The magazine for dental professionals working in Scotland
April/May 2011

Scottish Dental magazine

Breaking 400 years of tradition **Page 26**

At the sharp end

How will dentistry cope with the much-anticipated cuts after the election? **Page 16**

RECOGNITION FOR SCOTTISH DEAN
Professor Liz Kay receives FGDP accolade **Page 7**

ARE YOU AT THE END OF YOUR TETHER?
How to identify and deal with stress in your practice **Page 31**

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A full restoration of an edentulous upper arch **Page 45**

SPECIAL FEATURE
Treating the street kids of Arad in Romania
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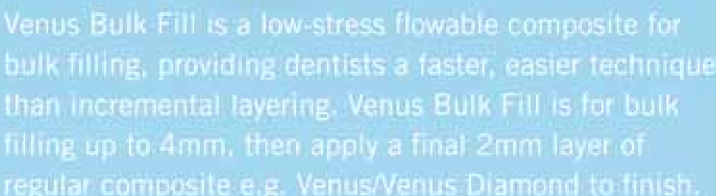

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*Integrated Media Survey, May 2010

ISSUE 2, VOL.2

Welcome

Editor's desk

with Bruce Oxley

Decision time

Election time is upon us again and you could be forgiven for giving in to the odd moment of pessimism about the whole process.

The dental profession, and the wider health service in general, has been living under the threat of cutbacks for more than two years now. And, despite making a few snips here and there, it is no major surprise that the SNP would stall on making the bulk of the difficult decisions until after the election. After all, it's not much of a vote winner to make wide-ranging cuts in an election year.

But, whoever wins the election will have to deal with it and hopefully they will deal with it sooner rather than later. As one of the dentists points out in our election news special on page 16, when the squeeze eventually comes we'll no doubt be playing "catch-up" with our colleagues down south.

Everyone will have their own specific worries and concerns as to what might be targeted when the axe eventually falls but a re-think on continuing registration seems to be high on the agenda for many. Whether a Labour administration would repeal the policy if they got in is another matter. ■

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

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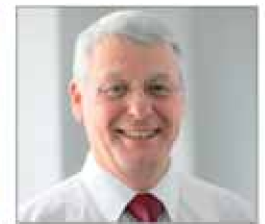

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Biting back

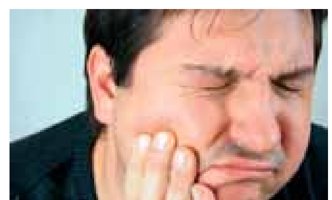
with Spencer Wells

Your fate in your patients' hands?

There's a lot of things you might say about patients. They are your bread and butter, sometimes your biggest champion and other times your worst enemy. But, if the GDC get their way, patients may well be a big deciding factor in your successful revalidation. Now there's a thought!

I don't know about you, but a fair number of my patients don't know which dentist they see in the practice. To be clear, there are only two of us, and we are not even the same gender. So, God help us if these fine specimens of the human race had to give feedback on their dental experience, or their 'patient journey' as they say in the hoity toity practices.

I haven't seen any samples of the type of questionnaires that might be used but, all joking apart, this really worries me. Some of our patients walk in the door, grunt their greeting at the receptionist then nip back outside for a swift fag, so that's not the best start. Even the better-bred patients – those who will sit in the waiting room quietly without feeling the need to swing from the chandeliers – are, with the best will in the world, not always the best people to judge the quality of their surroundings, or the care they have received.



> "Mind you, you have to feel sorry for the poor sod who will have to read all this rubbish"

How many times have you discussed a treatment plan with a patient, say for example, a post crown, and talked about why they need one, what to expect, before sending them back to reception. The receptionist asks them what the next appointment is for, and they say: "Oh I don't know, he didn't say." If you didn't have your nurse sitting there listening, you would swear you were losing the plot. It's like being in a parallel universe sometimes!

And what about a patient who is never happy, or even one who is only disgruntled with a recent course of treatment, but doesn't tell you about it? You can imagine their complete delight when they are asked to comment on their recent course of treatment. Mind you, you have to feel sorry for the poor sod who will have to read all this rubbish: "Ah cannae wear ma plate, it's too big", "Ma tooth wis alrite til he touched it". Give me strength!

The whole thing is getting ridiculous. I am all for fair treatment and patients' rights to be informed, and to be treated like a human being (in spite of occasional evidence to the contrary, judging by the look of their coupon) but this idea really is the pits. I hope the GDC dump it and come up with a better idea, but I am not holding my breath....

Early retirement, anyone? ■

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PSD reveal scale of problem

REGISTRATIONS

As the deadline for dentists to appeal withdrawn registrations came to a close, Practitioner Services Division (PSD) has revealed a clearer picture of the extent of the problems.

Late last year, PSD stopped in the region of 150,000 registrations that they had identified as duplicated, deceased or relating to a patient who had emigrated. As of 18 March, 244 dentists had submitted over 6,000 queries with the deadline closing on 31 March.

The registrations were withdrawn, with payments ceasing as of 1 September 2010, in response to an audit by PSD to match the Community Health Index numbers to the patient records they hold on their payment system, MIDAS. The exercise threw up over 150,000 potential inaccuracies, with dentists being asked to submit a DPD295 form if they disagreed with a withdrawn registration.

The initial deadline of 21 February was extended after the BDA's Scottish Dental Practice Committee chairman Robert Kinloch revealed that many dentists were struggling to meet the deadline due to the adverse weather conditions before Christmas.

Female first for Royal College

New appointment. Glasgow consultant becomes the first female vice-president

A consultant dentist from Glasgow Dental Hospital has become the first female vice-president appointed at the Royal College of Physicians and Surgeons of Glasgow in over 400 years.

Dr Alyson Wray has worked her way up from community dentistry to her current post as consultant in paediatric dentistry, often finding herself the only female around the table – but she believes the times are changing.

She said: "I'm not a supporter of positive discrimination – it's just discrimination in another guise. My view is that people should be selected only on their professional suitability for the job.

"I am witnessing more women coming into senior roles in dentistry and I believe this will continue in the future."

For many years, female dental undergraduates at the Glasgow Dental School have outnumbered their male counterparts and this is because, Dr Wray believes, dentistry offers a satisfying and flexible career for woman.

"It's difficult having children and continuing to develop your career, but it is possible. I've been lucky that I have had extended family for support and, as I live in the West End of Glasgow, if anything happens it's only a short run home."

And this came in handy when her 13-year old son cracked his teeth after an accident in a skateboard park!

To read our in-depth interview with Dr Wray, turn to page 26.

A doctor in all but name?

TITLE DEBATE

The British Dental Association (BDA) has accused the General Dental Council (GDC) of wasting time and resources over the issue of whether dentists should be allowed to use the courtesy title 'doctor'.

The association sent a letter outlining their position on the matter to the GDC ahead of their February council meeting, during which a decision was made to postpone a vote on the issue. The BDA argues that, at a time when the GDC is facing increasing financial constraints and the backlog of Fitness to Practise cases is growing ever larger, the council should be addressing these problems ahead of the title issue.

They have also called on the GDC to publish details of the resources it has expended reviewing this issue and warned of the significant harm stripping dentists of the courtesy title could do.

Dr Susie Sanderson (above), Chair of the BDA's Executive Board, said: "That the GDC is choosing to devote time and resources to this issue when it should be concentrating on addressing the backlog of Fitness to Practise cases is nothing short of astounding. Dentists and dental care professionals have seen hefty increases to their annual retention fee and will not be impressed by this profligate use of the GDC's swelled funds.

"The use of this courtesy title is not an important issue for the public. A ban has the potential to confuse patients and harm the reputation of the profession.

"We urge the GDC council to reject the recommendation of its standards committee and instead concentrate on the areas of its work that deliver a real benefit to the public."

Dentistry on show

The General Dental Council's internal audit of its Fitness to Practise (FtP) proceedings, the confusion surrounding CQC registration in England and the lack of political representation for the industry as a whole were just some of the issues tackled at the recent Dentistry Show at Birmingham's NEC.

A media briefing from indemnity organisation Dental Protection (DPL) explored the many problems with the GDC's FtP hearings that were highlighted by its own recent internal audit. These included inconsistent decisions made by caseworkers and and DCPs' presence on investigating committees that are exploring matters beyond their training or scope of practice.

The thorny issue of CQC registrations in England was also high on the agenda and DPL's Sue Boynton and the Dental Professionals Association's CEO Derek Watson both tackled the subject in separate talks. While Ms Boynton highlighted the potential problems and spoke in measured terms, Watson's talk was a little more partisan. "The dental profession is being suffocated by layer after layer of regulation," he opined.

And, while the CQC situation is not of direct relevance to Scotland, Watson did reserve some ire for Scotland's former dentist MP Anas Sarwar, stating that: "We are still waiting on his first speech on dentistry in the Commons…"

Signals towards no smoking

Dentists are being reminded of their crucial role in spotting mouth cancer early and providing vital smoking cessation advice, following this year's No Smoking Day that took place in March.

It is thought that around 21 per cent of the UK's population is still smoking, with tobacco linked to around three-quarters of all cases of mouth cancer.

Dr Nigel Carter of the British Dental Health Foundation said: "The dental profession is in a unique position to warn patients of the risks and consequences of smoking. In September, dentists in Dublin and Ireland offered free mouth examinations, and six cases of mouth cancer were found. This only serves to further reinforce the message that regular visits to the dentist can help detect early signs of mouth cancer."

Recognition for Scottish dean

FGPDP AWARD

A former senior lecturer at the University of Dundee has been awarded the Faculty of General Dental Practice (FGDP[UK])'s highest accolade, the Fellowship Ad Eundem.

Professor Liz Kay, who is the current dean of the Peninsula Dental School in Devon, received her award at the Annual Faculty of GDPs (UK) Diplomates Ceremony in London on 5 March. The honour is described as "a mark of achievement for those who have made a contribution to patient care or the profession of primary dental care, significantly over and above what might be reasonably expected of a member of the FGDP(UK)".

On her award, Prof Kay said: "I am of course delighted to have been awarded such a prestigious accolade. While it is me who has been made a fellow, it is an achievement that reflects the hard work and dedication of my colleagues and our students at the Peninsula Dental School, as much as it does me personally."

"It is an achievement that reflects the hard work and dedication of my colleagues and our students at the dental school"
Professor Liz Kay

Russ Ladwa, Dean of the FGDP(UK), added: "It is obvious for all to see that Professor Kay has an exceptional enthusiasm for her profession, and a willingness to help others along their chosen path. Her tireless work and support for dental practitioners to provide an improved quality of care for their patients is well known and I thank Professor Kay for that."

Prof Kay qualified BDS from the University of Edinburgh in 1982 and gained her Masters in Public Health from the University of Glasgow in 1984, followed by her PhD in 1991.

She then became senior lecturer at the University of Dundee before undertaking specialist training in dental public health. She has been a consultant in the specialty for the last 10 years.

In May 2006, she was appointed as the inaugural dean of the Peninsula Dental School, the UK's newest dental school and a collaboration between Exeter and Plymouth universities.

Goodwill valuations fall

Practice values. Although profits are slightly down the Scottish market is still very active

The goodwill value of dental practices in the UK has fallen to 84 per cent of turnover, compared with nearly 100 per cent this time last year.

The figures, released by the National Association of Specialist Dental Accountants (NASDA), show that goodwill as a percentage of fee income for sales has dropped to 84 per cent as of January this year and for valuations it is down at 90 per cent. However, NASDA revealed that enthusiasm for NHS practices remained high, while private practices in some areas are proving harder to sell.

The report, produced each year by NASDA firm Humphrey and Co, also looked at dental profits for 2009/2010. It showed that net profits over the year were either slightly down or remained static on the previous year.

The sample population for the report covers 600 practices and 500 associates, including members in Scotland, and are based on averages of actual accounts of both NHS and private practices rather than tax returns. The 09/10 results show an overall reduction in net profit, due to increases in materials and staff costs, from £141,835 to £139,569, or from 37.4 per cent to 35.8 per cent of overall income.

The figures showed that although associate income was slightly down – by £2,000 – practices with associates were generally more profitable. Net profits for a practice with associates was £148,408, while without associates it was £118,992. The report also found that, while there was a slight increase in fee income for private practitioners, from £358,717 to £364,924, there was a small reduction in net profit, from £130,621 to £126, 390 (from 36.4 per cent to 34.6 per cent).

Dougie Paton

Dougie Paton, a NASDA member and chartered accountant with Condie and Co in Dunfermline, commented: "We contribute to the NASDA collection of statistics because they are representative of expenditure and earnings by Scottish dentists and provide the best available barometer of the dental market. The same applies to the NASDA goodwill figures.

"Despite the lack of external funders, the sales market in Scotland is very active – currently we are dealing with three separate transactions. The NASDA statistics and goodwill surveys help us benchmark our forward-looking projections, assess deal values, and advise clients accordingly."

PVG Scheme goes live

CHILD PROTECTION

Scotland's delayed Protecting Vulnerable Groups (PVG) Scheme was launched at the end of February with the aim of replacing and improving on the previous disclosure arrangements.

The PVG Scheme had been due to start in November last year but was delayed by ministers in order to ensure the system that supports it was fully fit for purpose and robust. All dental professionals that work with children and protected adults will require to be registered and the General Dental Council (GDC) will have powers to refer its own registrants to the scheme.

The GDC will have the power to make a referral if it is felt that the individual has done something to harm a child or protected adult and the impact is so serious that the organisation has – or would be likely to – remove the individual from regulated work on a permanent basis.

The GDC may also receive information about its registrants from the scheme. The council has decided, however, that any information received would not result in automatic erasure from the register, but as an allegation of impaired fitness to practise.

The smile factor

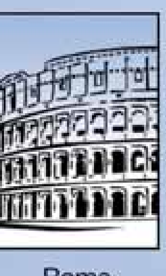
NATIONAL SMILE MONTH

Dentists across Scotland are being encouraged to do their bit to promote National Smile Month as this year's campaign marks its 35th birthday.

The theme of the awareness month, which runs from 15 May until 15 June, is the 'Smile Factor' with the aim of putting the smile back on peoples' faces. Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, described the thinking behind this year's campaign. He said: "A smile can be a very powerful show of emotion, yet not everyone has the confidence to do so.

"Others are being held back by poor oral well-being and its impact on their general health. This year's campaign is designed to challenge those perceptions and get your patients smiling again."

For more info on National Smile Month, call 01788 539792.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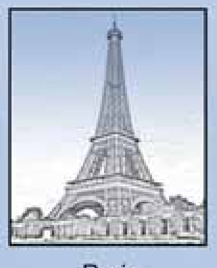
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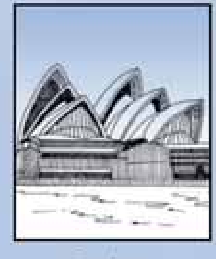
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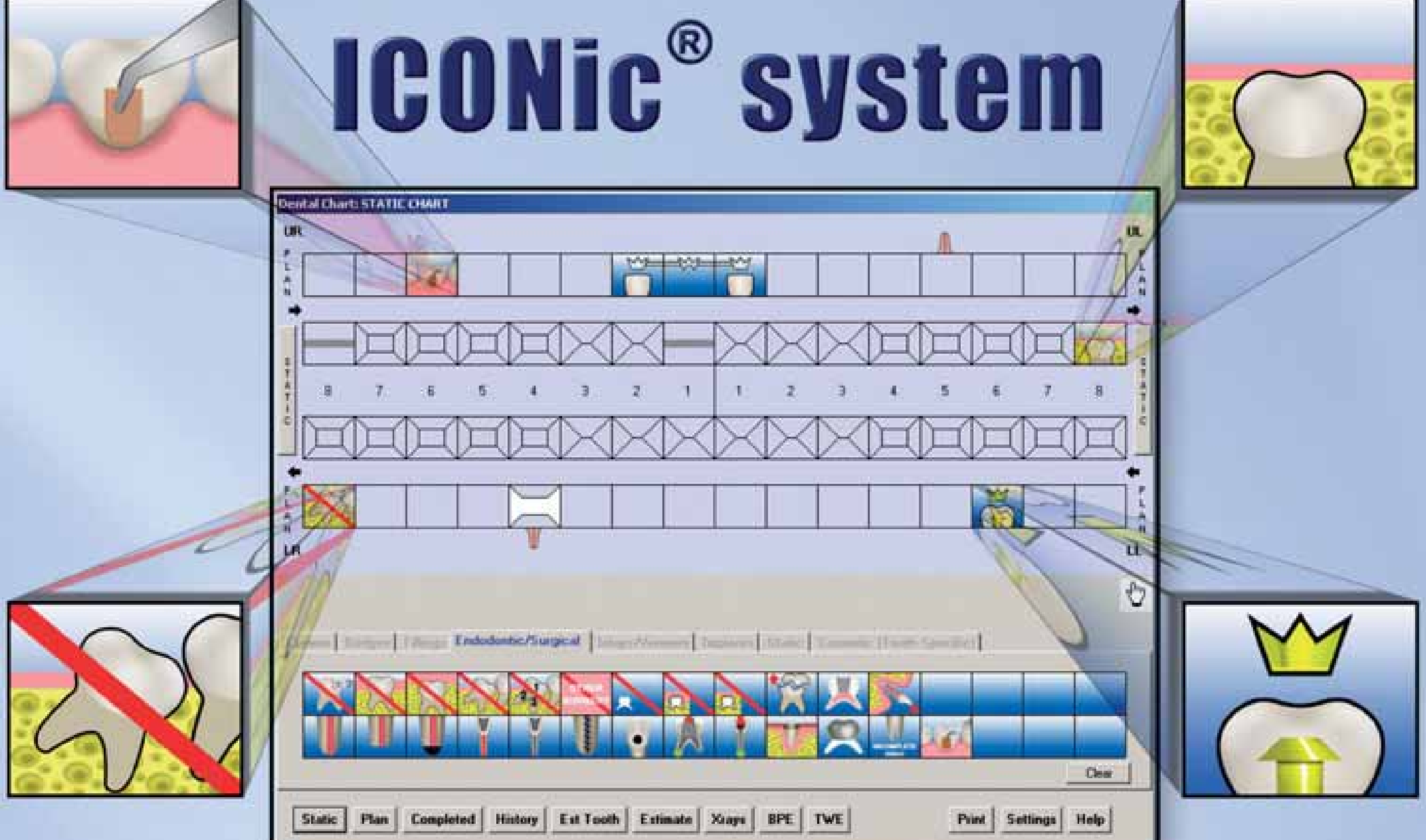

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Dental archive is launched

HISTORY OF DENTISTRY

The British Dental Association (BDA)'s director for Scotland and the chairman of the Scottish Dental Practice Committee were both present at the recent launch of a new archive documenting the history of dentistry.

