■

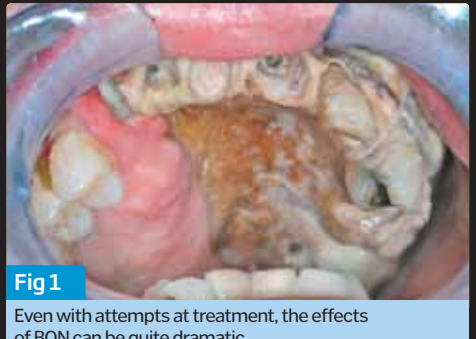


Fig 1
Even with attempts at treatment, the effects of BON can be quite dramatic

Photographs courtesy of Robert Dyas

Fig 2
BON following upper molar extraction

Eliminating risk factors

Managing aggressive periodontitis can be difficult and in some cases impossible but, like the chronic form of the disease, tackling the causes and arresting progression is the best approach, writes Alan Maxwell

Aggressive periodontitis is a rapidly destructive but less common form of periodontitis than chronic periodontitis (Fig 1). The aetiology is multifactorial including:

- The constituents and virulence of microbial plaque
- Host defence defects
- Genetic elements

A new classification system for periodontal diseases was published in *Annals of Periodontology* in 1999 and designated a localised and a generalised form which replace earlier classifications which placed too much emphasis on age presentation. Instead, the focus is on:

- Clinical findings
- Radiographic findings
- Historical findings
- Laboratory findings

Clinical signs and symptoms

There is no direct correlation between the amount of bacterial deposit and severity of destruction. Likewise, disease progression is not linear and attachment or bone loss may spontaneously accelerate or slow down. The tissues may look relatively normal or only mildly inflamed until periodontal examination or radiographs reveal the severity and extent of the problem. (Fig 2) In other cases the appearance can show obvious clinical evidence of the disease.

Localised aggressive periodontitis (formerly known as juvenile periodontitis)

This periodontal disease is often associated with the presence of Actinobacillusactinomycetemcomitans and with neutrophil dysfunction. Onset generally occurs around puberty and destruction is localised to permanent first molars and incisors. However, atypical forms of the disease do exist. Serum analysis shows evidence of an intense primary antibody response to bacterial infection.

Generalised aggressive periodontitis (formerly known as rapidly progressing periodontitis)

This form of periodontal disease usually occurs in subjects younger than 30 years of age. (Fig 3 and Fig 4) Proximal attachment losses occur during periods of disease activity and involve at least three permanent teeth, other than the first molars and incisors. A. actinomycetemcomitans and Porphyromonasgingivalis are frequently

involved. There is also evidence of abnormal neutrophil function. However, antibody response has been shown to be weak.

Treatment goals

Treatment aims at attenuating or eliminating microbial aetiologic factors as well as modifying predisposing risk factors. This helps in arresting disease progression and contributes to prevention of disease recurrence.

Management of aggressive periodontitis may be difficult or even impossible. This may be due to:

- Systemic factors
- Immune dysfunction
- Specific pathogenic flora

Treatment methods are the same as those used in chronic forms of periodontitis. In some cases, however, the main treatment goal is simply to limit the rate of disease progression.

Medical screening is some-

Continued »

Fig 1
Severe aggressive periodontitis in a 46-year-old patient

Fig 2
Moderate to severe periodontitis in a 41-year-old patient

Fig 3
Generalised aggressive periodontitis in a 24-year-old patient

Fig 4
24-year-old patient after oral hygiene instruction and further treatment

Continued »

times advised to rule out systemic disease; this is especially the case in younger patients presenting with advanced forms of periodontitis who respond poorly to periodontal treatment. In these cases the dentist should collaborate closely with the doctor. This may modify some of the environmental risk factors.

Conventional mechanical treatment alone does not usually allow for satisfactory control of disease progression. Adjunct antimicrobial therapy eventually followed by surgery is therefore indicated. Long-term results depend on patient compliance and an appropriately scheduled supportive therapy regimen.

Various antibiotic regimes have been supported in the literature (tetracycline 250mg four times a day for 14 days; doxycycline 200mg loading dose, then 100mg daily for 13 days), but the following has particular efficacy against A. actinomycetemcomitans: Metronidazole 200mg or 400mg and amoxicillin 250mg or 500mg three times a day for seven to 10 days

When deciduous teeth are involved, eruption of permanent teeth should be monitored to detect attachment loss. When there is evidence of familial predisposition to aggressive periodontitis screening of other family members is advised.

Conditions for success

Treatment of patients suffering from aggressive periodontitis should aim to:

- Reduce clinical signs of gingival inflammation
- Reduce probing depth
- Stabilise or gain clinical attachment
- Establish evidence of bone repair through radiographic evaluation
- Improve occlusal stability
- Reduce clinically detectable plaque to a level compatible with periodontal health

These conditions may not be attained if:

- Gingival inflammation persists
- Periodontal pockets persist or aggravate
- There is progressive loss of clinical attachment
- Tooth mobility increases

Severity and risk factors

Risk factors for aggressive periodontitis include excessive build-up of bacterial plaque, presence of specific bacterial strains or deleterious host response, tobacco use and systemic disease.

Severity is linked to these different parameters but as with chronic periodontitis, locally aggravating factors (dental, periodontal, functional or iatrogenic) are often involved.

