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CANCER FIGHT CONTINUES

Emma Shanks talks about her experiences with oral cancer and starting a new charity

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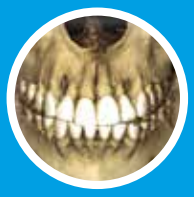

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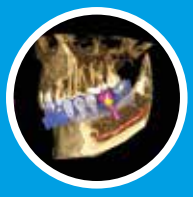

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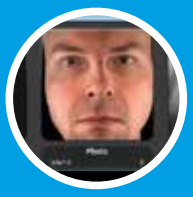

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When others would cast us as tax collectors, border guards, mechanics or shopkeepers, it falls to us... to show that our patients come first

MICK ARMSTRONG

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Philip Friel and his fellow dental professionals are registered with the General Dental Council. Philip's membership number is 77637. *Specialist orthodontist is Imran Shafi (GDC 79325).

Denplan
At the heart of dental care

Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
bruce@sdmag.co.uk

ANOTHER YEAR ANOTHER DENTAL SHOW

Sixth show is a huge hit with delegates and exhibitors

The dust has now settled on another Scottish Dental Show and this year proved to be the biggest yet. We had just over 2,000 people through the doors over the two days, which is 10 per cent more than we had last year. And, considering last year's attendance was more than 20 per cent up, we seem to be going in the right direction.

However, what we need now is your feedback. If you attended the show, can I ask you to please spend just five minutes telling us what you thought of the event so we can keep improving and making it as relevant and essential as we possibly can. The feedback survey can be completed online at bit.ly/SDShow2017

This is your event, your Scottish Dental Show and we need to know the good, the bad and the indifferent so we can deliver what you and your colleagues want and need.

You should all have, by now, received an email with a link to download your CPD certificate along with links to complete the feedback survey and a link to download the GP214 form for claiming back CPDA. More information on this can be found on page 24 or by visiting www.sdshow.co.uk/cpd

In this issue we have two picture specials, the first, starting on page 24, looks back at the Scottish Dental Show and features all the best images from Braehead Arena.

The second, starting on page 32, celebrates all the winners at this year's Scottish Dental Awards, held at the Glasgow Hilton. We welcomed nearly 500 people to the awards ceremony, which this year was hosted by the fantastic Des Clarke. There were 16 winners in all, with the final award of the night going to former NHS Education for Scotland director of postgraduate dental education, Alan Walker.

The chosen charity for this year's awards was The Ben Walton Trust (BWT), which links quite nicely to our cover story and interview with Emma Shanks on page 36. Emma is a cancer researcher working at the Beatson and has been heavily involved with the BWT over the last few years. She has also successfully fought oral cancer four times, which gives her a unique insight into the disease.

As is explained elsewhere, the trust is winding down and Emma is leading the formation of a new charity called TRACTion Cancer Support. It will continue much of the work that the BWT started and funded, but with a larger scope that will allow it to cover other cancers of the oesophageal tract.

We need to know the good, the bad and the indifferent so we can deliver what you and your colleagues need

I'm sure you will all join me in applauding Michael Walton for all he has done over the last 20 years and wishing him a very happy and well-earned retirement.

WE COULDN'T HAVE DONE IT WITHOUT...

1

EMMA SHANKS
(ON ORAL CANCER)
Emma is a cancer researcher at the Cancer Research UK Beatson Institute in Glasgow and one of the founders of TRACTion Cancer Support.

2

ARVIND SHARMA
(ON ENDODONTIC RETREATMENT)
Arvind Sharma qualified from the University of Dundee in 1996 and completed his masters in endodontology from UCLan.

3

MALCOLM HAMILTON
(ON DENTISTRY AND AUTISM)
Malcolm Hamilton is a senior dental officer in NHS Highlands Public Dental Service, where he has worked since 2009.

4

MARY DOWNIE
(ON PSYCHOLOGY AND DENTISTRY
Mary Downie gained her dental degree from Glasgow in 1980 and her psychology degree from the Open University in 2001.

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HAVING HIS SAY →
Arthur Dent is a practising NHS dentist in Scotland
arthurdent@sdmag.co.uk

REPRESENTING THE PROFESSION

Do you pay the LDC levy every month? Arthur explains what the LDCs do for you and why you should support the work of your LDC colleagues

What is the LDC levy for? We all see the line on our schedules each month, and hopefully the majority of us pay it too.

Local dental committees(LDCs) represent the profession at a local, health board level. Unfortunately, in Scotland some sparsely populated areas do not have LDCs. However, where they do exist they will provide information to health boards and debate local as well as national dental political issues. Many LDCs will also provide pastoral support to local dentists in need. LDCs are independent of the BDA.

Most LDCs will also have representation on Scottish Dental Practice Committee (SDPC), which negotiates with the Chief Dental Officer (CDO), and the Scottish Government. The LDC levy pays the guild rate to reimburse practitioners away from practice who are representing your political interests. So the £12-odd you pay each month is to make the CDO listen to you.

Every LDC can send delegates to the Scottish Conference of LDCs, normally held in April. The number of delegates depends on the number of dentists represented in the area – so, of course, Glasgow and Clyde is the largest LDC in Scotland. LDCs will submit motions which are debated at conference and, if passed, direct SDPC's direction in the year ahead.

This year, conference covered many different topics. The CDO may be pleased to note that not all of them involved money – although thanks to the 30 per cent pay cut in recent years, many did!

Lanarkshire LDC very reasonably asked for a percentage of the proposed sugar tax to be diverted to dentistry – an eminently sensible suggestion that I think should receive the full support of the CDO. Ms Taylor has previously bemoaned the profession's desire to always talk about money – here is an opportunity to provide more of it. This would lead to an increase in our budget, and should of course be reflected in a substantial fee uplift. We have had to pay increased wages in line with the proposed living wage, and are of course now facing staff pension contributions.

The LDC levy supports professionals who give up their time to represent their colleagues and peers

"The £12-odd you pay each month is to make the CDO listen to you"

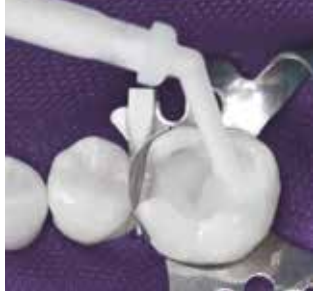
Following on from this, Glasgow and Clyde LDC asked for a review of the mechanism by which the profession negotiates on NHS fees. The BDA spends a lot of time and money each year on the DDRB review; yet the result is always in line with government targets of 1 per cent or less. This is not in line with inflation, never mind our own costs.

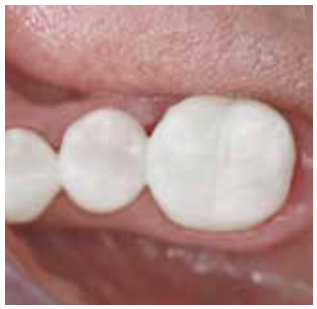
Another motion from Lanarkshire, regarding the inconsistencies in interpretation and implementation of the SDR, is hopefully, now out of date, as we have a new senior advisor at PSD.

Glasgow and Clyde have also asked for an urgent review of emergency drug kits and suggested the NHS supply these as a means of coping with short expiry dates and allowing standardisation. The NHS would also be able to negotiate an excellent rate for this as they would be bulk buying for all practices.

It was also very reasonably suggested that all dentists and staff to have access to occupational health services. This was previously available, and is now either unavailable or incurs a charge. It is still available to GMP practices, and we should have parity.

Many other motions were passed which also involved money. We look forward to the SDPC chair's report next year when we can hear how negotiations have progressed. And if you haven't filled in your LDC levy mandate, please do so!





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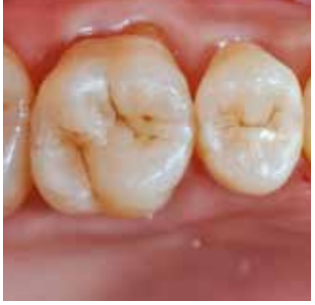

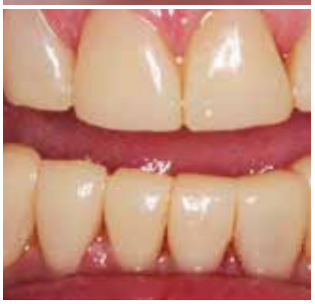

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Professor Brian Millar

BDS (Dundee) FDSRCS(Eng) PhD (Lon) FHEA

Professor of Blended Learning in Dentistry at King's College London and NHS Consultant in Restorative Dentistry at the King's College London Dental Institute at Guy's, King's and St Thomas' Hospitals. Specialist in Prosthodontics and in Restorative Dentistry. Programme Director for the internationally popular MClinDent (Fixed & Removable Prosthodontics) and in the past set up the highly successful MSc programmes in Aesthetic Dentistry and also Advanced General Dental Practice by blended learning at the KCL Dental Institute.

Over 35 years experience in clinical practice and currently an active specialist clinician in both hospital and private practice, particularly in treating tooth wear, aesthetic and occlusal problems utilising MI philosophies where possible.

Experienced teacher to undergraduates and postgraduates and well-known provider of postgraduate education nationally and internationally at conferences through lectures, seminars, webinars and hands-on courses.

Published over 180 papers, supervised over 200 PhD and Masters students, involved in setting up MOOCs with over 20,000 students. As well as the silencing the dental drill, research includes management of occlusal problems using MI techniques, bringing together aesthetics and function with a focus on tooth preservation.

