No.1 for dental professionals in Scotland
December 2011/January 2012

Scottish Dental magazine

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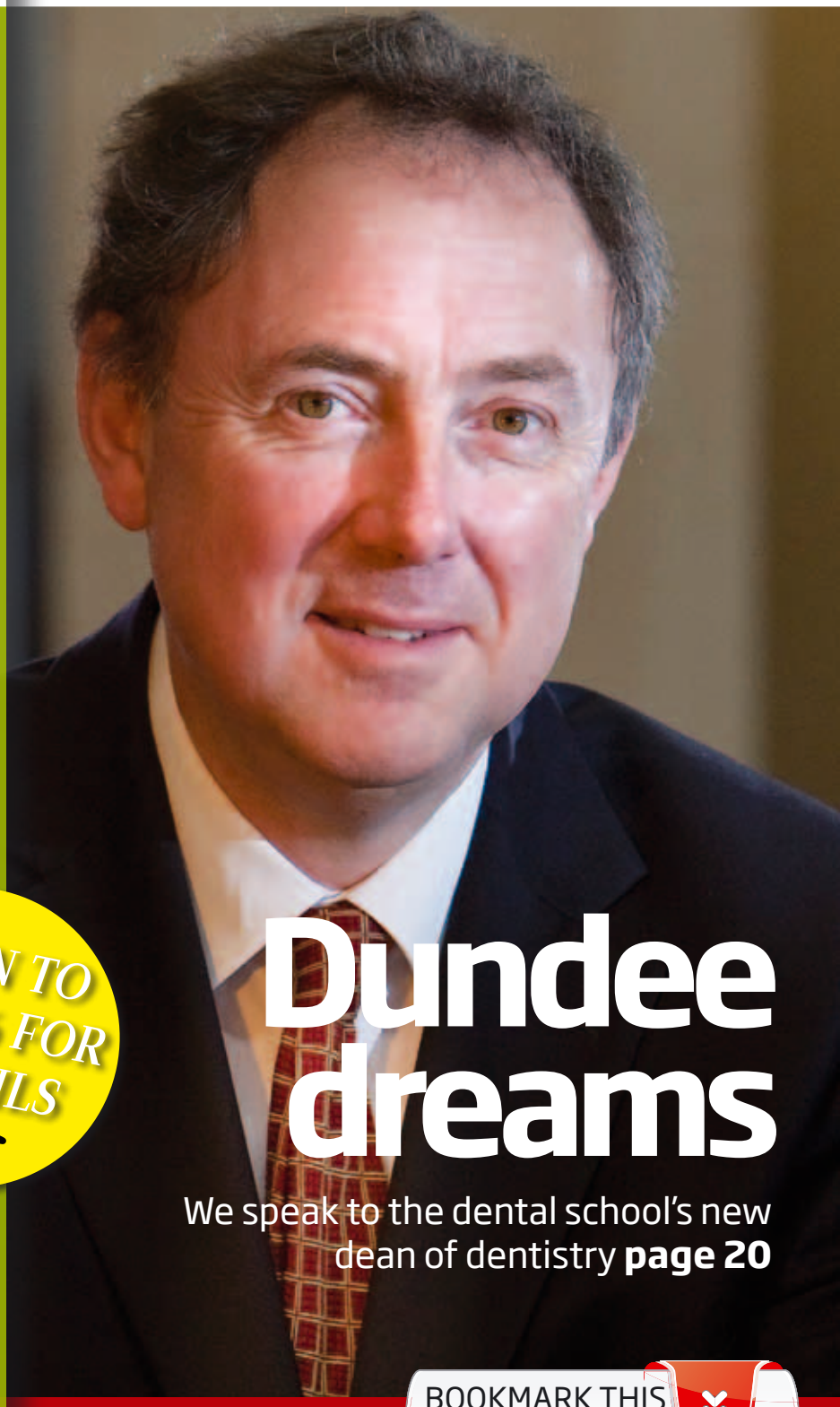

Dundee dreams

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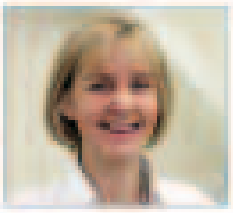

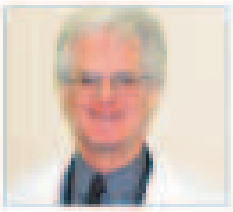


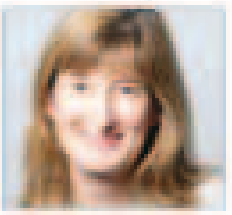
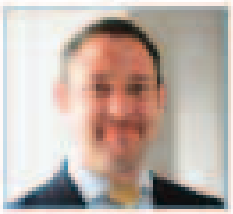


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Nobel Biocare

Welcome

Editor's desk

with Bruce Oxley

Call to action

Inside this issue of *Scottish Dental magazine* you should have found a special poster for the Scottish Dental Show on 24-25 May.

I think that this is going to be one of the most exciting events of its kind in many years and we are keen to spread the word to as many dental professionals as possible. So, please put this up on your staff noticeboard or in the lunch room and encourage your colleagues to register online – they may even win an iPad 2 for their trouble.

The trade exhibition at the show amazingly sold out within six weeks and the waiting list for companies hoping to exhibit is getting longer. The dental trade has supported the magazine with gusto for many years and I can't thank them enough for putting their faith in this inaugural event.

We are also extremely excited about the calibre of speakers that we have managed to secure. Once word got out about the show, we were inundated with requests from speakers and companies offering to host a talk or workshop.

Unfortunately, we couldn't fit everyone in, but I think the line-up of specialists and experts is second to none. From aesthetic dentists and implantologists, to accountants, business coaches and dento-legal advisors, we have a facinating array of talks for the entire dental team.

There will be 12 hours of verifiable CPD available to delegates over the two days of the event and we are hoping to include further hours in the show programme as well.

Finally, we will soon be launching a dedicated show website where you will be able to find all the latest news and information. However, in the meantime, you can still register your FREE place at the show, and be entered into a prize draw to win an iPad 2, by visiting www.scottishdentalmag/show

You can also follow us on Twitter – @ScottishDental – and find us on Facebook at www.Facebook.com/ScottishDental for up-to-date news, views and show information. ■

Bruce Oxley is editor of Scottish Dental magazine. To contact Bruce, email bruce@connectcommunications.co.uk

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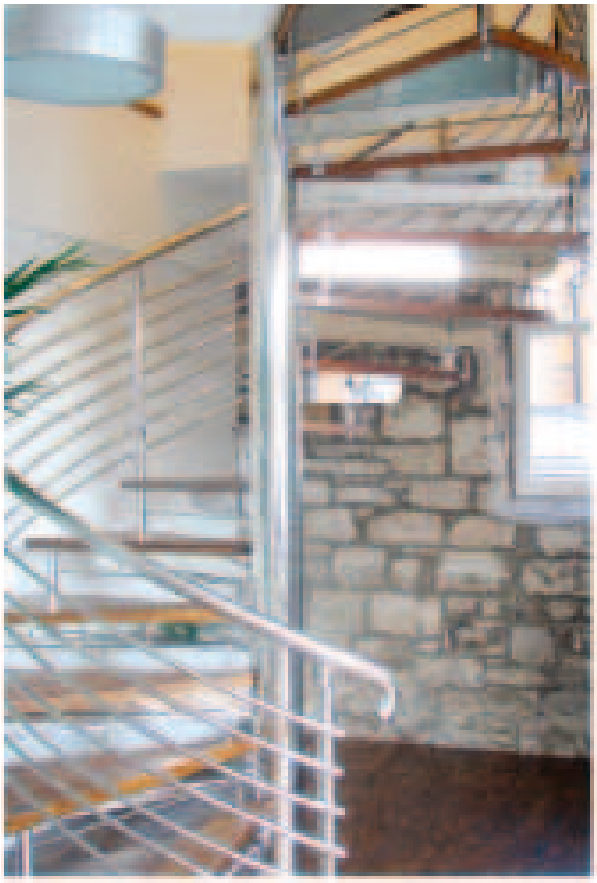

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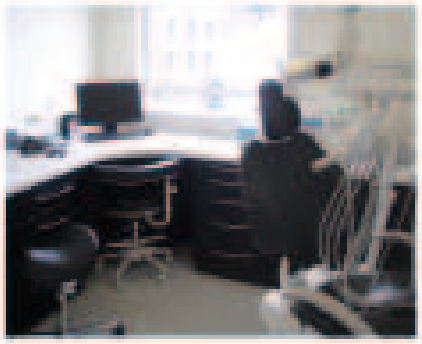

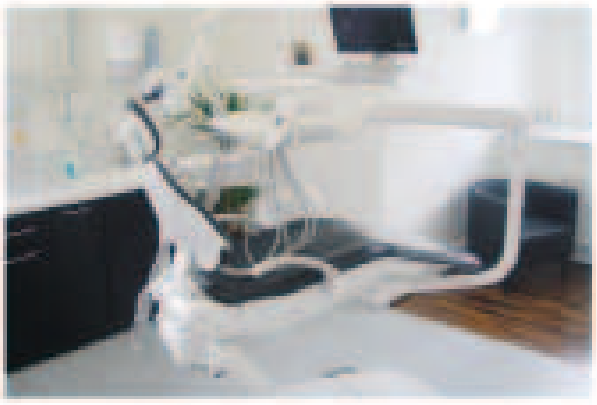

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Biting back

with Arthur Dent

The decon 'con'

Mention the word 'decontamination' in the company of dentists and the response will most likely be a cacophony of groans. Recent years have seen dentists bombarded with various, frequently changing recommendations and mandatory requirements punctuated by numerous target dates for compliance.

One of the most irritating features of the 'decon debacle' is the fact that the four nations of the UK require different standards of their dentists. A recent analysis by the British Dental Association shows that while the broad aims and principles of decontamination are the same, the details of what exactly is required by the four UK health departments varies considerably.

England, Wales and Northern Ireland follow their own variations of the dreaded HTM 01-05 (catchy title), but in Scotland, we have to follow the advice, recommendations and requirements of various bodies such as the Scottish Dental Clinical Effectiveness Programme (another catchy title), Health Improvement Scotland (HIS) or the Scottish Health Department itself.

So, for example, in England there are the mandatory Essential Quality Requirements which do not require practices to have a local decontamination unit (LDU), whereas in Scotland, all practices should by now have an LDU in operation or at least have submitted plans for possible extension or relocation to enable installation of one.

Scottish practices should have washer/disinfectors installed in their LDU, despite the fact that these are unreliable, with frequent breakdowns and leakages.

In Wales, standards are more relaxed (as in England), whereas the Northern Ireland department is taking a stricter 'Scottish-style' approach with a November 2012 deadline to meet the 'Best Practice' requirements of HTM 01-05.

The Chief Dental Officer in Scotland now chairs a group which oversees all Scotland's decontamination standards, so this has brought some sort of sense to our situation here. So, why these differing standards? The main problem seems to be that few of the standards are based on hard scientific evidence, but have instead flowed from the 'Precautionary Principle' and the four health departments have been at the mercy of whichever 'experts' they have chosen to consult. Some of them have taken a sensible, moderate and balanced view and given pragmatic practical advice, while others have been... let's say somewhat over-zealous!

"How ridiculous it is that in matters of such importance, dentists in different parts of the UK are judged by different standards"

How ridiculous it is that in matters of such importance, dentists in different parts of the UK are judged by different standards. If a dentist fails to comply with the relevant health department rules for their country, what sanctions might be used? Possibly referral to the General Dental Council (GDC) because it currently has UK-wide jurisdiction of all dentists and dental care professionals. What a dilemma for the GDC if a dentist fell short of the standards required by one health department, but would not be found wanting if judged by the rules of another part of the UK.

Surely it is time for all four health departments to get their act together and agree a common set of decontamination requirements which are sensible, practical and evidence-based? ■

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A unique event for the profession

With a packed trade show and a full list of outstanding speakers, the free to attend Scottish Dental Show will have something for all members of the team

As the only show of its kind north of the border, the Scottish Dental Show offers a unique opportunity for dental professionals to top up their CPD and see the latest products and services on offer, right on their doorstep.

Taking place at the home of Scottish football, Hampden Park, on 24 and 25 May, the new event is free to everyone involved in the dental industry, with something on offer for the whole dental team.

Even in these difficult economic times, the show's 84 trade stands amazingly sold out within six weeks. And, with a waiting list starting to grow, it is testament to the vibrancy of the Scottish dental industry that so many of the major dental companies have given their support to the event.

With product launches and demonstrations taking place throughout the day, there will be plenty to see and to do in the exhibition areas. Everyone from equipment manufacturers, implant companies, indemnity providers, dental labs and specialist referral clinics will be on hand to talk about their products and services, with many offering special deals and offers to delegates.

At the end of the first day there will also be an opportunity to catch up with colleagues and make new acquaintances at the evening drinks reception. As the event is being hosted at Scotland's national stadium, it seemed fitting to invite everyone's favourite BBC football reporter, Chick Young, to round off the first day in style.


Chick Young


Aubrey Craig

Speakers

The programme of speakers at the Scottish Dental Show will be second to none, with no less than 12 hours of verifiable CPD available to all delegates. With concurrent streams running throughout the two days, there is an unparalleled level of choice for the entire dental team.

Edinburgh GDP and former GDC president Hew Mathewson will be giving the welcoming address and he will be followed by a selection of some of the finest dentists working in Scotland today, including Brian Miller, Stephen Jacobs, Philip Friel, Kevin Lochhead, Abid Faqir, David Offord, Elaine Halley and Carol Tait.

They will be joined by the selling coach Ashley Latter who will be revealing his recession busting strategies on the first day and then

WIN AN IPAD 2

If you register online at www.ScottishDentalmag.co.uk/Show for your FREE place at the Scottish Dental Show, then you will automatically be entered into a prize draw to win an iPad 2.

So, if you didn't get one for Christmas then this is your chance to pick up one of the most desired gadgets on the market today. All you have to do is register your interest in attending the show and the draw will be made at Hampden in May.

Everyone who registers online is eligible to win the prize, but remember, you have to be in it, to win it!

Brian Miller

Elaine Halley

uncovering the secrets behind perfect communication in your practice on day two.

But that's not all, we also have indemnity specialists Hugh Harvie (Dental Protection) and Aubrey Craig (Medical and Dental Defence Union of Scotland) sharing their wisdom and experiences, John Barry from the Dental Business Academy revealing his secrets to running a successful dental business and Neil Morrison and Roy Hogg from accountants Campbell Dallas providing a topical update on finance and taxation.

Other confirmed speakers include John Meechan, Payman Langroudie, Louis Mackenzie, Bob McLelland, Richard Brookshaw and Farahbod Nakhaei.

Continued »

HOTEL DEALS

We have managed to secure a range of special rates for delegates and exhibitors during the show

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Kings Park Hotel

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www.kingsparkhotel.com

Alternatively there are a number of Premier Inn's around the Glasgow area offering good rates. Visit www.premierinn.com and search for Glasgow hotels.

And finally, there is always www.lastminute.com to see an array of hotels, bed and breakfasts and guest houses in the Glasgow area.

Continued »

Lifetime Achievement Award

The event will also see the introduction of the Scottish Dental Lifetime Achievement Award. This prestigious honour is intended to pay tribute to an individual who has made a real difference to dentistry in Scotland during their career.

We will be accepting nominations from everyone in the dental community in Scotland and details of how to nominate will be revealed in the New Year. So keep an eye on the website, in the magazine and on our social media sites for details.

Coming soon...

We will be launching a dedicated Scottish Dental Show website where all the latest news and information will be easily accessible. To make sure you find out exactly when the site is launched, simply register at the *Scottish Dental magazine* website (www.scottishdentalmag.co.uk/show) and we will contact you when it is up and running. ■

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Follow us on Twitter @Scottish-Dental for all the latest news and updates on the Scottish Dental Show. And don't forget to use the hashtag #ScottishDentalShow when retweeting or posting a message about the show to your own followers.

Our Facebook page (Facebook.com/ScottishDental) will also be updated regularly with pictures and information, so 'Like' us and keep yourself up to date.

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NHS sign-ups reach record level – report

REGISTRATIONS

Nearly four million people are now registered with an NHS dentist, according to figures released by ISD Scotland – the highest number ever recorded.

As of 30 September, 70 per cent of adults (3.1 million) and 86 per cent of children (894,000) were registered with an NHS dentist. The new figures represent an increase of 1.36 million since March 2007, when the SNP administration came to power.

The ISD report also highlights the fact that 69.4 per cent of primary seven children are showing no obvious signs of tooth decay, another record high and the first time that all NHS boards have met the Scottish Government's 60 per cent target in this area.

Public Health Minister Michael Matheson, whose party introduced continuous registration in April 2010, said: "It is fantastic that we now have an extra 1.3 million Scots registered with an NHS dentist.

"Our latest figures show there are record numbers of dentists working in NHS Scotland and this has resulted in more people being able to access an NHS dentist.

"With increased access we will expect to see improvements in the oral health of the nation and these figures show that we are already seeing leaps forward in children's dental health."

Honours for two former Scottish presidents

Edinburgh dentist and former President of the General Dental Council Hew Mathewson was among the recipients at the BDA Honours and Awards Dinner held at Chancery Court in London recently.

Hew, who was awarded a CBE in 2010, was presented with the BDA Fellowship by Stuart Johnston (chair of BDA representative body) in celebration of his outstanding and distinguished service to the BDA and the dental profession in general. Over the years, his BDA roles have included being chair of Branch Council, branch president, chair of the Scottish Dental Practice Committee, as well as vice chair of the General Dental Practice Committee.

There was also an award for another Scottish former GDC President and CBE recipient, this time the outgoing Dean of Dentistry at Kings College London, Nairn Wilson. Nairn was presented with the John Tomes medal, which is awarded in recognition of scientific eminence and outstanding

BDA Awards. Major recognition at prestigious London ceremony for pair

service to the dental profession. The University of Edinburgh graduate of 1973 was previously dean and Pro-Vice Chancellor at Manchester Dental School before becoming dean at KCL in 2001.

Durng his distinguished career he has been editor of the *Journal of Dentistry*, Chairman of the Joint Committee for Specialist Training in Dentistry and Dean of the Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh.

Nairn was a member of the team which developed light-cured composite systems. Subsequently, he has contributed extensively to the scientific and other literature in dentistry. He was appointed CBE in 2004 for services to dentistry and healthcare regulation.

BDA President Janet Clarke MBE said: "We are delighted to host these awards, which celebrate excellence across the whole dental family. They are our opportunity to say thank you to all those who contribute their time, expertise and goodwill for the betterment of the dental profession."

Stuart Johnston and Hew Mathewson

A new dental centre for RAH

NEW FACILITIES

A state-of-the-art £3.4 million dental centre has been officially opened at the Royal Alexandra Hospital (RAH) in Paisley.

The new centre, which also includes eight student outreach chairs, will amalgamate five former stand-alone clinics into the RAH: Dykebar Hospital, Glenburn Clinic, Johnstone Health Centre, the Russell Institute and one of the two surgeries based at Foxbar.

Approximately 3,000 patients who would have needed to travel into the Glasgow Dental School for treatment will now be able to be seen at the new Paisley centre.

All the new surgeries in the dental centre have been fully equipped to offer the full range of treatment, from oral surgery to orthodontics. Two of the surgeries have been specially-designed to treat special care patients with additional support needs: surgery 11 for younger patients and surgery 16 for sedation/adult special care patients.

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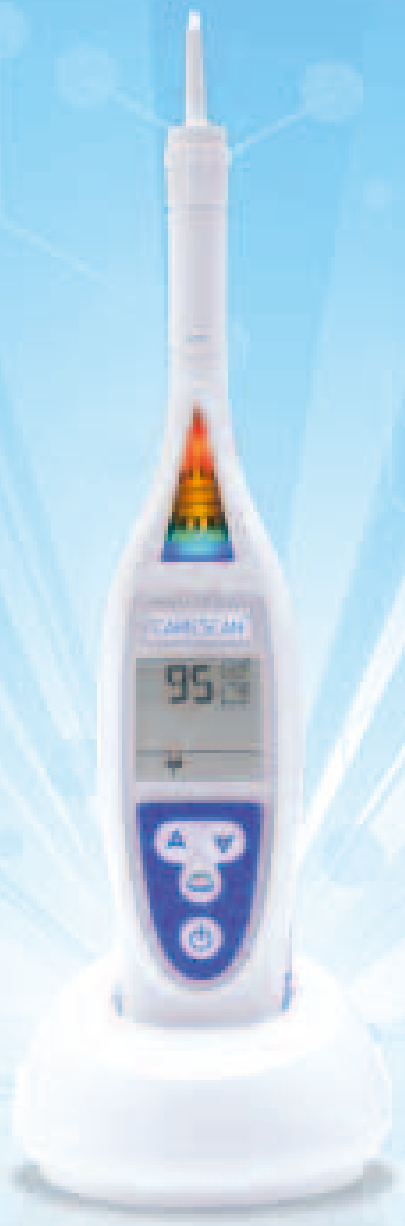

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Award. Glasgow dentist rubs shoulders with Lords and Baronesses at Downing Street

Glasgow dentist goes to Number 10

How does a dentist from Glasgow end up having lunch with the Prime Minister at Number 10, surrounded by Lords and Baronesses?

Well, in the case of Bath Street Dental Practice's principal dentist Rita Ahmad, it was thanks to an award she picked up last year for her entrepreneurial endeavours that got her an invitation to a celebratory Eid lunch at Downing Street.

"It was a very positive experience because he was very positive about the fact that democracy in Muslim countries has happened"

Rita Ahmad

Rita, who owns three other dental practices in the Glasgow area under the Peppermint Studios brand (Maryhill, Eglinton Toll and Chapelhall Dental Practices), was presented with the Entrepreneur of the Year award at the 2012 Scottish Asian Business Awards.

Rita said: "I think winning the award meant that I probably ticked a few boxes – young, female, Asian, business professional.

"It was actually Baroness Warsi, (co-chair of the Tory Party) who had been given the task of finding guests to come down and celebrate this lunch, who invited me along."

Rubbing shoulders: Rita with the Prime Minister and Baroness Warsi

And Rita explained that she was more starstruck by meeting the Baroness than she was meeting the Prime Minister: "She's amazing. She is one of the coolest Asian women in Britain in my eyes, and the things that she has done for Asian people is phenomenal.

"I got to speak to her for a wee while and I was just in awe of her to be honest."

As for the Prime Minister, Rita explained that she was impressed with his knowledge of Islam and his attitudes towards the burgeoning Arab democracies that have started to find their feet in recent months.

She said: "It was a very positive experience because he was very positive about the fact that democracy in Muslim countries has happened and he was very keen to demonstrate that he understands Islam and he understands Muslims."

Jacobs hands over ADI reigns to Ucer

APPOINTMENT

Bearsden-based dentist Stephen Jacobs has handed over the presidency of the Association of Dental Implantology to Professor Cemal Ucer after his two-year term of office came to an end.

Prof Ucer has been an active member of the ADI Board since 2005 as its North West representative and leader of the ADI's mentor training course at Salford University.

He has authored the foundation course for Ark – the ADI's online education resource – and is chairman of its editorial board.

He is a specialist oral surgeon, the clinical lead of the diploma/MSc programme in implant dentistry at the School of Health Care Professions of University of Salford and a member of the Faculty of Examiners for the Diploma in Implant Dentistry of the RCSEd.