Several factors may account for an altered host response:

- Neutrophil dysfunction
- HIV
- Smoking
- Diabetes
- Genetic predisposition
- Stress
- Hormonal imbalance
- Nutritional deficiency

The treatment goal is to reduce or eliminate risk factors. ■

Smoking is one of several factors that may account for an altered host response

ABOUT THE AUTHOR

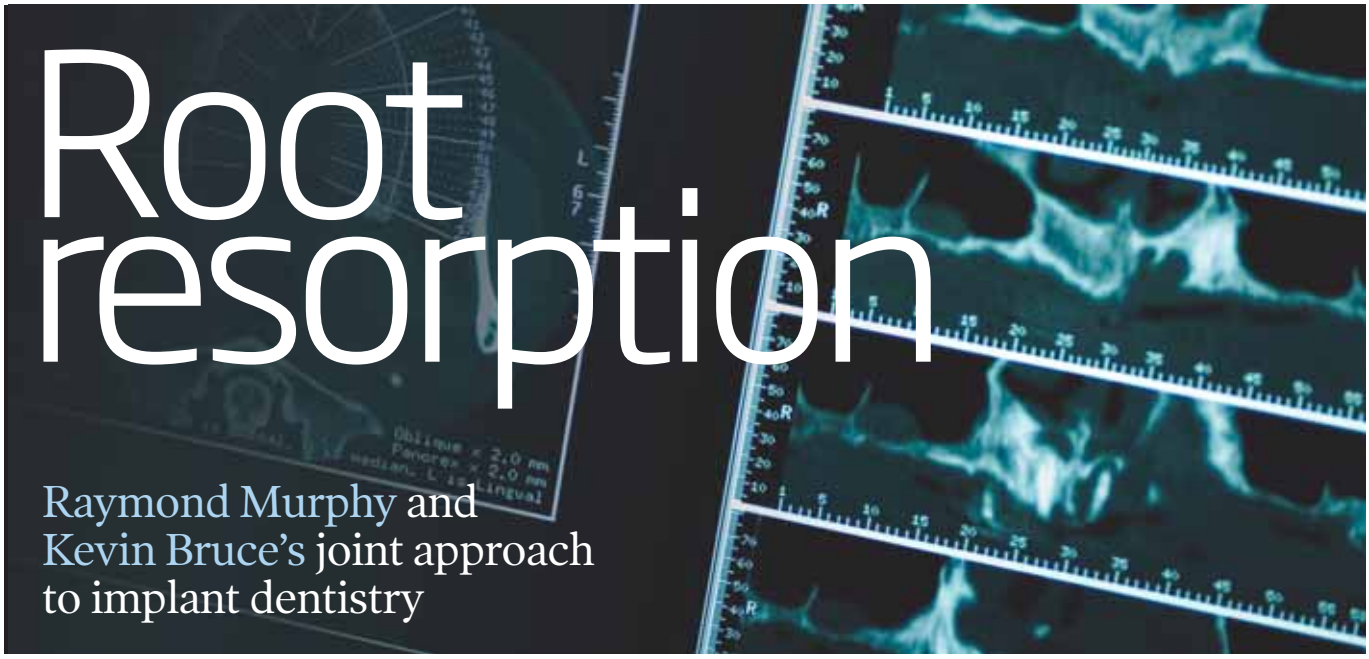
Dr Alan Maxwell MSc BDS MGDS RCS (Edin)

Alan is a specialist in periodontics. He graduated from the University of Glasgow Dental School in 1982 and subsequently obtained his MGDS from the Royal College of Surgeons in Edinburgh in 1990. After obtaining his MSc in periodontology in 1997 at the University of Bristol he was accepted onto the specialist register in periodontics in 2000.

Dr Maxwell now works full-time as a periodontal specialist undertaking all aspects of treatment within his field, with a major focus on regenerative therapy and cosmetic periodontal surgery. Part of that time is spent working for Care Dental Focus in Crieff (01764 655745).

He is a member of the British Society of Periodontology and has had his work published regularly in a number of leading dental journals. Alan also previously served as an examiner with the Royal College of Surgeons in Edinburgh and lectures to general dental practitioners on a regular basis. Alan would be glad to assess and treat any of your periodontal referrals.

Root resorption



Raymond Murphy and Kevin Bruce's joint approach to implant dentistry

A 21-year-old fit and healthy young male was referred by a colleague for assessment of a root-filled, symptomatic upper-right lateral incisor. The tooth had been traumatised and root filled about 10 years previously.

The patient had recently become aware of a bad taste from this area of his mouth. On examination, the tooth was noticeably discoloured, had pus discharging from the palatal margin but was firm to touch. (Figs 1 & 2). His dental health was otherwise unremarkable and his motivation for treatment was good.

A periapical radiograph was taken (Fig 3) which showed the presence of a radio-opaque root filling but no root structure. This has probably been due to the trauma resulting in external replacement root resorption. This is thought to take place as a result of direct bone contact to the root surface as the periodontal ligament necroses. The osteoclastic activity causes root resorption followed by osteoblastic activity and new bone formation. In this case, it has taken about 10 years to be significant. After discussing the options with the patient, he decided to proceed with an implant-borne restoration as a definitive treatment plan.