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AWARDS RAISE MONEY FOR CANCER CHARITY

Proceeds from raffle will go towards combating cancers of the head and neck

The Scottish Dental Awards 2017 raised nearly £3,500 for a leading cancer charity as the dental profession in Scotland dug deep for a great cause.

Held on 19 May at the Glasgow Hilton, the sixth annual awards ceremony saw just under 500 people join in the celebrations of the great and the good of Scottish dentistry. The charity raffle, which this year was in aid of the Ben Walton Trust, raised a grand total of £3,426.20.

The trust is entering its final few weeks as founder Mike Walton has decided to wind up the charity, with much of the work being continued by a new organisation, TRACTion Cancer Support. As such, the Scottish Dental Awards money may well turn out to be the last donation given to the Ben Walton Trust in its current form.

Emma Shanks, a researcher at Cancer Research UK Beatson Institute in Glasgow, will be taking over much of the work that the trust had begun, while also working in different areas. Speaking about the charity raffle, Emma said: "TRACTion Cancer Support is absolutely delighted to receive such a generous donation from those who attended the Scottish Dental Awards 2017.

"The principal aims of TRACTion are to support patients with head and neck cancers, as well as oesophageal and gastric cancers, many of which share similar emotional and physical outcomes. Early detection often leads to a more positive outcome for patients, and TRACTion is committed to improving early diagnosis. We will therefore continue to work to raise awareness of the signs and symptoms of disease in all patient populations. Inviting patients to talk about their experiences of cancer is a powerful way to do this.

"This extremely generous donation will go a long way to helping TRACTion Cancer Support achieve these important aims. Most importantly, it will allow us to provide fundamental support to patients and carers."

MORE INFORMATION

Turn to page 36 to read all about the new charity and Emma's own battles with mouth cancer.

See page 32 for a review of the Scottish Dental Awards

NOW TRENDING

2K

Just over 2,000 people came through the doors at this year's Scottish Dental Show

www.sdshow.co.uk

DENTAL SCHOOL RECEIVES GDC APPROVAL

Aberdeen Dental School has had its sufficiency status confirmed by the General Dental Council.

Sufficiency is essentially a seal of approval from the GDC, as it officially approves the dental school's programme to train dentists and graduates can subsequently apply to join the GDC Register.

Professor Richard Ibbetson, Director of Dentistry, was delighted to receive the confirmation. He said: "The recognition of the Bachelor of Dental Surgery (BDS) programme in Aberdeen is the culmination of eight years of hard work by the dedicated staff team at Aberdeen Dental School and Hospital, together with the sustained support of the Institute for Education in Medical and Dental Sciences.

"Formal recognition allows the dental school to move forward with its ambitious plans to develop the BDS degree programme further and also to add a portfolio of taught postgraduate programmes from 2018.

"These developments together with an expansion in research activity mean that the school is well-placed to serve the needs of Scotland and the rest of the UK."

GDC REVIEW FOCUS ON PUTTING PATIENT PROTECTION AT HEART OF DENTAL EDUCATION

Regulator's annual report highlights clear areas for development in learning programmes

Around a fifth of all dental education programmes inspected by the General Dental Council (GDC) in the past four years have required a re-inspection according to a new report by the regulator.

The GDC's Annual Review of Education 2014-16 showed that 14 programmes across 33 visits were inspected in 2014/15 and 12 programmes across 30 visits in 2015/16. However, following re-inspection, institutions inspected showed "significant improvement", on average improving in 50 per cent of requirements.

The report identified good practice and also highlighted areas for development and learning points for both education providers and the GDC. Areas for learning providers included a need to receive and use meaningful feedback from patients to inform student development. It also stressed the importance of making sure that students are able to provide a service to a sufficient number of patients from a range of age groups and backgrounds that have different treatment needs.

Ian Brack, GDC chief executive and registrar, said: "The GDC welcomes the focus on patient protection for education providers, which reflects the first principle for the dental team: put patients' interests first. This focus will help to prepare students for professional life as dentists or dental care professionals.

"However, as noted in previous annual reviews, many providers are not presenting a full map of their programmes against the GDC's learning outcomes and, to improve, there needs to be a more detailed and thorough detailing of the assessments taking place. We would also like to see clear and consistent procedures in place for concerns to be raised, incidents monitored and recorded."

WORRYING INCREASE IN NUMBER OF DENTISTS LEAVING PROFESSION EARLY

SDPC vice-chair says declining incomes have seen early retirements double in two years

Voluntary early retirement among Scottish GDPs has doubled in the last two years according to the vice-chair of the Scottish Dental Practice Committee (SDPC).

David McColl, who was speaking to the Conference of Scottish Local Dental Committees in Stirling recently, argued that the continuing decline in dentists' incomes along with plummeting morale and motivation was to blame. He said that Scottish GDPs have the lowest taxable income of the four UK countries and because income has not increased by as much as expenses, due to inflation, this has led to unprecedented high expense ratios and record low levels of net profits.

He revealed that, following this year's recommendations by the DDRB, BDA Scotland and SDPC had arranged an urgent meeting with the Chief Dental Officer Margie Taylor and her team to negotiate the expenses element of the recent DDRB award.

Among the motions that were passed at conference was a demand from Greater Glasgow and Clyde LDC that the Government's expressed intention "to work towards a reduced number of allowances" referred to in the consultation document *Scotland's Oral Health Plan* does not result in a reduction in the GDS allowances budget. This was passed unanimously.

Other motions that were passed unanimously included a call for Scottish Government to look again at water fluoridation, a call to extend the sugar tax to all high-sugar products and not just soft drinks, a demand for a decontamination allowance and a call for a review of the mechanisms by which the profession negotiates on NHS fees.

At the end of conference Motherwell dentist David McIntyre was inaugurated as the new chair taking over from this year's chair of conference Jacqueline Frederick.

CANCER ON PAGE 36

When you are diagnosed with cancer, it's very scary... you don't know what the long-term consequences will be

EMMA SHANKS

£2M FOR STUDY ON ORAL HEALTH OF YOUNG

Dundee researchers to work with Sheffield University on effects of deprivation

A new initiative led by researchers from the University of Dundee and Sheffield has been awarded nearly £2 million to investigate ways of improving the oral health of young people living in deprived areas.

The four-year Brushing Reminder 4 Good Oral Health (BRIGHT) will work with 48 schools and nearly 6,000 young people in Scotland, England and Wales. Funded by the National Institute for Health Research (NIHR), the study will investigate whether a classroom-based lesson about dental health followed by a series of text messages could increase how often and how well children aged 11-16 brush their teeth – and ultimately reduce levels of tooth decay.

In each school, one class will receive the talk and a series of text messages, while another will not. The team will collect information on tooth decay, frequency of brushing, and the impact decay has on the children's lives to determine whether those in the programme develop better oral health habits than those who don't participate.

"WE ARE LOOKING FORWARD TO TAKING UP THE CHALLENGE IN THIS OFTEN OVERLOOKED GROUP – YOUNG PEOPLE LIVING IN DEPRIVED AREAS"

PROFESSOR NICOLA INNES

Professor Nicola Innes, professor of paediatric dentistry and associate dean for learning and teaching at Dundee Dental School, said: "Dental decay is preventable and, in some ways, that should be simple. Just brush with a toothbrush and fluoride toothpaste. However, enacting that prevention at the level of the individual person isn't always so simple.

"We are looking forward to taking up the challenge in this often overlooked group – young people living in deprived areas – who suffer a disproportionate amount of dental disease, toothache, and subsequent loss of sleep and time at school."

The classroom-based teaching session has been created by Dundee's School of Education and Social Work, while the text messages will be delivered via TextApp, a software tool devised by the School of Medicine's Health Informatics Centre.

The Dundee and Sheffield researchers will work with colleagues from the Universities of Leeds and Cardiff and the York Trials Unit on the project.

MUCH-NEEDED DENTAL PRACTICE FOR SKYE

Portree Dental Care fills gap in provision

Dental provision for people living in Skye and Lochalsh has improved significantly with the opening of a new dental practice in Portree.

Portree Dental Care's three dentists will be based in the same building as the NHS Highland Public Dental Service Clinic at Sraid An Eorna.

A significant number of patients from the health board clinic, principally those not prioritised as having additional needs, will now be transferred to the new dental practice. Portree Dental Care will be run by Zahid Ahmad, who has relocated to Skye with his family, and will be joined at the practice by fellow dentists Muhammad Anwar and Rana Osman.

Announcing the new service, Zahid said: "The practice offers predominantly NHS general dental services. Our aim is ensuring affordable, accessible and quality routine dental care and emergency dental services for everyone in Portree and throughout the Isle of Skye. We have extended our opening hours to make it more convenient for all age groups. "

Alex Fraser, NHS Highland's dental service development manager, said: "This is great news. Our focus has always been to provide a sustainable and accessible dental service for the people in north Skye that will help to maintain and improve the oral health of all in the local community. The new dental practice will help us enormously to do just that."

WINNERS!

16

The number of awards presented at the Scottish Dental Awards 2017*

*

sdawards.co.uk

DDRB AWARD DOESN'T ADDRESS CRISIS OF MORALE

The chair of the Scottish Dental Practice Committee (SDPC) has criticised the Review Body on Doctors' and Dentists' Remuneration (DDRB) for its recommendation for a 1 per cent pay award for general dental practitioners in Scotland for 2017/18. Associates and practice owners in Scotland have seen their income fall by well over a quarter since 2009 and Dr Robert Donald didn't hold back with his criticism. "The 1 per cent award is extremely disappointing and does nothing to address the crisis of morale. It guarantees that we remain the lowest-paid dentists in the whole of the UK.