Taking over: Prof Cemal Ucer

Waiting room comes to life

ART

It's not often that a dental waiting room is described as a work of art, but for one practice in Edinburgh a collaboration with a local artist has turned their waiting room into a contemporary gallery space.

Having previously hosted small exhibitions of a friend's work when they first moved into the premises at Ferryburn House, principal dentist Janet Clarke is no stranger to the art world. But the exhibitions were short lived after the artist had a change of career and Janet busied herself running a successful practice.

However, when her patients started asking when the next exhibition would be, Janet decided that it was maybe time to consider making the gallery a permanent addition to the practice. So local artist Joan Ashcroft, a budding young painter, was contacted to display her works. An opening night drinks reception at the end of October saw more than 100 people visit the practice, with Joan selling 35 per cent of her stock.

Joint project: Joan Ashcroft (left) and practice owner Janet Clarke

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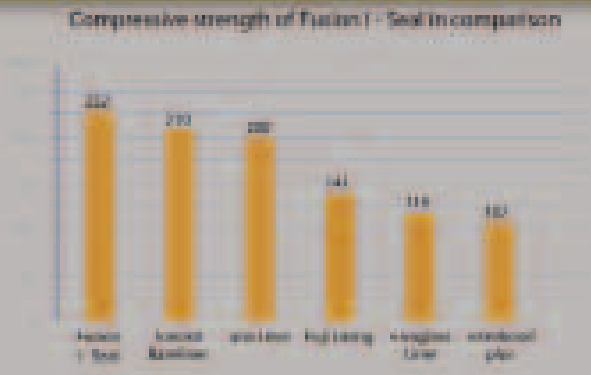

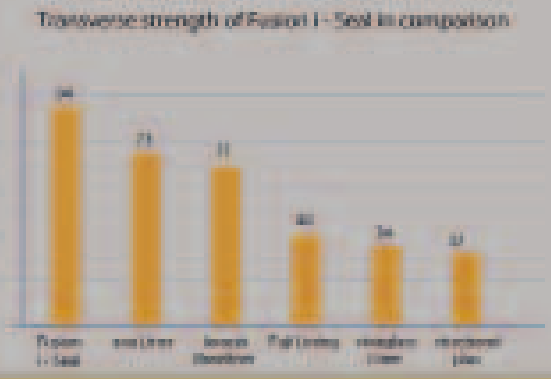

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Cash boost for dental schools

FUNDING

Glasgow and Dundee Dental Schools are set to benefit from a funding boost of £132,000 to strengthen their collaboration on dental and oral health research.

The money, from the Scottish Funding Council and spread over three years, will allow the schools to focus on inequalities in dental health, access to dental services, oral cancer and craniofacial birth defects. The two universities will also pool their resources to share an administrator who will help support their joint research activities and work with stakeholders, including primary carers and the University of Aberdeen Dental School.

Professor Jeremy Bagg, Head of the Dental School at the University of Glasgow, who has been involved in developing the Scottish Oral Health Research Strategy, said: "Glasgow and Dundee Dental Schools have been moving towards closer collaboration on a number of fronts in recent times. This funding from SFC provides an excellent opportunity to build a strong and sustainable oral health research portfolio.

"It will ensure that there is synergy and a sharing of expertise which will help both institutions to deliver research outputs relevant to the Scottish population and enhance their positions and research reputations within the UK and internationally."

Professor Mark Hector, Dean of Dentistry at the University of Dundee, said: "This SFC funding will facilitate a greater level of effective collaboration between experts at the Universities of Dundee and Glasgow to accelerate progress towards finding solutions to problems and implementing them with a beneficial impact on the health of the population."

"Glasgow and Dundee Dental Schools have been moving towards closer collaboration on a number of fronts in recent times"

Professor Jeremy Bagg

BADN abolish chairman's role

APPOINTMENT

The council of the British Association of Dental Nurses voted to abolish the position of chairman of council and expand the role of president at their recent AGM.

Glasgow dental nurse Nicola Docherty becomes the first president to take on the newly expanded role after she was officially inducted at the BDTA Showcase in October.

Speaking about the decision, which was proposed by a BADN member and passed by a 96 per cent majority, Nicola said: "I would like to thank past chairman Angie McBain for her sterling work on behalf of the association."

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Prizegiving season for Scottish dentists

AWARDS

A Glasgow dentist has celebrated the first anniversary of his clinic's launch by picking up a clutch of awards within the space of a few weeks.

Philip Friel Advanced Dentistry, which first opened its doors in Hyndland in November 2010, was named Scottish Practice of the Year and Most Attractive Practice of the Year at the Private Dentistry Awards and then Most Attractive Practice and Best Private Practice at the Dentistry Scotland Awards a few weeks later.

The practice was also highly commended in two categories: Practice of the Year – West, and for Most Outstanding Practitioner for Phil's dental implant nurse Kasia.

The Best Specialist Practice award at the Dentistry Scotland Awards was presented to Beam Orthodontics from Dundee, while Fergus and Glover from Aberdeen was named Best Employer at the event held at Gleneagles.

Gongs: Phil Friel and wife Stephanie

Legal. Westminister review may lead to change of rules

HIV consultation is set in motion

The Department of Health in Westminster has announced there is to be a public consultation into the relaxation of restrictions placed on healthcare workers with HIV.

The consultation, which launched on 1 December and will run until 9 March 2012, comes after a review by the Expert Advisory Group on AIDS found no reported transmissions of HIV from healthcare workers, despite investigations involving 10,000 patients who were tested for HIV. They also found that few other countries around the world have such tight restrictions as the UK.

As all elements of dentistry are currently considered 'exposure prone', any dental professional who contracts HIV is unable to work directly with patients. However, the recent review could be set to change that.

The review's chairman, Professor Brian Gazzard, said: "Our careful review of the evidence suggests that the current restrictions on healthcare workers with HIV are now out of step with evidence about the minimal risk of transmission of infection to patients and policies in most other countries. This risk can be reduced even further if the healthcare worker is taking effective drug therapy for HIV and being monitored by HIV and occupational health specialists."

> **"The changes to the regulations proposed by the Department of Health are a logical step that restores fairness"**
>
> Kevin Lewis, dental director, Dental Protection

Kevin Lewis, dental director of indemnity providers Dental Protection, who have long campaigned for a review of the regulations, welcomed the news: "The introduction of effective antiretroviral therapy in the 1990s, combined with the absence of any proven transmission in the dental setting, makes it totally unfair to continue to force members of the dental team to quit their chosen profession.

"Apart from the personal consequences, these skilled clinicians are removed from the workforce that currently struggles to provide sufficient access to dental care for the growing UK population."

Restored faith

APPOINTMENTS

A referral clinic in Edinburgh has recruited a new specialist to its team in the form of restorative dentist Dr Madeleine Murray.

Dr Murray will be joining Vermilion, based on St John's Road in Corstorphine, with a primary focus on periodontal disease. An alumnus of the class of 1984 at Glasgow Dental School, she has limited her practice to periodontics for the last 10 years.

She obtained her Fellowship in Dental Surgery from the Royal College of Physicians and Surgeons of Glasgow in 1988 and later that year she moved to The Royal London Hospital, where she discovered her interest in periodontics. Dr Murray was added to the GDC's specialist list as a restorative dentist in 1998, before returning to Scotland to help set up, and subsequently teach on, the Masters in Dental Primary Care course in Glasgow Dental School, which she combined with specialist private practice limited to periodontics while studying for her MPhil in Medical Law and Ethics.

Dr Murray has just returned from a five-year stint in Shanghai, China, where she worked as a specialist in a China-US joint venture clinic, as well as teaching Dental English in the Dental School of Jiaotong University.

Dr Madeleine Murray

Dr Murray comments: "I am delighted to return home and become involved, once again, in the treatment and support of patients with periodontal disease."

Fight NHS pension reform, says BDA

Pensions. Dr Robert Kinloch insists public sector strikes must be shown support

The chair of the British Dental Association's Scottish Council has urged dentists north of the border to join with their colleagues in other parts of the UK in voicing opposition to government changes to NHS pensions.

Dr Robert Kinloch made the pronouncement ahead of the day of action on 30 November, which saw dentists working in general practice, primary salaried care and hospitals in Scotland and across the UK participate in a cross-public sector campaign. While BDA members were not on strike, they were encouraged to show support for the public sector workers' strike by displaying posters, signing petitions and tweeting their opposition using the hashtag #30nov.

Dr Kinloch said: "The NHS pension scheme has been overhauled just a few years ago and remains in surplus. Further reform is untimely and unjustified. The Scottish Government has indicated that it intends to follow the pension reform path currently being trodden by its counterparts at Westminster. That is disappointing.

"Dentists in Scotland will share the anger of colleagues south of the border at what they see as unnecessary and unjustified reform of the NHS pension scheme that hard-working colleagues across the health service contribute to during their working lives. We urge them to make their feelings known." Dr Susie Sanderson, Chair of the BDA's Executive Board, said: "Like other public sector workers, dentists' pensions are under threat.

"The BDA and other unions have fought the Government hard on these proposals and some concessions have been won. Nonetheless, the proposals on the table still represent a significant attack on the pensions that hardworking NHS staff contribute to.

"The BDA has not, at this stage, balloted on potential strike action on this issue. It is important that decision is not misinterpreted as a lack of concern about the proposed changes and we encouraged dentists to join with colleagues across the public sector and show their support for the day of action on 30 November."

"The NHS pension scheme has been overhauled just a few years ago and remains in surplus"

Dr Robert Kinloch

First Coatbridge CPD set to become annual

CONFERENCE

More than 90 delegates attended the first continual professional development (CPD) conference for the entire dental team at Coatbridge College Dental School recently.

Speakers from NHS Education Scotland and Dental Protection were joined by those from general practice to provide an update on several core CPD subjects required by the GDC.

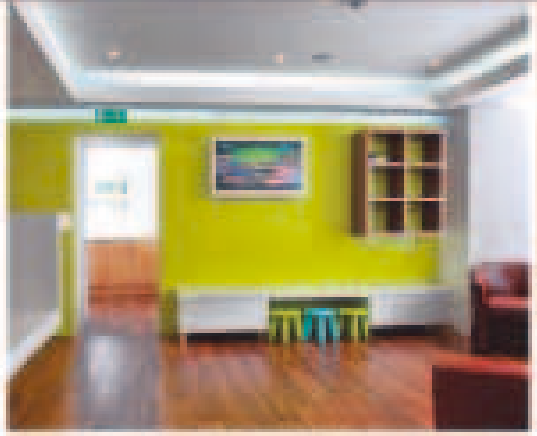
Topics included: 'Minimising the risk of infection control' presented by Irene Black, 'Medical Emergencies and the Dental Team' by Carol Anne Reid, 'Dental Radiography' by Iain Henderson and 'Legal and Ethical Issues and Complaints' presented by Helen Kaney.

Jennifer Lowe, Head of School for Dental Studies, said: "The conference was a fantastic day, as it provided a platform for learning and an opportunity for delegates to meet up with fellow dental practitioners.

"The speakers provided insightful and enjoyable presentations.

"Due to the success of the event, the dental school are now looking at making the CPD conference an annual event."

During the conference the school announced that it was in receipt of provisional GDC approval to offer a diploma in orthodontic therapy, a qualification that would allow DCPs to deliver orthodontic treatment to patients under the supervision and prescription of a specialist orthodontist.

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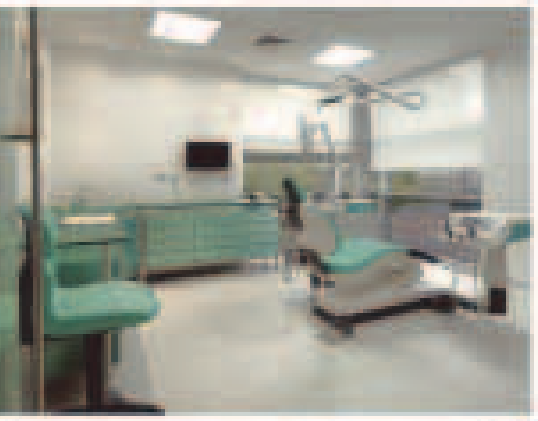
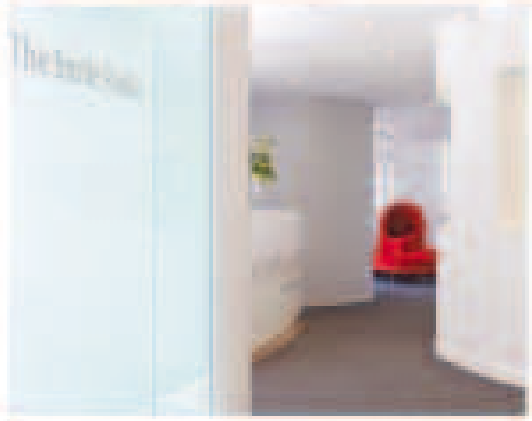


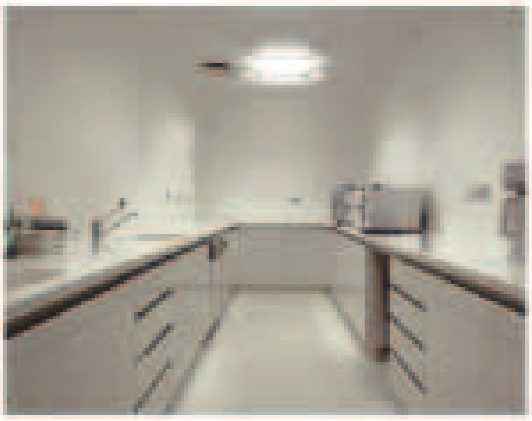
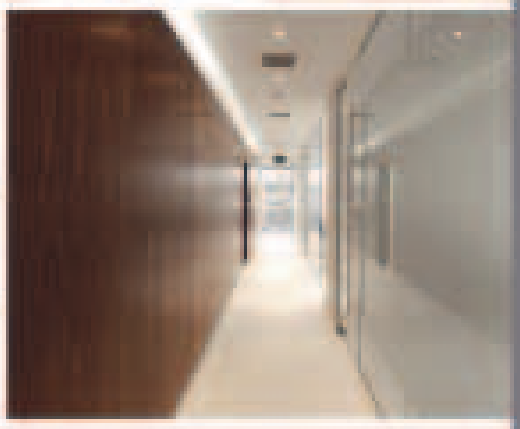

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From the chairside

with Alison McKenzie

Don't forget Madeline

For the first time in eight years the British Association of Dental Nurses (BADN) National Conference was to be hosted in Scotland. For the majority, this occasion would have been the first opportunity to attend and show support at the inauguration of a new Scottish president and provide an excellent platform to encourage new Scottish members. Also, for the first time, the BADN face outside competition, so the cancellation, due to the economic climate, of its most prominent event must have been a further disappointment to the association.

The realisation of the financial commitments with registration has revealed an increase in independent trade unions, CPD providers, and alternative websites for dental nurses, also insurance companies touting for our business. So, with the choices on offer, which route should Scottish dental nurses follow? Should we take advantage of the new alternatives available or the organisation formed for us by British dental nurse Madeline Winter?

Despite the restrictions of 1940s wartime Britain, Madeline travelled the country recruiting members for the new group she founded the BADN with her dentist Philip Grundy. Realising the advantage of a qualification, they formed the National Examination Board of Dental Nurses (NEBDN) in 1943 (which became independent from the BADN in 1987).

The BADN is still the only recognised professional association for dental nurses, a non-profit making group relying on the income of membership fees and voluntary workers covering nine regions and offering support and advice.

Its biggest achievement was a 40-year campaign for registration and professional status. It also developed indemnity insurance specifically for dental nursing based on a sliding scale fee, giving dental nurses with additional qualifications and responsibilities greater insurance protection. A recently published salary survey highlighted low wages and a recommended pay scale guideline is now available for employers. It fought on our behalf for tax relief on the ARF fee and laundry costs, and a new campaign for tax relief for CPD costs is currently under way. Along with the indemnity insurance, a quarterly journal, CPD and various discounts and benefits are included in the membership.

After I qualified I became a member of the BADN. I paid £120 this year; this is not expensive when you consider the membership package on offer. After some research, I found that if I were to purchase individual packages with other providers – i.e. 10 hours CPD at £20 (although free CPD is available, this rarely includes the recommended core units), journal subscription at £82, indemnity insurance at £84 – it totals £186. That's a difference of £66!

"Should we take advantage of the new alternatives available or the organisation formed for us by British dental nurse Madeline Winter?"

Of course, the choice is up to the individual who they wish to support, but, when making the decision, we should all remember that the BADN is the voice of our profession, there are 46,793 dental nurses in the UK, including 6,616 from Scotland, and regardless of whether you are a member or not, all dental nurses stand to benefit from the BADN's achievements as it campaigns on our behalf, surely it is only right that we should support it while it does so. ■

Northern Exposure

Professor Mark Hector, new dean of Dundee Dental School, tells of his shock at the snow after emigrating from Kenya aged six and how he is adjusting to the slower pace of life in Tayside, compared with the hustle and bustle of London

Having made the move from his childhood home in Kenya back to one of the worst winters in living memory, the new dean of dentistry at Dundee Dental School should have no problem acclimatising to his new position in Tayside.

The son of a colonial police officer, Professor Mark Hector was born in Nairobi and emigrated back to the UK at the age of six when Kenya declared independence in the winter of 1962/63. The contrast between the temperatures of East Africa and a severe British winter were quite drastic, as Prof Hector remembers vividly. He said: "The snow started on Boxing Day and didn't go away until 1 April. Even where we lived in the Bristol Channel it was lying three-feet deep in the garden. So it was an incredible amount of snow."

So, for the new dean, the contrast between his former life in London and his new one in the picturesque Tayside countryside, should be less of a shock, even if the last two Scottish winters are anything to go by.

After growing up in the West Country, Prof Hector began his academic life as a dental student in London. He enjoyed the scientific side of his studies so much that he took time out of his BDS studies to do a two-year inter-collated degree in physiology before returning to dentistry and qualifying in 1981.

He then spent three years dividing his time between Bristol University and Kings College London (KCL) while studying for his PhD, completing his thesis on the reflexes around salivary glands, specifically the way that receptors in the mouth control secretion around teeth. After

A TOUCH OF SILVER

In his spare time Professor Hector is a silversmith. He discovered his passion for silver during a dental meeting in Copenhagen. He visited the famous Georg Jensen workshop with his mentor, Prof Declan Anderson, and decided to try and replicate an ornate butter knife that was on display. So, after surreptitiously tracing it's outline and design on a piece of paper, he returned home to try his hand.

Over the last 25 years he has made a number of retirement gifts for colleagues and even pieces of jewellery for friends and family.

finishing his PhD studies he started work in oral medicine and oral pathology at Guy's Hospital in London, but in order to pursue that any further he would have had to go back and train as a doctor, which didn't interest him at the time. He was then approached about a job at the London Hospital Medical College (now the Queen Mary University of London).

Prof Hector takes up the story: "The then dean Professor Alan Brook offered me a post as a lecturer, which is what I was after, but in child dental health. At the time children's dentistry was not on my radar so to speak, but he explained that what he wanted out of the job was not so much the clinical dentistry but the other skills to help support postgraduate teaching.

"So I went along there in early 1987 and it was absolutely brilliant. I enjoyed the clinical work, working with children was fantastic. It has been very, very rewarding."

He found that the main differences between treating adults and children is mainly down to the ability to communicate and manage behaviour. He said: "You have to spend so much more time preparing children to accept dentistry. It takes a bit longer and there is a bit more patience required to get them to understand what we are trying to do and that it is not going to be too difficult for them.

"So the behaviour management is more difficult, it requires a little more time and patience. With an adult you can negotiate much more easily than you would be able to with a child, particularly younger children."

Prof Hector explained that in his experience in London many children's first visit to the dentist was to tackle disease and to take out teeth. He said: "So it wasn't the greatest start and there is a similar pattern up here.

"But one of the joys of coming to Dundee is the huge expertise in managing dental caries in a very conservative way. Taking a much more biological approach to it as opposed to a technical, reparative one. It's not all about fillings, it is about the other things that we can do, and the school has a really good reputation for that."

After nearly 25 years at the Queen Mary, where he moved up the ladder from lecturer, gaining his readership in 2001 and then becoming a professor of oral health of children in 2002, he was approached to take on the role of dean at Dundee. Having worked at Dundee as an external examiner previously he was aware of the school and its well-respected teaching and research reputation, as well as a few familiar faces who he had crossed paths with at Bristol and at KCL.

"I enjoyed the clinical work, working with children was fantastic. It has been very, very rewarding"
Professor Mark Hector

Continued »

Continued »

But, on top of the many draws that Dundee Dental School held for Prof Hector, another driver was his desire to get out of London.

He said: "Not being a Londoner, I've never really settled there, so the idea of moving out of London was an appealing one, and it has worked well for the family as well."

His two eldest sons are at university in Hull and Stirling, while his youngest is still in further education and will move up to Tayside in the summer with Prof Hector's wife when they have found a house in the area. And, as well as enjoying the easy commute from his rented apartment at the City Quays, which is in stark contrast to the busy traffic and crowded public transport of the UK's biggest city, he is relishing the opportunity to carry on the good work of his predecessor.

Professor William Saunders enjoyed a decade as dean of dentistry at Dundee, having been appointed in 2000. After stepping down he has reverted back to his research interests, which include endodontics and applied dental materials. Prof Hector said: "I think what Bill has achieved is a very stable and very well regarded school by other UK dental schools. Dundee has always been regarded as a very well-run school producing excellent students.

"I think what Bill has achieved is a very stable and very well regarded school by other UK dental schools"

Professor Mark Hector

"It also has quite a focused research agenda and it has a very good reputation. Some schools you don't hear very much about, but Dundee is very much on the map and that is very good."

Among his main aims at the school, Prof Hector is keen to expand the range of taught masters programmes offered and he is currently undertaking a redesign of the curriculum to try and reflect the growing emphasis on the dental team and where each member fits into the team. "The dentists will begin to take on the role of team leader," he explained, "delegating more of the work down to other members of the team. It will make for a more efficient way of working but it is going to require a big sea change in attitudes."

But, while their jobs may be changing in terms of scope and structure, Prof Hector is optimistic for the futures of the graduates the university is producing.

He said: "I think, at the moment, job prospects are very good and the vast majority will get work. Last year every single graduate got a job, and although that is not guaranteed now, the likelihood is that they will all get jobs."

When asked what the main differences are between students back in his university days and today, he replied that the people are generally the same, although the academic standards are far higher now. "When I started off I got two Cs and a D at A-Level," he said. "Whereas the expectation now at A-Level is three As, or Highers five As.

"I actually got in on below offer, I was offered three Cs and got in with two Cs and a D. But these days very few students get offered a place if they don't get all As."

However, while in the past dental students were expected to do as many fillings, extractions and make as many dentures as possible, nowadays the emphasis is on gaining competency.

Prof Hector added: "It's very much a competency-led approach and it is better in many ways because some people learn more quickly than others, some people are gifted with their hands and find the operative work really easy but may struggle a bit with the academic side, while there will be some who are the other way around.

"So this way everyone moves through the course at a slightly different rate. They all have to pitch up at the same exams but if someone is really struggling with something they can take a bit more time on it, and that happens rather more than it used to."

And, despite his new position, Prof Hector still remains passionate about teaching and hopes to carry on lecturing and working with students when everything has settled down. He said: "Teaching is my fundamental reason for staying in a dental school. Whether it is lecturing or working on the clinics, absolutely, that's what I want to do, that's what I enjoy doing.