PROCEDURE


Fig 1


Fig 2

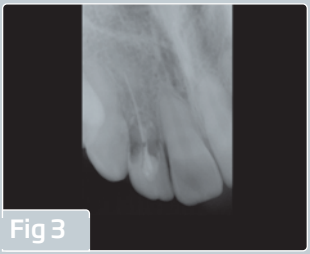


Fig 3


Fig 4


Fig 5


Fig 6


Fig 7


Fig 8

At this stage, I consulted my implant dentist, Kevin Bruce, on the likelihood of there being enough bone for implant placement without a grafting procedure. A decision was made to extract the tooth and directly assess the bone quantity and quality. On extraction of the tooth (Fig 4), the residual bone appeared to be of good quality, so much so that it was impossible to remove the apical portion of the root-filling material (Fig 5).

After a healing interval of six weeks, the implant was placed and the residual root filling material removed. A bone augmentation procedure was carried out, using bovine granules and a porcine membrane to restore the bone architecture, to achieve optimum aesthetic results with the final restoration. After a 12-week interval to allow osseointegration of the implant, the patient returned for the restorative procedure. Impressions were taken and the abutment and crown fitted two weeks later (Fig 6). The procedure took five months from initial appointment to finish and the patient was extremely satisfied with the outcome.

The challenges of implant treatment are many. For the patient, the smooth management of the treatment and the aesthetics are paramount. It is important that the pre-op interdental papillae appearance

"Too often, implants are placed in such a position that it can be difficult to restore"

(Fig 7) is created with the final restoration (Fig 8). Patients do not wish missing papillae, or 'black triangle disease' as it is known in the implant world.

At the Village Dental Surgery in Bothwell, I receive referrals from colleagues who are aware of the benefits of the service offered. At the initial appointment, I will discuss the patient's problem and offer a solution if possible. If special investigations such as CT scans are necessary, arrangements will be made to review the patient and offer a definitive treatment plan. At this stage, the patient will be made aware of the treatment cost and payment options available such as interest-free credit. Once the patient has decided to proceed with the treatment, an appointment will be arranged with my implant surgeon.

The advantages of working with Kevin are many. After graduation, he trained for five years in oral and maxillofacial surgery in both civilian/armed forces units where, as part of a multidisciplinary team, he treated everything from wisdom teeth to advanced trauma cases. His knowledge of anatomy and bone/soft tissue management ensures that the implants are placed perfectly for me to restore with the optimum functional and aesthetic outcome.

Our approach is a restorative-driven one where the final restoration is envisaged and the implants placed to allow this to happen. This can involve CT scans and full-mouth diagnostic wax-ups. Too often, implants are placed in such a position that it can be difficult, if not impossible, to restore satisfactorily.

Over the last three years, I have introduced implant dentistry to my practice. I have attended courses, scientific meetings and study groups to increase my knowledge. Mentoring with an experienced colleague is also important. I would recommend a hands-on introduction to implant dentistry supplemented by continuous learning if you wish to offer an implant service to your patients. Technical back-up from your implant company and laboratory are also important in this ever-advancing field of dentistry. ■

If you have any questions on this article, feel free to contact info@thevillagedentalsurgery.co.uk

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Kevin Bruce BDS (Glas.), FDSRCS (Eng.) graduated from Glasgow University in 1995. He has undertaken extensive postgraduate training throughout Europe and the USA in implant dentistry and its associated procedure, and has placed implants for 10 years. He mentors and lectures dentists and ancillary staff from all over the UK in the field of implant dentistry and is a visiting implant dentist at the Village Dental Surgery.

A new dimension

Joe Jackson looks at the advances in dental technology over the years

Patient care has benefited dramatically within the dental industry in the 60 plus years that the NHS has been in service. We have removed ourselves from the draconian days of tooth extraction on the first sign of toothache, to an industry capable of giving a smile to our oldest and dearest.

For dental surgeons, the standard of teaching in our universities is commendable, leading to the recognition of the significance of oral care in the wellbeing of individuals. This has led to life changing developments in the preservation of our smiles. With this emphasis in mind, oral care has become more affordable and this has resulted in greater choice of restoration and a more competitive market.

For dental technicians it has never been more important to keep abreast of the developments in order that our laboratories remain competent and experienced in all restorations.

Since July 2008 registration with the General Dental Council (GDC) came with a formal acknowledgement of technicians as a profession, ensuring we are all working competently and legally within the UK and are striving to meet GDC standards. It also ensures that our technicians remain informed of the regulations and requires them to keep up to date with new progress in the form of mandatory CPD hours. This gives assurance to our dental surgeons that we are competent in the work we are asked to carry out.

"New high-strength, bio-compatible ceramic materials have been introduced for dental devices"

The dental trade has grown from strength to strength creating a demand for safe and aesthetically pleasing dental materials. New high strength, bio-compatible ceramic materials have been introduced for dental devices. Since the development of osseointegration, using titanium to fuse to bone for dental implants, we have seen this discipline becoming more successful and the circle of users grow.

In 20 years we have seen the introduction of resin-bonded ceramic veneer, the development of dentine bonding agents, the introduction of resin-modified glass-ionomer cements, pressable ceramics, high strength zirconia and dental implants. More recently we have seen the all-important advance of computer-aided design and computer-aided

manufacturing (CAD/CAM) technology. Continually adapting our working environment to synchronize with these developments has proved to be efficient, cost effective and most importantly, inspiring in terms of patient satisfaction.

