No.1 for dental professionals in Scotland

June/July 2013

Scottish Dental magaz

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Looking to the future

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SCOTTISH DENTAL SHOW 2013

Turn to **page 6** to see all the pics from the 2013 Scottish Dental Show and all the winners from the first Scottish Dental Awards

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Nobel Biocare

Editor's desk

with Bruce Oxley

Bad decision?

Despite it being only a few short weeks since the Scottish Dental Show 2013 closed its doors, planning is already well under way for the 2014 event.

From our initial feedback, the event seems to have been another success, but we know we can always do better.

This is why we included the feedback form with every CPD form sent out after the show. If you could take five minutes and let us know what you thought was good, bad or indifferent, it would be a big help towards making next year's conference and trade show even better.

Please don't hold back in your praise or criticism, we can take it! Visit www.surveymonkey.com/s/SDS2013feedback

In other news, the GDC's decision to allow suitably qualified DCPs direct access to patients has certainly got people talking.

Our columnist Arthur Dent (page 5) asks whether this is really such a bad decision and urges his colleagues to try to find the positive within. He argues that once the dust has settled down, dentists may well view the new arrangements as "opportunities rather than threats".

However, that did not seem to be the consensus at the recent LDC conference in Stirling, where a motion to have an independent Scottish GDC was proposed and passed (see page 15).

One of the reasons behind the proposal was thought to be the direct access decision. The proposal itself stated that the written submission by the BDA and the voices of the profession had been drowned out by the consumerist lobby.

On page 26 of this issue, we also have a retired GDP weighing in with their opinion on the matter. While acknowledging that hygienists and therapists these days are highly skilled and trained to a high level, the author notes that the decision could have a negative impact on those dentists already in practice.

The author, who didn't want to be identified as they are still involved in the dental profession, goes on to ask what was the BDA doing to inform and warn its members of the upcoming decision.

What is clear at the moment is that nothing is particularly clear... And, while uncertainties abound, there will always be predictions of doom and gloom.

In the coming weeks and months it will be very interesting to note what effect this actually has. Please get in touch and let us know your thoughts. ■

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

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June - July 2013

Biting back

with Arthur Dent

Direct Access

Dentists have been getting themselves rather wound up and angry following a recent decision by the General Dental Council (GDC). Since 1 May 2013, certain DCP groups have been permitted to treat patients without following diagnosis and treatment planning as prescribed by a dentist. This mainly affects hygienists and therapists; patients can now see these DCPs directly without the need to visit the dentist first.

Most dentists are against this decision and indeed some have been wailing that it's the end of civilisation as we know it! But was this really a bad decision by the GDC, and is it the doomsday scenario that many predict? Are dentists likely to find a hygienist or therapist opening a practice next door, in competition?

Let's look at the facts. Firstly, the GDC states that DCPs who wish to provide treatment by direct access must ensure they are trained and competent to do so. This means that they will have to attend courses to learn and practise the skills of diagnosis and treatment-planning. Such courses will take time to organise and for significant numbers to acquire this training.

The DCPs must still remain within their permitted scope of practice, so for hygienists this will be mainly scaling, OHE and fissure sealants and therapists can add simple fillings and deciduous extractions. DCPs are NOT permitted to prescribe medicines etc. so will require the written authorisation of a dentist to administer local anaesthetic and for tooth whitening; also for authorisation of radiographs. Furthermore, DCPs require an agreed link with a dentist in order to refer any treatments which are beyond their scope of practice.

Treatment for patients in a DCP-only practice would have to be provided under private contract as there is currently no provision to issue an NHS list number to anyone other than a dentist. All of this conspires to make it less attractive for a DCP to open a practice independent of a dentist; indeed, I know of no DCPs at this time who have any appetite to do so.

However, direct access does open up some opportunities and advantages within current dental practice, with only minor changes to present arrangements. Patients with reasonable oral health, who perhaps attend the hygienist regularly, could continue to do so without the need to attend the dentist for examination. The hygienist would simply alert the dentist if anything gave concern about a patient's oral health.

"Was this really a bad decision and is it the doomsday scenario that many predict?"

Similarly, a therapist might be able to spend much more time examining and treating a very anxious child (or adult), building up the confidence of the patient and freeing the dentist to spend time more effectively.

Many of us dislike (even fear) change, especially if we feel it is being imposed out with our control, but let us continue to have a good relationship with our DCP colleagues. I am certain that once these new arrangements settle-in, we will view them as opportunities rather than threats. ■

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Putting on a great show for Scotland

The 2013 Scottish Dental Show was even bigger and better. The second year had more stands, more delegates and a more focused line-up of speakers. And, with your help, the next will be even better

With more stands, more delegates and a more focused lecture programme, the 2013 show was bigger and better than ever.

This year's Scottish Dental Show saw more than 1,500 people descend on Hampden Park last month (24 and 25 May) to see more than 100 exhibitors and enjoy more than 40 speaker sessions and workshops.

Delegates were able to take advantage of up to eight hours of verifiable CPD from a world-class speaker programme including Paul Tipton, Ashley Latter, Martyn Amsel, Kevin Lochhead, Paul Stone, Barbara Lamb, Professor Graham Ogden, Professor Angus Walls and Christine Young.

The trade show also included some of the biggest names in the industry, such as DTS, IDH, Coltene, DMG, AWB Textiles and Dolby Medical among many, many more.

Plans are coming together for the 2014 show and we hope to be able to announce the date and venue in the near future, so watch this space.

And don't forget, if you haven't filled out our feedback questionnaire, do it now! Visit www.surveymonkey.com/s/SDS2013feedback
You can also see all our videos from the 2013 show by visiting www.youtube.com/scottishdentalmag

Ashley Latter revealed his top business tips

Kevin Lochhead gave an insight into prosthodontics

Workshops provided a chance to gain verifiable CPD hours

More than 100 exhibitors attended the show

Delegates were spoilt for choice

Paul Tipton talked about facial aesthetics

The first ever Scottish Dental Awards were a huge success with more than 200 people enjoying a special night of celebrations at Hampden Park

SCOTTISH DENTAL AWARDS 2013

And the winners were...

Amy McCabe (right) receives her Student Dental Nurse of the Year award from Laura Junor of DTS

David MacPherson receives his Dentist of the Year award from *Scottish Dental magazine's* sales and events manager Ann Craib

Margaret Ross (right) presents Karen Scott with the Dental Hygienist/Therapist of the Year award

Awards host Peter Martin had the audience in stitches

Scottish Dental magazine editor Bruce Oxley presents the Best Nominated NHS Practice award to Mayfield Dental Practice

Trudie Imrie (left) is presented with the Dental Business Manager of the Year award from Jill Taylor

Margie Taylor presents Hari Lal with the Most Valuable Contribution to Patient Care award

Nicola Docherty (left) presents Justine MacDonald with the Dental Nurse of the Year award

Paul Stone (left) of Blackhills Clinic receives the Best Nominated Specialist/ Referral Practice award from John Glen

Connect MD Alan Ramsay (centre) presents Leca Dental Laboratory with the Best Nominated Dental Laboratory award

2013 Scottish Dental Lifetime Achievement award winner Alex Littlejohn

Kevin Lochhead (left) presents the Most Attractive Practice award to Your Perfect Smile Dental Clinic

Kieran Fallon (left) presents the team from Your Perfect Smile Dental Clinic with their Best Nominated Private Practice award

Lifetime Achievement award-winner Alex Littlejohn receives his award from Dolby Medical's Derek Gordon (left)

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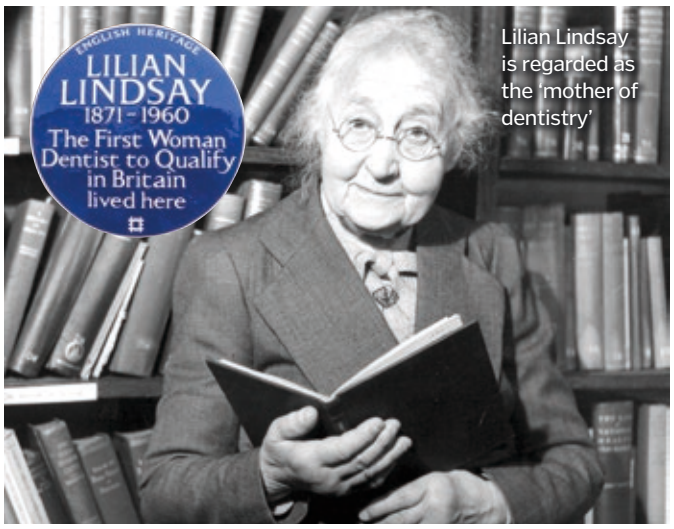
Recognition. English Heritage marks childhood home of first female dentist in Britain

Dental pioneer honoured

Britain's first ever female dentist, Lilian Lindsay, has been honoured after a blue plaque from the English Heritage was placed at her childhood home.

Although she grew up in Islington, Lilian was educated at Edinburgh Dental Hospital and School after English medical schools refused to enrol her.

A bright student, she became so determined to follow a career in dentistry that she fell out with her headmistress because she refused to follow her advice and train as a teacher. Her determination and legacy remains inspirational.



Lilian Lindsay is regarded as the 'mother of dentistry'

Dr Susan Skedd, blue plaques historian, said: "Lindsay was a truly remarkable figure. She successfully overcame the prejudices of her day to become the first woman to qualify and practise as a dentist in Britain."

Although modest about her extraordinary achievements, Lilian was awarded with a Tomes prize in 1946 and the Colyer gold medal in 1959. In 1946, she became the first elected female president of the BDA and, that same year, was awarded an OBE.

Susan added: "It is hardly surprising she is regarded as 'the mother of dentistry' in Britain."

In 1895, Lilian qualified with honours and set up a dental practise in Upper Holloway, which proved commercially successful.

While studying in Edinburgh, Lilian met Robert Lindsay, the couple married in 1905 and set up a dental practice at their marital home in Edinburgh. Lilian was 88-years-old when she died in 1960. The Lindsay Society, founded in 1962, was established to promote the study of dental history.

Prof Wise aesthetics study day

EDUCATION

Professor Michael Wise is hosting a Scottish study day in October entitled 'Aesthetics and implant-supported restorations'.

To be held at the Lighthouse in Glasgow on 4 October, the full-day workshop will include presentations and hands-on elements. The study day will start by looking at diagnosis and the factors that influence dental aesthetics, before going on to examine factors that influence the choice of ceramic for veneers, veneer preparation and the cementation of veneers.

Following lunch and a trade show featuring companies such as Optident, Heraeus, DTS, NSK and others, the afternoon will commence with a look at the factors influencing the choice of ceramic for crowns, crown preparation followed by aesthetic considerations for some implant situations, high density polymers, and finally porcelain onlays for a wear case.

For more information, contact Ian MacMillan on 07900 803 738 or email ianthemac2@hotmail.com

Prof Mike Wise

Glasgow ranked the best dental school

League table. *The Guardian*'s 2014 University Guide lists Glasgow as the top establishment in the United Kingdom

Glasgow Dental School has topped the Guardian's league table for dentistry, ahead of Aberdeen Dental School in second place and Dundee Dental School in fifth.

Glasgow takes over top spot from Queen's University Belfast, which slips down to third behind Aberdeen, which was placed fourth in 2012. Dundee has moved up from seventh last year to fifth this year.

Professor Jeremy Bagg (above), professor of clinical microbiology and head of the University of Glasgow Dental School, said: "We are delighted that Glasgow Dental School has achieved the top placing in the recently published Guardian University Guide league table. In recent years, Glasgow has been consistently towards the top of UK dental school league tables, including first place in the Times Good University Guide 2010 and in the Complete University Guide 2013.

"This consistency is testament to the quality of our undergraduate curriculum which has received 100 per cent overall student satisfaction in the National Student Survey over the past two years.

"I would like to pay tribute to the skill, conscientious hard work and dedication of all the dental school staff, together with the extremely high calibre students we attract to the programme. The ongoing enhancements

to the physical infrastructure of the building and the increasing strength of our research portfolio are also having a very positive effect on the school's activities, staff and students and I am confident of further sustained success for the school into the future."

Margie Taylor, chief dental officer, said: "It is excellent news for Scottish dental services that three schools have topped *the Guardian*'s 2014 University Guide league table for dentistry – with Glasgow scooping first place, Aberdeen taking second and Dundee in fifth place.

"These ratings reflect the high quality of courses available in Scotland and are testament to the staff and students at all three schools".

Glasgow is most expensive area for dentisty in Scotland

FINANCES

According to Scottish Government figures, dental treatment costs more in Glasgow than anywhere else in the country.

NHS Greater Glasgow and Clyde topped the list with £57 for adults and £73 for children while NHS Ayrshire and Arran, in second place, came in with £52 for adults and £71 for children.

At the other end, NHS Orkney was the cheapest for adults at £23, while NHS Western Isles was the cheapest for children at £32. NHS Lothian equalled the national average for adults at £46, with NHS Lanarkshire coming in at £51, NHS Tayside at £50, NHS Forth Valley at £48, NHS Fife at £40 and NHS Highland £32.

While the average amount spent adult treatment in Scotland was £46, the national average for children was £62.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Clinical Senior Lecturer / Honorary Consultant in Dental Public Health, University of Glasgow Dental School / NHS National Services Scotland
John Gibson
Professor of Medicine in Relation to Dentistry & Honorary Consultant in Oral Medicine, University of Glasgow Dental School
Tara Renton
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Plans under way for new Hunter Health Centre

The outline business case for a proposed £22 million health centre in East Kilbride, which will include a general dental practice among its facilities, has been approved.

The Hunter Health Centre will replace the current centre in a move described by NHS Lanarkshire chief executive, Ian Ross, as "an exciting development that will offer premises for a wide range of local services".

The next part of the process is submitting a full business case for government approval. The new centre is expected to be open by summer 2015, the first of three proposed centres of this kind in East Kilbride.

Glasgow students take to the streets

National Smile Month. Dental students spread the message to the public

Students from Glasgow Dental School took to the streets recently to spread the oral health message as part of National Smile Month.

Eight student volunteers and senior lecturer Dr David Conway gave up their time during the exam period to set up a stall on Buchanan Street in the shadow of Donald Dewar in an attempt to speak to members of the public. In a little over three hours they spoke with more than 550 people and handed out toothpaste, toothbrushes and other freebies courtesy of GSK, Oral-B and TePe.

The following day they attended an event at the Scottish Qualifications Authority (SQA) on Robertson Street where they dispensed advice and handed out supplies to SQA staff.

The SQA event came about as a result of a phone call from Maria Khoudary, administrator involved with health and wellbeing campaigns at SQA. She said: "One of our volunteers alerted us to National Smile Month earlier in the year and we decided it would be a good opportunity to highlight the importance of good oral health to our colleagues.

"We were very fortunate to get the dental students in to visit our staff. The information session they delivered was very popular and I know everyone who attended found it very useful."

Speaking about the Buchanan Street afternoon Steph O'Raw, a fourth-year student at Glasgow Dental School, said: "It was quite eye-opening to be honest. Some people came up who were quite clued up, while there were others who didn't really know that they should be brushing their teeth or what type of toothpaste to use."

And John McQueen, third-year student, said: "I felt that the majority of people that we spoke to would benefit from it in some way. One of the most common things we came across was people not being registered.

"We had a list of all the NHS practices in NHS Greater Glasgow and Clyde so we could give them the phone number of their nearest practice so they could get in contact and hopefully get registered."

Call for Scottish regulator

LDC CONFERENCE

A motion calling for an independent Scottish General Dental Council was tabled and passed at the recent Scottish LDC Conference in Stirling.

The motion was proposed by Robert Sweeney, a member of the conference's agenda committee, and was seen as a direct result of the direct access decision by the GDC. The proposal stated that it was felt that the written submission of the BDA and the voices of the profession had been drowned out by the consumerist lobby.

It was also thought that the change to a GDC consisting of 12 appointed members, with only six dental professionals, further dilutes the perceived future direction of the GDC.

The conference, which took place at the Stirling Management Centre at the University of Stirling, was attended by more than 70 delegates and guests. The two main speakers were Kevin O'Brien, chair of the GDC and Hew Mathewson, CBE, chair of the SDPB.

At the end of the event, the chain of office was passed from Laura Milby to Jeff Ellis who becomes chair of conference for two years, with Jacqueline Frederick as chair-elect.