"At the end of the day, it is all about the students. It is why we are here, it is why the hospital is here.

"The dental hospital and all the NHS staff who work within it wouldn't be here if it wasn't for the students. They essentially pay our salaries – so we have to work for them." ■

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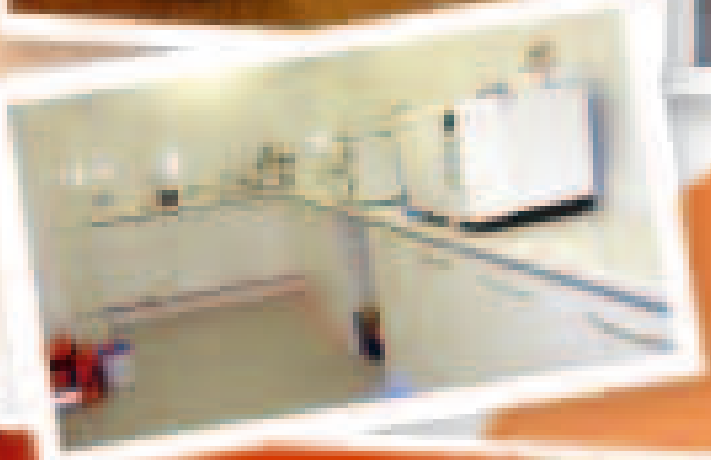

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Quality assured

As the National Clinical Lead for Quality, Jason Leitch is leading the drive to improve the standard of healthcare in Scotland. Here, he tells Tim Power why the dental industry needs to be proactive in achieving this aim

As the Scottish Government's Quality Strategy starts to impact on the healthcare sector, the dental profession has the chance to take a lead in developing a quality strategy of its own.

That's the opinion of Jason Leitch, dentist and oral surgeon at Glasgow Dental School who is now on secondment as National Clinical Lead for Quality.

Jason is part of the team spearheading the implementation of the Quality Strategy which was launched in May 2010.

This aims to deliver the highest quality of healthcare services to people in Scotland – and, through this, be recognised as among the best healthcare providers in the world.

However, while his focus is on medical care now, he foresees the momentum of the quality agenda encompassing other healthcare sectors, such as dentistry too.

That's why he believes it's the ideal time for the dental profession to take the initiative and take ownership for the development of its own standards in line with the Quality Strategy.

Jason explained: "The Quality Strategy is intended to affect all aspects of NHSScotland, including the dental profession, so now is the perfect opportunity for the profession to take a proactive stance on the issue. Why not take the initiative to develop your own quality

Jason continues to use his dental surgery skills by volunteering for the Indian Rural Evangelical Fellowship, which supports young people

systems rather than have them foisted on you?

"In conversations with the Chief Dental Officer and her Deputy, I have found that they are keen on having this conversation too. It's all about defining what quality looks like in the dental arena: is it about making fillings last longer and better customer care? Are there other aspects that can be looked at, and then how do you measure quality in a dental context?"

In fact, it's already on Scotland's Chief Dental Officer's radar, as Margie Taylor told *Scottish Dental magazine* earlier this year: "The Quality Strategy has helped focus our attention on what makes a 'quality dental practice' and we are going to be engaging with the profession in 2011 to ensure they get an opportunity to help define this clearly."

"Now is the perfect time for the dental profession to take a proactive stance on quality"

Jason Leitch, National Clinical Lead for Quality

So how did an Honorary Consultant in Oral Surgery become an acolyte for the quality mantra? His epiphany came about through a bit of serendipitous surfing on the web while he was looking for PhD funding for the Dental School. His online research led to the internationally renowned and highly influential Institute for Healthcare Improvement (IHI) in the US that was offering Quality Improvement Fellowships – and after reading more, he decided that this was a road he wanted to travel.

Before this happened, Jason was enjoying a successful career as an oral surgeon at Glasgow Dental School. He qualified as a graduate in 1991 and, as dental practice "did not float his boat", he decided on a career in surgery. He also completed a doctorate on the care of dental patients suffering from anxiety – specifically in the delivery of sedative drugs to patients undergoing dental treatment.

Jason said: "It was unique at the time and we invented a new drug delivery device that could be self-administered to the patient's needs – it was a leap forward in treating people with a phobia about dentists!"

However, his work in this field was put on hold when he decided to apply for the IHI Fellowship.

"I did not know it at the time, but this was a decision that would turn my career upside down," he said.

CHARITY WORK

Jason hasn't totally turned his back on dentistry – he still uses his dental and oral surgery skills every few years to help a community in south-east India which runs orphanages, schools and other educational work for about 2,000 children and young people.

As trustee for the UK wing of the Indian Rural Evangelical Fellowship, he helps organise a team of fellow health professionals to visit the remote state of Andhra Pradesh to provide much-needed healthcare.

Since 2006, he's raised nearly £30,000 for the charity and ran the Glasgow half marathon in September.

www.just-giving.com/user/4662333

He was successful and in 2005, he left Scotland with his wife for a year studying in Boston at the prestigious Harvard School of Public Health and working with the IHI.

The IHI has an international reputation for its focus on quality systems and Jason, like five other Fellows from that year, came under the thrall of its inspirational leader Dr Donald Berwick.

Jason explained the philosophy: "In Dr Berwick's world, everyone has two jobs: one that you do to the best of your technical ability; and a second that means striving to find a better way of doing it – and that means embracing a culture of continuous improvement.

"It was a fascinating year and it opened my eyes to quality systems in healthcare. In addition to studying, we also got to travel around the US to see public healthcare best practice in action, such as the Intermountain Healthcare in Salt Lake City, an association of 23 hospitals and medical services, and the Cincinnati Children's Hospital Medical Center.

"We also compared healthcare systems and I was pleased to see that Scotland compared pretty well with other countries, particularly in the universal provision of healthcare, but there were certainly pockets of excellence within the US and other countries such as Sweden that we could learn from.

"At the end of the year, I was

Continued »

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really looking forward to putting my new skills and training to use back in Scotland."

Jason returned to the Glasgow Dental School in 2006, but it wasn't long before he got the chance to put his new knowledge to good use in 2008 when he helped lead the Scottish Patient Safety Programme. The main aim was to reduce hospital mortality by 15 per cent in five years... and three-and-a-half years later, hospital standard mortality rates are down seven per cent.

His next challenge came when he was appointed National Clinical Lead for Quality following the publication of the Scottish Government's Quality Strategy in May 2010. This aims to put Scotland among the best in the world in terms of delivering high-quality healthcare services by putting people at the heart of the services, building on the values of the people working in and with healthcare services, and making measurable improvements in the quality of care.

Jason explained his involvement: "My role is to help implement the Quality Strategy across Scotland to remove geographical variations in effective delivery, while at the same time looking at costs and productivity."

He said the quality agenda will continue to play a big part in shaping healthcare in the future and will expand its remit into other areas of healthcare provision and eventually link into the social care sector – driven by the ethos that improvements in quality can bring savings in costs.

The key to a successful programme is developing a quality framework that identifies, measures and seeks to improve every aspect of healthcare provision from the technical expertise of practitioners, the patient experience and right through to staff development and job satisfaction.

So far, dentists have not been involved in this quality exercise, but as a former practitioner, Jason believes that the dental profession would find much to gain by taking a proactive role in developing their own quality systems.

"What we are doing in primary and acute healthcare provision can easily be replicated in dentist practices. In fact, I think dental practices have much to teach us, particularly in the area of patient experience. Dentists are small businesses who are very aware of the need for good customer relationships and, like GPs, are very good at developing this trust with whole families.

"I think the challenge for implementing quality systems in dentistry will be in assessing the technical quality of care, how we measure this and then improve on it in the context of providing value to money. If this can be done, there will be real value for dentists to show how accountable they are to public funding. The time is ripe for the dental profession to start a conversation about what quality means to them so they can drive their own quality agenda." ■

THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

The Institute for Healthcare Improvement (IHI) was co-established by Dr Donald Berwick in 1989 in Cambridge, Massachusetts, as a centre to promote safe and effective health care.

Originally a paediatrician in Harvard, Dr Berwick developed an interest in quality systems, and after investigating quality control measures in other industries such as aeronautics and manufacturing, he considered their application in healthcare settings

His vision for healthcare is: care that is safe, effective, patient-centred, timely, efficient, and equitable.

Today, IHI is a highly influential, independent, not-for-profit organisation focused on identifying and testing new models of healthcare in partnership with both patients and healthcare professionals; and ensuring the broadest possible adoption of best practices and effective innovations around the world.

In April 2010, President Obama appointed Dr Berwick as Administrator of the Centres for Medicare and Medicaid to help push through his healthcare reforms.

When Alasdair Reid's 24-year-old daughter was diagnosed with cancer, he knew he had to hit new heights in order to raise money for research into the disease, writes Bruce Oxley

Rising to the challenge

Alasdair Reid had just one thought in his mind as his legs started to grow heavier and heavier on the final push to the summit of the mountain – his 24-year-old daughter Morvern.

As he ploughed onward and upward, the Bearsden GDP took inspiration from his eldest daughter, who was diagnosed with ovarian cancer in March, and for whose chosen charity he was scaling the heights in aid of.

At the end of September, Alasdair, his friend and fellow dentist Stuart Craig from Auchinleck, and godson Graeme Reid from Johannesburg, took on the challenge of climbing 19,000 feet to the summit of Mount Kilimanjaro in Tanzania to help raise money for the Beatson Pebble Appeal.

The appeal is a £10 million campaign to raise funds to build the Beatson Translational Research Centre, the final element in the creation of the Glasgow Centre for Cancer Research. After receiving chemotherapy at the Beatson West of Scotland Cancer Centre earlier this year, Morvern decided to try to raise as much money as she could for the appeal in recognition of the outstanding care she received from the dedicated staff there. So far, Morvern and her determined band of fundraising friends and family have managed to raise just short of £25,000 and donations are still being gratefully accepted at Justgiving.com/morvern4thebeatson

She started off with a car boot sale in July that raised £156 and then 20 of her friends agreed to run the Paisley 10k in August, with all sponsorship going to her online Just Giving page. In early September, Morvern's younger sister Susie and her sixth year classmates at Glennifer High School in Paisley held a bake sale and managed to raise an amazing £510. Morvern's mum Pamela, along with a group of friends, then took part in a sponsored walk of the 90 miles of the Great Glen Way from Inverness to Fort William, which they completed in mid-October.

On top of all these planned events, there were also a number of spontaneous moments of generosity that surprised Morvern and her family. One of her mum's work colleagues turned her 60th birthday party into a fundraising event by asking for donations to the appeal instead of presents. She turned up at the Reid's door with £850 in a poly bag.

"That last day's walk I was just thinking about Morvern and the reasons we were doing this"

Alasdair Reid

Then, one of Alasdair's friends, Kenny Fairlie, managed to raise £1,000 in sponsorship by completing the Glasgow 10k, immediately followed by the half marathon. He simply crossed the finish line after the 10k, trotted over the road and started on the marathon course, without breaking stride.

With all these events being planned or under way, Alasdair knew he would need to do something special to get people, especially his patients in the practice, to dig deep and donate money to the cause. And so the idea of walking up Mount Kilimanjaro, the highest point in Africa, came into being.

Pack mentality: Alasdair Reid (right) and Stuart Craig

New horizons: a spectacular sunrise

Band of brothers: Graeme, Alasdair and Stuart

Peak practice: the top of Mount Kilimanjaro

Morvern

On the trail: group begin their long ascent

Alasdair convinced fellow dentist and friend of the family Stuart to join him and, with neither men having much experience of hill climbing, let alone mountain climbing, they decided to get a bit of training in. In the weeks and months leading up to the September trip out to East Africa, Alasdair and Stuart started a campaign of hill walking in an attempt to get in shape for the challenge that lay ahead.

However, despite their preparation, the actual climb itself tested both men to the limit. Alasdair explained: "It was a great experience. But that final day climb was the hardest thing I have ever done in my life. I had maybe underestimated it. We had done loads of preparation, we had climbed a Scottish hill every weekend for about three months before we went, so we were both fit enough.

"It was just the height. The base camp was at 15,000 feet and it was that climb from 15,000 up to 19,000 through the night that was really tough."

The final day trek, which started at 11pm and saw the men reach the summit at just after dawn, was the culmination of a six-day expedition up the mountain and was followed by a two-day descent. Alasdair explained that the five days prior to reaching the summit were not particularly difficult, with the only surprise being the weather. He said: "It rained every single day. It was either rain or snow. On the third day it was like walking through Glencoe in December. There was two or three inches of snow lying on the ground, just like home!

"But none of the climbs in the first five days were that difficult. Just long, slow, steady climbs."

However, on the sixth day Alasdair, Stuart and Graeme along with the rest of their group were woken at 11pm, fed and set on their way to the peak, with the aim to get to the top and then start back down again in one day.

But, as they got closer and closer to the top, each climber to a man started to struggle with the lack of oxygen – or more precisely the lack of oxygen pressure. Alasdair said: "The hardest thing is just not having the puff. As we got near the top I found I was just trying my hardest to get one foot to go in front of the other. It was like an old man shuffling along. You look around and everyone is the same. Everyone is in their own wee world and that last hour just stretches on and on forever."

And Alasdair revealed that his daughter was always high in his thoughts as he got closer to the top. He said: "That last day's walk I was just thinking about Morvern and the reasons we were doing this. Stuart said the same thing, there was a reason we were there and we just had to get to the top. But that was what kept us going.

"Your legs are saying you don't have to do this, just turn around and go home. But we did have to do it. For Morvern."

As they went on, the sounds of other groups reaching the top started to filter down. "Up ahead you can hear folk cheering when they get to the top," explained Alasdair. "So you start to hear that as you get closer. But you just say to yourself: 'Just keep going, don't look up, don't look up'.

"And then, at about 6am the sun came up over the horizon just as we were approaching the summit and it was fabulous. There is another volcano that sits adjacent to Kilimanjaro and the sun just came up over the peak of that and it was just spectacular, absolutely fantastic."

Just before they reached the summit, Alasdair decided to leave a keepsake on the mountainside, in the form of an impromptu time capsule: "We put a rock to one side and put a picture of Morvern with a wee message on the back, a bit of Scottish quartz as well as a few other bits and pieces and rolled the rock back over."

Just like her father and his walking buddies as they neared the summit, the family are hoping there is light at the end of the tunnel for Morvern and her treatment.

She finished her last round of chemotherapy the week before Alasdair left for Africa and the latest round of scans have been largely positive, although the family are determined to stay realistic and not get their hopes up.

Alasdair explained: "She recently went in for an MRI scan and we will wait two weeks for the results. If that comes back okay, then that's the end of her treatment and she will be reviewed three-monthly and scanned six-monthly for the next three years."

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Becoming the perfect salesperson

Changing your mindset and giving customers what they need can help boost business, says Ashley Latter

Hard sell: Ashley Latter

Are you in sales? I recently asked this question at a presentation I was delivering to more than 300 people from the dental profession: "How many people here are in sales?" Only a few hands went up, maybe less than 20 per cent. So why is it only a few hands went up? And currently, how do you feel about selling?

Well, maybe you don't see yourself as a salesperson; after all you spent over seven years learning about dentistry, not communication, or business skills. However, every day you have to sell your ideas, whether it be to the patients/clients or to other staff members. If you are not convincing and you are not speaking the language of the person who you are selling to, they probably will not buy into your ideas.

Everyone in your practice is selling an idea every day. Your reception team are the most important people in your team. They can often make or break whether someone visits your practice or not, by the way they answer your telephone.

This article is not going to give you a 180 per degree change in your way of thinking. However, only a small change in your thinking can enable you to become more successful in generating more business and giving the patient what they want. After all, if you are a private dentist it could be that 100 per cent of your income will derive from your ability to influence patients. In the current economic climate these skills may be paramount if your practice is going to survive.

Many studies have been done about what makes a person successful. In fact, here is a simple exercise to do. Think about a person you know who is successful in dentistry and develop a list of all the skills, attitudes and

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attributes that person has. Once you have done this, list them into 'Skills', 'Attitudes' and 'Product Knowledge'.

I bet on the list there are many skills such as good communication and listening skills, and the ability to build empathy with the patient. On the attitudes side, are there things like positivity and enthusiasm? Have they also got product knowledge?

On occasions, when I have a discussion with a dentist, the technical skills are often left out. Although important and vital, technical skills for doing the job only usually account for about 10-15 per cent of a person's success and, without good communication skills, and the ability to build empathy and patient commitment, you might never be able to put into practice your technical ability.

"It is hardly surprising that, when I ask the question, 80 per cent never consider themselves in sales"

So why is there sometimes negative thinking with regard to the word sales?

Well, maybe our national media doesn't help. It seems that whenever we see something in the news about selling, often it is about unscrupulous tactics from salespeople supposedly conning their vulnerable customers. I often think this is unfair, as it is only a very small percentage that might give the many millions of good sales people out there a bad name. If you think about it, without the ability to sell, the whole country would come to a halt and nothing would ever get made.

It may also be associated with the assumption that sales is about pushing something on a customer when they don't really want it. It is hardly surprising that, when I ask the question, 80 per cent of the room never consider themselves in sales.

What is the definition of sales?

A dictionary definition will tell you that it is to exchange goods and services for money or kind; to convince of value.

There is nothing in the definition that states that it is about pushing people or forcing people into decisions. Let us look at another key word here – the word value. I think value is about finding out what true value is to the other person in their context, or in other words, their situation. So what about changing your mindset from one of selling, or pushing to:

- finding out what the patient thinks is value (wants and needs)
- showing how you can satisfy the want/need
- when he believes you can, that person will probably buy.

It really isn't about selling it is about being the provider of significant value. To do this effectively, you have to follow just a few simple common sense steps.

These include:

1. Preparing for your appointment – here you can check the previous notes from your patient's records, have a team meeting for the day and ensure that you are fully prepared mentally and that you are positive about your day. You are serving the public, be excited and positive.
2. Build rapport – spend just a few minutes building rapport and making the patient feel important. Talk about work, then, become genuinely interested in the person and make them feel like the most important person in the world. Put them at ease.
3. Ask questions – after building rapport you can carry on asking questions, but this time about their clinical health. What they like or don't like about their appearance and what they would like to change. Find out their vision.
4. Provide a solution. Only when you fully understand the patient's goals do you provide a solution. Use benefits and do not talk too technical. Use evidence to back up what you are saying.
5. Test for commitment – once you have provided a solution, ask the patient if they are happy and what their reaction is.
6. Ask for commitment – if the patient is very keen to move forward, then you can ask for commitment.

So, think about how you can change your mindset. Look inside yourself and ask what is stopping you. If you think you provide significant value to patients, then why not give more patients the opportunity to have more of the same services. You are doing them and you an injustice if you don't.

Pay attention to what you are saying to yourself, such as can't or won't, and change to can and will. Change your mindset to the fact that: "I provide significant value everyday to patients" and read some of the letters you receive from happy patients.

Your team's jobs exist because of your ability to influence people and, if you think about it, without these skills, the UK economy would come to a halt.

Sales is something to be proud of. Without your ability to communicate well and listen emphatically, patients will not get what they need and, in most cases, want and no one then benefits. It is something to be proud of. When done right, both parties benefit. ■

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Left: Figure 1, Extract from patient data sheet

Right, Figure 2, Audit results summary sheet (poor records falling below acceptable standards are highlighted in red). This results table shows with 87 per cent compliance that a target level would have been met for round one but not round two

Keeping tabs on patient notes

Record keeping for dental practitioners: a comprehensive audit. By Dr Terry Simpson

Time and time again we are told of the importance of record keeping and perhaps it is right firstly to consider why we need good records. The British Dental Association (BDA) sees record keeping as fulfilling the following purposes:

- patient safety
- monitoring
- accounts
- probity enquiries
- evaluation of treatment.

However, the General Dental Council in its *Standards for dental professionals* is more vague, stating only: "Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their record."

In discussions with dentists over the years, it is clear that many will admit to deficiencies in the past when recording some of the information that we now accept should help comprise a good clinical record. Very often time is cited as the reason; sometimes dentists only see positive findings as requiring any detail. Whatever the reason, it is clear that it is our responsibility to maintain good contemporaneous and complete notes from clinical encounters.

This incompleteness of clinical records is very much supported in the evidence we have available from published audits. In 2001, an audit looking at the records from 47 general dental practitioners entering the quality assurance programme of a private capitation scheme (BUPA) in England and Wales found various deficiencies[1].

These records were examined by an independent assessor and measured against seven different domains for which a standard was identified (effectively one domain split into two separate further areas of interest giving eight domains). The domains were medical history, examination of soft tissues, full tooth

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charting, periodontal screening, at-risk periodontally and pocket depth chart (the separated domain), diagnosis and treatment planning.

The results showed dentists only to have achieved more than 50 per cent of target frequency of recording in one domain – full tooth charting (70 per cent). Completed medical histories were only available in 45 per cent of clinical records and, worst of all, nearly 80 per cent of patients had no periodontal screening at all.

Another audit from 2009 showed an improving picture but still with some deficiencies[2]. However, unlike the 2001 audit, the method employed in this study was self-assessment, which is largely dependent on how well-calibrated and rigorous the assessors were in applying the criteria. If, indeed, the quality of clinical records is improving, we have the defence societies and professional bodies such as the Faculty of General Dental Practitioners (FGDP) to thank for continually preaching the importance and assisting us in achieving a better standard.

The Lothian Record Keeping Audit

Other articles have presented a thoughtful case for incorporating clinical audit (and significant event analysis [SEA]) into everyday practice[3,4]. These sentiments have been similarly recognised by the Quality Improvement Team for Dentistry in Lothian (Lothian Committee for Quality in Dentistry – LCQD).

In April 2009, the committee commissioned an audit on clinical documentation standards that could be used by all dental professionals. This audit was to use the planned updated standards issued by the FGDP as the basis for the audit. The following year the protocol and data gathering tool were approved by LCQD for distribution to all dentists in Lothian. The remit was to produce an audit that:

- was comprehensive covering all aspects of record keeping
- set out the data sheet as a set of simple questions
- allowed the data gatherer to answer questions 'yes', 'no' or 'not applicable'
- resulted in one overall figure for compliance.

Having looked at several audits and the data gathering tools that accompanied them, several points became apparent. Record keeping audits had concentrated on certain domains such as periodontal treatment and medical histories. While using a domain-focused audit can be very useful, it would appear to miss the important first step of analysing all areas of record keeping which might be overlooked e.g. quality of referral letters, details of surgical procedures, etc. This approach can also be messy as there are different results for different domains. Having a single compliance figure overcomes some of these problems.

In developing the Lothian audit data gathering tool it was decided to leave it simple with each 'yes', 'no' or 'not applicable' answers carrying the same weight and total compliance expressed as a percentage. It should be stressed at this juncture that before embarking on any audit an acceptable standard needs to be set by those involved in the project. This is up to the individual practitioner to decide, but in the pilot studies the target for round one was set at 80 per cent and round two at 90 per cent.

An example of the data gathered is shown in figure one. This shows the information split into several questions which require a 'yes', 'no' or 'not applicable' answer. Changing any of the answers will automatically change the totals at the bottom of each column which are then used to calculate the total compliance.

Totals for each patient record audited can then easily be transferred to a results summary sheet (*Fig 2*). By completing the results electronically, calculation can be made for each data sheet based on a compliance figure (Yes/Yes + No x 100 per cent). When all 25 patient records are complete, an overall compliance figure for all patients can be attained.