"While our earnings have been driven into the ground, costs associated with red tape, and an overbearing regulatory regime are spiralling out of control. Ministers need to know that dentists have had it to the back teeth in terms of doing 'more with less'; and I fear there is no give left in the system without compromising patient care."

SHARE YOUR SUCCESSES, DENTISTS URGED

BDA chair launches 'We Are Dentistry' campaign at annual conference

Mick Armstrong: "We are a profession succeeding in spite of everything"

The chair of the British Dental Association (BDA) has called on the dental profession to share their stories and show the difference they are making in their communities.

Speaking during his keynote address at the recent British Dental Conference and Exhibition, Mick Armstrong launched the "We are Dentistry" campaign by calling on members of the profession to take pride in their achievements and set out their "remarkable contribution to UK healthcare".

He said: "This last year has demonstrated that as a profession we must define ourselves clearly. When others would cast us as tax collectors, border guards, mechanics or shopkeepers, it falls to us, the clinicians, to show what matters, and that our patients come first.

"We are a profession succeeding in spite of everything, in the absence of strategy or priority from government, beset by failed contracts, red tape and overregulation.

"Ours is a story of over 40,000 men and women doing exceptional things every day, in patient care and in cutting-edge research, from community clinics to Harley Street; highly trained professionals juggling multiple roles.

"So we are posing colleagues a simple question: What is a dentist? The answer is so much more than a practising certificate, a number on the GDC register, or an allotment of UDAs on a government database. Your answers will help us celebrate the teachers, the entrepreneurs and the innovators, the researchers, the leaders and the problem-solvers who make up this profession."

MORE INFORMATION
For more information and to share your stories, visit ww.bda.org/wearedentistry

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DENTISTS GIVE THEIR SUPPORT TO HPV CAMPAIGN

An overwhelming majority of dentists and GPs have given their backing to calls for the UK government to expand the HPV vaccination programme to school-aged boys.

A recent survey published to coincide with the recent HPV Action for World Immunisation Week (24-28 April), 97 per cent of dentists backed expansion of the programme, with the same proportion saying if they had a son they would want them to receive the vaccination.

The survey was sent to members of the British Dental Association, the Faculty of General Dental Practice (UK) and the British Medical Association. Findings come as the Government's vaccination advisory committee moves towards a decision on whether boys should be given the HPV vaccination. Up to 80 per cent of sexually active people will be infected by HPV at some point, with five per cent of all cancers are caused by HPV. Some of these, notably oral cancers, are now rising sharply in incidence.

STELLAR LINE-UP FOR BAOS STUDY DAY

A recent study day organised by the British Association of Oral Surgeons took place in Edinburgh with a stellar line-up of speakers.

Organised by Dr Norma O'Connor, Dr Eleni Besi and Dr Naomi Rahman, the study day at the Novotel was followed by a masterclass on soft tissue management.

The speakers on the day included Dr Stephanie Sammut, co-chair of the SDCEP guidance development group for medication-related osteonecrosis of the jaw (MRONJ), giving a presentation on the pathophysiology of these medications, the importance of prevention, risk assessment of patients and the management of MRONJ.

She was followed by Dr Paul Stone, who spoke on he topic of bone-grafting techniques, Dr Dominiki Chatzopoulo, (soft tissue grafting and socket preservation), Dr Aman Ulhaq (management of orthognathic patients). and Dr Robert Philpott (periradicular surgery).

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DECADE OF DENTAL DILIGENCE AT BLACKHILLS CLINIC

Perthshire team celebrates 10 years of referral business

A Perthshire referral clinic is celebrating 10 years in business this year after treating more than 8,000 patients from more than 800 referring dentists.

Starting out with just two clinicians, a nurse and a manager, Blackhills Specialist Dental Clinic has grown over the last decade to a grand total of 20 staff including seven specialists. Paul Stone and Ken Watkins (now retired) opened the doors in early 2007 and the practice has developed into one of the foremost specialist referral centres in the country.

Asked if he would do anything differently, Paul said: "It's always tempting to say you would like to progress things faster, but I think the time we took developing the way we now work was necessary. It takes vision and organisation from all the staff and clinicians to develop the many little processes that make the whole 'machine' work effectively; this could never be achieved overnight.

Blackhills has developed into one of the foremost specialist referral centres in the country

"If I could start again, I'd probably include a bigger storage space for archiving everything we have to these days. The one we have is barely large enough now."

And, when asked what he is most proud of, he said: "Personally, I'm most proud that I had the courage to actually do it – to create what I believed would really benefit patient care while working in close co-operation with the referring dentist."

Paul explained that it is "all about the team at Blackhills" and that includes the referring dentists. He said: "I'd like to say a huge thank you to the many hundreds of colleagues who have referred to Blackhills Specialist Clinic. Please don't stop! To those who have yet to experience working with our all-specialist clinic, please contact us, come and visit the clinic or attend one of our events."

MORE INFORMATION

For more information, visit www.blackhillsclinic.com and click 'refer your patient' for secure online referrals.

For full anniversary Q&A with Paul, visit www.sdmagco.uk

NOW TRENDING

67%

Two thirds of the general public admit to being apprehensive when it comes to visiting the dentist for a check-up*

* Source: Oral Health Foundation

PENINSULA ACADEMIC PICKS UP ROYAL HONOUR

Scottish graduate and Plymouth foundation dean recognised with MBE

Professor Liz Kay, Edinburgh graduate and foundation dean of Peninsula Dental School, was presented with her MBE in recognition of her services to dental education at Buckingham Palace recently.

Prof Kay graduated from Edinburgh in 1982 and completed her masters in public health (1984) and PhD (1991) from Glasgow. She gained her FDS from the Royal College of Physicians and Surgeons of Glasgow in 1988.

She led the development and implementation of the Peninsula Dental School in Plymouth, which was the first new dental school in the UK in 40 years and currently ranks second out of 15 dental schools in the Guardian's league table.

After receiving her award from HRH Prince William, Duke of Cambridge, Prof Kay said: "This really was a most wonderful experience and it was great to meet other awardees, many of whom had the most amazing and humbling stories to tell. I am fortunate to be surrounded by the most wonderful, talented and supportive colleagues and associates, without whom I may not have been recognised for this amazing honour.

"At Plymouth University Peninsula School of Dentistry we teach our dental health profession students that they are part of a team – dentist, dental nurse, dental therapist and hygienist – and this award stands testament to the strong team ethic across our organisation."

Professor Liz Kay

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SPECIAL RECOGNITION FOR STUDENTS' WORK ON PUBLIC HEALTH INITIATIVES

Oral Health Foundation president presents award to Dundee group participating in projects with community organisations

The president of the Oral Health Foundation visited the Univeristy of Dundee Dental School recently to present awards to a group of fourth-year students who have produced exceptional projects during their degrees.

Janet Goodwin heard how the students had set out to teach marginalised groups in Dundee how to develop good oral hygiene routines, despite their specific situations.

As part of their Dental Public Health programme, the students collaborated with voluntary and community organisations which helped them reach out to individuals with learning disabilities, mental health issues and those serving time in prison.

One group, who worked with the Steeple Church drop-in centre for people experiencing homelessness, were awarded a special prize by the president of the charity for building the most successful project.

Janet said: "I always enjoy my visits to Dundee Dental School because each year the standard of work and effort that the students put in never fails to impress.

"Each student that participated in the projects has helped to illustrate the potential for dental care professionals to address the issues which prevent people from maintaining good oral hygiene routines.

"The students in the winning group identified the key factors which prevent good oral health among those who are homeless. Mental illness, self-esteem issues and marginalisation are just a few of the issues that the students attempted to address through a series of five workshops aimed at building their confidence with regards to dental care over time."

The competition was judged by an expert panel comprised of Janet Goodwin; Professor Mark Hector, dean of dentistry; Dr Kevin Davey, associate dean for quality and academic standards; and Derek Richards, director of the Centre for Evidence-based Dentistry, DHSRU.

"I really hope that other schools in the country and other dental care professionals will take inspiration from the work these students have done for the marginalised members of their community," Janet added.

"Spreading vital oral health messages with all members of the society, regardless of what personal issues they may face, is extremely important and so is making sure that the next generation of dental care professionals understand that."

PILOT STUDY STARTS TO BUILD PICTURE OF OUR NATION'S TEETH

A pilot study led by the University of Dundee School of Dentistry has started to build an in-depth picture of the nation's teeth.

The Scottish Adult Oral Health Survey, analysed data collected by dentists during routine examinations of 1,867 patients between December 2015 and March 2016. Among its key findings was that nearly all adults aged 45 or over had at least one natural tooth, and two-thirds of those with at least one natural tooth were able to eat comfortably. It also found that adults living in the most deprived areas in Scotland were more likely to smoke cigarettes, and there is a higher level of gum disease recorded for those adults who smoke.

The data also suggested that older patients and those living in more deprived areas in Scotland were less likely to be able to eat comfortably, and had fewer natural teeth.

Susan Carson, clinical lecturer and honorary specialty registrar in dental public health at Dundee, was a key member of the survey steering group. She said: "The contribution of dentists from across Scotland was crucial, not only in terms of collecting data, but also in providing feedback on the acceptability of the system to their patients and staff."

The survey, commissioned by the Scottish Dental Epidemiological Co-ordinatiing Committee, was a collaboration between Dundee, the University of Glasgow, NHS Information Services Division, NHS Education for Scotland and colleagues from across NHS boards.