Andrew Lamb and Robert Kinloch saw a £50,000 bequest from the family of former BDA president John Walford McLean, presented, to see the creation of The John McLean Archive: A Living History of Dentistry. The new archive will document the history of dentistry since the inception of the NHS and is being developed in conjunction with the King's College London Dental Institute (KCLDI)'s Unit for the History of Dentistry.

The project will comprise a series of witness seminars and individual oral history interviews, the first of which was hosted by Professor Nairn Wilson, head of KCLDI, at the end of March. The session will explore dentistry prior to 1956, the role of the Dental Board, the introduction of the General Dental Council, interaction with the BDA, specialisation, and the role of the protection organisations.

Head of BDA Museum Services Rachel Bairsto said: "This archive will provide an essential record of the significant evolution of the dental profession. This will be invaluable for generations of professionals to come. We are honoured to be given the opportunity to realise this project through the generosity of one of the most highly-regarded leaders in the profession, John McLean, whose legacy will long be remembered."

John Walford McLean OBE was a leading dental practitioner and internationally renowned dental materials scientist, author and lecturer.

Bullying tops ortho survey results

Almost 90 per cent of people polled during National Orthodontic Week revealed that they thought orthodontic treatment should be available on the NHS, but only half thought that it was available on the health service.

The research survey, conducted to coincide with the British Orthodontic Society's (BOS) annual awareness week in February, also asked respondents to list the main reasons for wanting treatment on protruding teeth.

The top reasons given in the BOS survey were to improve self-confidence (85 per cent) and to prevent teasing and bullying (77 per cent).

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A Bridge2Aid dentist training a Tanzanian clinical officer on emergency dentistry

Charity cycle challenge

Thirteen brave bikers from dental equipment manufacturer A-dec are participating in the infamous Coast2Coast bike ride in April.

The group are raising money for Bridge2Aid, the dental charity set up by Scottish dentist Ian Wilson to provide vital dental treatment and training in the Mwanza region of Tanzania. The Coast2Coast bike ride is a challenging 150-mile, three-day journey across the Pennines from Whitehaven on the west coast to Tynemouth on the east.

To support the A-dec group, visit the online sponsorship pages at http://uk.virginmoneygiving.com/team/A-dec

Research. New study aims to provide evidence for the best way to deal with decay in children

Getting the facts out of FiCTION

A new trial led by researchers at the University of Dundee is inviting hundreds of dental practices across the UK to assess different methods of managing decay in children.

The FiCTION (Filling Children's Teeth: Indicated or Not) trial has been commissioned by the National Health Research Health Technology Assessment (NIHR HTA) and letters have been sent out to over 300 practices in Dundee, Glasgow, Leeds, Cardiff, London, Newcastle and Sheffield appealing for participants.

The trial is led by the University of Dundee and the University of Leeds, working with university colleagues in the five other participating cities. It will examine the benefits of three methods of managing decay in deciduous teeth.

The first method is using only preventive techniques recommended by the national guidance such as better tooth-brushing, less sugar in the diet etc, to stop the decay, the second method will look at conventional fillings along with preventive techniques and the third will examine biological treatment of the decay alongside preventive techniques. The study will also gauge what the children, all aged between three and seven, think of the different types of treatment.

Dr Nicola Innes, University of Dundee Dental School

Dr Nicola Innes, of the University of Dundee Dental School, one of the lead researchers for the FiCTION trial, said: "Conventional clinical opinion is that baby teeth showing decay should be filled, yet the majority of cavities in young children are left unrestored.

"There is, as yet, no conclusive evidence for the most effective approach to managing decay in baby teeth. With this trial we are looking to provide that evidence."

Caution urged for pregnant patients

HEALTH WARNING

The Medical and Dental Defence Union of Scotland (MDDUS) is urging caution after a rise in calls concerning the treatment of pregnant patients.

The defence organisation has seen an increase in queries from dentists regarding the taking of X-rays and the use of amalgam fillings during pregnancy. Although the pregnancy status of patients should be apparent from their current medical history, the Ionising Radiation (Medical Exposure) Regulations require that specific enquiry is made before a female of child-bearing age is exposed to a medical radiograph.

While pelvic radiation in dentistry is highly improbable, with the Health Protection Agency advising that foetal risk in relation to most intra-oral radiography is infinitesimal, MDDUS has urged caution and pointed clinicians to the justification protocols set out by the FGDP.

The indemnity body has also urged caution when using amalgam fillings, despite the lack of conclusive evidence linking the restoration to birth defects or still births. "Clearly, the best solution is to delay treatment which involves even the most theoretical foetal risk until after the pregnancy is complete," warned MDDUS dental adviser Doug Hamilton.

Hamilton also pointed out that, during pregnancy, the Dental Practice Board in Scotland can, subject to prior approval, issue discretionary codes for the placement of a variety of non-amalgam materials in the posterior teeth of pregnant patients.

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Budget. Chancellor's speech provides more positives than negatives for the dental profession as a whole

Quick and relatively painless

At just under an hour, George Osbourne's Budget speech may have been one of the shortest in the last 150 years but it brought with it a modest amount of good news for dentists.

The Chancellor confirmed that he regards the 50 per cent personal tax rate as a temporary measure and a few high-earning incorporated dentists are likely to benefit from the reduction in tax payable on profits.

The rate of corporation tax payable on profits exceeding £300,000 will fall to 26 per cent from 28 per cent on 1 April and to 25 per cent from 1 April 2012. The small companies' rate, payable on profits of up to £300,000, will fall to 20 per cent on 1 April this year.

There will also be some structural reforms to tax relief for capital expenditure relating to the definition of short life assets where the time limit will increase from four to eight years. This could be of particular relevance to the tax treatment of new surgery equipment

Another benefit is the increase in entrepreneur's relief from £5 million to £10 million. This means that dentists will pay capital gains tax at 10 per cent – instead of 18 or 28 per cent – on lifetime gains on the sale of dental practices up to £10 million.

Applying the law

MEDICAL DEVICES

A year on from the changes to the Medical Devices Directive affecting the provision and manufacture of dental appliances, the General Dental Council (GDC) has issued a reminder to dentists of their responsibilities.

One of the main elements of the amendment related to the statement of manufacture. Patients must be made aware that they can request a statement of manufacture and dentists have a responsibility to ensure it is made available if requested. Not doing so is punishable as a criminal offence.

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Scottish Parliament elections. On 5 May the country will go to the polls to elect a new government. Ahead of the vote we asked the BDA, DPA and a selection of practitioners their views on the matter

Keeping dentistry on the election agenda

BDA MANIFESTO

With the Scottish Government elections just weeks away, the campaign trail is really starting to heat up. Dentistry is rarely front page news and you'll be hard pressed to find mention of the profession in any party manifesto, but that doesn't mean the election won't affect practices up and down the country.

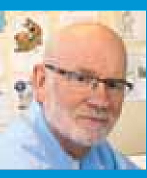
The British Dental Association (BDA) in Scotland has highlighted combating oral health inequalities as its major manifesto issue. It argues that despite improvements over the last 40 years or so, Scotland's oral health still lags behind the rest of Western Europe and that inequalities between those with the best and worst oral health still persist.

The BDA recognises the role the successful Childsmile scheme has played in making inroads but it is calling for the fluoridation of water supplies to be put back on the agenda so that communities themselves can decide whether they would like to benefit from the measure.

"Candidates standing for election this year must pledge to work with the dental profession to take on those challenges and deliver improvements for patients"

Andrew Lamb, BDA Director for Scotland

VOX POP: We asked five dentists about their hopes, and fears, for the dental profession after the election



JACKIE MORRISON, community dentist in Lanarkshire, vice chair of the Scottish Salaried Dentist Committee and chair of the Scottish Accredited Rep Group of the BDA

"As salaried dentists we jealously guard our special needs function and we hope that, with times being tight over the next few years, funds and time are made available for us to continue this.

"We have problems with recruitment and retention in the salaried service, which may be due to the protracted negotiations delaying the delivery of a new contract which compares favourably with what has been agreed in England. It is worth noting that we are the last part of the NHS not to have a review of our contract. The negotiations on this continue.

"Our main concern is funding. We are committed to seeing and treating vulnerable groups and those who find it difficult to access NHS dentistry. For this to continue proper funding must be assured.

"It seems that to make savings, posts will not be filled as people retire or move on, perhaps to parts of the country with better pay and conditions. Many salaried dentists, including myself are coming to the end of their career. If our posts are not filled, either to cut costs, or because new graduates do not find the jobs attractive, the concern is that vulnerable groups will not receive the treatment they are entitled to."

LACHLAN MACDONALD, GDP in Paisley, Renfrewshire

"England is rapidly moving towards private health care similar to the American model and, despite cries to the contrary from the Scottish National Party (similar to the student tuition fees fiasco), it is difficult to see how we are to fund both medical and dental care for the Scots who are gaily eating, smoking and drinking themselves to death.

"The mixture of dentists doing both private and NHS work must be addressed. Some private charges are appalling and yet the department of Dental Public Health within the Scottish Government Health Directorate will not increase the number of dentists working at the NHS 'enamel face'.

"One answer is that any dentist who qualifies in Scotland should be obliged to work in the NHS (not in the private sector) for five or six years. Either that or that we nationalise the 'tooth fairy' and send the proceeds to Alex Salmond!"

MORVEN SWAN, GDP in Huntly, Aberdeenshire

"As an NHS dentist working in times of recession and cutbacks, my main hope would be that money will continue to be invested towards improving NHS facilities and services, particularly in remote and rural areas.

"Over the past few years, my health board, NHS Grampian has invested in several major

The issue of lifelong registration is another item that the association in Scotland says needs a rethink by any new administration. The BDA is calling on the new government to recognise the importance of regular attendance in stemming the growing number of oral cancer cases. The union also highlights the number and location of dentists in the country as requiring attention, with a shortage of dental academics and geographical disparities in the provision of both primary and secondary care as problems that need to be addressed.

Andrew Lamb, BDA Director for Scotland, said: "Despite improvements in the dental health of Scotland over the last 40 years, there is still a great deal to do if we are to eradicate persistent oral health inequalities.

"We have successes to celebrate, including the excellent Childsmile scheme and improvements in access to dental care in some areas, but the new government will nonetheless face significant challenges in the field of dentistry and oral health.

"Candidates standing for election this year must pledge to work with the dental profession to take on those challenges and deliver improvements for patients." ■

DPA MANIFESTO

"This subject must be revisited urgently before large parts of the service revert to pain relief only"

Reg Short, DPA council member

In its election wish list the Dental Professionals Association (DPA) also highlighted lifelong registration as one of their key issues. Reg Short, one of the association's council members for Scotland, pointed out that, for dentists, continuing registration was never seen as anything other than a ploy to produce ever-improving registration figures.

However, he said: "The public could be forgiven for believing that this meant that the dental service was therefore improving. The profession warned that the reverse was likely since the incentive to visit for examination periodically was being removed.

"The only other incentive for many patients is the need for emergency treatment for relief of pain. This subject must be revisited as a matter of urgency before large parts of the service revert to pain relief only."

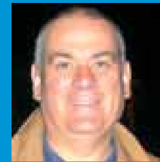
The DPA also points to the recent problems with Practitioner Services Division's records (see page 6), saying a new IT system is needed.

The association also questions whether any incoming administration would take on what it regards as "a misuse of public funds" and address the misgivings within the profession over the ongoing decontamination issue.

The DPA maintains that no convincing case has ever been put forward that the proper, reasonable decontamination and sterilisation methods used prior to 2005 ever resulted in harm. It says that due to the precautionary principle, dentists are now bound to guard against risks that cannot be shown to exist. ■

developments such as the new Aberdeen Dental School, the Spynie Outreach Centre in Elgin and our own dental practice in Huntly which offers independent, salaried and specialist services all within the one centre. I feel that, as a direct result of the increased funding we have received, both patient registrations and dentist numbers are now at an all time high within the region, and I would hope that sustaining this level of investment would allow these figures to rise even further.

"I would also hope that money would continue to be spent on improving oral health, in particular through the Childsmile programme. The most recent National Dental Inspection Programme produced the best ever results for children's oral health, which not only illustrates the impact the scheme has already had on preventative care, but highlights the importance of continuing to invest in the Childsmile programme to ensure children from an early age are primed for a lifetime of good oral health."



TERRY SIMPSON, GDP in Livingston, West Lothian, honorary research fellow at Edinburgh Dental Institute and clinical effectiveness advisor for NHS Lothian

"In general terms I think any Scottish Government is going to have its hands tied to some extent by the economic conditions. Whatever happens there is going to be quite a tight squeeze on the finances and I think it is bound to come through to dentistry eventually.

"In fact, in some ways there is the argument that perhaps it should have been implemented a bit earlier. The fact that it has taken so long for the government to make cutbacks in Scotland means that there is probably going to be a bit of a catch-up process with our colleagues south of the border.

"I think there has also been a build up of bureaucracy within the system which needs to be slimmed back and we need to concentrate on the patient-dentist relationship more. I think there has been far too much interference by government and the problem is that this can detract a lot from patient care."

TONY COIA, GDP from Clydebank, West Dunbartonshire and chair of LDC conference

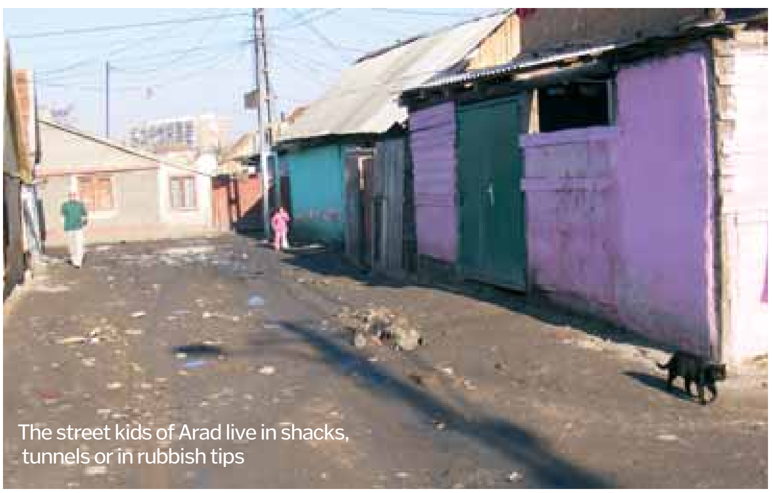
"I think the first thing would be the effect of any future public sector cuts within dentistry. I'm sure that high street private independent dentistry is feeling the strain just now, but as far as health service dentistry is concerned, I think an awful lot will depend on whether the allowances are tinkered with because that would make a huge difference to the profitability of practices. We've had very little, less than one/one and a half per cent over the past three to four years, plus with the VAT increase people are struggling just now and profits are being squeezed.

"The other issue is pensions and that's going to have a profound effect on morale, not so much for the dentists in their 30s but certainly for people in their 40s and older who are beginning to flag a wee bit and the thought of maybe another five, six or even seven years working doesn't fill them with much optimism.

"I'm hoping that, coming up on 57 myself, I'll be able to get out before things start to really hit the fan, but we will just have to wait and see."

Scottish dentists Eoin MacGillivray and Andy MacKinnon have set up a surgery for treating the street kids of Arad in Romania. Chris Fitzgerald met up with the duo to find out why

Putting a smile on the street



The street kids of Arad live in shacks, tunnels or in rubbish tips

Sniffing glue to suppress hunger pangs is just one of many depressing daily rituals performed by the street kids of Romania.

Living in squalor, often in tunnels beneath the country's major cities, these forsaken children will do anything to survive.

Needless to say, oral hygiene rates pretty low on their list of day-to-day priorities, but by neglecting their teeth these children often end up suffering intolerable pain.