All audits suffer to some extent from not weighting the data by importance. For example, would having a dog-eared written record card equate in importance to not having a current medical history – probably not?

However, further refinements of the audit in future might allow weighting to be applied to the results and this would be a relatively simple tweak to incorporate into the data collection tool. It would be possible with this audit to adapt it further and weight each answer according to a system of desirable or essential outcomes. We hope this audit will continue to evolve and assist many dental practitioners for years to come! ■

This article first appeared in the Autumn 2011 issue of Summons

ABOUT THE AUTHOR

Dr Terry Simpson is a general dental practitioner and honorary research fellow at the University of Edinburgh.
Terry would like to acknowledge the contribution of the Clinical Governance Support Team at NHS Lothian and, in particular, Denise Needham in constructing and promoting this audit. He would also like to acknowledge NCAAG (National Clinical Audit Group in E & W) which piloted the initial spreadsheet design.

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OBTAINING A COPY

Copies of the audit comprising instructions, protocol, data collection sheets (one per patient) and results summary sheets can be obtained, in electronic version only, by contacting Denise Needham at NHS Lothian (Denise.Needham@luht.scot.nhs.uk). Printed sheets can be made from these if the data gatherer prefers but the data collections sheets fit best on A3 sheets or alternatively several landscape A4 sheets.

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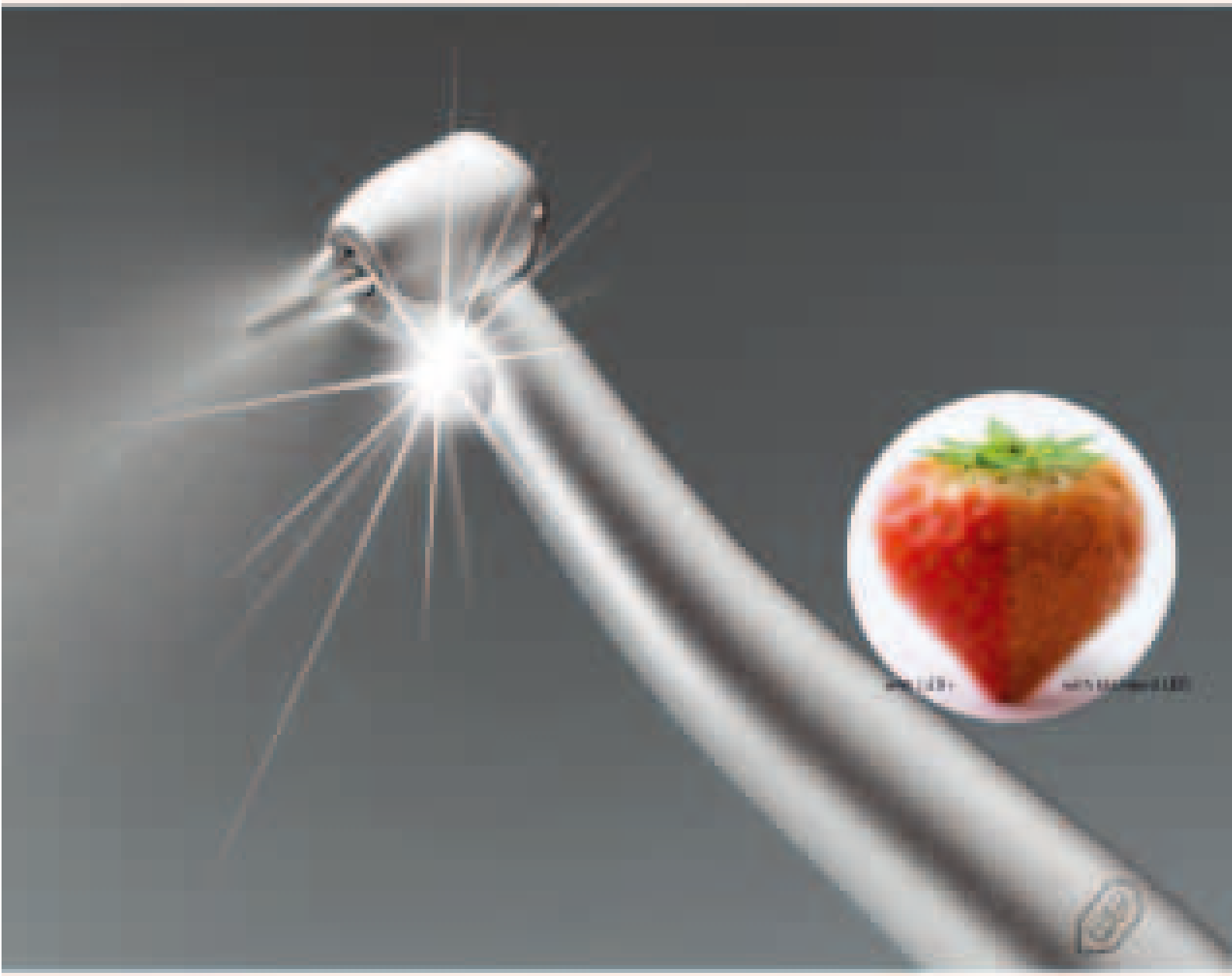

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Scotland has long punched above its weight in the dental field, producing and attracting some of the finest clinicians in the world. Here we celebrate the wealth of talent at our disposal

Who's who in Scottish dentistry

Welcome to the first *Scottish Dental magazine* Who's Who in Scottish Dentistry.

We are extremely fortunate to have such a wealth of talent, experience and innovation in our dental community and this feature aims to highlight some of the key players practising north of the border.

Many of these clinicians have reputations that are recognised around the world, holding leading positions in various associations, professional bodies and committees.

And, while not a definitive list by any means, we still have some of the finest minds and most recognisable faces in the Scottish dental community on these pages.

Given the size of the dental world in Scotland, chances are you will know, have worked with, or rubbed shoulders with many of them and we're sure you'll agree that this is an impressive line-up.

Dr Philip Friel, BDS, BSc, MFDS

Dr Friel is clinical director at Philip Friel Advanced Dentistry in Glasgow's West End, heading an 18-strong team.

His clinic was recently named 'Best Private Practice' and 'Most Attractive Practice' in the prestigious Dentistry Scotland Awards and also named 'Practice of the Year – Scotland' in the Private Dentistry Awards 2011.

Glasgow University graduate Dr Friel concentrates on restorative and cosmetic dentistry with particular focus on dental implants. As a referral clinic, Dr Friel and his team work with and mentor a number of Scottish dentists.

Named in *Dentistry Magazine's* 2010 list of the UK's Top 50 Most Influential Dentists, Dr Friel was said to be "regarded as one of Scotland's finest implants surgeons".

He is currently President-Elect of the Association of Dental Implantology.

Arshad Ali, BDS, FDSRCS, FDSRCPS, DRD, MRD RCS

Arshad is clinical director of the Scottish Centre of Excellence for Dentistry (SCED).

He qualified with commendation at the University of Glasgow in 1978 and carried out ten years of postgraduate training in Glasgow, Cardiff, London and Sweden. He was the first NHS consultant in restorative dentistry in Wales and, until recently, was consultant in restorative dentistry in Glasgow Dental Hospital and School.

Arshad gives lectures and courses in crowns, bridges and implants. He was also an examiner in Dental Surgery for The Royal College of Physicians and Surgeons of Glasgow. He has served on the Specialist Advisory Committee at the Royal College of Surgeons and has been a Council member of the Royal College of Physicians and Surgeons of Glasgow.

Jacqueline Fergus,
BDS, MSc ImpDent

Jacqueline has been in partnership at Fergus & Glover for 15 years, growing the practice to its current award-winning status from scratch; winning 'Best Employer' at the 2009 Private Dentistry Awards and 2011 Dentistry Scotland Awards.

Having served on the Council of the IAAFA for many years, facial aesthetics in dentistry is of special interest to Jacqueline, along with implantology, and she was awarded with the prize for 'Best Facial Aesthetic Smile' at the Smile Awards.

Jacqueline has lectured internationally on the subject of dental implants and is currently a GIFT Tutor as part of the Warwick University MSc programme in implant dentistry. Jacqueline is also one of the UK clinical mentors for the Avinent Implant System.

Stephen Jacobs, BDS

Stephen qualified from The University of Birmingham in 1985 and entered general practice in London. In 1990 he moved with his future wife, Lucy, to Glasgow and joined Lewis Geneen's prestigious practice, where he stayed, becoming a partner, until 2006. This phase was vital to him in developing the skills that are now required in today's competitive market-place with increasingly demanding patients.

Stephen first started with implant dentistry in 1991. It became an increasingly bigger part of his day-to-day practice and led him to set up Dental fx, the referral centre for implant and reconstructive dentistry, where all treatments in the field of implantology are carried out, including the treatment of peri-implantitis. Two years ago saw the acquisition of a cone beam CT scanner, and to date he has placed over 4,200 implants and carried out in excess of 800 sinus grafts.

He lectures throughout Europe on various aspects of implant dentistry, has published many articles and is on the editorial board of three journals.

Stephen is the Immediate Past President of The Association of Dental Implantology (UK) and is actively involved with the Association of Osseointegration (USA).

He runs a variety of courses, ranging from simple introductory implant courses to a comprehensive one-year modular course on implants, this latter one with Clive Schmulian.

He is currently researching a number of areas including insertion torques, peri-implantitis and sinus graft biomaterials.

Dr Kevin A. Lochhead,
BDS, MFGDP

Dr Lochhead qualified from Kings College London in 1987. His special interests lie in complex reconstruction, dental implants and cosmetic dentistry. In 2002, he was recognised by the GDC as a specialist in prosthodontics.

Dr Lochhead is clinical director of Edinburgh Dental Specialists, a referral only, multidisciplinary practice comprising 12 GDC or GMC-recognised specialists and a support team of over thirty staff. The practice also benefits from its own onsite laboratory, with six technicians including a master ceramist, carrying out all aspects of prosthetic and crown and bridgework.

At various times in the past 18 years, Dr Lochhead has represented the Association of Dental Implantology in Scotland, been diploma tutor for the east of Scotland Faculty of General Dental Practitioners and clinical tutor on the MSc in Primary Dental Care at Glasgow Dental Hospital.

Dr Rita Ahmad, BDS

Dr Ahmad is the owner of the Peppermint Studios group of dental practices in Glasgow.

The University of Glasgow graduate (1999) took over Bath Street Dental practice in 2003, a practice that has been in operation for more than 100 years. Since that first acquisition she has gone on to purchase three other practices in the Glasgow area: Maryhill Dental Practice, Eglinton Toll Dental Practice and Chapelhall Dental Practice.

In November, Dr Ahmad was a guest of the Prime Minister David Cameron for a celebratory Eid lunch at Downing Street and she is a regular spokesperson on the BBC Asian Network on dental health and diabetes issues.

The 2010 'Entrepreneur of the Year' at the Scottish Asian Business Awards is also a member of the Glasgow Local Dental Committee and has recently been appointed to the Scottish committee for Oxfam.

Mrs Gillian Ainsworth,
BDS, FDS RCPS, MSc, MSurgDent

After graduation from the University of Sheffield in 1996, Gillian worked in general practice, a district general hospital and a busy city maxillo-facial surgery unit. In 2003, she became one of the first two surgeons to complete the new specialist training programme in surgical dentistry, also obtaining a MSc research degree.

For the last eight years, Gillian has worked at Glasgow Dental Hospital providing oral surgery under local anaesthetic or sedation and teaching both undergraduate dental students and newly qualified NHS staff.

Gillian is a recognised oral surgery specialist, a fellow of the Royal College of Physicians and Surgeons of Glasgow and a member of the Royal College of Surgeons of Edinburgh.

Dr Judith Lello,
BDS , MDS

Since graduating from Sheffield University in 1978, Judith has undertaken extensive post-graduate training. She spent three years at Zurich Dental Institute, undertaking teaching, research and patient management: following which, she received a masters degree from Sheffield University.

She spent one year in Johannesberg at the University of Witwatersand, before returning to the UK in 1988 to practice in Manchester. Since moving to Edinburgh in 1990, she has maintained a special interest in advanced restorative work and a commitment to postgraduate and research activities. She is a GDC certified specialist in prosthodontics and she continues to limit her practice to complete reconstruction, dental implants and aesthetic dentistry.

Ruaridh McKelvey
BDS, FDSRCS, M.Orth

Ruaridh graduated in 1995 from the University of Glasgow and gained his fellowship in dental surgery with the Royal College of Surgeons in 1998. He then spent three years in specialist orthodontic training on the prestigious Bristol post-graduate course, completing the orthodontic exam in Edinburgh in 2002.

After completing his orthodontic specialist training he served as an army reservist in the UK Special Forces.

In 2005, he and his wife Jane launched Beam Orthodontics in Dundee.

Beam was awarded 'Best Specialist Practice' and was highly commended in the Best Dental Team category at the recently-held Dentistry Scotland awards.

Ruaridh is also the creator and founding member of the national Specialist Orthodontist Society.

Scot Muir,
BDS, MFGDP, RCS, MSc

Since graduating from the University of Glasgow in the mid-nineties, Scot has spent his time developing a career in implantology and smile design.
He has graduated from the Royal College of Surgeons in England and completed his masters degree in implantology at Warwick University.

He currently provides the clinical training in implant dentistry, from certificate to full masters level for the University of Central Lancashire (UcLan) and for the online educational certificate course provided through Smiletube.

Scot practices at Loveyoursmile Dental Care practice in Prestwick and Hamilton, and at Whitecross Dental Care in Edinburgh city centre.

His practice centres around the provision of dental implantology at all levels including bone grafting and sinus lifts.

Alastair MacDonald, BDS

Alastair qualified from Glasgow University in June 1985. After five years in general dental practice in Glasgow, he decided to specialise in endodontics. After a fact-finding mission to the USA, where endodontics has been an ADA-accredited speciality since 1963, he entered a two-year programme in 1990 at Indiana University and qualified with a certificate and masters degree in endodontics in 1992.

On returning to Scotland, Alastair established the first specialist endodontic referral practice. He is the only American-trained endodontist in Scotland. Referrals are taken from general and specialist dentists from all over Scotland and beyond for orthograde and surgical endodontics.

Dr David Offord,
BDS MFDS RCPS Dip.Con.Sed.

Dr Offord graduated from the University of Edinburgh in 1994.
He spent six years in general dental practice before moving to hospital-based oral and maxillofacial surgery positions.

In 2007, he was recognised by the GDC as a specialist in oral surgery.

His extensive experience in implant surgery has led to him being Scotland's representative at the Association of Dental Implantology.

Clive Schmulian,
DGDP, MGDS, FFGDP, RCS

Clive graduated from the University of Glasgow in 1993 and is a partner at Clyde Dental Practice, Ivy Cottage Dental Practice and Commonwealth Dental Practice.

He also supervises undergraduates in the restorative department at Glasgow Dental School, lecturing on CBCT in dental practice.

His practices welcome patient referrals for restorative and oral surgery under conscious sedation.

Dr Fran Veldhuizen, BDS,
MFDS RCS, M Clin Dent, MRD RCS

Dr Veldhuizen qualified from the University of Dundee in 1996. She spent several years in general practice and developed her interest in prosthodontics gaining her MFDS prior to taking up the position of specialist registrar in Edinburgh.

In 2007, she gained her masters degree in fixed and removable prosthodontics and in 2009 she was awarded her postgraduate specialist qualification, from the Royal College of Surgeons of Edinburgh.

Dr Crawford Bain, BDS, DDS, MSc, MBA Cert. Perio, Cert. Fixed Pros

After spending nine years in general practice in Scotland and Canada, Dr Bain completed speciality training in periodontics and prosthodontics at the University of Pennsylvania in 1981. Since then he has been at various times director of occlusion, head of periodontics and director of implant dentistry at Dalhousie University, Canada.

In 1990-1991 he was the Branemark surgical implant fellow at UCLA, USA, where his research into implants and smoking resulted in the Osseointegration Foundation/Quintessence Publishing Company Award for the best scientific article in the International Journal of Oral and Maxillo-Facial Implants in 1993. He has maintained a specialist practice since 1981, returning to Scotland in 1995.

Dr Bain is certified by the GDC as a specialist in periodontics, prosthodontics and restorative dentistry.

Dr Janet Clarke, BDS, FDS RCPS

Dr Clarke qualified from Birmingham with BDS in 1988 and initially worked in the hospital service rotating through oral surgery and then restorative and orthodontic and paediatric positions in Birmingham and London. She gained FDS RCPS from Glasgow and in 1995 moved to Edinburgh and started working in the practice she became principal of in 1997. Dr Clarke relocated the practice in June 2003 and renamed it Ferryburn Dental Care. It currently has a staff of three dentists, two hygienists and six nurses in the four-surgery practice.

She also work as an advisor for Denplan implementing the Excel Accreditation programme of which all Ferryburn dentists are part of. As part of her role with Denplan she has achieved the Certificate of Appraisal of Dental Practices and plans next year to enrol in the Certificate in Mentoring.

Dr Bruce Strickland, BDS, DipImpDent, RCS

Dr Strickland has been placing dental implants in general practice for the last 13 years. He has pursued his interest in implants by completing his Implant Diploma with Advanced Certification in Bone Grafting with the Royal College of Surgeons. He is a lecturer and member of the International Team for Implantology.

Over this period of time he has placed more than 3,000 implants and worked closely with his referring dentists from all over Scotland.

His aim is to partner with other clinicians as an extension of their team to provide a referral service which enhances the treatment portfolio offered to their patients.

These partnerships are built around a win/win relationship as Bruce aims to support those who wish to restore their own patients through his mentoring programme and with the support of his on-site laboratory technicians.

Dr Stuart W McLaren, MBChB, BDS, MFDS, RCS

Dr McLaren qualified in dentistry from Glasgow University in 1999 and gained his Membership to the Faculty of Dental Surgeons at The Royal College of Surgeons of Edinburgh in 2001. At this time, he then entered medical school at Dundee University, qualifying as a medical doctor in 2005.

Following this, he took up several positions encompassing many disciplines in medicine and surgery, latterly having a significant interest in emergency medicine.

In September 2011, Dr McLaren opened Prestige Dental Clinic in Rutherglen, Glasgow, where they carry out general, cosmetic and implant dentistry, accepting referrals from colleagues in all aspects of implant dentistry.

He is a member of the British Medical Association, The Royal College of Surgeons of Edinburgh and the Association of Dental Implantology.

Dr Penny Hodge, BDS, PhD, FDS RCS(Ed). Specialist in periodontics

Dr Hodge is a specialist periodontist who, in addition to practicing at Edinburgh Dental Specialists, is also a part-time clinical lecturer in periodontology at Glasgow Dental School.

Her main area of research is risk factors in periodontitis, including smoking, diabetes and genetics. Dr Hodge was awarded her PhD in 1999 and was admitted to the General Dental Council's specialist list in periodontics in 2002.

Simon Miller, BDS, MDO, RCPS, MSc, FDS RCPS

Simon is the principal orthodontist at Glasgow Orthodontics specialist referral practice in Renfield Street in the centre of Glasgow.

Along with his experienced dental team, Simon has been producing consistently excellent results since 1998.

With no waiting list and an excellent working relationship with Practitioner Services, their cases are currently being approved within two weeks.

Simon is supported by a large team of dedicated specialists and qualified therapists who strive to provide a high quality service to their patients, parents and referring dentists.

Dr Pierluigi Coli,
DDS, PhD

Dr Coli graduated from the University of Genova, Italy in 1990. He then trained as a specialist in periodontology, dental implantology and prosthodontics at Goteborg University where he also received his PhD in prosthetic dentistry and oral material sciences.

He has been involved in the training of undergraduate and postgraduate students at the faculty of odontology, Goteborg University, where he worked as a specialist.

He then moved to the UK to join the Edinburgh Dental Specialists.

Stuart Campbell,
BDS, MFDS, RCS

Stuart qualified in 2001 from Dundee, and is currently a partner at Loanhead Dental Practice in Midlothian.

He is an LDFT trainer in the South East of Scotland and Chairman of the Edinburgh branch of the British Academy of Restorative Dentistry.

He has two main clinical interests – adhesive dentistry and dental implants.

He has written several clinical articles for *Scottish Dental magazine* and has recently had a paper accepted for publication in a future issue of the *Dental Update*.

Dr Willie Jack, BDS, DGDP RCS, MGDS RCS, MMedSci
Dental Implantology

Willie Jack qualified from Edinburgh in 1983 and after two years with Lothian Health Board he moved to Shropshire and mid Wales. He practised there for the next 25 years in his own practice and in corporate dentistry.

He was awarded two post-graduate diplomas from The Royal Colleges in Edinburgh and London before gaining a masters degree in Implantology from the University of Sheffield.

He returned to Edinburgh to join colleagues at Stafford Street Dental Care in 2010, where he offers a surgical a restorative implantology referral service and an ongoing implant teaching programme.

He is the clinical director for Euroteknika Implant Systems for which he teaches and mentors dentists in UK and France.

Mr Martin Paley, BDS, MB ChB, FFDRCSI, FRCS, FRCSEd

Martin is a consultant oral and maxillofacial surgeon for NHS Lothian based in the Regional Maxillofacial Unit at St John's Hospital. His main area of interest is head and neck cancer and he performs the complex reconstruction and oral rehabilitation using free tissue transfer techniques and dental implantology.

He has recently introduced the newer minimally invasive techniques of sialoendoscopy to manage salivary gland disease to the unit. He has clinics at the Western General Hospital Oncology Centre, Edinburgh Dental Institute and in both Fife and the Borders. He also has a weekly clinic at the Spire Murrayfield Hospital.

Zannar Ossi,
BDS, MFDS RCS EMClinDent Prosth

Zannar graduated from Kharkov State Medical University in Ukraine in 1998, followed by intensive hospital residency training in general dentistry with a special interest in prosthodontics.

He then pursued his career in a private clinic, concentrating on prosthodontics, aesthetic dentistry and dental implants.

As well as attending and presenting at various implantology conferences, Zannar also works as a lecturer at the Edinburgh Postgraduate Dental Institute.

George Glover,
BDS, MSc, ImpDent

George has been a partner at Fergus & Glover in Aberdeen for 15 years, one of Scotland's most widely recognised dental practices.

With a special interest in dental implants and aesthetic dentistry, lifelong learning is extremely important to George. He is an honorary clinical tutor at the University of Warwick for the MSc in implant dentistry, ans a GIFT tutor and clinical mentor for the Avinent Implant system.

George's leadership skills were acknowledged when the practice won Best Employer at the 2009 Private Dentistry Awards and the 2011 Dentistry Scotland Awards at Gleneagles.

Dr Carol Tait,
BDS Hons, MSc, MFDS RCS, MRD RCS

After qualifying from the University of Dundee in 1987, Dr Tait worked in general practice developing her interest in endodontics before moving to Cape Town in 1998, where she worked as a lecturer in restorative dentistry teaching endodontics and gained an MSc in endodontics.

After returning to the UK, she worked as a clinical lecturer and specialist registrar in endodontics at the University of Dundee. She gained her postgraduate specialist qualification in 2004.

She is proficient in modern endodontic techniques and carries out non-surgical and surgical treatments.

Professor Glenn E. Lello, BDS, FDS RCS, RCP, MRCS, MBBCH, FRCS, PhD

Professor Lello undertook dental, medical, oral and cranio maxillo-facial surgery training and practice in association with seven Universities in a number of countries, including South Africa, Switzerland, USA and the UK.