NOW TRENDING

33%

A third of Brits don't realise dental care is free for kids*

* Source: mydentist National Smile Month survey

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THE FORGOTTEN PROFESSION

IS WORKPLACE STRESS FOR DENTISTS IN SCOTLAND AN UNDOCUMENTED PROBLEM?

The mental health of healthcare professionals is becoming a more often-talked-about issue in the news these days. However, in Scotland, the BDA feels that dentists are often the forgotten profession when it comes to revealing the scale of the problem, and impact of the often stressful and frustrating environments we work in.

Admitting you are feeling stressed is never an easy thing to do. But nearly all of us experience stress or other problems at some point in our lives. Indeed, it's well reported by the charity Mind that one in four people in the UK are likely to suffer from a mental health problem each year, and they are working hard to combat the stigma around mental health, encouraging people to step up and ask for support if they need it, rather than suffering in silence.

It was reported earlier this year that GPs are to get £20 million for specialist help to deal with the stress of their roles in a new NHS initiative. The trial scheme would give GPs in 13 areas in England access to counselling or medication, with the aim of rolling it out nationally, if it's successful.

Data from 2016 revealed that almost 30 per cent of UK GPs were planning to quit in the next five years, with levels of stress being cited as the key driver in their decision to go. Six in 10 GPs said they found their work stressful and levels in the UK were far higher than in other western countries.

There is no comparable access for general dental practitioners. GDPs in Scotland have no access to local NHS-funded occupational health services.

The Cabinet Secretary for Health and Wellbeing announced at the BMA Scottish Local Medical Conference in March 2016, that an additional £2 million over a two-year period would be invested in occupational health services for doctors, but did not include dentists.

Currently, we simply don't know the extent of the problem of stress and burnout for dentists in Scotland, as there is no official data to draw on.

The Scottish Dental Practice Committee is leading a working group to examine the impact of stress in the dental workplace and to investigate the support and resources that should be available to help combat the issue.

The BDA is also working on a UK-wide project to look at the causes of stress and burnout and the underlying reasons for low levels of morale and job satisfaction amongst dentists.

We are in discussions with Scotland's Chief Dental Officer, Margie Taylor CBE, to express our concern about the lack of support for dentists who are experiencing stress and burnout.

We have asked that she undertakes an official government study into the extent and prevalence of stress and burnout among Scottish GDPs, and we have highlighted the findings of an earlier Northern Ireland study, which reveals that 25 per cent of GDPs in Northern Ireland are at serious risk of professional burnout, with 15 per cent already reporting experiencing the symptoms and effects of burnout.

We think there is likely to be a comparable problem in Scotland and the issue needs to be investigated and addressed, with real funding coming forward to help combat it.

Ruth Freeman, Professor of Dental Public Health Research, Honorary Consultant in Dental Public Health, DHSRU, University of Dundee, will be speaking at the Scottish Dental Conference and Exhibition on 'Stress and general dental practitioners: understanding work-related stress and developing a stress protocol for general practice'. Find out what is meant by stress and burnout, learn about the prevalence of work-related stress in general dental practice and know the steps to take to develop a stress protocol for your practice.

MORE INFORMATION

Book your place today – Scottish Dental Conference and Exhibition 2017. A day for the whole dental team.

Other topics include: aesthetics, oral cancer, periodontics, paediatrics and prosthodontics.

Friday 1 September 2017 at the Crowne Plaza Glasgow. Book online at bda.org/scottishconference

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In depth

ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

ONTO A WINNER

THE SCOTTISH DENTAL AWARDS PICTURE SPECIAL

See page 32

SHOW GOES FROM STRENGTH TO STRENGTH

MORE THAN 2,000 PEOPLE THROUGH THE DOORS AT THE TWO-DAY GLASGOW EVENT

BRUCE OXLEY SCOTT RICHMOND

The sixth annual Scottish Dental Show welcomed just over 2,000 people to Braehead Arena making it the event's most successful yet.

And, with nearly half of the exhibition space at the 2018 show (27 and 28 April, Braehead Arena) already sold, it is clear that Scotland's biggest dental conference and trade show is a firm favourite with the profession and industry alike.

Featuring high-calibre speakers such as Christopher Orr, Professor Brian Millar, Ashley Latter, Prof Graham Ogden, Arshad Ali, Attiq Rahman, Aubrey Craig and Helen Kaney, the 2017 lecture programme provided a wealth of CPD opportunities. And, with up to nine hours of verifiable CPD, including eight sessions of CORE CPD, there was something for all members of the dental team.

Here is a selection of some of the fantastic feedback we have received from delegates:

"*We come every year and we think it's fantastic. You can get all your CPD in one place – it's brilliant. We wouldn't miss it.*"

"*It's really exciting. I always enjoy seeing what the stalls have to offer and attending some of the lectures, we really enjoyed it.*"

And exhibitors:

"*You guys do a great job, a fantastic Show yet again.*"

"*We were inundated with new business potential due to the increase in footfall at the show. We cannot praise you all enough for all your hard work and effort. Thank you once again.*"

"*A great two days at the Show! We look forward to being on the same stand next year.*"

CLAIMING YOUR CPD

You can claim your CPD certificate from the Scottish Dental Show 2017 in a number of ways:

1. Every delegate should have received an email with a link to download the CPD certificate. There will also be a link to download the GP214 form. This will enable you to claim Continuing Professional Development Allowance for your time at the show. The 2017 show has been approved for up to four sessions (nine hours) but, please note, travel and subsistence costs are NOT reclaimable.

2. If you still have you delegate badge you will see a website address – cpd.onlineregistration.co.uk – along with a unique 16-digit code. Just enter this online and you will be able to download your certificate.

3. The same web address and 16-digit code were also included in the confirmation email you would have received when registering online for the show. Again, head to the website and enter the code.

If you still haven't received your CPD certificate or you are having problems, please email info@sdshow.co.uk and a member of the Scottish Dental Show team will be able to help you.

SAVE THE DATE – SCOTTISH DENTAL SHOW 2018 WILL BE ON 27 AND 28 APRIL AT BRAEHEAD ARENA

Keynote speaker Christopher Orr gave two lectures

"WE THINK IT'S FANTASTIC. YOU CAN GET ALL YOUR CPD IN ONE PLACE – IT'S BRILLIANT. WE WOULDN'T MISS IT"

A member of staff at the Fizzbuzz prosecco bar getting all social

Adam Morgan spoke about how to grow a 'power practice'

Bob Philpott at the Dentsply Sirona workshop area

SCED's implant workshops proved to be very popular

Diamond sponsors Leca Dental Laboratory

Prof Brian Millar presented a lecture and two workshops at the show

"YOU GUYS DO A GREAT JOB, A FANTASTIC SHOW YET AGAIN"

The winner of the Best Stand Award went to mydentist

Attiq Rahman gave a talk on precision prep techniques

DENTAL RECRUITMENT SPECIALISTS

Another year and another success at the Dental Show for us at PS Newjob, with many more vacancies brought on and many more dental staff joining our ever growing PS team of exceptional candidates.

For us this is a great exhibition to meet all our existing clients and candidates and show how much they support us as well as us supporting them. This is a great way to also introduce ourselves to all others that haven't used our Recruitment Services yet and this year was no exception. We have secured many more vacancies and have now been introduced to many candidates who over the next few weeks will be offered their ideal jobs.

The buzz of the exhibition was contagious and I feel that hopefully the people that didn't know what we did before will now know. But just in-case for all of you that didn't make it to our stand here is a quick run down:

- We recruit for ALL DENTAL STAFF across Scotland on a temporary and permanent basis.
- We work with many many DENTAL PRACTICES across Scotland supporting them at short notice and for long term positions
- NO registration fee for candidates and NO up-front fees for any Dental Practices
- 24/7 contact with professional support and advice from our Dental Consultants
- 20 years experience of RECRUITMENT AND OF THE DENTAL ENVIRONMENT
- Our Temporary Nurses get rewarded for good attendance and every Temp nurse will receive a PS Newjob Tunic.

If you want more information or just a bit more support please just pick up the telephone and we will be able to help you. Every call is treated in confidence.

We are so grateful for everyone that came along to our stand to chat and find out more about our services and of course win our now well-known Dentist Ducks. As usual our ducks "flew" out the door and with the new addition of the Dental Nurse Duck it became apparent that everyone just loves a rubber duck. We raised just over £170 for cancer research with our hook a duck game, again thank you so much to every- one that took part and joined in for a great charity.

A special congratulations goes out to Marissa Heede who was recognised for outstanding contribution to PS Newjob over the last year. We presented Marissa on Saturday with a shopping voucher, flowers and a full set of new Scrubs (tunic and trousers).

PS – REMEMBER WE HAVE A HUGE AMOUNT OF VACANCIES TO FILL SO IF YOU ARE A DENTIST THROUGH TO A DENTAL NURSE/RECEPTIONIST PLEASE CALL US IMMEDIATELY FOR MORE INFORMATION.

SEE YOU ALL NEXT YEAR

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Arshad Ali gave his 'Top tips for crown and bridge work'

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"I ALWAYS ENJOY SEEING WHAT THE STALLS HAVE TO OFFER AND ATTENDING SOME OF THE LECTURES, WE REALLY ENJOYED IT"

Philip Friel instructing a delegate during his implant workshop

Ashley Latter returned to the show with two presentations and two workshops

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CAM2136 05-17

Silver Sponsors Dentsply Sirona

John Wibberley spoke about fixed and removable options for teeth and gums

"WE WERE INUNDATED WITH NEW BUSINESS POTENTIAL"

STIRRING UP INTEREST AT SD SHOW 2017

My White Clinic launched their new cosmetic dentistry information website at the Scottish Dental Show with a lot of interest. The website MyWhiteClinic.com is for patients to use as an educational resource which also helps to generate interest and the take-up of private cosmetic treatments. The website can also be used be used by dental professionals who are members.