The 2012 event held in Dublane

A day for the whole dental team

Protect your patients and increase your confidence in dealing with oral cancer at this year's Scottish Scientific Conference

The number of cases of oral cancer across the UK continues to increase, with latest figures showing that 6,000 new cases will be diagnosed each year, making it one of the fastest growing cancers in the UK.

Professor David Conway, clinical senior lecturer in Dental Public Health at the University of Glasgow, who published his research paper Socioeconomic Risk Factors Associated with Upper Aerodigestive Tract Cancer, will speak on this topic at this year's Scottish Scientific Conference & Exhibition to be held at the Crowne Plaza on 6 September.

As is so often the case with cancer, raising awareness among the public and health care professionals is key to early diagnosis.

This is just one of the many sessions available to attend at this year's event, suitable for the whole dental team. Other sessions include how to harness the power of social media for your practice with speaker Mark Oborn, who will also show you how to set up Facebook and Twitter for your practice.

Core CPD sessions will cover medical emergencies in the dental practice as well as sessions on oral cancer and safeguarding vulnerable children. Other programme highlights includes sessions on ceramics for use in crown and bridgework with Mike Cassidy, who will also share with you top tips for success in this area of dentistry.

Forming part of the clinical stream of lectures suitable for GDPs, Graham Gilmour will help you avoid failure in fixed restorations and discuss treatment planning in practice.

For more information on the conference programme and to book your place, visit www.bda.org/scottishscientific or call the events team on 020 7563 4590.

SDCEP guidance on acute problems

PUBLICATION

New guidance launched by The Scottish Dental Clinical Effectiveness Programme (SDCEP) 'Management of Acute Dental Problems', aims to provide consistency in treating patients with dental complaints.

Patients often seek advice or treatment from non-dental professionals before seeing their dentist, according to Graham Ball, chairman of the National Dental Advisory Committee (NDAC). The guidance is intended for all healthcare professionals.

He said: "This guidance helps non-dental and dental professionals to identify those rare cases where emergency attention is required and in all cases to give the correct advice regarding symptom relief and appropriate subsequent care."

Supported by NHS Education for Scotland , NDAC developed SDCEP in 2004 with the aim to improve the quality of dental care by providing user-friendly guidance for oral health care in Scotland.

Available in print, online and interactive electronic versions, the guidance is also suitable to be downloaded on tablet or mobile phone.

For more information and to see the latest guidance, visit online at www.sdcep.org.uk

New UK business manager for Prestige Medical

APPOINTMENT

Prestige Medical has announced the appointment of Christine Bowness as UK business manager with responsibility for sales and marketing across the UK.

Christine has been with the company for four years as sales and marketing manager.

Lee Watkins has recently left Prestige Medical to take the position of international sales director with an ultrasonics company in Florida.

www.prestigemedical.co.uk/uk/dentistry

New Sales rep for Shofu

NEW ROLE

Former dental nurse Heather Macmillan has been announced as the new sales representative for Scotland at Shofu.

After nearly 20 years of experience in the dental practice, she made the decision to take on a new challenge by switching to a career in dental sales. She has since worked with the likes of Coltene Whaledent and Align Technology before accepting this new Shofu role.

Having trained as a dental nurse in Glasgow, Heather went on to become certified in radiography and conscious sedation before changing her career. In her new role she will be responsible for providing customers with support and advice on the best Shofu products for practice or laboratory.

Clarification

In the April/May issue of *Scottish Dental magazine*, we ran an advertising feature for Impulse Dental Laboratory (page 55).

In the article it stated that Stephen Heath was previously head ceramist and manager at Pearl White Dental Laboratory.

It has been brought to our attention that this was not the case and, while he was employed by the laboratory, he was not employed in a managerial position.

Class of '63 go back to school

Reunion. Golden jubilee celebration for Glasgow alumni

Glasgow Dental School played host to a Golden Jubilee celebration recently when the class of 1963 returned to their alma mater.

The group were treated to a day of classes and presentations including histology and the use of phantom heads to experience the latest in multimedia enhanced learning.

The histology class took place in the Dorothy Geddes Multimedia Laboratory, a high-specification installation with support for virtual microscopy and an active 3D projection system, the first of its kind in the university.

The phantom head class, sponsored by Ivoclar Vivadent, took place in the Pre-Clinical Skills Laboratory, where the group had a skills demonstration using its state-of-the-art multimedia equipment.

The alumni day was part of an ongoing campaign to develop a stronger relationship between the school and its alumni, led by senior clinical university teacher Dr William McLean. The school's magazine, *Dental Mirror*, has been re-established and will be published three times a year (http://bit.ly/Gla-Dent-Mirror).

Dr McLean said: "One of the goals of resurrecting *Dental Mirror* was to re-engage with alumni.

"We generally have fond memories of our alma mater, but it is all too easy to lose touch due to our busy lives. It is shame that the relationship so often ends at, or soon after graduation.

"The school also has a great deal to gain from an active alumni group, but there is a genuine pride in the graduates that leave and an interest in their journey."

To find out more about the alumni activities at Glasgow Dental School, visit www.gla.ac.uk/schools/dental

Graduates given the third degree

ACHIEVEMENT

Two University of Dundee dental graduates have achieved a UK first when they became the first to graduate with three degrees.

Dentists Jennifer Galloway and Charlene Kasaven are the first to complete an integrated Masters research degree alongside their other studies.

Jennifer and Charlene both graduated as Bachelor of Dental Surgery and

Jennifer (left) and Charlene celebrate their landmark achievement

Master of Dental Science, having already completed the intercalated Bachelor of Medical Science.

Professor Peter Mossey, from the School of Dentistry, said Jennifer and Charlene's achievements marked a first for dental education in the UK.

He said: "Their successful completion of this programme of research alongside their clinical studies represents an historical landmark in dental education in the United Kingdom, and was all the more remarkable in that it was achieved with ongoing excellence in their clinical studies."

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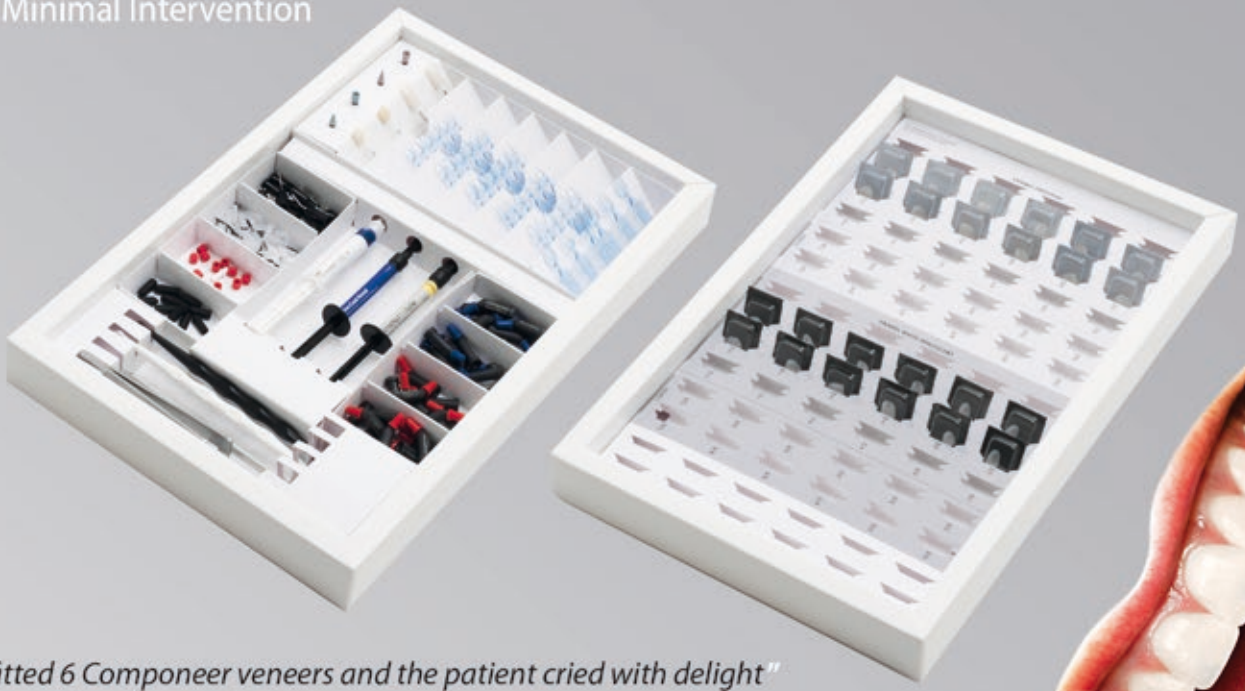

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Planning starts for 2015 Glasgow congress

Event. ADI focus turns to Scotland for the next scientifc meeting

The baton was officially passed on to Glasgow dentist Philip Friel in the wake of the Association of Dental Implantology's 25th Anniversary Team Congress in Manchester.

President-elect Friel will host the next biannual congress in Glasgow on 13 to 16 May 2015, assisted by his scientific co-ordinator, Stephen Jacobs. He takes over from current president Cemal Ucer, who hosted this year's event at the Manchester Central Convention Complex in May.

President-elect Phil Friel will host the 2015 congress

The 2013 congress featured some of the biggest names in the field, including Tomas Albrektsson and Franck Renouard from Europe, German Galluci from the USA and Tara Renton from the UK. The event also included the ADI's largest team programme to date, with workshops ranging from surgical complications to dental photography in the practice and a technician programme with Christian Coachman from Brazil as lead presenter.

A pre-congress presentation of posters, cases and research findings by clinicians, technicians or postgraduate students was held, with the case study competition prize awarded to Tong Wah Lim and the poster presentation prize to Mital Patel.

President Cemal Ucer presented two ADI Honorary Membership Awards to Ashok Sethi and Eddie Scher.

IDH opens dental academy

TRAINING

Leading UK dental group IDH has opened a new state-of-the-art dental training academy and practice with the ambition to deliver training to more than 7,000 people.

Barbara Sutherland, head of the dental academy, said: "The academy is our way of providing IDH people with a well-defined career path."

The academy will also provide training and development for clinicians and dental professionals outside the corporate once it is established.

By Bruce Oxley

The BDA's new director for Scotland Pat Kilpatrick describes her journey from trainee manager in the NHS to her new post

Rising to the challenge

Despite a career that has afforded her great experience of the inner workings of the NHS across the whole of the UK, the BDA's new director for Scotland acknowledges that her new role is unlike anything she has ever done before.

Born and raised in Paisley, Pat studied modern history and political science at Dundee University before joining the NHS graduate management training scheme in 1979.

The two-year training programme took her to Edinburgh, Glasgow and Dundee but her first role after the scheme was at Yorkhill Children's Hospital. From there she worked in Tayside before moving to Argyll and Clyde and then Forth Valley, where she took on the role of hospital manager at the Stirling Royal Infirmary.

Her next role was at the University of Stirling where she was taken on as a research fellow, and subsequently senior lecturer, spending the next six years setting up an MBA programme for doctors and dentists in association with the BMA. Pat then moved on to join the Scottish Government as a policy advisor in what was her biggest exposure to primary care – including primary care dentistry – so far. She led the national task force on the development of primary care trusts (PCTs) in Scotland, which brought about the introduction of PCTs. The outcome of the taskforce was the government white paper in 1996 called *Designed to Care*.

Pat explained: "It was a very challenging role because primary care had never really worked in organisations before. They had all been independent of each other and now they were being organised into primary care trusts who would manage them and their services on a grander scale. So that was a big change for them."

The changes involved included to the budgets, so where previously services were funded on a practice level, they were now going to be funded through PCTs. Pat continued: "So that was a big change and there was a lot of opposition within the professions and within the NHS generally.

"It was quite an interesting job though and I had an all-Scotland remit. My job was to make sure every health board was ready for the changes and we put a lot of organisational development money into promoting and helping the changes to take place."

After her role with the Scottish Government, Pat was appointed as the director of clinical service development at Argyll and Clyde. She said: "It was my job to improve and develop services, introduce quality initiatives and reconfigure services.

"It was a politically contentious job, lots of public consultation, lots of political opposition, lots of public involvement – trying to help the public understand why these changes would help provide a better service, rather than a reduced service."

From Argyll and Clyde, she joined NHS Greater Glasgow and Clyde where she became the director of planning in North Glasgow University Hospitals Trust before moving to join consultancy firm Tribal in 2006. Although based nominally in Scotland, this new role took Pat all over the UK, from the south east of England to Northern Ireland.

Her main duties involved mainly working with acute trusts that were financially challenged. She explained: "What you tend to find is that if an organisation has financial problems, it has other problems. That financial deficit is the manifestation of a whole lot of other things that are going on. So trusts that are in financial difficulty have often got clinical problems, management problems and patient care problems as well as other issues.

"So it was my job to go in with a team and help them put together a recovery plan and try and turn it round."

After four years, Pat decided to set up her own business and launched Kilpatrick Consulting, targeting much the same areas as her previous role. Again, she worked mainly with acute trusts in the north west of England and Northern Ireland, where she also worked with the department of health. During this time she was appointed as the acting director of surgery for Pennine Acute Hospitals NHS Trust. She said: "I went down to help them sort out their surgical service and, at that time

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the director left, so they asked me to stay on and become the interim director. That was interesting. They had a big financial deficit and it required us to restructure all the surgical services. It was good for me because it took me back from working at a strategic level to looking at the detail in an operational division, with lots of staff and clinical issues."

The role also provided her with experience of working in a big organisation again – experience that would prove useful for her next role at the BDA.

Pat explained that when she saw the post advertised she saw it as an interesting new challenge in a brand new role. She said: "I thought that this was another opportunity to do something different in a different type of organisation, with different stakeholders, representing different people – I am no longer with a private company and it is no longer about winning new business. It is also no longer about working for the NHS and the constraints of the NHS management system."

"We need to do our best to make sure the lives of dentists are manageable"

And, during the interview process, Pat briefly came face-to-face with her predecessor, Andrew Lamb, who was involved with the first stage of the interview process. She paid tribute to the work that he had spearheaded over the last decade, with regards to the salaried services contract – which is finally nearing conclusion – the manifesto document for the last

election and his work looking at services for the older patient, to name but a few.

She said: "I think Andrew's career and successes speak for themselves. He came across as a quiet and unassuming man but he worked tirelessly in pursuit of the issues and the challenges of the job.

"I think he had a very reflective style and it was very successful and effective. It's no surprise that people still talk affectionately about him."

Pat has identified that her first priority in the role is to renew contacts that Andrew had built up over his career in dentistry and latterly in the BDA. She said: "It is my job to get out and create my own opportunity to understand the industry better, while at the same time raising the profile of the BDA as much as I can by talking to people, going to LDC meetings, conferences and trying to engage with dentists in whatever forum they are in."

As well as the new salaried services contract, one of the main challenges facing Pat are the problems with duplicate registrations affecting more than 7,000 NHS list numbers and the attempted clawback of more than £3.5 million in funds by PSD.

She said: "Dentists are quite rightly very unhappy and we have made a legal challenge under the terms of the regulations. If it goes ahead, then dentists will have to trawl back over all their records to validate it all and say which registrations are correct or not.

"I think it is a big administrative nightmare for PSD, and to some extent we are sympathetic to that, but on the other side of the coin it is a big nightmare for our members."

Despite all this, Pat remains very positive for the future of dentistry, both NHS and private, in Scotland. She said: "I think we are quite fortunate in Scotland because the Scottish Government is deeply committed to NHS dentistry. I don't get any sense that there is any question over that.

"It has invested significant amounts of money promoting access and access is now very good. People don't have the same sort of difficulties that they had five years ago getting registered."

She continued: "For me it is all about the members. My job is to make sure that we promote dentistry and the needs and aspirations of dentists in Scotland.

"We need to make sure that we do our very best to make sure that the lives of dentists are manageable and that the resources are there for them to do the best for their patients." ■

A profession in **disarray?**

Competition may heat up following the GDC's Direct Access decision

Direct Access. These are the words on everyone's lips just now, or at least they ought to be, because on 28 March 2013, the GDC decided to permit direct access to dental hygienists and therapists.

This is surely one of the biggest changes in dentistry for a long time. Patients can now seek treatment from a hygienist or therapist without seeing a dentist first. The 'Summary of Stakeholder Feedback' and 'The Literature Review', which are the main documents upon which the decision was based, are well worth a look (http://bit.ly/GDC-direct-access). In fact, they are essential reading.

One of the reasons behind the decision is that hygienists and therapists will be able to treat patients in outlying areas, or those patients who do not normally attend.