He has held many positions within training and professional associations including the Royal College of Surgeons of Edinburgh and England. He has published many articles and served as editor of the *British Journal of Oral and Maxillofacial Surgery*. For the past 16 years he has held a consultant NHS post in Edinburgh and maintains a specialist practice including dental implants.

Dr Elaine Halley, BDS, MFGDP

Dr Halley is the principal dentist at the Cherrybank Dental Spas, private dental practices in Perth and, more recently, Edinburgh.

She was president of the British Academy of Cosmetic Dentistry in 2009, and is the only dentist in Scotland to have achieved BACD accreditation. She was recently recognised as the winner of the Outstanding Individual for her services to dentistry at the Scottish Dental Awards in November 2011.

Her main interest is cosmetic and advanced restorative dentistry. She is currently nearing the end of a masters degree in aesthetic and restorative dentistry.

She is also on the editorial board for *Private Dentistry* and *Aesthetic Dentistry Today*.

Colin Burns, BDS, MFDS RCS

Colin Burns graduated from Glasgow in 1990 and having fulfilled various hospital posts he settled down to general practice and now works entirely from his Crow Road practice, located in Jordanhill, Glasgow.

Colin's specialist interest is in surgical and implant dentistry with an emphasis on cosmetic and aesthetic smile design and in order to further his expertise in this area he is undertaking a masters degree in implant dentistry at the University of Warwick.

Colin is a member of the Association of Dental Implantology, the International Team for Implantology, Society for the Advancement of Anaesthesia in Dentistry and is the Glasgow/Edinburgh Study Club director.

Dr Neil Heath, DCR(R), BDS, MSc, MFDS RCS, DDR RCR

Neil works as an NHS consultant and honorary clinical senior lecturer in oral and maxillo-facial radiology at Glasgow Dental Hospital and School.

He qualified as a diagnostic radiographer from Sheffield in 1987 then worked as a general radiographer at the Royal Hallamshire Hospital gaining experience in neuro, orthopaedic and A&E radiography.

He qualified in Restorative dentistry from Newcastle in 1995 and completed his VT in Edinburgh in 1996. An MSc in restorative dentistry followed and he became a member of the dental faculty at the Royal College of Surgeons in Edinburgh in 2001.

Jennifer Lowe

As head of school for dental studies at Coatbridge College, Jennifer is in charge of courses which have been designed to up-skill the dental team.

The school offer Professional Development Awards in: Dental Management as well as Dental Administration and Facilitating Learning, Training and Assessment in the Workplace.

The success of their core CPD conference resulted in the school developing a core CPD evening programm offering six hours of verifiable CPD.

Specialist qualifications in orthodontics; radiography; oral health education; implant dentistry; scope of practice; tooth whitening; and customer care are available.

Professor Lars Sennerby, DDS, PhD

Professor Sennerby graduated from the Faculty of Dentistry at the University of Gothenburg in 1986. He trained in oral surgery at the Branemark Clinic, Public Health Service and Faculty of Dentistry in Gothenburg. The Branemark Clinic served as an international centre for clinical work, research and education regarding treatment of edentulous patients with dental implants. In 1993, he was appointed associate professor and then professor in clinical and experimental oral implantology at the University of Gothenburg.

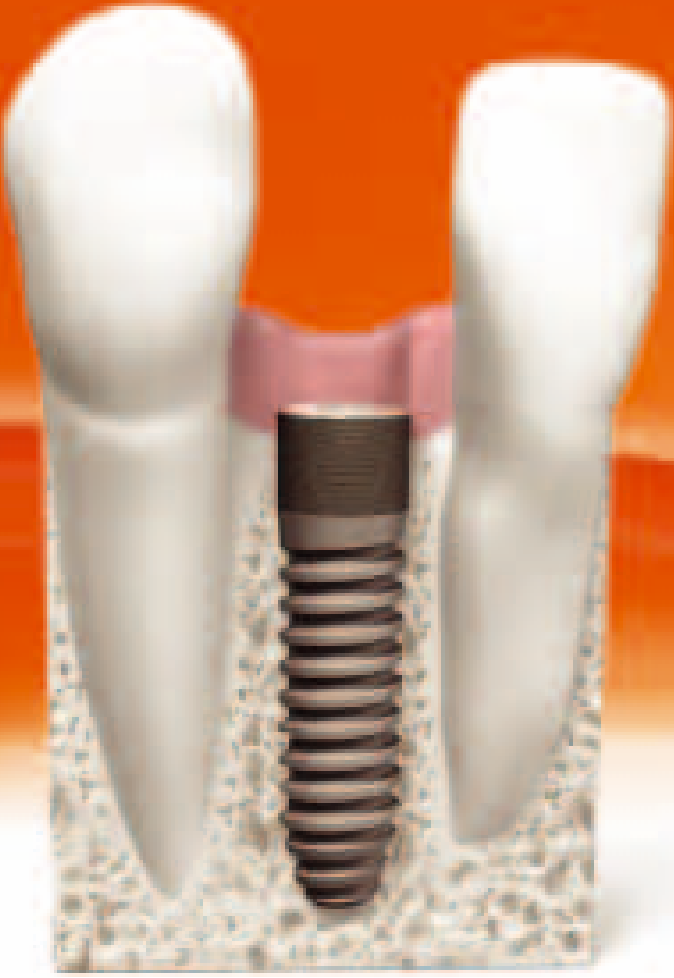
He is now a part-time professor at the Department of Oral and Maxillo-facial Surgery, Institute of Odontology, Sahlgrenska Academy at Gothenburg University, and works with implant surgery in private practice in Sweden, Italy and Scotland.

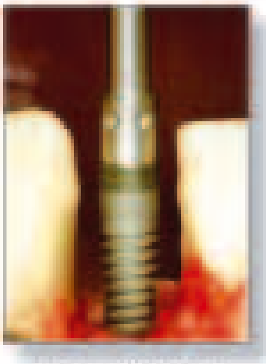
Mark Skimming, BDS

Mark opened his clinic Dentistry on the Square to establish a referral practice focusing on restorative dentistry and orthodontics.

Mark gained a diploma from the Royal College of Surgeons, leading to an MSc in advanced restorative dentistry from the University of Leeds. He leads a team of clinicians focused on minimally invasive and 'pain-free' dentistry. This is achieved through techniques such as the 'quick sleeper' pain-free injection system, IV sedation and the RA system. The clinic has visiting specialists in maxillo-facial surgery and orthodontics as well as highly skilled clinicians.

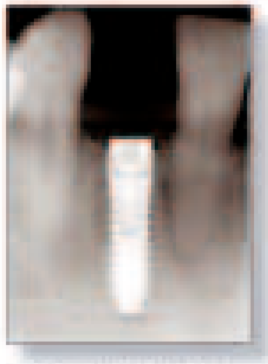
Treat small spaces with confidence





Laser-Lok 3.0 placed in aesthetic zone.

Image courtesy of Michael Reddy, DDS



Radiograph shows proper implant spacing in limited site.

Image courtesy of Cary Shapoff, DDS

Introducing the Laser-Lok® 3.0 implant

Laser-Lok 3.0 is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar[1]. Designed specifically for limited spaces in the aesthetic zone, the Laser-Lok 3.0 comes with a broad array of prosthetic options making it the perfect choice for high profile cases.

- Two-piece 3mm design offers restorative flexibility in narrow spaces
- Implant design is more than 20% stronger than competitor implant[2]
- 3mm threadform shown to be effective when immediately loaded[3]
- Laser-Lok microchannels create a physical connective tissue attachment (unlike Sharpey fibers)[4]

For more information, contact BioHorizons Customer Care: [illegible] or visit us online at [illegible]

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Setting the standard

In the next part of our journey through a live course of implant treatment, Stephen Jacobs talks about placement and healing

In the last issue we had atraumatically extracted both upper central incisor tooth roots, and having fitted the adhesive bridge, our patient NC, was delighted with the result. The sockets were noted to be healing well over the following weeks (*Figs 1, 2 and 3*), however the adhesive bridge did require re-bonding on a few occasions.

I find that when using an adhesive bridge in this situation, particularly where the lateral incisors are being used to replace both centrals, the lack of surface area for the palatal wings can predispose to de-bonding of the bridge. On reflection, using metal wings in a classic 'Rochette bridge', may or may not have been less susceptible to de-bonding. However, in any such case, when educating and informing the patient of this possibility at the planning stages, they may be prepared to accept this compromise, rather than wear a partial denture. Our patient, NC, was very much a good case in point in this regard.

CBCT

Five weeks post-extraction, it was decided that a cone beam CT scan was justified in order to assess the bone volume for the proposed implants. I have been using cone beam scanning technology for several years, culminating with the acquisition of a CBCT machine (PaxDuo,Vatech-Ewoo) almost two years ago. Having an onsite CBCT machine at Dental fx has been a resounding success, improving the efficiency and service to the patients, not to mention our referring colleagues. The images generated, together with the software functionality, allow me to plan and assess implant cases with a huge amount of detail and predictability. We have found that we carry out far less bone grafting as a result.

On looking at the cross-sectional images of the two prospective implant sites, it can be seen that in the 11 position, the coronal half of the buccal plate is absent *(Fig 4)*, while the 21 would appear to have the bony socket intact *(Fig 5)*. These findings are consistent with the direct inspection and sounding of the socket at the time of extraction. Also, bearing in mind that it is only weeks following extraction, the outline of the sockets can be clearly seen, and with adequate bone apico-palatal to the sockets, where the implants are planned to be positioned.

The placement of the implants was planned for a few weeks later, when sufficient soft tissue healing over the sockets had been obtained, and NC was informed that guided bone regeneration would be required, but that the implants could be placed at the same visit.

Implant placement

On the day of placement, following removal of the provisional bridge, NC was given a chlorhexidine (0.2 per cent) mouthwash for two minutes, after which infiltration local anaesthesia (articaine 4 per cent, 1:100,000 adrenaline) was administered.

A mucoperiosteal incision was made, palatal to the crest of the ridge, with vertical relieving incisions from just distal to the buccal gingival zenith of the lateral incisors, extended beyond the muco-gingival

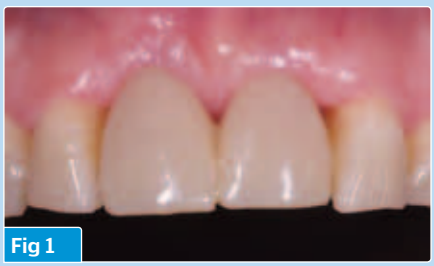
Fig 1

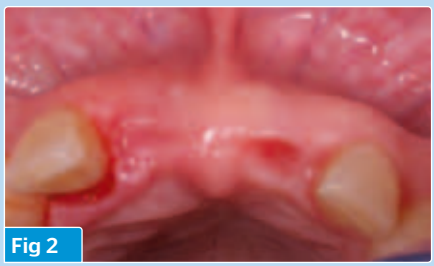
Fig 2

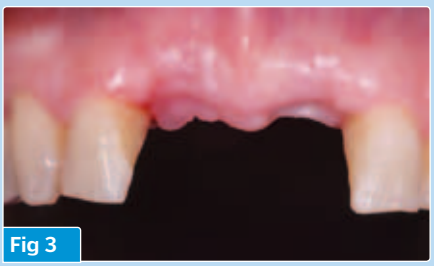
Fig 3

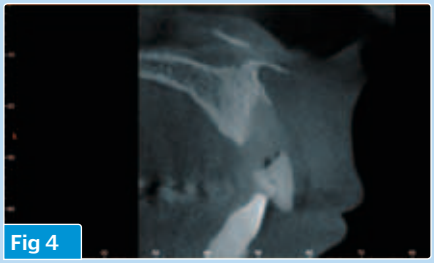
Fig 4

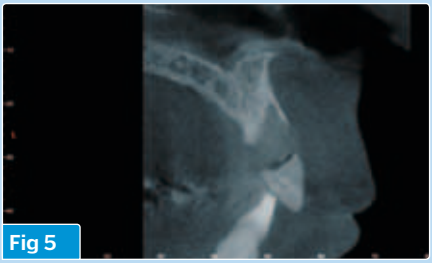
Fig 5

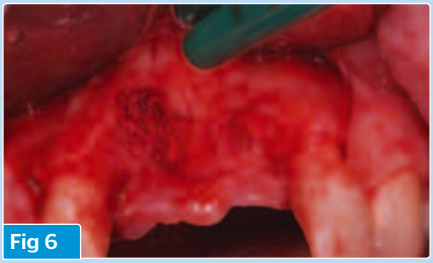
Fig 6

junction. Reflection of the flap revealed a mass of granulation tissue in the 11 site, that once curetted left a dehiscence defect of approximately 5mm, the contralateral site, at 21, having better bone morphology, but nevertheless with a smaller crestal defect *(Fig 6)*. These findings were once again consistent with the cross sectional images seen on the CT scan.

At this stage, in view of the augmentation of the site that would be required, periosteal relieving incisions were made *(Fig 7)*. I carry this out at this stage, due to the vascularity of the periosteum, allowing any bleeding to have subsided by the time the biomaterials would be required and handled.

It was decided that, with all the information to hand and the fact that the implants were to be positioned where the original tooth roots were, from the mesio-distal perspective, a surgical guide was not required.

The osteotomies were prepared, starting with a small round bur introduced towards the palatal wall of the socket, similar to the technique of placing into immediate extraction sockets. The 2mm twist drill was used and prepared to a depth of 13mm, with care taken to ensure that the long axis emerged between the cingulum and incisal edges of the two teeth to be replaced. The osteotomies were enlarged using the 3.2mm twist drill *(Figs 8 and 9)* and finally the conical drill *(Fig 10)*, which is part of the implant system being used, completed the site preparation *(Fig 11)*.

Two 4.5mm diameter, 13mm long implants *(Fig 12)*, were placed (AstraTech, Dentsply) by hand *(Fig 13)*, with the insertion torques then being measured at 18Ncm using an electronic torque controller (NSK, Japan). Implant stiffness was measured using a resonance frequency machine (Osstell ISQ, Goteborg, Sweden), the ISQ (implant stability quotient) values being 65 for the 11 and 71 for the 21 implants. Cover screws were then attached to the implants.

Care was taken to ensure that the depth of placement was optimal, the implant platform being 2-3mm apical to the cemento-enamel junction of the adjacent teeth.

It may strike some that these implants have been placed with remarkably low implant insertion torques. This subject is one of the current hot topics in implant dentistry.

However, some recent unpublished work has shown that low insertion torque using a fluoride modified textured implant surface produces a flatter implant stability time line[1], a study that I, with a co-worker, have modified and are currently working on.

A personal view of mine is that many implants these days are being placed at very high insertion torques, sometimes in excess of 50Ncm, something that I feel cannot be good for osseous healing, and possibly slowing down the osseointegration process, if one looks at the healing/integration graphs that are produced when primary stability is investigated as a variable.

Further, in a study accepted for

Continued »


Fig 10


Fig 7

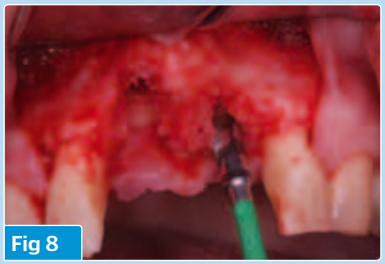
Fig 8

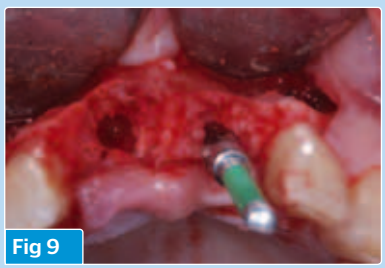
Fig 9

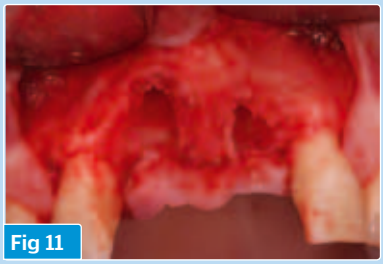
Fig 11


Fig 12


Fig 13


Fig 14

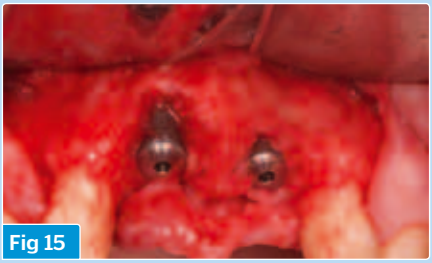
Fig 15

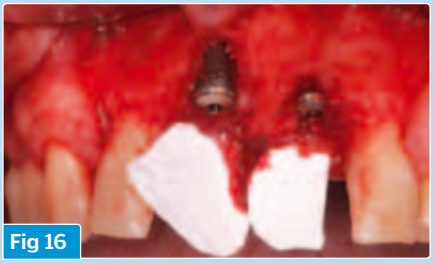
Fig 16

Continued »

publication, there has been shown a 95.5 per cent implant survival rate on 68 immediately placed and provisionalised implants in extraction sockets over a follow-up period up to nine years, where the insertion torque was ≤25Ncm[1].

Guided bone regeneration

As can be seen in Figures 14 and 15, a large defect revealed the microthreads on the conical shaped part of the 11 implant being uncovered by bone, with a smaller defect on the 21 implant, where several coronal microthreads were exposed.

Some autogenous bone, that was collected on the drill flutes during the osteotomy preparation, was placed directly on the implant surface, with a deproteinated bovine bone mineral xenograft (BioOss, Geistlich Biomaterials) layered on top of this. A collagen porcine membrane (BioGide, Geistlich Biomaterials) was placed in two layers, over the xenograft in order to protect it and create a bony healing compartment *(Figs 16, 17 and 18)*.

Closure was obtained using 5-0 Vicryl Rapide (Ethicon) sutures. This closure was tension free as a result of the periosteal relieving incisions referred to earlier. Further, the surgical site was relatively dry with minimal bleeding, because these scoring incisions were carried out near the beginning of the procedure *(Fig 19)*.

Post-operative instructions

Antibiotics and non-steroidal anti-inflammatories were prescribed, together with 0.2 per cent chlorhexidene mouthwashes. NC was advised to apply ice packs to the outside of the face, for the remainder

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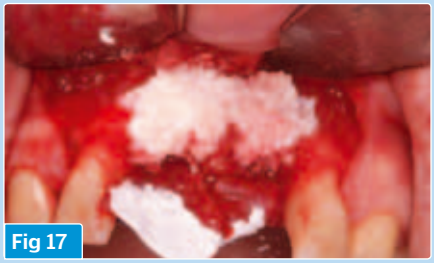
Fig 17

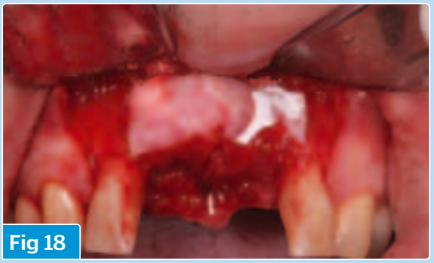
Fig 18

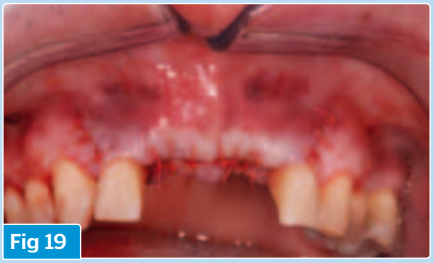
Fig 19

Continued »

of the day in order to reduce the swelling.

Initial healing was uneventful, except for the one occasion where NC was experiencing some fairly significant pain, three days following surgery. Post-operative pain is very unusual – I would actually say it was rare – following implant surgery, assuming that the correct analgesia is provided. So, to receive a telephone call on a Sunday afternoon, while I was at a wedding, came somewhat as a surprise.

Advice, and more importantly, reassurance, was given over the phone and the pain very quickly settled completely, in fact by the following day NC was pain free. This highlights the importance of giving patients your contact details in case of any problems, even if it is only advice and reassurance that they require, it is an essential part of patient management.

NC was to be reviewed one week after surgery followed by a period of three to four months to allow osseo-integration and graft maturation. During this time the profile of the soft tissue was to be assessed in order to determine the next stages.

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As painless as possible

Contrary to how it looks, Patient NC explains that he felt little post-operative pain after his treatment

In my house, it is well known that I have the pain threshold of a sunburned three-year-old whose useless parents forgot to bring the calamine lotion. Man or mouse? Pass the cheese.

My plight is compounded when she who must be obeyed happens to be a former nursing sister, so reducing the prospects of a distress-easing cup of tea to below zero. It has to be clinically proven confirmation of my mortal coil departure before any form of gentle ministration is forthcoming. Getting the picture?

But I merely set the scene. You will have digested the science bit from the good Doctor Jacobs. So, when he describes a post-operative day of excruciating agony (I'm a journalist, I exaggerate professionally) as "some fairly significant pain", I immediately suspect he and my other half of a clandestine conversation before I set out on this journey! The sympathy clearly lying with Dr Jacobs, of course.

At this point, I would also issue a public health warning. Regardless of how much oral pain you are in, never think salvation lies at the Southern General's emergency GP clinic. Presenting dental pain to the hard-pressed team there elicits roughly the same response as asking the recently repossessed homeowner to discuss the merits of the banking profession! They really don't want to know; a fact proven by the four and half hour wait before I finally gave up and fled into the night. Before I left, they did, however, give me – I suspect – a DF118 (or its modern equivalent) that certainly did for the pain... and nearly for me when I added a large Lagavulin to the mix to ensure blessed sleep.

Now, let's get some perspective into this. The truth is that I WAS in some "fairly significant pain" for about 18 hours, three days after the procedure. Bizarre and unexplained, I know.

Perhaps the reason it was so surprising was that I had been completely at ease during the actual procedure, thanks to the thorough explanation of what was to be done and excellent anaesthetic management. At no time was there any discomfort in the hour or so I was in the chair, probably longer than generally required because of the number of images being taken for your benefit! While orally more invasive than anything I have experienced, it was, in truth, not really arduous at all. Slightly nervy – then again I am – but simple and straightforward from the patient perspective.

What was remarkable was that there was no pain post-operatively from the site of the procedure and there was minimal bruising and swelling. The comprehensive post-operative guidance was exemplary and worked (my own outstanding contribution to medical science is to have devised an ingenious new cold pack to reduce swelling which I WILL patent, so don't get any ideas: simply roll frozen peas into cling film, mold into a moustache shape, freeze and apply to the upper lip, replacing each one as it melts – a hell of a lot easier than trying to get an entire bag of frozen veg on your face... which, being a bit thick, I tried!).

"Regardless of how much oral pain you are in, never think salvation lies at the Southern General's emergency GP clinic"

The "worst", I am told, is over and we are now on the last lap to my new teeth. The trials of the flying bridge (see last issue) and the discomfort of post-op are now behind me. Surely there is nothing more to come.

But wait: the editor has just shown me pictures of what was done inside my mouth while I wasn't looking. That's it, back to the whisky bottle... no wonder it bloody hurt! ■

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Brushing up on your financial systems

It is important to weigh the benefits and pitfalls of any investment, writes Jayne Clifford

All of my dental clients are keen to add value to their practice in one way or another. This is especially true in today's economic climate where, although there is not necessarily a 'recession' in terms of patient numbers, there is an element of people delaying having major dental works carried out because of their own personal finances, and there is certainly a funding squeeze as banks tighten up their lending criteria.