While much is being made about the need to improve oral hygiene among children in Scotland, two dentists here are focusing on the plight of those in a much less privileged country.

Eoin MacGillivray, now retired, is determined to use his time, money and skills to help treat these street children, who, unlike their Scottish peers, have no access to free dental care.

When he was working out of his practice in Bridge of Weir, Eoin had travelled to Romania to run a couple of projects that were designed to help these children. Sadly, he had to give up this work at the age of 47, when he retired from dentistry due to ill heath.

Eight years on, however, he has been drawn back to Romania, inspired by two friends who have opened a centre in Arad, dedicated to helping the street children there.

> **"My friends originally went out to Romania to drive some of my dental equipment into the country but were so moved by the plight of the children they ended up moving out there"**
> Eoin MacGillivray

With the help of friend Andy MacKinnon, a dentist based in the east end of Glasgow, Eoin is now fully ensconced in plans to set up a medical/dental facility in the basement of this centre, situated in western Romania, in the Criflana region, on the river Murefl.

Once the basement is officially up and running, Eoin said both he and Andy will fly out frequently from the UK to help manage things, while a couple of Romanian dentists and a doctor will staff the facility on a more regular basis.

To the casual observer this might seem like a lot of effort for very little reward, but as a humanitarian Eoin believes his new Romanian project is a necessity. After taking inspiration from his two friends already out there, he said he felt compelled to offer his help.

"My friends, who are both teachers, felt they needed to put something more permanent in place for the children and so they privately raised funds to renovate and open this centre," Eoin told *Scottish Dental magazine*.

"The centre is a place for the poor and Roma to come and get food, wash, get their clothes washed and get some peace.

"My friends originally went out to Romania to drive some of my dental equipment into the country but were so moved by the plight of the children they ended up moving out there with their families the next year. Their children were educated there and they now have a daughter who is a

Eoin MacGillivray (left) and Andy MacKinnon plan to travel to Arad whenever they can

student medic. It makes sense that I should offer the centre what I can in terms of promoting oral hygiene. It's a humanitarian project, not a business venture. It's an interesting and rewarding experience as well."

And by offering his help, Eoin will be able to rekindle his love of a profession that was cut cruelly short.

Although he beat cancer, Eoin had to retire from dentistry at the age of 47. The chemotherapy, though saving his life, left him with problems in his day-to-day functionality, the more major in relation to dentistry being peripheral neuropathy – which means he cannot feel with his fingers.

"Yes it was sad, but I live for today," Eoin said. "You can't go back, you have to go forward. I'm still involved in lots of other things as well, such as the health board, children's panel and so on. I do a lot of work with children."

So, not wanting to undertake this epic new Romanian project alone, Eoin has enlisted the help of his close friend Andy MacKinnon.

"Andy did his work experience with me when he was at school and then went on to do dentistry," Eoin said. "We both attend West Glasgow New Church and it supports the work we want to do, and has done for many years, and we feel that our project is an extension of this humanitarian work."

And due to Eoin's medical condition, Andy will carry out the bulk of the practical work involved.

"Eoin facilitates," Andy explained. "He'll get the surgery set up and I'll do the clinical stuff. Eoin knows what is needed in terms of dental equipment and how to put that dental equipment in place. We didn't need engineers as much as you may think because Eoin knows what he's doing – he's already been out to Arad and knows the requirements."

Continued »

CHANGING ROOMS

The Arad centre basement needed a lot of work to get it up to a standard suitable for treating patients

Continued »

While Eoin is retired, Andy is still a working man. However, he insists his trips to Arad won't affect his own practice in Glasgow.

"The huge advantage is I'm self-employed and can take time off whenever I want," he said. "Obviously I don't earn when I take time off but the idea is to set this up and then get other dentists to go out there too, such as friends of ours, Romanian dentists and so on, meaning I don't have to be there all the time."

The street centre itself is a 100-year-old building that served as a jeweller's workshop prior to being renovated by Eoin's friends. The basement, however, was still in a state of disrepair when Eoin and Andy came out to have a look.

"The basement was riddled with cobwebs and the floor was flooded before work started," Andy said. "It was a huge job for the builders but they did a great job getting it inhabitable. The courtyard up above is now the waiting room for the surgery. It all looks quite lovely."

The building work was paid for by funds raised from ceilidhs held in Scotland and also from a support group in Falkirk.

"We pay for flights and other smaller costs ourselves," Andy added.

ROMANIA TRIVIA

THE BASEMENT SURGERY in Arad won't be used by dentists seven days a week. It will also be used by local specialists to offer free eye tests to the street children, as well as HIV and AIDS tests, and chiropody.

MANY OF ARAD'S poor and Roma have made their way to Govanhill in Glasgow, where they attempt to earn a living selling *The Big Issue* on the city's streets.

STREET KIDS IN Romania are usually a mixture of those who have come out of orphanages – either by running away or turning eighteen – or are runaways from abusive homes. There are also kids born on the streets whose parents are also street kids.

Charity Dentaid and other UK businesses have provided most of the surgical equipment – chair, handpieces and so on – with Eoin and Andy only now missing a dental light, delivery cart, compressor and some cabinets.

"We need to demonstrate a proper surgery to proper standards in order to get the necessary certificates," said Andy. "We feel that this should actually be measured against UK standards, which are higher than those in Romania, so that is what we have set out to achieve."

"We have made contact with the local dental committee and the registration is ongoing," Eoin added.

As for staffing, Andy said he is relying on a lot of good will from local practioners.

"We hope that Romanian dentists will help out and we have some contacts there who have made such promises," he said. "Our aim is to get a retired Romanian dentist to work in the clinic once a week. When we achieve this we will be more able to assess the impact of our work. The Romanian dentists and doctors will all volunteer their time as a service to society. Most are humanitarian and feel they should do this."

Poverty

Exacerbated by the collapse of communism at the end of the '80s, poverty is rife in Romania. Although most of the country's street children are in desperate need of dental care, they have grown suspicious of anyone offering to help them for free.

So, in a bid to gauge demand and see how practical the basement would be in treating a broad church of dental ailments, Andy performed a session in the half-fitted facility last October.

"These people were not getting any treatment before," he said. "The common problems among street kids from what I could see are carious or rotten teeth. Their biggest needs would be extractions and advice."

Street kids are not all children, a lot of them are now in their twenties and thirties, but they're still known as kids.

"A number of these adult patients came in too," Andy said. "They had suffered toothache and extreme pain for months prior to us doing treatment. Extracting the rotten teeth relieved this problem immediately."

Most of the children in Arad do not own a toothbrush either, according to Andy, and so he and Eoin plan to provide these and toothpaste for a number of families, backed up with simple advice on how to brush their teeth properly. Andy said: "We are going to go around schools, nurseries and the streets with an interpreter, and get them to come along to our surgery. Poor kids in Romania do not go to see a dentist. There's no NHS – they simply can't afford it.

> **"The decay rates in the east end of Glasgow are probably as bad as anywhere in Europe. But at least the kids in the east end have access to a dentist"**
> Andy MacKinnon

"But, believe it or not, there's not a whole lot of difference between the tooth decay rates of these street kids and the children in the east end of Glasgow, where I work. The decay rates in the east end are probably as bad as anywhere in Europe, as is well documented.

"But at least the kids in Glasgow have access to a dentist. Romanian street kids simply don't. Not seeing a dentist regularly can create a fear of them too and that's something we want to help the kids of Arad get over."

While Andy will endeavour to provide the same treatment to the children of Arad as he would those at his Ruchazie practice, at the moment he said he cannot offer replacement teeth when he has to extract.

"The problem is paying for it," he said. "We've not gone that far yet. We're just looking at providing emergency care for the time being. We would need to raise more money to set up something to fund tooth replacement and more complex surgery.

"But who knows what the future will hold and how the surgery will develop. Right now I just want to urge as many dentists as possible who read this article to consider coming out here to help. It's a very worthwhile cause." ■

If you would like to offer your help or get more information on the Romanian project, contact Andy MacKinnon on 0141 774 9467 or by email at andy.mackinnon2@btinternet.com

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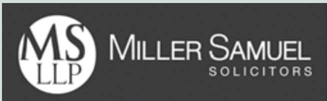

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Another layer of regulation?

Healthcare Improvement Scotland has taken over from The Scottish Commission for the Regulation of Care (aka the Care Commission). Helen Kaney explains the situation at the start of 2011

Dentists throughout Scotland cannot have escaped the uncertainties currently being experienced by their English colleagues in relation to the Care Quality Commission (CQC) and the requirement to be registered with the CQC from 1 April. Many dentists working in Scotland may also be wondering about the introduction of a similar requirement. The question being asked by many dentists is: "Will we be next?"

The Scottish Commission for the Regulation of Care, otherwise known as the Care Commission, was established in April 2002 and was intended to regulate and improve care services in Scotland, including GP services and dental services. However, the Scottish Government announced some time ago that, from 1 April 2011, the functions of the Care Commission will be split and there will be a new single body to scrutinise health services, with another new separate body regulating care services and social work.

The new health scrutiny body, Healthcare Improvement Scotland (HIS), will bring together a variety of functions, including the scrutiny of independent healthcare, which was the original remit of the Care Commission; although for a variety of logistical reasons the Care Commission didn't actually introduce anything that affected dentists in Scotland.

The legislation implementing these recent changes is The Public Service Reform (Scotland) Act 2010, which came into force earlier this year. Part six of the act established HIS and provides powers in relation to scrutiny of NHS and independent healthcare services.

The act provides HIS with responsibility for a variety of functions, such as a duty to provide information to the public about the availability and quality of services provided under the health service and a duty to provide the Scottish ministers with advice about any matter that is relevant to the health service.

The Act also amends the NHS (Scotland) Act 1978 and the powers of HIS cover both NHS and independent health care services, including independent clinics where services are provided by a medical or dental practitioner. Apparently the practical implications of this are still being considered by the Scottish Government.

HIS has powers to inspect and also has the power to investigate an incident, event or cause for concern. An inspection must be carried out by an authorised person and there is authorisation under the act for inspection of records. The new chair of HIS took up office on 6 September 2010 and the appointment of a chief executive is apparently in hand. HIS will have 250 staff and an estimated initial budget of around £19 million.

At this stage, it is uncertain how matters will develop with regard to the regulation and inspection of dental services in Scotland by HIS. It should be noted that HIS will regulate and inspect dental services, but not the dentists who are already regulated by the GDC.

The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations

"HIS has the powers to inspect and investigate an incident, event or cause for concern"

"This doesn't take into account other bodies who can attend and inspect various aspects of a practice if they see fit"

2011, came into force on 1 April 2011. These regulations provide some insight into future plans for private practices in Scotland. For example, there is specific provision for the preparation of Patient Care Records which must include details of every consultation or examination and the outcome, plus details of any treatment.

Obviously dentists are well used to their obligations in relation to clinical record keeping but these regulations are quite specific and, among other things, include the requirement to record the name of the healthcare professional providing the treatment.

NHS dentists and their practices in Scotland are already inspected on a three-yearly basis as well as by NHS Education Scotland if the practice is a training practice. This doesn't take into account other bodies who can attend and inspect various aspects of a practice if they see fit. The current issue is whether HIS will also be inspecting NHS practices.

Where matters go from here is still not clear. The British Dental Association in Scotland has replied to the Scottish Government's consultation and has been pragmatic in suggesting that there is no value in re-inventing the wheel and, given that NHS practices are already inspected regularly by Scottish Health Boards, it would make sense that any new arrangements should only apply to wholly private practices which are not inspected in the same way. Not to do so would leave HIS with the fairly onerous task of trying to organise the regulation and inspection of the 900 or so Scottish practices.

The Scottish Government's response to the consultation process is due to be published in the spring and it remains to be seen how things will evolve in practical terms. Given the situation in England, Scottish dental practices and dentists may well have some valid concerns about yet another level of inspection and regulation. One obvious downside for dental practices is that there may well be costs that could be imposed that they may think they can well do without.

Hopefully, a more sensible and pragmatic approach will be taken here than in England. Ongoing discussions suggest that further announcements will be forthcoming. So, watch this space... ■

Helen Kaney is a dento-legal adviser for Dental Protection in Edinburgh.

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Interview
By Tim Power

A real Wray of sunshine

Dr Alyson Wray has become the first female Vice President in the history of the Royal College of Physicians and Surgeons of Glasgow and now she's determined to widen the institution's appeal

Having broken the "glass ceiling" at the Royal College of Physicians and Surgeons of Glasgow (RCPSG) by becoming the first female Vice President in the institution's 400-year history, Dr Alyson Wray is also keen to modernise the appeal of the College by making it more inclusive for dental professionals.

Dr Wray is the new Vice-President (Dental) and Dean of the Dental Faculty of the College and now sits at the "big table" on the College Council and Executive Board, making strategic decisions to develop professional post-graduate standards for doctors, surgeons and dentists.

Dr Wray explained: "As Vice-President, I have responsibility for developing post-graduate training for dentists, but I am keen to make the College more inclusive for the whole dental team.

"We are looking at promoting Associate Memberships for general practice dentists and designing events that will be of interest to dental care professionals."

Although Dr Wray is relaxed in her new surroundings at the College's headquarters in St Vincent Street, she is aware that there has been a perception of a "members' club" ambience of the place, with its wood panelled walls, gleaming chandeliers and austere portraits of past presidents.

This can be a little intimidating for some – herself included. She readily admits, as a graduate dentist, to running through the college doors and straight out again when she first entered the building to find the results of her exams that were posted on the reception message board.

"I can appreciate how the College's traditional ambience could turn people off the institution and decide that it is not for them, but we have to strike a balance between the College's heritage and its importance in today's world.

"The College's heritage has given it its longevity and credibility, but we also need to balance this with a more dynamic and forward looking image that is all about promoting and supporting professional development and commitment."

Treating children is Dr Wray's passion – an interest she developed in her vocational training in 1983 as a dentist in a community clinic in Pollok.

She explained: "I was also involved in school inspections and was shocked at the level of dental disease in the children.

"When I found out that the level of disease had stayed the same over the past 20 years, despite a fall in the number of children on the school role over the same time, I felt something had to be done."

Dr Wray spoke to Professor Ken Stephen, an expert in preventative dentistry and water fluoridation and one of her former lecturers at the Glasgow Dental School, and they helped develop a dental health campaign with the local health board. This resulted in two years' work in the East End of Glasgow and provided her with the motivation to pursue a PhD, working in association with

"We have to strike a balance between the College's heritage and its importance in today's world"
Alyson Wray

Unilever conducting clinical trials into toothpaste formulations to prevent tooth decay.

After her PhD, she spent two years developing her clinical expertise at the Glasgow Dental Hospital before pursuing a specialist training path to become a Fellow of the Royal College of Physicians and Surgeons of Glasgow. She later went on to become Vice Dean and Director of the Dental Membership Services Board of the College before taking up her current role in October 2010.

In 1993 an exciting opportunity came Dr Wray's way, which enticed her to the US with brand giant Procter & Gamble to research site-specific antibiotic applications for periodontal disease in Cincinnati.

She said: "This was a great job, as we were conducting clinical trials across the whole of the US.

"When I took up the post I originally planned to stay, but I found I was not able to do any clinical work in the States because I could not get a licence to practice. I missed this aspect of dentistry, particularly working with children, so I eventually decided to return to Scotland."

Back at the Glasgow Dental School, she lectured for a few years and qualified as Consultant in Paediatric Dentistry working at the Glasgow Dental Hospital, the Royal Hospital for Sick Children and Gartnavel General Hospital.

She currently spends three days a week working for NHS Greater Glasgow and Clyde and two days on postgraduate work for NHS Education for Scotland. ■

CAREER FILE: Alyson Wray, PhD, BDS, FDS (Paed) RCPS

DR ALYSON WRAY is a Consultant in Paediatric Dentistry in Glasgow Dental Hospital and is also the Hospital Dental Services Postgraduate Tutor for the West of Scotland.

She graduated from Glasgow University and completed her Vocational Training in the Community Dental Services (CDS).

After four years in the CDS she came back to hospital dentistry and completed her FDS in 1993.

She spent a year in Cincinnati working on clinical trials for Procter & Gamble before returning to Glasgow as a Lecturer in Paediatric Dentistry.

She completed her PhD in 1995, and was awarded her Exit Fellowship in Paediatric Dentistry in 1997.

She has been a Consultant since 1999, chaired the Intercollegiate Fellowship Board in Paediatric Dentistry, and is currently the Dean of the Dental Faculty and Vice President (Dental) of the Royal College of Physicians & Surgeons of Glasgow.

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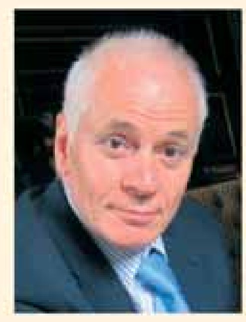

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Are you at the end of your tether?

From concerns over clinical errors, to the strains of increasing bureacracy and complaints handling, Robert Broadfoot looks at how to identify the reasons for and work to reduce your levels of stress

My interest in stress management started as a result of supporting recent graduates experiencing the problems of transition from undergraduate dental school to general dental practice. These problems were shared with me in my role as regional adviser for vocational training in the west of Scotland.