The educational information on the site includes videos and helps new and existing patients to feel more confident to discuss new treatments and generate new treatments.

Dental professionals who are members pay a small monthly fee and get an exclusive listing of their practice on the website which means they will be the only one search result in their postcode.

Take a look at the dental professionals area at mywhiteclinic.com to find out about becoming a member.

A NIGHT OF CELEBRATION

ALAN WALKER WAS THE RECIPIENT OF THE 2017 SCOTTISH DENTAL LIFETIME ACHIEVEMENT AWARD AT A STAR-STUDDED AWARDS CELEBRATION AT THE GLASGOW HILTON

BRUCE OXLEY SCOTT RICHMOND

The Scottish Dental Awards 2017, which was hosted by comedian and radio presenter Des Clarke, saw 500 members of the Scottish dental community come together to celebrate the best the industry has to offer.

Tryst Dental in Stenhousemuir picked up two awards on the night, the Community Award and Business Manager/Administrator of the Year for practice manager Linsey Paton.

Two of the other big awards on the night went to Edinburgh practices, with Southside Dental Care picking up Practice of the Year and City Health Clinic's Ciara Sutherland being named Dentist of the Year.

The Young Dentist Award went to Lauren Anderson from Milngavie Orthodontics, and The Orthodontic Clinic in Aberdeen picked up the Dental Team Award.

Employer of the Year went to Karen MacCulloch from KM Dental Care, DCP Star was presented to Kyle Anderson of Southwest Smile Care Centre and the Unsung Hero winner was Alastair Knox of Clyde Munro.

The Style Award was presented to Fergus and Glover for their Glasgow practice, and Ruby Rae Dental Recruitment and Consulting picked up the Business Excellence Award.

The Scottish Dental Representative Award 2017 went to Donna Morrison from The Dental Directory, and the newest award, the Best Professional Advisor, was presented to Adam Morgan.


Awards host Des Clarke

The final award of the night was presented to former NHS Education for Scotland (NES) director of postgraduate dental education Alan Walker who was introduced by friend and former colleague Jimmy Boyle, associate postgraduate dental dean at NES.

Alan, who retired in 2015, received a standing ovation and regaled the crowd with stories from his career which began in 1979. He was a general dental practitioner for 27 years and, for 23 of these, he was a practice owner.

He was a CPD Tutor for SCPMDE and then for NES and introduced continuing professional development courses across the West of Scotland. He was appointed director of postgraduate dental education and led vocational training locally and then nationally for 21 years.

SCOTTISH DENTAL AWARDS 2017 WINNERS IN FULL:

- Scottish Dental Lifetime Achievement Award – Alan Walker
- Practice of the Year – Southside Dental Care, Edinburgh
- Dentist of the Year– Ciara Sutherland, City Health Clinic, Edinburgh
- Young Dentist Award – Lauren Anderson, Milngavie Orthodontics
- Dental Team Award – The Orthodontic Clinic, Aberdeen
- Employer of the Year – Karen MacCulloch, KM Dental Care
- Business Manager/Administrator of the Year – Linsey Paton, Tryst Dental, Stenhousemuir
- DCP Star – Kyle Anderson, Southwest Smile Care Centre, Stranraer
- Unsung Hero – Alastair Knox, Clyde Munro
- Laboratory of the Year – Pearl White Dental Laboratory, Airdrie
- Website of the Year – Leca Dental Laboratory, Glasgow
- The Community Award – Tryst Dental, Stenhousemuir
- The Style Award – Fergus and Glover, Glasgow
- Business Excellence Award – Ruby Rae Dental Recruitment and Consulting
- Scottish Dental Representative Award 2017 – Donna Morrison, The Dental Directory
- Best Professional Advisor – Adam Morgan, The Adam Morgan Company

ABOVE: Jimmy Boyle presents Alan Walker (right) with his Lifetime Achievement Award
LEFT: Adam Morgan with awards judge Nicola Docherty
RIGHT: Bruce Oxley with Diane and Debbie from Ruby Rae Dental Recruitment and Consultancy
BELOW: Dentist of the Year Ciara Sutherland with award sponsor Nick Leca

Awards judge Colin McClure (left) with Laboratory of the Year winners Pearl White Dental Laboratory

Connect's Paul McGinnity (centre) presents the Website of the Year award to Martin and Nick, Leca Dental Laboratory

DCP Star Kyle Anderson with Nicola Docherty

Employer of the Year Karen MacCulloch with award presenter Jane Deane

Donna Morrison with her Scottish Dental Representative Award 2017 and SD Awards judge Tariq Ali

Community Award winners Tryst Dental with SD Awards judge Hazel Cameron (right)

Practice of the Year, Southside Dental Care

Unsung Hero winner Alastair Knox (left), with Connect's Tim Power

Linsey Paton (right) with her Business Manager/ Administrator of the Year Award, presented by sponsor April East of PS NewJob

The Style Award winners Fergus and Glover (Glasgow), with Connect MD Alan Ramsay

Young Dentist Award winner Lauren Anderson with award sponsor Jim Hall of Clyde Munro

Team of the Year The Orthodontic Clinic, Aberdeen, with SD Awards judge Gordon Morson (left)

CANCER FIGHT GAINS TRACTion

NEW CHARITY TO CONTINUE THE WORK OF THE MUCH-LOVED AND WELL-RESPECTED BEN WALTON TRUST, WHICH IS WINDING DOWN

A newly established Scottish charity is offering support for patients suffering from cancer of the aerodigestive tract (head and neck, oesophagus, stomach).

Its founders, Emma Shanks and Liz Grant, were previously active in the Ben Walton Trust, which is being wound up. They will carry on with part of the work established by Mike Walton (see 'Trust to go, but work continues', page 38), while covering other areas.

The new charity aims to maintain strong links with the dental profession to continue raising awareness of head and neck cancers. Emma is well placed to give a unique perspective on the impacts of the disease. Not only is she a cancer researcher at the Cancer Research UK Beatson Institute in Glasgow, she has also developed oral cancer on no fewer than four occasions (see 'Emma's Story', page 38).

She explained: "Mike and I had a discussion about what would happen after the Ben Walton Trust was wound up. I didn't want to see all the good things Mike had done disappear. Having been a patient, I loved the fact that the trust was spreading the message that young people do get oral cancer.

"It's vital to make dental and medical students aware of the signs and symptoms of the disease so that early diagnosis can be made. As part of my activity with the Ben Walton Trust, I have given talks from a young cancer patient perspective to other cancer patients and medical and dental students."

Emma outlined the objectives of TRACTion Cancer Support. They are to:

- engage patients in an excellent quality of life during and after treatment for cancer of the aerodigestive tract (ADT)
- establish a patient-focused community, offering support and guidance through all aspects of treatment, with a strong emphasis on post-treatment recovery
- raise awareness of the signs and symptoms of ADT cancer in all age groups
- offer research funding to better understand and meet the needs of patients, principally in collaboration with the Royal College of Physicians and Surgeons, Glasgow.

One of the initiatives pioneered by the

"HAVING BEEN A PATIENT, I LOVED THE FACT THAT THE TRUST WAS SPREADING THE WORD THAT YOUNG PEOPLE DO GET ORAL CANCER"

Ben Walton Trust that TRACTion Cancer Support will take forward and develop is the *Dinner with a Difference* soft food cookbook.

Emma added: "That has been a real success and we want to maximise its use and disseminate it as widely as possible. It's an excellent resource not only for oral cancer patients but also for those who have suffered oesophageal or stomach cancer, and other illnesses as well.

"People who have been affected by ADT cancer can often feel alienated from the social aspects of mealtime, and can disengage from an interest in food generally, which then has an impact on their nutrition. But the *Dinner with a Difference* event, which prompted the creation of the cookbook, saw patients re-engage with the act of sharing a meal and the impact was profound."

Emma and Liz are joined by another trustee in the charity – Dundee-based Dr Gareth Inman, who like Emma, is involved in cancer research.

It is relatively early days for TRACTion. Its official launch will take place on 15 September. But the charity is already active, with social media platforms now active and a website under development.

"Our launch will be at the Hilton in Glasgow," said Emma. "It is open to everyone, but we will personally invite patients who wouldn't normally be able to come to these types of event.

"It will be at lunchtime and we will offer samples of food prepared from the cookbook."

She added: "Our intention to create a patient-focused community is very important. When you are diagnosed with cancer, it's very scary and intimidating: your treatment plan is described to you, but you don't know what the long-term consequences will be. Having contact with someone who has been through that and come out the other side is a huge benefit. I know that from personal experience. One of the goals for TRACTion is to make arranging such interactions simpler and easier."

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TRUST TO GO, BUT WORK CONTINUES

The charity has achieved a great deal over the years (see Scottish Dental November 2015). However, Mike has decided it is an ideal time to pass the baton to other hands. He does so with the trust having made its mark in several ways. Among other things, it has:

- Helped to fund the King's study by employing Dr Alison Giles and Carrie Llewelyn as part-time researchers
- Set up, with the late Richard Horner, the Scottish Oral Cancer Action Group, and delivered a presentation to the Scottish Parliament
- Submitted a proposal to SIGN and Mike worked as a patient representative on the guidelines on head and neck cancers
- Worked with dental students on increasing awareness by holding annual events where students speak to other students about risk factors
- Supported and developed with BMJ Learning the online module, "Mouth cancer: recognising it and referring early"
- Organised and funded the *Dinner with a Difference* and the resulting soft food cookbook.