Anyway, who thinks dental therapists are more altruistic than anyone else? Therapists and hygienists may now and, given the choice, want to be their own boss and do their own thing. Therapists can already do 70 per cent of the procedures that dentists do and that percentage is set to increase.

According to the president of the British Society of Dental Hygiene and Therapy, they are now lobbying to be allowed to take radiographs (for which they are already trained), prescribe some drugs, perform tooth whitening and are seeking to attain NHS numbers to undertake NHS contracts.

Above: Therapists have been trained to a high degree

By August this year, they will be able to access Vocational Training, if desired. Since 2002, therapists have had a pretty robust training. At the top end, they can achieve a BSc in Oral Health Sciences which takes four years and is, according to a letter by D Monks in the Feb/Mar issue of *Scottish Dental magazine* (p21),"...the same educational level to which dental graduates are trained".

So, therapists can do most dental procedures and as well as us dentists, according to all the research out there. Google Tom Dyer or Paul Brocklehurst, (Cochrane & Wiley Libraries) – you will find that, in fact, auxiliaries' work has been compared with that of dentists for some time now and the results for therapists have been favourable.

Also, a recent article in the *BDJ*, by T Dyer et al ('What matters to patients when their care is delegated to dental therapists?') reports positive views and experiences of the care provided by dental therapists.

Research currently being undertaken by Dyer, Brocklehurst et al (again) is called 'Dental auxiliaries for dental care' and sets out to compare dental auxiliaries with dentists in the following areas: the diagnosis of oral disease and conditions, their technical competence in the delivery of some aspects of dental care, oral education and other oral health promotion measures, delivery of dental care that is acceptable to patients and to critically appraise and summarise current evidence on the costs and cost effectiveness of dental auxiliaries with dentists in providing care.

So, what does this all mean to us dentists? The words 'cheaper alternatives', 'competition', perhaps even 'redundancies/unemployment' (certainly expected in the salaried service, according to the consultation document) spring to mind. The Dental Workforce Report already predicts a surplus of dentists anyway.

I am sure, though, that therapists will not want to undertake the duties

of a dentist for their current £16 an hour, and quite rightly. There is nothing to stop them setting up on their own and you might find some of your patients wander from your flock, especially in this worsening economic climate.

But 'collaboration' is the idea and if a therapist finds themself unable to perform some aspect of treatment, they will have to refer the patient back to you. I am sure you will be delighted to oblige! Actually, you will be duty bound to. They certainly could potentially work as/instead of associates within established practices... Who knows?

So, to my last point. While you have been busy working incredibly hard, doing a great job of keeping the public happy (this is 'evidence-based', by the way) and trying to run a business while heavily regulated, what have all these dental bodies to whom you subscribe been doing to protect your interests?

Well the BDA, at the end of March – coinciding with the GDC decision – has changed its website and is now offering different membership rates, starting with an 'Essential Package'. Aimed at lots of possible new members? Click on DCP and it comes up with a huge range of dental courses and training (at reduced rates, of course). There was nothing on its site immediately prior to the GDC decision informing us of the impending meeting. There was only one older blog entry from Dr Judith Husband mentioning direct access and her reservations. They do have an entry in the 'Stakeholder Feedback', however.

"I am sure that therapists will not want to undertake the duties of dentists for their current £16 an hour, and quite rightly"

The GDC, on the other hand, had all documents for view on its website in the days before the decision, covering all the responses to the consultation. Unfortunately, they could not be accessed as the website was 'malfunctioning'. There were 1,400 responses received overall but, considering the thousands of dentists and DCPs in the UK, this seems a paltry number... Did we not realise what was happening? Probably not.

The hygienists and therapists certainly did and champagne corks have been popping!

Maybe it is all nothing to worry about? In fact the GDC states that therapists will only be able to work within their 'competence and capabilities' (that will vary according to training). In fact, they are not permitted at present to "diagnose decay" but as they will be treating patients without a dentist seeing them first, they are allowed to 'make a dental assessment' before undertaking treatment. Is this not the same thing? I am confused.

Certainly, with training, what is to prevent some therapists becoming competent in all dental procedures and, dare I say it, calling themselves dentists?

So, will you be wishing your son or daughter to follow in your footsteps and apply for a university place to train as a dentist? They require, astonishingly, five A-grade Highers and, after the five/six year course, will graduate with a lot of debt and enter a profession in disarray. ■

The author is a retired GDP who has worked in both England and Scotland.

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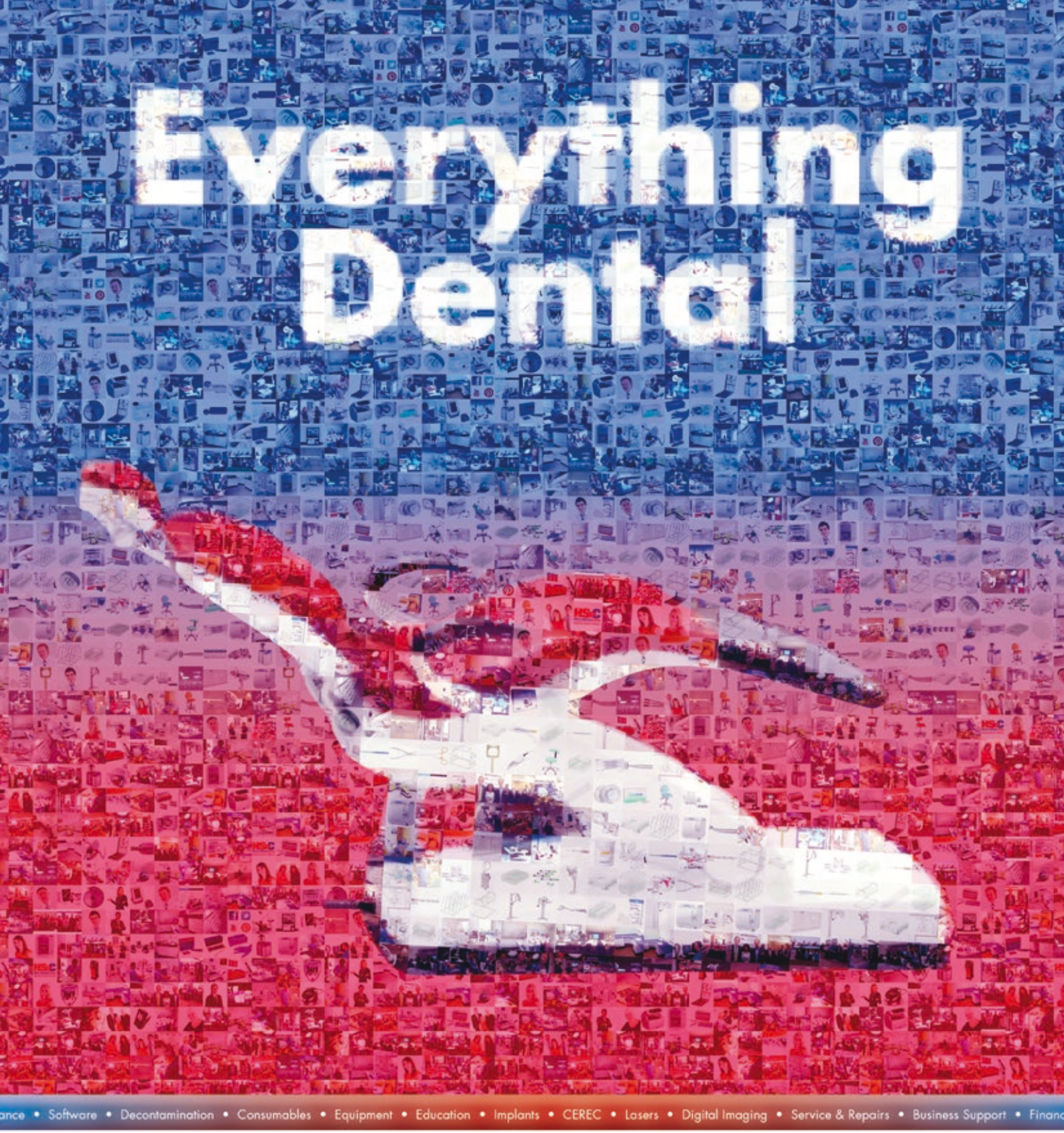

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DENTAL

Big expansion for Alloa practice

Macdonald and Morson Dental Care in Alloa has recently made a seven-figure move to new premises in what is thought to be the largest of its kind in Scotland

Securing funding for expanding your premises may be easier now than it was at the height of the recent recession, but one Alloa practice has raised the bar to an impressive level.

Macdonald and Morson Dental Care, which has been established in the Clackmannanshire town for more than 27 years, has recently completed a £1.8 million move to new premises.

Funding for the new practice came through the owners, NHS Scotland and a loan from the Clydesdale Bank. The investment is thought to be the largest of its kind in Scotland and the new purpose-built 12-surgery practice is contained within 11,500 sq ft. The decision to move was based on a combination of factors, namely to comply with decontamination regulations and to meet an ever-increasing demand for NHS services.

Owners Charles Macdonald and Gordon Morson realised that their old premises in Mar Place couldn't achieve what they wanted, so they decided to look for alternatives in the area. Fortunately for them, they managed to find an ideal location only 200 yards down the road on Drysdale Street.

They brought in Machin Associates and, in conjunction with the project team, they helped design the new practice and incorporating single-storey access, 12 new individual surgeries, an extensive decontamination and sterilisation facility and staff room with conference facilities for up to 50 people.

Other members of the team included quantity surveyor Craig Dunsmore of Stirling-based firm Brownriggs and John Rae of GR Engineering Services, who brought his years of experience to developing the new surgeries' air conditioning, heating and fail-safe electrical systems.

The main contractors for the build were East Kilbride builders Dickie and Moore, a firm with a strong track record in the dental industry. James Macdonald, operations manager at the new practice and project manager on the new build was very

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Gordon and Charles are delighted with the new practice

"They were a very profesional outfit, friendly, always offering options and meeting their targets - a delight to work with"

Continued »

impressed with the contractors. He said: "William Dickie and his team were very proactive in offering their experience and knowledge as the project developed, thus ensuring the finished building is operational, safe, easy to clean and extremely functional as a dental surgery to both staff and patients.

"They were a very professional outfit, friendly, always offering options and meeting their targets – a delight to work with."

James also paid tribute to Stephen and George, owners of Lithium Systems: "They worked tirelessly over the weekend before we opened the new practice, moving all data records to ensure continuity for the business."

At the end of the seven-month build, the owners were left with a bright and modern dental practice featuring an open-plan reception and waiting area. The corridors, off which the surgeries are based, include rows of comfortable and contemporary bench seating for patients.

The new surgery also has plenty to offer staff with air conditioning, a large staff room, gym – complete with all-new equipment – TV area and fresh and bright environment.

Each of the 12 surgeries has been fitted with brand-new Sirona chairs sourced through Ian Lucas at Henry Schein as well as all associated equipment, surgery furniture, compressors and suction units. The latest decontamination equipment was supplied and fitted by Dolby Medical in Stirling, with the sundries and other consumables provided by The Dental Directory.

Charles and Gordon said that they expect to add a further 2,000 patients to their books in the coming weeks and months due to an increase in demand for NHS

Continued »

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check-ups and further treatment. Now that the practice has relocated to its larger base, they are finally in a position to meet that demand.

While they also provide a full range of private treatments alongside their NHS commitment, both owners insist that they value very highly the work they do under the health service. Charles said: "In recent years we have seen many other practices go solely private, but we are firm believers in offering a choice of both private and NHS services to our patients."

Charles and Gordon explained that they are looking forward to welcoming a new dentist and dental nurse to the practice in August to work alongside the current workforce of six dentists, 14 dental nurses, four dental hygienists, four reception staff, two decontamination staff and three administration staff.

"I just want to thank all our patients from Alloa, Tullibody and other local areas for their support over the years"

Gordon believes that patients will truly benefit from the move. He said: "Building our new premises from scratch will allow us to expand significantly and increase our service position, enabling our surgery to reduce waiting times for patients and increase the number of NHS registrations it can accept."

And Charles echoed his partner's comments. He added: "Widening access to dental care is key to tackling Scotland's poor record in oral health and our new surgery will enable many people to access dental treatment.

"On behalf of myself, Gordon and the rest of the team, I just want to thank all our patients from Alloa, Tullibody and other local areas for their support over many years and look forward to everyone joining us in our new practice." ■

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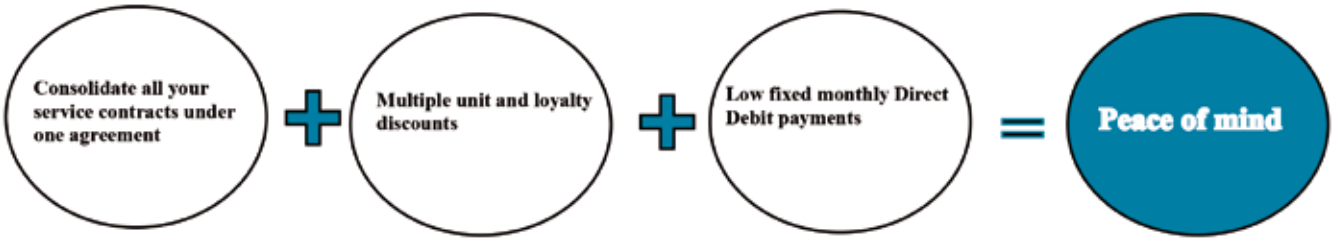

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James Macdonald is the Business Manager of Macdonald and Morson Dental Care in Alloa and a customer of Carestream Dental. Last month, the practice upgraded their computer system to a 20-user CS R4 Clinical+ practice management software and the CS 7600 digital plate imaging system, including the time saving 'scan and go' technology.

"CS R4 Clinical+ is an excellent product that does exactly what it says on the tin," said James. "When we chose R4, the most important factors were a consistent reliable product and excellent backup support from the company.

"We're a busy practice with six dentists and four hygienists, so selecting a system which can handle this was critical for us. I wouldn't hesitate to recommend the Carestream team or products. Bruce gave us invaluable support, as did Michael and David. We've always had a quick response to any queries we have and the helpdesk has been excellent."

Bruce Deane, Scottish Territory Manager, said: "This was a great practice to work with, everyone is enthusiastic and prepared for the new system. I look forward to supporting the practice for many years to come." ■

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The reception team Janet Martin, Elaine Johnson and Helen Wallace are delighted with the new system

Debate

Water fluoridation international update

The Health and Social Care Act 2012 has introduced significant changes to the organisation of the NHS in England, and for the role of local councils. What are the likely implications for water fluoridation south of the Scottish border?

Currently, an estimated six million people benefit from drinking water in England, which has either natural or adjusted levels of fluoride to around one part per million. Globally, 370 million people benefit from water fluoridation schemes, including a massive expansion in the last 10 years.

In the USA alone, about 200 million (more than 70 per cent) of people drink fluoridated water, as do about two thirds of New Zealanders, Australians, Irish, Chileans, Malaysian and all of the inhabitants of Singapore and Hong Kong (see table one for the full list).

A recent study from Denmark, which combined comprehensive national data on tooth decay and fluoride levels in water, confirmed previous findings of an inverse relation between fluoride concentration in the drinking water and dental caries in children (Kirkeskov et al 2010). The caries preventive effect was reported in both primary and permanent teeth and at a level of fluoride of around 1 mg/litre (1 ppm), a reduction of approximately 50 per cent was found. So, in a modern western European country, water fluoridated at 1ppm still halved tooth decay in children in permanent and deciduous teeth.

These results are pretty much

ABOUT THE AUTHOR

Colwyn M Jones is consultant in dental public health for NHS Health Scotland and honorary senior lecturer with the University of Edinburgh. The views and opinions expressed in this article are solely those of the author.

exactly in line with systematic reviews confirming that water fluoridation is effective. However, a more interesting quote is: "This correlation was found in spite of the extensive use of fluoridated toothpaste and caries-preventive programmes implemented by the municipal dental services in Denmark."

For those who might suggest that the Danish study was looking at natural fluoride, not added compounds, so is not relevant, can read the recent European Union Scientific Committee on Health and Environmental Risks Report; a critical review of any new evidence on the hazard profile, health effects and human exposure to fluoride and the fluoridating agents of drinking water, published in May 2011. It concluded that "these compounds are rapidly and completely hydrolysed to the fluoride ion". So fluoride is fluoride, regardless of the source.

