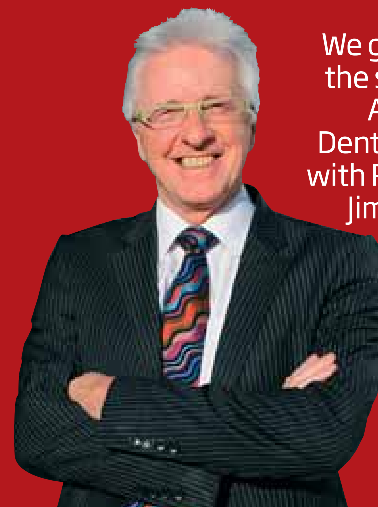
The magazine for dental professionals working in Scotland
October/November 2010

Scottish Dental magazine



We go behind the scenes at Aberdeen Dental School with Professor Jim Newton **Page 27**

GOVERNMENT WITHDRAWS GUIDANCE

Pressure from the BDA leads to a new PCA being issued for the new NHS regs **Page 9**

GETTING THE WHOLE STORY

Stewart Wright explains about his holistic approach to treating patients **Page 34**

THE PERILS OF PERIODONTITIS

Examining the treatment options for high-risk periodontal sites **Page 42**

Sticks and stones

An innovative charity set up by three dental professionals aims to spread the word that violence is preventable **Page 20**

DID YOU KNOW? Your Scottish Dental magazine is now available online with new and exclusive content **PLUS** regular news updates

BOOKMARK THIS LINK TODAY...
www.scottishdentalmag.co.uk

Me & Henry Schein

"We pride ourselves on being much more than "order takers", we like to think our clients see us as part of their external support mechanism, people who can help develop their practice by offering a service which is ongoing and business related."

Joanne Robertson
Henry Schein Minerva Field Sales Consultant

Partnership in Practice

Visit us at **Stand H13**
BDTA Dental Showcase 2010

growth@henryschein.co.uk
www.henryschein.co.uk

Practice Software
Business Solutions
Dental Innovations
Consultancy Services
Education & Development
Surgery Design & Installation
Best Value Dental Consumables

Henry Schein Minerva Dental Centurion Close Gillingham Kent ME8 0SB
08700 10 20 43

HENRY SCHEIN®
MINERVA DENTAL

London Cardiff Glasgow Belfast

Welcome

Editor's desk

with Bruce Oxley

Coming together to change lives

Christine Goodall and John Carnochan have seen more their fair share of violence and violent behaviour in their respective careers.

As an oral surgeon, Christine has stitched up and set the bones of thousands of victims of violence, many of whom are young men under the influence of alcohol.

And, as head of Strathclyde Police's Violence Reduction Unit (VRU), as well as in his previous postings in the force, Detective Chief Superintendent John Carnochan has seen first-hand the victims and perpetrators of countless instances of violence.

The idea that violence in our communities is a public health issue and not just a matter for the police, the courts, or any one individual authority, led in part to the formation of both the VRU and Medics Against Violence (MAV), a charity set up by Christine and two maxillo-facial surgeon colleagues.

An estimated £4.5 million is spent every year in the west of Scotland treating victims of serious facial injuries. In response, Christine and her colleagues decided that they would try to do something in an attempt to stop the violence before it happens.

The charity has now given presentations to more than 5,000 pupils in high schools across Scotland and they are only just beginning. They are looking to recruit more medical and dental professionals to help them spread their message and reach as many children in as many parts of the country as possible.

MAV doesn't currently have any general dentists on their books but they are keen to recruit GDPs and DCPs to help them show children that a life of violence is no life at all. ■

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

Contents

October/November 2010

NEWS>
06 Dentists to help spot domestic abuse
08 Registrations rise, but access issues remain
09 Government withdraws guidance

FEATURES>
20 Medics Against Violence
27 Aberdeen Dental School
34 Interview: Stewart Wright

CLINICAL>
42 Periodontal regeneration techniques
44 Removal of the dental biofilm

FINANCIAL>
40 Tax relief
69 Buying advice

CONTACT CLAIRE WALSH AT: clairewalshbds@aol.com

Biting back

with Claire Walsh

Only time will tell how well new regulations will bed in, but on the bright side the lot of the dentist north of the border appears better in many ways than those in England

Life in the fast lane...

Sad to say, this will be my last column for the *Scottish Dental magazine*. It's still a relatively new publication, and I hate to let the editor down, but my commitments are getting heavier and time is getting tighter, so something has to give. So here I am again on my second farewell tour – I'm almost as bad as The Eagles, but this is definitely my last tour of duty!

As we edge nearer to 2011, where are we just now, as Scottish dentists?

We have new regs, which are still bedding in, and time will tell how "user-friendly" they are, particularly in relation to corporate bodies. We have had lifetime registration for a few months, and I haven't heard of practices collapsing under the weight of patients...so maybe this is working out better than we initially feared?

We have a practice support manual from NHS Education for Scotland (NES) – I must confess I only had a quick look, but it seems a welcome addition to the guidance available. On the downside, NES now charge for section 63 courses, but given the amount, I don't think we can moan too much about it.

"We have had lifetime registration for a few months, and I haven't heard of practices collapsing under the weight of patients"

One thing we don't have to worry about is the Care Quality Commission (CQC), which English dentists are trying to get to grips with right now. We do have a Care Commission, which will focus its attention on private dental practices, so this is a much smaller exercise than our English chums.

Our GDS system is fairer in many respects than the UDA system, which effectively discourages dentists from planning a course of treatment for a high-need patient. Our system is not perfect, but at least you feel that you are paid a fee for every item you carry out.

Grants and allowances are available, and we get paid to carry out clinical audit, unlike our neighbours who are expected to carry it out as part of their contract. Mind you, it looks like their contract will be changing again in the next three or four years, so they will all be demented with it.

Scottish dentists are not under the same threat of legal action as English dentists, and for this we can be very grateful – and we can only hope it stays that way!

So, where would you rather practice dentistry? I know what I would say!

I'm sure I'm not the only person out there with opinions on Scottish dentistry, so if you want to be heard, let off steam, or share your experiences, think about writing a column. I have contributed off and on for many years and have enjoyed it. Don't worry if you aren't another Wordsworth – editors can work wonders!

All the best, and don't work too hard. ■

If you are interested in writing for Scottish Dental magazine, contact the editor at bruce@connectcommunications.co.uk or by phoning 0141 560 3050.

DETAILS AND CONTRIBUTORS

Editor
Bruce Oxley
Tel: 0141 560 3050
bruce@connectcommunications.co.uk

Senior sub-editor
Wendy Fenemore

Sub-editors:
Gary Atkinson, Jim Byers, Penny Murray

Design and production
Renny Hutchison, Mark Davies, Paul McGinnity

Sales manager
Ann Craib
Tel: 0141 560 3021
ann@connectcommunications.co.uk

Subscriptions
Ann Craib
Tel: 0141 560 3021
ann@connectcommunications.co.uk

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

The copyright in all articles published in *Scottish Dental magazine* is reserved, and as such articles may not be reproduced without permission. Neither the publishers nor the editor necessarily agree with views expressed in the magazine. ISSN 2042-9762

Scottish Dental magazine is published by connect publications
Studio 2001, Mile End, Paisley PA1 1JS
Tel: 0141 561 0300
Fax: 0141 561 0400
www.scottishdentalmag.co.uk

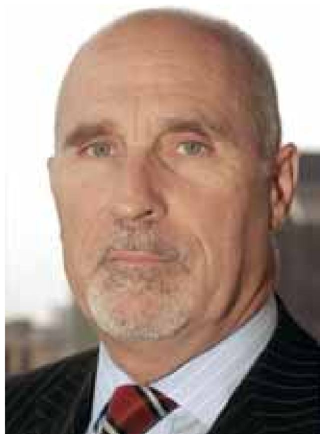
"The violence is not for any purpose, they are just being violent for the sake of it" PAGE 20

Dentists to help spot domestic abuse

DOMESTIC VIOLENCE INITIATIVE

A domestic violence initiative aimed at giving dentists the skills to spot abuse and point victims to where they can get help is being trialled in Ayrshire.

The initiative is the brainchild of Strathclyde Police's Violence Reduction Unit (VRU) and Medics Against Violence (MAV), a charity set up by three oral surgeons at Glasgow Dental Hospital.



It will initially take the form of a CPD programme and, if successful, will be rolled out nationwide and potentially included in the undergraduate programme at Scotland's dental schools.

Christine Goodall, oral surgeon at Glasgow Dental Hospital and one of the co-founders of MAV, said: "Dentists will see women and men who have suffered injuries at the hands of their partners. We know that the majority of victims of domestic violence will suffer injuries to the head and neck, so dentists are actually quite likely to see these people first as broken teeth will also be a big part of that."

Christine explained that all the initiative is aiming to do is give dentists the skills and confidence to broach the subject. "We are not expecting them to do a lot," she continued. "We are just expecting them to ask a question and show concern for the person. That has been shown in studies in America to be something that will motivate people to seek help. If a health professional has expressed concern about them, then they are more likely to go and seek help."

Detective Chief Superintendent John Carnochan (pictured left), head of the VRU, said: "We know that domestic abuse is very under-reported. We have to be far more audacious about how we help people. We can't force help upon them, but we have to make sure they know that you don't necessarily have to report it to police, and there are other avenues to get help."

To find out more about Medics Against Violence, turn to page 20 for our feature article on the ground-breaking new charity.

Dundee dental student events

Students at Dundee Dental School are holding an oral cancer awareness week from 15-19 November at the University of Dundee to highlight the danger of this disease. The week will also raise funds for the Ben Walton Trust – a charity which campaigns for greater awareness of oral cancer in young people, as early detection can lead to a significantly improved survival rate.

Fifth-year dental student Andy Kinnear said: "We'll be holding a lot of different events including carbon monoxide testing, alcohol measuring and other interactive oral cancer awareness activities. Plus we will be giving out questionnaires to gauge awareness and leaflets telling people about the disease and what symptoms to look out for."

"We'll be holding a lot of different events throughout the week including carbon monoxide testing and other interactive oral cancer awareness activities"

The week ends with a ceilidh at the Student Union which is sponsored by GlaxoSmithKline and Joe and Wendy Jackson of Pearl White Dental Laboratory, whose daughter is a fifth-year dentistry student at the School.

For more information email Andy Kinnear at a.z.kinnear @dundee.ac.uk or visit www.benwaltontrust.org

Shock over illegal denture clinics

ILLEGAL PRACTICES

A clinical dental technician (CDT) from Fife has revealed his shock at the number of patients he has seen who have previously visited illegal denture clinics.

Rob Leggett, who works at the International Smiles clinic in Burntisland, explained that they have seen dozens of patients whose dentures were made by clinics and CDTs not registered with the General Dental Council (GDC).

Rob, who qualified as a CDT along with his colleague Alan Petrie at the end of last year, said: "It has come as quite a shock. I don't know if it is because the patient has been unable to get registered with a dentist, so they have gone to an illegal practice.

"The quality of the dentures does vary to be honest, some are absolutely awful but some are actually quite good.

"My colleague Alan said to one of his patients who had been to an illegal practice: 'Why would you risk your oral health to go to someone you know is illegal?' Her reply was that she was so desperate that she would have gone anywhere."

Interim Chief Executive and Registrar of the GDC Ian Todd said: "Anyone who works as a dental professional without being registered risks serious repercussions. The recent series of successful prosecutions demonstrates that we are committed to prosecuting in every appropriate case."

So far in 2010, the GDC has successfully prosecuted 10 cases of illegal practice.

Opalite©

Crowns & Bridges

Opalite© is breaking the boundaries. It is the first, cost-effective All-Zirconia, completely digitally created, crowns & bridges. Only available from DTS.

Opalite© is indicated for the posterior region and is milled from one solid block of monolithic, medical grade Zirconia so it is virtually unbreakable. With a final flexural strength of 1100MPa it is undoubtedly one of the most reliable materials around and now you can enjoy its aesthetics as well. DTS has worked with some of the leading dental manufacturers across the globe to develop a more translucent Zirconia so there is no need for a porcelain overlay. Your patient gets the aesthetics they want with the strength they need.

Opalite© is available for **just £79 per unit – order yours today!**

DTS

DTS Dental Laboratory
8 Annfield Place, Duke Street, Glasgow, Scotland G31 2XQ
Tel. +44 141 556 5619 Fax. +44 141 551 9162
dts@dts-international.com www.dts-international.com

Visit **www.dts-international.com/opalite** to find out more

| Practice news p18 | Interview p34 | New products p73

Call for views on education

The General Dental Council (GDC) wants to hear views on a fresh approach to dental education.

It is developing new learning outcomes for qualifications that lead to registration with the GDC. The focus is on creating an up-to-date publication aimed at delivering better results for patients and the dental team.

It's proposed that the publication will replace the dentists' curriculum 'The First Five Years' and the dental care professional curricula 'Developing the Dental Team'.

The GDC is launching a consultation on the publication called 'Learning Outcomes'.

Chair of the Education Committee Kevin O'Brien said: "It's very important we hear from people involved in all areas of dentistry.

"The outcomes that have been produced are intended to reflect the knowledge, skills, attitudes and behaviours the registrant must have to practise safely, effectively and professionally.

The aim is to develop a rounded professional who, as well as being a competent clinician or technician, will have the skills to begin working as part of a dental team and be well prepared for independent practice."

The consultation went live on 13 September and will close on 3 December. It can be found at www.gdc-uk.org

Registrations rise, but access issues remain

DENTAL REGISTRATIONS

New statistics on dental registrations in Scotland have produced a mixed response from the Scottish Government and the profession.

Public health minister Shona Robison said: "I am pleased that there have been increases in both child and adult dental registrations in the last quarter.

"However, we know there are still problems with access to an NHS dentist in certain parts of Scotland and we are continuing to tackle this.

"Last year we announced capital funding of £82m...most of which will be used for the development of NHS dental services.

"Our latest figures show there are record numbers of dentists working in NHSScotland and I expect this to result in improved access to dentistry across Scotland."

But the British Dental Association (BDA) suggested that the registration figures don't tell the full story.

Robert Donald (pictured) of the BDA's Scottish Dental Practice Committee said: "As the Scottish Government has acknowledged, recent estimates of the number of individuals registered with NHS dentists in Scotland have included deceased and duplicated patients.

"Although work to remove duplicate patient records has begun, some patient records are not matched to Community Health Index numbers. Until they are, it will be impossible to have complete confidence that the registration figures are robust.

"A second issue is raised by the introduction of lifelong registration. This step means that the significant number of patients who are registered, but not actually visiting a dentist, will also be included in these figures.

Our understanding is that almost a quarter of a million individuals in today's statistics haven't visited their dentist during the last three years.

"What makes a difference to the nation's oral health isn't the number of people who can theoretically access a dentist; it's how many actually do."

The statistics are available at: www.isdscotland.org/isd/6375.html

Against all the odds

AWARD

Five years of orthodontic treatment has earned a teenager the British Orthodontic Society's Against the Odds Award for 2010.

Eva Hulme was 11 when she started her treatment at the Lakeside Clinic in West Kirby, Wirral.

She suffered humiliation because of her teeth and was bullied throughout both primary and secondary school.

Despite several years of corrective care, her upper front teeth protruded at an angle of 44 degrees, 11 mm in front of her lower teeth, and her appearance wasn't helped by her extremely short upper lip, which meant her gums were always visible.

Now 16, this young woman's journey to achieving a smile that has turned her life around has won her first prize in the national competition.

Above: Eva Hulme, now 16, started treatment when she was 11

Eva was treated by Dr Jonty Meisner, who is principal orthodontist at Lakeside Orthodontics in West Kirby. She won £750 worth of travel vouchers thanks to the support for the competition from SDS Ormco, while Dr Meisner was awarded a trophy at the British Orthodontic Society's annual conference in Brighton in September.

Jungle Jim heads for the Amazon

An Aberdeen GDP is heading off to South America next month in order to help provide much-needed healthcare for remote communities along the Amazon river.

Jim Donaldson, who is also the president of the Dental Practitioners Association, will be travelling to Peru with the Vine Trust to work with marginalised communities in the Peruvian Andes.

Jim Donaldson

The Vine Trust is an international interdenominational charity started in 1985 in response to the famine in Ethiopia and the Sudan. In 2001 the charity sent an ex-Royal Navy fleet tender to Peru and now the project delivers a basic health service for around 160,000 people.

If you are interested in supporting the Vine Trust, Jim has a page at www.justgiving.com where you can donate.

If you would like to find out more about travelling to Peru with the charity, phone 01875 812 252, or email health@vinetrust.org

Government withdraws guidance

Dr Robert Kinloch

NHS REGULATIONS

The Scottish Government has been forced to issue revised guidance for the new GDS regulations following emergency consultations with the British Dental Association (BDA).

The NHS (General Dental Services) (Scotland) Regulations 2010 were only introduced on 2 July but it has been revealed that the guidance notes issued alongside contained a number of discrepancies.

The government had stated in PCA(D)(2010)(4) and PCA(D)(2010)(6) that dental associates would not be able to establish associateship agreements with listed dental bodies corporate (DBC). However, this was inconsistent with the regulations themselves, which stated that dentists would be able to establish such agreements with DBCs.

In response to meetings between the BDA and the Scottish Government Health Directorate, a new guidance document was issued on 24 September that superseded the previous PCAs.

Robert Kinloch, chairman of the Scottish Dental Practice Committee, said: "We are pleased to see this issue resolved by the publication of revised guidance. We are glad to see that our concerns have been recognised and acted on."

A Scottish Government spokesman said: "After the original PCA was issued, a number of questions were put forward by the profession on the topic of listing of dental bodies corporate and this circular provides further clarification on this."

United in their independence

The Unite Convention returned to Scotland this year after previous outings in Bruges, Amsterdam and Palma.

The biennial event run by Independent Care Plans UK and incorporating all the independent dental groups of Scotland was held at the Turnberry Resort in Ayrshire in September.

The convention saw 31 delegates and organisers from around Scotland come together for a weekend of lectures and socialising – including a golf tournament and a trip to the nearby Culzean Castle.

The delegates were piped into Culzean Castle

Raj Rattan gave presentations on the Friday and Saturday focusing on how to keep your patients for life, creating a 'wow factor' and improving communications.

A model service

We help you connect with employees, members or customers.

We're Scotland's top creative communications company and we know how to marry content and design to produce high-quality, affordable print and multi-media solutions.

0141 561 0300
www.connectcommunications.co.uk

connect
creative communications

Dentist falls foul of language rules

SUSPENSION

A dentist from Dumfries has been suspended by the health board for failing to prove he has the required standard of English language skills to practise.

Onofrio Antonino Brancato, who qualified in Bologna, Italy, in 1985, is thought to be the first dentist to fall foul of the new NHS regulations that came into force on 2 July.

NHS Dumfries and Galloway suspended Brancato, who works at the DADDS dental surgery in the town, meaning that he will be unable to undertake NHS work until a formal hearing is convened.