Although there are many materials and products available to a technician, it is the technique and ability of the technician to communicate with the dentist that will result in a successful restoration. A technician must know which technique to utilise and have a strong understanding of the materials they are working with. Sooner rather than later these new restorations and techniques will replace those that have been the mainstay of technical dentistry. Parallel training for dentists and technicians has proved to be the way forward to ensure we are working coherently and providing the best possible restoration.

Communication between the dental team is paramount and the key to ensuring we are working together and achieving the desired end result.

Technology has evolved dramatically in the last 60 years

This will also minimise any mistakes made in producing them.

Building on this professional relationship through email, telephone, and surgery/lab slips is vital. Quite often patients only have a superficial knowledge of the procedure to be carried out. However, recent exciting developments suggest we are moving towards a software package which will create shared files and allow interaction between surgery and lab during the patients appointment and providing them with a 3D image of the mouth and smile profile. This will allow the clinician to make adjustments on screen if required through patient/lab input, thus reducing the amount of visits the patient has to make in creating a perfect result.

So what is the future?

It is clear that innovations such as CAD/CAM, intra-oral scanning, pre-operative planning and workflow management will have an impact on dentistry in the years to come. This will require good computer knowledge and the ability to work in both two and three dimensions, creating new challenges for the dental technician. ■

Joe Jackson, director of Pearl White Dental Laboratory.

Aesthetics vs function

ZIRCONIA CROWNS

In aesthetic dentistry, there is a plethora of materials allowing practitioners to provide outstanding results. With materials such as lithium disilcate and layered zirconia, clinicians can achieve exceptional outcomes when sufficient clearance for such materials is provided.

Unfortunately, general dentistry provides added challenges such as bruxing, worn, limited or broken-down tooth structure, over-closure, sensitivity, limited coronal height and larger pulp.

Providing such patients with tooth-like restorations without compromising the vitality of the natural tooth structure or the usual masticulatory maxillary mandibular relationship can prove challenging.

In the past, we would normally see a full gold crown (FGC) or unsightly metal island/occlusion or devitalisation of the natural tooth structure.

We need to find a solution that will ensure the patient can maintain function during demanding applications while still delivering tooth-like results. Gold or alloy solutions do not meet these criteria, nor does any application where porcelain is bonded to a substructure due to the delamination discrepancies.

Zirconia crowns are extremely strong

Studies such as "Synergy in Dentistry" point us in the right direction: Dr John Sorenson states: "Zirconia has the best physical properties of any dental ceramic available today."

This solid medical-grade material possesses a hard-sintered flexural strength of about 1100MPa and has been used successfully in the mouth for many years. Zirconia is most commonly used as a framework, with a layer of porcelain applied to the zirconia substructure.

However, in situations where there is minimal clearance, weaknesses are introduced by the thin layer of overlying porcelain or the bond between the porcelain and the frame.

"Zirconia has the best physical properties of any dental ceramic available today"

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Sandy Littlejohn is a director at DTS International.

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MIRIS 2 masterclass

David Molyneux reports from a Highland Dental Plan training day held at the Kingsmill Hotel in Inverness

Dr Philip Redfearn was the host of the event that centred on the MIRIS 2 system and its unique shade selection technique. Dr Redfearn completed an MSc in Primary Dental Care in 2004 in Glasgow and joined the PREP panel, mainly consisting of postgraduate dentists who evaluate new products and materials, in 2005. After evaluating MIRIS in 2006, he switched to this system, as he was impressed by its simplicity and reproducibility in high-end cosmetic situations.

Most of the delegates had no experience of the system and were interested in its potential to improve the aesthetics of composite restorations. Other layered composite systems, such as Enamel Plus HFO, are very complex and time consuming to place with unorthodox shading systems and a myriad selection of composites including 'glass connectors'. The MIRIS 2 system (from Coltene Whaledent) offers an opportunity to place layered composites with a much simpler system and move up from the standard 'monochromatic' posterior A2/A3 type restoration.

The MIRIS concept was developed by Dr Didier Dietschi in 1997 and is simple – two composites are used which each replicate the optical characteristics of enamel and dentine. There are eight dentine shades, five opalescent enamel shades and four effect shades for simulating white spots, dark fissures etc. A simple and unique shade selection system involves, at first, taking the dentine shade, then the enamel shade. Next, the enamel tab chosen can fit directly over the dentine tab (water of glycerine was suggested as a medium for the 'nesting' of tabs) – this is the raison d'etre of MIRIS – allowing a preview of the layered composites before placement.

Dr Redfearn then demonstrated the placement of the composite on anterior teeth. Rubber dam is always used (after taking the shade), the cavity prepared, a bonding agent placed (a total etch technique was preferred by the speaker, seventh/eighth generation one-bottle systems requiring preparation of enamel), then the placement of the first enamel layer against a putty silicone index. Dentine composite is placed, then the proximal and buccal enamel built up. A new polishing system, Swissflex by Diatech, with discs and strips, proved on usage to be superior to the standard 3M Soflex, with its thinner foil disc and covered mandrel.

A posterior placement technique demonstrated the use of the V-system matrix, and evolution of the Palodent ring system (http://www.triodent.co.uk). The nickel-titanium rings are more robust, can be stacked and the wedge can be placed after ring placement. The Wave Wedges have a far better adaption to the proximal surface than standard wooden wedges. Dr Redfearn was very enthusiastic of the V-system, which seemed to eliminate most of the contact problems associated with posterior composites. One also felt the rings were far less likely to 'ping-off' than the thinner standard Palodent.