Many practitioners are adding value to their practices by carrying out renovations to plant and equipment, improving the décor of their practice, increasing marketing and providing additional services above and beyond traditional dentistry. It is about spending now to accumulate later.

This provides a timely reminder that the Annual Investment Allowance for tax decreases from £100,000 to £25,000 from 1 April 2012, so if you are planning renovations, time is starting to run out.

The vast majority of dentists, and indeed all my clients, are ambitious for themselves, their trainees, their patients and their practices. But how do you know how much of a financial return you are achieving on this investment?

It is important in any size and type of organisation to monitor performance and costs. Charities, small and medium sized enterprises, right up to major PLCs do this. While I am loathe to suggest a target-focused culture to dental practices where medical need is the primary driver, key performance indicators are crucial to ensure all is going to plan in your practice.

The installation of a computerised accounting package can assist with this. My firm, Martin Aitken & Co, is a member of the Sage Accountants Club, meaning we can provide accountancy software solutions to organisations of all sizes. The program is designed to be used by non-finance personnel, and can provide you with timely and regular financial information.

The installation of a software package such as Sage (others are available), will make it possible to quickly and simply pull off reports each month or quarter as suits. Figures will then be available to compare fee income, expenses and overheads to previous periods and ensure your practice is headed in the right direction and operating efficiently.

Good accountants will discuss such things with you at your accounting year-end, but imagine how much more useful these figures would be to you if you could take corrective action as and when issues are identified, rather than several months later down the line?

There are additional benefits too: if HMRC came knocking on your door for a spot check on your record keeping, are you satisfied you could provide them with all the answers within a reasonable time period? Or would you have to take time out to get your bank statements, invoices and NHS schedules together and spend your leisure time writing up spreadsheets and cashbooks?

We work closely with many of the banks and financiers operating within the healthcare sector, and where you require finance such as a loan or overdraft facility, it is helpful to be able to produce good quality management accounts each quarter or half year to furnish the bank with the required information they are increasingly asking for to satisfy themselves.

Many practice management software tools will let you track appointments, items of service provided and track these over time. Is your practice management software also capable of providing more detailed financial information on figures such as income breakdown and details of overheads?

Different sizes of practices will have different requirements, and to ensure clear, accurate and useful management information is available to you, your software package has to be set up properly from day one. If you think computerising your financial records could benefit you, save you time, give peace of mind and assist with adding further value to your practice, then get in touch with your accountant and see what they can recommend. We offer practical training services to get you up and running in no time so you can get back to focusing on what really matters – providing patients with high quality care and service. ■

Right: Jayne Clifford

ABOUT THE AUTHOR

Jayne Clifford is a partner at Martin Aitken & Co and has advised many dentist clients, including those both in the NHS and private sectors, for over twenty years. Jayne is contactable at jfc@maco.co.uk and by telephone on 0141 272 0000. You can find out more about Martin Aitken & Co by looking at their website 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.

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Inhalation sedation – friend or foe?

Janet Pickles of RA Medical gives an update on relative analgesia in general dentistry

Pain control is an invaluable part of the dentist's toolbox. Often the way this is performed is down to individual preference. Many dentists' only experience of inhalation sedation will have come as part of their undergraduate training and, as this varies appreciably according to which dental school they attended, can result in a somewhat 'patchy' approach to the use of relative analgesia in dental practices.

It is estimated that use of inhalation sedation in the UK could be as low as 15 per cent – and in some geographical areas this drops to zero. Contrast this with the US where the figure rises to somewhere between 50-58 per cent of dentists using this valuable tool on a daily basis. The use, as you travel around European countries, varies significantly, but it is reported that sales of inhalation sedation equipment in the Scandinavian countries have almost reached 'saturation' level, suggesting that an extremely high percentage of dentists use this facility.

The recent NICE report actively seeks to encourage more use of conscious sedation. Flexibility of method is the watchword and all forms of pain control are to be encouraged and used wherever possible. Already, practitioners regularly employ varying methods of IV, mucosal, oral and RA sedation – often in combination and whichever seems most appropriate for the individual. In order to utilise this, dental practices will have to equip and familiarise themselves with the relevant equipment. Indeed, there is a school of thought that states: "Sedation should be offered as a matter of course to avoid creating a generation of dental phobics."

Some members of the profession have stated that they find inhalation sedation "too much of a bother" or "too expensive". Surely this is over simplification? The technique should not be dismissed purely on these grounds – indeed, it smacks of 'throwing the baby out with the bathwater' to ignore this well-proven, safe and valuable asset.

Of all the techniques of conscious sedation, undoubtedly, inhalation sedation, or as more commonly called, relative analgesia, is the one which has the greatest inbuilt flexibility and by far the widest application to all age groups.

The particular concept of relative analgesia dates from 1940 when Harry Langa and other enthusiasts began to use low concentrations of nitrous oxide allied to semi-hypnotic suggestions for their dental patients. They discovered that

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Continued »

when fear, anxiety and apprehensions are eliminated and the patient is given a changed mental focus, a number of valuable effects follow. One of the most dramatic of these is a raising of the pain threshold, so that minor discomfort is no longer magnified and exaggerated by fear[1].

Once it has been established that relative analgesia can be a great asset to the dental practice, then great care must be taken to ensure the equipment complies with all the latest specification and requirements. This does not necessarily have to be difficult or expensive. Great leaps forward in provision of titrated flowmeters and scavenging sundries have been made in recent years and a comprehensive range of equipment is available to suit all requirements.

If cost remains an issue, re-conditioned equipment should be considered. We are fortunate in the UK as the Quantiflex range used to be manufactured here in the 1960s and 70s, including the MDM, Mark I and Mark II sedation flowmeters. These have proved long lasting – some units currently in daily use are over 40 years old.

A recent article for *Dental Nursing*, written by a trained sedation nurse, mentions one such unit in almost daily use and comments: "Regularly serviced it still looks as good as new. There are not many pieces of dental equipment that will still be working every day after this length of time." This clearly illustrates the benefits of taking re-conditioned equipment into consideration when evaluating the costings for setting up of this facility, the only drawback being availability, which is limited at times. There are many indications that the use of inhalation sedation within dental practices – both high street and community are enjoying a period of growth. Indeed, this equipment, which has always traditionally been perceived as solely for dental use, is starting to move outside this, into other areas – being employed in hospital emergency departments – more specifically for paediatric use.

"The use of relative analgesia in general dental practice should not be dismissed lightly"

The BDJ has recently published a number of articles around the subject of inhalation sedation. September[2] saw a research summary published on The Indicator of Sedation Need (IOSN) a new assessment tool written by a team of six dental professionals headed by Professor Paul Coulthard of Manchester Dental School.

This document, divided into an estimated four or five parts, was launched at the Dental Sedation Teacher Group Meeting (DSTG) in May 2011 and was well received by the large number of delegates. The 22 October issue[3] contained an article written by David Craig of Kings College London. This was an explanation of the work of the new Independent Expert Group on Training Standards for Sedation in Dentistry (IEGTSSD) – comprising many former members of the IACSD.

Details of this group, and the work already carried out, were presented to delegates of this year's Society for Advancement of Anaesthesia in Dentistry (SAAD) held in September. This long-established group saw record numbers attending in 2011 and is a further indication of the increased interest in the whole field of conscious sedation.

A further development is the introduction of training for hygienists in inhalation sedation techniques. The first course took place in 2010 and the second in November 2011.

There appears to be considerable interest although a slight issue appears to have arisen around the area of finding suitable places/mentors to practice. SAAD have declared that their selection process will exclude any candidate who cannot prove that their place of work will provide them with this facility.

This may have the result of discouraging some interested parties and seems a great shame. There does appear to be quite a strong element of interest and articles on the subject are already starting to appear, aimed specifically at dental hygienists and therapists.

Conclusions

Although financial considerations cannot be ignored, the use of relative analgesia as a valuable tool in general dental practice should not be dismissed lightly.

Expert advice should be sought on initial requirement and purchasing of equipment to avoid expensive 'mistakes' and the use of an efficient scavenging system is an absolute necessity on grounds of COSHH (Control of Substances Hazardous to Health) and health and safety.

However, once the hurdle of establishing a sedation facility is passed, then the equipment should, if maintained correctly, give many years of trouble free usage, adding an extra dimension to the practice facilities on offer and further cementing the dentist/patient bond. ■

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1 Allen W. Relative Analgesia. Dental Practice Vol.14 no: 5 May 1976
2 BDJ Volume 211 No.5 September 10 2011
3 BDJ Volume 211 No.8 October 22 2011

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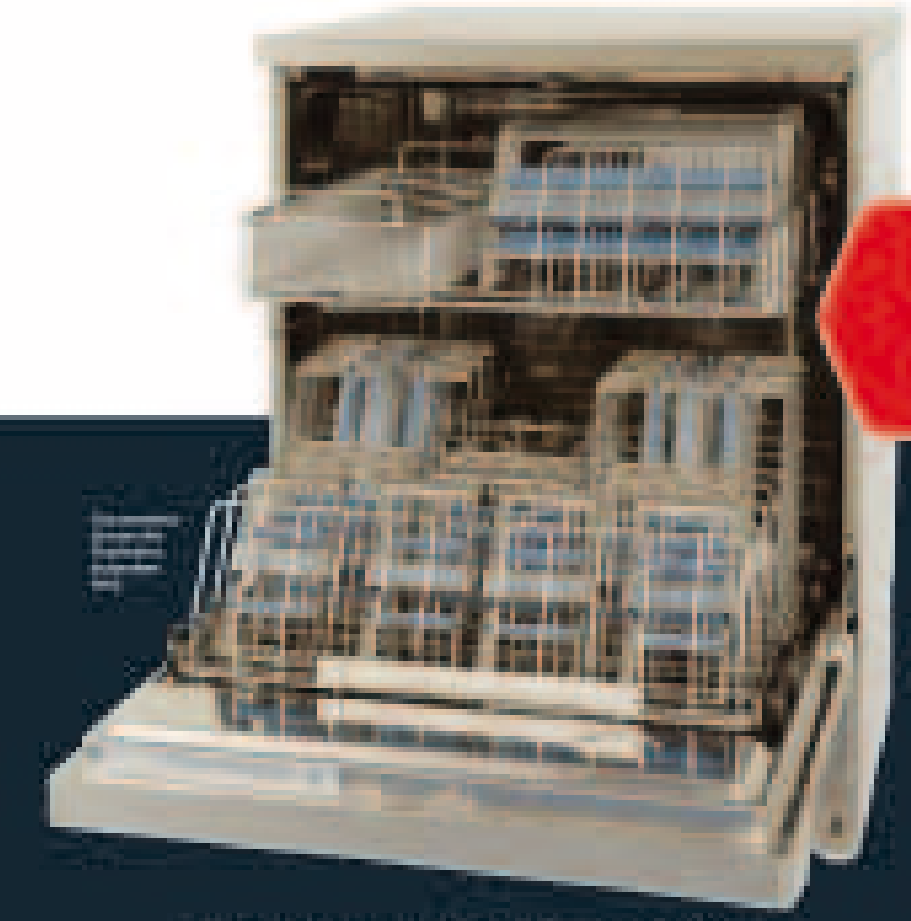

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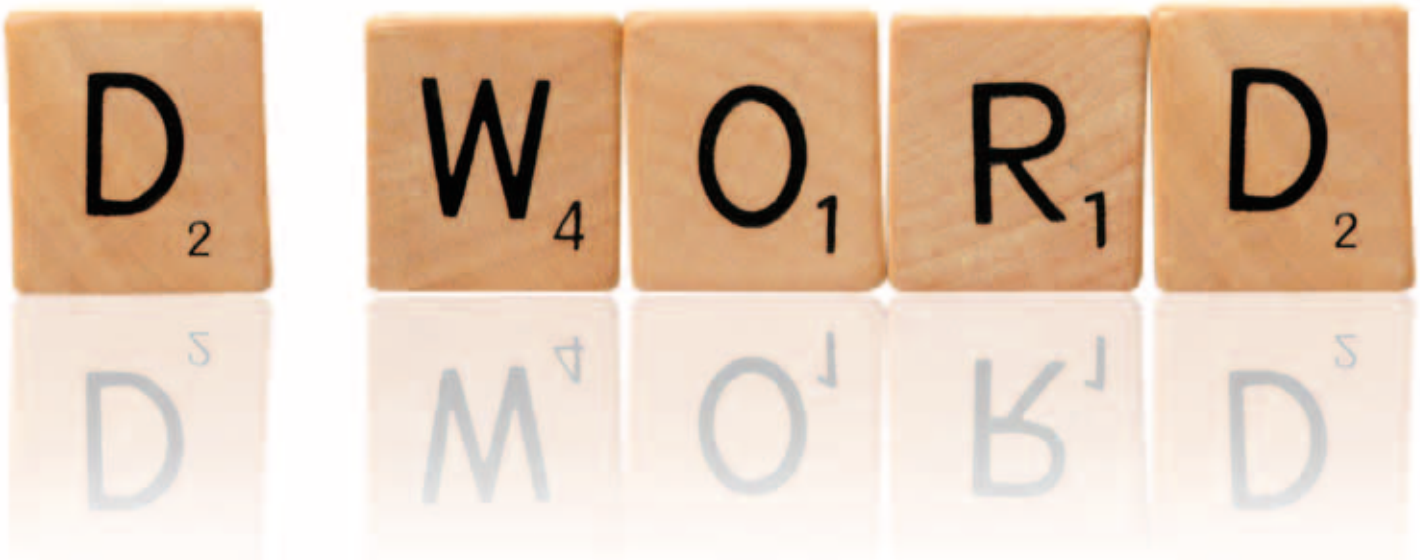

A personal review of a contentious problem by Irene Black

Decontamination is never far away from the headlines and controversy. Although I'm still a practice owner with the same concerns as every GDP, my other roles mean I often need to step back from the ranting and take a balanced view of the overall picture.

Over the last 10 years I've seen deadlines pass and lead organisations and individuals come and go. I've watched new participants, with some vested interest, moving from committee to committee. Shuffling deck chairs on the Titanic frequently springs to mind.

One constant has been the mantra that there can only be one standard and that no risk can ever be acceptable. At first glance, the idea of one standard across all sectors in both acute and primary care appears plausible. With insight, however, this is more than a little naïve. In my opinion, the requirement has to be appropriate standards for each sector based on the level of risk to patient safety. The difficulty being that the specifics of these risks have never been clearly identified or defined.

Evidence

Evidence, or rather the lack of it, has been another fundamental problem. Dentists, understandably, have demanded evidence of the necessity for these major changes. Many have argued about the lack of evidence of harm caused by our infection control and decontamination processes. The counterpoint is that the lack of evidence of harm is not evidence that no harm has occurred. The experts' argument being that no one has actually looked.

Research is being carried out in a variety of related topics. Some of these studies are likely to look further at microbiological contamination of dental instruments following our potentially inadequate processing systems. I'm not entirely convinced that this will help. This type of evidence is difficult to argue with. My confession is that I struggle to understand at which point the specific microbiology, the level of contamination and the potential to cause harm becomes significant. Zero, or a number close, appears to be the only acceptable level. The protestation as to the heavily contaminated field of operation, i.e. patient's mouths, appears to be irrelevant.

"The counterpoint is that the lack of evidence of harm is not evidence that no harm has occured"

Irene Black

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Policy and implementation

Over the years, the organisations charged with leading on decontamination have appeared to have little understanding of independent contractor's arrangements. They have found our anomalous contractual situation within the GDS difficult to deal with. There has been confusion around the differences between the directly managed service and a misconception that the GDS was the 'private' sector.

I believe this lack of understanding has improved although they are still unsure how to deal with dental practices as they have no direct connection, influence or control.

Our current strong leadership has enabled the relationship with these organisations to mature significantly over the last three years. Communications have improved with a willingness to listen and some recognition of the need for joined up working has been agreed.

I do actually have some sympathy for those tasked with advising government on decontamination policy. Their corporate concerns are mainly focused on the legal implications when anything goes wrong. This is exacerbated by the worry of the inevitable media repercussions. Hence the reason they rigidly apply guidance and regulation as a non-negotiable stance. Even if they were unconvinced as to the extent of risk in our sector, they are constrained by their circumstances and can never actually deviate from that policy position.

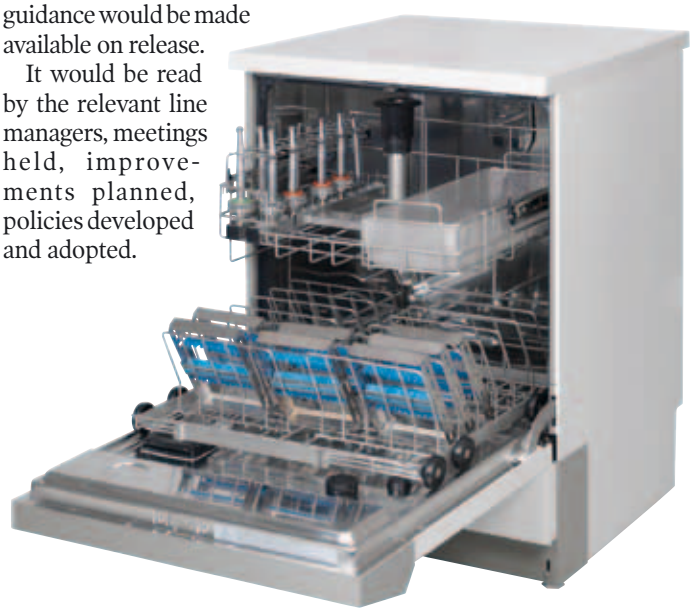
In reality, for those of us in a GDS setting, if something does go horribly wrong, the risk is entirely our own. There would certainly be some repercussions for our health board and external organisations but, generally, the buck stops with us.

Guidance

Adhering to all relevant guidance and regulation is the mainstay of ensuring compliance.

In managed sectors this guidance would be made available on release.

It would be read by the relevant line managers, meetings held, improvements planned, policies developed and adopted.



The information in these guidance documents filters down significantly slower in our sector. As we eventually became more aware of the guidance, the barriers to application become apparent. Guidance such as the Scottish

Health Technical Memoranda (SHTMs) are extensive technical documents. These were produced many years ago by technical experts and are certainly not an easy read for dentists and their teams.

Few would disagree that these documents are now in urgent need of review and revision in line with technological changes and emerging evidence. The conundrum here is that until this guidance is reviewed nothing can actually change. The experts exhibit a limpet like adherence to the letter of guidance despite the fact it may no longer be entirely appropriate.

Another source of confusion in relation to guidance is the fact that the rest of the UK adopted HTM 01-05 in 2009. Scotland did not. The reason for this was that our experts believe our standards are higher than those in HTM 01-05 and we were leading the pack.

Although HTM 01-05 has not exactly been welcomed with open arms by our colleagues in the south, it is at least a single readable document. The general principles are virtually the same as our requirements. There are differences in the details, some of which are even more challenging than ours.

Some details in HTM 01-05 have already been challenged in relation to emerging evidence in areas such as storage times, which were originally based on expert's best guesstimates. I believe there is a plan to revise the whole structure of HTM 01-05 and potentially change it significantly in the coming year.

Manufacturers and suppliers

Manufacturers and suppliers are inevitably involved with the provision of decontamination equipment. This presents

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"Few would disagree that these documents are now in urgent need of review and revision"

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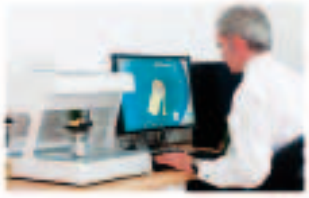

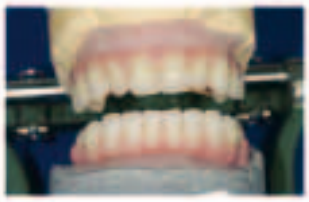

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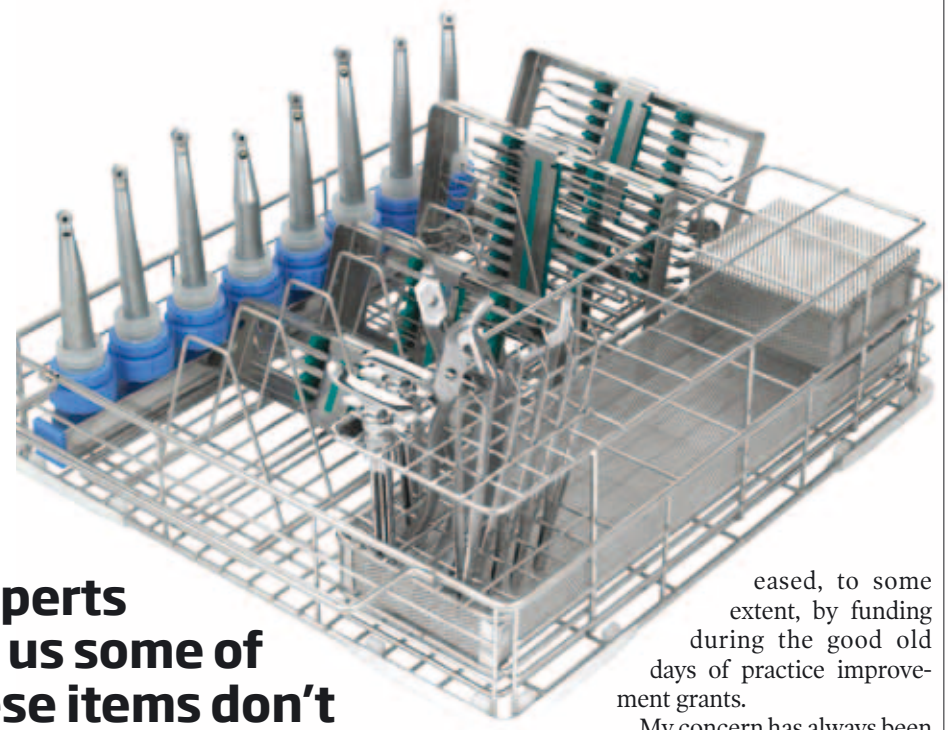
dentists with another dilemma; on one hand these companies are trying to convince us that they can solve all our problems simply and cost effectively if we purchase their product. On the other hand, the experts tell us some of these items don't fulfil all the technical requirements. Who are we supposed to believe? This has left dentists, as usual, between a rock and a hard place.

One example of this problem has to be washer disinfectors and the difficulties with cleaning handpieces. These companies must shoulder some of the blame here.

All manufacturers and suppliers have had 10 years since the first Glennie technical guidance demanded a move to automated cleaning processes. Some forward thinking and joined up working might have served to obviate some of the problems we have to work through now.

There appears to have been a serious lack of communication on all sides which has resulted in a classic case of the cart before horse.



"Experts tell us some of these items don't fulfil all the technical requirements. Who are we supposed to believe?"

Recent progress

Despite this seemingly despondent diatribe, there have been some glimmers of light at the end of a very dark tunnel.

In these times of recession I do sense a hint of a more pragmatic approach from some quarters. I sometimes even convince myself that the precautionary principle might have slithered off into the long grass.

The tangible effects have resulted in some significant concessions; one being an acknowledgment that manufacturers' instructions are the legal position in relation to testing requirements. The other was the statement from Scottish Healthcare Technologies Group that there is no evidence for improved patient safety or cost benefit in having vacuum autoclaves in the GDS. Commonsense had prevailed for a short time at least. Predictably, these positive changes are being challenged by academics and the technical experts. We will need to watch this space.