Many young graduates were under considerable stress with the potential risk of clinical errors, as well as risks to their health and wellbeing. This led me to gaining the Diploma in Stress Management in 2005. Since then I have been presenting courses on stress management to GDPs and VDPs. This article will draw on the experiences of these courses.

General dental practice has the reputation of being one of the most stressful professions. The league table of suicide rates by profession identifies dentists and vets to be at the highest risk. This article will also explore the reasons for the apparently stressful nature of dental practice, examine the perception that the job is becoming more stressful

Continued »

"The league table of suicide rates in the professions identifies dentists and vets to be at the highest risk"

Continued »

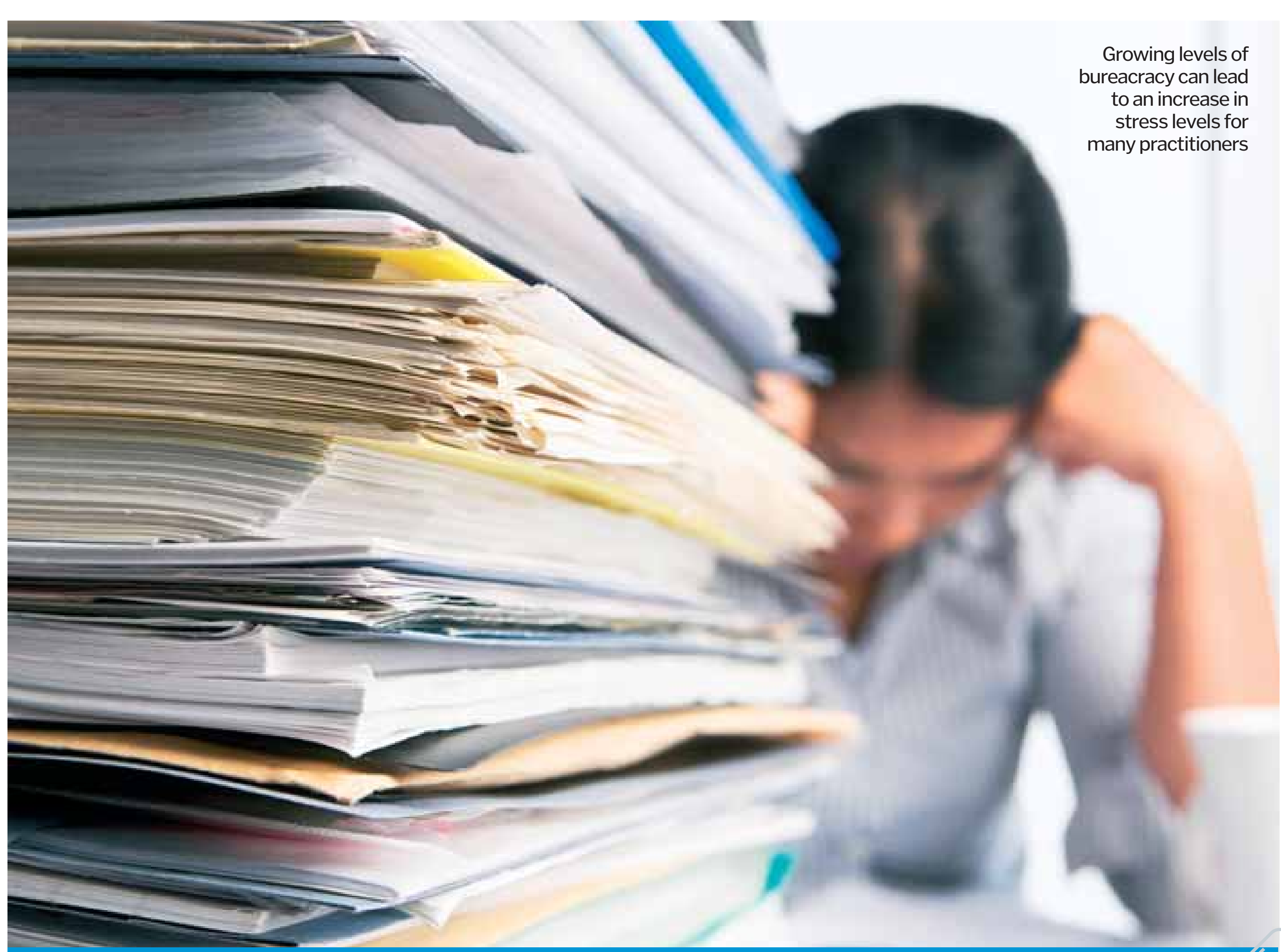
and discuss how dental teams can reduce their levels of stress.

The conflict between the profit motive implicit in running a business and delivering the highest possible standard of healthcare is a major stressor. Young dentists telephone defence societies on a daily basis with real concerns about the quality of care they are delivering due to constraints such as lack of nursing support, ineffective systems and absence of teamwork.

Practice owners and dental companies tend to focus on providing modern equipment, an extensive choice of materials and selection of high-quality laboratories, but often fail to recognise the importance of team working, effective systems and good communications. For those of you who are thinking: "Not more management gobbledegook", the analysis of complaints and referrals to the GDC clearly identifies these failures as the root cause in most cases.

In addition, these areas of management in general dental practice cannot be taught in dental school. Modern dental practice is delivered by teams and if these teams are supported and developed as teams, rather than as groups of individuals, job satisfaction and patient satisfaction will improve. It is noticeable that well-organised, efficient practices find it easier to recruit associates and retain them to ensure continuity.

In relation to the perception that the job is becoming more stressful, as part of my presentation to VDPs on the fight or flight response, I ask if they have felt this response happening in the surgery. All participants report that they have experienced the response to varying degrees. The commonest reason for this is the increasing incidence of aggressive patients attempting to bully the dentist into treatments against their better judgement.



Growing levels of bureacracy can lead to an increase in stress levels for many practitioners

IDENTIFYING YOUR STRESS: Warning signs

Everyone suffers stress to one degree or another. But when it rises to levels which impact on the way you work and live your life, then it is vitally important that you act to reduce these stress levels.

However, sometimes it can be difficult to identify the symptoms of stress and, often, the root cause of the stress.

So, to help you look out for the things that you can identify if you think you're stressed, here's a list of classic indicators:

- Not being able to switch off
- Needing alcohol regularly
- Losing temper quicker than usual
- Sleep affected
- Weight loss/gain
- Headaches
- Back/neck pain
- Digestive disorders
- Longer working hours
- Less time for family
- Frequent colds
- Performance issues.

The concept that we are the dentist and we know best may be old fashioned, but we do have to sometimes say: “No, I am not prepared to carry out that treatment as it is not appropriate.” If the patient storms out of the surgery saying they are going elsewhere, then this outcome may not be as disastrous as you think at the time. Assertiveness training – how to say no – should be an integral part of VT.

Increasing bureaucracy is the other oft-quoted reason for the job becoming more stressful. The list of organisations that have become involved in some aspect of dental practice grows by the day. Disclosure Scotland, Medicines and Healthcare Products Regulatory Agency, Vulnerable Groups Scheme, Care Commission and IHAS Quality Mark Scheme are just some of the recent additions. It seems obvious that if the dentist is attempting to deal personally with these agencies, as well as the ones directly involved in patient care, then overload and stress will occur. Delegation is the key.

I have been involved in training programmes for dental practice managers for more than 10 years and it is refreshing to see practice managers playing an increasingly important role in teamwork in practices. This is especially relevant in relation to patient complaints, which are on the increase and patients can now complain directly to GDC.

We should remember that a complaint is an expression of dissatisfaction, verbal or written, about a dental service or treatment – whether justified or not. In dealing with a complaint, some dentists will concentrate on the ‘whether justified or not’ element rather than listening to the patient and finding out their perception of the problem.

When a veneer becomes dislodged, the dentist’s first words to the patient are often: “Well, you must have been grinding your teeth.” A practice manager on the other hand will usually establish a rapport with the patient, ask how it happened and begin to explore solutions to the cosmetic disaster. The teamwork solution is again appropriate.

My stress management courses were initially aimed at dentists and focused on the above examples of why dental practice appeared to be more stressful than before. Other areas discussed were staff shortages/absences, demanding patients, pace of change, bad debts, etc. There were several dentists on these courses who stated that they felt fairly stressed.

My recent courses have been provided for dental teams and have been held over two separate days. This format has allowed the development of action plans on the first day which can be implemented back at the practice. There is no doubt in my mind that if the problem is tackled by the dental team rather than just the dentist, the chances of success are higher.

The second day can then assess the success of the action plans as a group discussion. Action plans often include making basic changes to appointment systems, delegating complaints to the best communicator in the practice, improving the system for coping with emergency patients and developing a team approach to avoiding bad debts. These improved systems will reduce practice stress levels.

In relation to a dentist’s individual stress levels, the solutions have included making a thorough assessment of patient expectations, developing listening skills, avoiding constant time pressures and being willing to change.

Remember, in relation to change, if you do what you have always done you will get what you have always got. Changing the way you work can prevent stress developing. ■

Robert Broadfoot was a general dental practitioner in the west of Scotland for 30 years. He runs courses and workshops on stress management and also works as a part time associate dento-legal adviser with Dental Protection.

TAKING ACTION: combat stress

If you are aware of one stress indicator in your life, then give the cause serious thought.

If, however, you are aware of several of these indicators in your life then you should seek help and make changes to counteract these stress levels.

There are a number of key routes down which you can go to get the help that you will need to reduce the stress and put you back on the right track.

Here are some suggestions on where to seek help:

- Initially, discuss your thoughts with your partner (if appropriate) or with a trusted friend
- Your next step could be talk to your doctor. It is important that you never self-medicate
- An excellent source of advice and guidance is the Dentist Support Scheme. Their helpful staff can be reached by calling 0207 224 4671
- If your circumstances are appropriate, why not talk to your dental practice adviser?
- Your postgraduate tutor can also be an excellent source of help.

It must be remembered that self-medication prevents the essential communication with a second party who can be objective. And it can also lead to addiction.

“It is noticeable that well-organised, efficient practices find it easier to recruit associates and retain them”

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Ayr practice gets a new start

After more than 20 years in the same location, Mark Fitzpatrick decided the time was right to move and find the perfect premises

Mark Fitzpatrick had only been out of dental school five years when he took over from his retiring principal and became a practice owner. Now, a little more than 20 years later, he has relocated, renamed and breathed new life into his successful Ayr practice.

Mark fully admits that, even without the advent of the decontamination requirements, it had become apparent that they needed to move. The practice was situated over two first-floor tenement flats and, as such, the premises didn't meet disability access requirements. The health board had helped out by providing a ground-floor surgery at the hospital for them to see disabled patients, but it was far from an ideal situation.

"Mark had been looking for the perfect location for the best part of four years, to no avail"

Before the new premises came onto the market, Mark had been looking for the perfect location for the best part of four years, to no avail. Then, in early 2010, he identified a former bedroom furniture showroom that was available just around the corner and he started to put his plans into action.

With the help of one of his patients, Stephen McGhee, who is a practising architect with Lawrence McPherson Associates, he set about redesigning the open showroom-style floorspace into a modern dental practice. One of Mark's initial concerns was lighting as, due to the nature of the building, all the surgeries would need to be internal.

In the old practice, all of the surgeries had windows letting in natural light and he was concerned that for shade taking and the general wellbeing of the staff, the

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lack of direct light could be an issue. However, this was emphasised to Stephen and the builders Dickie and Moore, early on and became one of the key considerations.

It took until September for the purchase of the building and all the planning permissions to be finalised and work began in November. Mark received grants from the Scottish Dental Access Initiative in order to help finance the move and he was very happy with the experience, saying that the grants were secured and paid very quickly.

The layout of the space was open plan with only a few concrete pillars dictating the positions of the internal walls. It was decided that the front of the building, which was formerly the shop window, would house the reception and waiting areas so that the patients would benefit from the natural light coming through the full-length windows. From this a central corridor leads to the clinical areas with the four surgeries – two on each side – branching off from this walkway.

The initial plans included glass panelled doors for each of the surgeries in order to let as much light as possible into the room. But, during the build this was amended so that now the surgeries have solid doors with full-length smoked glass panels alongside. All the surgeries feature daylight bulbs and are laid out in a similar way to enable staff to move between rooms if necessary without any problem.

Mark's own surgery was brand new, with a Castellini chair bought through CEI Dental and all new cabinetry. Two of the other surgeries have chairs brought from the old practice but brand new cabinetry and other equipment, while the final surgery – which was only refurbished two years previously – was brought over from the previous premises in its entirety.

Further down the corridor, through the 'Staff Only' fire-door, is the two-room LDU and staff areas including plant room, staff room, toilets and storage. Mark currently has three associates: Robert Carter, who has been with him for the last 18 years; Fiona Standbridge, who has been there for five years; and his newest addition, Hugh Morton, who is currently covering for Fiona's maternity leave. Sandgate Dentistry also features a hygienist, a technician (still based in the old premises) and eight dental nurses. Mark's wife, Liz, has taken over more of the management responsibilities in order for her husband to concentrate fully on the business of dentistry.

Despite it being a long time coming, Mark, his staff and his patients are all delighted with the new practice. He said: "The equipment is great, the layout of the building is great, the staff are so much happier and we are so much busier, so it's been a great move.

"Before, I would say that I was just a dentist in Ayr. Now I am really proud of where I am." ■

"Before, I would say that I was just a dentist in Ayr. Now I'm really proud of where I am"

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Steven McGhee of Lawrence McPherson stated...
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Right place, right time, first time

Joyce Dalgleish, Communications Manager for the 18 Weeks Referral to Treatment programme, explains the process involved in the development of dental specialties referral pathways for orthodontics and oral surgery

IN BRIEF

PATIENT PATHWAYS
18 Weeks RTT website: www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/patient-pathways/dental-specialties/

DENTAL SPECIALTIES TASK AND FINISH GROUP
18 Weeks RTT website: www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/task-and-finishgroups/dental-specialties/

PRESENTATIONS FROM TRANSFORMING DENTAL SPECIALITIES EVENT
are available on the Scottish Health Service Centre website. Search under 'view past events': www.shsceventsbookings.co.uk

Referral pathways help ensure that patients are referred to the right professional in the right place at the right time, first time. Pathways provide an excellent basis for standardisation and consistency, ensuring equity of access and care.

In 2009, the 18 Weeks Referral to Treatment Time Standard Dental Specialties Task and Finish Group, in conjunction with consultant dental colleagues, identified the need for national referral pathways and protocols in two high-volume dental specialties – orthodontics and oral surgery. The national pathways that were subsequently developed and are now published by that group, represent a clinical consensus across NHS Scotland. These pathways have also been endorsed by two professional bodies – The Scottish Orthodontic Consultants' Group and the Scottish Oral and Maxillofacial Society, among other stakeholders.

18 Weeks Referral to Treatment Time (RTT) Standard

From December 2011, 18 weeks will become the maximum wait for referral to treatment for non-urgent patients in NHS Scotland. The 18 Weeks RTT Standard is different from previous waiting time targets because it does not focus on a single stage of treatment. Instead, it applies to the whole patient pathway from a referral, up to the point where treatment begins. Achieving the standard requires NHS Scotland to manage each patient's journey in a timely and efficient manner.

Almost all patient pathways begin and end through primary and community health service. 18 Weeks RTT recognises the importance of whole-system working. The emphasis is on joint working, seeking collaborations between primary and secondary services and, where possible, ensuring diagnosis and treatment taking place local to the patient without the need for unnecessary hospital visits.

"The 18 Weeks RTT philosophy of 'Right place, right time, first time' chimes clearly with the three quality ambitions of delivering safe, person-centred and effective healthcare contained within the NHS Scotland Quality Strategy. I am delighted that these themes have been brought together in order to help improve the patient journey in two key clinical areas in dentistry. I would like to thank everyone who contributed to this innovative piece of work"

Margie Taylor, Chief Dental Officer

Dental Specialties Task and Finish Group

This is one of eight task and finish groups which exist as part of the 18 Weeks RTT programme. These groups bring together clinical and managerial specialists in each field. Its members support NHS Scotland, implement sustainable changes to improve their services. They seek opportunities for streamlining services and patient-focused improvements while ensuring that the appropriate drivers are in place to minimise the risk to delivery of the 18 Weeks RTT standard.

Getting started

The Scottish Government's Service Redesign and Transformation Programme's Improvement and Support Team hosted a series of national dental specialties events to engage with the dental community. Through a series of half-day 'visioning' events and masterclasses, they provided a forum to discuss collaborative working, delivery expectations, share best practice and consider how NHS Scotland might collectively address bottlenecks in creating a critical path for delivery.

A pathway sub-group was established for each specialty. Each pathway group had clinical representation. The orthodontic pathway had representation from primary and community care general dental practitioners, a primary care specialist orthodontic practitioner and secondary care consultant orthodontists.

The oral surgery pathway had clinical representation from primary care specialist practitioners, secondary care oral surgeons and secondary care oral and maxillofacial surgeons. The members of the group started the development process by identifying and collecting local protocols for review. Reviewing what already existed was an opportunity to see where there was good practice and avoid the duplication of existing protocols already used within NHS boards.

Transforming Dental Specialties event – March 2010

Chief Dental Officer Margie Taylor set the scene for this session, drawing on the policy document *Better Health Better Care*. Considering the changes in the Scottish population and associated increases in demand for services, Margie emphasised the need for agreed patient pathways in dental specialties.