It is the final of these achievements that is being built on by TRACTion Cancer Support. "We have provided a donation to help them take things on," said Mike. "One of our funders had embraced the idea of the cookbook and wanted part of the money they'd raised to go towards reprinting the book when necessary.

"Emma comes at things from a different perspective and we thought that was a good thing to continue. Because she has been a sufferer of oral cancer, it makes things very real for the people she delivers talks to. I wish her and Liz every success."

ROYAL COLLEGE

The trust will continue to keep a website presence for the next three years to act as a source of information and links to other sites, such as BMJ Learning. A sum of money has been set aside to allow an update of the BMJ Learning module.

Meantime, there is an agreement to distribute remaining funds with the Royal College of Physicians and Surgeons of Glasgow. "They will open an account named 'The Ben Walton Oral Cancer Fund'," said Mike.

"In alternate years this will be used to award prizes and support projects and host an invited lecture. Donations will still be accepted into that fund."

Mike added that it has been difficult to give up his work with the charity. However, he believes the efforts to tackle the disease and its effects will benefit from new energy.

"I'm happy that I've done my bit. We've had tremendous support from a huge range of people. Many of the dental practices we have dealt with realise what a genuine and dreadful disease oral cancer is.

"Now, there are many dentists, medics and students who have the problems in their sights and will bring new energy and drive to increasing awareness of the signs and symptoms and the need for rapid detection and treatment of mouth cancers. I wish them success."

EMMA TELLS HER STORY

I was 24 and studying molecular biology when I noticed an ulcer on the side of my tongue. It was still there a few months later and wasn't healing – in fact it started to hurt all the time.

A little later I moved to Dundee to start my PhD in molecular biology. I registered with a dentist and things changed. The dentist was aware of the signs and symptoms of oral cancer and referred me to the dental hospital.

Biopsies were taken from the area around the ulcer. The results showed I had oral cancer.

I felt numb when they told me, but because it had been caught early the outlook was good. I had surgery to remove about a third of my tongue.

Seven years later I noticed some white spots on my tongue. My cancer had come back. It was a massive blow. By this time I was with David – he was an immense support. I had more surgery to remove more of my tongue and it was a success.

Life carried on for the next two years and we had our first child, Jamie.

THEN, THE CANCER CAME BACK.

This time round, Jamie was a whole new reason to survive. I had a third surgery. It was extremely tough, but I got through it.

A year later, I was enjoying working as a cancer researcher and had given birth to my second child, Isobel.

Two weeks after that, the bubble burst again. I was diagnosed with oral cancer for a fourth time.

This time the treatment was more complex and even more painful. I had an eight-hour operation to remove a large section of my tongue, which was then replaced with a graft from my forearm. I needed a tube in my neck so I could breathe and another tube to eat.

THIS TIME WAS THE HARDEST, AND NOT JUST BECAUSE OF THE TREATMENT.

I couldn't see my son Jamie the whole time I was in hospital – it would have been too hard for him to see me like that. Thankfully, I did see Isobel since she was too young to fully understand what was happening.

I wanted to spend more time with my family. I had to get better for them, and for myself.

My parents were amazing each time I was diagnosed, but particularly the fourth time. They were an invaluable support.

When I left the hospital after my reconstruction operation – my fifth in total – I was so emotional.

It felt like I'd been released from jail. I'm grateful that I can enjoy the simple things in life now, like seeing Jamie and Isobel feed the animals on our farm.

It's amazing what doctors can do and how far we've come in treating cancer. And despite how hard my treatment was, I feel lucky to be alive.

I've been told there is a less than 3 per cent chance of the cancer returning, so I'm hopeful I've beaten the disease. I may have had cancer four times, but it won't define me.

Having cancer makes my work even more meaningful and I'm even more motivated to find better, smarter ways of treating cancer now.

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ENDODONTIC RETREATMENT

PART TWO

ENDODONTICS

Arvind Sharma concludes his two-part article on non-surgical root retreatment of the mandibular left first premolar

ARVIND SHARMA

In the first part of this article we looked at the medical and dental history, radiographic examination and diagnosis of a 49-year-old male patient who initially attended for an emergency appointment. He was experiencing pain and swelling from LL4, which had previously been root treated while on holiday.

Treatment plan

Since the patient was well motivated and wished for a predictable long-term solution, he opted for reduction of the infection with root canal retreatment under private contract. He did not wish to keep the tooth under observation since there was a risk of his symptoms returning and he did not wish for extraction of tooth LL4 since this would have functional and aesthetic implications for him.

The treatment procedures with risks were discussed at length. The patient was advised that treatment success would be achieved by removing all of the previous obturation materials, locating the additional canal(s), chemically and mechanically disinfecting the canals and finally obturating the canals and providing a definitive coronal seal.

The patient was given the opportunity to ask questions and these were answered to the patient's satisfaction. The patient was given a good prognosis upon successful completion of treatment with a success rate approximated at 62-86 per cent, based on evidence published by Sjogren et al 1990. The patient was advised that non-surgical root canal retreatment was indicated as a primary treatment option as indicated by Rahbaran et al 2001. Consent was taken and two subsequent appointments made.

Treatment plan was as follows:

a) Antibiotic prescription to reduce facial swelling.
b) Oral hygiene advice and instruction plus interdental cleaning demonstration.
c) Scale and polish
d) Restorability assessment and root canal re-treatment of tooth LL4 over two visits
e) Definitive composite restoration of access cavity
f) Review (one year).

Items b and c were performed by the practice dental hygienist.

Treatment description

After the patient was questioned about his lack of any allergies, a prescription for amoxicillin 500mgs tds for five days was given as per recommendations by SDCEP (Scottish Dental Clinical Effectiveness Programme) 2014.

The patient attended when he could schedule an appointment around his work commitments, which was 16 days later. The restorability of tooth LL4 was discussed and, since the present restoration was well fitting and functioning well, it was decided to maintain this onlay and perform the root canal retreatment through the occlusal surface. This decision was based on evidence published by Saunders and Saunders 1994. The patient, however, was warned that in the event that the onlay suffered damage as a result of the access cavity, he would require a new restoration. The possibility of a future full coverage crown was also discussed. The procedure was again explained and the patient consented to treatment.

Topical anaesthesia was administered with 20 per cent benzocaine. After 60 seconds, as recommended by Malamed 1990, a buccal and lingual infiltration was administered with Septanest 2.2mls articaine hydrochloride 4 per cent with adrenaline 1:100,000. An articaine infiltration was chosen as opposed to a 2 per cent lignocaine or 3 per cent prilocaine inferior dental block since, in the author's experience, articaine gives fast and profound anaesthesia which is ideal for root canal treatments of lower premolars, as recommended by Malamed et al 2000. Rubber dam

FIGURE 1
Previous GP removed

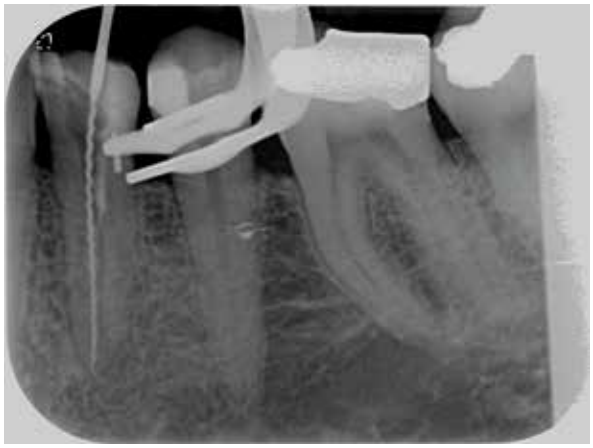

FIG 2
LL4 WL radiograph of buccal canal

(Optidam, Kerr) was then placed and sealed with oraseal to prevent any liquid leakage into the oral cavity.

An access cavity was prepared with Dentsply Access Cavity burs, through the existing composite onlay with the aid of X2 magnification surgical loupes. The obturation material was located buccally and identified as pink gutta percha. This was subsequently removed with the aid of Gates Glidden burs, Hedstrom stainless steel files sizes 25 and 30 and solvent (chloroform). This solvent was used since Tamse et al 1986 showed chloroform to be an effective solvent for the purposes of gutta percha removal. Also, Chutich et al 1998 advised chloroform poses minimal risks to the operator and patient when used in retreatment cases. Figure 1 shows a piece of gutta percha removed.

The canal was irrigated copiously with 5.25 per cent heated (50 degrees celsius) sodium hypochlorite. Heated sodium hypochlorite was used because research by Cunningham et al 1980, Abou-Rass et al 1981, Gambarini et al 1998 and Sirtes et al 2005 have all shown the enhanced tissue dissolving effects of 5.25 per cent sodium hypochlorite when heated to 45-60°C. A radiograph was then taken to verify the working length (20mm from the occlusal surface reference point) and to confirm gutta percha removal since a zero reading had been achieved (at 20.5mm and 0.5mm deducted to give the correct working length) with an electronic apex locator (EAL) (Morital ZX). The EAL was used since much published research appears to have the aforementioned EAL model as being the gold standard amongst other EAL's. Kobayashi et al 1995 discussed the accuracy of EAL's of measuring the working length to 0.5mm of the apical foramen. Many studies have concurred with this study. Patency had also been achieved in the buccal canal (Fig 2).