The conclusions of the Danish study confirm results found in both the systematic reviews of water fluoridation and the Cochrane review of fluoridated toothpaste (Marinho et al 2003) that the preventive benefits of fluoride toothpaste and water fluoridation are independent. They are complementary, not mutually exclusive.

A new and innovative study using intra oral photographs, comparing 12-year-olds in fluoridated Newcastle and non-fluoridated Manchester gave results which "support existing work suggesting water fluoridation together with the use of fluoridated dentifrice provides improved caries prevention over the use of fluoridated dentifrice alone." It continues: "The social gradient between caries and deprivation appears to be lower in the fluoridated population compared to the non-fluoridated population, particularly when considering caries into dentine, demonstrating a reduction in inequalities of oral health for the most deprived individuals in the population." (McGrady et al 2012).

In April 2013, NHS England was established to ensure that the NHS delivers better outcomes for patients, and the new local Clinical Commissioning Groups (CCGs) will commission the majority of NHS services for their populations. Is this a possible way that water fluoridation could be developed for the benefit of the wider population?

From April 2013, oral health needs assessments are part of joint strategic needs assessments (JSNAs). NHS England is expected to work with local authorities and Public Health England to develop and deliver oral health improvement strategies and commissioning plans specific to the needs of local populations (NHS Commissioning Board 2012). One major change is that local authorities will be responsible for commissioning surveys of dental health and improving the oral health of their populations. Local authorities in England now have a statutory responsibility for dental health and should come to realise that water fluoridation is effective and safe in preventing tooth decay, and will reduce dental health inequalities.

Further evidence now also shows that water fluoridation provides dental benefits that extend into adult life. Griffith's review from 2007 showed adults with lifelong residency in a fluoridated area had a reduced Risk Ratio of carious teeth with an overall relative risk ratio = 0.65. (95 per cent confidence interval [CI]: 0.49-0.874); this is a prevented fraction of 27 per cent. A very recent paper showed that the benefits of water fluoridation to adult dental health with 11 per cent fewer DMF teeth in a nationally representative sample of Australian adults (Slade et al 2013).

Is there the political will to introduce water fluoridation more widely in England? Again, evidence from Queensland, Australia confirms that political activity can work. In 2002, only 5 per cent of the Queensland population enjoyed the benefit of water fluoridation. After the launch of a petition supported by the Australian Dental Association of Queensland, more than 25,000 Queenslanders supported fluoridation and in 2008, introduced legislation to extend fluoridation to 90 per cent of the population by 2012.

There was a statutory duty to fluoridate water supplies to more than 1,000 people and by 2011, 92 per cent of the Queensland population were already covered. Just as the ban on smoking in public places was successfully enacted across the UK, to measurably benefit the health of the nation, political action over water fluoridation may be the next public health success. ■

International levels of water fluoridation (Selected countries)

Country	Percentage of population	Estimated population receiving fluoridated water
Scotland	0%	Natural fluoride up to 0.5ppm
England	10%	6 million
USA	73.9%	204 million
Canada	45%	32 million
Ireland	67%	3 million
Israel	70%	4.2 million
Chile	70%	11 million
Malaysia	75%	20.5 million
Australia	65%	11.5 million
New Zealand	61%	2.3 million
Singapore	100%	5 million
Hong Kong	100%	6 million

Source. British Fluoridation Society website.

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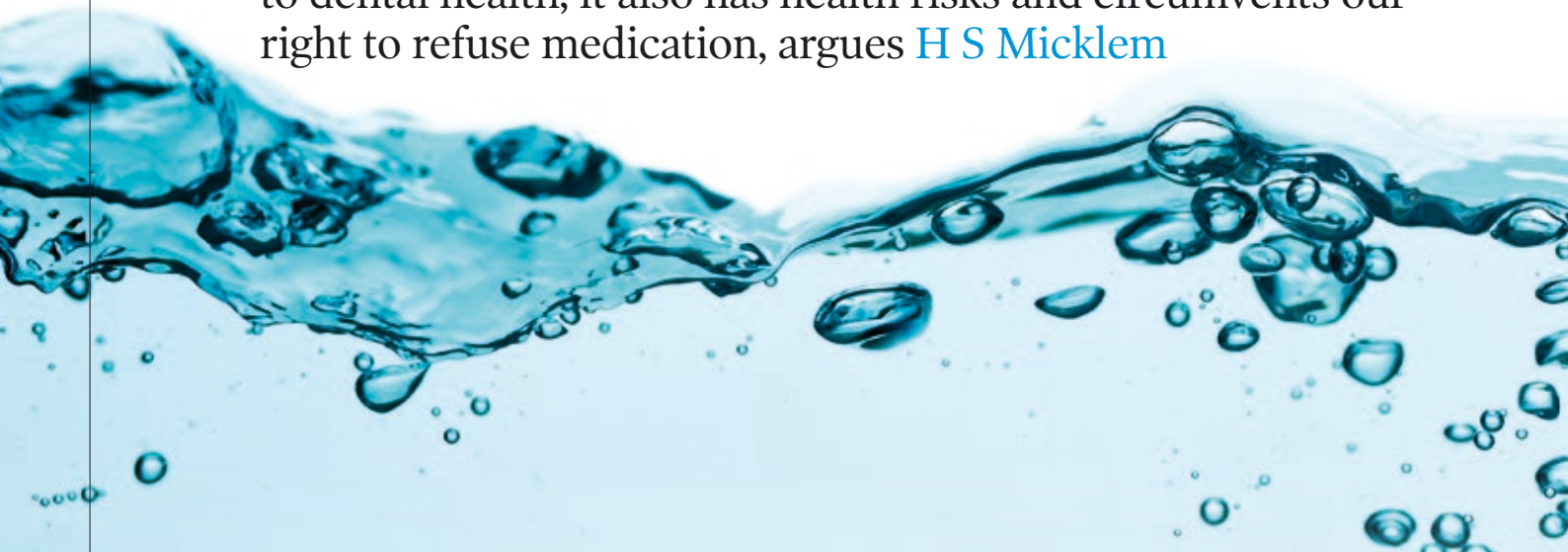
A case against water fluoridation

Not only does fluoridation of water have only a marginal benefit to dental health, it also has health risks and circumvents our right to refuse medication, argues H S Micklem



'Safe and effective' has long been the mantra of proponents of water fluoridation. To be clear at the outset, I am not discussing here the use of topical fluoride (as in toothpaste, rinses etc), but questioning the mantra over the efficacy, safety – and also propriety – of adding fluoride to the public water supply.

In line with nearly all of Europe and most other countries, we do not fluoridate our water in Scotland, relying instead on the forward-looking Childsmile programme. But occasional voices still call for its reintroduction[1] and it is worth considering how inadvisable such a retrograde step would be.

Does it work?

Since the early trials, more than 60 years ago, the incidence of caries has declined similarly in fluoridated and non-fluoridated communities[2], probably due in part to fluoride toothpaste and, in part, to better diet and living conditions. Today, fluoridation may still have some effect, but it is marginal and less than has often been claimed.

Such a lukewarm endorsement may seem surprising when one considers how energetically the practice has been promoted, even described by the US Centers for Disease Control as 'one of the great public health achievements of the twentieth century'. But any benefit of fluoride is now agreed to be primarily topical and does not, as was long believed, involve incorporation into the enamel of the developing teeth (which results in fluorosis, see below).

Thus it does not need to be swallowed. While salivary fluoride is often believed to play a role in caries control, it appears that the concentration of fluoride in ductal saliva is too low to exert a significant effect, the residue from toothpaste being a more important source [3,4].

None of the largest trials conducted since the 1980s has demonstrated more than an almost trivial effect. That has not usually been apparent from the abstracts of the reports, which talk about impressive-sounding reductions in caries of 25 per cent or more. But the use of relative percentage changes can be very misleading when small numbers are involved. For example, a 25 per cent reduction reported for 12 year olds in 1990[5] turned out to represent just one-sixth of a tooth surface, an absolute reduction of less than 1 per cent.

Moreover, even that small reduction is really only a delay: the number of DMF teeth increases during the teens almost equally in fluoridated and non-fluoridated areas with the former lagging the latter by a few months. This may simply be due to a delay in the eruption of the permanent teeth[6]. An even smaller effect was seen in Australia[7]. A recent survey using registry data from Denmark[8] provides a curious exception, describing an anti-caries effect of even very low concentrations (0.125-0.25 mg/l) of naturally occurring fluoride in drinking water, even where fluoride toothpaste is generally used.

Vitamin D status could be a

"Since the early trials, more than 60 years ago, the incidence of caries has declined similarly in fluoridated and non-fluoridated communities"

possible confounding factor here, since it happens that areas of high natural fluoride levels in the east of Denmark also tend to receive higher levels of UV-B irradiation[9], but further investigation is needed. Reports from Finland, the former East Germany and Cuba[10-12] show that when fluoridation ceased, caries rates in children remained static or declined. This may have been partly due to the use of topical fluoride applications, but the important point is that fluoridation was clearly shown to be either ineffective or easily replaceable.

Although it is widely believed that fluoridation is particularly beneficial to poorer communities, the York[13] and European Commission SCHER[14] reports considered that the evidence supporting such a selective benefit was fairly weak. It has been described with some reason as a 'sticking plaster' measure to avoid dealing with inequalities in a more fundamental way. Awofeso[15] has recently argued cogently that fluoridation cannot be justified ethically on the grounds of its public value. Cheng et al[2] also provide a useful discussion of this issue.

What are the risks?

Numerous government agencies in the main fluoridating countries – USA, Australia, New Zealand, Irish Republic – have continued to assert the safety of fluoridation since its original endorsement by the US Public Health Service in 1950. Such assurances rest more on faith than reality since very few studies have, in fact, been done to investigate the range of plausible dangers identified in animal or biochemical studies or the prolific anecdotal evidence that some people are hypersensitive to fluoride. So, health authorities can continue to state that there is 'no evidence' of harm. The oft-repeated belief that 'if there was any danger we'd have noticed it by now' is not well founded.

There are many sources of fluoride exposure, so even if the fluoride imbibed with water alone is not enough on its own to cause harm, its presence may tip the scales. Mansfield[16] has calculated that many people in the UK are exceeding the total intake of fluoride that is officially recognised as safe, and the proportion is higher in fluoridated areas.

Dental fluorosis

This is the one risk that everyone agrees about – usually (not always) very mild or mild, but readily visible particularly on the maxillary incisors, and not always appreciated by the owner. More important than any cosmetic effect are the underlying mechanisms, including disruption of normal mineralisation by the incorporation of fluoride into apatite crystals producing fluorapatite and interference with the function of ameloblasts[17] with resulting irregularities in the mineral structure. The teeth provide a visible window to the largely hidden effects that these processes may have on the skeleton over a lifetime.

Skeletal fluorosis

Throughout life, about 50 per cent of

Continued »

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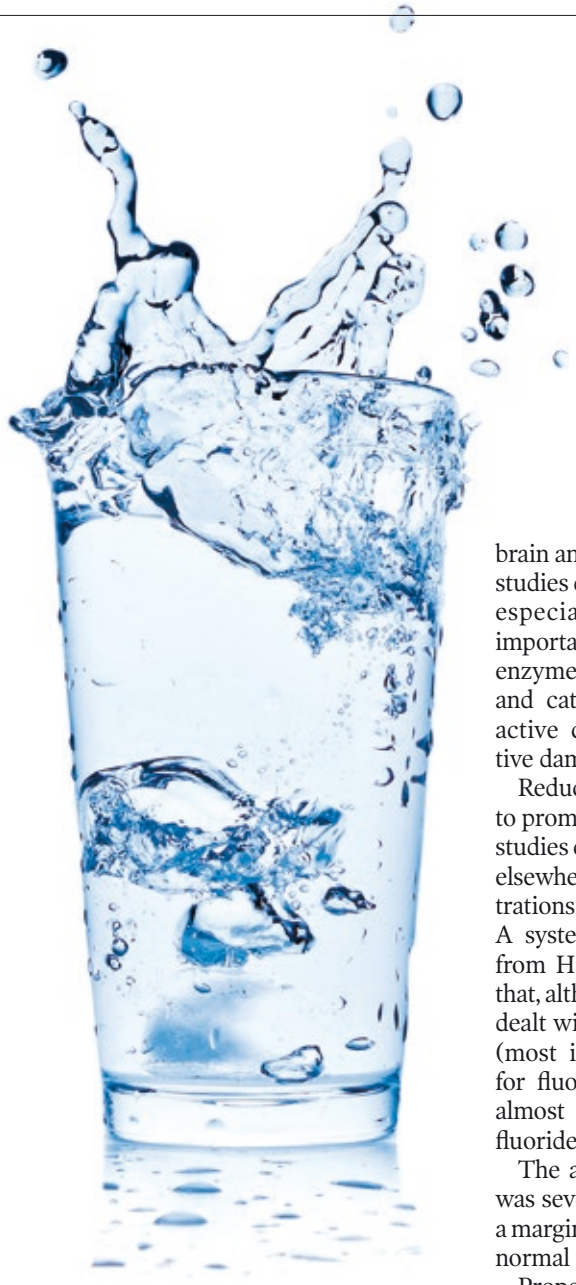

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ingested fluoride accumulates in the skeleton, especially at sites of bone formation. Advanced (clinical Stage 3) skeletal fluorosis occurs in parts of India and elsewhere where fluoride is naturally present in the water at 5ppm or more – a devastating condition fortunately very rare in the west. The question mark for us hangs over the earlier clinical Stages 1 and 2, which manifest as aches and pains and later arthritis. The extent to which this may contribute to the spectrum of arthritic conditions in western countries is unknown[18,19].

Carcinogenesis

Related to its localisation in bone, fluoridated water consumption specifically between the ages of five and eight has been implicated in the development of osteosarcoma in young men[20]. This was a carefully conducted case-control study that confirmed tentative suggestions from some earlier cross-sectional studies.

Although ecological studies have mostly failed to detect an association between osteosarcoma and fluoridation, that may well be due to the rarity of the disease and the relative weakness of cross-sectional investigations. So far there have not been any attempts to repeat Bassin's work, or any convincing evidence to suggest that its conclusions were wrong, so it remains both biologically plausible and unrefuted.

Fluoride has also been claimed to be a more general carcinogen, but the evidence remains unconvincing. However, the silicofluorides commonly used for fluoridation are contaminated with arsenic.

A typical (USA) concentration of 30mg As per kg of silicofluoride would be expected, assuming a linear carcinogenic dose-response relationship, to result in 2.7 extra cases of lung and bladder cancers per million people drinking the fluoridated water[21].

Thyroid and other organs

Fluoride interferes with the activity of a large number of enzymes in vitro. Animal studies have indicated low-dose toxicity of fluoride to several organs and systems including the kidneys and particularly the thyroid[18]. It is considered to be an endocrine disruptor[18]. There is as yet no compelling evidence that dietary fluoride intake can affect these organs in humans, but the possibility has received scant research attention and urgently requires more.

"There are animal studies documenting damage to the brain, especially during development"

Brain and IQ

One topic that is receiving considerable attention at present is the developing brain and IQ. There are numerous animal studies documenting damage to the brain, especially during development. One important mechanism is interference with enzymes such as superoxide dismutase and catalase that protect metabolically active cells and tissues against oxidative damage[22].

Reductions in children's IQ have come to prominence as a result of more than 30 studies conducted in regions of China and elsewhere that have naturally high concentrations of fluoride in the drinking water. A systematic review and meta-analysis from Harvard of 27 studies[23] concluded that, although most had shortcomings and dealt with higher fluoride concentrations (most in the range 1-5ppm) than used for fluoridation (0.7-1.0ppm), there was almost universal agreement that higher fluoride led to lower IQ.

The average reduction over the series was seven IQ points. At best, this implies a margin of safety that is extremely low by normal toxicological standards.

Proponents of fluoridation have been quick to denigrate and downplay these studies, but despite some weaknesses in the individual studies – some inherent in the type of epidemiological design used – the consistency of the results demands attention. While they do not directly implicate artificially fluoridated water at 0.7-1.0 mg/l, the risk is clearly there and, as the review authors say, requires further research.

Is it ethical?

Our right as individuals to refuse medication is enshrined in law though whether that right is absolute or conditional – on, for example, an estimate of a public good such as the care of poor children (2, 15) – is disputed. Proponents argue that fluoride is not a medicine, but a natural mineral nutrient, like calcium, that is simply supplemented to an 'optimal' concentration.