David Morrant of NHS Ayrshire and Arran and Helen Devennie of NHS Highland each described the development of pathways for orthodontics and oral surgery respectively.

In his presentation, David highlighted five reasons why dental pathways are required:

- to act as a statement of good referral practice
- to provide a road map for the patient
- to break a patient's journey into recognisable steps
- to identify where there might be avoidable delays
- to identify areas for further development of technology or streamlining of the pathway.

Mike Lyon, Deputy Director of Delivery for the Scottish Government Health Directorate, presented analysis for 2007/2008, which showed that approximately 40 per cent of oral surgery activity consisted of simple extractions. Delegates were encouraged to agree pathways, which would encourage more work to be carried out in a primary or community care setting.

Patient pathways

The two pathways share a similar format. The first part is the patient pathway and this is separated into two elements – first point of contact care and specialist care and advice.

First point of contact care is the initial contact between the patient and primary care services. Specialist care and advice can take place in primary specialist and/or secondary care. The pathway identifies where referrals can be appropriately made.

The second part is a referral guidance table, which is aimed at the primary care practitioner. This goes into further detail of appropriate referrals, dependent on the assessment of the patient's presenting condition.

The referral management tables can be used as a basis for discussions for agreement at local level. The intention is that they are tailored to accommodate local provision of these services, and although the fundamental principles must apply, local issues should be addressed accordingly.

Right place, right time, first time

The aim of the pathways is to ensure that patients are referred to the right professional in the right place at the right time, first time.

Achieving and sustaining this will require ongoing collaborative working between primary and secondary care dental colleagues. This collaboration will also contribute to ongoing education and professional development and to the further streamlining of pathways. ■

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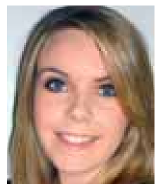
Intra-oral bone grafting: a clinical audit



An assessment of the early and long-term success of intra-oral bone grafting performed under local anaesthesia prior to implant placement. An analysis of 11 consecutively performed procedures with comparison to bench mark. By Maria Devine and Nick Malden, from the department of oral surgery, Edinburgh Dental Institute

Background

Replacement of missing teeth has traditionally been achieved with a fixed or removable prosthesis, such as a bridge or partial denture. An alternative and more permanent solution is the use of dental implants, which are inserted into the alveolus and become integrated into alveolar bone (osseointegration).[1]

However, the placement of dental implants is dependant on the presence of an adequate volume of bone at the implant site. Inadequate bone volume may be a consequence of trauma or ridge resorption following tooth loss.[2] Alveolar bone can be augmented prior to implant placement with a number of techniques.

The 'gold standard' technique is the use of autologous bone grafts, which are grafts taken from the patient, at a local or distant site from the implant recipient site.[3] Other techniques include allografts (bone grafts derived from cadavers), xenografts (grafts derived from animals), synthetic bone substitutes, guided bone regeneration, bone promoting proteins, ridge expansion and distraction osteogenesis.[2]

Patients included in this audit received autologous grafts from local sites; mandibular symphysis or ramus. The procedure was carried out under antibiotic cover with post-operative antibiotics continued for five days. The procedure for the symphysis graft was carried out as follows: a buccal mucoperiosteal flap was raised and elevated to just above the lower border of the mandible. The graft was taken using a saline cooled bur (0.5mm diameter fissure bur) and fashioned to the dimensions of the recipient site using a bone wax stent (see Figure 1). The recipient site was prepared by raising a buccal mucoperiosteal flap. The cortex underneath the graft was perforated using a saline cooled bur and the graft was secured with titanium screws (see Figure 2).

> "Patients included in this audit received autologous grafts from local sites; mandibular symphysis or ramus"

Both sites were closed with vicryl rapide sutures. Implants were placed at the recipient sites circa six months following the grafting procedure.

Aims and objectives

The primary aim of this audit was to assess the success of the technique of autologous intra-oral bone grafting, performed prior to implant placement, as practised by the oral surgery team in the Edinburgh Dental Institute (EDI). This was achieved by comparing the EDI results against those of a previously published series (Misch CM 1997)[4], which was chosen as a benchmark. A patient satisfaction questionnaire was carried out between five and seven years post-completion of the procedure.

The published benchmark selected was a paper by Craig Misch entitled 'Comparison of Intra-oral Donor Sites for Onlay Grafting Prior to Implant Placement' published in

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Fig 1
Access to symphysis graft donor site

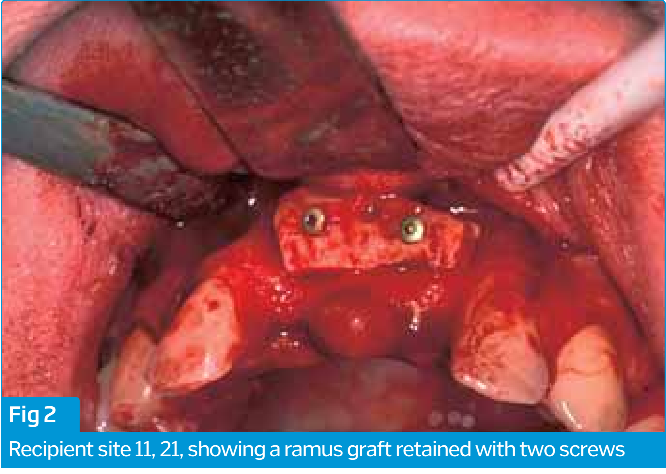
Fig 2
Recipient site 11, 21, showing a ramus graft retained with two screws

Continued »

the *International Journal of Oral and Maxillofacial Implants*. This paper presented a clinical evaluation and comparison of bone grafting from the mandibular symphysis (31 cases) and ramus (19 cases) prior to implant placement. The parameters measured and used to evaluate the success of the procedure in the EDI are presented in Table 1 (below).

Methodology

A retrospective audit was carried out on 11 consecutive cases of autologous bone grafting performed in the oral surgery department of the EDI between January 2003 and November 2005. Data on post-operative complications, graft and implant success was collected from the electronic patient record and placed on a data collection form. Those patients on long-term recall were asked to complete a patient satisfaction questionnaire and in January 2010 the questionnaire was also posted to those patients not responding to recall. All patients were given the opportunity to attend the department for a review appointment to discuss any concerns regarding their treatment. Data was collected and analysed using Microsoft Excel.

Results

Of the 11 original cases (nine male, two female) in the series, seven had autologous bone grafts harvested from the mandibular symphysis and four had grafts harvested from the mandibular ramus. A total of 18 implants were placed (between one and three per patient). Seventeen implants were placed in the anterior maxilla and one was placed in the posterior right mandible. All surgical procedures were carried out under local anaesthesia.

Ten of the patients had lost teeth in the anterior maxilla through trauma and one had lost teeth in the posterior right mandible through caries. All grafts and implants placed were considered successful at one-year post implant placement. Eight cases from the original 11 (73 per cent) were successfully contacted to allow completion of a satisfaction questionnaire.

> "All grafts and implants were successful at one-year post implant placement"

Early results

The incidence of post-operative complications following bone grafting is presented in Fig 3 and Table 2. The cases included compared favourably with the benchmark data. Although the EDI group had a lower incidence of nerve injury at the symphysis harvest site, there was a much higher incidence of nerve injury at the ramus harvest site.

However, this was transient paraesthesia and occurred in one of the four cases of ramus donor sites. The patient record gives no explanation why this should have occurred in this case. The percentage incidence of wound dehiscence at the symphysis was slightly higher in the EDI group – however this only occurred in one case.

The incidence of donor site infection at the symphysis was lower in the EDI group than the benchmark. All other incidences of post-operative complications in the EDI group were comparable to the benchmark.

Figure 3 and Table 2 show the comparison of post-operative complications after intra-oral bone grafting in EDI group compared to benchmark (Misch CM 1997). Table 2 shows comparison of EDI results to benchmark.

Long-term results

The patient satisfaction

Table 1: Parameters measured (adapted from Misch CM 1997)

Graft harvest site	Symphysis (n=31)	Ramus (n=19)
Cosmetic concern	High	Low
Bone quality	Type 2 > 1	Type 1 > 2
Trauma	Moderate	Mild/Moderate
Nerve damage (transient)	10%	Rare
Tooth vitality loss	29%	Rare
Wound dehiscence	11%	Rare
Harvest site infection	6%	Rare
Graft success	100%	100%
Implant success	100%	100%

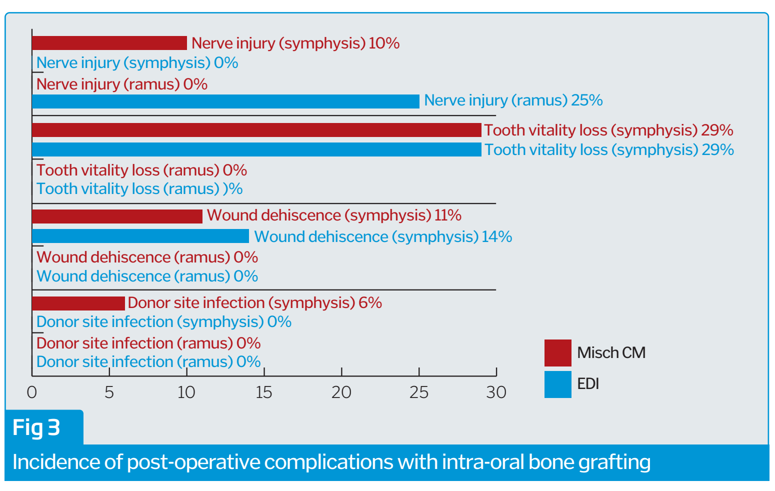

Fig 3
Incidence of post-operative complications with intra-oral bone grafting

questionnaire was completed in the clinic or sent by post in January 2010. Of the 11 initial patients in the series, eight (six male, two female) were contacted to complete the questionnaire, giving a high response rate of 73 per cent. When asked if they had confidence to chew with their dental implants, all patients (except one) replied yes. The one negative responder wrote that they were "cautious biting into hard foods".

All respondents were happy with the way their dental implant teeth looked, although one "had concerns for the future". None of the respondents thought that someone else would be able to tell that the teeth were implant-supported. All would undergo the grafting and implant procedure again.

Two of the seven respondents stated that the mandibular symphysis grafting procedure was the worst part of the treatment and one found the local anaesthetic administration for implant placement the worst part of the procedure. One case found the sensation of bone chips falling onto his tongue, during implant placement, an unpleasant experience. The remaining respondents did not report a negative aspect of the treatment provided.

> "One case found the sensation of bone chips falling onto his tongue, an unpleasant experience"

Conclusions

The purpose of this audit was to compare the success of intra oral bone grafting prior to the placement of dental implants at the EDI to a published benchmark. The early success rate of the grafting procedure was 100 per cent with a low rate of post-operative complications comparable to that of the benchmark.

All patients who responded to the questionnaire reported that they were happy with the treatment they received and would go through the process again. It is clear that this group of patients was highly motivated as the majority had lost anterior teeth through trauma and were keen to cease wearing a partial denture.

It is concluded that the success rate of this consecutive series of intra-oral bone grafting procedures, performed prior to dental implant placement, is high and matches a selected benchmark. It is also concluded that the long-term satisfaction with treatment, of this motivated patient group, is also high. ■

Maria Devine BDS (Nwc), MFDS, is a former dental foundation trainee at the Edinburgh Dental Institute and now works in general dental practice in East Lothian.
Nick Malden BDS, FDS, is a consultant in oral surgery at the Edinburgh Dental Institute.

Table 2: Comparison of EDI results to benchmark

Numbers & gender	Misch n=31	EDI n=7, M=6, F=1	Misch n=19	EDI n=4, M=3, F=1
Graft donor complications	Symphysis	Symphysis	Ramus	Ramus
Cosmetic concern	High	Low	Low	Low
Bone quality	Type 2 > 1	Type 1 > 2	Type 1 > 2	Type 1 > 2
Trauma	Moderate	Moderate	Mild/Moderate	Mild/Moderate
Nerve injury	10% (n=3)	0%	0%	25% (n=1)
Tooth vitality loss	29% (n=9)	29% (n=2)	0%	0%
Wound dehiscence	11% (3/28)*	14% (n=1)	0%	0%
Harvest site infection	6% (n=2)	0%	0%	0%

*Using vestibular approach

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Image courtesy of Michael Reddy, DDS

Radiograph shows proper implant spacing in limited site.

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SPMP10109 REV D SEP 2010

A permanent smile solution

Dr Eilert Eilertsen presents the case of a patient who had been edentulous in the maxilla for more than 30 years and the treatment he carried out to place an implant-supported upper denture

This article describes the restoration of a fully edentulous upper arch. The patient had been edentulous for more than 30 years on the upper jaw. The lower jaw was fully-functional and, although some teeth were missing, was in good health.

The patient requested an appointment to discuss the possibility of having her upper denture replaced using dental implants. She was finding that, with the passage of time, her upper jaw was becoming increasingly atrophic, her denture was becoming increasingly unstable and she was concerned about its long-term prognosis.

A long period of discussion ensued, during which the patient explored various treatment options. The first option was to do nothing. However, the patient was concerned

Continued »

PROCEDURE

Fig 1

Pre-operative radiograph

Fig 2

The patient's denture

Continued »

that in a few years she may not be able to wear her upper denture at all because, with continued atrophy of the maxilla, there would be little or no retention.

The second option involved placing two or three implants – if sufficient primary stability could be found – and subsequent retention using locator abutments and ring retainers inserted in the denture. The third option was to carry out bilateral sinus grafts and optimally place the implants away from the resorbed anterior maxilla, so that a full mouth rehabilitation could be carried out.

The patient was given information on this procedure and the invasive nature of the surgery involved. Also discussed at length were the risks, including the possibility of post-operative infection, the small risk of an oro-antral fistula if healing did not progress well and the possibility of failure of the graft to integrate. The possibility of facial bruising in the weeks following the procedure was also discussed.

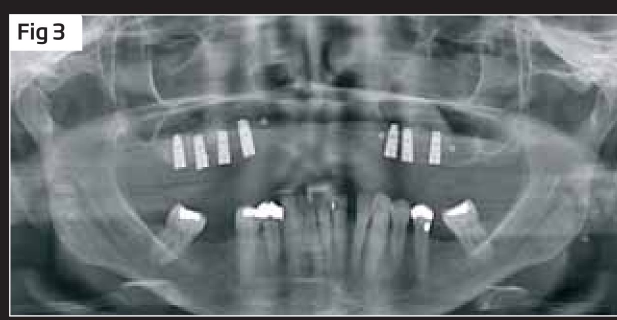
The radiograph in Figure 1 shows the preoperative maxilla with thin antral walls and much resorbtion of the premaxilla. A ridge map of this area showed

"The patient was concerned that in a few years she may not be able to wear her denture"

Continued »

PROCEDURE

Fig 3



Post-operative radiograph

Fig 4

Healing caps in place

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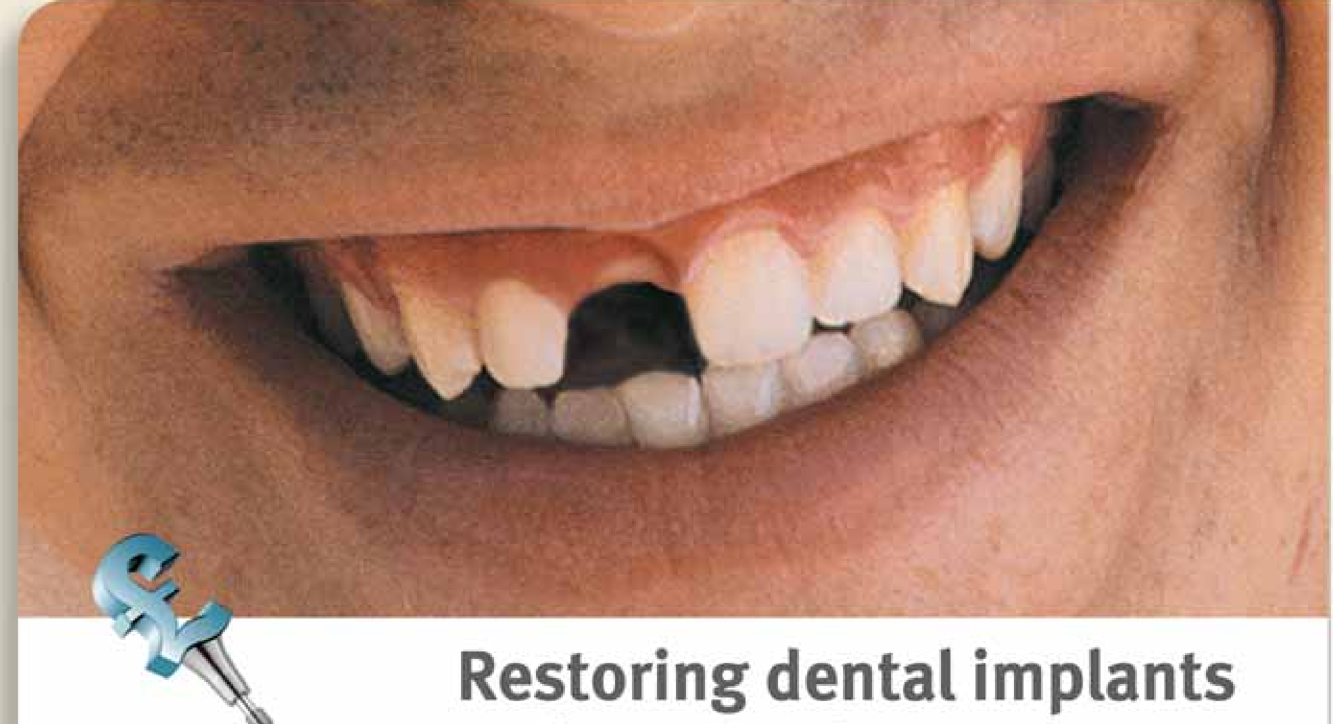

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"The healing period for the sinus grafts went well, with no complaint from the patient"

Continued »

there was only thin fibrous tissue insufficient for implant fixtures.