"The MIRIS 2 system offers an opportunity to place layered composites with a much simpler system"

After lunch, we were given an opportunity to try the MIRIS 2 system out. The composite had good handling properties and was straightforward to place. Using only two composites was simple and there was a marked improvement in aesthetics, the enamel layer of composite giving a much more natural appearance allowing the colour of the underlying composite to show through. However, it was difficult to finish the composite, as only battery-operated slow handpieces were available (originally the course was to be held at the Centre of Health Science at Raigmore Hospital, but it was cancelled due to poor weather). The composite finishing instruments supplied were far better at carving fissures and grooves than the usual standard instruments.

To fully appreciate the system, an intro kit can be purchased with five dentine shades, three enamel shades, a black shade, bond and the associated unique shade selector guide. It was not recommended to purchase just a single shade to try it out, as the concept of MIRIS would be missed. Dr Redfearn advised to book longer appointments for placement of these restorations initially and he offers in his practice a standard 'monochromatic' composite and a high-end MIRIS composite with separate fee scales.

Overall, it was an enjoyable and informative day, introducing a layered composite system that could be used in practice to improve the aesthetics of composites without an associated high learning curve and an innovative new matrix system, which seemed to be a marked improvement over older designs. ■

Above: Dr Redfearn shows how it's done

Above: getting to grips with the new system

Above: delegates trying the MIRIS 2 system

David Molyneux is an associate GDP at McIntyre & Corbet Associates, Dingwall and Invergordon, Ross-shire. Highland Dental Plan is a member of the IndepenDent Care Plans group.

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Start-up support from RBS

Dr Ali Bilgrami explains why he made the move from south of the border

When Dr Ali Bilgrami decided to base his new dental practice in Scotland, he knew it was going to be a challenge.

Originally from southern India, Dr Bilgrami had worked as an associate for Boots Dental Care in Aylesbury from 2004 to 2006 and his only experience of life north of the border was on a few holidays – but the short time he spent in Edinburgh was enough for him to decide he wanted to make a new life in Scotland.

"I'd been to Edinburgh a few times and was impressed," explained Dr Bilgrami. "I liked the city and surrounding countryside and found Scottish people to be very friendly."

He had tried to establish his own dental practice in the south of England, but had been frustrated by the new NHS pre-arrangement dental contracts which only matched a fixed treatment arrangement to the value of the NHS contract.

Dr Bilgrami said: "This made it very difficult to set up the type of practice I wanted to develop. I spoke to the NHS but they said that they had no more money.

"As I had been to Edinburgh a few times, I thought Scotland would be the place to set up my own operation."

After a few exploratory trips north of the border, he was able to assess what the market would be like for a new dental practice. He liked West Lothian but, after

several meetings with the health board, found that East Lothian was a richer vein to mine instead.

Dr Bilgrami said: "East Lothian is one of the fastest-growing areas in Scotland with good schools, good transport links and a good quality of life – and, more importantly, the NHS statistics show that 50 per cent of the population is not registered with a dentist!

After researching properties on the internet, he found an old veterinary surgery with plenty of space and then went about seeking finance to make his dream come true.

He approached two local banks, but liked the approach of Royal Bank of Scotland (RBS) which had its own specialist healthcare Business Development Manager in Sarah Ferguson.

Dr Bilgrami said: "I was impressed with the professional and prompt approach of RBS to my requests for financial support. They took the time to understand what I was attempting to achieve through my business plan and cash-flow projections."

"As I had been to Edinburgh a few times, I thought Scotland would be the place to set up my own operation"

Sarah Ferguson explained RBS' approach: "We deal with a lot of customers in the healthcare sector, especially dentists, so we are very familiar with their needs for property, refurbishment and equipment as well as dealing with NHS grants.

"Dr Bilgrami was setting up his surgery from scratch, so we were able to arrange a £240,000 mortgage over 15 years for the property and £90,000 loan for the refurbishment which would be mostly offset by his NHS grant once the dental practice was up and running."

Sarah also suggested purchasing dental equipment on hire purchase through RBS's subsidiary Lombard, which would help to give Dr Bilgrami more flexibility with his loan arrangements with the bank.

Lombard's Relationship Manager Susan Cooper dealt with the hire purchase arrangements. She said: "Once Dr Bilgrami had decided on his suppliers, we were able to deal directly with them to arrange payment right through to the delivery so that he had no initial outlay or hassles."

There were some initial issues with the building that held up the mortgage but, once these were sorted out, the whole financing arrangements went through fairly smoothly.

Dr Bilgrami now has a state-of-the-art dental practice in Haddington that includes a reception and waiting room, three operating surgeries, a separate x-ray room and two decontamination rooms.

The Council also insisted on a few additions such as a new disabled access ramp and a parents and baby room. "As I have a two year-old, my daughter Imaan, I can see the benefit of having a separate parents and baby room," laughed Dr Bilgrami.

The two other surgeries have been taken by two self-employed associates and the office is being run by his wife Reshma.

When asked what has been the biggest challenge, Dr Bilgrami replied: "All of it!" But the most frustrating time was waiting a week for the newly commissioned dental practice to be signed off by the Council's Building Warrant Officer before he could open for business.