The fact that it is 'natural' carries no weight: arsenic is natural too. Nor is it in any way comparable to calcium, an essen-

Continued »

"It is delivered in an incompetent manner, since the so-called optimal concentration is a statistical compromise"

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tial nutrient, or even to selenium, which despite being highly toxic is still essential in trace quantities; fluoride is not required for any physiological process at all. It is not a nutrient, but a medicine, delivered without individual consent.

Moreover, it is delivered in a most incompetent manner, since the so-called optimal concentration is a statistical compromise and tells us little about the dosage to an individual consumer – an essential consideration for any prescribed medicine. Young children are particularly likely to receive an excessively high dosage (14,19).

Fluoride's medicinal status is confirmed legally by Lord Jauncey's opinion: "Section 130 [of the Medicines Act 1968] defines 'medicinal product' and I am satisfied that fluoride in whatever form it is ultimately purchased by the respondents falls within the definition." [24]

Shaw[25] argues that fluoridation in the UK subsists on the assumption that fluoride is not a medicine and that the assumption is a 'legal fiction'.

Conclusion

The precautionary principle calls for risks not to be taken unless more than balanced by countervailing benefits. If there is one situation where the principle should be invoked, it is surely the involuntary mass-medication of a population with largely uncontrolled dosages via the public water supply.

The risks of water fluoridation are substantial and varied, if still mostly unproven, and the benefits today are marginal. People should not be medicated without consent. Ineffectiveness, safety concerns and ethics all point in the same direction: we are better off without it. ■

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An alternative method of identification or a myth?

The 'oral fingerprint'

Within forensic odontology, the use of the dental restorations, teeth and supporting bone to compare post-mortem findings with an ante-mortem record are the most commonly used and widely accepted methods of establishing identity.

The reasons for this have been described: "Under most conditions occurring in nature, the teeth are the least destructible part of the body and they may readily survive all of these changes... fire, putrefaction or prolonged immersion in water."[1] However, there may be circumstances where these tissues cannot be used – perhaps due to trauma, disease, absence of teeth, or significant change which has occurred within a dentition since the last record was made.

The term palatoscopy or palatal rugoscopy is the name given to the study of the palatal rugae in order to establish the identity of an individual. It was first proposed as an alternative method of human identification in 1889 by Dr Harrison Allen[2]. Since then, many have attempted to classify the palatal rugae with a view to employing rugoscopy techniques in those instances where primary, standalone methods of identification, such as DNA analysis, finger print analysis and conventional dental identification have failed or cannot be used.

"Are the palatal rugae of any relevance in the field of forensic odontology?"

The palatal rugae are irregular, asymmetrical ridges of mucous membrane found in the roof of the human mouth extending laterally from behind the incisive papilla and across the anterior part of the median palatal raphe[3]. The rugae form in the 12th to 14th week of intra-uterine life from the hard connective tissue covering the palatal bone and their formation is under genetic control [3-4].

Many researchers hypothesise that once formed, the palatal rugae pattern is distinct to an individual, and does not change throughout life, except for an increase in size due to normal growth. It follows that the palatal rugae, as a characteristic feature, could potentially be considered as a type of 'oral fingerprint' and used as a tool in forensic human identification.

However, very few studies using the palatal rugae as a means of forensic identification have been published and the perceived usefulness of the palatal rugae as an individualising marker within forensic odontology is controversial, throwing up numerous questions. Are the palatal rugae unique to the individual? Is the number of rugae stable throughout life? Does the palatal pattern change, other than due to normal growth? Can the palatal rugae pattern be classified and analysed? Is the interpretation of the analysis useful to an individual investigator, or on a universal basis? Are the palatal rugae of any relevance in human identification or in the field of forensic odontology?

To answer these questions fully would be beyond the scope of this article. In summary, published studies [5,8] concur that palatal rugae patterns are distinct to the individual. The sample sizes studied are generally small, but within each sample, distinctiveness to the individual is demonstrated. This concurs with the author's own experimental research.

The effect of age on the mean number of palatal rugae does not appear to have, as yet, been fully addressed by the literature, there being a number of apparent contradictions. Various studies have reported rugae numbers increasing with age, decreasing with age, being stable from age 10 years until after death and rugae numbers increasing markedly from middle-age onwards[9, 13].

The palatal pattern has been shown to change in length, shape and orientation with growth and with orthodontic treatment. One study demonstrated that 32

per cent of rugae changed shape, while 26 per cent changed direction as subjects moved through their teens[14, 16]. This does not promote the idea of a stable rugae pattern.

Numerous classification systems have been developed over the years, primarily descriptive in terms of the number and morphology of the rugae. Thomas and Kotze developed a comprehensive classification system for palatal rugae and claim to have had success identifying individuals using their method. Despite this, they consider a universal system of palatal rugae classification to be impossible, but suggest that standardising the analysis procedure would prove beneficial. They conclude that an individual operator, using his/her own classification method can "very successfully apply it in a comparative project" and that it is the "results of the comparisons and not the classification itself" which is important [2, 17, 18].

Which brings us to the key question: are the palatal rugae of any relevance in human identification or in the field of forensic odontology?

The position of the palate in the head means that rugae are often well protected from external trauma while being insulated from thermal insult by the tongue and the buccal fat pads. The rugae pattern has been shown to resist decomposition for up to seven days after death [19, 20].

While much of this sounds promising, there are many issues and problems to be addressed before this method can, or should be embraced. One main issue surrounds the collection of the ante-mortem record to ensure that it is a true representation of the palatal rugae pattern.

The ante-mortem record will usually take the form of a dental cast or a clinical photograph of the dentition which has coincidentally captured the rugae pattern, which would be taken as part of the routine treatment for a particular patient and

Continued »

Fig 1
Illustration of photographic distortion

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"Does it matter if it is only a small change? Isn't any change a change?"

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form part of the dental record belonging to that individual. While the dental cast is a direct replication of the dentition and surrounding oral tissues, intra-oral photographs present some difficulties, specifically concerning inherent distortion within the image.

When photographing an object with the aim of minimising distortion, the object should be perpendicular to the digital sensor within the camera – in the case of the palatal rugae this is extremely difficult due to human anatomy. Intra-oral mirrors, held at appropriate angles, are used in an attempt to correct this inherent distortion. The image is usually being taken to assess the dentition, specifically the occlusal surfaces of the teeth.

In such images, there may be 'zones' where the palatal rugae are clearly focused, and therefore representative in shape and length. In other areas of the image, usually towards the periphery, distortion will have affected the appearance of the rugae, causing blurring and lack of distinction. Figure one illustrates inherent photographic distortion due to the vaulted anatomy of the human palate, with the central zone being focused and the peripheral rugae being out of focus.

Another issue surrounds the concept of 'normal accepted growth'. It seems that the pattern changes over time are less well understood. Changes in orientation of the rugae and changes in the shape of the rugae are still changes, no matter how small they may be. While the distinctiveness of palatal rugae patterns to an individual may be accepted, it is more difficult to assess lifelong stability of the rugae pattern from the methodologies used in studies to date.

The hypothesis this technique bases itself on is that the palatal rugae pattern is distinct to the individual and does not change throughout life, except for an increase in length due to normal growth. If we consider the hypothesis differently, it is actually stating that there is a change in the rugae pattern and that it should be expected in accordance with normal growth.

The distinct pattern may appear 'differently' in the same individual at various phases within that individual's chronological and dental development. But what is 'normal' growth? Is growth accurately predictable? Is growth uniform across age, ethnicity and the global population? If palatal rugae are to be relied upon as a supportive method of human identification, can we tolerate any change? Does it matter if it is only a small change? Isn't any change a change?

Longitudinal studies may help resolve some of these questions, and are necessary if we are to accurately observe the behaviour and stability of the rugae pattern over a lifetime. Monitoring the palatal rugae patterns in a group of patients, starting from around age 14 when the dental arch width is considered fully developed and following the rugae pattern into late adulthood, is one way we can truly assess lifelong stability of the pattern, or otherwise. Even with necessary ethical approval in place for such a study, the logistics of acquiring and maintaining a suitable, consistent sample over a long number of years may prove challenging.

The current usefulness of rugoscopy as a supportive technique in human forensic identification may be improved by the development of practical and cost-effective three-dimensional intra-oral recording devices. Used along with complementary software, 3D images of the palate would help reduce the effects of distortion in current 2D clinical images, potentially elevating the usefulness of this technique.

The variation between the palatal patterns of individuals is often minor, and the inherent distortion when comparing what is in life a 3D structure as a flat, 2D image limits current usefulness of this technique. The development of palatal rugoscopy may only reach fruition when 3D technology becomes commonplace.

Interestingly, the Brazilian government

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insist upon 3D palatal scans of all pilots to ensure their speedy identification should they be involved in an accident[2].

This article seems to raise more questions than it answers about the potential role of palatal rugae in human forensic identification, but the advancement of scientific techniques relies on such questions being asked, with those questions becoming the focus of future studies.

To summarise, there is, as yet, no reliable and consistent method of using the palatal rugae pattern successfully to aid human forensic identification. The potential changes in rugae patterns, whether growth-related, age-related or otherwise, need to be better understood as to whether these changes are tolerable and have a place in this technique. Reliability and repeatability will only be proven by continuing to research new knowledge and new methods which apply to lesser- known techniques. Just because a method is unconventional does not make it bad science. It should be as robust in its reasoning and testability as conventional methods.

Dental identification, conventional or otherwise, can bring immeasurable comfort and closure to a grieving family or loved one. On the rare occasion that conventional methods cannot be used, we owe it to the deceased, their family and to ourselves professionally to ensure we acknowledge the potential downfalls in alternative techniques, using them to support other forensic disciplines rather than as standalone methods. ■

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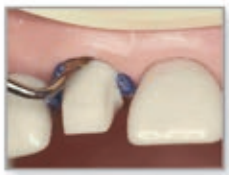

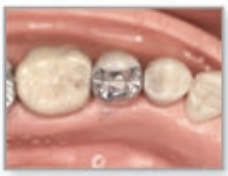
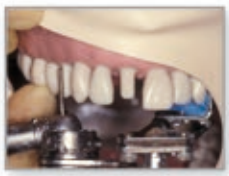
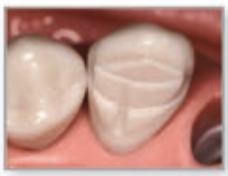


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Restoration fundamentals

Despite the new materials available, tried-and-tested techniques are the fundamentals of full mouth reconstruction. Dr Paul Tipton begins a series of articles with a discussion of occlusion and occlusal concepts

Most advanced restorative dentistry techniques have changed little over the past 20 to 30 years, including that of the full mouth reconstruction. However, the impact of new dental materials, such as titanium and zirconia, has had a major influence on aesthetic dentistry and implantology during this time.

As a result, the profession may have an over-reliance on new materials rather than tried-and-tested techniques. Some fundamental techniques are just as relevant today as they were when I started my master's degree in conservative dentistry at the Eastman Dental Hospital in London in 1987.

In this article, some of the old restorative techniques will be revisited in light of today's aesthetic and restorative requirements and some newer concepts will be discussed in greater detail while dealing with the overall topic of full mouth reconstruction. This article discusses the topic of occlusion and occlusal concepts.

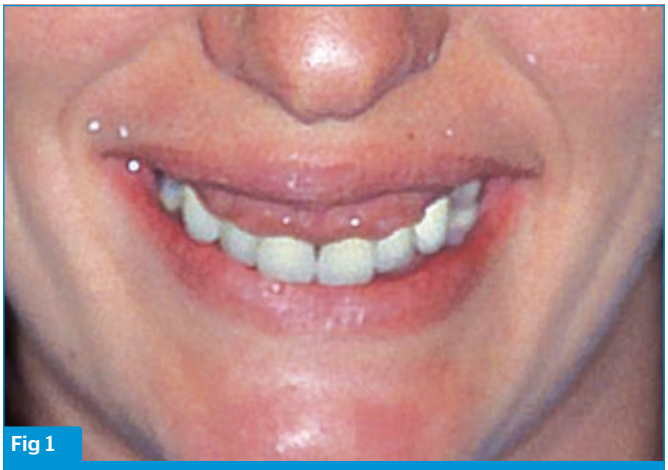

Fig 1 Pre-op view

Gnathology

Stallard coined the term gnathology in 1924, defining it as the science that relates to the anatomy, histology, physiology and pathology of the masticatory system. McCollum formed the Gnathological Society in 1926 and is credited with the discovery of the first positive method of locating the transverse horizontal axis and transferring the recording to an articulator using a facebow.

Stuart became associated with the Gnathological Society early and published the classic 'Research Report' with McCollum in 1955. Their observations led to the development of the principles of mandibular movements, transverse horizontal axis, maxillomandibular relationships, and an arcon-style articulator that was designed to accept the transfer of these occlusal records.

The goal was to truly capture maxillomandibular relationships that accurately reproduced border jaw movements and which would then allow the technician to produce the most stable, functional and aesthetic occlusal form for indirect cast restorations. The registration of the horizontal and sagittal movements of patients was believed to allow the maximum cusp height-fossae depth with proper placement of ridges and grooves to enhance stability, function and aesthetics.

Fundamentals of gnathology

The fundamentals of gnathology include the concepts of retruded axis position (centric relation), anterior guidance, occlusal vertical dimension, the intercuspal design and the relationship of the determinants of mandibular movements recorded using complex instrumentation to the occlusion in fixed prosthodontics. This has evolved into the five principles of occlusion I embrace today:

1. RCP = ICP around RAP
2. Mutually protected occlusion
3. Anterior guidance
4. No non-working side contacts
5. Posterior stability.

Continued »

Fig 2 ICP

Fig 3 Facebow recording

Fig 4 Diagnostic waxing front view

Fig 5 Lower wax-up

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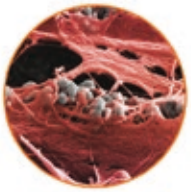

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The early gnathologists studied the recorded tracings made during mandibular movements. When the mandible travels forward along the sagittal plane it is considered a protrusive excursion or protrusion. Therefore, retrusion is the movement toward the posterior. It is the most retruded physiologic relation of the mandible to the maxilla to and from which the individual can make lateral movements that initially defined retruded axis position (RAP) or centric relation (CR) to the gnathologist. Further investigations led the gnathologists to believe that mandibular (condylar) movements are governed by the three axes of rotation.

The concept of retruded axis position evolved into a three-dimensional position, resulting in its description as the rearmost, uppermost, and midmost (RUM) position of the condyles in the glenoid fossa. More recently, with the input of anatomists and physiologists, the concept has also included a bone-braced position slightly anterior to the RUM position. While there can be discussions between groups as to the exact definition of RAP, it is generally accepted as a muscular relaxed, reproducible and braced position that is an area not a pinpoint and can only be achieved with relaxed musculature.

Placing the condyles with the correct position and having immediate disclusion (canine guidance and incisor guidance) upon movement away from that position, with no vertical or horizontal deflective contacts is fundamental to gnathology. Tooth wear is considered pathological in gnathology and one of its fundamental concepts is trying to advance a dentition with minimal wear.

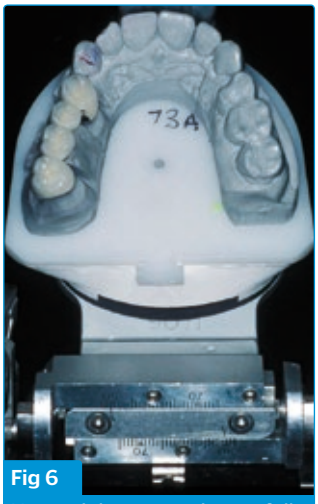

Fig 6 Upper right restoration on fully adjustable articulator

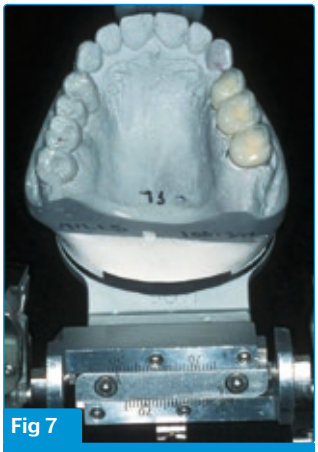

Fig 7 Upper left restoration on fully adjustable articulator

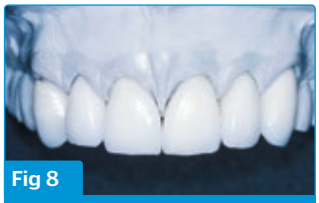

Fig 8 Anterior crowns front view

Fig 9 Upper arch occlusal view

Fig 10 Upper right quadrant with palatal ramps

Fig 11 Upper left quadrant with palatal ramps

Fig 12 Intercuspal position with no anterior contacts

Fig 13 Upper anteriors

Fig 14 Upper anteriors final view

Fig 15 Lower anteriors final view

Alternative occlusal concepts: Pankey Mann Schuyler

As gnathology was evolving, several competing occlusal concepts and permutations were theorised, such as the Pankey Mann Schuyler (PMS) theory of occlusion. The PMS concepts evolved out of an initial study group headed by LD Pankey on the east coast of America. Nomenclature was different and included centre relation (CR) instead of retruded axis position (RAP); centre-related occlusion (CRO) instead of retruded contact position (RCP) and centric occlusion (CO) instead of inter-cuspal position (ICP). Beyron, following his observations on Australian Aborgines, suggested that uniform tooth contact and resultant wear on several teeth in lateral occlusion was a positive and inevitable outcome.