A spokesman from the health board said: "In accordance with the National Health Service (General Dental Services) (Scotland) Regulations 2010, Dumfries and Galloway health board has taken the decision to suspend a general dental practitioner from providing general dental services. This suspension is on the grounds that the practitioner has not been able to provide evidence of his attainment of the required standard of English language skills.

"The suspension will remain in force pending the outcome of a final hearing.

"In the meantime, the DADDS practice at 124 Queensberry Street is making arrangements for the continuing care and treatment of patients."

Brancato, who registered with the General Dental Council (GDC) in 2006, was already working under conditions imposed by the council's Interim Orders Committee in May last year. The conditions, which were set for an 18-month period, were reviewed and updated most recently at the end of August. Alongside other conditions, he was also ordered to only work with patients alongside a registered dental nurse who is prepared to assist with communication in the dental surgery.

Earlier restrictions imposed on his registration included the conditions that he must work under the supervision of a clinical assessor, undergoing an NCAS assessment at his own cost and working with a postgraduate dean to formulate a personal development plan.

Lamey to work under supervision

An Edinburgh Dental School graduate working in Northern Ireland has been ordered to work under supervision by the General Dental Council (GDC).

Philip-John Lamey of Holywood in Co Down appeared in front of the GDC's Interim Orders Committee in London, and was told that his registration was to be restricted by conditions for 18 months.

Dr Lamey is to have his day-to-day work in clinical practice overseen by a registered medical or dental practitioner of consultant grade or equivalent. He must also inform the GDC of any professional appointment he accepts for which registration with the GDC is required.

The conditions run until January 2012.

More claims delay case a third time

MISCONDUCT

An American dentist who has already been found guilty by the General Dental Council (GDC) of serious professional misconduct, has had his case adjourned for the third time in as many years due to new allegations.

Stephen James Bray, who is Member of both the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh, first appeared in front of the GDC's Professional Conduct Committee (PCC) in August 2008. He was found guilty of serious professional misconduct with regard to his treatment of four patients in the Dorset surgery where he was employed.

The PCC criticised his approach to scanning, nutritional supplements and the use of electromyography. The committee stated that his treatment was found to be "philosophy-driven, rather than patient-centred", and in some cases he carried out invasive treatments based on his strongly held beliefs, even when it was not in the best interests of his patients.

Above: The council chamber at the GDC's headquarters in London

The committee decided to postpone judgement for 12 months to see if Dr Bray's performance improved but when they met again in July 2009, an application was made to adjourn for a further 12 months after two new outstanding complaints came to light.

And, in the latest meeting of the PCC, judgement in Dr Bray's case was again postponed for a period of 12 months after a further two new complaints were received by the GDC. The allegations have since been passed to the GDC's investigating committee, who will report back on their findings in due course.

Looking to keep your NHS income but treat fewer patients and maximise your business potential?

Get the perfect balance.

Are you a practice-owning dentist who would like to spend more time caring for fewer, more profitable patients, while still offering NHS treatment in the practice? Do your NHS patients ever opt for additional or alternative treatment privately?

We can help. Denplan are the experts at maximising business success and can support you in offering your patients the best possible care.

We can help you give your patients options: stay with you on a private basis with a flexible payment plan, or be treated under the NHS by your Associate. This enables the practice to offer NHS treatment, while enjoying the financial rewards of a reliable private patient base.

Get the following benefits with Denplan:

- A predictable, regular income
- Maximised earning potential
- Security of loyal patients who attend regularly
- Networking opportunities with like-minded professionals
- Marketing and business support with bespoke marketing materials and financial plans
- Practical support with cross infection control and Local Decontamination Units
- Verifiable CPD training for you and your team
- More time to run your practice and a better work/life balance

To find out more about how this can help you and your practice, call a Practice Support Advisor on **0800 169 9962**.

CAM343 09-10

Denplan Limited, Denplan Court, Victoria Road, Winchester, SO23 7RG, UK. Tel: +44 (0) 1962 828000. Fax: +44 (0) 1962 840846. Email: denplan@denplan.co.uk Registered in England No. 1981238. Registered address 5 Old Broad Street, London, EC2N 1AD, UK. Lines are open 8.30am to 5.30pm Monday to Thursday and 8.30am to 4.30pm Friday. We may record and/or monitor calls.

Missing link found on disease

Scientists may have discovered an explanation behind the link between gum disease and heart disease.

The link has been established for some time, though the reason has been unclear.

Health experts now believe that bacteria, entering the bloodstream through sore gums, deposits a clot-forming protein that can increase the risk of heart attacks.

Scientists from the University of Bristol and the Royal College of Surgeons in Ireland suggest it is the Streptococcus bacterium that is causing the problem.

This is the bacteria responsible for causing gum disease and tooth plaque. Research shows that once it enters the bloodstream, it creates a protein known as PadA, which causes the platelets in the blood to stick together and clot. The platelets encase the bacteria, protecting it from the immune system and antibiotics.

Professor Howard Jenkinson, who led the research, said: "As well as helping out the bacteria, platelet clumping can cause small blood clots, growth on the heart valves, or inflammation of blood vessels that can block the blood supply to the heart and brain."

Previous studies have suggested that Preventella Intermedia and Tannerella Forsynthesis bacterium are also likely to increase the risk of heart attacks.

ORAL HEALTH

Team spreads the word with a smile

NHS Ayrshire & Arran's Oral Health Promotion Team celebrated National Smile Month in the Doon Valley – helping to spread the message of good oral health.

With the tagline 'Teeth4Life', the campaign focused on the importance of looking after your mouth in order to keep your body healthy.

The team organised a National Smile Month event in Dalmellington Community Centre. The drop-in event gave people an opportunity to find out about the dental services and programmes available in the Doon Valley.

There was something to suit people of all ages, including street dancers from Doon Academy and the Zone, while Patna Primary School's Primary 4 class recited a poem, "I wish I'd looked after my teeth".

There were competitions and prizes, face painting and a free dental goody bag for everyone who attended. The Maternal and Child Nutrition Team offered healthy snacks to raise awareness of the importance of a healthy diet.

Local primary schools took part in a competition to design their own toothbrush and the winners received their prizes on the day. People who were unsure about going to the dentist were able to have a chat with a local dentist, sit in the chair and have the dental equipment explained.

Karen Parker, Senior Oral Health Promotion Co-ordinator, said: "We are delighted to get involved in National Smile Month and involve the Doon Valley Community. Good oral health is very important and, as the event proved, can be great fun!"

NHS Ayrshire & Arran's Oral Health Promotion Team at the centre

Thousands taken off GDC register

FEE NON-PAYMENT

More than 3,800 dental care professionals (DCP) have been removed from the General Dental Council's (GDC) register, the vast majority for failing to pay their Annual Retention Fee (ARF).

The council removed 3,387 DCPs for non-payment with 494 requesting to be removed from the list. Those removed included 3,287 dental nurses, 450 dental technicians, 108 dental hygienists and 16 dental therapists.

GDC Head of Registration Gurvinder Soomal said: "We worked hard to ensure that all dental care professionals knew about the deadline and understood what would happen if they didn't pay their ARF on time. We are equally committed to making sure those who want to restore to our register are helped through this process. At the end of July there were more than 58,000 DCPs on our register and, while 3,387 have been removed for non-payment, we are pleased that so many met this year's deadline."

Those DCPs who wish to be reinstated to the GDC's register must complete the relevant form, pay a fee of £120, have a medical examination and provide a character reference. They must also provide evidence they have completed the required amount of continuing professional development. If they were working in the UK at the time of their removal, they must also provide a letter from themselves and their employer explaining the circumstances around their failure to pay the ARF. Individuals would also be advised to contact their solicitor or defence organisation.

DCPs who were practising overseas at the time of their removal must provide a letter of good standing from the relevant authority of the country or state in which they last worked.

The deadline for dentists to pay their ARF remains 31 December each year.

For further information, visit www.gdc-uk.org, or call 0845 222 4141.

Evolution in action

The original LED turbine just got even better!

120 Years W&H.
Help us support SOS Children's Villages!

Try LED+ on Stand L07
BDTA Dental Showcase, ExCeL London
14-16 October 2010

It scarcely seems possible that it is just three years since W&H revolutionised dental illumination with the introduction of LED handpieces - because nowadays, LED instruments seem commonplace.

But not all LEDs are the same - and we want our customers to have the best. So we are pleased to announce that W&H has raised the bar once again! Improved positioning of the LED source at the head of the handpiece ensures accurate bright illumination of your treatment site. The new LED+ also has an unparalleled Colour Rendering Index (CRI) giving colours a supremely natural feel. And Synea has a small head too, so your daylight quality light will not be obscured by your handpiece.

Contact W&H today to see things more clearly with Synea LED+.

synea led+

W&H (UK) Limited
6 Stroud Wood Business Centre
Park Street, St Albans
Hertfordshire AL2 2NJ, United Kingdom
t +44 (0) 1727 874990
f +44 (0) 1727 874629
e office.uk@wh.com
wh.com

Training to help Africa

Bridge2Aid, the charity set up by Scottish dentist Ian Wilson, is launching an exciting new partnership for dental practices and businesses at the BDTA Showcase next month.

The new Unity Partnership aims to benefit practices that join, as well as Bridge2Aid's vital work in East Africa.

The Dental Volunteer Programme is a scheme that involves UK dentists visiting East Africa and training local clinical officers in emergency dentistry. The officers go on to provide emergency pain relief to their local community.

"The partnership aims to benefit partners and vital work in East Africa"

A partner trains an African clinical officer

Involvement in the partnership is recognised through use of the Bridge2Aid logo and branding on marketing communications, a plaque for the partner's premises and support with PR. The partners will receive regular updates on the progress of the clinical officer they support and the community in which they work, as well as professional advice and help with their own fundraising efforts.

Partner numbers will be limited to 48 in 2011. The first training by partners will take place in January 2011.

More details and the founder members will be announced at a launch press conference At Bridge2Aid/A-dec's stand Q04, 11am on Friday 15 October at London Dental Showcase Excel.

Firms unite for charity

A number of leading dental companies have come together to create a set of Christmas cards for dental charity Bridge2Aid.

The cards, developed by plan provider Practice Plan Ltd, include two festive designs with an African twist.

Bridge2Aid Corporate Friends are representatives from a number of the dental corporate firms, including A-dec (UK), Dentsply, Practice Plan and Schulke.

The cards cost £3.49 for a pack of 10, and all proceeds go directly to Bridge2Aid, which in turn goes straight towards helping the people of Tanzania.

For more details, visit www.bridge2aid.org or email your order to Brian@bridge2aid.org

Event hosts world-class speakers

SYMPOSIUM

An array of world-class speakers was brought together in London recently to celebrate the 30th anniversary of osseointegration in the UK and Ireland.

Dr George Zarb, Professor Tomas Albrektsson and Dr Bertil Friberg were just some of the high-profile names to appear at the Nobel Biocare UK Symposium, held at the Royal Institute of British Architects last month.

The scientific programme was put together by Professor Ian Brook and Professor Harold Preiskel and spanned two days, with a gala dinner held at the Langham Hotel in between.

The opening remarks of the symposium were given by Dr George Zarb and he spoke about implantology and prosthodontics being at a crossroad. He warned against what he described as "implantomania" where implants are regarded as a virtual panacea and remarked that the initial work of P I Branemark should be regarded as a world heritage site, at least for dentists.

Following Dr Zarb onto the podium was Professor Ashraf Ayoub of Glasgow Dental Hospital who spoke about methods of alveolar reconstruction including autogenous bone grafts and zygomatic implants.

Speaking after the event, he described his excitement at being asked to speak.

He said: "It was a great honour to be contributing to a meeting such as this as all the speakers were of a very high standard. I think there can be no debate as to the standard when you have Dr George Zarb speaking, as he is such a big name."

Sticky and also tricky

BDA SCOTTISH SCIENTIFIC CONFERENCE

More than 200 dentists, vocational trainees and dental care professionals were in attendance for the British Dental Association's (BDA) Scottish Scientific Conference 2010 in Dunblane last month.

The event's two speakers, Professor Brian Millar and Professor Mike Lewis, presented on the general conference theme of: 'Sticky and tricky – an update on aspects of adhesion, occlusion, oral medicine and dental plaque'.

Robert Kinloch, chairman of the association's Scottish Council, hosted the event and in his opening remarks he welcomed both the BDA President Amarjit Gill and BDA Chief Executive to the conference. He also highlighted that the conference was being held on the same day the BDA announced that it's membership figures had topped 24,000 for the first time, of which nearly 19,940 are dentists.

Above: Professor Mike Lewis

The day's first speaker was Professor Brian Millar, a Dundee University graduate who is now professor of blended learning in dentistry and consultant in restorative dentistry at Kings College, London. He gave two presentations on avoiding problems in restorative dentistry.

The first was entitled 'Should we stick with it?' and examined questions around cosmetic treatments as well as looking at alternative materials to amalgam and caries management. His second 'Occlusion, not confusion' examined how to use occlusion to assist in teeth wear and looked at non-invasive options for cracked cusps.

Professor Mike Lewis then took to the podium and the dean of Cardiff Dental School presided over a quiz before he presented 'An essential guide to oral biofilm – what's in the slime?' His second talk included 3D video and modern imaging techniques.

New practice for Dalbeattie

BIRCH VALLEY PRACTICE

People in the town of Dalbeattie now have access to south-west Scotland's newest NHS dental practice.

The Birch Valley practice was opened in September 2010 to look after the dental needs of people in the town and surrounding area after a long period when Dalbeattie was without a local practice and patients had to travel long distances, or pay for a private consultation.

The partners at Birch Valley are Joanne Woods and Laura Kerr, and opening their own practice is a long-held ambition for both.

Joanne, a qualified dental nurse and radiographer, is the practice manager. She said: "Laura and I have worked together for a number of years and always talked of opening our own NHS dental practice.

"With the full support of NHS Dumfries & Galloway, we have set up in Dalbeattie and the welcome we have received from the townspeople has been phenomenal. We have been inundated with registration enquiries."

Laura, who qualified in Cardiff, has twice been to Bislapur in India as a volunteer for the charity Teeth for Life.

The partners are in talks with the local health board to have the clinic as the region's flagship, and may also connect with the University of the Highlands and Islands (Dumfries School of Dental Therapy) to use the clinic to encourage dentists to employ a dental therapist.

The practice aims to register about 5,000 patients by 2012.

"The new design has been endorsed by many of the leading dental companies who have, in their own way, associated themselves with the project"
Dr Philip Friel

Award for work on injectable cosmetics

RECOGNITION

Kirriemuir Dental Practice partner Aisling Hanly has been awarded a quality assurance mark for injectable cosmetics from Independent Healthcare Advisory Services.

The practice is one of the very few in Scotland to have achieved the accreditation.

Aisling (pictured, left), who qualified in Dundee in 1997, was trained in injectable cosmetic treatment at Dr Bob Khanna's training institute in Reading, and plans to return in December for advanced filler training and oro facial applications of botox.

Aisling told *Scottish Dental magazine*: "Dr Khanna told me that dentists are in an ideal position to provide these treatments as they have an extensive knowledge of facial anatomy, and are very used to giving injections.

"Patients too are happy for a dentist to carry out these procedures in the clinical setting of the dental environment."

The Kirriemuir Dental Practice has been established for more than 30 years, and is currently awaiting planning consent for a new seven-surgery practice.

Aisling added: "Moving to a new building will enable us to provide other services, and we will be able to offer the services of a chiropodist, a beauty therapist and a dedicated room for injectable cosmetics."

In the swing!

The annual Scottish Centre for Excellence golf day took place recently in glorious sunshine at Pollok Golf Cub.

Abid Faqir picked up the first place trophy with second place going to Peter Connolly of LabPlus. Other awards included longest drive, which went to SCED's periodontist Alan Maxwell.

The event was sponsored by Nobel Biocare and any referring dentists wishing to play in next year's competition should email Heather McCaffery at pgc@scottishdentistry.com

State-of-the-art Hyndland clinic

NEW GLASGOW PRACTICE

Bespoke, dynamic and different – that's how Dr Philip Friel sums up his new practice at 154 Hyndland Road in Glasgow.

Philip, who's moving soon from his current premises nearby at No 170, has taken three years to plan his new practice. Housing six surgeries, two decontamination suites and lecture facilities capable of housing up to 20 staff across two levels of the red sandstone tenement building, the clinic also has a cone beam CT scanner installed.

Fully equipped and computerised, it has state-of-the-art music facilities and intelligent communications to enhance the patient experience.

Philip said: "Juggling the new clinic plans and my patient workload has been one of the most exciting periods of my professional career.

"This is a real dream come true for me. I had very specific aims and objectives about how the new clinic would be. Today's patients have high expectations in terms of patient care and comfort, and my own standards are high.

"I did extensive research on how the clinic would be fitted out, with input from all over the world. The plans are a real melting pot, bringing together what the patient needs and expects, and my vision to create an environment that's different."

He added: "The new design has been endorsed by many of the leading dental companies who have, in their own way, associated themselves with the project."

As well as the extensive internal work, Philip has given the exterior and gardens a facelift too. "I live in Hyndland and love the area. I know the importance of keeping our neighbourhood looking great and vibrant."

He said: "There's a great sense of community in this area, and I love working among so many long-established local businesses."

Raising profile of CDTs

CLINICAL DENTAL TECHNOLOGY

The biggest hurdle facing the small number of clinical dental technicians (CDT) working in Scotland is the fact that many dental professionals simply don't know who they are and what they can do.

That's the view of Burntisland CDT Rob Leggett, who was speaking after he picked up his diploma in Clinical Dental Technology from the Royal College of Surgeons of Edinburgh.

He said: "There are only two of us who qualified from Edinburgh and a cohort of four who qualified through Canada, so many people don't know who we are yet. We still speak to general dental practitioners and they have never heard of clinical dental technicians, I don't think that is going to get any better until there are more of us."

Above (from left): CDTs Alan Petrie, Rob Leggett and Mark Maley (from Sunderland) all received their diplomas from the Royal College of Surgeons in Edinburgh

Rob's frustration is compounded by the fact that the course he and his colleague Alan Petrie took last year has not been repeated and there doesn't seem to be any sign of a new intake for next year.

"I think it is disappointing. The biggest hurdle we face as clinical dental technicians is how to raise our professional profile," he added.

However, Rob has been working in practice at International Smiles since he graduated at the turn of the year, and the ceremony in Edinburgh was the official recognition of a year's studying.

New face at Edinburgh Dental Specialists

Edinburgh Dental Specialists has welcomed a new addition to its roster in the form of periodontist Dr Penny Hodge, who is joining on a part-time basis.

Dr Hodge is a graduate of the University of Edinburgh and also currently works part-time as a clinical lecturer at Glasgow Dental School. Her main area of research is risk factors in periodontitis, including smoking, diabetes and genetics.

Kevin Lochhead, practice principal, said: "We are absolutely delighted to announce the appointment of Penny Hodge. She will be limiting her practice exclusively to the treatment of periodontal disease and related conditions. Penny's methodology for managing patients begins with intensive treatment by herself. Penny is happy to receive referrals for any periodontally related condition."