Fig 2 shows the patient's denture. It was relined with Fuji soft tissue conditioner several times during the treatment.

Sinus grafting

The patient finally decided that she wished to progress with the treatment programme, placing implants in each grafted sinus.

The patient was sedated using Midazolam and the right maxillary sinus was accessed using a lateral window utilising a technique first described by Hilt Tatum. The sinus membrane was lifted intact, a Bio-Oss collagen membrane then inserted below the raised sinus to protect the elevated sinus lining, and four Ankylos 11mm implants were inserted through the floor of the antrum such that good primary stability was achieved. Supplementary allograft was then compressed around the implants and the lateral window closed by tacking a Bio-Guide collagen membrane over the opening. The flap was then closed. This procedure was repeated

Continued »

PROCEDURE

Fig 5

Open tray pick-up impression

Fig 6

Abutments in place on cast

Fig 7

Abutments located using lab-fabricated jigs

Fig 8

Metalwork try-in bite check

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PROCEDURE

Fig 9

Finished prosthesis showing lateral fixation screw apertures

Fig 10

Prosthesis in place with lateral fixation screws located

Fig 11

Appearance from anterior showing small cleanable flange

Fig 12

Facial appearance showing good lip support

Continued »

approximately one month later on the opposite side.

The denture was relined with a soft lining and the patient was dismissed for six months (Fig 3).

Restoration

The healing period for the sinus grafts went well, with no complaint from the patient and she returned after a period of about six months to begin the restorative phase of her treatment. Healing caps were placed and it was noted that all the implants seemed to be well osseointegrated.

The healing caps were left in place for about one month, allowing the gingival margins to form above the implants (Fig 4). After about one month, an open tray impression was taken of the full arch using a customised special tray (Fig 5). This impression was sent to the laboratory so that abutments could be placed and modified as necessary and a metal casting returned for try-in or modification (Figs 6-8).

The metalwork and the abutments were then returned to the laboratory, the prescription being to make the bridge in composite rather than ceramic so that minor repairs and adjustments could be facilitated. In this case the laboratory used Gradia, which has a high ceramic particle content but can be bonded to with relative ease. Lateral fixation screws (Bredent) were also prescribed so that if necessary the whole prosthesis could be removed for cleaning or for minor maintenance (Fig 9).

"I feel I have achieved what I hope will be a lifelong improvement"

The prosthesis was tried in again on return from the laboratory, however the lateral fixation screws proved quite difficult to insert. This was attributed to the jigs not having lateral screws through them and so allowing for a small lateral orientation error to creep in – there being no indexation used in this case (Figs 10, 11).

I was reasonably pleased with the outcome of this case (Fig 12). I feel I have overcome some big hurdles and achieved what I hope will be a lifelong improvement in this patient's dentition. On the day I was writing this up, the patient sent in her testimonial (see page 52), which provides quite a different perspective in terms of the aspects of the treatment that she found difficult (placing the healing caps) and those that she felt she managed well (the sinus grafts). ■

Dr Eilert Eilertsen, BDS UDUND 1976, Eilertsen Dental Care in Inverness.

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The implant patient's perspective

Having had an upper denture (the result of botched dental treatment following a playground injury that damaged my teeth) since I was a teenager, I expected to have one till my Maker called me home. So, when Dr Eilertsen first suggested bone grafts and dental implants as the most effective way to deal with severe upper jaw bone loss and potential problems with denture retention, I was a bit stunned and not a little scared.

However, he explained the procedure – its benefits and risks – and, after a period of due reflection, I decided to go ahead with the treatment.

After the first session, I had no unpleasant after-effects, other than a bit of vague aching. However, a few hours after the second surgery I experienced about 20 minutes of excruciating pain that came in surges, and made me scream out in agony. There was no evidence of bleeding or anything being amiss and, after a telephone consultation with Dr Eilertsen during which the pain subsided, we decided an emergency visit to the surgery wasn't necessary.

Dr Eilertsen believed that the pain could have been caused by the small blood vessels opening up rather suddenly as the anaesthetic wore off. I also experienced some bruising on my cheeks some days after both sessions of surgery, which persisted for about two weeks.

After six months of waiting for the grafts to 'take', the next stage was fitting the healing caps. I actually found this the hardest stage in terms of discomfort/pain and inconvenience. The small openings in the gum were made under local anaesthetic and did not hurt, but the bone graft had been so successful that the bone had already grown over the ends of the implants and had to be removed before the caps could be fitted. This involved a lot of pushing, scraping and general heaving around in my mouth, and left me with aching jaws for several days. Also, once the local anaesthetic had worn off, the action of the healing caps to shape the gum at the ends of the implants caused considerable pain for several days.

I removed my denture to clean it, and could not get it back in, leaving me toothless for a few days. Fortunately I'm self-employed and it was the weekend, so I simply stayed in until I could get an appointment with Dr Eilertsen. By that time the healing was well under way and the pain gone, so he relined the denture, put it in for me, and I was able eat and speak more easily again. Social life was still much curtailed though, because I was pretty desperate to remove the lined denture by late afternoon.

At last the big day came, and the prosthesis clamped on perfectly and felt remarkably natural, with the exception of one tooth at the back, which Dr Eilertsen adjusted. I am now at the stage of learning to adapt how I eat, speak and use my jaws with this new structure in my mouth. At present, I tend to bite both my tongue and my cheeks, and my neck aches, I think because I am using different muscles to move my tongue as I learn to accommodate the prosthesis. Dr Eilertsen said this process might take as long as three months. It is tiring making this adjustment, and particularly so when this learning process is on top of nine months of treatment that was also a strain in various ways.

So, in conclusion, I am delighted with the final outcome, at this stage certainly, and my delight grows every day. I have every confidence that it will soon feel as natural as any other part of my body. Family and friends say it looks very good and my husband says it has made me look more youthful around the mouth, so that's an added bonus! ■

"I am at the stage of learning to adapt how I eat, speak and use my jaws with this new structure in my mouth"

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The legal aspects of selling your practice: Michael Royden and Ewan Miller, partners with Thorntons Law LLP, have between them almost 30 years' experience of advising dental practices, dealing with all their legal requirements including the sale and acquisition of practices. The various legal aspects of selling your practice will be covered including forward planning which will assist in making the sale as smooth as possible.

Accounting issues when selling your practice: Cliff Fleming (partner) and Scott Hallesy (tax strategist) of Condies will cover taxation issues on the sale of the practice including the use of entrepreneurs' relief and pre-retirement tax strategies. Condies is one of Scotland's leading firms of accountants and one of the few practices in Scotland who are members of NASDA (National Association of Specialist Dental Accountants).

Financial planning for retirement: Independent financial advisers and PFM directors John Fearn and Jon Drysdale have many years experience of providing specialist financial advice to dentists. They will consider how delegates can best forecast various income sources in retirement and develop a pre and post-retirement financial planning strategy. The NHS Pension will be covered in detail including flexible retirement options.

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The seminar will start and 10.00 am and finish at 4.30 pm. To book your delegate place, please email your name and address to Mandy Wraige (PFM): mandy.wraige@pfmdental.co.uk or call Mandy on 01904 670820. The delegate rate is £50 inclusive of lunch. Places are limited.

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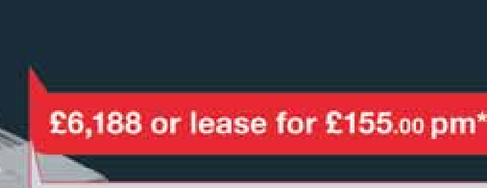

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Mighty white

The process of teeth whitening can be an in-depth one for patients, with much to consider. Laura Higgins gives *Scottish Dental magazine* a case study to illustrate the process, step-by-step

A female patient was referred to the practice, wishing to have her teeth whitened. She'd had her teeth whitened a couple of years ago but felt they had darkened since then.

The patient was fit and well with no relevant medical history and a regular attendee of her own general dental practitioner. She is a non-smoker and has moderate alcohol intake.

We discussed the various whitening options with the patient and an in-office whitening treatment was chosen.

Intra oral examination showed that the patient had some old, palatal resin restorations on the upper anterior teeth that were discoloured. There were generalised deposits of supra-gingival calculus present on the lower anterior teeth and some areas of recession. The patient was informed about the calculus deposits and also the areas of recession and advised to have hygiene treatment as it would compromise the overall result. She was also informed that she may need to change the old resin restorations after the whitening procedure as the whitening gel would not affect the resin restorations.

The patient wished to continue with the in-office whitening procedure. The procedure was explained to the patient and after-care instructions were explained as well. The patient was happy to proceed, and a consent form duly signed.

Before commencing the whitening procedure, a pre-operative shade was taken and also a digital photograph. The patient's teeth pre-operative shade was A1.

The patient was given ZOOM protective eyewear and made comfortable on the dental chair. The room temperature was also made suitable. Patients can often feel cold when lying on the dental chair for long periods of time and a blanket is often offered to patients in such cases. Patients are also offered a movie to watch on Eye-Trek lenses to pass the time.

The ZOOM mouth retractor was placed in the patient's mouth to retract the lips. This also allows the patient to relax and not worry about consistently keeping their mouth open throughout the procedure. It also ensures the Discus plasma light head is accurately positioned at all times.

Rope-like cotton rolls were placed in the upper and lower labial sulcus to keep the lips away from the teeth. In order to protect the gingivae from the whitening gel and light, the buccal sulcus was then packed with gauze squares to provide further protection. A face bib was then placed around the retractor, a liquid dam applied to all remaining gingivae and light cured. When light curing the liquid dam, the light cure was moved across the teeth to minimise heat transfer from the light cure to the teeth.

At this stage only the teeth were visible. The ZOOM whitening gel was applied to all the teeth that were visible. The end of the light head was then fitted into the mouth retractor. The patient was advised not to move her head as this would disengage the light. The patient had three 15-minute whitening sessions. After each 15-minute session, the whitening gel was removed with high volume suction and further fresh whitening gel was placed on the teeth.

The patient was comfortable during the procedure and only felt slight sensitivity during the last session. A desensitising gel

"The patient was delighted with the results and couldn't believe the difference in shade from start to finish. The post-op shade was 020"

was applied at the end of the three sessions and left on for five minutes. It was then removed with the high volume suction. All barriers were removed and the patient was allowed to rinse her mouth.

The patient was delighted with the results and couldn't believe the difference in shade from start to finish. The post-operative shade was 020 and a post-op photograph was taken.

The patient was given post-op care instructions again – avoiding all coloured foods and drinks, including coloured toothpaste and mouthwashes. The patient was given desensitising toothpaste to use for the next couple of days. A courtesy call the next day was made to the patient and the patient was fine and couldn't stop smiling.

At the Kalyani dental lounge, we are more than happy with the results of the ZOOM Advanced Power Whitening System. Everything that is required to carry out the procedure comes in one simple kit. It is easy to use and the results are fabulous. The average results are seven to eight shades lighter in less than an hour. All our patients are amazed at the end of their whitening procedure. It is good to see patients leaving with a happy and big, beautiful smile that provides them with greater confidence. ■

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Laura Higgins qualified with a diploma in dental hygiene in December 2002 from Glasgow Dental School. She is a member of the British Society of Dental Hygiene and Therapy and currently works at the Kalyani Dental Lounge in Glasgow.

Fig 1
ZOOM mouth retractor in place, rolls placed in upper and lower labial sulcus

Fig 2
Face bib fixed around retractor

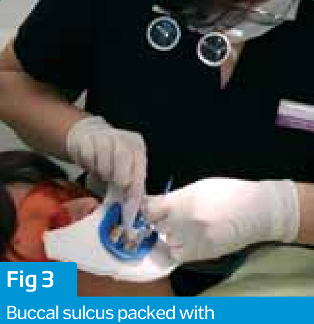

Fig 3
Buccal sulcus packed with gauze squares

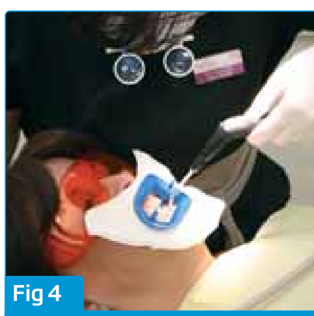

Fig 4
Suction to remove excess saliva

Fig 5
Application of Liquidam

Fig 6
Liquidam covering periodontal areas

Fig 7
Light curing

Fig 8
Whitening gel application

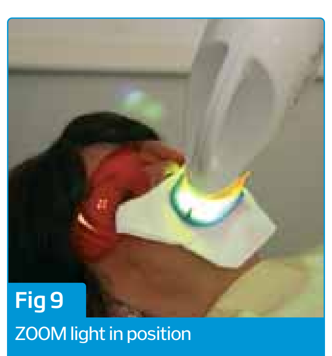

Fig 9
ZOOM light in position

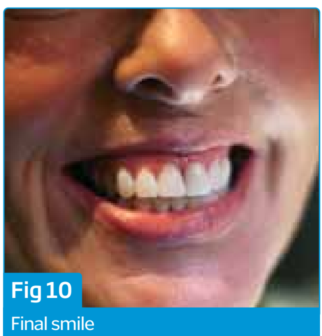

Fig 10
Final smile

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Change the way you look at things

William McLean describes his journey towards using a dental operating microscope and the benefits it has brought him in practice

Since qualifying nearly 15 years ago I have taken a somewhat atypical professional pathway. After qualifying I took up an oral surgery house job, however, this was destined to be a short appointment as I had already been awarded an Action Research (now Action Medical Research) Training Fellowship to pursue my PhD. The following five years were spent at Harvard Medical School investigating craniofacial and skeletal development.

On completing my PhD I returned from the United States to take up a position at Manchester University as a lecturer in biosciences. During this time I ran a small research group and taught undergraduate and postgraduate students. While immersed in a non-clinical academic setting I began to yearn for a return to clinical practice. I took the plunge and so began the next chapter.

The return to clinical practice was extremely exciting and, with the support of the practice owner, this transition was readily made. I was surrounded by a great team; the principal was involved in implant dentistry and another associate was developing an interest in periodontics. Both had previously been on one of Paul Tipton's courses and both had returned full of enthusiasm and new-found skills. I enrolled on the year-long restorative course.

I must say it changed the way I viewed what I do day-to-day. One of the course components was a day of endodontics. Gary Zolty was the endodontist and he was so passionate about his subject that he opened my eyes to this exciting and challenging discipline. I started to look for postgraduate courses in endodontics and in 2006 I started the simplyendo endodontic coaching programme led by Mike Horrocks.

During this time I developed a greater understanding of the biology of endodontic disease and explored contemporary endodontic techniques. In collaboration with Chester University, Mike has developed a Masters Programme in Endodontology. To date I have completed the Post-graduate Diploma in

Continued »

Continued »

Endodontology. Mike has been an inspiration; his commitment to endodontic practice and teaching is unfaltering.

I had started offering in-house endodontic referral services while practising in England and this continued after moving to Scotland. I now offer endodontic referral services to all. This includes all aspects of endodontics from first-time treatments to retreatment – including management of cases with complex anatomy, sclerosed canals, open apices, resorptive defects and removal of fractured posts and separated instruments.

We are all aware of the ever-increasing provision of implant restorations and, in the appropriate clinical situation, these are the gold standard for replacing missing teeth. It is, however, very important to recognise that the retention of a restorable tooth is still the ideal. In fact, with a large number of patients receiving bisphosphonate therapy and the concomitant risk of bisphosphonate-related osteonecrosis of the jaw, retaining borderline restorable teeth can be considered favourable[1]. Treatment outcome studies clearly show that success rates of good quality endodontic therapy can equate to that of implant restorations[2].

I recognise that retention of a tooth may not be the right choice for all patients for reasons of, for example, finance or health but what I always discuss with patients is that dental treatment is a journey, each step taking a finite time, this may be five or 15 years but each appropriate intervention delays progression to the next step with the ultimate aim of retaining natural teeth for as long as possible. However, it must be remembered that even the treatments following tooth loss have a finite lifespan and this includes implants.

Having spent much of my practising life in both NHS and private general practice, I am acutely aware of the demands that are placed upon us. We all want to provide the best level of care for our patients and ensure predictability of the treatments we offer. The diagnosis and management of endondontic pathologies are among the most challenging.

Despite a myriad of treatment systems proclaiming to be the answer to all of our endodontic needs, canal preparation and obturation in complex cases is technically demanding. When asked, Rupert Hoppenbrouwers, Head of the DDU reported that in 2008 (the most recent year for which figures have been published) endodontics represented around 19 per cent of dental claims. Endodontics also represents an increasing proportion of the claims settled by the DDU on behalf of members in recent years.