As a modification of canine guidance, the PMS philosophy in complete full mouth reconstruction was to have simultaneous contacts of the canine and posterior teeth in the laterotrusive (working) excursion, known as group function, and only anterior teeth contact in the protrusive excursive movement.

Schuyler further suggested that incisal guidance without freedom of movement from a centric-related occlusion (CRO) to a more anterior tooth intercuspation (CO) will 'lock-in' the posterior occlusion (long centric).

The incisal guidance, along with 'long centric', is determined by the distance from transverse horizontal axis-centric relation and the normal freedom of movement in the envelope of function. This method requires that the incisal guidance be established and the mandibular posterior buccal cusps be placed to a height measured along the occlusal plane as dictated by the curve of Monson.

The maxillary posterior teeth are developed after the completion of the mandibular restorations as dictated by a wax functionally generated path record. The definitive restorations are equilibrated into a centric relation position with mandibular buccal cusps onto a flattened fossae-marginal ridge contact with 'freedom in centric' anterior guidance and group function in laterotrusive (working) excursion.

Deflective contacts

Though 90 per cent of natural dentitions have a deflective occlusal contact or an occlusal 'prematurity' between CRO and CO, it is usually in the

Continued »

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form of a slide that has both a vertical and horizontal component occurring in all three planes. According to Ash and Ramfjord, the horizontal 'long centric' from CRO to CO should be incorporated into a restoration with a post-restorative occlusal adjustment.

Dawson illustrates the 'freedom in centric' concept within the lingual concavity of the maxillary anterior teeth. He redefines long centric as 'freedom to close the mandible either into centric relation or slightly anterior to it without varying the vertical dimension at the anterior teeth'. Additionally, long centric accommodated changes in head position and postural closure (Mohl position).

Gnathology versus PMS

Gnathologists believe that, once the condyles are positioned in retruded axis position (centric relation), any movement out of this position should disocclude the posterior segment, thus nullifying any horizontal cusp-fossae area contact.

This belief, combined with the immediate anterior disocclusion, forms the basis of a mutually protected occlusion and limits tooth wear. The PMS occlusal scheme, however, encourages multiple occlusal contacts during lateral movements (group function or wide centre) and during protrusive movements (long centric).

This may have the effect of increasing tooth wear. It is, therefore, logical that the PMS occlusal scheme recommends that occlusal wear is physiological, not pathological as suggested by gnathologists. The task of adjusting maximum intercuspation contacts in two different positions on an articulator may result in a lack of precision in both positions. However, the masticatory system has the ability to adapt to various influences and though, in the author's opinion, the concept of gnathology will produce

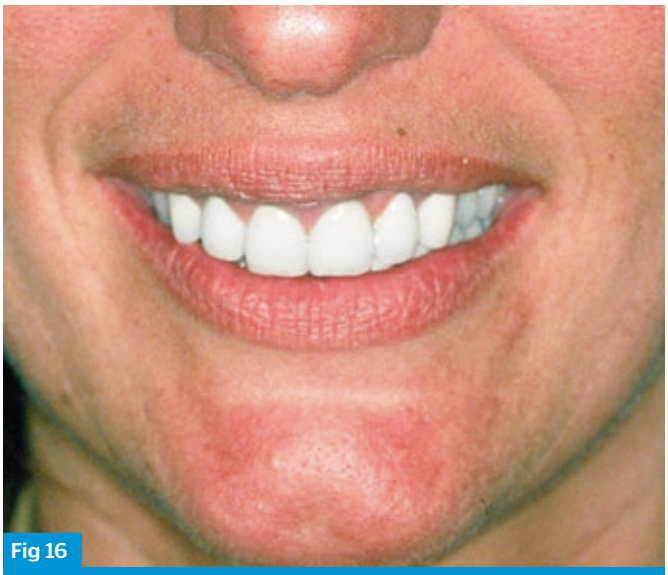

Fig 16
Final view

"Though gnathology will produce stable long-term results, some patients may require more freedom in their occlusion"

stable long-term results, some patients may require more freedom in their occlusion and the PMS concepts are not to be dismissed in these patients. Indeed, some PMS concepts such as waxing-up the curve of Spee and Monson prior to occlusal rehabilitation are incorporated into everyday occlusal practice.

Case study

Patient A was referred to me for a full mouth reconstruction and aesthetic improvements to her smile (Figures 1-2). Initial impressions, facebow and jaw registration were taken for mounted study models (Figure 3). The study models showed the degree of over-eruption of her anterior segments and disturbances to the occlusal plane.

Initial diagnostic waxing (Figures 4 and 5), prototypes and prep guides were completed using a lower curve of Spee of a 4" radius (anatomical average as recommended by the PMS techniques).

Initial prototypes were placed with large palatal ramps on the upper anterior teeth to allow anterior tooth contacts and thus an immediate disclusion style of occlusal scheme as recommended in the gnathological approach.

During the course of the initial preparation and prototypes and after a period of stabilisation, the patient was struggling to come to terms with the palatal ramps from a speech and comfort point of view.

The decision was made to change the occlusal scheme to a PMS 'freedom in centric' style approach where initial guidance in both left and right lateral excursions came from posterior teeth until such time as the canines contacted and then took over as canine guidance. In protrusion, a similar long centric was established on posterior teeth so that in protrusive movements the initial guidance was from the posterior teeth until such time as the incisors touched and then took over the further smooth protrusive movements. This was achieved by using a fully adjustable articulator to complete the restorations (Figures 6 and 7).

Conclusions

The definitive anterior crowns were made of veneered zirconia (Figure 8). The posteriors were constructed of traditional porcelain fused to metal with large flat areas on the palatal cusps for the establishment of both 'long and wide centric' (Figures 9-11) as in the new intercuspal position there were no anterior contacts (Figure 12) due to loss of the palatal ramps. The final aesthetic result can be seen in Figures 13 to 16.

Occlusion and the various occlusal concepts have caused – and continue to cause – debate. Whilst the author has been trained throughout his career in the concepts of gnathology, there is the recognition that other occlusal concepts, such as PMS and bilateral balance, may have a part to play in treatment of some patients. ■

ABOUT THE AUTHOR

A highly respected specialist Prosthodontist, Dr Paul Tipton has published many scientific articles in the dental press and is an expert lecturer in his field with Tipton Training Academies in Dublin, Manchester and London.
He received specialist status in prosthodontics in 1999 from the GDC.

He is a past-president of the British Academy of Implant Dentistry (www.baid.org.uk) and the current president of the British Academy of Restorative Dentistry (www.bard.uk.com)

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Tricia Halliday of Martin Aitken & Co Chartered Accountants describes how to manage tax in the new financial year

New tax year, new opportunities

The new tax year started on 6 April and it brings with it opportunities for tax planning. Here are some...

Capital Allowances Annual Investment Allowance

The Capital Allowances Annual Investment Allowance (AIA) was increased to £250,000 from 1 January 2013, for a two-year period. This offers a tax write off against plant and machinery such as washer disinfectors and dental compressors.

Normally, capital allowances can only be claimed at 18 per cent on plant and machinery, but the AIA offers a 100 per cent tax write off on qualifying expenditure every year. If cash is available, now's a good time to think about replacing or upgrading your IT, dental equipment and any other qualifying assets.

A word of caution though – where the accounting period of your business does not begin on 1 January (i.e. coterminous with the start date of the AIA uplift), the calculation of the AIA is somewhat convoluted and timing of expenditure can be critical to maximise allowances. Before making purchases, you should discuss the matter with your tax advisor.

Pension contributions relief

Pension contributions are a tax-efficient way of providing for your retirement. They attract income tax relief and any unused allowances in the previous three tax years can be used in the current tax year.

It is possible to invest up to £200,000 in a private pension plan before 6 April 2014. When considering pension contributions, it is important to bear in mind the personal pension annual allowance currently £50,000 pa (reducing to £40,000 pa from 6 April 2014) and the lifetime allowance currently £1.5 million (reducing to £1.25m from 6 April 2014).

Any calculations must take into account your NHS pension contributions. It may be worth speaking to your pensions advisor to see how much you can invest in a private pension scheme before 6 April 2014.

Real Time Information

On 6 April, Real Time Information (RTI) came into operation for most employers. RTI has been introduced for a number of reasons. The current PAYE system cannot keep up with the fluidity of many working people's lives – many people now have more than one job or may take on casual work as well as their main employment.

RTI also promises to deliver the required data for the universal credits system.

RTI has changed the face of payroll reporting and represents a huge burden for employers. The roll out has been far from smooth and not helped by glitches in HM Revenue & Custom's RTI software used by many employers. If you are experiencing problems with RTI you should seek professional assistance as soon as possible.

Inheritance Tax

Inheritance Tax (IHT) is a tax levied on the value of your estate at the date of death. It also reels in any gifts made in the seven years prior to death. The government announced a freeze on IHT nil rate band, currently £325,000, until 5 April 2018.

Now may be a good time to conduct some estate planning and satisfy yourself that your practice qualifies for Business Property Relief and the accompanying 40 per cent tax relief. (see Dec 12/Jan 13 issue of *Scottish Dental magazine*, page 75, 'Avoid the tax traps').

National Insurance

One of the coalition's major drives is to reduce red tape and reduce the amount of time spent on compliance. In support of this, and to simplify tax and boost employment, the Chancellor introduced an annual allowance for employer National Insurance Contributions (NICs). This modest NIC break (£2,000) will reduce the costs of employing staff in your practice.

You will, however, have to wait until April 2014 to access the new allowance. The implementation process is still subject to consultation so we will update you once we know the exact details. ■

Should you have any queries in respect of the information contained in this article, please contact Tricia Halliday at Martin Aitken & Co on 0141 272 0000.

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Better conversations **better outcomes**

Kim Henry of Essential Mediation describes how a proactive approach to dealing with complaints can resolve issues quickly

I have previously written about the benefits of positive communication to enhance relationships generally in dental practice, whether with patients, professional colleagues or support staff. In the light of the new Patients Rights (Scotland) Act 2011, which provides the legal right to lodge a complaint, now is an opportune time to revisit some of these concepts. I'd like to concentrate on the following:

- The benefit of a well-written, considered Complaints/ Concerns Policy
- Some practical pointers for dealing with concerns raised
- The appropriate training for anyone handling feedback.

Firstly, I prefer to refer to complaints as concerns. The word complaint is too negative and can sometimes prevent people from offering useful comment as they assume it will not be perceived in a constructive way. The policy should provide a simple statement detailing that any contributions are welcome, will inform future professional practice, and will receive individual attention. Please be empathetic. No liability attaches to compassion.

Acknowledge that regardless of the rights or wrongs of the actual concerns, the person is clearly distressed enough to be taking action, and give a clear message that you are listening. If you do this, there is more likelihood that they in turn will hear and consider your own point of view, particularly when it comes to addressing clinical issues.

Be realistic about your timescales for dealing with concerns. Ensure you ask for proper contact details from the patient and when it is convenient to liase with them. Importantly, be proactive about asking the patient what they would like to happen at the outset, as this can provide invaluable guidance on how to take matters forward. To see a style Concerns Policy, please refer to the Resources section of my website.

Your first contact with the patient further to a concern being received is vitally important. Please don't send a pro forma response. Take the time to consider the issues and view the situation as objectively as you can. Take three simple steps:

- Acknowledge distress straight away, and give assurance to let the patient know you are listening
- Lay out your responses based on the facts and give ground where you feel you can. At this stage, you may require professional advice
- If you consider you can provide a solution reasonably quickly, make the offer and if you need further information, advise as appropriate, but always within considered timescales. Keep the patient advised of any delays – open channels of communication are vital.

As with all professionals, dentists live with the continuous fear of being sued. As your Concerns Policy is the first contact you have with a patient, you must use this opportunity to set the correct tone. The benefit of having this Policy managed by someone with a legal and conflict management background is twofold.

ABOUT THE AUTHOR

Kim Henry, LLB, LLM, Dip LP, NP, Cert Mgt, Ass M CI Arb, has been a lawyer for almost 20 years. She has lectured, managed and worked in private practice, as well as the public and voluntary sector. She has experience of working with dental practices and is the founder of Essential Mediation.

The conflict management training means that the individual knows how to respond appropriately to persons with a grievance and, if beneficial, can facilitate a confidential environment where issues can be addressed and resolved face to face quickly. The legal training indicates that person knows how much ground the dentist can give to resolve something without potentially opening themselves up to further liability.

This really is the key to dealing with matters promptly and effectively without having issues hanging around in the background, causing unnecessary stress, extensive damage via twitter and word of mouth and considerable legal fees.

Finally, while I appreciate that most dentists now have a Complaints Policy because they must, if you feel you do not have time to embrace these concepts, then do consider instructing another professional such as myself on a case by case basis. It will be worthwhile. ■

To find out more information, visit www.essentialmediation.com

Training to save lives

Duncan Turnbull from First Aid Scotland explains how the use of Automated External Defibrillators can save lives in an emergency

About 100,000 people in the UK each year die from Sudden Cardiac Arrest (SCA) before they reach hospital. The early use of effective Basic Life Support (BLS), coupled with the early use of an Automated External Defibrillator (AED), can triple a patient's chance of survival.

The latest guidelines from the Resuscitation Council (UK) advise that AEDs should be available in every healthcare environment and that the dental surgery is not seen as an exception.

BLS training is one of the four core continuing professional development modules set out by the GDC, which can also include modules on AED use and safety, and is usually carried out on an annual basis.

Many first aid training companies, including First Aid Scotland, provide BLS training to dental practices. Some also carry out AED training, however, most do not have the working knowledge on the specific units the practice or surgery may have. First Aid Scotland is a training organisation, approved by the Health & Safety Executive, but is also an AED distributor, which trains, advises and supplies dental practices with units and consumables.

Above: An Automated External Defibrillator can triple a patient's chance of survival

Duncan Turnbull, managing director at First Aid Scotland, said: "We train healthcare professionals within the dental profession using model-specific presentations, aimed at their level of professional understanding, from dental surgeons to reception staff."

All First Aid Scotland training includes the use, maintenance and safety of AED use. Staff are fully trained and assessed on their AED competency during their training.■

For more information, contact Duncan on 0800 0431 327 or duncan@firstaidscotland.co.uk

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Dealing effectively with the unexpected

Dental practices should ensure they are equipped to deal with medical emergencies

by Donald Oleforo of BOC Healthcare

The UK dental industry prides itself on its safety record and its commitment to providing dental treatment as a contribution to improving general health in the population. However, as in virtually all medical procedures, there is a finite risk of unforeseen events happening, including medical emergencies. Dental practices need to be aware of these risks and to take action to minimise their consequences.

In this area, the Medical Emergencies and Resuscitation Standards published by the UK's Resuscitation Council set out best practice for the industry. This document, which was revised and reissued in December 2012, stresses that, although medical emergencies are rare in general dental practice, "there is a public expectation that dental practitioners and dental care professionals should be competent in managing common medical emergencies".

The medical emergencies most likely to be encountered in dental practices include asthma, anaphylaxis, angina, cardiac arrest, epileptic seizure, hypoglycaemia, syncope, choking and aspiration, and adrenal insufficiency. The Resuscitation Council document sets out the initial steps to be taken by practitioners while awaiting professional medical help from the ambulance service. The council also lists emergency drugs and equipment that should be routinely available in all UK dental surgeries.

A key resource that should be available is medical oxygen in cylinders. The guidelines say that: "Oxygen cylinders should be of sufficient size to be easily portable, but also allow for adequate flow rates, e.g. 15 litres per minute, until the arrival of an ambulance or the patient fully recovers.