Above: Dr Penny Hodge

Dr Hodge was awarded her PhD by the University of Glasgow in 1999 and was admitted to the specialist list in periodontics in 2002. She is a Fellow of the Royal College of Surgeons of Edinburgh and a member of the British Society of Periodontology.

She is also a member of the International Association for Dental Research.

Fighting the good fight

After spending thousands of hours treating victims of facial trauma, three surgeons from Glasgow decided enough was enough. Bruce Oxley reports

Hospitals in Glasgow treat a serious facial injury every six hours, most of which are the result of heavy drinking. Over a quarter of these patients will be back again with a similar injury within the year.

Oral surgeon Christine Goodall has seen thousands of young men who have been injured as a result of 'recreational violence' – in other words, violence perpetrated for no discernable reason.

She explained: "It's not a terribly good word to use because there is nothing recreational about it, it is all quite nasty. The violence is not for any purpose, they are just being violent for the sake of it.

"Probably the most common injuries we see are fractured mandibles, fractured cheekbones and fractured noses from blunt trauma. But probably about 25 per cent of all the injuries we see will be knife-related, such as slashes. But we often see a mixture of blunt trauma and knife wounds, for example."

It was this cumulative effect of seeing patient after patient coming through the doors of the various A&Es and operating theatres she has worked in that led Christine, along with two colleagues at Glasgow Dental Hospital, to set up an innovative charity to try and stop violence before it happens.

Christine, along with maxillo-facial surgeons Mark Devlin and David Koppel, founded Medics Against Violence (MAV) in 2008, becoming a registered charity the following year. Their aim was to reduce violent injuries, especially among the young, seeing it as an entirely preventable problem.

"Mark, David and I all felt that perhaps we could do more than just fix the people," said Christine. "That perhaps we should be thinking about stopping it happening in the first place. And that is really why we set up Medics Against Violence."

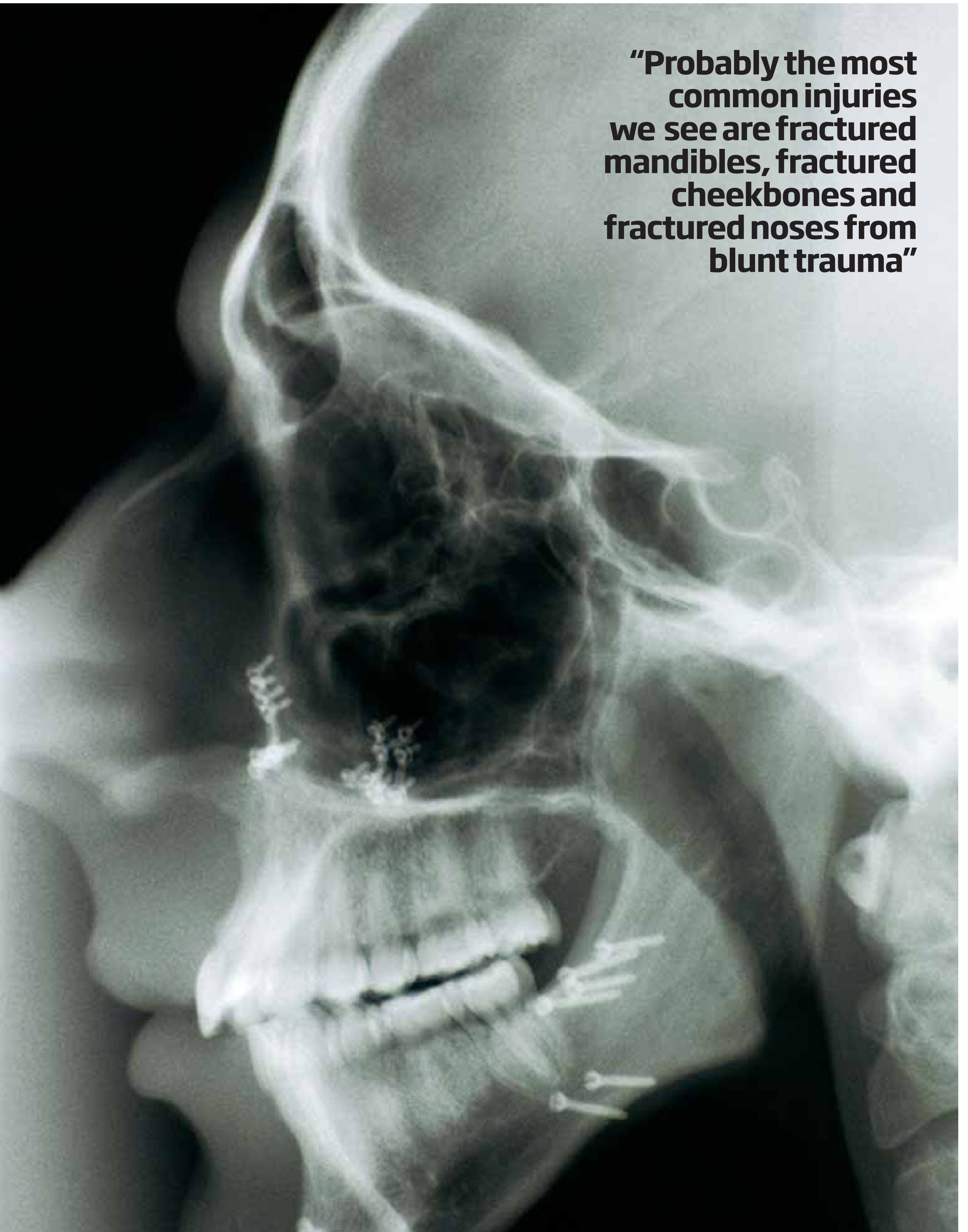
Before she qualified as an oral surgeon, Christine worked as a research scientist. It was her current research into alcohol-related facial trauma that put her into contact with Strathclyde Police's Violence Reduction Unit (VRU). The VRU co-sponsored a brief interventional programme called COVAID (Control of Violence for Angry Impulsive Drinkers), which Christine co-ordinated.

The VRU was formed in 2005 following an initiative by Strathclyde Police to develop sustainable reductions in violence. Detective Chief Superintendent John Carnochan and his deputy, Karyn McClusky, were tasked with developing a long-term strategy that evolved into the creation of the unit. Det Ch Supt Carnochan explains that, early on in the life of the unit, they came across a World Health Organisation report that identified interpersonal violence as a public health issue. "If you look at violence through the lens of

DAVID GILLANDERS

Below: Christine Goodall

Continued »



"Probably the most common injuries we see are fractured mandibles, fractured cheekbones and fractured noses from blunt trauma"

Continued »

public health and through the lens of a scientific model, it allows you to be far more forensic in identifying what the issues are.

"So it's not just about more cops on the street, but rather at looking at what happened the night before that incidence of violence? What happened in that life beforehand?"

However, while the COVAID programme identified victims of interpersonal violence, it wasn't able to wind back the clock and stop the violence occurring. Christine said: "The brief interventions with facial trauma patients try to help them cut down their drinking and cut down their involvement in violence, but these are all things that happen after someone has been injured. What we wanted to do is get to people before they get injured.

"We felt that the best way to do this was to speak to young people, not older teenagers but 13 to 14-year-olds, before they think about getting involved in those kind of activities."

Above: Detective Chief Superintendent John Carnochan

With funding support from the VRU and the Scottish Government, MAV was formed in November 2008. Christine, David and Mark carried out the first visit themselves to St Mungos Academy in Glasgow and since then they have recruited 120 doctors and consultants from across Glasgow, Ayrshire, Lanarkshire, Forth Valley and Dundee. So far they don't have any members further north than that and they don't have any general dentists on board, as yet.

The charity has visited about 5,000 pupils from more than 20 schools in Glasgow, Ayrshire and Lanarkshire, with more than a dozen extra schools expressing an interest for the coming school year. MAV members, who include doctors and consultants from a broad range of disciplines and departments, give interactive presentations to the pupils, showing them the real consequences of violence. The presentation includes a short film that tells the stories of real-life

Continued »

GDP CASE STUDY

Catherine Jones, GDP from Belhaven Dental Surgery in Port Glasgow

"The most common injuries we see in practice are broken teeth, occasionally avulsed teeth that are completely knocked out.

"Also young boys who have had broken or lost teeth in the past through fights coming in with broken dentures, that's a fairly regular occurrence.

"Quite often they come in and they are not entirely sure what has happened to them due to alcohol. They've been out drinking and they really don't know what's happened.

"It is just indicative that they are really out of control when they have absolutely no idea how they have received their injuries."

"What we wanted to do was get to people before they get injured"

DAVID GILLANDERS

Continued »

victims and perpetrators of violence.

Christine said: "I think the kids relate quite well to the patient stories and, personally, I just draw on the thousands of people that I have seen over the years. They are all broadly similar, it is often young guys who have been out fighting. They don't appreciate at the time that they are going to be left with a scar for life or how the broken facial bones will affect them."

Christine explained that around 75 per cent of the kids they speak to will be okay and won't get involved in violence, whereas there are around 5 per cent who will not respond to their presentations and will inevitably become involved. However, it is the remaining 20 per cent that they are trying to reach.

She said: "These are the kids we are really trying to get at – we could potentially change their minds. This 20 per cent could go either way, they could get saved by a good role model – parent, uncle, teacher – or they could fall off the edge and it will be happenstance as to why that happens. Which is why we believe MAV is so important.

"Even if it is to get them to leave the knife behind when they go out at night, or to walk away from a certain situation. It just has to be one little thing, it doesn't take much to stop these things from happening. It just takes somebody making a positive decision not to do something."

And, according to Det Ch Supt John Carnochan, in some cases the ability to make these decisions needs to be learned. He said: "We don't learn to be violent, we learn not to be violent. Learning these life skills allow us to develop a whole range of other strategies to deal with the challenges we'll face in our lives. But the young guys who are getting into trouble don't have these other strategies. The only strategies they have is to fight, to be aggressive and to resort to violence.

"If young people acquire these skills it then becomes about more than just the violence, it will affect whether they will make good decisions about themselves; about what they drink, about socialising, about relationships."

Det Ch Supt Carnochan believes that MAV is an important force in helping to reduce violence in communities across Scotland. He continued: "MAV has a powerful role to play. Their members' advocacy, the fact that they say it out loud, the simple fact that they exist.

"The fact that they are saying, 'Look, we exist because we believe we can prevent some of this happening in the first place', is absolutely vital.

"Our motto at the VRU is 'violence is preventable, not inevitable', so the fact that MAV is standing up there and saying just that, confirms it and it really is a powerful message."

Christine explained that while the response from teachers and pupils has been encouraging so far, this needs to be a long-term project. She said: "I don't think the change in attitudes will happen overnight, but we're in this for the long haul. We just hope that if we see enough kids, and speak to enough kids, that they will see that this is not the way to go." ■

FIND OUT MORE

If you are interested in joining Medics Against Violence, or finding out more information about their schools programme, email the charity's administrator at lauren.thompson@vruscotland.pnn.police.uk or visit the MAV website at medicsagainstviolence.co.uk

Aberdeen's Northern lights

PHOTOGRAPHY BY KATE SUTHERLAND

Graeme Smith talks to the director of Scotland's newest dental school

Before they finish their first year of studies at Scotland's newest dental school, students are treating patients – almost two years earlier than on most other dental courses.

The speed with which the students are given hands-on experience is just one of the innovations of the new course, which is taught in a striking new building in the grounds of Aberdeen Royal Infirmary.

With a waiting list of about 30,000 for NHS treatment in the north-east, Aberdeen was the obvious place to site the ground-breaking facility with its pioneering curriculum.

The four-year course for graduate entrants is patient focused and the clinical skills facility is just one of the high-tech resources in which the students learn their skills. There are also high-tech systems to allow the students to see exactly what the clinician is demonstrating and on which the students can be monitored.

When they have proved their competency at specific skills on the state-of-the-art equipment, they are given the earliest possible opportunity to use these skills to help patients on the waiting list.

Professor Jim Newton is director of the £17.7 million Aberdeen Dental School, which was delivered on time and under budget, and was officially opened by First Minister Alex Salmond in January.

When the Scottish Government decided to build the graduate entry school as part of its commitment to reverse the long-term decline in dentist numbers, it looked to

Continued »

CASE STUDY

STUDENT: ALISON INGRAM

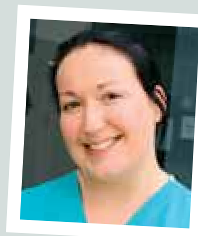
Alison Ingram, 44, is a former psychiatric nurse who went on to gain a degree in microbiology.

She has worked overseas and around England and the need for dentists in the area prompted her to move back near her hometown of Dufftown.

"I am thoroughly enjoying it as it is a very hands-on, practical course and right from the start we have to consider patients. Even all the academic elements are very patient focused.

"We are very lucky to have all these facilities. The teachers have been very supportive and it's a great place to learn."

CASE STUDY



STUDENT: LAUREN McKENNA

Lauren McKenna, 28, is a former research scientist for a diagnostics company in Dundee with a first degree in biochemistry and pharmacology who wanted a switch from sitting in front of a computer writing reports.

"I am quite settled in Aberdeen now and would be happy to stay in the area if there is a job.

"The course is fantastic and it has definitely been the right move for me.

"Some patients say they have been on waiting lists for seven years plus, so I get a sense that they really appreciate us being there. "

Continued »

the University of Dundee Dental School for expertise.

The government announced in the summer of 2007 that the first students – it takes 20 a year - would start in September 2008. A four-year programme was drafted and those involved in its delivery agreed it was the way forward for dental education in Scotland.

Professor Newton said: "It was the opportunity, starting with a blank sheet of paper, to develop a curriculum using past experience, good practice and educational evidence to change the way we educated and trained dentists.

"It has been built around the fact that the patient is at the centre of everything in the course, which is structured around six themes: general health and disease; dental health and disease; behavioural science and dental public health; law, ethics and professionalism; patient care; decontamination and infection control.

"We set a minimum qualification of a 2.1 in a biological or biomedical degree, or equivalent. The third intake has just started and the vast majority of the students are from Scotland and have degrees from Scottish universities. The average age is 27 and the majority are female."

However before the first students started, Professor Newton and his colleagues had to design the complete four-year course. With no similar model anywhere else, everything had to be done from scratch.

"This is a unique course developed specifically for Aberdeen dental school," said Professor Newton. "We have taken good practice, good evidence from other places in the UK and around the world.

"We have tried to inculcate up-to-date educational methods and assessment procedures so we know our students are fit to progress from one year to the next or to treat patients. We have moved away from many of the standard processes dentists in the past will have experienced.

"They are much more objective now. Outcomes are much more clearly defined. A lot of what we do, particularly on the clinical side, is looking at competency. We don't let them carry out any procedures on patients until they have carried these out in the student laboratory or in the clinical skills facility."

"We have tried to inculcate up-to-date educational methods and assessment procedures so we know our students are fit to progress from one year to the next or to treat patients"

Professor Jim Newton, director of the Aberdeen Dental School

He said this was completely different to the students' previous university experience, but they are embracing it enthusiastically.

"A great deal of it is practical sessions or presentations – it is much more interactive. It is a move away from what some people might regard as the traditional way of doing things. We try to limit the amount of didactic teaching and concentrate on those skills needed to join the profession. At the beginning of the first semester of first year, they go into clinical skills and begin to carry out practical dental activities and they love it.

"When I was training it took me until third year before I actually got to do any dentistry. They spend a day a week wearing scrubs, gloves and face masks and they carry out decontamination procedures – it is run as if it were a clinic. The students are highly motivated as they are treating patients in the June and July of their first year – assuming they have successfully completed all their assessments."

He said the success rate is high and describes the performance of some of the students as 'positively outstanding'.

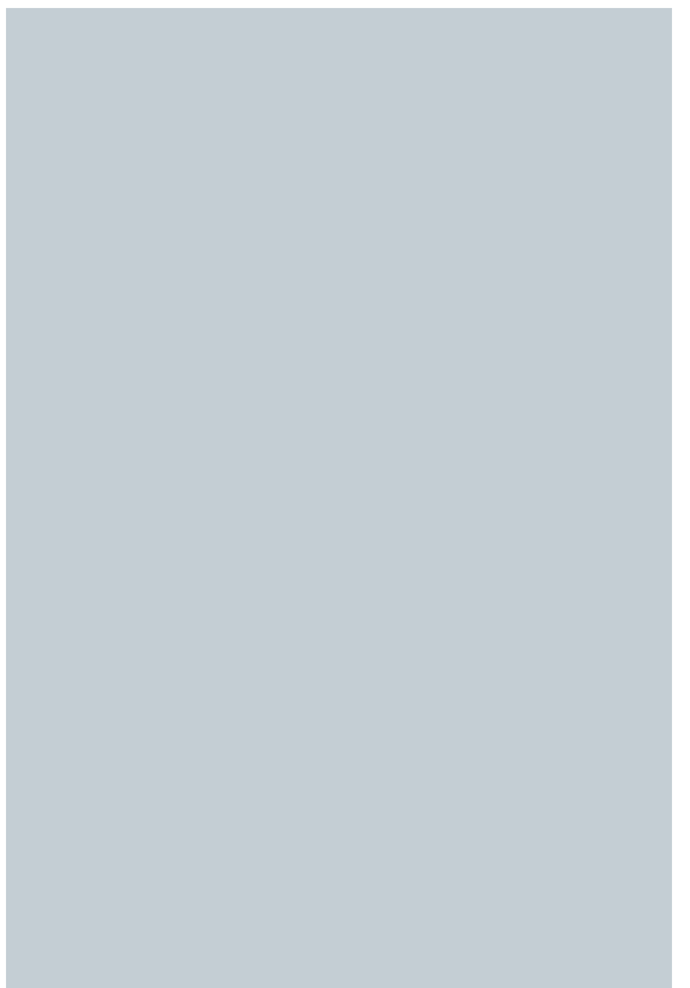
"We also assess professionalism from the very beginning. There is a clinical dress code and a behavioural code in place which are key aspects of the professionalism strand of the course. We use the GDC's document *Standards for Dental Professionals* and they sign an oath of professionalism at the start of every year which lays out how they should behave and how they should treat patients."

The school is meeting two key dental issues for the north-east. It is treating patients from the extensive waiting list while producing 20 trained dentists a year, many of whom will remain in the area.

"If we were not here, these patients would stay on the waiting lists or try to register with a private care practice."

For Professor Newton the experience has been an exciting challenge: "Who has the opportunity to come to a place like this, with a blank sheet of paper and build the first new dental school for many years?

"This is an exciting opportunity to develop a centre of excellence for dentistry which will be beneficial not only for Aberdeen and Grampian, but for Scotland as a whole." ■



There may be trouble ahead…

Introducing his series on 10 things to avoid to stay out of trouble, Hew Mathewson, former President of the GDC, gets to grips with fraud and the thorny subject of fees

Often when people think of getting into trouble as a dentist, it is the spectre of the ghastly mistake that floats into the mind: the procedure gone wrong with a single patient, the complaint to the General Dentist Council and the momentous consequences that ensue.

The reality is very different. Covering up and lying about such an incident will definitely not help your case but, faced up to squarely and honestly, the 'procedure gone wrong' experience is rarely disastrous. From both the USA and Australia there is now very considerable evidence that an early admission to the patient combined with an apology and a commitment to do your best to remedy the situation avoids more serious consequences in 98 per cent of cases.