However, he's happy with the Council's efforts as publicity from his Council Development Officer brought interest from 580 people who were looking to sign up to his new dental practice.

"I can't wait to start working," he added. ■

Nine key steps to build a successful support team

Chris Barrow continues his series for *Scottish Dental* magazine with a look at how to create a harmonious and effective team

It's an interesting observation that more than 50 per cent of the calls and emails I receive from clients are on the subject of "team" or "personnel" issues:

a: How do I recruit the right people?
b: How do I train them?
c: How do I pay them?
d: How do I stop them fighting each other?
e: How do I stop them irritating the clients?

The list goes on, but these are some of the more popular.

Over the years, I have recognised nine key steps that seem to separate the winners and losers in the game of team building.

The nine "ates'

1: Eliminate – do not tolerate. Let's start with the most controversial issue. I often listen to principals rolling out a list of "offences" committed by a belligerent or miserable member of staff.

Interestingly, we need to make a distinction here between issues of performance (is the technical job done correctly?) and behaviour (does this person treat others in a courteous way?).

I notice that, most often, the problem is behavioural, not performance-related. Employment law gives you little protection in this case.

The medium-term strategy is to first make a genuine enquiry as to whether this behaviour is as a result of some problem at work or outside work – after all, if someone is going through an especially difficult patch personally, we have responsibility as employers to show some compassion.

If not, then ask for an improvement in behaviour and, if none is forthcoming, simply work hard at your customer service systems and experience shows that the miserable employee will usually move away in time. Please note – in the world of employment law, you do NOTHING without checking the situation with your lawyer first.

2: Fabricate – an organisational structure in the practice. Your business operates within five areas of responsibility – finance, sales, marketing, operational resources and personnel. If you are responsible for running all of these functions yourself, then you have a practice and not a business. The transition to becoming a business owner occurs when you have other people managing these functions and reporting back to you.

3: Orchestrate – a business functions effectively when its people are operating systems. Systems that are written down, so that new joiners and job-swappers can learn them quickly. Systems that leave little to chance. Not just operational systems, but financial systems, sales systems, marketing systems and personnel systems – and perhaps most importantly, customer service systems.

4: Motivate – it is necessary for you to create an environment in which your team become self-motivated. They will do so if they understand your vision for where the practice is headed and can see "what's in it for them" and are treated with respect and courtesy by you, their colleagues and the clients.

"Please note – in the world of employment law, you do NOTHING without checking the situation with your lawyer first"

They will become motivated if they follow the example of your own behaviour – if you smile, they smile and if you are miserable and stressed, so are they. They will become motivated if you let go of management and focus on leadership.

5: Indoctrinate – this means that you have a vision and that the vision is communicated to the team and that they are informed of changes in the vision and posted on progress.

6: Delegate – delegation is an art. It involves trusting people to do the job properly, accepting that they will make mistakes as they learn your systems and understanding that patience is required to learn on your part. Good delegaters explain exactly what they expect, leave the team member to discover the solution and set a deadline by which they will report back – then they move away and stop interfering!

7: Congregate – good teams meet together frequently to discuss the past, present and future; daily huddles to review the tasks for the day, weekly meetings to discuss overall performance, monthly sessions to look at the big picture and annual retreats to celebrate and plan.

8: Compensate – great teams are fabulously well paid and have an element of their pay that is linked to the performance of the business overall. Nobody ever scans "situations vacant" just to see if a few more pounds can be squeezed out of another employer. They are loyal because they feel truly appreciated.

9: Educate – good leaders ask their team what they want to learn more about – and facilitate in-house and external training to invest in the skill of their people. Of course, some will leave – that's life – most will stay and your investment will be repaid over and over.

So if you can work on these none key elements in your own practice – you will enjoy the pleasure of free time in the evenings, great weekends and family holidays – safe in the knowledge that your championship support team are safely in control. ■

Above: The championship support team

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Here for you

Counting the cost

New regulations create a dilemma of which legal entity to choose for the most benefit, says Stephen Neville

The National Health Services (GDS) (Scotland) Regulations that came into force on 2 July have had many implications for NHS practitioners. Some of these have had an impact on the financial side of maintaining a practice, with particular reference to Dental Body Corporates (DBCs).

The dental lists maintained by each NHS board will be split into two – the first will detail all those dentists and DBCs who are contracted with the health board to provide general dentistry services (GDS), the second list shall be those approved to only provide assistance with GDS provision.

As DBCs have a legal personality of their own, in addition to the persons behind the operation, it is the company that is required to register to provide general dental services. In the case of a sole practitioner or partnership, each person who engages with the NHS to provide GDS must register, thus each person would appear on the first list.

Practitioners trading as a DBC would not appear in the first list along with their company – they would appear on the second list only because they are assisting the DBC, in the same way as an associate would assist within a practice. There are important financial implications arising from this change.

When a practitioner trading via a DBC moves from the first list to the second list, they will lose entitlement to various benefits such as seniority payments, vocational training allowances and remote areas allowances, among others.

Most importantly, the practice will lose entitlements to grants for practice improvements, except for those grants available via the Scottish Dental Access Initiative.

Furthermore, as practitioners essentially become assistants to the DBC, the obligation to provide maternity, paternity and adoptive leave payments falls upon the company, not the NHS health board.