Visualisation using the DOM in a retreatment case

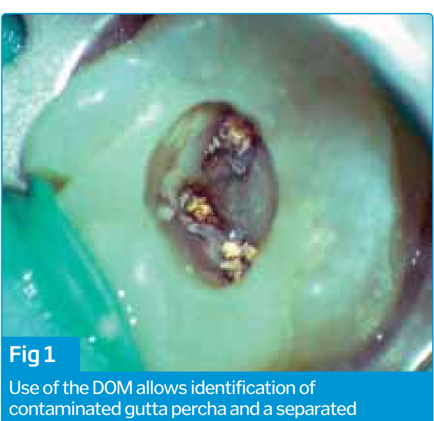

Fig 1 Use of the DOM allows identification of contaminated gutta percha and a separated instrument in the disto-buccal canal orifice

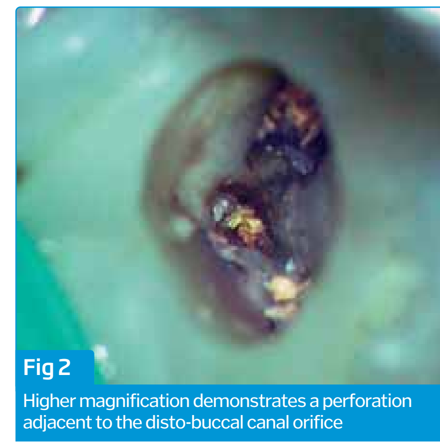

Fig 2 Higher magnification demonstrates a perforation adjacent to the disto-buccal canal orifice

Fig 3 Removal of gutta percha reveals furcation tissue through the perforation

Fig 4 Instrument retrieved

IMAGES COURTESY OF MIKE HORROCKS OF SIMPLYENDO

How do we make our endodontics as predictable as possible? Despite recent advances in endodontics, especially in preparation with the introduction of nickel-titanium rotary instruments, we still fall down if we cannot see what we are doing. The importance of magnification became apparent very early on in my endodontic training. The dental operating microscope (DOM) offers an unrivalled view.

The DOM, in its first incarnation, was introduced nearly 30 years ago. However, it was not widely accepted due to ease of use issues. It was nearly a decade later that Gary Carr developed a DOM for endodontic use that overcame the limitations of the early DOM[3]. I am sure as you read this you are thinking how one could justify the cost of a DOM. Surprisingly, it is possible to find used examples of great quality or entry level new models for only a few thousand pounds more than a set of good quality loupes. It is not a huge stretch and after just a few days of use you will soon wonder how you worked without it.

The use of the DOM in conjunction with ultrasonics and micro-endodontic instruments has revolutionised the provision of endodontic therapy. In general, magnification can be set between 4x and 24x. Due to the use of a coaxial radiating light source, shadow-free lighting is produced. The enhanced magnification and illumination allows the operator to: diagnose micro fractures and vertical fractures; gain access to the pulp chamber with greater predictability; identify and remove pulp stones and negotiate obstructions due to canal calcification.

It is possible to identify and explore anatomy that would otherwise be missed. Just a few things to consider – 93 per cent of upper first molars have a MB2[4], 60 per cent of upper second molars have a MB2[4], up to 15 per cent of lower first molars have a mid-mesial[5]. I used to joke about using the force to identify canals (too much Star Wars as a child); with magnification the force is strong. Obviously an understanding of anatomy is essential, but the operator can be guided by the simplest of things – a few bubbles in the irrigant solution or a colour change in tooth substance.

The transition to microscopic endodontics was definitely eased by years of sitting behind microscopes in my exploration of developmental systems. In general it does take time to get used to using

a DOM; treatment tends to be slower initially but, after time, one does become more efficient. I use the DOM from examination/diagnosis to completion of treatment. I sometimes return home from a day on the DOM and when I sit down with the family for dinner feel that everything on the plate seems just a little small!

It is at this point I should also highlight another massive advantage of using the scope – through improved working posture the physical impact of a day in the surgery is much reduced.

The DOM allows treatment of previously unsalvageable situations – perforation repair, retrieval of separated instruments and fractured posts. So often you are amazed at what you can see and therefore achieve. I still remember the first time I looked down to the apex of a straight root canal. It is this ability that makes the manipulation of mineral trioxide aggregate in apexification so predictable.

Just today I saw a patient who had been referred to me for removal of a separated instrument. Radiographically it was evident that the instrument had separated in the apical third of the DB canal of an upper first molar. The canal system had been obturated up to the fragment but latterly the tooth had become symptomatic. Retrieval of instruments in this portion of the canal can be challenging.

Upon access and removal of the gutta percha it became apparent that the DB canal was curved but I could visualise the top of the instrument at the point of curvature. With patience, hand files and the use of ultrasonics the fragment was retrieved. This would have been impossible without the use of the DOM. The use of this level of magnification allows the operator to perform the task with minimal collateral damage. The more tooth preserved the better the long-term prognosis.

It is a difficult to convey in writing how much the DOM has changed my practising life. It allows complete immersion in the process. A few cubic millimetres of space fills my field of view for the time I am working on a tooth. With another reference to science fiction it is my own 'Innerspace'. ■

Dr William McLean works at Care Dental Focus in Crieff. He is happy to partner with other practitioners by providing a timely referral service for their patients. For referrals, please email referrals@care-dental.co.uk or call 01764 655745.
If you would like to comment on this article you can contact William at william@mcleanendo.co.uk

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Endodontic Referrals at Care Dental Focus

Dr William McLean
BSc (Hons), BDS, PhD,
PG Dip (Endodontology)

Will's dental training has been long and varied. He graduated from the University of Wales in 1997 – BDS with Merit, after which he spent some time in an oral surgery position in Cardiff before moving to the USA to study for his PhD at Harvard Medical School.

Since returning to general practice he has completed a year-long restorative course in Manchester in 2006 and has also been awarded a Postgraduate Diploma in Endodontology from the University of Chester.

He covers all aspects of endodontic referrals including management of cases with complex anatomy, sclerosed canals, open apices and resorptive defects, management of failed orthograde root canal treatment and iatrogenic damage, removal of fractured posts and separated instruments. Within his treatments he routinely uses magnification and occasionally C.T. Scanning.

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The Centre for Advanced Dental Education (CADE) launches its first Scottish teaching experience

Implant course arrives

The directors of CADE are delighted to announce that the implant course is coming to Scotland.

Having explored several options we are very pleased to have the opportunity to build a relationship with Phil Friel using his world-class new facility. We feel that this relationship will create a long-term educational experience, bringing together some of the UK's top clinicians and technicians creating a course that will be unrivalled in Scotland and will also be one of the best in the UK.

The support we have from John Wibberley and his excellent team at Watersedge and the interaction with Nobel Biocare, the world's biggest implant company, gives us the strength and confidence to offer the very best in course quality, materials and technical support.

We firmly believe that we take our delegates on a life-long educational programme, building relationships, providing inspiration and support from day one. Moreover, we aim to give tailored mentoring access to each delegate following completion of the course. This sets us apart from our competitors as we feel that we can provide a unique and valuable learning experience.

Bob McLelland

Bob and Richard with business manager Sarah

In order to establish our popular implant course in Scotland, CADE are delighted to welcome Phil Friel. Phil will be joining the CADE team to host the implant course from his prestigious, state-of-the-art practice in Glasgow.

Phil is a highly respected and prominent dental surgeon with a wealth of experience. This will be integral to the delivery of the course and we feel that this opportunity highlights our commitment to deliver high-quality dental education and training throughout the country.

Richard Brookshaw

I am delighted to be welcoming CADE to Glasgow. Since the implant course's inception it has proven to be one of the most comprehensive implant courses available, providing interaction, practical and theoretical training and mentoring. The facilities in the clinic will support the course superbly and already the amount of interest in year one has been overwhelming. The course will provide teaching and supervision from three highly experienced individuals to build knowledge and confidence in the delegates allowing the incorporation of the exciting area of implant dentistry into their every day practice.

Phil Friel

The CADE team would like to welcome enquiries from dentists who are interested in integrating dental implantology treatments into their regular practice. CADE will be launching our latest implant year course in Scotland, based at Hyndland dental clinic, Hyndland Road, Glasgow.

This represents an excellent opportunity to attend a comprehensive year-long implant training course north of the border.

Sarah Simpson, CADE business manager

I enrolled on the course to learn about implants and get some hands-on experience on the surgical and restorative aspects of implant dentistry.

"I don't think we could have a better partner than Phil. His practice is amazing and his attention to detail superb. His clinical skills make him a pleasure to work with"

John Wibberley – Watersedge Ceramics

I chose CADE because the practical and clinical experience appeared to be much better than any other courses on offer.

Richard and Bob are fantastic teachers. It is a very relaxed atmosphere to learn in and we are always encouraged to ask questions, which are answered comprehensively. There is always a practical aspect after the theory session and there have been a lot of opportunities to attend practical implant days to put the theory into practice. The opportunity of hands-on experience has been excellent.

The CADE team are always at the end of an iPhone (or iPad), to answer any questions or queries on patient treatment plans or general implant questions. The course has been absolutely brilliant and we have been supplied with iPads which was the icing on the cake for all of us gadget freaks.

I really feel my dentistry and confidence has improved since doing the course and the reassurance that when we complete the course, we will be mentored when we place implants in practice. I would definitely recommend CADE.

A current course delegate

To find out more about the CADE implant course in Scotland email admin@theimplantcourse.com, or phone them on 0845 604 6448

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Budgeting for consistency

Despite the lack of major suprises and last-minute giveaways, George Osborne's latest Budget still has plenty to benefit the profession. Jayne Clifford delves a little deeper into the Chancellor's speech

Just as your copy of the *Scottish Dental magazine* was going to print, I was sitting watching George Osborne make his second Budget statement as Chancellor looking for new and exciting changes to flag up in this article. Gone are the days of last-minute giveaways. Instead, consistency and longer term Budget plans set out in advance have replaced sudden surprise announcements, which would leave accountants such as myself scribbling away into the night.

Of the new announcements that the Chancellor did make, there are some pleasant sweeteners that may be particularly relevant to those involved in the dental profession, whether employed or self-employed. The major point, which impacts on nearly everyone, is the £1,000 increase in the tax-free personal allowance, bringing this up to £7,475 per annum from April 2011, with a further increase to £8,105 from April 2012.

Not everyone can expect lower tax bills though – this was paid for by decreasing the threshold at which individuals start paying higher-rate tax of 40 per cent from £37,400 to £35,000 from April 2011. There are some winners and some losers as a result of the interaction of the change in this threshold, and the increase in personal allowances.

Lower earners will generally pay less tax, but those earning over £43,875 will pay more. So there is good news for some, and bad news for others.

The 50 per cent 'higher' higher-rate of tax remains in place. The Chancellor intends this to be a temporary measure, but abolition will not be forthcoming until the economic recovery looks more certain.

There is some good news for practitioners who own their own practice, or indeed a chain of practices. Entreprenuers Relief has not been withdrawn in the Budget and has in fact been increased again from £5 million to £10 million. This will benefit those dentists who have built up a network of practices and then sell these at a capital gain. The purpose of Entrepreneurs Relief is to discount the amount of Capital Gains Tax individuals pay when disposing of assets so that the effective rate of tax on the gain is 10 per cent rather than 18 per cent or 28 per cent.

The Chancellor announced a change to Inheritance Tax to encourage charitable bequests from April 2012. The new measure announced will effectively mean where at least 10 per cent of an estate is passed on to registered charities, the rate of Inheritance Tax applied will be 36 per cent rather than 40 per cent. If you bequeath 10 per cent of your estate to charity then your beneficiaries will neither gain nor lose, but charities of your choosing will gain.

"This will benefit those dentists who have built up a network of practices and then sell these at a capital gain"

Business Premises Renovation Allowance has been extended from April 2012 for five further years, taking it up to April 2017. This means expenditure on renovating buildings within designated areas of deprivation that have not been used for a year before conversion/renovation can attract an accelerated tax write-off against the whole relevant cost of the renovation project. This helps keep your tax bills much lower when renovation costs are incurred, rather than a smaller reduction in your tax liability over a longer course of time.

Areas where empty premises can attract Business Premises Renovation Allowance are designated by local authority 'wards'. In some cases, the majority of a local authority area is designated and therefore eligible (such as areas in Glasgow, Dundee, Fife and both North and South Lanarkshire).

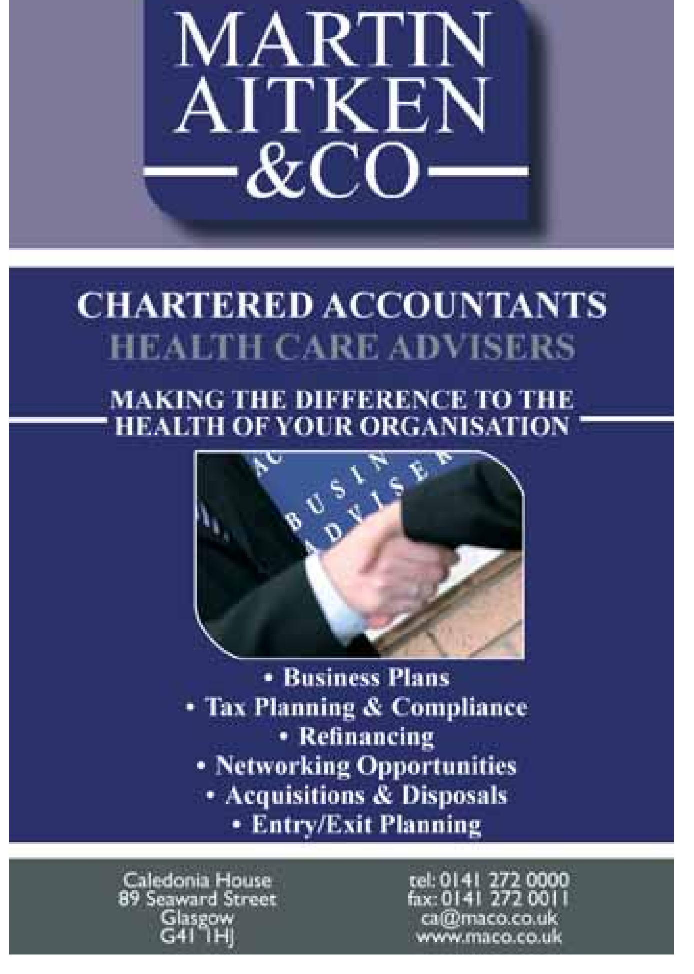
There are examples of practices relocating into eligible buildings that have been very successfully brought back into use. It is clear to see that this allowance has plenty of scope to be beneficial to dental practitioners.

"This helps keep your tax bills much lower when renovation costs are incurred"

And finally, although this is not a new announcement, I would like to take this opportunity to remind you all that 2011/12 will be the last year that Annual Investment Allowances are available at £100,000, and from April 2012 they will be restricted to £25,000. Annual Investment Allowances allow for an instant write-off of eligible plant and machinery capital investment, thus accelerating tax relief.

I recommend any practitioners who are looking to spend substantial sums upgrading their practices and/or equipment to consider whether to do this before 31 March 2012. ■

Jayne Clifford is a partner at Martin Aitken & Co. Jayne can be contacted by email at jfc@maco.co.uk or by telephone on 0141 272 0000. To find out more about Martin Aitken & Co you can visit their website at www.maco.co.uk



Share issues

Jon Drysdale, independent financial adviser and director of specialist dental financial planners PFM, considers how partnerships can adequately protect themselves

Many dentists working in partnership or trading as a limited company may not have considered the financial impact on their business and importantly on their financial dependents, if a partner dies or becomes seriously ill. By implementing some simple measures you could protect your financial dependents, yourself and the value of your business.

Case study – partnership protection

Three partners, goodwill and equipment valued at £600,000. Practice property valued at £300,000. Total value of £900,000.

One partner dies, leaving a ⅓ share of the practice and freehold to his surviving spouse, who is a non-dentist. The two surviving business partners would like to purchase the deceased business partner's share of the business and freehold from the surviving spouse. Unfortunately the two surviving business partners have substantial bank borrowings from previously financing the purchase of their own partnership shares. They also have significant borrowings relating to personal residential mortgages. Their partnership agreement doesn't clearly state how the business should be valued.

From the surviving business partners' point of view:

1. Due to the recent banking crisis they struggle to raise the £300,000 required to purchase the deceased partner's share at a competitive rate. Their own retirement plans haven't allowed for the costly repayment of the additional loan.
2. They can't find a suitable successor (internal or external) who has the financial means to 'buy into' the partnership.
3. There may be a suitable successor but a 'fair value' cannot be agreed with the deceased partner's spouse as there is no provision for this in the partnership agreement.

4. The deceased partner's spouse agrees to sell the newly acquired share to an external third party. As the partnership agreement doesn't cover this eventuality, the surviving business partners are powerless to stop this.
5. Due to probate there is a delay of 12 months before the surviving spouse is able to sell their inherited share. The partnership agreement does not give any guidance on how the practice should be valued. As a result of this valuation the surviving spouse expects the surviving business partners to pay more than they feel is fair value.