There are, in fact, a myriad other much easier ways in which dentists can come to the notice of the GDC and the other authorities, and it is these that I am going to focus on in this series of articles on maintaining a trouble-free practice.

The first two trouble spots I want to deal with are fraud and the problems arising from fees charged. The second of these, generally having to do with overcharging, could be said to be a specialised subset of the first, but bearing in mind the undoubted complexity of the fee scale, it is worth looking at in its own right.

For many of the frauds that are discovered – either because it has come to light through the offices of the Counter Fraud Services (CFS) or after a patient complains to the GDC – the dentists responsible fall into one of two camps: those who deliberately set out with malice aforethought to profit from breaking the rules and those who stumble into it, usually through ignorance of the rules themselves.

Of course, there are some fraudulent acts nobody can ever claim to have stumbled into – no one, for example, invents 50 phantom patients by accident or claims, time and time again, fees and allowances to which they're clearly not entitled. Those dentists – and thankfully there are only a very few of them – will eventually be found out and will rightly face the consequences.

But, for most of the rest, the infraction is

> **"Dentists responsible for fraud fall into one of two camps: those who set out with malice aforethought to profit from breaking the rules and those who stumble into it"**

usually of an inadvertent nature. A dentist might for example, claim 100 per cent of an allowance on the NHS, not realising that the proportion of private income they have earned has crept above the 10 per cent limit set out in the regulations. By not remaining up to date with the state of their accounts, that dentist will have unwittingly made a false claim – and strictly speaking, that's fraud.

Lack of attention to detail can lead dentists astray in other ways too. Not specifying clearly on their laboratory tickets the type of metal they require for different appliances, for example, or not checking the goods received against those ordered. A laboratory could well end up supplying crowns with a non-precious metal, while the dentist has been merrily claiming a higher fee for gold or palladium.

Even if a laboratory were deliberately misleading a dentist, as the provider of the 'appliance' to the patient, the dentist remains responsible. In this case, good record keeping will be essential further down the line: you have to be able to show that you requested the precious metal and that you paid for it.

Poor record keeping is also the source of many an unwitting charging error. Without the documentation easily to hand, it would be a simple matter to charge a patient for a restoration that had been supplied within the last 12 months, when in fact that restoration effectively comes with a year's free replacement. The dentist then processes the claim, which is perhaps paid out in full on the understanding that no money has been received from the patient on the second occasion, when in fact the reverse is true. The dentist has at best unwittingly overcharged the patient. Do that too often and you are likely to attract the attention of the ex-policemen who man the CFS.

On the other hand, it is quite possible that the dentist who charges twice in one year for such a restoration is not a chaotic keeper of records, but simply hasn't got to grips with labyrinthine fee scales that have been agreed with the NHS. It is easy to see how this can happen. A young dentist, faced with a plethora of new experiences and responsibilities during their vocational training, might only half-ingest the detail of the fee scales. It is the experienced practice staff – both dentists and administrators – who keep them on the right track. That dentist might then go on to do a year in hospital or in the salaried services and forget the half they did learn. Unfortunately, back in practice a year or two later, trouble awaits.

"It is possible that the dentist who charges twice in one year is not a chaotic keeper of records, but simply hasn't got to grips with labyrinthine fee scales that have been agreed with the NHS"

I therefore urge all colleagues to make sure they – and their staff – are up to date with what is a complicated fee structure in terms of both the number of items and allowances, and the conditions that apply to them. Without that knowledge, you are at risk of sleepwalking into problems: charging patients for procedures that should have been free, misleading others about what is available on the health service and claiming allowances incorrectly. And unfortunately, ignorance is not a defence.

This may seem harsh but it is easy to understand why it has to be this way: one person's ignorance is another's calculated deception. Patterns of mis-charging, whether they are deliberate or otherwise, look the same when run through the CFS's investigative computer programs.

I don't plan to dwell on the inveterate fraudster, those 'bad apple' dentists simply looking to profit from their misdeeds. They know what they're doing and will take the consequences. But within the 'deliberate' category of the dentist in trouble I would like to highlight two groups in particular, who I believe are basically good people who take a wrong turn and end up in trouble despite themselves: I shall call them the 'justifying sinners' and the 'slip-sliders'.

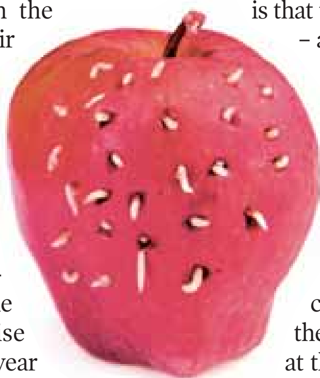
The first group comprises those dentists who might say, for example: "I'm not prepared to do that on the health service – if I do, I'll just get tuppence ha'penny, which is ridiculous for an hour and a quarter's work", when they are well aware they should offer the procedure in question. Alternatively,

Continued »

Continued »

they might find themselves claiming a greater degree of difficulty for an extraction because of the amount of time it's taken to talk the patient round, to check their medical records and phone their GP. In both cases – and there are many more just like this – they feel their actions are justified because "the system is unfair".

And while I accept it's true that some procedures aren't very economic and that this can be frustrating part of the job, I don't hesitate to point out that dentists are well rewarded for many other procedures and by a host of allowances. My advice to them is to take the rough with the smooth rather than put their fitness to practice at serious risk.



The 'slip-sliders' are those dentists who find themselves in such desperate straits that they resort to short-term deception in the hope they can buy themselves time. It could be the dentist who doesn't realise they've had a bad financial year until their accountant reports the gory details six months after the event, or the one whose spouse has walked out and left them with three children; it could be the dentist who has got health problems and hasn't been generating the same level of income but has continued to spend at the same level both personally and professionally and the bank manager has stopped their overdraft – oh, and the tax bill has just dropped through the letterbox.

Suddenly their life is in a mess and they're tempted to do something foolish. So, they invent a patient or make a false claim. And very often, because the wheels grind slowly, they get away with it at first. So they do it again. And again. But the reality is that they haven't got away with it – and when the CFS investigators pay a visit, with a mass of evidence, it's too late.

Over my years at the GDC, I came across many unlikely people who had got into trouble in this way and I urge anyone who finds the pressures of life closing in on them to pick up the phone to their legal adviser at their indemnity provider. I'm afraid they won't send you a cheque but they will definitely help you navigate your way into calmer waters. There is also other help available from the likes of the BDA Benevolent Fund.

This advice to pick up the phone to your protection agency holds true for any dentist being investigated by the CFS – even those who are innocent, which is sometimes the case. Occasionally dentists have good reasons for showing particular patterns of claims that might appear fraudulent but which are not. And they may have all the paperwork to prove what they're doing is okay, but they should still take advice.

It goes without saying that if it transpires you have deliberately transgressed, your indemnity provider can reserve the right not to defend you. But even in that eventuality they will likely put you in touch with suitable solicitors to represent you in the criminal court.

Financially, you will be on your own – the dental community isn't always as one on policy matters but that's something I'm sure you will agree is appropriate. ■

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

By Tim Power

Analyse **this**

For Stewart Wright, treating patients isn't just about teeth, its about the whole person – drawing on a range of alternative therapies

When a patient walks through the door at Stewart Wright's Greenock-based surgery, he sees the person, not the problem.

This has been Stewart's guiding principal over the past 20 years as he has researched and integrated a wide range of complementary therapies into this dentistry practice to develop a holistic approach to treating patients.

Stewart explained: "I don't look at the teeth in isolation, but as a part of the total physiological system. The teeth are connected to the jaw bone which, in turn, is connected to the skull, and therefore the spine and the connection throughout the body goes on."

Of course, he is not allowed to practice these therapies in the dental setting, but by using techniques learned from studying therapies such as CranioSacral therapy or THJ treatment, he said he is able to enhance his dentistry skills and practice by giving a more holistic diagnosis of a patient's health.

"These therapies are not 'up in the air'. There's enormous research that shows why and how they work on the body's system. I've spent a lot of time studying them and I use these learnings to make my dentistry better," he added.

An extreme example of this is when Stewart treated a long-time patient who was complaining of a bleeding tooth. After a through examination and seeing no dental reason for the abscess, Stewart urged the man to see his GP...and get his prostate checked. The man was a bit shocked to hear this advice from his dentist, but he trusted Stewart so, when he told them that the problem was not related to his teeth, he took his advice. The man rang Stewart the next day to say that he was going into surgery to have the polyps removed that his doctor's examination of his prostate had revealed!

Not everyone is comfortable when Stewart suggests employing a complementary therapy as part of an integrated approach to help a patient with their health issues. Stewart said: "I can generally sense if a patient will be amenable to an alternative way of treating their problems. I have found that people of all ages and backgrounds are accepting of this approach and are actually interested in learning more about the therapies."

If the patient is interested, then Stewart reaches for his special box of 'tricks' containing illustrated skulls, jaw bones and teeth imprints which help to explain the therapies in a practical way to the layperson.

"I explain what therapy I believe will help them and allow them to make up their own minds. I certainly don't pressure them – it's just an option I offer," he said.

Stewart qualified in dental surgery from Glasgow University in 1979 and became interested in an alternative approach to dentistry after attending a lecture by Harold Gelb in the late 1980s – one of the leading proponents of Temporomandibular Joint Dysfunction treatment.

"I can generally sense if a patient will be amenable to an alternative way of treating their problems"

His journey into the world of complementary therapies has led him to question everything – a philosophy that he feels is not encouraged in dentistry school.

He describes himself as an open-minded sceptic and has used this approach to analyse the therapies he has studied. He said: "I've read the books, studied the courses, looked at the research and questioned the science. I can see how and why they work. I don't simply accept them or discard them at face value. If it makes sense, then I'm interested in finding out more."

This questioning has led him into hot water with some of his profession – such as his deeply held belief that mercury in dental fillings has a detrimental impact on health.

Stewart had his own 'Road to Damascus' moment when he started suffering from numbness in his limbs that he thought was the onset of multiple sclerosis. His GP referred him to a consultant neurologist who, after many nerve and blood tests, told him he was suffering from idiopathic peripheral neuropathy.

Stewart explained: "Idiopathic peripheral neuropathy isn't a condition – it's a description of symptoms. As they didn't know how it occurred, I was no better off. I felt there had to be a specific reason for the problem so I started to look at the materials I was using at work. After much analysis and searching through medical literature I concluded that my significant daily exposure to mercury from working with mercury amalgam fillings was the source of my problems.

"I've been concerned about the damaging effects of mercury from dental amalgam filling for many years and for this reason have not used fillings containing mercury since the early 1990s.

Continued »

CAREER FILE: Stewart Wright

- Qualified in dental surgery from Glasgow University in 1979.
- Runs the George Square Dental Centre in Greenock and is a consultant to the Berkeley Clinic in Glasgow.
- Describes himself as a holistic dental practitioner and has studied TMJ treatment, orthodontics, advanced restorative, orthopaedics, applied kinesiology, homeopathy and visceral manipulation.
- Has a Certification of Techniques in Upledger CranioSacral Therapy and teaches in this discipline. He is also a Licensed Associate of the Faculty of Homeopathy.

Continued »

While Stewart's numbness receded considerably when he stopped working with mercury, he had occasional relapses, though not as bad as before. That's when he came across Field Control Therapy (FCT) and this approach has made enormous improvements to his health.

Stewart explained: "FCT understands that some of the body's organs have been weakened by toxins such as mercury, which leaks from the dental fillings that most of us have.

"FCT can detect which organs are affected using a system of muscle testing and it then helps the body to release these toxins using a form of homeopathy. This form of homeopathy is also used to boost the particular organ as well as to bring the body in general back to health.

"I now view the numbness that crept into my life as almost a blessing in disguise. It was the symptom that alerted me to the fact that something was very wrong and let me to become aware of the affects of mercury on health."

While the British Dental Health Foundation and the US Food and Drug Administration do not consider that the use of dental amalgam containing mercury poses a significant health risk, research in Canada led to the conclusion that up to two fillings in children and four fillings in adults would be fine – any more than this would be "an unacceptable risk to the health of the patient".

Stewart takes a practical approach to the situation and offers his patients the option of the safe removal of mercury amalgam fillings. Patients are often referred to him from the Berkeley Clinic in Glasgow where he practices on a part-time basis as part of their cosmetic treatment of teeth and substitution by 'white' fillings.

Stewart explained: "Ironically, it's more dangerous to remove fillings by drilling than leaving them in the teeth as the mercury-containing particles will just get swallowed. Mercury vapour released from the filling as a result of the heat created by drilling can be inhaled by the practitioner.

"To remove the filling safely, you need to create a totally enclosed environment with a separate air supply, aspiration of the tooth core and careful removal of the filling material to avoid contamination of the patient and dentist."

"Ironically, its more dangerous to remove fillings by drilling than leaving them in the teeth"

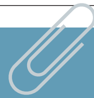
Through integrating complementary therapies into his diagnostic approach to patients' health problems, Stewart believes he has become a better dentist.

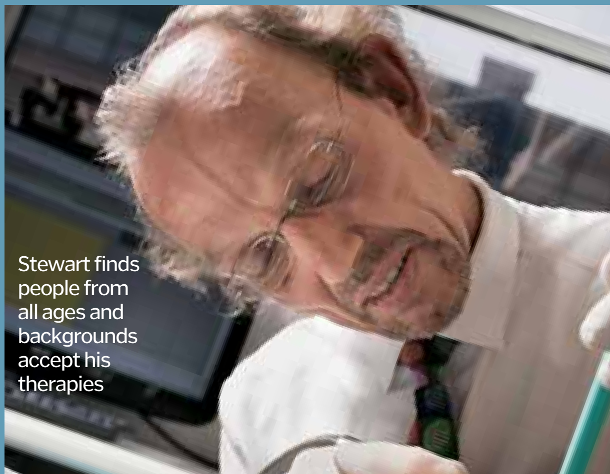
"I believe the teeth are important elements in the body's system and we, as dentists, have a very privileged part to play in improving people's health. I know a lot of people will think I'm really far out here, but I get results and, more importantly, my patients can see them too," he added.

He admits that the more he delves into new techniques and therapies, the more he is interested in passing on his knowledge – and not just in a dental-related environment.

"I've used Thought Field Therapy on autistic kids at a chiropractor's practice with encouraging results. In fact, I'd love to open up a centre to focus on more of these therapies for other conditions. I tell you, this exciting journey never ends!" ■

ALTERNATIVE THERAPIES





Stewart finds people from all ages and backgrounds accept his therapies

Some of the alternative therapies that Stewart uses in his dentistry practice…

TMJ TREATMENT

TMJ is the commonly used acronym for temporo-mandibular joint disorder. The pain associated with TMJ is thought to be caused by displacement of the cartilage where the lower jaw connects to the skull, causing pressure and stretching of the associated sensory nerves. It is a generic term which encompasses a whole spectrum of diseases, derangements of the articulating elements in the joint, and injured or damaged tissues affecting the function of the joint.

APPLIED KINESIOLOGY

Applied kinesiology (AK) is a form of diagnosis using muscle testing as a primary feedback mechanism to examine how a person's body is functioning. When properly applied, the outcome of an AK diagnosis will determine the best form of therapy for the patient. Since AK draws together the core elements of many complementary therapies, it provides an interdisciplinary approach to health care.

FIELD CONTROL THERAPY

Field Control Therapy is a relatively new healthcare system that specifically addresses the illnesses of the 21st century. Modern lifestyle comes at a cost. Poor diet, increased exposure to radiation, environmental pollutants and toxic metals are creating a host of new health problems from chronic fatigue to immunodeficiency, autism and MS, to name a few. FCT identifies key toxins underlying illness and treats with 'causative homeopathy' to restore healthy cellular functioning.

VISCERAL MANIPULATION

Visceral manipulation involves the release of tension in the ligaments of the organs in the body. It is a gentle, but relatively deep tissue therapy with the entire emphasis on making sure that the organs move and glide freely. Frequently the cause of the lack of motion in the organs is due to severe trauma to the body (i.e. car accidents, falls, etc.).

CRANIOSACRAL THERAPY

CranioSacral therapy involves gently working with the spine and the skull to ease the restrictions of nerve passages, optimise the movement of cerebrospinal fluid through the spinal cord and restore misaligned bones to their proper position.

It is used to treat mental stress, neck and back pain, migraines, TMJ Syndrome, and for chronic pain conditions.

Turn a new leaf on

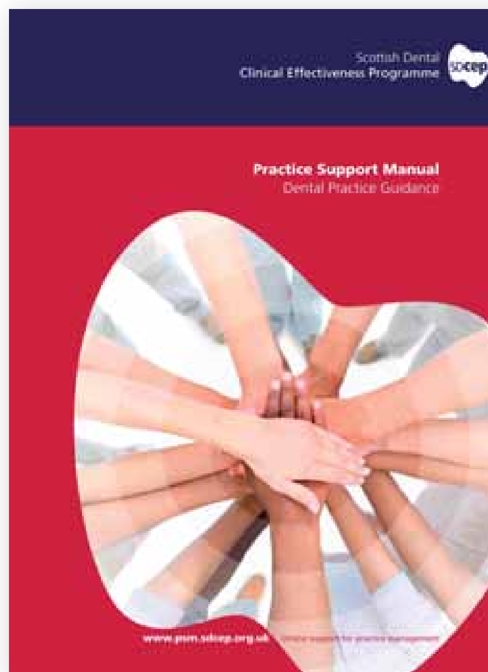
A range of guidance is set to offer dentists in Scotland vital advice, writes Doug Stirling

Earlier this year, an online ‘Practice Support Manual’ (PSM) was launched by the Scottish Dental Clinical Effectiveness Programme (SDCEP). The PSM is designed to become a first port of call for advice on a range of non-clinical aspects of running and managing a modern dental practice.

Initially, the PSM included advice on record keeping; risk management; medical emergencies and life support; audit and significant event analysis. Another topic – ethical practice (including data protection, freedom of information, child protection, consent) – has recently been added, with more to follow.

The PSM includes template forms, policies and checklists to help in following the advice provided and is of relevance to all members of the dental team.

The PSM is freely available to practices in Scotland at www.psm.sdcep.org.uk. To register for access, use the link



The PSM includes template forms, policies and checklists to help in following the advice provided and is of relevance to all members of the dental team

Sinus Lift Course

Dr. Stephen Jacobs

A course designed for dentists who have working knowledge and experience in basic dental implant placement and would like to further their skills with sinus lift procedures. Attendees will learn the principles and surgical procedures required for Sinus Lift and implant placement. Participants will have the chance to practice through hands-on workshops and post-course mentoring.

Dates:
19–20 November 2010
25–26 March 2011

Course Venue:
Dental FX: Implants and Cosmetic Dentistry
84 Drymen Road • Bearsden Glasgow G61 2RH

Price:
£655 + VAT

For more information and registration please contact: **Ms. Jenny Wilson** on 44 (0)1628 519 162 or e-mail 3iukm.marketing@biomet.com

support

on the homepage and follow the instructions.