The future – compliance

Compliance with guidance means more than having a separate room for decontamination. It involves having validated equipment tested and maintained, robust processes, documented training, management systems in place and lots more besides.

As we hurtle headlong towards the December 2012 deadline and this mysterious concept, the answer to the million dollar question of who will come and get us if we don't, can't or won't fully comply, is still not certain.

The potential for Health Improvement Scotland to assume the role of inspection and inspection regulation of dental services in Scotland is still alive and well.

The fact that the CQC has assumed this role in England has heightened my concerns.

The preferred option, in my opinion, would be for a new robust and efficient practice inspection system to be introduced. This would cover infection control and the general requirements for decontamination compliance. I would welcome a move away from a tick box exercise proven to have little value in reality.

This could still be undertaken through health boards and retain peer input. If this could be accepted by all parties we might manage to keep the burden of further external scrutiny and regulation at bay.

The last word

It's hard to argue that our practices did not need to improve in response to public and Government demands around the highly charged issue of healthcare associated infection. The status quo was not an option.

Over the years I've seen the general mood of the profession move gradually from incredulous disbelief to a disgruntled acceptance that decontamination requirements are here to stay. This transition was eased, to some extent, by funding during the good old days of practice improvement grants.

My concern has always been the provision of support, both financial and practical as the missing components. That has been resolved to an extent through concerted efforts from dental practice advisers, NHS Education, some health boards and the Scottish Dental Clinical Effectiveness Programme.

There are certainly still barriers in relation to fully embracing and implementing the changes but most are moving in the right general direction.

I firmly believe the days of ranting about the general principles of these changes are done. However, there is still plenty of scope for vociferous haggling over the detail.

Decontamination has certainly been a catalyst for change. Despite our intrinsic resistance, in many situations there have been positive outcomes.

Those who have seen this as an opportunity and not a threat have grasped the potential to improve their practices. Delivering patient care in pleasant surroundings with better working conditions for our hard-pressed teams can only be a positive experience for both patients and professionals.

Change is never comfortable. It is usually an inevitability and can occasionally have a happy ending. ■

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Waking up to **hypnosis**

Lindsay C Howden, consultant clinical hypnotherapist, explores the history of hypnotherapy as an aid to easing patients' fear, and details the potential benefits in modern-day treatment

One in three people fear the dentist.

Fear of dental procedures is a very common and distressing condition and, according to the BDA, affects one adult in three. The problem also exists in many children. People may neglect their dental health so much that oral disease seriously affects their general health and quality of life. Some people are so afraid of the dentist that they seldom or never attend, with serious health consequences.

Hypnotic techniques can help many anxious and seriously phobic patients. Patients who experience gagging, bruxism, temporomandibular joint problems and excessive salivation can also benefit. Simple hypnotic techniques can be used in the chair while some patients may require a longer course of hypnosis, conducted either by a dentist trained in hypnosis or a consultant hypnotherapist.

For people with a severe phobia, whose extreme anxiety makes it impossible for them to enter a dental surgery and talk to a dentist, the initial consultation is likely to be held away from the surgery and carried out by a hypnotherapist or the patient's GP. In the longer term, the aim is to enable the patient to cope with dental treatment with greatly reduced anxiety.

Continued »

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A brief history of modern hypnosis

General interest in science and such things as gravity and magnetism influenced the beliefs of Franz Anton Mesmer (1734-1815) who undoubtedly became the most famous, or perhaps infamous, of early hypnotists. After a French government commission largely discredited Mesmer's work, a number of pioneers toned down and refined Mesmer's techniques. Notably, the Marquis de Puységur and the Abbé Feria hypnotised large numbers of people. They replaced the theatrical mesmeric passing of hands or wand over the body with verbal suggestion.

The most interesting results came from India in the 1840s where Dr James Esdaile, a Scottish surgeon, used hypnosis as an anaesthetic in hundreds of operations, including amputations and the removal of scrotal tumours. This work was further advanced by James Braid, another Scottish doctor. As well as popularising the term 'hypnosis', he developed the modern eye-fixation techniques.

His favoured method of inducing the state was to hold a shiny scalpel case in front of, and slightly above, his patients' eyes, bringing about visual fatigue, eye closure and then trance. All of this had come a long way from the days of Mesmer. Hypnotism was made even more popular when physicians with the eminence of Jean-Martin Charcot in Paris took up its practice. The first reference to an extraction being performed under hypnosis was in 1836 when a Parisian dentist by the name of Oudet carried out the procedure.

The discovery and development of inhalation anaesthetics in surgery, including dental surgery, led to a decline in the popularity of hypnosis by the end of the 19th century. However, by the middle of the 20th century, doctors and dentists were rediscovering the benefits that hypnosis could offer their patients. By the 21st century, a general medical and scientific consensus has been reached that hypnotherapy can benefit patients suffering from a wide range of conditions and this is backed up by thousands of scientific studies. To take only one example, hypnotherapy is now the treatment of choice for patients with irritable bowel syndrome as recommended by NICE in England and Wales.

What is hypnotherapy and how does it work?

Hypnosis is defined by the British Psychological Society as: "...an interaction between one person, the 'hypnotist', and another person or people, 'the subjects'. In this interaction the hypnotist attempts to influence the subjects' perceptions, feelings, thinking and behaviour by asking them to concentrate on appropriate ideas and images. The verbal communications that the hypnotist uses to achieve these effects are termed 'suggestions.' Suggestions differ from everyday kinds of instructions in that they imply that a 'successful' response experienced by the subject has a quality of involuntariness or effortlessness. Subjects may learn to go through the hypnotic procedures on their own, and this is termed 'self-hypnosis'."

Hypnotherapy is simply the application of hypnosis for the benefit of the patient. Almost everyone can be hypnotised and, in fact, several times each day we will all find ourselves in a natural hypnotic state, particularly first thing in the morning when neither fully asleep nor fully awake, or when reading an engrossing book and losing track of time.

Dental anxiety and phobia

The term 'hypnodontics' was coined 60 years ago to describe the application of controlled suggestion and hypnosis to the practice of dentistry. Much can be done to reduce anxiety levels in patients from the moment they arrive at the surgery. It has even been suggested that something as apparently minor as the doorbell volume and tone can have an impact on anxiety.

Many dentists and their staff are well aware of the importance of creating a welcoming atmosphere and give careful attention to the layout and décor of the reception area and the waiting room. It is also very important to recognise the impact of the language used with the patient. In using hypnosis for weight loss, for example, many experts recommend avoiding the use of the word 'heavy'.

During hypnotic induction and suggestion, the language used is carefully selected to obtain the most positive outcome. It is just as important to be aware of the potential for invoking anxiety attached to certain words, such as 'pain'. Words like 'pressure' or 'discomfort' may be less worrying to the patient. When discussing a patient's feelings about an imminent procedure the dentist might talk about 'concern' rather than 'fear'.

Hypnotic treatment of the phobic patient

Probably the most effective treatment for the phobic patient is systematic desensitisation, as described by Joseph Wolpe. This is a gradual process best carried out away from the surgery and is likely to require several sessions.

Under hypnosis, the patient is first taught how to quickly reach a deep state of relaxation. The anxiety-provoking stimulus is then broken down into a number of steps or stages starting with the least frightening and graduating to the most frightening in around five steps. The response to each stimulus is rated by the patient using the subjective feelings of distress scale (SUDS) with zero representing no fear at all (perhaps sitting in a comfortable chair at home) and five representing frank terror (perhaps hearing the sound of the drill). Clearly frightening stimuli will vary for each individual, reflecting their personal history of dental treatment.

"His favoured method of inducing hypnosis was to hold a shiny scalpel case in front of, and slightly above, his patients' eyes, bringing about visual fatigue, eye closure and then trance"

ABOUT THE AUTHOR

Lindsay Howden, PhD CBiol GQHP GHR Reg. is an analytical hypnotherapist who is on the General Hypnotherapy Register. He is also a chartered biologist and practiced as a pharmacist for many years in both hospital – where he ran a medicines information centre – and in the community. He first became interested and involved in hypnotherapy many years ago. He has a private practice in the new town of Edinburgh.

Under hypnosis, each stimulus, starting with the least challenging, is rated by the patient both before and after, triggering powerful relaxation images. This may need to be repeated several times until the anxiety subsides significantly. The next most challenging stimulus is then introduced and the process is continued with desensitisation being achieved at each stage until the whole anxiety-provoking scenario has been worked through.

The relaxing image and sensations can also be 'anchored' to a covert gesture such as fist clenching or pressing the thumb and index finger together. The patient can then use this when presented with the actual anxiety-provoking stimulus in the waiting room and then in the dentist's chair. A posthypnotic suggestion can also be given that each and every time the worrying situation is encountered the patient will feel more and more relaxed about facing the scenario.

It is also very useful to teach the patient how to quickly and easily self-hypnotise and to suggest that, after practising this technique, it should be used the night before going to the dentist and while sitting in the waiting room. It is essential that the dentist is aware the patient will be using hypnosis and can allow the patient time to prepare.

Use of hypnosis for specific conditions

Hypnosis has been used to help with the treatment of a number of specific problems and conditions:

Bruxism

Many patients with clenching and tooth-grinding are very tense and stressed individuals and the relaxation obtained through hypnosis and particularly self-hypnosis has been found to be very successful in treating this condition, often bringing relief.

Temperomandibular joint dysfunction

Hypnosis has been found to be an extremely useful adjunct in the treatment of this problem. Hypnosis can be used along with traditional treatment and can help improve pain control and relaxation.

Analgesia, bleeding control, gagging and excessive salivation

Pharmacological analgesia and local anaesthesia can be enhanced by hypnosis and, in some patients, the need for local anaesthetic can be lessened or eliminated. The problems of excessive bleeding, gagging and copious salivation can also be addressed using hypnosis in suitable patients.

Conclusion

Weiner says that "unless dentists broaden their diagnostic skills and management abilities, dental fear will remain as prevalent in the future as it has been in the past. All the modern equipment and technical skills are useless, if the practitioner does not get and keep the patient coming for regular care." Hypnotherapy has proven to be a valuable adjunct to the expertise of the dentist. ■

FURTHER READING

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Weiner. The Fearful Dental Patient: A guide to understanding and managing. Wiley-Blackwell 2011

Hammond. Handbook of Hypnotic Suggestions and Metaphors. Norton 1990

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Christine Hanson tells how new cadavers have helped students learn

Teaching extractions is no longer a pain

Extracting teeth was historically taught by an apprenticeship scheme and it wasn't until the early 1700s that Paul Fauchard first published a book for dentists, which included a description of the stance and position that the operator should adopt. Something we still do today "plus ça change plus c'est la même chose".

Teaching students how to extract teeth has progressed from a system that was, in essence, a continuation of the old hands-on apprenticeship to the present, where students are versed in the science behind their actions and practise on models before treating patients. Investigation into old Dundee Dental School student records, and interviews with retired dentists, produced an amazing level of undergraduate and postgraduate experience of tooth extraction. In the '30s, one Dundee student took out 280 teeth in one month and in the '60s a dental surgeon took out, from patients under general anaesthetic, 283 teeth in one day.

The number has fallen slowly over the years and the reasons are multiple. There is now better access to dental care in Tayside. Education, fluoride in toothpaste, recent celebrities' tooth-whitening fads and the television programme

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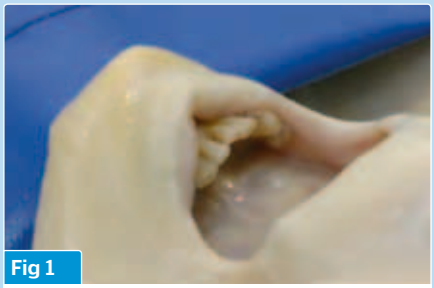

Fig 1
A Thiel body before the dental students' attention

Fig 2
A cadaver being prepared for a class

Fig 3
Somewhat apprehensive students look on at a demonstration extraction

Continued »

'Ten Years Younger' have, it would seem, all encouraged people in our catchment area to look after their teeth.

To teach the skill of extraction to students we have always needed a practice model. Talking to retired dentists at the Lindsay Society for the Study of the History of Dentistry, this model was the patient; with a lecturer literally hands-on guiding the student's. Later, it was the pig's head. The event, with all the cultural and aesthetic drawbacks, was memorable if only for the pungent odour of the heads on a warm day in the laboratory.

Frasaco produced replaceable metal teeth in a mannequin head, which was infinitely preferable. It was then easy to get the student and the forceps in the right place to do the deed. It gave a degree of realism but still did not have the feel of withdrawing the tooth from bone and, indeed, if the teeth were extracted from the mannequins, they wore out and were very expensive to replace. The models were very basic in form and this limited their use.

In Dundee University there is the Centre for Human Identification, under the direction of professor Sue Black. They have bodies donated for use in medical science, including training and research. Cadavers embalmed by the newly introduced Thiel method leaves

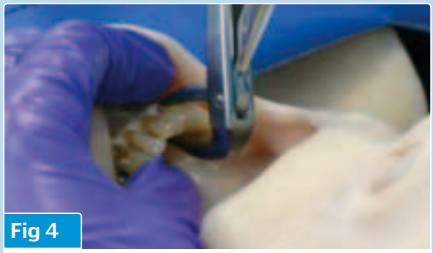

Fig 4

The oral tissues remain supple and can easily be retracted. It gives a good hands-on feel to allow positioning of forceps prior to a real extraction

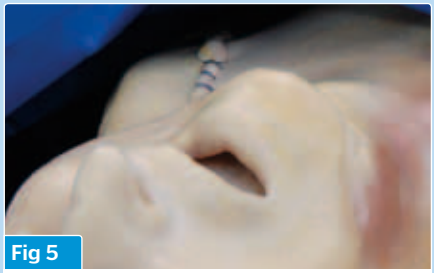

Fig 5

The bodies may well have been used by the medical school to teach surgery before we arrive

Fig 7

Literally hands-on during an extraction

them soft and supple, unlike the hard unyielding high formalin preserved ones that most will remember. You only have to shut your eyes to recall the nose-searing smell on entering the dissecting room for the first time.

Thiels have little smell. They have all the attributes of a live patient, the tissues are soft and easily retracted as in life. They have though, a strange appearance, reminiscent of an unfinished wax doll, in that all hair is lost during this process. There is a little degeneration in the perio membrane, too, but it's not significant to our students' experience of their first extraction. It does not make it easier to extract the teeth – as some of them found out when they fractured the roots.

However, another trial using Thiels for teaching minor oral surgery work found that the longer they had been embalmed the thinner and more tissue-paper like the mucosa became. It was not robust enough for students to manipulate and we still use silicon models for this. But despite this, the students could experience the hard tissue, bone cutting and tooth cleaving aspects of dento-alveolar surgery. The centre plans to change their embalming technique so that all bodies will be prepared in this way, but at present there were only sufficient numbers to allow a pilot study to appraise the value of Thiels as a teaching model for the

Continued »

Fig 8
Student attempts an extraction

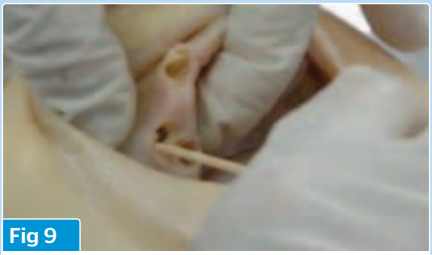

Fig 9
One Theil body had an OAC which could be demonstrated by inserting a quill to its maximum depth. Something most certainly not advised in a live patient

Fig 10
Students observing an extraction

Continued »

staff and students. It was carried out this summer for the students who were to make the transition from books to clinic in the autumn. The students seemed at ease with the concept of working on the bodies. Only one out of 32 students did not want to extract a tooth.

Already, there is considerable experience in using these cadavers for all the basic dental local anaesthetic techniques. The local dissipates and can be given repeatedly. For the extractions, they were given a scenario for each case and encouraged to explain and interact with the Thiel as if it were a patient. It gave them the opportunity to begin to build an interactive script and develop their clinical manner, albeit with an unresponsive patient. They are usually so concerned with the mechanics of their first live extraction that conversation with the patient stalls and explanations to patients that they may experience deep pressure etc, becomes forgotten.

Feedback showed that those who did not have this primary introduction to extraction felt they were disadvantaged. Some would have liked to return after they had carried out their first in vivo extraction – "Why wouldn't you want to practise?" was one comment. They wanted to ask more questions which might have been difficult in front of a patient and realised that the problems could be easily demonstrated on the Thiels. All students in the third BDS year, not only those that got this experience, seemed keen that it should be rolled out to all students in following years. It is possible that these bodies should be used for other post graduate procedures, for example implant placement. I have experienced implant courses that use isolated plastic mandibles but it is difficult to find the words without seeming to over exaggerate to emphasise how superior the bodies are.

As a lecturer I recognise that it is difficult to find a practise model that has translational validity and it has always been a tiring struggle to take mannequin theory into the clinic, but I was unprepared for just how good these bodies are for teaching. The ability to freeze-frame, intervene and correct with explanations, which would be entirely inappropriate in the clinical setting, was liberating.

Some with the Thiel experience agreed that it bolstered their confidence, which was just as well, for those who made this comment rated their confidence to carry out their first extraction on the low side. Would these have been the students who were so apprehensive that they would have dragged their heels to be among the last to extract teeth, and building up more of a psychological barrier to success as time went on? They have also said that they would love to have done more extractions and that the term should be a mix of live patients and Thiel bodies.

Over the years I have tried to produce realistic models for teaching. With the exceptions that the patient is not seated and there is a lack of interaction, these are my ideal bodies for teaching extraction techniques. It is a teaching opportunity not to be missed and I hope that we can extend this facility to all the undergraduates in the next academic year.

Professor Sue Black and her team, who some of you will remember from their television series, is running the somewhat unusual campaign 'Million for a Morgue' to raise money for building a modern morgue where all the bodies will be preserved in this way. The University of Dundee has earmarked £1 million to expand the centre for Anatomy and Human Identification (CAHID) and the campaign target is to match this.

Details of it can be found at www.millionforamorgue.com ■

ABOUT THE AUTHOR

Dr Christine J. Hanson, is a Lecturer/ Associate Specialist in Oral Surgery at Dundee Dental School, Dundee University.

"The ability to freeze-frame, intervene and correct with explanations, which would be entirely inappropriate in the clinical setting, was liberating"

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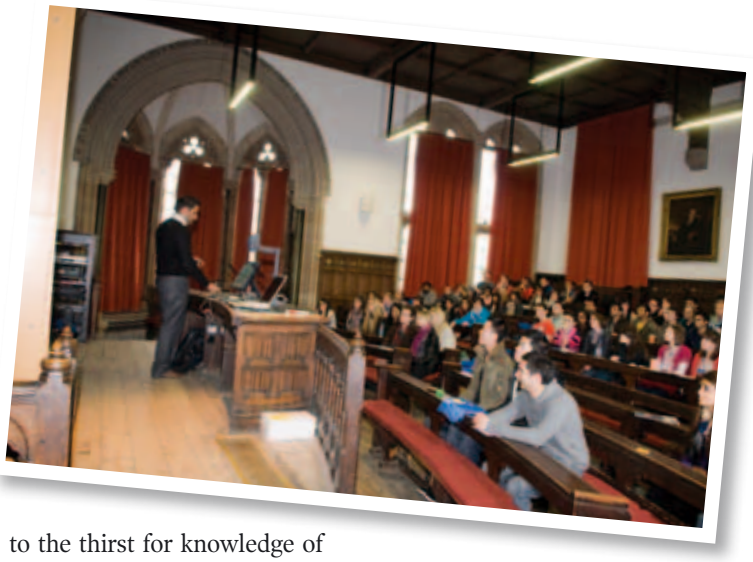
Constant thirst for knowledge

Former Glasgow dental student and founder of the British Medical Dental Careers Fair at the University of Glasgow, Bilal Aslam, says students' high motivation levels and ceaseless desire for new information is the reason behind the meteoric growth of the upcoming event



Following two previous successful events, March 2012 will see the return of the British Medical Dental Careers Fair at the University of Glasgow.

The brainchild of former Glasgow dental student, Bilal Aslam, the fair has grown from around 500 delegates at the inaugural event in 2008, to 1,000 in 2010, within the region of 2,000 delegates expected to attend next year's fair at Hunter Halls on Saturday, 3 March 2012.

Bilal, who is also the organiser and president of the Careers Fair Committee, explained how the event started. He said: "The concept for a careers fair arose during my third year in dental school while trying to find information about a specialty I was interested in. After looking around for advice, there were still a number of queries I had. Having realised this gap in career information for the dental profession, I approached the dean of Glasgow Dental School, Professor Jeremy Bagg, with a proposition for the British Dental Careers Fair."

And he believes that the event has been a success thanks to the thirst for knowledge of the students that attend. He said: "I believe dental students and dentists are extremely motivated individuals who like to be well informed when it comes to making decisions about their respective careers. It is only with their support that the careers fair is still running."

However, after two successful events, Bilal explained that they have decided to expand the event to also include CPD lectures. He said: "This year we are lucky enough to work in collaboration with the Royal College of Physicians and Surgeons of Glasgow, and therefore are able to offer dentists the opportunity to listen to world-renowned speakers and gain core verifiable CPD at the event. We have also opened up the event

CONFIRMED SPEAKERS:

Mrs Laetitia Brocklebank, Consultant in Dental Radiology
Dr Alexander Crighton, Consultant in Oral Medicine
Ms Serpil Djemal, Consultant in Restorative Dentistry
Mrs Laura Mitchell, Consultant in Orthodontics
Mr David Mitchell, Consultant in Oral and Maxillofacial Surgery
Professor Andrew Smith, Professor in Microbiology
Professor Richard Welbury, Professor in Paediatric Dentistry

to 1,000 medical students from across Scotland in addition to dental students from across the UK."

Having completed his vocational training with the London Deanery, Bilal is currently working at his six-month post at the oral surgery department at the Glasgow Dental Hospital, followed by a six-month post as a senior house officer in oral and max-fac surgery at the Southern General Hospital. ■

For more information on the British Medical Dental Careers Fair or to register for the event, visit www.mdcareersfair.com/register

Please note, early registration is highly recommended as delegate places are limited.

Date: Saturday 3 March 2012
Time: 2pm-6pm
Venue: Hunter Halls, University of Glasgow, G12 8QQ

CONFIRMED EXHIBITORS:

British Dental Association
British Orthodontic Society
British Society of Paediatric Dentistry
Dental Defence Union
Dental Protection
General Dental Council
HSBC
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Scottish Dental magazine
Wesleyan Medical Sickness

CBCT versus traditional radiography

Comparing the clinical benefits of focused-field CBCT with X-ray assessments in endodontics

Scientific evaluation is crucial to establishing the potential results of endodontic therapy, providing practitioners with the means to accurately predict the likely outcome of a range of medical care options. In this way, it greatly empowers patients when it comes to deciding which endodontic treatment to proceed with as they have sufficient knowledge to make an informed choice.

Endodontic treatment evaluation has typically been associated with the use of X-ray radiography for almost a century. This method of using X-rays to determine the health of the tooth root, dental pulp and surrounding tissue, offers a far more verifiable appraisal than performing an examination and referring to medical history.