DBCs on the health board lists will only be able to claim for the reimbursement of non-domestic rates, practice expenses, clinical audit allowances and for grants under the Scottish Dental Access Initiative. Commitment payments are paid to the DBC in the expectation that these are distributed among the practitioners in the appropriate proportion. Practice allowances are still also claimable.

These changes considered, incorporation is still worthwhile for dentists in the private sector. These changes impact only on NHS practitioners and for those who can incorporate without losing out on grants and allowances. Especially considering the previously proposed 1 per cent increase in the small companies' rate of corporation tax that has been reversed, the rate has been cut by a further 1 per cent, giving an overall small companies rate of 20 per cent.

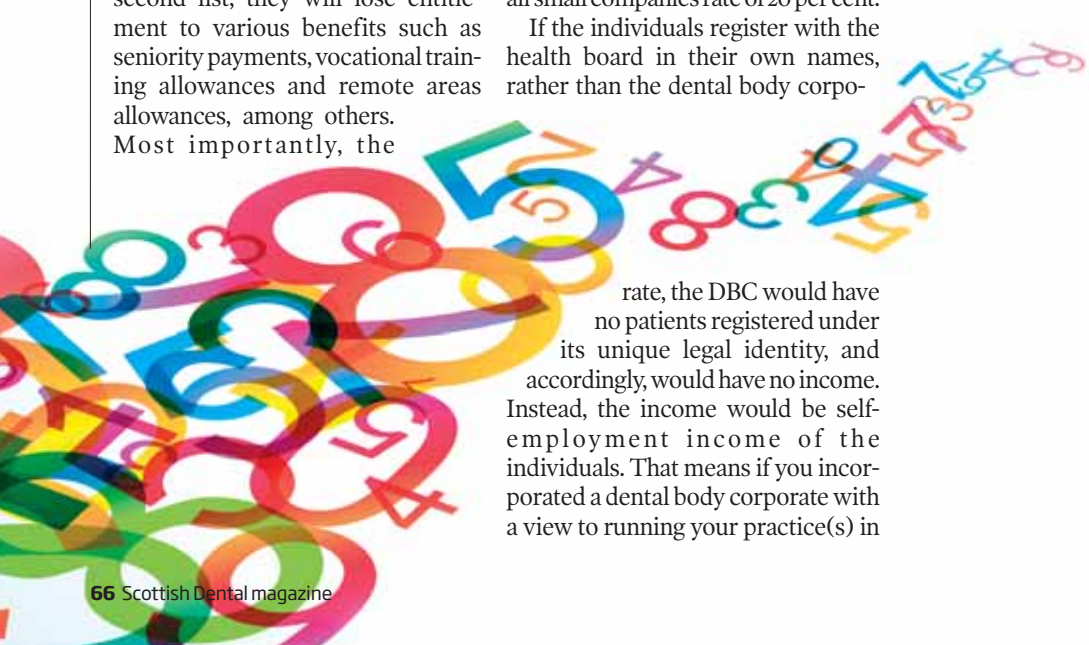
If the individuals register with the health board in their own names, rather than the dental body corporate, the DBC would have no patients registered under its unique legal identity, and accordingly, would have no income. Instead, the income would be self-employment income of the individuals. That means if you incorporated a dental body corporate with a view to running your practice(s) in a more tax-efficient manner, your plans may have been undone. It's a choice between losing out on grants and allowances, or paying a higher rate of tax.

"It's a choice between losing out on grants, or paying a higher rate of tax"

If you are considering whether incorporation would be worthwhile for you and your practice, there are new factors to be considered. If you are trading as a dental body corporate and have concerns on what impact the new regulations are going to have, then it may be worthwhile considering disincorporation and reverting to trading as a sole practitioner or partnership. However, this could be complicated and you should seek professional advice.

The financial benefits and drawbacks are clear: with a company, you as an individual pay tax only on sums withdrawn from the company. Therefore, profits in excess of your current requirements can remain in the company taxed at lower rates than you would pay as an individual. However, you would lose out on the allowances and grants referred to earlier. As an individual or partnership, you pay a higher rate of tax on all profits generated by your practice, irrespective of your level of drawings, but there is more certainty of receiving significant grants and allowances from the health board. If you qualify for seniority payments, then this is a factor you may also wish to consider.

The new NHS regulations will have a big impact on the way dentists are registered with health boards. Because of the way in which determinations are set out in the Statement of Dental Remuneration, there will be financial consequences for DBCs. ■



Stephen Neville is a Partner at Martin Aitken & Co and has advised many dentist clients for more than 20 years. Contact Stephen on 0141 272 0000, or scn@maco.co.uk Find out more about Martin Aitken & Co at www.maco.co.uk

This is our understanding of the law at this point in time, and we would advise you to seek professional advice prior to taking any actions based on the above. This article is not intended as professional advice – it is for information purposes only.

The stock market – an autumn collapse?

You can make, or lose, a lot of money – the choice is yours, writes Alan Saunders

Buying shares, equity funds or unit trusts needs much more than just a 'buy and hold' approach – particularly if they are bought for a pension fund. All will suffer when the stock market goes into decline.

So, it is hugely valuable – and can save you thousands of pounds – to know which way the FTSE is heading over the coming weeks. This article is designed to give you that information but bear in mind the market is ongoing so, by the time you read this, the advice will need updating. Technical analysis of the FTSE can be found at sharehunter.com.