SDCEP is also developing guidance entitled *Oral Health Assessment and Review* (OHAR). This follows an extensive consultation and subsequent discussion with general dental practitioners to better understand concerns about the draft guidance and how it could be made more suitable for use in practice.

The net result of this is an amended version that will present the concept of OHAR without a lot of detail. Example forms for recording information that underpins this approach will be provided.

The OHAR guidance aims to facilitate long-term, individualised patient care with an emphasis on prevention. Many practices will already be providing care for many of their patients in a way that reflects this approach. However, for others, this may represent a significant change to current practice and will inevitably take time to implement. Clearly, there are wider implications and challenges associated with adopting this approach that need to be understood and thought through.

SDCEP has a remit to provide user-friendly guidance on topics identified as priorities for dentistry in Scotland

To this end, working with volunteer practices to explore implementation will be crucial and recruitment will begin shortly. If you are interested in taking part, please let the SDCEP office know (see details right).

Finally, SDCEP has a remit to provide user-friendly guidance on topics identified as priorities for dentistry in Scotland with the aim of supporting dental teams in delivering quality care for their patients. In the last edition of *Scottish Dental magazine*, two topical issues were featured that are also being tackled by SDCEP.

The first is decontamination. *Sterilisation of Dental Instruments* is nearing publication and follows previous SDCEP guidance on instrument cleaning. The second part of the decontamination guidance has taken a considerable time to agree and write, which reflects the complexity of this subject and the effort involved in working through this.

The second issue is the development of guidance on the oral health management of patients prescribed bisphosphonates. While of particular relevance to dentists and these patients, it is also important that prescribers and dispensers of bisphosphonates are aware of the very rare, but serious oral health implications of taking these drugs and how to advise patients about minimising their risk of developing complications.

Consequently, this guidance is directed to a range of healthcare professionals and it may include patient information. A draft of the guidance is being made available for consultation during October with a view to publishing the finalised guidance in the spring. ■

SDCEP is an initiative of the National Dental Advisory Committee and operates within NHS Education for Scotland (NES). To learn more about SDCEP, visit the website at www.scottishdental.org/cep For enquires, email scottishdental.cep@nes.scot.nhs.uk or phone 01382 425751.

Doug Stirling is Programme Development Manager, Scottish Dental Clinical Effectiveness Programme (SDCEP).

Upgrades and evaluations

Practices are being encouraged to update their equipment, hygiene and decor, but unlocking tax relief to achieve this is no simple matter, explains Jayne Clifford

In recent years, there has been increased focus by dental practices – encouraged by health boards – to upgrade their practices by updating equipment, hygiene and decor. A recent example of this is the requirement for local decontamination units in practices.

Patients now expect a higher level of technology and quality of furnishings in practices.

The timing of, and the type of equipment purchased during, a refit ought to be considered from an accounting and taxation perspective, as there are differing rules for obtaining tax relief on your outlay.

Although day-to-day practice running expenses are usually allowable for tax relief – such as receptionists' wages, materials, and lab bills etc – obtaining tax relief for expenditure of a capital nature is not so straightforward.

In the past, practices would be eligible to claim 40 per cent or 50 per cent of the purchase cost of plant and equipment in the tax year of acquisition, and thereafter relief of 25 per cent per year on the remaining balance.

For some years now, Enhanced Capital Allowances (ECAs) have been available as tax allowances. These are claimable on items of plant, equipment and fixtures which feature some form of energy-saving or environmentally friendly properties as determined by the Government. All such eligible expenditure attracts a full write-off against taxable profits in the year of purchase.

Items typically eligible include heating, ventilation and air-conditioning (HVAC) fixtures and controls; boilers; specialist lighting equipment; compressed air equipment; power factor correction equipment; refrigeration equipment; ventilation systems; and washing equipment. All equipment attracting ECAs can be found on the Carbon Trust's website (www.eca.gov.uk).

The Annual Investment Allowance (AIA) was introduced with effect from April 2008. This allows the first portion of capital expenditure each year up to a level set by the Chancellor to be relievable against taxable profits in full, with some exceptions for items that have their own rules, such as cars.

The AIA was increased to £100,000 for the current tax year. Where levels of investment are below £100,000, (the AIA level for the current tax year), there is little difference in practice between non-ECA and ECA-eligible additions, as both will obtain 100 per cent relief.

Where additions are in excess of £100,000, ECA-eligible plant is entitled to 100 per cent relief on its own and the £100,000 AIA relief is still available for other qualifying capital expenditure.

As part of the Government's austerity measures, the AIA will be reduced to £25,000 from 1 April 2012, therefore if you are planning on capital expenditure such as a renovation or a refit, it may be worthwhile accelerating these works to complete prior to this date.

Although grants covering part of the costs of such improvements are usually available for practices operating in the public sector, it is worth bearing in mind the energy-saving potential of practice upgrades and replacements, as these will reduce overheads year on year via lower utility bills.

If energy-saving criteria can be demonstrated across a renovation project as a whole, and not on the mere acquisition of one or two items of equipment, you could be eligible for an interest-free loan from the Carbon Trust, with a repayment term of up to four years.

To qualify, your practice/Dental Body Corporate must be a small or medium-sized enterprise and have been already trading for 12 months.

The other criteria is:

- Have fewer than 250 full-time equivalent employees
- Annual turnover is below £40 million, and/or
- balance sheet total is below £35 million.

"If you are planning on capital expenditure such as a renovation or a refit, it may be worthwhile accelerating these works"
Jayne Clifford

One example of where this could be beneficial is where you as an established practitioner acquire another practice and wish to renovate the new practice to fit your corporate image.

It is worth noting that ECA-eligible plant and equipment, and improvement projects eligible for an interest-free loan, are mutually exclusive. The focus of the interest-free loans from the Carbon Trust are on replacement projects as a whole, rather than finance for certain items of plant only, whereas the focus with ECAs is on individual pieces of plant. Also, equipment forming part of a project could be eligible for an interest-free loan, but not be eligible for ECAs, and vice versa.

It is not feasible for accountants to know and understand every single piece of equipment dental laboratories and practices use and which has energy-saving potential. Likewise, dentists are not expected to retain specialist tax know-how. It is important to ensure you discuss the options with your accountant before the event, rather than afterward where any potential advice your accountant could offer is too little, too late. ■

Jayne Clifford is a partner at Martin Aitken & Co and has advised many dental clients, including those in the NHS and private sectors, for more than 20 years. Contact Jayne at jfc@maco.co.uk or on 0141 272 0000. Find out more about Martin Aitken & Co at www.maco.co.uk

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

Perils of periodontitis

Dr Alan Maxwell presents an examination of high-risk periodontal sites – and looks at treatment options such as regeneration techniques

Areas of destruction most often display an uneven distribution in advanced periodontitis. Sites associated with higher risk for recurrence are those areas exhibiting poor response to periodontal surgery, even though overall improvement may have occurred.

These sites become potential reservoirs for pathogenic bacteria. Subgingival recolonisation from these sites increases the chance for disease recurrence or progression. In addition, plaque control cannot be carried out appropriately and durably in these sites. Finally, when the balance between pathogenic and beneficial bacteria is unfavourable, these sites continue to undergo attachment loss. Adequate adjunctive treatment should be initiated.

There are three distinct types of risk sites:

1. Deep pockets
2. Interradicular lesions
3. Mobile teeth.

Bone defects

Residual deep pockets are usually associated with the presence of bony lesions that have responded poorly to initial therapy. Specific adjunctive therapy consists of carrying out reparative surgery through guided tissue regeneration or bone grafting. Numerous different grafting materials have been assessed in clinical studies: these include autogenous graft tissues, decalcified and calcified allografts, xenografts (purified bovine-derived enamel matrix components), and alloplastic bone substitutes (synthetic hydroxyapatite, tricalcic phosphates and bioactive ceramic materials). Most of these materials serve as guides for the regeneration of bone tissue.

The goal of periodontal regeneration techniques is the restoration of connective attachment tissue and enhancement of the growth of new cementum tissue, periodontal ligament and bone tissue. Regeneration of interproximal bone defects can only be performed through guided tissue regeneration using resorbable or non-resorbable membranes.

Results are difficult to predict. Membranes are frequently distorted, particularly in large lesions: this reduces the regeneration rate. In addition, when the membrane is exposed, it is highly susceptible to colonisation by plaque; this delays proper healing and may even compromise the overall outcome.

Prognosis is better for deep, narrow lesions than for shallow, wide lesions such as osseous craters. ■

> “The goal of periodontal regeneration techniques is the restoration of connective attachment tissue and enhancement of the growth of new cementum tissue, periodontal ligament and bone tissue”

TREATMENT PROCEDURE

TREATMENT OF AN OSSEOUS LESION WITH BONE GRAFTING AND REGENERATION.

- **Fig 1:** A 55-year-old female patient with aggressive periodontitis was referred by a colleague for assessment and treatment.
- **Fig 2:** After four one-hour periodontal sessions for full mouth root surface debridement under local anaesthetic, a deep periodontal pocket persisted around her maxillary right canine.

> “A periodontal flap was raised and the pocket further debrided and granulation tissue was removed”

- **Fig 3:** A periodontal flap was raised and the pocket further debrided and granulation tissue was removed. Attachment loss was estimated to be 14mm.
- **Fig 4:** Particles of Bio-oss mixed into the blood clot to form a firm coagulum that can be fitted to the destroyed septum. A resorbable membrane then was used to cover the site.
- **Fig 5:** Recorded pocket depth is 11mm post-operatively.
- **Fig 6:** Three years after surgery, periodontal tissue is healthy. Pocket reduction and gain of attachment are 9mm.
- **Fig 7:** Bone destruction reaches the periapical region (post-op radiograph).
- **Fig 8:** Outcome of the grafting procedure, three years after surgery. True regeneration was achieved.

Fig 1

Fig 2

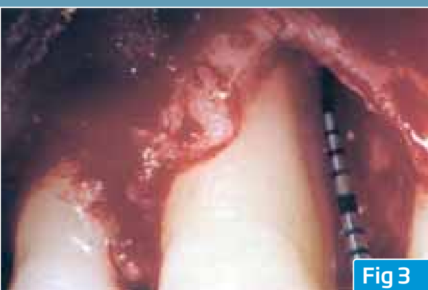


Fig 3

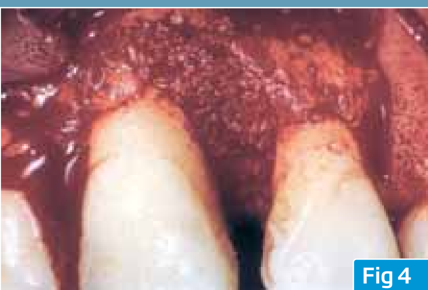


Fig 4

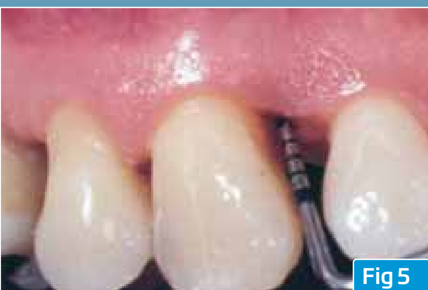


Fig 5

Fig 6

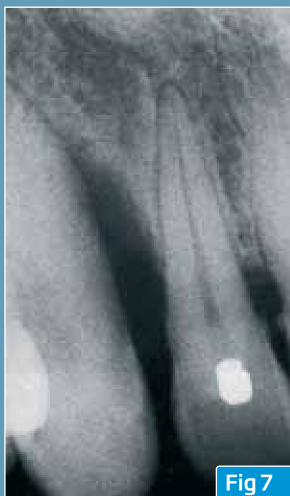


Fig 7

Fig 8

About the author:

Dr Maxwell is a specialist in periodontics. He graduated from the University of Glasgow Dental School in 1982 and obtained his MGDS from the Royal College of Surgeons in Edinburgh in 1990.

After obtaining his MSc in periodontology in 1997 at the University of Bristol, he was accepted on to the specialist register in periodontology in 2000.

Dr Maxwell is now based on Mondays and Tuesdays at Care Dental Focus in Crieff (01764 655745) and on Wednesdays, Thursdays and Fridayss at the Scottish Centre for Excellence in Dentistry (0141 427 4530), working as a periodontal specialist. He undertakes all aspects of treatment within his field, with a major focus on regenerative therapy and cosmetic periodontal surgery.

Dr Maxwell is a member of the British Society of Periodontology and has had his work published regularly in a number of leading dental journals. He also served as an examiner with the Royal College of Surgeons in Edinburgh and lectures to general dental practitioners and dental hygienists on a regular basis.

Removal of the dental biofilm

Marilou Ciantar explains the role patients and clinicians play in removing the dental bacterial biofilm, the cornerstone of non-surgical periodontal therapy

The formation of a biofilm is ubiquitous when bacteria and a solid surface are concurrently present in a fluid environment. The oral cavity is no exception.

Soon after birth, the mucous membrane of the oral cavity is colonised by bacteria partly derived from the mother and partly from the new environment (food etc) with which it comes into contact. A biofilm (plaque) forms on the oral mucous membrane, the thickness of which is kept in check by shedding oral mucosal cells. Eruption of teeth presents a different surface where the dental biofilm (dental plaque) can become established.

The presence of a hard, non-shedding tooth surface facilitates the development of the dental biofilm. Within a few minutes of tooth eruption or cleaning of a tooth surface, an acquired salivary pellicle develops almost immediately on the enamel surface. Within hours of pellicle formation, bacterial colonisation ensues through the ability of bacterial cells to bind directly to the pellicle and also to each other. If the biofilm is left undisturbed for about two to three weeks after pellicle formation, an increase in the complexity (quantity and quality) of the bacterial community leads to the formation of a mature biofilm.

The tooth-gingiva junction is a unique area in the body – it is the only site where a hard surface penetrates the soft tissue integument. It is specifically at this junction that the prevention or treatment of periodontal diseases takes place.

It was the seminal work of the eminent Swedish periodontist Harald Löe[1] which demonstrated very clearly that the accumulation of dental plaque at the tooth-gingiva interface led to the initiation of gingival inflammation (gingivitis) and that removal of dental plaque by instituting effective daily oral hygiene measures led to resolution of gingival inflammation and restitution of gingival health. This forms the basis of non-surgical periodontal therapy as we know it today.

Removal of dental biofilm – the patient's role

Considering how quickly plaque forms on teeth after its removal, the effective daily removal of the dental biofilm by the patient is the most reliable way of preventing its build up. Practically all patients own a toothbrush, be it a mechanical or a powered one. However, whether it is used effectively is another matter. Most patients brush their teeth on average once or twice a day and this helps them maintain good dental health.

Fig 1
Patient demonstration, on a model, of the use of dental floss and interspace brushes

However, most are not aware of the importance of brushing the tooth-gingiva junction, i.e. the most crucial aspect in preventing or treating periodontal disease, and thus maintaining good periodontal health. In fact most patients withdraw from approaching the gingiva with a toothbrush when they experience gingival bleeding. Others think that it is normal for gums to bleed as "they have always done so".

When asked whether they are aware of where the problem lies and how to follow effective daily tooth brushing regimes, most patients reply negatively. Most patients have never been given oral hygiene instructions. It is impossible to expect patients to perform such measures when they are unaware of where the problem lies or, more importantly, how to deal with it. What might seem common knowledge of dental anatomy to clinicians or dental care professionals might not be so obvious to our patients.

The first step in implementing an effective plaque control programme is by educating the patient on such measures. This is ideally done by performing an oral hygiene programme, which is individually tailored to each patient[2]. An assessment of the patient's knowledge of the disease, expectations and long-term goals should be established. This should be followed by an assessment of the patient's frequency of tooth brushing, motivation and assessment of manual dexterity.

The majority of clinicians, dental hygienists or therapists might be inclined to commence instrumentation at the first visit when patients attend for periodontal therapy. While this will lead to some improvement in the patient's periodontal status, it is only a short-term measure if the patient does not achieve and maintain a strict supragingival plaque control regime. Instrumentation of a heavily inflamed periodontium will be particularly uncomfortable for the patient and bleeding will hamper proper instrumentation.

Furthermore, instrumentation at this stage will impart the notion to the patient that the onus of periodontal therapy (more specifically supragingival plaque control)

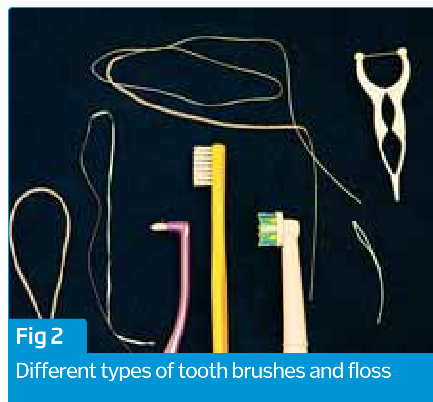


Fig 2
Different types of tooth brushes and floss

lies with the dental professional rather than with the patient. The importance of the patient's effective self-performed plaque control to a level compatible with periodontal health cannot be overemphasised.

Establishment of full mouth bleeding scores and plaque scores provides the patient with a tangible picture, and the clinician with documented evidence, of the level of plaque control. Demonstration of the periodontal status – plaque accumulation, periodontal pockets, bleeding on probing (BOP) etc – to the patient should be performed in the patient's mouth and also by explanation of the dental chart.

Implementation of the appropriate oral hygiene techniques will help the patient attain and maintain periodontal health at the dento-gingival junction. The discussion at this stage should focus on the demonstration of effective tooth brushing techniques (Fig 1), including the use of interdental cleaning aids such as interspace brushes and dental floss (Figs 2, 3). Powered toothbrushes seem to offer additional benefit over manual toothbrushes[3], while single tufted toothbrushes are particularly useful for entering periodontal pockets (Fig. 4).

Removal of the dental biofilm at the orifice of the periodontal pocket will deter microbial colonisation within the periodontal pocket. Several clinical studies have shown that, in the absence of strict supragingival plaque control, recolonisation of periodontal pockets can take place as early as three weeks following instrumentation[4]. Mouthwashes may be used as adjuncts in non-surgical periodontal therapy[5]; while they are capable of reducing the bacterial load supragingivally, they do not penetrate periodontal pockets[6].

Removal of dental biofilm – the clinician's role

Periodontal pockets provide the ideal ecological environment for harbouring periodontal pathogens that migrate subgingivally from the supragingival microflora. The accumulation of subgingival microflora leads to the formation of a subgingival biofilm on the root surface. In contrast with the supragingival bacteria, the predominant subgingival bacteria are anaerobic and Gram-negative. These bacteria release various toxins including lipopolysaccharide (LPS, released by Gram-negative bacteria), which are capable of eliciting an inflammatory response by the host. The subgingival biofilm might also calcify to form subgingival calculus.

The removal of the subgingival biofilm, especially in moderately deep (4-5mm) or deep (>6mm) pockets is equally as important as removal of its supragingival counterpart by the patient. Subgingival instrumentation is the remit of the dental surgeon, hygienist or therapist and should corroborate the patients' efforts.