The tooth was then assessed with the aid of a surgical operating microscope (Carl Zeiss Pico) at x10 magnification. The remaining gutta percha was removed with the aid of Gooseneck burs and a DG16 probe. To locate the lingual canal which was apparent on the initial radiograph, root dentine was removed with ultrasonics (Satalec P5, Satalec-Acteon Merignac, France) using a Start X size three tip and K1 carbon file (Sybron Endo) used to enter the canal. A working length was established as before and measured with an EAL and verified with another radiograph. The lingual canal was again patent and had a working length of 19mm from the occlusal surface reference point (Fig 3).

GG burs were again used to achieve straight-line access being careful not to remove excessive dentine and restoration material. Copious irrigation with 5.25 per cent heated sodium hypochlorite was performed and a glide path was established with 2 per cent taper K files, 10-20 with patency being confirmed by recapitulating with a size 10 stainless steel K file. The files were used with a watch-winding action and finished with a push-pull motion until a smooth glide path was created.

Canals were dried and a temporary dressing of calcium hydroxide paste (Ultracal ultradent USA) placed in each canal with 1mm of the WL. Several studies including Mohammadi et al 2011, Siqueira et al 1999 and Sjogren et al 1991 have shown and discussed the antimicrobial benefits of calcium hydroxide as an inter-appointment medicament and have recommended its use for between two and four weeks. A foam pellet (Roeko) was placed in the pulp chamber since this is easily removed and does not have fibres which may lodge into a root canal space unlike cotton wool. A GI temporary restoration was placed in the access cavity. POIG and the patient made an appointment for two weeks later.

At the second appointment the patient reported tooth LL4 to be completely symptom-free. Upon clinical

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examination, no submandibular swelling was noted, no buccal or lingual swelling noted, the tooth was not TTP and the temporary dressing was in situ and well-sealed.

Topical anesthetic was placed as before and septanest LA was administered as before. Rubber dam with oraseal was placed and the temporary dressing removed. The canals were irrigated with 5.25 per cent heated NaOCl and, after gauging the canal dimensions with size 20 and 25 K files, were prepared with Reciproc R25 reciprocating rotary file (tip diameter of 0.25mm with a 8 per cent taper) using a X-Smart Plus Endodontic motor (Dentsply). The Reciproc rotary file system was chosen to ensure complete residual gutta percha removal, efficient infected root dentine removal whilst maintaining the integrity of the root canal space. This file has M-Wire technology which has been shown to have greater flexibility and resist cyclic fatigue fracture. It has an S-shaped cross-section which enhances dentine removal from the root canal and a regressive taper. Research by Yared 2008, Yared 2011 and Gavini et al 2012 have shown this file to have superior properties when compared to a continuous motion NiTi file system and has been shown to be particularly efficient when used in retreatment cases.

Both canals were prepared to length with a pecking motion as per the manufacturers guidelines. A MAC radiograph was taken to verify GP lengths after gauging each canal to an apical width size 25 (MAF) (Fig 4).

A final rinse was performed with 5.25 per cent heated NaOCl with sonic agitation using a Waterpik flosser for 30 seconds in each canal. This device uses sonic energy to vibrate a polymer tip which does not damage the root dentine if touched. It works at the same frequency and principle as the Endoactivator which Ruddle 2007, Ruddle 2008, Mancini et al 2013 and Paragliola et al 2010 have shown enhances smear layer removal and the effectiveness of the final rinse protocol. Each canal was again irrigated with NaOCl and then irrigated with 17 per cent EDTA (as recommended by Bystrom et al 1985 and Calt et al 2002) for a further 30 seconds with a final flush with NaOCl. The canals were then dried with R25 paper points until the tips of the points were withdrawn from the canals dry.

Obturation was performed with R25 gutta percha cones sealed with AH Plus sealer via continuous wave and heated backfill. B&L (alpha and beta) hot-tip and GP gun were used to facilitate this. AH Plus sealer has been shown to have excellent sealing qualities as described by Ungor et al 2006 and Siqueira et al 2000. The heated GP was condensed with a size two Machtou plugger. A heated obturation method was chosen to achieve a 3 dimensional seal as advised by Schilder 1967.

The continuous wave method of root canal oburation has been shown to be an efficient method to achieve a homogenous gutta percha seal as described by Buchanan 1994 and 1996. Gooseneck burs were then used to level and smooth the GP to the canal orifice level. The chamber was cleansed with isopropyl alcohol and sealed with SDR light-cured flowable composite after applying 37 per cent hydrophosphoric acid for 20 seconds, washing with water for 20 seconds, drying with air and applying a dentine bonding agent (Prime and Bond NT). The remainder of the access cavity was restored with composite resin (Filtek Supreme A3) and light cured for 20 seconds.

The rubber dam was then removed, the occlusion checked in ICP and lateral excursions and the surface polished with rubber cups and diamond polishing paste. A final radiograph was taken showing a well-condensed obturation with good coronal, mid and apical seal. Some sealer extrusion was noted (Fig 5).

Review

At a one-year review appointment the patient reported no symptoms and he was delighted at how quickly the tooth had settled post-treatment. Clinical examination reported no significant findings (no soft tissue swelling or tenderness to percussion). The radiograph taken (Fig 6) shows signs of radiographic healing since the radiolucency visible on the pre-operative radiograph is not present. Interestingly, there appears to be some sealer present mid canal on either one or both canals. This may be a lateral canal(s) which was not evident from the initial post-op radiograph taken a year ago. Again, some sealer extrusion is noted in the lingual canal. The definitive restoration was also functioning well.

Discussion

Root canal treatment can be a very challenging dental discipline due to the complexity of the root canal system. Root canal retreatment adds another dimension because the clinician has to dismantle another clinician's work and orientate himself according to the radiographic evidence available. Fortunately, in this case, the radiographic view available was sufficient to obtain the necessary canal anatomy. Upon reflection, another 5 degree angled- view peri-apical radiograph may have given a better image of the additional root. The decision was made, however, according to IRMER(2000) and IRR99, not to expose the patient to further radiation and that the available radiograph was sufficient for diagnostic purposes.

This case also demonstrates the importance of using a surgical operating microscope (SOM). As discussed by Vertucci 1984 and 2005, mandibular permanent first premolars can present with a number of canal configurations. In this case a class V configuration is noted and according to Vertucci 1984, approximately 24 per cent of mandibular lower first premolars have this configuration. The lingual canal could be seen with the SOM but was not visible with x2 magnification surgical loupes. The SOM certainly enhanced the operative procedure and enabled me to treat this case more effectively and with greater precision.

In every endodontic case I complete, I feel it important to reflect and identify where the treatment could have been improved. In this case a radiograph taken after placement of

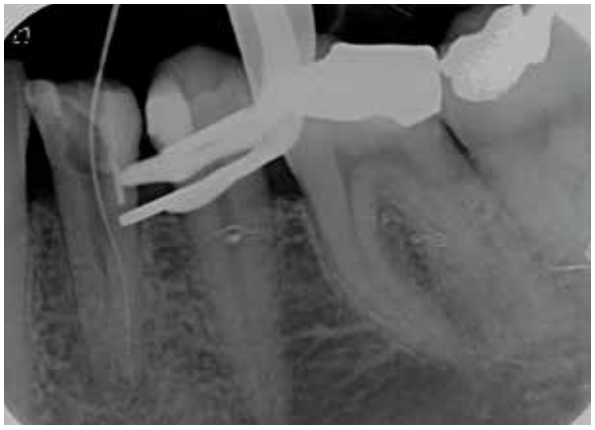

FIGURE 3
LL4 WL radiograph of lingual canal

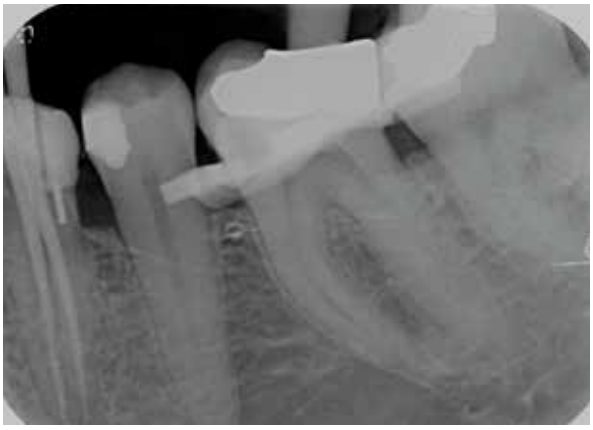

FIGURE 4.
LL4 MAC radiograph

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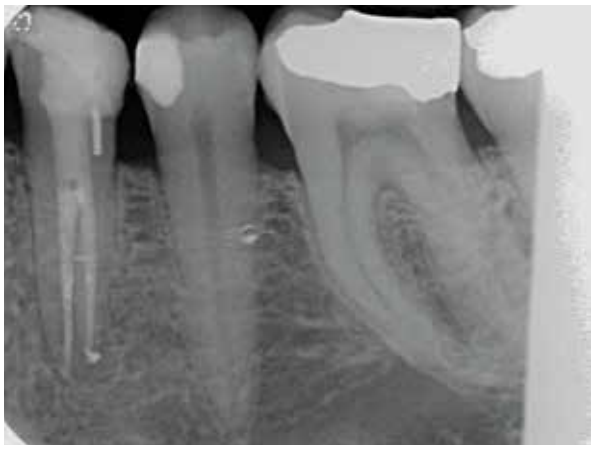

FIGURE 5
LL4 final radiograph

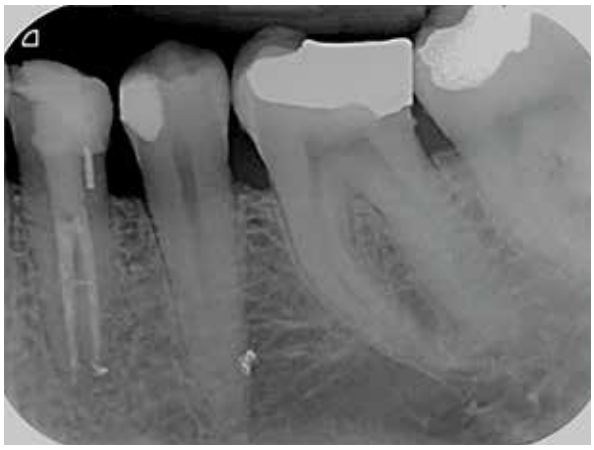

FIGURE 6
LL4 one-year review radiograph

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Ca(OH)2 would have shown me the position of the radio-opaque paste and given me confirmation that it was placed within 1-2mm of the radiographic apex in the apical third of the root canals. Also, a radiograph taken as a midfill would have confirmed that the apical third had been obturated adequately before the heated backfill obturation was commenced. Since obtaining a good apical seal is paramount, a customised MAC possibly could have been used to achieve the apical anatomical detail with the use of chloroform solvent.