The FTSE has tried, but failed, to get back above both its 30-week moving average and the resistance presented by the 5350 level. It is not presenting a strong picture at all. In fact, the signals currently being given by the FTSE indicate that a series of steep falls is likely to occur sometime in the near future.

It is not possible to be precise as to exactly when, but the September to October 2010 period looks to be favourite. Meanwhile, the FTSE is likely to continue to bounce along, up and down, in a sideways moving trend; really much as it has been doing for the past 10 weeks or so.

Current analysis shows that the FTSE is likely to fall to the 4750 area again and then to quicken its rate of decent to 4500 and then to 4325 and then, perhaps, all the way back down to the 3500 area!

It is important not to get caught out holding shares when this happens; it will even be possible to make a lot of capital gain when the collapse happens by using the right products.

Adding to this as a likely scenario is the weakness being displayed by the Wall Street indices. The S&P 500 is displaying signals of increasing weakness and of a propensity for a fast fall to the 940 level. Should this happen, it would have a definitely negative effect on the FTSE.

So the message is:

1. Don't be tempted to buy shares, equity funds or unit trusts – other than for short-term trades.

2. If you are holding a portfolio of stocks, start to identify those that you can do without and which might be better sold now, ahead of what could become a very painful time otherwise. ■

Analysis is current at July 2010
Alan Saunders is chief analyst at ShareHunter.com

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"The SDR filling technique provides a speed of setting that is excellent, especially being able to bulk-fill rather than employing time-consuming multiple layering and curing of composites. It also means there is less chance of contamination during the process.

"Overall, SDR makes for a much more pleasant material to use."

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BioHorizons launch Laser-Lok 3mm in the US

In May, BioHorizons launched its Laser-Lok 3mm implant in the US to high acclaim. It is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar.

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Andy Denny hosts new implant course for GDPs and hygienists

Andy Denny of Twenty 2 Dental is hosting a full day of interactive dental education for GDPs and dental hygienists on 16 September at the Aztec West Hotel in Bristol.

This course, sponsored by BioHorizons and focusing on the essentials of implant care and maintenance, will provide six hours of certifiable CPD (certificated) and will include course materials, lunch and refreshments.

The full-day interactive course, which will take the form of lectures, videos, demonstrations and hands-on sessions, will include the principles of implant dentistry, an update on periodontal disease, providing hygiene care for the implant patient, as well as how to identify peri-implant problems.

For more information or to book a place, contact mandy@twenty2dental.com or call 01934 620220. Places are limited. Bookings paid by 31 July will receive £50 off first delegate (full price £295) and £25 off delegates from the same practice (full price £195).

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DENTSPLY at the BDTA Dental Showcase

DENTSPLY strongly values its customers' views and places great importance on working hand-in-hand with the dental profession. Accordingly, the company has tailored its stand at this year's British Dental Trade Association (BDTA) Dental Showcase to accurately reflect feed back from the dental profession.

Delegates will have the chance to explore DENTSPLY's innovative new endodontic and restorative products, including the revolutionary Smart Dentin Replacement (SDR). The company's dentists and experienced team will be on hand to demonstrate how to use the new products in each range.

The DENTSPLY team look forward to welcoming you to stand D01 at the BDTA, at the ExCel in London (14 to 16 October).

For more information or to book an appointment with your local DENTSPLY product specialist, call 0800 072 3313, email enquiry-uk@dentsply.com or visit www.dentsply.co.uk

Don't miss DENTSPLY's Endodontic Roadshow

Clinicians with an interest in endodontics should not miss DENTSPLY's 2010 Endodontic Roadshow in September, where they can gain the latest advice on how to use market-leading endodontic products such as ProTaper, along with recent innovations, including PathFiles.

Renowned speaker, Dr Arnaldo Castellucci (visiting Professor of Endodontics at the University of Florence Dental School, Italy) will be joined by a guest speaker at each event: Dr Mike Horrocks in Manchester (15-16 September), Professor William Saunders in Edinburgh (17-18 September), Dr Hal Duncan in Dublin (20-21 September) and Professor Phil J Lumley in Cardiff (22-23 September).

Day one lecture costs £100 + VAT (£117.50), day one and day two £175 + VAT (£192.50).

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New unveiling for Practice Plan at BDTA 2010

Practice Plan, will once again be taking centre stage at this year's BDTA Dental Showcase.

Taking place from 14– 16 October at Excel, London, Practice Plan are inviting you to come along to stand M02 and be part of a new unveiling. Under wraps until the showcase itself, see first hand what Practice Plan has been keeping tight lipped about.

As a visitor to the stand, you will not only be able to learn more about how Practice Plan supports the business of dentistry but you'll also have the opportunity to talk to existing Practice Plan clients.

They will be on hand to talk about their experiences and tell you what it's really like to work with Practice Plan.

To find out more about Practice Plan and how they can support you, please call 01691 684135 or visit them online at www.practiceplan.co.uk

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Telio, the system for temporary restorations, has been developed for dentists, CAD/CAM users and dental technicians.

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Ivoclar Vivadent has devised the Telio system, a product solution for temporary restorations that offers users coordinated products and equally meets the requirements of dentists, CAD/CAM users and dental technicians.

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