Mechanical removal of the subgingival biofilm can take place either via hand, sonic or ultrasonic instrumentation. Several studies have confirmed that the different subgingival modalities yield similar clinical improvements in therapeutic outcomes in both moderately deep[7,8] and deep[9,10] periodontal pockets. The use of ultrasonic debridement might have the added benefits of its cavitational effect and of being kinder to the clinician and patient. Recent clinical studies have shown that one episode of full mouth ultrasonic debridement is as effective as the more time-consuming (and possibly more painful) quadrant by quadrant scaling and root planing[11,12].

Fig 3
Different sizes and types of inter dental tooth brushes

Traditional periodontal instrumentation has been based on scaling i.e. the removal of supragingival calculus and/or root planing i.e. the instrumentation aimed at removing the microbial flora on the root surface or lying free in the pocket, all flecks of calculus and all contaminated cementum and dentin[13]. The emphasis was on removal of 'contaminated' and 'infected' cementum and thus sharp (hand) instruments were used to remove cementum until a smooth root surface was established.

The removal of cementum invariably leads to the removal of the notorious subgingival biofilm associated with its surface and hence leads to improvement in clinical symptoms i.e. probing depths, bleeding and suppuration[14]. The removal of cementum *per se* has been questioned as soft tissue healing via a long junctional epithelium has been observed if the cementum is kept plaque free[15,16].

Furthermore, *in vitro* studies have shown that the bacterial endotoxin (lipopolysaccharide) and other bacterial toxins are very superficially bound by cementum and these can be relatively easily removed by brushing or a conservative regime of ultrasonic root debridement[17,18]. Smart et al (1990)[18] proposed the use of the term root surface debridement (RSD), defined as ultrasonic instrumentation of the root surface using overlapping strokes and assuming light pressure and limited time. This is distinct from the more traditional root surface planing (RSP) which involved the deliberate removal of root cementum[13].

The presence of a smooth surface after RSP was considered to be the therapeutic goal; however, clinical success should be judged by the resolution of clinical periodontal symptoms (BOP, reduction in pockets depths, etc) upon clinical re-evaluation at a subsequent visit rather than on the smoothness of the root surface.

Maintenance of periodontal health – patient's and clinician's role

Once the active phase of periodontal therapy is over, each patient's periodontal status is re-evaluated in order to ascertain the effect of non-surgical periodontal therapy. In some patients, periodontal pockets might persist and these pockets would warrant surgical elimination. At re-examination, some patients' manifest complete resolution of periodontal pocketing and these proceed directly to the maintenance phase of periodontal therapy, also known as supportive periodontal therapy (SPT). SPT is defined as "the essential need for therapeutic measures

Continued »

Fig 4
Biofilm removal at the entrance of a periodontal pocket via use of a single tufted brush

Continued »

to support the patient's own efforts to control periodontal infections and to avoid recontamination"[19].

Two integral components of SPT are:

1. Regular visits by the patient – these should yield positive feedback, encouraging the patient to maintain as plaque-free a dentition as possible
2. Continuous diagnostic monitoring of the patient by the clinician in order to intercept with adequate therapy at the optimal time.

Continuous monitoring should include recording of plaque and bleeding scores. It has been clearly established that plaque-free dentitions which are under regular supportive care maintain periodontal stability for many years, while plaque-infected dentitions will manifest recurrence of periodontal breakdown[20,21,22]. The frequency of recall visits should be based on each patient's needs as assessed by the individual's periodontal risk assessment (PRA), which should be established at the end of active treatment. Based on the PRA, some high-risk patients might need to be seen every three months for continuous monitoring and possibly for further treatment as determined by the clinical findings.

Some patients might continue to have good periodontal health at the three-month recall visit and, if low risk, would not need any further instrumentation, but a review visit possibly at a longer time interval than three months. Instrumentation at healthy, i.e. non-inflamed, periodontal sites will actually induce loss of attachment[23,24].

Marilou Ciantar

Thus, not all patients require three-monthly visits to the dentist or hygienist; some benefit from six-monthly (medium risk) or annual visits (low-risk cases). The frequency of recall is determined by consideration of previous disease predisposition as well as general factors (systemic/environmental/genetic) and local factors (BOP, pocket probing depths >5mm, tooth loss, bone loss)[25].

Conclusions

1. Removal of the bacterial biofilm remains the cornerstone of non-surgical periodontal therapy.
2. The importance of the patient's self-performed plaque control cannot be over emphasised.
3. Mechanical disruption of the sub-gingival biofilm, in addition to strict supragingival plaque control, is crucially important and leads to improved clinical outcomes.
4. Removal of cementum is unwarranted.
5. Maintenance of periodontal health should be jointly established by the patient's continued supragingival plaque control and the clinician's subgingival instrumentation when indicated.
6. The frequency of recall visits should be tailored according to patient's needs. ■

Marilou Ciantar is a specialist periodontist and oral surgeon based at Blackhills Clinic in Aberuthven. She welcomes referrals for any aspect of periodontal therapy, oral surgery or implant surgery, with conscious sedation if required. www.blackhillsclinic.com

REFERENCES

1. Löe H, Theilade E, Jensen SB. Experimental gingivitis in man. J Periodontol. May-Jun; 36: 177-87.
2. Jönsson B, Öhrn K, Oscarson N, Lindberg P. The effectiveness of an individually tailored oral health educational programme on oral hygiene behaviour in patients with periodontal disease: a blinded randomised-controlled clinical trial (one-year follow up). J Clin Periodontol 2009; 36: 1025-1034.
3. Robinson PG, Deacon SA, Deery C, et al. Manual versus powered tooth brushing for oral health. Cochrane Database Syst Rev 2005; Apr 18:CD002281 (revised from 2003).
4. Sbordone L, Ramaglia L, Gulletta E, Iacono V. Recolonisation of the subgingival microflora after scaling and root planing in human periodontitis. J Periodontol 1990; 61: 579-584.
5. Ciantar M. Chemical agents in periodontal therapy: use or misuse? Dental Update 1995: Jul/Aug; 238-242.
6. Pitcher GR, Newman HN, Strahan JD. Access to subgingival plaque by disclosing agents using mouth rinsing and direct irrigation. J Clin Periodontol 1980; 7: 300-308.
7. Torfasen T, Kiger R, Selvig KA, Egelberg J. Clinical improvement of gingival conditions following ultrasonic versus hand instrumentation of periodontal pockets. J Clin Periodontol 1979; 6: 165-176.
8. Badersten A, Nilveus R, Egelberg J. Effect of nonsurgical periodontal therapy (I). Moderately advanced periodontitis. J Clin Periodontol 1981; 8: 57-72.
9. Badersten A, Nilveus R, Egelberg J. Effect of nonsurgical periodontal therapy (II). Severely advanced periodontitis. J Clin Periodontol 1984; 11: 63-76.
10. Oosterwaal PJM, Matee MI, Mikx FHM, et al. The effect of subgingival debridement with hand and ultrasonic instruments on the subgingival microflora. J Clin Periodontol 1987; 4: 528-533.
11. Zanatta GM, Bittencourt S, Nociti FH Jr, et al. Periodontal debridement with povidone-iodine in periodontal treatment: short-term clinical and biochemical observations. J Periodontol. 2006; 77: 498-505.
12. Del Peloso Ribiero E, Bittencourt S, Sallum EA et al. Periodontal debridement as a therapeutic approach for severe chronic periodontitis: a clinical, microbiological and immunological study. J Clin Periodontol 2008; 35: 789-798.
13. O'Leary T. The impact of research on scaling and root planing. J Periodontol 1986; 57: 69-75.
14. Slots J, Mashimo P, Levine MJ, Genco RJ. Periodontal therapy in humans.I. Microbiological and clinical effects of a single course of periodontal scaling and root planing and of adjunctive tetracycline therapy. J Periodontol 1979; 50: 495-509.
15. Listgarten MA, Ellegard B. Electron microscopic evidence of a cellular attachment between junctional epithelium and dental calculus. J Periodontal Res. 1973; 8: 143-50.
16. Nyman S, Sarhed G, Ericsson I, Gottlow J, Karring T. Role of "diseased" root cementum in healing following treatment of periodontal disease. An experimental study in the dog. J Periodontal Res 1986 Sep; 21: 496-503.
17. Moore J, Wilson M, Kieser JB. The distribution of bacterial lipopolysaccharide (endotoxin) in relation to periodontally involved root surfaces. J Clin Periodontol 1986; 13: 748-751.
18. Smart GJ, Wilson M, Davies EH, Kieser JB. Assessment of ultrasonic root surface debridement by determination of residual endotoxin levels. J Clin Periodontol 1990: 17; 174-178.
19. Lang NP, Bragger U, Salvi G, Tonetti MS. Supportive periodontal therapy. In: Clinical periodontology and implant dentistry. Ed: Lang NP, Lindhe J. 2008; Chapter 59; p 1257.
20. Rosling B, Nyman S, Lindhe J, Jern B. The healing potential of the periodontal tissues following different techniques of periodontal surgery in plaque-free dentitions. J Clin Periodontol 1976; 3: 233-250.
21. Axelsson P, Lindhe J. Effect of controlled oral hygiene procedures on caries and periodontal disease in adults. Results after 6 years. J Clin Periodontol 1981a; 8: 239-248.
22. Axelsson P, Lindhe J. The significance of maintenance care in the treatment of periodontal disease. J Clin Periodontol 1981b; 8: 281-294.
23. Lindhe J, Nyman S, Karring T. Scaling and root planing in shallow pockets. J Clin Periodontol 1982; 9: 415-418.
24. Cobb CM. Non surgical pocket therapy: mechanical. Ann Periodontol 1996: 1 : 443-490.
25. Lang NP, Tonetti MS. Periodontal risk assessment for patients in supportive periodontal therapy (SPT). Oral Health Prev Dent 2003; 1: 7-16.

SYNERGY® D6

UNIVERSAL NANO HYBRID COMPOSITE

BEAUTY MADE SIMPLE

SPECIAL VALUE £49.50

Synergy D6 Tips OC7.0 + SwissFlex Promo Kit

20 tips, 0.25g each
(Dentin: A1/B1, A2/B2, A3/D3, Enamel Universal)
1 x SwissFlex (1 Mandrel + 9 Discs) 1 x OC7.0 (5ml)

+ 3 refill packs (tips only) FREE*
Save £102.50 on RRP

REASONS TO USE SYNERGY D6

- Perfect Aesthetics every time
- Excellent handling

Synergy D6 Syringe OC7.0 + SwissFlex Promo Kit

3 syringes, 4g each
(Dentin: A1/B1, A2/B2, A3/D3)
1 x SwissFlex (1 Mandrel + 9 Discs)
1 x OC7.0 (5ml)

Save £97.20 on RRP

✱ BUY A SYNERGY D6 WELCOME KIT AND GET A SWISSFLEX KIT FREE ✱

SwissFlex™

No slippage of the mandrel
Higher efficiency

Covered Mandrel
Avoids scarring and discolouration

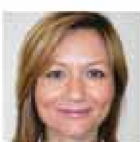
Super thin foil disc
Ideal access to the tooth surface

SwissFlex Welcome Kit contents:
200 x discs, 40 x strips, 3 x mandrels

PRICECHECK: COLTENE PRICES NOT AFFECTED BY CURRENCY FLUCTUATIONS

Contact your local representative

East Scotland
Gillien Duncan
07788 146109



West Scotland
Heather MacMillan
07900 892612

or FREEPHONE 0500 295 454 ext's 223 Julie, 224 Adrian
www.coltene.com

*FREE goods sent from C/W direct on proof of purchase Fax: 01444 870640

coltène whaledent

Pins and needles

Acupuncture has been practised for thousands of years, yet it's only recently that dentists have realised how it can help their patients. Tom Thayer explains a few of the therapy's applications

Acupuncture as a therapy is practised worldwide, but has strong cultural ties with China and the Far East. It was first formalised by the Yellow Emperor in China about 2,600BC – although the therapy was probably ancient even then.

Acupuncture relies upon the insertion of a solid needle through the skin to stimulate the body and produce therapeutic effects. The present therapeutic systems of acupuncture are the results of centuries of observational medicine – reproducible effects identified by practitioners and used to provide a system of treatment for patients.

To many with a western medical or scientific education, the acupuncture system can seem bizarre and unbelievable. This is not helped by the use of names that appear to relate to structures but actually don't (such as stomach meridian or gall bladder meridian), and concepts of the Yin and Yang, and the body's life energy – the Chi.

Acupuncture has, however, enjoyed a renaissance over the past 30 or so years in the west, with a vast number of practitioners across the UK. Some have a traditional Chinese training, others a western training. Some restrict their approach to specific systems – such as ear acupuncture, and some mix their practice with other therapies – traditional, or western such as physiotherapy.

Acupuncture as a therapy to use within dentistry has developed slowly – a few articles appeared in the 1980s and 1990s from practitioners who had integrated the technique into their practice, but a paper by Rosted reflected a growing interest in the possibility of the use of acupuncture by dentists.

This has since been followed by a number of further papers by the same and other authors looking at a range of applications for acupuncture to help

Continued »

To many with a western medical or scientific education, acupuncture seems bizarre and unbelievable at times

Continued »

dental patients. They now include: temporomandibular disorders (TMD), facial pain, chronic headache and migraine, neuralgias, post-operative pain, sinusitis and rhinitis, gagging and dental anxiety. Xerostomia can be helped in suitable patients by stimulating salivary activity – provided any active glandular tissue remains, and there are also suggestions that acupuncture may be helpful for oral dysaesthesias, and possibly apthous ulceration, although no evidence exists for this as yet.

Perhaps the most important and dramatic impact for dental treatment is the impact that acupuncture may have on controlling gagging.

Either of two main sites can dramatically reduce, and normally eliminate, gagging in most patients. As a consequence, the potentially traumatic treatment session can become routine. It is important to note that patients with gagging due to severe anxiety will not respond – and are best treated with Midazolam for anxiety control.

Needles are placed at specific sites – either on the chin, or above the tragus of the ear on both sides, or at all three sites. The effect is typically evident within 60 seconds, although may take a little longer in some cases, and has a reliability of around 80 per cent. The effect lasts while the needles are in place, and generally for a short time after – but normally does not give persistent changes in gagging sensitivity.

The technique is quick, cheap (needles are approximately 10p each), requires limited training, and has a very low risk of morbidity or complications. It also does not rely upon patient co-operation – unlike hypnosis, visualisation or distraction. Practitioners and patients alike are usually astounded at how effective the technique is.

A further adoption for the control of the gag reflex is following the fitting of new dentures. Some patients struggle to cope initially, and arm sites used for the control of nausea and vomiting may also be used to control of gagging – but require 20 minutes to take effect. Small indwelling needles can be placed on both arms and left in situ for several days while the patient adapts to the new denture, easing their transition. A combination of ear/chin points for the fitting of the denture followed by arm sites to follow on with is used.

Needle at chin point for gagging

Acupuncture may also be used to relax patients before or during their treatment. The approach relies upon the fact that acupuncture leads to a release of endorphins and serotonin within the central nervous system, and these produce both a relaxation of the patient and a change in mood – an effect that can last days for some patients.

Ear point used for gagging

The technique is quick, cheap, requires limited training, and has a very low risk of morbidity or complications

A site in the midline, behind the vertex of the head, is used, sometimes with accessory supportive points, for this effect, although sedation as a side effect is seen with most acupuncture sites to a greater or lesser extent. When you have put half a dozen needles in the patient's face and they go to sleep in the dental chair it reinforces the belief that acupuncture works!

Temporomandibular disorders are also well treated with acupuncture. Needling of the muscles of mastication can reduce pain, improve function, and reduce trismus. Clicking can also be improved or in some cases eliminated with needling – mainly to lateral pterygoid muscles. Typically masseter, anterior part of temporalis, and sometimes lateral pterygoids are needled, and responses can be dramatic – with reduction in symptoms obvious almost immediately in about 50 per cent of patients, some showing delayed improvement.

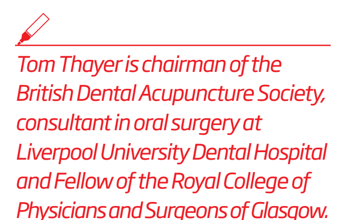
An average of four visits will normally significantly improve patients' symptoms.

Effectively, acupuncture is part of a dynamic therapeutic approach to manage differing aspects of the patient's symptoms. Headaches associated with TMD are also successfully treated with acupuncture. Recent Cochrane reviews indicate that acupuncture is as effective as conventional therapies for chronic headache and migraine prophylaxis, but with superior side effect profiles.

Outcomes with acupuncture are generally positive. Patient feedback is also usually positive, but occasionally responses can be delayed, taking two or three treatments to improve, and occasionally hyper-responders can feel unwell for several days following a treatment.

Some patients are unsuitable for acupuncture: atypical facial pain, and atypical odontalgia are poorly treated in most patients, and acupuncture will never replace local analgesia – although it may improve the effectiveness of analgesia.

Acupuncture should be used realistically – it will not cure caries, or an acute abscess – and dentists should remember they are dentists first! ■


Tom Thayer is chairman of the British Dental Acupuncture Society, consultant in oral surgery at Liverpool University Dental Hospital and Fellow of the Royal College of Physicians and Surgeons of Glasgow.

Advancing Implant Knowledge Through High Quality Courses

“ An excellent thorough grounding for any budding implantologists or experienced operators, with evidence-based references. The course is provided by two experienced and enthusiastic implantologists, in a first class facility. ” KC Chan, Dental Practitioner, Glasgow

The **GIFT Continuum** teaching programme is an on-going series of specific dental implant based topics that can be attended in any order, delivering units of information that combine to form the building blocks of a course that may be expanded to a postgraduate degree.

Regional and International Training
Training is delivered via a network of regional and international teaching centres. Facilities are appropriate to the practice of implant dentistry, providing the highest quality teaching environment and standard of clinical training.

Theoretical and Clinical
This course is ideal for those practitioners who wish to incorporate implant treatment into their practice, to advance their implant knowledge or consolidate existing expertise, but who are unable to commit to a degree programme. This does not preclude the delegate from following the degree programme at a later date and credit will be given towards the University of Warwick MSc and diploma courses in Implant Dentistry. Both MSc and diploma are registerable with the GDC as additional professional qualifications.

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

Tel: 0207 5801373 Email: admin@gift.org.gg

Is there an electronic way to refer patients to secondary care? NHS Fife eHealth clinician Dr Grant Forrest explains how the health board is improving efficiency and safety by adapting existing secure systems

The challenges ahead

Referral to secondary care is fairly common. So it seems odd that, with so many advances in electronic communication, the process is still largely paper-based, with the great majority of referrals from GDPs to orthodontics, oral and maxillo-facial surgery (OMFS) or community dental services being either typed or handwritten and then printed and sent by post.

Over the past 18 months, NHS Fife (in common with a number of other NHS Scotland boards) has been seeking to promote electronic referral. This article presents our experience and reflects on the situation nationally in terms of what is being done and what still needs to be done to move away from paper.