From the surviving spouse's point of view:

1. The surviving spouse and surviving business partners dispute the value of the practice and can't agree a sale price.
2. Due to probate the sale of the newly-acquired share is delayed by 12 months. Unfortunately the surviving spouse is reliant on this capital for income and has to make alternative arrangements.
3. The surviving business partners can't raise the finance required to purchase the deceased's share of the practice. The surviving spouse has no option but to accept a lower price or enter complex negotiations with a third party, incurring legal costs and further delay.

The solution

1. A life policy written under trust is taken out by each partner as follows:

Life assured	Sum assured	Trust Beneficiaries
Partner A	£300,000	Partner B and C
Partner B	£300,000	Partner A and C
Partner C	£300,000	Partner A and B

On the death of any partner the surviving business partners benefit by a tax-free amount of £300,000.

2. A cross-option agreement is signed by all three partners. This means if the surviving partners offer to buy the deceased partner's share the surviving spouse must sell. If the surviving spouse wishes to sell the surviving business partners must buy.
3. The partnership agreement is revised to include reference to the cross option agreement, binding all three business partners to its effect.

Critical illness cover can be added to this arrangement, ensuring that the practice and partners are protected in the event that a partner becomes seriously ill.

These simple measures ensure that the practice can continue to operate without the distraction of a legal dispute, or the uncertainty and cost of raising finance. Importantly all partners will have peace of mind that their financial dependents have been adequately protected. ■

PFM offer independent financial advice exclusively for dentists and dental Partnerships/ Limited Companies. Visit www.pfmdental.co.uk for more information or call 01904 670820 to review your partnership protection requirements. PFM also offer a practice valuation service across Scotland, England and Wales.

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Scottish tutors (Aberdeen) Jacqueline Fergus and George Glover both hold a Master of Science in Implant Dentistry and are experienced GIFT regional tutors and mentors running courses from their state of the art facility in Aberdeen.

For further information on Gift Continuum, visit www.gift.org.gg

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Membership information from
www.dentalprotection.org

Prevent needle stick injuries with Ultra Safety Plus

For any dental professional dealing with needles one of the biggest safety risks is contracting a blood borne virus through a needle stick injury.

Septodont, a global leader in dental pharmaceuticals and the UK's number one manufacturer of dental anaesthetics, has developed the Ultra Safety Plus System to address this problem.

Indicated for the routine administration of local anaesthetics, the sterile, single use, aspirating syringe system comes equipped with a needle stick injury prevention device.

The Ultra Safety Plus range includes 27g short, 27g long, 30g short and 30g ultra short needles making it a not only safe but versatile choice.

For more information, visit www.septodont.co.uk or call 01622 695 520.

Safe and effective biofilm removal for dental unit water lines

Biofilm has long been an issue in terms of the contamination of dental unit water lines caused because, in the majority of today's most commonly used treatment centres, water is delivered via narrow bore tubing, providing an ideal environment for the development of biofilm.

NEW Bioclear is a simple once-a-week treatment that has proven efficacy against the bacteria that make up biofilm, inhibiting re-growth of the film and enabling the maintenance of water quality of <200 cfu/ml. Bioclear is water-based, odourless, alcohol-free and pH neutral and is easy to use; available in 200ml one-dose bottles, enough to treat a single chair for a week.

Bioclear is just one of a range of infection control products from Dentisan, whose full range is available from Henry Schein Minerva. Its field sales consultants are now conducting free water tests to determine the levels of biofilm contamination in your input and output water.

Call 08700 10 20 43 or visit dentisan.co.uk for a free water test.

New UnoDent Etch 'n' Bond ONE!

The Dental Directory is pleased to announce a new addition to the UnoDent range, Etch 'n' Bond ONE. UnoDent is the quality value-for-money range exclusively available from The Dental Directory.

UnoDent Etch 'n' Bond ONE is a light curing, single component, self etching bonding agent for use in the adhesive restorative technique. With a long lasting bond to enamel and dentine, UnoDent Etch 'n' Bond ONE is fluoride-releasing and has a low pH level of 1.4. Available in 5ml bottles, the new UnoDent Etch 'n' Bond ONE is easy to apply and will ensure you save time on your patient restorations.

For the latest prices and to order, quote product code FBD 095 and call 0800 585 586 or visit www.dental-directory.co.uk

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Oral-B Scientific Exchange Seminars for Dentists, Hygienists and Therapists*

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Periodontal Medicine – a window on the internal medicine of the body

Professor Nicola West
New concepts in tooth wear and dentine sensitivity management!

Professor Trevor Burke
A pragmatic approach to the treatment of tooth wear

16 February 2011 - Torquay, Imperial Hotel
Professor Chapple and Professor West

8 March 2011 - Sheffield, Kenwood Hall
Professor Chapple and Professor West

10 March 2011 - Birmingham, The National Motorcycle Museum
Professor Chapple and Professor Burke

31 March 2011 - Reading, Hilton Hotel
Professor Chapple and Professor Burke

7 April 2011 - Cardiff, St David's Hotel
Professor Chapple and Professor West

14 April 2011 - Warrington, The Park Royal Hotel
Professor Chapple and Professor Burke

5 May 2011 - Newcastle, Life Centre
Professor Chapple and Professor Burke

12 May 2011 - London, The Royal College of Physicians
Professor Chapple and Professor West

23 June 2011 - Glasgow, The Hilton Hotel, Strathclyde
Professor Chapple and Professor West

30 June 2011 - Milton Keynes, Horwood House
Professor Chapple and Professor West

Registration/ Buffet from 6pm with the first lecture beginning at 7pm.
The event will close at 9.30pm.

How to register

Please e-mail the information opposite to the Event Organiser, Julia Fish (julia@ab-communications.com) who will send you a confirmation by email within five working days.

- Your name & position held
- Your contact telephone number
- Name(s) & position(s) of other delegates attending
- Your practice postal address

*Oral-B offer free CPD support to all. Other members of the dental team can gain three hours of free verifiable CPD by requesting a copy of 'Dental Summary Review – Team Issue'. You can get these from your local representative. If you're unsure who your representative is, please call 0870-2421850.

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Product news

New infection prevention products in UnoDent and Classic ranges

The Dental Directory is pleased to announce new additions to the infection control products within the UnoDent and Classic ranges.

- Classic Touch-Free Auto Dispenser (GHC 030) – Holds 650ml pouches of Surgical Hand Scrub (GHC 035), Pink Hand Gel (GHC 040) or Hand Soap (GHC 045) for touch-free hand sanitisation.
- Classic Automatic Paper Towel Dispenser (CAU 080) – sensor-controlled to prevent cross contamination.
- UnoDent Green Heavy Duty Nitrile Gloves (CGS 200-215) – latex-free and available in small to extra large sizes.
- UnoDent Long Handled Scrubbing Brush (CGS 220) – fully autoclavable and perfect for instrument cleaning.
- Classic Alcohol Free Hard Surface Disinfectant with Detergent – available in 1L bottle (GSC 335), 5L Refill (GSC 336) and in packs of 80 wipes (CAW 660), 330mm x 220mm.

For further information, please call 0800 585 586 or visit www.dental-directory.co.uk

DENTAL STOCK X-CHANGE

Boost your budget with the Dental Stock X-Change

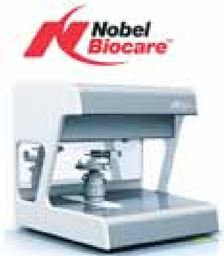
The Dental Stock X-Change is the UK's first online marketplace exclusively for dental professionals and provides dentists, dental students, technicians and nurses, practice managers and veterinary dentists with a way to buy and sell products without having to wade through thousands of listings of irrelevant, non-dental stock.

If you feel, like many others, that you would be happier buying new materials and equipment if you could make some return on your old stock, then the Dental Stock X-Change is the solution.

In addition to being a great way to finance new purchases, the Dental Stock X-Change helps you to help the Earth, by giving you a way to recycle redundant materials and equipment, without having to send it to one of the UK's many, methane-producing landfill sites!

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

Perfect restorations with NobelProcera



NobelProcera is an easy to use, practical system by Nobel Biocare, designed to help practitioners save time when creating dental prosthetics in the dental practice.

Using the very best in CAD/CAM technology with excellent visuals, NobelProcera enables the dental practitioner to produce perfect restorations. Unique, patented scanning technology (conoscopic holography) allows for highly precise data acquisition.

The system has been designed with intuitive navigation in mind and boasts a number of useful tools such as an anatomic tooth library, automatic cut-back functions and automatic setting of the finish line.

For more information on the benefits of NobelProcera, please call 0208 756 3300 or visit www.nobelbiocare.com

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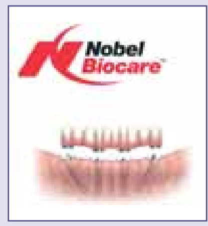

The prospect of temporarily wearing a denture during the healing process is another factor that may influence treatment uptake. However, with Nobel Biocare's All-on-4 system, this no longer has to be a concern.

The All-on-4 system uses four implants placed at an angle to ensure a secure support for a prosthetic bridge, making it ideal for patients who wear dentures, are edentulous, or have terminal dentition due to periodontal disease or caries.

Nobel Biocare's All-on-4 technique was developed to maximise the use of available bone, allowing practitioners to fit a fixed bridge on the same day as extraction.

For further information, call Nobel Biocare on 020 875 633 00, or visit www.nobelbiocare.com

Reassuringly simple

The Vistascan digital scanner comes with the reassurance of an optional four-year warranty; evidence of Durr Dental's absolute confidence in the quality and reliability of its product.

But what happens if a problem does arise? Practitioners can be further comforted in the knowledge that software problems can often be quickly diagnosed and resolved without the need for an engineer to set foot in the practice.

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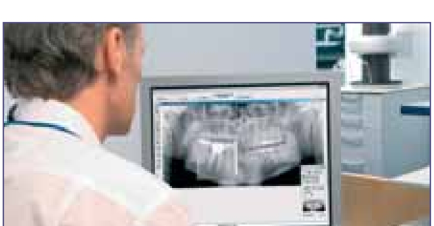
For more information, call Durr Dental on 01536 526740.



Orascoptic UK launch the Freedom 'cordless' LED light system

Orascoptic has developed the industry's first light system that does not employ belt-packs, long electrical cables or buttons.

Lightweight battery pods connect to the temple arms of the loupe and are compatible with 95 per cent of all TTL frames on the market. A unique mounting clip securely fastens the headlight to 95 per cent of the TTL frames on the market.

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Product news

Nitram Dental launches new portal about good hygiene

Nitram Dental is making it easier for dentists all over the world to provide their patients with the highest standards of hygiene and, at the same time, run a stream-lined business operation.

The key to this win-win situation is the relaunch of the nitramdental.com website, which presents detailed information about the company's flagship product – the DAC Universal combination autoclave – that cleans, lubricates and sterilises handpieces and turbines automatically.

The new portal also contains plenty of technical information and demonstration films about the new DAC Universal, which is made in Denmark.

For more information, call +45 87439060, or email ld@nitramdental.com

If you've got it, go for it

It's not very British to shout about one's achievements but The Elite Practice Awards are a little different. We're not looking just at aesthetics or flamboyant marketing campaigns, but at those practices that make a real difference to their patients' lives.

So if you believe you go the extra mile, then enter! The winners will be showcased later in the year so that others can learn from their example.

These events are free to enter and all you need to do is visit www.elitepracticeawards.com or email entry@elitepracticeawards.com to request an entry form.

Accompanying your form should be a selection of photographs and any material that you think would demonstrate how you and your team consistently exceed expectations.

But you're going to have to hurry as the closing date for entries is 29 April. The Elite Practice Awards are supported by Click Dental, Denplan, Oral-B, Paradigm Design and Roland Dental Solution.

Johnson & Johnson, stand C25 at the BDA Conference

A warm welcome awaits DCPs and dentists visiting the Johnson & Johnson Listerine display stand C25 at the BDA Conference in Manchester on 19-21 May.

This is a very good opportunity for the whole dental team to learn more about the role of mouthwash in oral hygiene and to experience Listerine mouthwashes which are available to try at the rinsing booth on the stand.

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*Patented in Germany, further patents pending.
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Can so much really be true of one toothpaste?

Oral-B's all-in-one Pro-Expert toothpaste is about to be launched in the UK, bringing an innovative and comprehensive range of oral health benefits.

The innovation of Oral-B Pro-Expert toothpaste lies in the synergy of the combination of the two main ingredients. They provide the united strengths of stannous fluoride's antimicrobial properties and polyphosphate as a gentle cleaning agent to inhibit calculus and stains.

The therapeutic advantages of Oral-B Pro-Expert toothpaste are also supported by years of research and development.

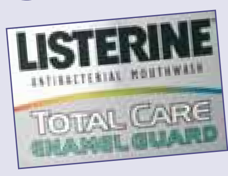
Determined research wins the day

Newly launched Oral-B Pro-Expert toothpaste provides its extensive health benefits with the joint heritage of two-company backing (Procter & Gamble and Oral-B) with decades of steady research and clinical development.

The all-in-one Oral-B Pro-Expert toothpaste derives its deliverable benefits against gum problems, plaque, caries, calculus formation, dentinal hypersensitivity, staining and bad breath from the evolution of its two main active ingredients; stabilised stannous fluoride and polyphosphate.

Stannous fluoride is an effective antimicrobial, delivering plaque control and anti-caries benefits as well as dentinal hypersensitivity relief, while polyphosphate protects against calculus formation, staining and bad breath.

Orthodontics – the hygiene challenge



It is well recognised that fixed orthodontic appliances are considered to be a clinical risk factor for demineralisation of enamel because of plaque accumulation around the bracket base.

It has been suggested by many researchers that if preventive measures are followed and maintained throughout the course of orthodontic treatment, then the number of white spot lesions may be reduced.

Consideration should be given to using an essential oil mouthwash such as Listerine Total Care. Mouthwashes have the advantage that their antimicrobial activity can access hard to reach areas.

For more information, please contact Johnson & Johnson on 0800 328 0750.

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Oral-B signs TV's dental expert, Dr James Russell

Oral-B, the UK's leading oral healthcare brand, is delighted to announce that Dr James Russell, from Channel 4's 'Embarrassing Bodies', will be representing the brand as an ambassador. Dr James Russell will work alongside the experts at Oral-B to highlight the importance of maintaining good oral health.

Dr James Russell is the youngest of only eight dentists in the country to be awarded accreditation with the British Academy of Cosmetic Dentistry (BACD) and is regularly featured in the media. He is the resident dentist on Channel 4's Embarrassing Bodies, where he offers expert opinion and advice on oral hygiene and health.

For more information on Oral-B's range of power brushes, please contact Georgina Dawson at georgina.dawson@ketchumpleon.com 0207 611 3565 or Sophie Hynes at sophie.hynes@ketchumpleon.com 0207 611 3578.

Philips launches world first

BDA Conference delegates will be able to witness the unveiling of a world innovation in oral health on the Philips stand (C16).

The new product is not a toothbrush, but it is an innovation from Philips' immediate field of competence in oral healthcare and bio-film management of dental plaque.

Philips will also be announcing ground-breaking developments to the Sonicare sonic toothbrush range which will take brushing upscale to an altogether more sophisticated level.

As well as launching not one but two new Sonicare products at the BDA, Philips, is also presenting the full suite of current Sonicare toothbrushes.

The newest innovation in interproximal cleaning

Philips, maker of the Sonicare toothbrush, is pleased to unveil the Philips Sonicare AirFloss, an easier way to clean between teeth.

Dental professionals often struggle to get patients to floss on a regular basis and the Sonicare AirFloss, with its breakthrough microburst technology, has been specially designed to address this problem by increasing ease of use while maximising interdental plaque removal and ultimately improving gum health. During Philips consumer testing, 86 per cent of patients found Sonicare AirFloss easier to use than floss and Sonicare AirFloss removes up to 99 per cent more plaque in-between teeth than manual brushing.

"We understand the struggle that many dental practitioners experience in getting patients to regularly clean between their teeth," says Erik Hollander, Senior Marketing Director at Philips Consumer Lifestyle.

Featuring, powerful performance and LED for **all** connections

Many practitioners are already experiencing the powerful benefits of LED using NSK LED couplings for NSK, KaVo® and Sirona®, now Ti-Max X Series turbines and S-Max turbines with integral LED are available from NSK for both W&H® and Bien-Air®.

NSK's premium Ti-Max X Series turbines are available in 3 head sizes* and feature a Dual Air Jet turbine that makes the X700L the most powerful turbine on the market. Compatible with all major manufacturers' couplings the sleek, titanium body of the Ti-Max X Series is a stylish yet durable addition to any surgery set-up.

The S-Max M range has the same ceramic bearings, clean head system and cellular glass optics as the Ti-Max, but in a slim stainless steel body that is comfortable to hold and use.

The option of LED across the NSK range makes daylight equivalent illumination available to all practitioners, improving visibility and enhancing treatment but generating less heat than a traditional halogen light.

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Arshad Ali

Arshad Ali BDS, FDSRCS (Eng & Edin), FDSRCPS (Glasg), DRD, MRD,RCS (Edin)
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Clinical Director and Managing Director, Scottish Centre for Excellence in Dentistry

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