"A full 'D' size cylinder contains 340 litres of oxygen and should allow a flow rate of 15 litres per minute for approximately 20 minutes. Two such cylinders may be necessary to ensure the supply of oxygen does not fail when it is used in a medical emergency."

These cylinders should be fitted with a pressure reduction valve and a flowmeter.

An Automated External Defibrillator (AED) should also be available. The combination of oxygen and AED as a basic medical emergency strategy has been gaining ground across the UK over the last few years. Many football clubs have this kind of equipment, as well as an increasing number of schools.

While the resuscitation guidelines do not have the force of law, they do set a benchmark for the industry and dental practices need to give them due consideration. Given dentistry's commitment to health and to providing the highest standards of care for patients, implementing these guidelines should be a priority for all practices. ■

Donald Oleforo is a product manager at BOC Healthcare, part of the Linde Group, specialists in healthcare provision across the globe. BOC Healthcare provides a range of products and services across the Healthcare sector, including essential equipment listed by the Resuscitation Council for use in medical emergencies. For more details, call 0161 930 6096 or email bochealthcare-uk@boc.com

MINIMUM RECOMMENDED EQUIPMENT

Minimum emergency and resuscitation equipment for dental surgeries (Resuscitation Council recommendations):

All clinical areas should have immediate access to resuscitation drugs, equipment for airway management and an automated external defibrillator (AED). Staff must be familiar with the location of all resuscitation equipment within their working area.

The following is the minimum equipment recommended:

- Portable oxygen cylinder (D size) with pressure reduction valve and flowmeter
- Oxygen face mask with reservoir and tubing
- Basic set of oropharyngeal airways (sizes 1, 2, 3 and 4)
- Pocket mask with oxygen port
- Self-inflating bag and mask apparatus with oxygen reservoir and tubing (1 litre size bag) where staff have been appropriately trained
- Variety of well-fitting adult and child face masks for attaching to self-inflating bag
- Portable suction with appropriate suction catheters and tubing e.g. the Yankauer sucker
- Single-use sterile syringes and needles
- 'Spacer' device for inhaled bronchodilators
- Automated blood glucose measurement device
- Automated External Defibrillator (AED).

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DÜRR DENTAL

Quality, service and price

Bolton-based laboratory Aesthetic World has been serving customers in Scotland for more than 20 years

Aesthetic World has been providing quality, cost-effective restorations throughout Scotland since its inception in 1989. Known predominantly as a specialist cosmetic and implant laboratory, it can provide everything from a single crown to full zirconia frameworks and customised milled abutments.

With dental technology moving at such a fast pace and new materials and processes being introduced, it is refreshing to see a laboratory embracing such technologies with the clinician at the forefront of the business model. It is often said that you get what you pay for and, in the case of Aesthetic World, this definitely equates to quality, service and price.

"It is refreshing to see a laboratory embracing such technologies with the clinician at the forefront of the business model"

The laboratory has always had a reputation for quality as it is DAMAS accredited, DLA registered, employs GDC-registered technicians and even carries the British Bite Mark. As a full service laboratory, it is proud to be able to manufacture everything in the laboratory based on Spa Road in Bolton, Lancashire. This in-house approach ensures that work can be turned around efficiently in the laboratory in a maximum of five days upon receipt of your impressions, with an express service available if required. With both postal and courier collections available throughout Scotland, it's no surprise that more clinicians are finding out about one of Scotland's best-kept secrets.

Aesthetic World believes in providing a high standard of work at very competitive prices and has established a large following of clinicians who share the ethos of honest laboratory pricing. ■

To find out more about Aesthetic World or its postal/collection services, please get in contact via the website at www.aestheticworld.co.uk by email chrismangnall@aestheticworld.co.uk on Twitter @aestheticworld1 or by calling 01204 365 622.

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Adding value and removing the 'red tape' burden

Robb Ferguson, a specialist accountancy firm in the dental sector, offers clients a wide range of services

Robb Ferguson is an independent mid-tier firm of chartered accountants and business advisers.

The practice was founded in the late 1800s in Glasgow and as such is one of the longest established practices in Scotland. The firm today is a dynamic and forward-thinking practice where the client comes first with service delivery that is partner led, backed up by trained chartered accountants and technical staff.

The firm has a specialism in the dental sector and two of the partners, Graham Cantlay CA and Brian Curran CA, are the principals in this area and lead the healthcare team. Both Graham and Brian have been acting for dental practices, orthodontists and associates for a number of years and are therefore experts in this area of accounting and taxation.

Above: Brian Curran

The firm offers a wide range of services to clients, including the preparation of annual accounts, taxation returns and bespoke planning, business advice, bookkeeping services and payroll services among others. Each client gets a tailored solution to their own specific needs as it is the firms' view that no two clients require the same solution.

Above: Graham Cantlay

Beyond just routine advice, Graham and Brian have been involved in practice acquisition, disposal, new practice set up, including assistance with finance raising and general wealth planning issues that can be common with dentists.

The firm is always delighted to meet with new clients and offers a genuinely free of charge initial meeting where an open discussion can be had to establish common ground. If you feel you would like to work with a forward-thinking and hands-on firm of chartered accountants who can add value and take away some of the 'red tape' burden, feel free to contact either Graham or Brian to make a no-obligation appointment. ■

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VATECH

Proud of the difference we can make together

Stark Main & Co's team of financial experts has extensive knowledge of the dental market

If you are looking for an accountant or tax adviser who has the skill and knowledge to help you achieve your goals, then Stark Main & Co Dental are well placed to assist.

With a dedicated team for the dental market, the company is keen to work with dental practitioners who are ready to commit to constant development, profit improvement, efficiency and tax reduction.

Its dental clients have averaged £25,000 in tax savings in the last two years, rising to £86,000 for each practice acquisition. Being a dually-qualified firm – accredited by the Institute of Chartered Accountants of Scotland and the Chartered Institute of Tax – the company is perfectly placed to minimise the tax bills of its dental clients.

To celebrate the opening of its dedicated Edinburgh dental office, the company is offering free health checks on practice structure, tax savings, remuneration and benchmarking. Its dental offering also includes: guaranteed proactivity or your money back; fixed-fee certainty, analysis of your performance, with a benchmarking and financial performance review service; and help with running your practice as a business.

Director Ian Main said: "Our core message is 'Proud of the difference we can make together' and we have extensive experience working within the dental sector." ■

AWARD WINNERS

British Accountancy Awards 2012 – Scottish Accountant of the Year
Practice Excellence Awards – UK Small Firm of the Year 2012
SBB Excellence Awards – Employer of the Year 2011
UK Firm of the Year 2011-2012 – Accountants Club
Featured in the book 'The UK's Best Accountancy Practices' (2011)

Make your time work for you

A few simple strategies should help you – and your staff – make better use of your working day

Do you sometimes forget files, meetings, dates, keys or deadlines? Do you need more than 24 hours in a day just to tread water on your to-do list? Despite using top-of-the-range time-management/CRM software in your practice, do you feel you never have enough time to work on your practice, rather than merely working in your practice?

If this sounds familiar, you are not alone – accountants and dentists have far more in common than you'd think! We both make our living from easing our patients of pain – whether that is physical pain, the emotional pain of holding hang-ups over one's smile, or the emotional pain of having to deal with a relentless tax inspector.

Our diaries tend to be wall-to-wall dispensing our knowledge and skill to our clients, leaving us with little

time to take a bird's eye view and make our practices more profitable, or even just to enjoy life more.

Here are a few strategies to help you get more organised:

Prioritise your to-do list into a matrix – on one side, what is important and what is not important, on the other what is urgent versus non-urgent to form a grid. Important, urgent tasks must take precedence over all else, such as an emergency. Non-important, non-urgent items should be bottom of your priorities.

When making strategic plans for your practice, ensure you write these down in an action plan. Set specific, measurable, accurate, realistic and time-bound targets. In other words, be 'SMART'er with your ambitions and time.

Consider delegating, passing on or subcontracting work which others can do to free up your time for only what you can do. If you are a principal, this includes taking leadership of the financial and strategic direction of the practice. Pass on operational responsibilities where appropriate to give you adequate time to develop the practice.

Time is the one commodity we all have an equal share of – it is how we spend it that defines how successful we can be. ■

ABOUT THE AUTHOR

Damian Turner CA is partner of Turner Medical LLP, a chartered accountancy firm offering specialist value-added accountancy, taxation and financial services to the medical sector.

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Practice structuring in the future

Sandy Dargie from William Duncan explains that the way your business is structured can have a significant impact on your tax liabilities

During the recent Scottish Dental Show at Hampden Park, we took some time to network with the attendees and many of the exhibitors.

Throughout the day we talked to practitioners about how their records are maintained. The requirement to complete form GP234, making the declaration of the percentage of NHS earnings, recently highlighted a lack of focus in keeping the right type of financial information.

A number of practitioners still prepare their financial records manually despite the advances in technology that have been available for many years. At William Duncan, we have recently moved on to a cloud-based platform, recommending software which is very simple to operate and gives key financial information in a very visible and presentable manner.

Many of the advantages and disadvantages of incorporation have been documented on frequent occasions. The area that still causes most debate is over the principal's continued rights to superannuation under this corporate structure.

Suffice to say there can be significant taxation savings arising from incorporating, however, care needs to be taken over the availability of grants and an awareness of information about the business being publicly available.

Recently, businesses have strived to create more tax effective structures making use of corporate partners. While it can be a reasonably cost-effective and flexible way of structuring your business, you really must take some robust guidance before considering such a change.

Just to further add doubts to thoughts on business structure, there was an announcement in the budget indicating that legislation would be included in this year's Finance Bill to introduce a general 'anti-abuse' rule, to give HMRC an additional way of challenging tax avoidance schemes. It seems unlikely that the process of incorporation itself would be challenged, although perhaps corporate partners and artificial remuneration strategies could be some of the areas which are looked at.

As accountants, we are intrigued by the developments in the dental profession and the way dental practices will be structured in the future – the message is that care must be taken when considering your options, and planning and advice is at the forefront. ■

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Passionate about prosthetics

Teeth=us, the international manufacturer of dental prosthetics, is now open for business, providing premium restorations and appliances to the UK and Irish dental markets.

With bases in the US, Sweden, Denmark and Norway, Teeth=us has unrivalled experience producing dental prostheses to the highest aesthetic and technical requirements.

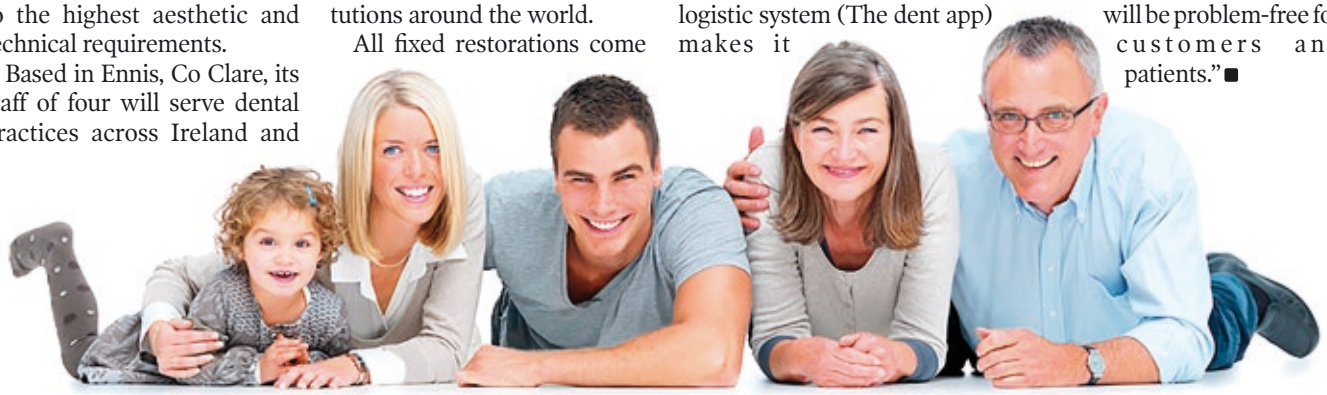
Based in Ennis, Co Clare, its staff of four will serve dental practices across Ireland and the UK. Using state-of-the-art laboratories in Chengdu and Hong Kong, the company's focus is to produce dental units to dental labs and dental institutions around the world.

Now open. With long warranties and only quality materials, the products from Teeth=us are state-of-the-art prosthetics

All fixed restorations come with a 10-year warranty. This warranty provides assurance to clients and illustrates the company's confidence in the products. All materials inside a finished product contain only the best materials from well-known producers. Its unique logistic system (The dent app) makes it easy to back track historical cases to find all necessary information from the production line.

Mary Lyons, CEO of Teeth=us said: "We love what we do. Perhaps that is why we have earned the trust of so many dentists and have the great opportunity to produce their dental prosthetics.

"We do everything we can to create the perfect product that will be problem-free for customers and patients." ■



Preparing for retirement course 2013

Booking now open

Edinburgh – Friday 20 September 2013

Practice valuers and sales agents PFM Dental in association with dental solicitors Thorntons and dental accountants Campbell Dallas invite practice owners to a retirement course at The Marriot Hotel (Edinburgh Airport). The seminar is ideal for practice owners within 10 years of retirement and will cover:

Goodwill values and successfully marketing your practice: Practice valuer and sales agent Martyn Bradshaw (PFM Dental) explains how to achieve the best price for your practice, with terms that suit you. The presentation covers Goodwill valuations.

Selling to a Corporate: Steve McCarron of PFM Dental has over 10 years of experience in corporate dentistry including 5 years as an acquisitions manager with IDH. Steve reveals how corporates value a practice and helps delegates identify if their practice is suitable for a corporate buyer.

The legal aspects of selling your practice: Michael Royden and Ewan Miller of Thorntons provide specialist legal advice to dentists and will cover the various legal aspects of selling a dental practice including pre-sale planning. Thorntons are a leading provider of legal advice for dentists in Scotland.

Accounting issues when selling your practice: Roy Hogg and Neil Morrison of Campbell Dallas cover taxation issues on the sale of the practice including the use of entrepreneurs' relief and pre-retirement tax strategies. Campbell Dallas is one of Scotland's leading firms of accountants with a specialist healthcare division.

Financial planning for retirement: Independent financial adviser Jon Drysdale of PFM Dental considers how delegates can best forecast various income sources in retirement. The NHS Pension will be covered including flexible retirement options.

Wills and Estate Planning: Nick Barclay of Thorntons is a registered Trust and Estate Practitioner and has Law society accreditation as a specialist in Trust Law.

****New for 2013 – Edinburgh dentist Ray Ross, shares his experience of selling a dental practice to both corporate and private buyers. ****

FOR MORE INFORMATION AND BOOKING:

The seminar runs between and 10.00 and 4.30. To book your place(s), please email your name and address to Mandy Wraige: mandy.wraige@pfmdental.co.uk or call Mandy on 0845 241 4480. The delegate rate is £60 inclusive of lunch.

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Each implant design features a tapered thread and sharp pinpoint tack tip to improve soft tissue penetration and insertion and aid immediate fixation. Surface texturing is standard on all miniMARK implants, improving the speed and effectiveness of osseointegration.

miniMARK dental implants provide a significant addition to Henry Schein Dental's surgical provision and are backed by a highly trained specialist team which is able to provide complete, pre and post-sales support.

For more information, call 08700 10 20 43 or visit www.henryschein.co.uk to arrange a visit from a surgical specialist.

New formula SEPTALKAN wet-wipes

SEPTALKAN professional disinfectant wet-wipes are bactericidal, yeasticidal and virucidal. They are also alcohol free, dye free, allergen free and fragrance free.

SEPTALKAN 100 soft spun-lace wipes are saturated in solution and scientifically developed for medical devices.

Ideal for the thorough cleaning and disinfection of both invasive and non-invasive medical devices and equipment, they provide a high level of active disinfection from contact to 99.9999 per cent activity.

They are single use, with no rinsing required. Now available in soft flow dispense packs each containing 100 x (200mm x 180mm) spun-lace wipes.

For more information, ask your dealer representative or visit www.alkapharm.co.uk

Minimally invasive, maximally effective

Piezomed is the new force in bone surgery. This device from W&H puts all the advantages of innovative ultrasound technology at the surgeon's fingertips: high-frequency microvibrations allow cutting with incredible precision and the cavitation effect ensures an almost blood-free surgical site. Minimally invasive, maximally effective!