NHS (N3) Network (www.n3.nhs.uk/n3scotland/)

Some years ago, the Scottish Government committed itself to delivering secure, reliable N3 network connections to dental practices. Following an extended roll-out programme, this has largely been delivered. Having a secure, dedicated connection to the N3 network is a prerequisite for sending and receiving confidential, patient-identifiable information. It has never been acceptable to send this kind of information over the public internet, not even with appropriate encryption.

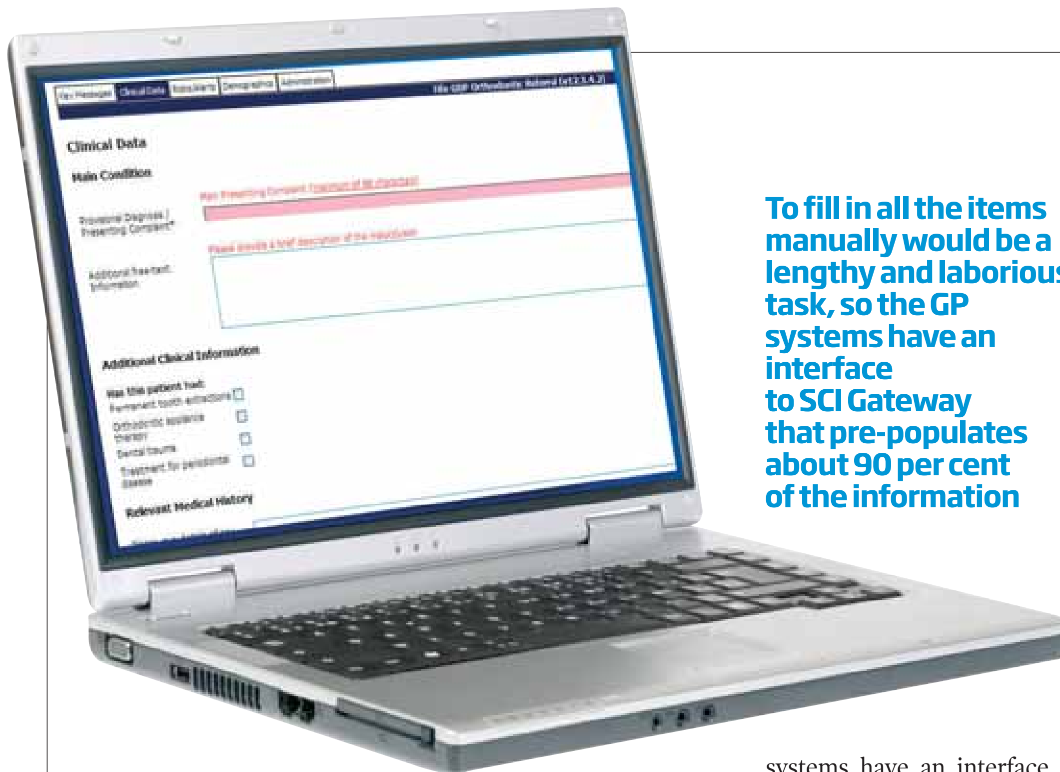
The difficulty for GDPs is that their N3 connection is likely to sit alongside (rather than replacing) their existing practice network and business broadband connection. If they

The difficulty for GDPs is that their N3 connection is likely to sit alongside (rather than replacing) their existing practice network and business broadband connection

have a dental practice management system (DPMS) such as R4 or SOE, it's highly likely that it will use the existing practice broadband connection to download patches and updates. Many GDPs will use their practice broadband connection for email (business and personal) and to browse the internet.

Unfortunately, this connection can't be used to send confidential patient-identifiable information, and while the N3

Continued »



Continued »

connection is approved for that purpose, it will be subjected to some restrictions, normally outlined in the Service Level Agreement (SLA).

SCI Gateway, the Scottish eReferral system

Leaving the network integration problems aside for a moment, it seems appropriate at this point to describe SCI Gateway, the approved system for sending referrals electronically in NHS Scotland.

SCI (Scottish Care Information) is an NHSScotland team that develops and supports a number of clinical applications. SCI Gateway is a simple web-based messaging system that can transmit structured clinical information from a sender to a receiver. It's used extensively by GPs to refer to secondary care. In Fife alone, more than 7,000 referrals were sent using SCI Gateway in March 2010 and nationally, the figure tops 50,000 per month.

Although it's possible to send referrals by email, SCI Gateway offers many advantages, including:

- Structured forms for entering clinical, demographic and administrative data
- Guaranteed delivery
- Referral status information (viewed, printed, etc)
- A comprehensive audit trail
- 'Work list' of referrals in progress.

Access to SCI Gateway is limited to N3 connections – i.e. you need to be on the NHS network to log in and use it. In Fife, we've developed a couple of forms specific to orthodontics and OMFS, so that relevant information can be captured and displayed in the referral letter.

Each health board has the ability to create its own referral 'protocols' which are essentially web-based forms, much the same as those you would come across on any

Of particular concern has been the handling of the CHI number. CHI, or Community Health Index, is the unique 10-digit patient identifier for NHS Scotland. Until recently, it has not been possible for GDPs to get access to this number

website. For GPs, the forms have large sections for:

- Demographics
- Medical history
- Medication
- Risks and alerts
- Administration e.g. patient transport requirements.

To fill in all the items manually would be a lengthy and laborious task, so the GP

To fill in all the items manually would be a lengthy and laborious task, so the GP systems have an interface to SCI Gateway that pre-populates about 90 per cent of the information

systems have an interface to SCI Gateway that pre-populates about 90 per cent of the information – filling it in automatically by extracting it from the patient's record in the GP system.

Unfortunately, there is no equivalent interface between SCI Gateway and the dental practice systems, although I believe that this has been discussed at the national R4 user group meetings.

Clearly, discussion has to take place with the other DPMS software suppliers too. As you can imagine for the GP system suppliers, it was a lengthy process getting them all wired into SCI Gateway, particularly when many of them were committed to developing their products for the English market which, over the past few years, has seen investment of an estimated £12 billion into the Connecting for Health programme.

In the absence of an interface, and anticipating a similar slow pace of development, we decided to push ahead with electronic referral, choosing to strip away as much of the unnecessary detail in the referral as possible. We chose to remove the medical history, medication and risks/alerts sections and replace them with a simple text box to allow the GDP to record any information that may be relevant, acknowledging that the GDP's medical summary will not be as comprehensive as that held by the patient's GP. In the final part of the clinical data form, the GDP can record their practice information.

We have been through a lengthy process with the Information and Statistics Division (ISD) of NHSScotland to get the Fife GDP demographics added to SCI Gateway. We now have this information on a development version of SCI Gateway and are testing it to see whether it can be used to pre-populate this section of the form, in the same way that GP information is handled.

The last section of the referral form deals with the patient's demographics. Of particular concern has been the handling of the CHI number. CHI, or Community Health Index, is the unique 10-digit patient identifier for NHSScotland. Until recently, it has not been possible for GDPs to get access to this number. Some recent work with Kodak has enabled the R4 system to communicate with the national CHI database and do a 'look up' of the patient's CHI number, but we accepted that few GDPs would have the ability to do this, so we chose to exclude CHI from the mandatory items in the form. In other words, SCI Gateway will accept a referral even though the patient's CHI number is missing.

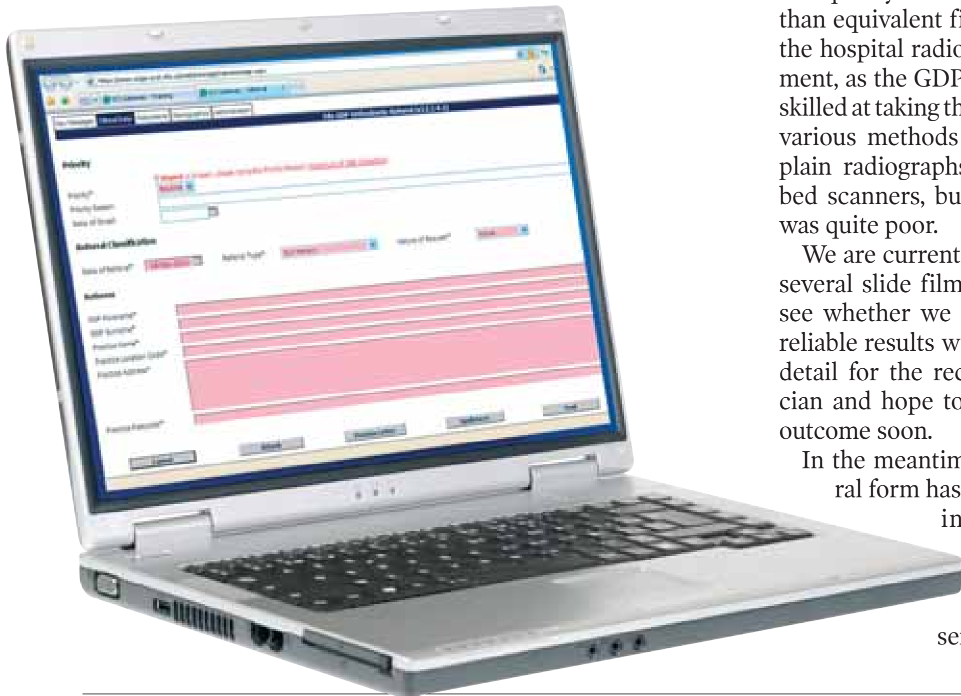
Assuming all the information on the form is complete, the referrer hits send and the referral is accepted by SCI Gateway. At the receiving end, staff in orthodontics or OMFS can log in and view or print the referral.

Radiographs

The proportion of GDPs with access to digital radiography is rising, but remains low in some areas, so we had to look at solutions for sending both digital and plain-film radiographs. For digital radiographs, the process was fairly simple. Images in R4 can be saved locally as jpeg files on the practice computer. SCI Gateway allows the referrer to attach any number of files to the

referral, including image files.

There may be practical issues around transferring image files from the practice computer to the N3-connected computer where the referral is being created. We've considered using USB sticks, but a more practical solution would be to connect both computers to a shared drive on the practice network and store the images in a dedicated folder.



For plain radiographs, we asked our colleagues in OMFS and orthodontics what value they place on these. Not surprisingly, they commented that the quality was often higher than equivalent films taken in the hospital radiology department, as the GDPs were more skilled at taking them. We tried various methods of scanning plain radiographs on A4 flat bed scanners, but the quality was quite poor.

We are currently evaluating several slide film scanners to see whether we can produce reliable results with sufficient detail for the receiving clinician and hope to publish the outcome soon.

In the meantime, our referral form has an option to indicate that plain radiographs will be sent separately by post, with the receiving specialty marrying them up with the electronic referral on arrival.

Challenges ahead

By far the biggest challenge will be to work with the DPMS suppliers to integrate their software with SCI Gateway. Preliminary discussions with Kodak are underway, but we need to define a process for engaging the other suppliers and selling the benefits of using SCI Gateway for referral.

There are huge potential benefits be gained from electronic referral in terms of efficiency and patient safety, but it has to be sold as a concept to the GDPs, it has to be quicker and easier than existing paper processes and the software integration has to be co-ordinated nationally. ■

Email: grant.forrest@nhs.net

Space to grow

When Joe and Wendy refurbished the Pearl White Dental Laboratory, they made the most of their large premises

After 21 years of trading, Joe and Wendy Jackson of Pearl White Dental Laboratory decided their business premises were in need of restoration. They were also keen to maximise the space at their Airdrie base.

Wendy said: "When we moved into the building 12 years ago we knew we had more space than we required, but it was a great building with lots of potential.

"Following our split with Diamond Ceramics last year, the time had come to create a new facility that not only gave us a modern, efficient and more specialised environment, but also gave us the opportunity to diversify and maximise space."

The pair turned to SAS Shopfitters for advice because of its expertise in this area and experience in carrying out refits while allowing the client's business to run as normal.

When Dereck Lang and Terry Cuthill of SAS arrived at the Airdrie laboratory they could see the building's potential. They listened to what Joe wanted to do, and quickly turned the premises into a state-of-the-art facility incorporating a new dental service.

Dereck said: "The main work involved creating the customised work benches and a total overhaul of the extraction system, but we could see the potential in walling off the extra space to create two dental surgeries, which the Jacksons agreed to."

This required applying for a "change of use" application with the local council as well as obtaining building consent, which took about six months.

Once building consent was in place, SAS Shopfitters got to work, renovating the entire building with Karndean flooring, antibacterial wall panelling and Corian worktops. They split the building in half, allowing Joe's team to work at one end of the building while they renovated the other and then switched over to finish the rest.

In addition to the bench-lined laboratory, the facility also has a scanning room, administration office, three toilets (one disabled), a large staff room, a consultation room, two surgeries, LDU room and a reception/waiting area.

Wendy said: "Now our technicians are working in a more professional environment which creates a great work ethos.

"We are also looking to offer our facilities for training purposes at weekends. I have liaised with training providers to examine the benefits of hosting training seminars. Similarly, we are approaching dental schools in the hope that they will bring dental professionals to see what is involved in the manufacturing of dental restorations and to see the latest technology on the market."

Joe and Wendy have a daughter, Jade, in her fifth year of dentistry at Dundee Dental School. Through the years she has been involved with the lab, which has given her a great understanding of crown and bridge work.

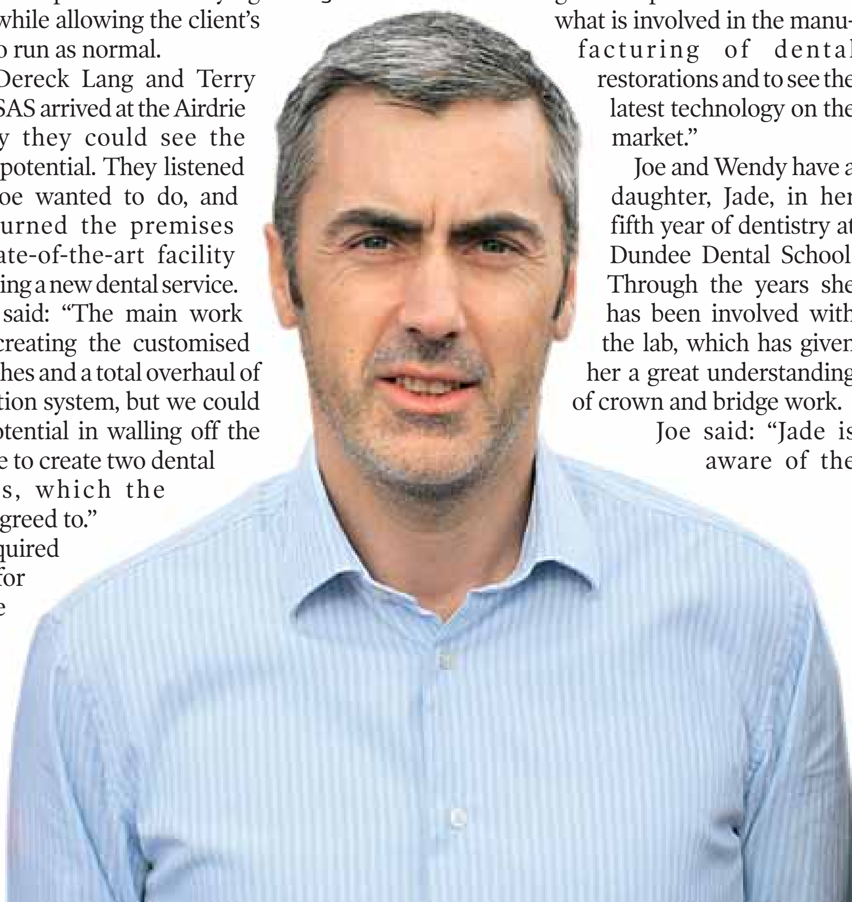
Joe said: "Jade is aware of the latest products on the market and has a good understanding of using them. She recently returned from her elective in Australia where she was able to discuss the new full zirconia posterior crown with dental surgeons out there – a new product which we manufacture at the laboratory."

Now that the work is in its final stages, Joe and Wendy are looking to develop the business further. They believe Airdrie and the surrounding district would benefit from an orthodontist and they would be glad to rent out their new surgeries to an interested party.

Joe added: "We have worked in this area for 21 years and recently there has been a lot of interest in raising Airdrie's profile.

"We would like to think we could be part of that process. We have been working with our local dentists since opening the laboratory and are grateful for their business. Hopefully bringing an orthodontist to the area would help with their patient referrals and cut down waiting times." ■

Contact Joe or Wendy on 01236 760707.



Joe and Wendy Jackson have made space in their laboratory for two dental surgeries

• **Metal Free Restorations** • **Procera** – Lava & e.max approved laboratory
• **Implant work** – Nobel Biocare – Straumann – Ankylos and most other systems
• **Quality Crown & Bridge** – Prosthetics – Gradia Inlays

We have a dedicated private department and use only quality materials, highly trained and experienced technicians.

Lava™

Free collection service available from Glasgow, Ayrshire, Lanarkshire and West of Scotland locations.

tel: 0141 332 9252 – 17 Park Circus Place, Glasgow G3 6AH – email: admin@adairdentallab.com

*Lava Crown and Bridges are trademarks of the 3M company or 3M ESPE AG

How you can improve your success rate

Make the most of your relationship with technicians to give patients a great service, and generate positive word of mouth, says Jim Mason

The relationship between dental technician and dentist can sometimes be taken for granted, but by improving communication, co-operation and teamwork, you can significantly improve your success rate.

In recent years, increasing focus on patient protection and registration of the whole dental team has opened up many additional responsibilities for dental technicians.

However, quality starts with you, the dentist. Your patients only want your best work, so surely the best way to give your patients what they were promised is to really work together with your technicians to improve their results.

You can only build a sustainable practice by creating genuine word of mouth referrals. If you're thinking of cutting your prices or if you have to constantly search for new business, you'll never be at peace and you'll probably burn out.

We all suffer from some degree of performance lag – the difference between the exceptional services we want to provide on a daily basis, and how it really is. If you cut every corner it will be even harder to provide the service you really want to provide. So we would all benefit if we worked as a team to improve our services and success.

I have chosen to highlight some of the main things that technicians need from their client dentists to delight their patients because these are the points that matter the most. If we could pin them all down it would greatly improve our success rate. Examples of your best work, so to speak.

Accurate impressions in metal or custom full arch trays as standard

You need to understand why poor impressions and flimsy trays cause many of your occlusal problems. You need to recognise often subtle, but important, features in impressions that create problems with the fit of your work, or which indicate a retake. When you've had a bad day, the lab needs to phone you and let you know.

Meaningful and accurate occlusal records

When the occlusion is unstable, you need to know how to provide us with accurate and stabilising occlusal records. You need to know when a facebow record is advisable and when a centric-relation record is a necessity. We need to agree the protocols when reorganising the occlusion or raising the OVD.

Surgery and lab stage protocols

Surgery and lab stage protocols need to be understood by the whole team and knowledge transferred accurately every time. The big cases are your opportunity to delight your patients and generate genuine word of mouth referrals. However, if they

are a disaster, they have the potential to destroy your confidence and reputation.