X-rays, however, are far from foolproof. Even half a century ago, researchers noted[1] that radiography couldn't accurately and reliably identify periapical lesions in spongy bone. Indeed, there are many published cases recording the shortcomings of X-rays, particularly the inherent problems associated with reducing a complicated, involved, 3D image into a 2D radiograph. The resulting X-ray can be difficult to read because of blurring and malformation of shapes within the image.

Imperfections such as these can lead to incorrect diagnosis, either of the severity of the problem or whether or not there is even an endodontic problem at all[2]. Thanks to imaging developments in recent years, the solution to this is clear. Investigations have shown[3] that periapical lesions which were not identified on X-rays were subsequently discovered using Cone Beam CT scans. This 3D imaging system avoids the problems, or restraints, commonly associated with 2D intraoral radiographs.

Both in vivo and ex vivo analyses[4] have come to the conclusion that CBCT is a far greater method of accurately diagnosing periapical lesions. A study looking at diseased root canals in dogs[5] involved taking X-rays and CBCT scans of the periapical tissues post-mortem, then checking these images and subsequent findings against the conclusions of a histopathological assessment. The research concluded that CBCT was the better system for predictable and precise identi-

fication of apical periodontitis, with a clarity of image that was significantly lacking in the X-rays. The inquiry also confirmed that by using X-rays, practitioners were more likely to misjudge the extent of disease.

However, the enhanced precision of CBCT does come at a cost: the procedure requires the patient to take a larger dose of radiation. Having said that, scans required for endodontic diagnosis require the smallest depth of field, so patients are given the least possible dose for maximum effect[6].

Because CBCT is able to target the required area, only pertinent information is captured and the volume of superfluous scanning is minimal[7]. In addition to this, findings are indicating that it's possible to have an effective lower dose by altering the equipment's default exposure settings, with no impact on diagnostic capacity[8]. Specifically, research looking at periapical lesion diagnosis using CBCT scans[9], showed that halving the scanning arc from 360 to 180 degrees had no negative repercussions on pathology identification, while greatly reducing patient risk.

Technological advances offer practitioners the opportunity to reassess their methodology for determining endodontic treatment. CBCT offers a predictability with diagnosis that has been demonstrated as superior to radiography, which is essential in certain circumstances. Such precision imagery is apt to provide clinical information that will clearly show which treatment approach is more likely to reap success. The limitations of X-rays can potentially be harmful to the patient, increasing the possibility of misdiagnosis and unsuitable or ineffective treatment. Only when the way forward is clear to the practitioner can they offer genuine advice on endodontic treatment options.

Above all else it is imperative to provide patients with an understanding of the risks and the likelihood of a positive outcome, in order for them to make important decisions relating to their health. It is not only the ethical thing to do, it is also a requirement of the CQC that we empower patients with the ability to give informed consent to recommended courses of treatment.

Mounting evidence suggests that the accuracy of CBCT scanning, in particular with regard to potential apical periodontitis, along with dose-control capability, is one of the most effective diagnostic tools to have in the surgery.

One example of a powerful and easy-to-use Cone Beam 3D system is the Kodak 9500 from Carestream Dental. The technology delivers anatomically correct images while an intelligent design allows the swift and simple selection of the field of view that best matches clinical needs, optimises radiation dose and minimises patient risk. ■

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[1] Bender & Seltzer (1961)
[2] Bender (1997), Lofthag-Hansen et al. (2007), Paula-Silva et al. (2009a)
[3] Bornstein et al. (2011)
[4] O¨zen et al. (2009), Patel et al. (2009), Paula-Silva et al. (2009b,c)
[5] Paula-Silva et al. (2009 b,c)
[6] Loubele et al. (2009)
[7] Holroyd & Gulson 2009, Patel & Horner (2009)
[8] Durack et al. (2011)
[9] Lennon et al. (2011).

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

The ADI welcomes Dr Michael Pikos

The Association of Dental Implantology is proud to present the latest in our Masterclass series: 'Maxillary Alveolar Ridge Regenerative Strategies: From Extraction Site Management to Full Arch Reconstruction' with Dr Michael A. Pikos, on Monday 26 March 2012.

Dr Pikos, originally from Campbell, Ohio, is one of the world's leading exponents on hard and soft-tissue grafting procedures in implant dentistry. He is founder and CEO of the Pikos Implant Institute. Since 1990, Dr Pikos has been teaching advanced bone and soft-tissue grafting courses with alumni that now number more than 2,400 from around the world.

Dr Pikos is also a well-published author, who has lectured extensively on dental implants in North and South America, Europe, Asia, and the Middle East.

The ADI is delighted that Dr Pikos has accepted our invitation to present this six-hour in-depth lecture. It is a topic that will appeal to both experts and beginners in the dental implant field.

Masterclasses are an integral part of the ADI calendar, giving clinicians, technicians and DCPs the opportunity to listen to highly acclaimed dental professionals.

After the lecture attendees will be able to:

1. Understand the importance of a sequential CBCT-based digital diagnostic protocol for maxillary alveolar ridge augmentation.
2. Appreciate the indications for maxillary extraction site management and ridge augmentation.
3. Understand the application and protocols of current hard and soft tissue grafting techniques for maxillary alveolar ridge augmentation.

The ADI's new President, Professor Cemal Ucer, who recently took over from Scottish dentist Stephen Jacobs, is particularly looking forward to the Masterclass. He said: "The combination of a high-quality speaker, fascinating topic and peer interaction, all in a full-day masterclass format, should make this event one not to be missed." ■

The Masterclass will take place at the Royal College of Surgeons of England, London. You can register for the event at www.adi.org.uk/masterclass2012 or call the ADI office on 020 8487 5555.

Get the knowledge – get the WYSdom

ICONic Dental Practice Software developer WYSdom Dental Technologies, based in Milton Keynes, has launched an **all-inclusive hardware and software rental scheme** for the Scottish and Northern Ireland dental markets.

In a move that offers a three-year scheme with a fixed monthly price to cover installation of all hardware, software and maintenance – and guaranteed to have no price increase for up to six years – WYSdom particularly hopes to tempt those practices which still use paper-based patient records.

For practices that currently don't have a computerised system this option makes a very attractive proposition as it gives the practice an opportunity to get to grips with the whole concept of computerisation for minimal outlay. There's also the bonus of £50 discount per month for the first 10 customers of the scheme, with systems starting at just £349 plus vat.

The ICONic system is widely accepted to be the easiest software to use currently on the market and, with its image-based charting, it reduces the learning curve for dentists and nurses significantly and at the same time makes charting very simple, accurate and fast.

The system typically comes with business-level professional hardware, too, so reliability is high and running costs (consumables such as printer cartridges and appointment cards remain the practice's responsibility) are kept to a minimum. All equipment is covered under the maintenance element of the support contract so no nasty surprises if something stops working for some reason.

Every three years all the hardware will be replaced with brand new equipment ready for the next rental period so clients will always have up-to-date computers and printers ready to take advantage of the latest technologies available.

Not only do WYSdom customers get a great hardware service, the software support staff are ex-dental professionals.

Key Features:

- Fixed all-inclusive monthly rental fee, guaranteed for up to six years.
- Easy to learn image-driven charting.
- Business-quality hardware.
- All new hardware every three years
- One-stop-shop, single point of contact hardware and software support. ■

Go to www.wysdom.co.uk/rentals for more information, or call Marion on 01908 324045.

Small things, big difference

In these tough economic times, Dentsply understand that small things can make a big difference to dental practices that want to keep an eye on costs without compromising on quality. That is why the Dentsply Rewards website (www.dentsplyrewards.co.uk), which offers rewards to customers, is proving so popular.

Dentsply is the leading manufacturer of dental materials and equipment in the UK and Ireland, with a sound reputation for quality products. By ordering via the easy-to-use Dentsply Rewards website, practices accrue rewards that can then be redeemed on other Dentsply products. Get the highest-quality dental products and save money!

For more information, visit dentsply.co.uk or phone 0800 072 3313. Earn rewards against purchases at dentsplyrewards.co.uk Access webinars and products demonstrations and earn CPD at dentsplyacademy.co.uk

UnoDent Nitrile Gloves, soothe on the move

For examination gloves that are also kind to the skin, The Dental Directory now stock UnoDent Nitrile gloves with Aloe vera.

Each ambidextrous glove is specially coated with Aloe vera – a substance renowned for its soothing, anti-inflammatory properties, and the cooling, moisturising effect it can have on the skin.

UnoDent Nitrile Aloe vera gGloves come in boxes of 100 and in a range of sizes. These gloves have been manufactured and tested to standard EN 455 (Parts 1 and 2) for your peace of mind.

For more information on the UnoDent Nitrile Aloe vera gloves and other types within the range, contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

New from UnoDent, Nine Plus Capsules

Trust...
The Dental Directory

A resin-free glass ionomer restorative that isn't sticky and handles with ease. Biocompatible and radiopaque, Nine Plus isn't sensitive to moisture, with the advantage of being insoluble in water and acidic conditions after setting. In addition Nine Plus offers lower opacity than many of its competitors, giving better translucency and aesthetics, with superior fluoride release. Capsules available in shades A2, A3 and A3.5. Available as an assorted pack of 30 (10 x A2, A3 and A3.5) or boxes of 50, with optional Capsule Applicator.

To accompany the capsules are Nine Plus LC Varnish – a nano-filled, light-cured coating to protect the surface of restorations from exposure to moisture/saliva, as well as Conditioner – designed to clean the cavity and condition dentine and enamel to enhance the bond between the ionomer and the tooth structure.

Contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

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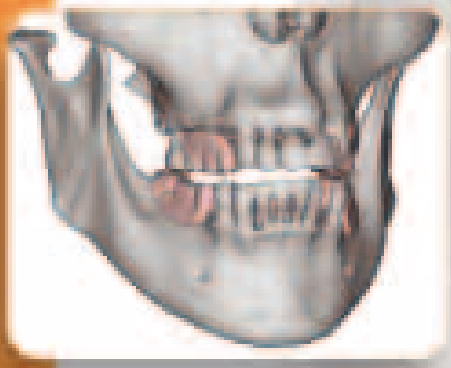
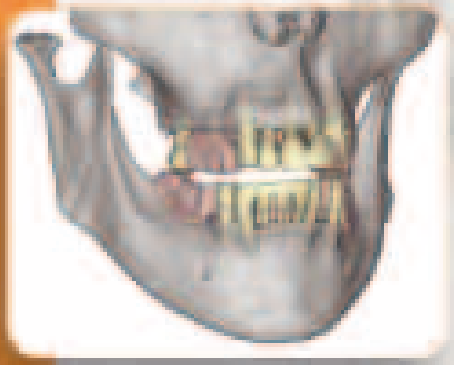


£50
Basic (per arch)



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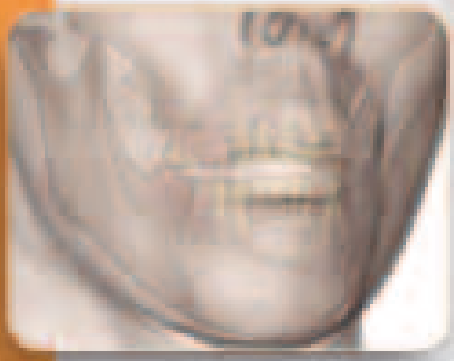

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Number one on The Gadget Show

The Oral-B Triumph 5000 toothbrush was recently ranked the number one power toothbrush by The Gadget Show. The products were tested under the supervision of Dr Uchenna Okoye, the dentist who does the teeth makeovers on the TV programme '10 Years Younger'.

Dr Okoye praised the effectiveness of the Oral-B 5000 and made it her top recommendation. So what is it that makes it so good? Well, as well as being extremely efficient at removing plaque, it also tackles the issue of compliance. The key to compliance is communication and that's why this ingenious model has functions to help patients to brush for longer, without applying too much pressure.

A pressure indicator lights up when too much force is applied, and an override mechanism automatically reduces speed and stops the pulsating motion.

The unit also alerts users when they've brushed for two minutes, even displaying a 'three-minute reward'.

Five times more

The Oral-B Precision Clean brush head has been proven to remove up to five times more plaque along the gum line versus a regular manual brush. The bristle head configuration of the Oral-B power toothbrush works in harmony with the handle and gives the user an amazing clean sensation. The small, round brush head mimics the action used in dental prophlyaxis. It is designed to conform gently to the contours of the teeth, thus encouraging patients to clean each tooth individually. It also facilitates access to posterior teeth.

Whatever your patients' dentition, you can be sure that Oral-B has a suitable solution.

Your patients plan to keep their teeth for life. Your care, combined with Oral-B's expertise, will help them achieve this goal.

Finance 4 Patients

Finance 4 Patients
A revolution in patient finance...

Finance 4 Patients provides a revolutionary, interest-free finance product into the dentistry market.

Traditionally, when a dental practice offers finance, it's the practice staff that does all the work. Filling out the credit application forms, printing copies for the customer and their provider, waiting for documents to be returned.

Finance 4 Patient provides a simple and affordable way for the costs of dental treatment, including private treatments, to be paid for with a 12-month interest-free loan – with not a paper form in sight. Designed from the ground up around a paperless e-signature process, Finance 4 Patients redefines finance for the digital age. Now dentists can offer credit without the staffing cost overhead.

For an e-brouchure, contact Brian Thomson on 01294 318718 or email info@finance4patients.com www.Finance4patients.com

Special New Year offer

This is an excellent time to buy Kemdent's Diamond Micro Luting Cement Capsules. Available in boxes of 20 x 0.25g capsules, if you buy 60 capsules you'll receive a 38 per cent discount. That works out at £59.40 for 60 capsules during January 2012 – less than £1 per capsule!

Diamond Micro is a resin-reinforced, chemically-curing, glass ionomer cement for permanent cementation of orthodontic appliances. With a working time of two to four minutes at room temperature and a sets-in-the-mouth time of three to five minutes, these capsules are easy to handle, have a low solubility in the mouth and high adhesion. They also have an excellent potential for luting zirconium oxide crowns.

For information on Kemdent's full range of Diamond products or to request your free sample, call Helen or Jackie on 01793 770090 or visit our website, www.kemdent.co.uk and follow us on twitter @Kemdent

Alkaspray-Ultra

Alkaspray-Ultra is specifically formulated for use within the medical/dental environment to both clean and disinfect all non-pervious hard surfaces in one simple operation.

Alkaspray-Ultra formulation contains highly effective cleansing agents to thoroughly clean hard surface areas, while its unique disinfectant properties achieve a high level of disinfection.

Sixty-second high-level disinfection for bactericidal (incl MRSA) tuberculocidal; virucidal (HBV/HCV/HIV, SARS, vaccinia, herpes, influenza H1N1/H5N1. It is also yeasticidal and fungicidal.

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Available in both a one-litre bottle with trigger and five-litre economy drums.

Visit our website www.alkapharm.co.uk

Free CPD at the Dentistry Show 2012

The Dentistry Show 2012 is firmly focused on the future, and with over 55 hours of free, verifiable CPD available, aims to help dental healthcare professionals meet the challenges ahead.

The two-day event, at the NEC in Birmingham on 2-3 March is very much geared to the whole dental team and offers an exciting range of seminars, live-surgery demonstrations and workshops aimed at clinicians, managers, nurses, hygienists, therapists and technicians. Leading policy-makers, clinicians and experts will air their views in a series of thought-provoking panel debates that range from recession-proofing businesses, to the changing role of hygienists and therapists, to competition for UK dental labs and much, much more.

And, thanks to 4everlearning (www.4everlearning.com), everyone visiting the show will also be able to access free online CPD.

For more information, please visit www.thedentistryshow.co.uk, call 020 7348 5269 or email info@thedentistryshow.co.uk

Quality repairs and servicing from Handpiece Express

Handpiece Express is the brand name for The Dental Directory's handpiece repairs and servicing branch, offering service and repair packages for all handpieces, motors, couplings and sonic scalers.

Every repair and service by Handpiece Express is guaranteed, with each instrument tested to ensure its performance matches specifications.

For absolute quality of service, all Handpiece Express technicians are manufacturer-accredited, and will ensure the quality of every repair by individually testing all replacement parts. If your handpiece is not returned within 24 hours of a telephone quote, you will not be charged.

To find out more about handpiece service and repair, contact Handpiece Express today on 01253 600 090 to receive impartial expert advice and fantastic value. Alternatively, contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

Learn the key to implant success

The Implantology Year Course with Dr David Guy, in association with Biohorizons, comprises 10 lectures over 12 months, as well as practical sessions, and commences in January .

Offering 70 hours of verifiable CPD and requiring no experience of implantology, this course provides a very high level of training, enabling clinicians to perform implant dentistry skilfully.

The lectures and practical sessions will be held at Dr Guy's practice in Cardiff.

Dr Guy achieved a distinction in his MSc in Implant Dentistry and holds a Certificate in Restorative Dentistry. The Implantology Year Course costs £4,000 per person and is limited to eight participants.

For further details, please visit www.courses.guysdentalclinic.co.uk, email courses @guysdentalclinic.co.uk or call 02920 220 794.

Nitram Dental goes off like a 'gazelle'

With the DAC Universal combination autoclave as the driving force, the Danish company Nitram Dental A/S has grown throughout the financial crisis – partly as a result of dental clinics having a greater focus on hygiene.

As a result, the company has just been allocated 'gazelle' status – a Danish designation for high-growth companies.

DAC Universal combination autoclaves clean, lubricate and sterilise dental instruments. They also provide a healthy business for the manufacturer – Nitram Dental in Denmark. As a result, the company has been able to turn its back on the current financial crisis.

Nitram Dental has more than doubled its turnover in the course of just four years, and has returned a profit each year. The company has therefore just been designated an exceptional growth company by the most important Danish business newspaper, Børsen. Out of more than 560,000 registered companies in Denmark, only 827 have achieved the coveted gazelle status.

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Virtual and real-time efficiency with the Atlantis 3D Editor

Astra Tech Dental, leader and provider of comprehensive solutions for implant dentistry, is pleased to announce the introduction of Atlantis 3D Editor, a service that will further improve efficiency and turnaround time.

Atlantis 3D Editor is the latest service offered in the internet-based Atlantis WebOrder system, a natural next step and an enhancement to the Atlantis 3D Viewer software. Atlantis 3D Editor provides the possibility to make real-time modifications, such as core, margin and shoulder adjustments to their Atlantis abutment designs. In addition, it offers the convenience of 24/7 access to their Atlantis cases.

For further information, please contact Chris Orpin, product manager, on 0845 450 0586, email implants.uk@astratech.com or visit www.astratechdental.co.uk or www.atlantisabutment.com

Latest patient-specific CAD/CAM abutments

Astra Tech Dental is pleased to announce the introduction of Atlantis crown abutment for single-tooth screw-retained restorations. The introduction of Atlantis crown abutment will be an important addition to dentists preferring screw-retained prosthetic solutions. The Atlantis crown abutment is uniquely designed from the final tooth shape for a more natural result. The abutment is available in five shades of biocompatible zirconia, including the exclusive translucent white zirconia. A cost-effective solution, saving time and money.

Contact Astra Tech product manager Chris Orpin on 0845 450 0586, e-mail: implants.uk@astratech.com or visit www.astratechdental.co.uk or www.atlantisabutment.com

'No-touch' technology

The all new compact, wall mountable touch-less Saraya UD9000 infrared dispenser with its 'no-touch' technology will accurately dispense Alsoft-E clinical/surgical hand disinfectant or hand soap.

Features include: a new compact design (152x100x290mm) and full clinical hand disinfection in just 15 seconds. We are also offering a special introductory offer where each dispenser comes with a FREE choice of either:

- Alsoft-E 1.2 litre sensitive hand/skin disinfectant (800 applications)
- Saraya 1.2 litre mild foaming hand soap (1500 applications). (Terms and conditions apply.)

Now available complete with a 1.2 litre refill pack for just £89.

Call Alkapharm customer service 01785 714919 or for comprehensive product Information, simply visit our website www.alkapharm.co.uk

"A very exciting development"

Dr Eoin Fleetwood is based at Eyre Square Dental Clinic, a state-of-the-art dental practice in Galway, West Ireland. He has been working with the new NobelReplace Platform Shift implants from Nobel Biocare.

"The introduction of a true platform-shift ability with the NobelReplace is a very exciting development," said Dr Fleetwood. "We have worked with the NobelReplace Tri-Lobe for the last ten years and find it a very simple platform to work with, as do our referring dentists.

"This platform shift will allow more predictability in maintaining the bone height close to the restored platform of the fixture, which can only help to minimise the possibility of recession problems. The fact that we do not have to order a new inventory of restorative components is also very desirable."

Contact Nobel Biocare on 0208 756 3300 or visit www.nobelbiocare.com

Ease the cost of decontamination

From 2012, a decontamination room will be a legal requirement in all dental practices and failure to comply could result in your practice being closed down.

For those who require significant changes this work can cost many thousands of pounds and funding such finance from day-to-day cashflow can be difficult when appointment books are not necessarily full. Moreover, finding a suitable loan in the current climate, can be a real challenge. With this in mind, DPAS have teamed up with Campbell Montague International (CMI), to offer their client practices a loan to cover expenditure associated specifically with the implementation of HTM01-05 regulations.

The unsecured loans are underwritten by a major UK bank with a strong track record working with the medical and dental professions.

Practices should contact their DPAS practice consultant for more information or telephone 01747 870910 for an application form.

Enjoy many fantastic discounts with Value+

In these difficult financial times, there are numerous challenges facing the modern dental practice. The increasing cost of regulation and compliance is certainly one – as too is the cost of overheads. While outgoings may be increasing, income is dropping, with fewer patients attending.

In response, The Dental Directory is offering savings of up to 54 per cent off its competitors' published catalogue prices with its special Value+ promotion that will run until the end of the year.

A one-stop-shop for all your everyday essentials, The Dental Directory also stocks specialist materials from the likes of orthodontics and facial aesthetics.

For more information, contact The Dental Directory on 0800 585 586, or visit www.dental-directory.co.uk

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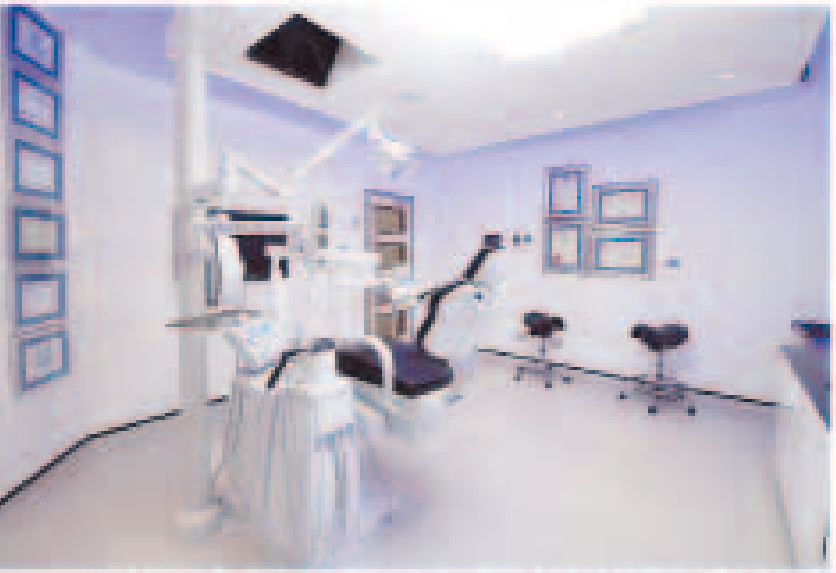

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