Only the bone is removed and the surrounding soft tissue is left undamaged, improving patient comfort and providing the best conditions for rapid healing.

W&H has also achieved another world first: as soon as an instrument is inserted, Piezomed automatically detects the instrument and assigns it to the correct power class, simplifying operation and reducing the risk of overloading the instruments.

For further information, contact 01727 874 990 or office.uk@wh.com

New advanced formula Alkaspray-Ultra AF

New Alkaspray-Ultra with Advanced Formula provides alcohol-free medical device and surface cleaning disinfection.

It cleans and disinfects all invasive and non-invasive medical devices and equipment. It's bactericidal, yeasticidal and virucidal, providing active disinfection from contact up to 99.9999 per cent.

The ready-to-use solution needs no rinsing. It is free from alcohol, dyes, allergens and fragrances.

New Alkaspray-Ultra with Advanced Formula is now available from your usual supplier. It is sold in 750ml ready-to-use solution with trigger spray dispense, or a 5-litre ready-to-use solution economy-refill drum.

For comprehensive product information, please ask your dealer representative or visit www.alkapharm.co.uk

Introducing the Esthetic Alliance Program (EAP) from Nobel Biocare

The Esthetic Alliance Program (EAP) from Nobel Biocare is designed to help GDPs realise the many restorative opportunities associated with dental implants. It also offers experienced implant surgeons the chance to foster excellent relationships with local dentists.

Dr Ian Lane recently hosted the first module of the Nobel Biocare EAP at his practice Queensway Dental Clinic, Billingham. He said: "EAP is an excellent introduction to implant dentistry. Delegates will receive 12 hours of CPD from each module, and the course is completely free to attend."

Call 0208 756 3300 or visit www.nobelbiocare.com

Discover the potential of dental implants

General dental practitioners can learn the fundamentals of implant dentistry on a two-day introductory programme in Glasgow on 6 and 7 September.

Presented by Dr Allan Pirie and Dr Colin Burns, the Dental Implant Foundation Course helps delegates to find out if they are suited to implant dentistry. Further details can be found on the DENTSPLY Implants education website at www.courses4implants.com

The course combines lectures, live surgery observation and restorative procedure practice. Topics covered include anatomy, physiology and case planning.

Contact Lesley Woods on 0141 353 3020 or email cliftondentalclinic@yahoo.co.uk

Raise your game

Raise your game for career development and patient care with ProDentalCPD, the world leader in online learning. The system allows access to more than 400 hours of peer-reviewed verifiable CPD.

Just one annual payment provides any member of the dental team with fresh and challenging education. Compatible with PCs, tablets and smartphones, ProDentalCPD is hugely flexible.

With more than 2,000 authors and 50 subject areas, it includes all GDC core topics, and new content is added every week.

ProDentalCPD also develops partnerships with organisations such as the British Association of Dental Nurses (BADN) to ensure the website meets members' educational needs. The result is a dynamic range of audio, video and written materials, which are up-to-date, validated, informed and evidence-based.

Contact ProDentalCPD on 0114 282 3509, or visit www.prodentalcpd.com

A cockpit for your dental surgery

A dentist relies on equipment and technology to practice. Clearly, without a compressor and suction system, very little can be done.

Wouldn't it be practical if you could see and control all systems from your PC?

Now you can, with the unit monitor from Dürr Dental. The unit monitor clearly summarises relevant data, while the software shows the operating condition,

any errors and provides support during diagnostics and maintenance.

For more information, call 01536 526 740.

A great reminder

Getting patients to heed your oral hygiene advice is not easy. One of the main reasons for this is that patients do not remember exactly what it was they were supposed to buy once they leave the surgery.

This is particularly the case with power toothbrushes. In response to dental professional feedback, Oral-B has produced patient sample packs of its power refill toothbrush heads.

The packs are generic in the sense that they allow hygienists to recommend the model that they feel would most suit their patient.

They also encourage patients to change the toothbrush head regularly.

Each pack contains 30 samples. If you would like a pack please contact your local Oral-B representative. If you are unsure who your representative is, call 0870 242 1850.

Alpha: a new non-vacuum autoclave for practices

The new Alpha autoclave from Prestige Medical offers dental practices an extremely affordable sterilisation solution.

Highly efficient, yet compact, it can process six full-sized trays.

A 16 litre 'N' class non-vacuum autoclave, Alpha includes both 121°C and 134°C cycles with a drying option. It is supplied complete with three trays, a printer or data logger and comes with a one-year warranty.

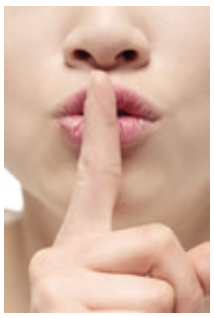
Alpha will be installed and commissioned by our engineer, who will also train your staff on how to use it – all completely free.

Call 01254 844 103, email sales@prestigemedical.co.uk or visit www.prestigemedical.co.uk/uk/dentistry

Peace and power

Dürr Dental are renowned for the sturdiness, durability and performance of its equipment. Now it has further enhanced its Tornado compressors, making both the one and two-cylinder systems not only extremely quiet but particularly efficient energy.

The new Tornado 1 and Tornado 2 combine all the advantages of their predecessors: dental air of the highest quality, a compact form, excellent sturdiness and lasting value. An optional, pre-assembled, noise-reducing hood subtly emphasises the award-winning design. Together with an elaborate air extraction solution, it operates at an incredibly quiet 54dB, comparable to the noise level of a whispered conversation!



The new Tornados also work substantially more efficiently than earlier models and require 15 per cent less energy for the same performance.

Tornado compressors are powerful and economic enough to supply up to three treatment rooms.

We're supporting you

Oral-B recognises and values the influence a dental professional has on an individual's decision to purchase a power toothbrush.

For that reason, Oral-B has produced a range of free quality items that can be personalised. Appointment cards, for example will contain your practice address and phone number, or maybe you'd like some bespoke A1 posters?

Many practices have requested larger point of sale items for promotional days or educational talks.

In response, practices can now order 7ft pop-up banners, printed with the practices' details.

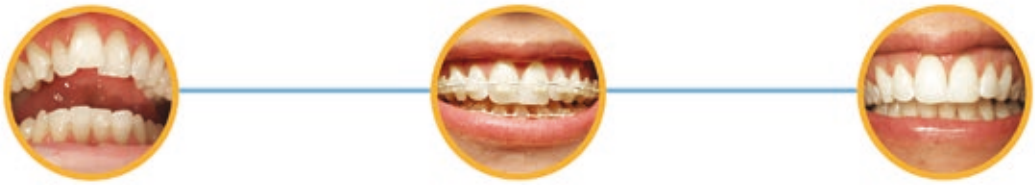
Your local representative can place an order on your behalf. If you are unsure who your representative is, call 0870 242 1850.

DAZ Says:

"**As a GDP, Six Month Smiles** has added a **new dimension** to the way I treat my patients, one of the best decisions I've ever made."

-Dr. Daz Singh • Ollie and Darsh, Liverpool, UK

Six Month Smiles is a cosmetic, minimally invasive system to straighten your adult patient's teeth in about 6 months.



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Upcoming Courses

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~~12-13~~	~~Jul~~	~~Birmingham, UK~~ Sold Out
06-07	Sep	Dublin, Ireland
~~20-21~~	~~Sep~~	~~London, UK~~ Sold Out
11-12	Oct	Manchester, UK
22-23	Nov	London, UK

Register at:
www.SixMonthSmiles.com/Level1

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DEXIS Platinum is here!

The DEXIS Platinum, North America's best selling X-ray sensor system, is now available exclusively in the UK from The Dental Directory.

With direct USB capabilities, the DEXIS Platinum is quick and simple to use. There is no need for a separate adapter or docking station.

The DEXIS Platinum's PureImage Technology offers outstanding image quality, with more than 20 visible line pairs and almost no visual noise.

The DEXIS Platinum can take both vertical and horizontal bitewings as well as peripherals with one sensor.

The single-sensor concept of the DEXIS Platinum makes it more portable and more comfortable for the patient.

Call 0800 585 585, or visit www.dental-directory.co.uk

Catering to all dental needs

The Dental Directory prides itself on providing fantastic customer service and stocking a fantastic range of different products. With more than 27,000 different products available you can be sure that The Dental Directory has the solutions for any dental requirement.

From surgical instruments to larger equipment, The Dental Directory is the UK's largest full-service dental dealer. Whether in need of sundries or a complete surgery overhaul, The Dental Directory can help.

Dr Patricia Webley, principal dentist at Octagon Dental Centre in Southampton, said: "I recently had new X-ray equipment installed by The Dental Directory. From the initial quote to the sale, installation and after support, I was very well looked after and extremely happy. I highly recommend The Dental Directory."

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

Power and reliability

The Synea Fusion range from W&H offers a synthesis of design, technology and value. The excellent Synea Fusion range offers great performance at an attractive price, with proven quality and reliability, building on the already established and respected reputation of the W&H Synea brand.

Synea Fusion offers the choice of a midi (Ø 11.5mm) and a mini (Ø 10.0mm) head turbine along with a 1:1 contra-angle, 1:5 speed-increasing contra-angle, 2:1 speed-reducing contra-angle and 1:1 straight handpiece. The new ergonomically designed Synea Fusion range offers powerful and reliable performance. All turbines have ceramic bearings and all optic turbines offer improved illumination using LED+ technology. W&H handpieces, including Synea Fusion, are thermo washer disinfectable and sterilizable, and come with a scannable etched data matrix code as standard for traceability – making W&H the ideal choice for everyday use according to the latest decontamination best practice guidelines.

Contact W&H (UK) Ltd on 01727 874990 or email marketing.uk@wh.com

UnoDent: reliable, high-quality products at incredible prices

Many dentists are discovering the high quality of UnoDent, The Dental Directory's range of cost-effective alternatives to brandname products. UnoDent's ever increasing range of consumables, sundries and equipment now covers more than 2,500 products that will suit all of your needs.

Dr David Gale of The Specialist Orthodontic Referral Centre in Fareham, Hampshire, has been using the UnoDent Orthoblaster.

He said: "The orthoblaster is quick and convenient to use and can reach most areas.

"It can be connected via a standard silicone tube from the high-pressure dental air line."

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

Seeing is believing

New to GC UK's product range is Tri Plaque ID Gel. As the name suggests, Tri Plaque ID Gel allows you and your patient to identify areas of plaque in three easy steps.

GC's Tri Plaque ID Gel quickly identifies new, mature and acid producing biofilms. This unique gel also highlights exactly where the bacteria are most active by disclosing the acidic pH. This additional information will be a great help in your daily practice to motivate your patients to improve their oral hygiene. Because after all, people often need to see something to believe it.

The Gel is colour coded for easy identification:

- blue/purple – old plaque (more than 48 hours)
- red/pink – newly formed plaque
- light blue – high-risk plaque.

Tri Plaque ID Gel encourages patients to be more precise with their tooth brushing technique. Once diagnosis is complete, simply brush the teeth to clean them.

Contact GC UK on 01908 218 999.

Extra teams up with Made in Chelsea star

Extra partnered with Made in Chelsea star Binky Felstead during National Smile Month (20 May to 20 June) to boost oral healthcare education among people in their teens and early 20s.

Louisa Rowntree, Wrigley Oral Healthcare programme manager in the UK, said: "Our research shows that, even though the oral care benefits of sugarfree gum are what drive the majority of chewers, some younger people are still uninformed about the importance of oral care. This is why we launched our nationwide Superstar Smile campaign in National Smile Month."

For more information, visit www.wrigleyoralhealthcare.co.uk

New catalogue out now

Containing more than ever before, the all new General Medical Specialist Catalogue Issue 11 includes everything the modern dental practice could wish for, and is designed to make the provision of treatment quicker, easier and more profitable.

It now includes an even wider selection of innovations including the Quicksleeper 4 digitally controlled local anaesthetic delivery system, the NEW Zest LODI Locator Overdenture Implant System, the revolutionary iChiropro from Bien Air and the complete range of Mectron curing lights and prophylaxis units.

Other highlights include the Mectron Piezosurgery Touch, the latest advanced instruments from Helmut Zepf, a comprehensive range of cost-effective surgical disposables, Locator self-aligning implant attachments and a huge choice of bone augmentation materials.

For more information and to obtain your copy, call 01380 734 990, visit www.generalmedical.co.uk or email info@generalmedical.co.uk

The new Assistina 3X3 system from W&H

The Assistina 3X3 from W&H is the most thorough handpiece cleaning system available, cleaning and lubricating three handpieces in three steps for ideal handpiece care.

It provides an extensive cleaning process, combining thorough cleaning of internal spray channels and transmission parts with external handpiece cleaning and precise, consistent, automatic lubrication of all internal components.

The new Assistina 3X3 is an ideal part of your decontamination routine as it is validated to remove commonly encountered microbes in the dental surgery, with an efficacy of more than 99 per cent.

Contact W&H (UK) Ltd on 01727 874990 or marketing.uk@wh.com

Powerful gum protection

Prevention is the cornerstone of oral health, and oral health care is central to good practice. It was this philosophy that drove the innovation of Oral-B Pro-Expert toothpaste and more recently the introduction of Oral-B Pro-Expect Gum Protection.

In addition to the powerful combination of stabilised stannous fluoride and polyphosphate, Oral-B has enhanced its formulation with the inclusion of stannous chloride. This results in 70 per cent more bioavailable stannous, enhancing the bacteriostatic and bactericidal properties of the formula to make it ideal for patients with gum problems.

Furthermore, as it also contains the powerful combination of stabilised stannous fluoride and polyphosphate, your patients will also be protected against plaque formation, caries development, calculus formation, dentinal hypersensitivity, staining and oral malodour!

Premium prevention

Oral-B is an authority on toothbrush design. The company has developed its manual toothbrush enormously over the years and is constantly looking to enhance performance.

Innovation has also heralded the latest offering, Oral-B Pro-Expert Premium Pro Flex. The brush has 'wings', so it can adjust to the contours of an individual's teeth and gums. These wings are flexible, ensuring no gingival damage, but firm enough to facilitate a 35 per cent greater plaque reduction at the gingival margin versus an ADA standard brush.

Oral-B has also introduced Pro-Expert Premium Floss. Combating flossing inertia among patients isn't easy, which is why Oral-B has made its new floss easier to use as well as more effective. The monofilament strand is non-shredding and slips easily between even the tightest of contacts.

In clinical trials, 75 per cent of patients preferred this type of floss and cited ease of use as the main reason.

Contact your local representative for samples or more information.

Healthy gums, healthy mouth, healthy smile

Healthy habits and good oral hygiene are crucial in the fight against gum disease and Beverly Hills Formula has the ideal 'at-home' solution to help patients combat this common dental problem.

Specifically developed to help prevent the causes and effects of gum disease, Dentist's Choice Gum & Whitening Expert toothpaste boasts a unique gum protection system that contains Vitamin E to invigorate and strengthen the gums, fluoride to protect the exposed root area, and Permethol to help reduce and stop bleeding gums.

By recommending Beverly Hills Formula Dentist's Choice Gum & Whitening Expert toothpaste your patients no longer need suffer from inflammation, irritation and swelling of the gums.

For more info, call 01842 6611, email info@beverlyhillsformula.com or visit www.beverlyhillsformula.com

Innovation in comfort, ergonomics and quality

Fantastic technological advancements, ergonomics and patient comfort characterise the new Skema 8 dental unit from Castellini. The Skema 8 has an extensive range of instruments including the Surgison 2 and Implantor LED Micro Motor with integrated Physio Dispenser.

The Skema 8's patient chair provides comfort and is easy to manoeuvre. Its sliding function makes it rise as the backrest is lowered. This keeps the distance ratios between the operating zone and the unit modules constant.

Call 08000 933 975 for details of your local Castellini dealer.

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What our Dentists say:

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" We needed to prove that we provide NHS access and with Toothpick we can ..."

Dr Akram, principal
Govan Dental Care, Glasgow

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Dr Doshi, principal

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"We were amazed how much easier it has made it for patients and reception. "

Dr Mike Cooper, principal

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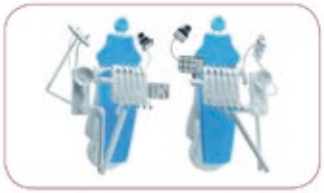

Table Version
ESTETICA E30 TM

Swing Arm Version
ESTETICA E30 S

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