Shade matching and smile design

When expectations are high, you really

need to up your game and it all takes time. You need to understand the science behind a beautiful smile and you need to

Continued »

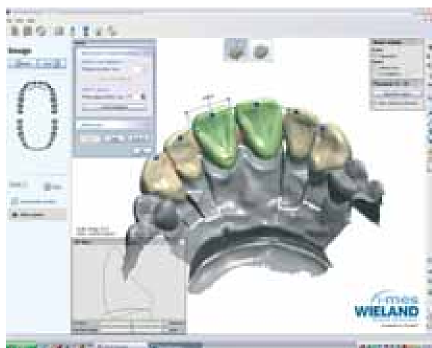
Continued »

understand materials and prep design so we can give you our most aesthetic products that last. When you provide us with your best work, we should give you ours.

We should consistently provide you with:

1 Restorations that fit as well in the mouth as they do on the working casts

With accurate dies, our scanners and milling machines can create the most perfect fitting crowns and bridges we have ever produced.



2 Restorations that fit comfortably within the occlusal scheme with the very minimum of adjustment

We fully understand occlusion and, with accurate records, we'll mount your casts and return your cases equilibrated every time they require it.

3 Complex works completed exactly the way you expect them to be

The most successful dentists plan their bigger cases better than the others plan theirs, and they work closer with the technicians at the lab.

4 Your technician should provide custom shade matching at the lab to reinforce your commitment to quality

We can all take a shade – matching a shade is our goal. Shades in the aesthetic zone can be demanding, especially matching an upper central incisor. Ceramists really need to see their work in the mouth to truly appreciate the demands that are placed upon them.

So how's your success rate?

You've probably created the reputation you deserve; we all have. Do your past clients always tell their friends about how you created their beautiful smile? On average, your success rate for non-complex restorative work from the lab should be at least 95 per cent.

On complex or private work, 90 per cent could be more realistic as you take on the more demanding cases and your patients expect more attention to detail. Incorporating verification stages in complex cases keeps you in control and improves your success rate. Your lab should be able to advise you what your success rate is, and how to improve it.

We could all do better and there is so much to learn. I would encourage any dentists seeing gaps appearing in their books to use the spare time wisely and seek training with their team. Technicians love to see their cases succeed just as much as you do and they want to improve their success rate too. ■

Jim Mason is a partner of Lincoln Ceramics cosmetic and dental implant lab in Glasgow. He has a passion for learning alongside dentists for the benefit of their patients.

Do you speak my language?

From a good grasp of English to non-verbal cues, clear communication is key, says Hugh Harvie

The press recently reported on a European dentist working in Scotland who was suspended by the health board on the grounds that he had been unable to provide evidence of his attainment of the required standard of English language skills.

This reflects one of the many changes in GDS regulations in Scotland, which came into effect on 2 July, wherein health boards now have the power to seek evidence of language skills in EEA state applicants. This is in contrast to the General Dental Council, which presently does not have the power to demand such evidence when a dentist who qualified in an EEA state applies to join the dental register.

Communication

Communication is one of the most important aspects of dental care, aside from the actual performance of clinical dentistry. Communication may be written, verbal or non-verbal, and each has its part to play in providing dental treatment.

Written communication may be in the form of a treatment plan, a post-operative instruction leaflet, a prescription for medicines, a prescription to a hygienist and, indeed, clinical record keeping. The importance of record keeping cannot be emphasised enough, including advice given, radiographic reports, warnings made and treatment refused. Any conversations about consent should be recorded, as well as details of appointments kept, broken or cancelled, as these points can all be very useful if you are faced with a complaint.

Verbal communication is a critical aspect of dental care, and assists in ensuring that the patient consents to the treatment proposed, understands potential problem areas, and is able to follow post-operative instructions. If the patient is forewarned of potential adverse sequelae, for example possible pain following a root treatment, they are less likely to raise a complaint if the situation does arise; it is also important to record in your notes that the advice or warning was given. Remember, information given prior to an event is an explanation, whereas if it is given after the fact, it can sound like an excuse! Warnings of this type can also be very useful when dentures are being constructed, particularly if the patient has anatomical features which might adversely affect the retention or fit of a denture.

Non-verbal communication is an ongoing, sometimes subconscious method of interaction, and is hugely helpful in gathering more information about a patient. For example, a patient may say they are happy to proceed, but their body language tells a different story, such as looking away, clutching the arms of the chair, or moving away from the dentist during treatment. It may be wise to stop, check the patient is happy to carry on, and consider postponing treatment if there are difficulties.

Barriers

It follows from this that the dentist planning to work in the UK should have a strong grasp of English language. However, what of the patient whose mother tongue is not English? This is increasingly common, and can present difficulties to the dental team – from the receptionist trying to arrange an appointment, to the dentist and nurse attempting to clarify a medical history.

If the patient has a poor grasp of, or indeed, no English, you would be wise to gain the assistance of a professional interpreter. Your heath board often provides this service free of charge, so it is worth checking to see if this facility is available. If a patient attends without an interpreter, and you are unable to discuss medical and dental histories for the patient, Dental Protection advises that treatment to deal with pain only should be provided and the treatment be as simple as possible in the patient's best interests, such as placing a temporary dressing on a broken tooth, then arranging a follow-up appointment with an interpreter.

Interpretation

When using an interpreter, bear in mind that the appointment will generally take longer than a routine appointment. It is best to avoid jargon and long sentences, and always look at the patient when speaking, rather than the interpreter. You may also want to consider the use of diagrams or photographs to illustrate a point, and it is important to remember that confidentiality should always be respected.

Children should not be used as interpreters, regardless of their language ability, as they may not be able to understand the nuances of medical and dental treatment. By a similar token, you should be cautious about using family members to interpret for the patient, as the family member may not reliably translate what you have said, or the patient may not wish to disclose sensitive, but relevant, information in front of the particular family member present.

If you have any concerns, either from your own perspective as a dentist who has come to the UK to practice, or about treating patients with whom communication is difficult, I would recommend that you contact your indemntity organisation for further advice. ■

Reference:
BDA Advice Sheet E6 – Treating Patients from Overseas

Dental Protection continues to increase its membership in **Scotland** in 2010

International strength and experience

Local knowledge and expertise

39 George Street
Edinburgh
EH2 2HN

For membership information visit
www.dentalprotection.org

or contact our membership department
Telephone
0845 718 7187
Email
member.help@mps.org.uk

Dental Protection

Jon Drysdale of Practice Financial Management Ltd (PFM) considers how best to approach a practice purchase in the post-credit-crunch environment

Like pulling teeth?

Dentists continue to take the plunge from associate to practice owner, aiming to bring autonomy to their clinical output, career path and long-term income prospects.

However buying a practice is no walkover, not least finding a suitable dental business in the first place and then raising the cash in the wake of the recent banking crisis. While some banks consider dentists to be lower risk than many small businesses, there are still hurdles to overcome. Here we consider some of the steps that ease the purchase process and get your chosen bank onside:

Forget high street and avoid the 'restaurant rate'

Your local bank branch or current account provider probably isn't the best place to ask for a significant six-figure loan. Although many high street banks have commercial lending facilities, dentists will probably be offered what is known in the business as the 'restaurant rate'. No disrespect to restaurateurs is intended, but you should avoid your business proposition being subject to lending terms usually reserved for far riskier ventures.

Our experience tells us that banks with specialist healthcare divisions are the best place to start. Quite simply, their credit assessors (the people who say yes or no to your loan application) will understand how a dental business operates – importantly, they have an understanding of fundamentals such as NHS funding and patient payment plans.

Your local bank branch or current account provider probably isn't the best place to ask for a significant six-figure loan… dentists will probably be offered what is known as the 'restaurant rate'

Build your case – the details count

A well-constructed loan application should reassure the bank that you and your chosen practice are compatible. For example, a credit assessor may raise concerns if your new practice demands a significantly greater personal fee output than is visible in your associate accounts. A plausible explanation will be required, such as: "The applicant is currently working four days a week and intends to increase this to five days post-purchase."

It is vital to provide a realistic projected profit and loss statement in support of your application. Specialist healthcare lenders will not accept the previous owner's accounts in isolation. Care should be taken to explain anomalies such as: "The current owner pays their spouse £30,000 pa. Future spousal wages are likely to be only £10,000 pa."

Negotiate on terms, conditions and costs

Dentists should expect to command a variable interest rate as low as 2.75 per cent plus Bank of England Base Rate, although a strong application is required for the most competitive rates. Fixed rates will be significantly higher. Expect to pay an arrangement fee of up to 1.5 per cent of the loan amount. Overdraft and free banking facilities can be negotiated, although aren't guaranteed. A deposit isn't always necessary but alternative security may be expected, such as a 'second charge' on your home. This means if you fail to make your loan repayments the bank can repossess your home and claim any equity (after your mortgage lender has been repaid). The 'second charge' could be released in the future, as long as you can demonstrate continued profitability in your new business.

Fulfilling loan preconditions

If your loan is accepted in principal you will receive a 'facility' letter detailing certain preconditions to be satisfied before the purchase completes. These are likely to include: a freehold valuation where appropriate; life/critical illness policy for the loan amount; evidence of adequate income protection insurance; locum/expenses insurance; surgery insurance; second charge arrangements to be satisfied.

Using a professional adviser to guide your application can be a great advantage and could make the difference between success and failure. Your adviser should be able to demonstrate a strong relationship with the 'healthcare' banks. ■

Jon Drysdale is a director of independent financial advisers PFM, which provides financial and business advice exclusively to dentists.

PFM offer independent advice on financing a practice purchase in Scotland, England and Wales. Please contact Jon Drysdale at PFM on 01904 670820 for more details or visit www.pfmdental.co.uk

The 1st flowable bulk-fill base

CONTACT US FOR YOUR FREE SAMPLE*

SDR™

Smart Dentin Replacement

Changing dentistry 4mm at a time

- Bulk-fill in increments of 4mm without layering
- Excellent cavity adaptation reducing post-operative sensitivity
- Provides excellent self-levelling properties
- Already thousands of users**

To join the SDR revolution, contact us now for your FREE SAMPLE*
(quoting 'free SDR sample' and giving your full name and practice address)

+44 (0)1932 837303 enquiry.uk@dentsply.com

www.dentsply.co.uk www.dentsply.com

For better dentistry

DENTSPLY

*Limited stock available. Please allow up to 28 days for delivery by your Sales Specialist. **Users worldwide

UKP00265

Lifetime guarantee

DENTSPLY is proud to offer a lifetime guarantee on extraction instruments such as the Ash forceps.

All DENTSPLY Ash forceps are guaranteed against material and manufacturing defects for the duration of their lifetime and will be repaired free of charge upon return. To ensure a longer lifespan, they should be disinfected according to the processing guidelines provided.

Restorative hand instruments such as DENTSPLY Artio amalgam pluggers and burnishers carry a five-year warranty against manufacturing defects and material failure.

Periodontal tools, such as the Flexichange range of silicone-handled instruments with replaceable ends, come with a two-year guarantee.

DENTSPLY will repair or replace any defective product resulting from material or manufacturing failures, providing that practitioners have followed the proper care instructions.

For more information and full terms and conditions of the guarantees, call 0800 072 3313 or visit www.dentsply.co.uk

For better dentistry
DENTSPLY

Now available – Citanest 3 per cent with Octapressin

DENTSPLY is delighted to announce that Citanest 3 per cent with Octapressin Dental Injection (prilocaine hydrochloride and octapressin corresponding to felypressin) is now available in 2.2ml standard and self-aspirating cartridges

It is compatible with patient medications where plain and adrenaline-containing solutions are not, and avoids the cardiovascular effects of adrenaline.

Citanest contains prilocaine, which is 40 per cent less toxic than lidocaine, yet still provides the depth and duration demanded by routine dental procedures.

To help ensure patient safety, Citanest is latex-free and adrenaline free.

For further information, please contact DENTSPLY on 0800 072 3313.

The latest dentistry solutions

Biomet 3i, industry leader in implant dentistry, and Renishaw plc, a leading manufacturer of in-lab dental scanning systems offer comprehensive digital solutions.

These include: 3i incise copings and frameworks, Renishaw contact scanners, 3i incise CAD software and Renishaw in-lab milling machines.

Using the Renishaw scanner and 3i incise CAD software, laboratories can obtain broader access to a wide range of dental milling options, including the ability to scan precision copy milled bar patterns. Laboratories utilizing the ProceraForte scanner can also benefit from all of these options by using the 3i incise CAD software.

Clinicians can now offer patients 3i incise copings and frameworks in Zirconia and Cobalt Chrome and precision milled bars.

For further information, contact Biomet 3i on 01628 829 314.

BIOMET 3i™
PROVIDING SOLUTIONS – ONE PATIENT AT A TIME™

The Ultimate Implant Year Course for 2011

BioHorizons is pleased to announce the second edition of its highly successful implant course run by Dr Ken Nicholson.

Sponsored by BioHorizons and SmileTube, The Ultimate Implant Year Course will run from February 2011.

Having spent the last ten years involved in dental implant education Dr Ken Nicholson has listened to his students, the GDC and academic colleagues and combined his own experience to provide the necessary education and training to introduce dental implant treatment to their dental practice.

The Ultimate Implant Course includes three residential days, ten clinical days, 65 hours of online lectures as well as delegates playing an integral role in placing and restoring implants on live cases.

For more course information, call BioHorizons on 01344 752560, 07843 089155, or call NIDIC on 02892 617471.
Further information is also available at www.SmileTube.tv

BIOHORIZONS®

DENTSPLY Academy's live webinars 2010

Following the success of DENTSPLY's 2009 webinars and in response to popular demand, the DENTSPLY Academy is offering clinicians a new series of free of charge webinars due to begin in September 2010.

High-profile speakers from various fields of expertise will take to the virtual stage. Throughout each event, attendees will have the opportunity to put their questions to the speaker and delve deeper into any issues raised of particular interest to them.

Webinars offer practitioners a convenient way to study and accrue valuable CPD points without having to travel to lectures and seminars.

For more information, or to book your place on a webinar, go to www.dentalwebinars.co.uk

Philips gears up for Christmas time

In the run up to Christmas, dental professionals are being offered an exclusive Sonicare HealthyWhite Dual Handle promotional pack which will only be available in dental practices.

Sonicare HealthyWhite is clinically proven to whiten teeth by up to two shades in two weeks.

The dual handle promotion provides the equivalent of a buy one, get one free offer and is exclusive to CTS Dental Supplies. It will be offered at the BDTA and between October and December 2010.

Philips, through CTS, is running a series of other promotions for the rest of its Sonicare product range in the fourth quarter of the year.

For more information, visit www.sonicare.co.uk/dp call 800 0567 222 or visit www.cts-dental.com

Scottish Centre for Excellence in Dentistry

Totally Committed to Quality Care and Excellence...

a refreshing change

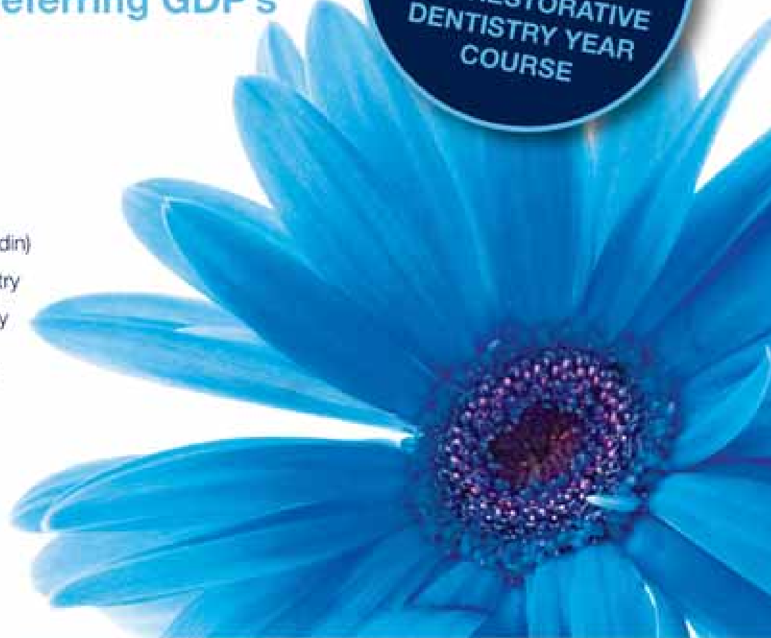
We are happy to accept referrals for all aspects of dentistry including implants, oral and facial surgery, periodontics, orthodontics, prosthodontics, endodontics, restorative dentistry, facial rejuvenation, hypnotherapy and sedation.

We can offer advice only, carry out part of the treatment or all of the treatment; the choice is yours. We can place implants for your patients and you can restore them; call or email us for further details.

Why not come and take a look around our centre and see for yourself where your patient would come to be treated.

- **New referrals seen within 2 weeks**
- **Emergency patients seen on the same day**
- **Complimentary update seminars for referring GDP's**

We run a series of courses throughout the year for GDP's - see our website for details



Arshad Ali

Arshad Ali BDS, FDSRCS (Eng & Edin), FDSRCPS (Glasg), DRD, MRD,RCS (Edin)

Consultant, Specialist and Honorary Clinical Senior Lecturer in Restorative Dentistry

Clinical Director and Managing Director, Scottish Centre for Excellence in Dentistry

One of the Leading Dental Centers of the World, www.leadingdentalcenters.com
Winner of Best Practice Scotland, The Dentistry Awards 2009
Highly Commended , Practice of the Year, UK Private Dentistry Awards 2009
Runner up, Best Specialist Referral Practice, UK Private Dentistry Awards 2009
Runner up, Best New Practice, UK Private Dentistry Awards 2009
Arshad Ali, Businessman of the Year, Scottish Asian Business Awards 2009
Claire Sweeney, Scottish Dental Nurse Achievement Award 2009
Finalists for Team of The Year, The Dental Awards 2010
Arshad Ali, Regional Finalist, Ernst & Young UK Entrepreneur of the Year 2010

All REFERRALS WELCOME – PLEASE CONTACT US TO ARRANGE A VISIT TO OUR CENTRE

Watermark Business Park 335 Govan Road Glasgow G51 1HJ

t 0141 427 4530 **f** 0141 427 6471 **e** enquiry@scottishdentistry.com

www.scottishdentistry.com

The **ART** of **EX**ACT™

ART

Attract • Retain • Treat

"What If" you could...

* Improve your appointment book utilisation by 68%

* Improve your recall effectiveness by 28%

* Increase your hourly earnings by 10%

You can with EXACT™!

EXACT™ is a powerful practice management software system that lets you extract vital statistical information about different aspects of your practice. Our business managers can then use this data to predict what might happen if you were to change certain key variables, giving you real-time targets against which to monitor future activities and performance.

If your practice management software doesn't help you answer the "What If" question, call Software of Excellence and talk to one of our business managers to find out what your future might hold.

Attract, Retain, Treat – that's the ART of EXACT™

Transform your practice into a business

Call: 0800 328 6227 Visit: www.soeidental.com

SOFTWARE OF EXCELLENCE

A HENRY SCHEIN® COMPANY

Software of Excellence, Eclipse House, Eclipse Park, Sittingbourne Road, Maidstone, Kent, ME14 3EN.

* Data taken from THRIVE trial 2009/10