This method, however, was not used since the heated method of obturation used enabled an accurate apical seal. Fortunately the final radiograph shows a well compacted obturation in both canals at the correct working length. A criticism of the final radiograph would be that there appears to be a small void above the GP where the SDR has been placed. This will be kept under observation and since the remainder of the composite restoration is well condensed, I see no reason to replace the composite at this time. There is also some sealer extrusion but according to Sari et al 2007 and Augsburger and Peters 1990, no consequences should result and no foreign body reaction should ensue. Periapical healing is not impaired in adults. Sari et al 2007 also showed that approximately 56 per cent of extruded AH Plus disappears over a 4 year period. The patient has been advised and this will be reviewed, although not with a radiograph due to limiting the patient to x radiation, at every subsequent examination.

The one-year post-operative radiograph shows signs of radiographic healing. There are, of course, limitations of this imaging modality. Radiographs give a two-dimensional view of a three-dimensional spatial relationship. Although there appears to be radiographic healing, the image does not show all of the surfaces of this tooth's apex. Cone beam computed tomography (CBCT) could give a more detailed and accurate view of all the tooth's surfaces and allow a more definitive conclusion to be made with regards to the healed status of the tooth. Ultimately, histological analysis would provide a definitive answer but this is not possible.

Since the patient reports that the tooth is asymptomatic, taking a CBCT image would not be recommended and is not indicated according to current European Society of Endodontology 2014 guidelines. According to Patel et al 2015, teeth that appear radiographically as healed may be diagnosed as having a radiolucent periapical area on a CBCT. This may be present in an asymptomatic tooth and raises the question of what should be done to manage this if the patient is not experiencing any symptoms.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:
1. To review clinical history and endodontic diagnosis
2. To recognise the importance of preoperative radiographs
3. To illustrate to the clinician the complexity of root canal anatomy of mandibular first premolars
4. To highlight the benefits of a microscope in endodontics
5. To provide the clinician some of the advantages of heated obturation.

LEARNING OUTCOMES:
1. Be aware of the incidence and location of additional canals in mandibular first premolars and be able to assess and diagnose mandibular first premolars which may have two root canals
2. Be able to highlight the importance of microscopes in endodontic case management
3. Know when to consider making an endodontic referral.

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DENTISTRY AND AUTISM

SPECIAL CARE DENTISTRY

NHS Highland public dental service dentist Malcolm Hamilton provides some useful advice and information for practices treating autistic patients

MALCOLM HAMILTON

In this article I hope to cover the development and evolution of a training programme covering dentistry and autism before moving onto the more practical aspects of dealing with autistic patients in a dental practice.

My own personal experience of delivering training in autism started more than a decade ago with some basic autism awareness raising and since then has evolved into a more specific dentistry and autism, delivered in a variety of settings and to various groups. I currently sit on NHS Highland's Autism Strategy Group and participate in the Healthy Lives SubGroup. These groups are composed of a mixture of health, education and social care professionals and representatives of the autism community, either those with autism themselves or carers.

When considering dentistry and autism training there are various levels and facets to consider. Firstly, why is such specific training needed, to whom should such training be delivered, by whom, when and at what level?

Why is such specific training needed?

The current incident of autism diagnosis is increasing. There are various theories and explanations given for this rise, whether it be better diagnosis, earlier recognition or if there is an overall increase – it's a multifaceted answer beyond the reach of this article. What is evident though is that the dental team is becoming more aware of the increasing numbers of autistic patients within all our practices. Autism is a spectrum condition; this means that the effects on an individual can vary from minimal to profound. There can be no affect on intellectual ability or a profound learning disability. There are various training packages available both nationally and locally (from the Open University and the National Autistic Society, to those run by local groups) but, in general, they deal with the condition itself only. If you are lucky, it will mention dentistry, but usually only briefly and then it will mention the difficulties involved.

What is required is training that highlights the needs and requirements of autistic patients and their carers within a dental setting. This training, while highlighting the main issues of autism, also needs to tackle those issues from a dental practice point of view.

To whom should training be delivered?

As part of NHS Highland's Autism Strategy Group I recently surveyed local GPs on their experience of autism training. The results of this survey showed that, while most of those doctors had received some level of autism training, the reverse was true of their receptionists. This front-line element of dealing with autistic patients is vital. As such, we have ensured that when we are delivering training on any group of patients who may have additional needs that the training is delivered to the whole team, both clinical and administrator.

Those on the front desks are a vital element in reducing the stress and distress which can accompany dental visits by their communication skills and ability to adjust them accordingly. Within the dental setting it is imperative that all team members from front desk to surgery are included in any training.

While we train our dental teams on how to deal with an autistic patient, another aspect to be considered is providing training to local autism groups as to what they can expect and reasonably request in terms of visiting the dentist. Oral health advice leaflets can be distributed via drop-in centres and oral health messages incorporated into newsletters.

Who should deliver training?

During my own journey working with autism, I very quickly came to learn how political a community it can be. There are those who believe that all training on autism can only be successfully delivered by those with autism. Others are happy if there is consultation. We do, however, have to avoid the trap of producing a training programme and

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FIGURE 1
In a pre-visit pack, a picture of the practice/health centre itself could be used with a caption such as: "On Tuesday, I am going to have my teeth counted at the Golspie Dental Centre"

FIGURE 2
Waiting area with caption: "This is the waiting room where I will sit before I have my teeth counted"

FIGURE 3
Dental chair: "This is the chair I will sit in to have my teeth counted by the dentist"

FROM PREVIOUS PAGE>

then sending it out for comments. This can leave people feeling uninvolved in the development of a programme, almost as if they are an afterthought.

There are numerous autistic societies throughout the country; some are national such as National Autistic Society while others will be more local. An example near myself is ARGH! (Autism Rights Group Highland!). A good relationship with both national and local groups can pay dividends in terms of disseminating oral health messages. We have training delivered by a dental team on its own, a dental team with autism diagnostician or a dental team with autism patient. Each has its own merits and advantages.

When should be training be delivered?

As with any training, this will depend upon need. Figures show the numbers of those with diagnosis is increasing. Whether that is due to better diagnosis, more diagnosticians or an absolute increase is still debated. As the Public Dental Service, we know that the number of referrals we are receiving for autistic patients is increasing, both adults and children. While some of these will be heading straight down a GA pathway due to their level of co-operation and ability to communicate, many others are for general dentistry.

As such, each practice should be aware of their own needs for training and arrange as frequently as they see fit. Ideally, new staff should be given training as soon as they start. Refresher training will depend upon your need – paradoxically it may be that if you do not deal with autistic patients often, you will require refresher training more frequently as, with so many things learned on courses, if you don't use it you lose it.

At what level should training be delivered?

There are two aspects to training in dentistry and autism, there is the general awareness raising of autism and its associated traits and comorbidities, and then there are the elements specific to dentistry. All healthcare professionals should be aware of autism and how it may affect patients, but surprisingly few have ever been given any formal training in this. Attending any meeting on autism and health, it soon becomes apparent that the bulk of most agendas is actually about diagnosis services rather than interacting with all the other elements of healthcare.

With regard to the elements specific to dentistry, the exact level will depend upon your patient base. A community clinic, which is seeing more complex cases will require more in depth training than a GDP practice would. Such additional training may include work on consent, working under GA, violence and aggression training, including the use of clinical holding.

How should training be delivered?

Training is available from a variety of sources, and there are numerous online packages at various prices. These are mostly very general in nature and, if you are lucky, may mention dentistry in passing. The Scottish Government has recently been funding professionals through an Open

University Understanding Autism module, but within it there is no mention of dentistry at all. However, for an overview of autism it is very useful. The best for dentistry, therefore, is a specific training session, which can be as short as an hour or as long as an entire day. They are, however, few and far between. The ideal is an in-practice session attended by all staff members, not just the clinical team but also the receptionists.

Accumulation of marginal gains

I shall now explore various hints, tips and strategies that can help when dealing with patients on the Autistic Spectrum and their carers. I shall highlight a number of areas where small changes can together combine to bring about a more successful outcome. The phrase "accumulation of marginal gains" came into popular culture during the 2012 Olympics as it was the mantra of the Team GB Cycling team. The philosophy is that there is unlikely to be any one major change which gives you a revolutionary step ahead, but by bettering performance in a multitude of minor areas it will give an overall improvement.

As such, we will explore the options where we can make such small changes in the hope that they can combine to give us, as a dental team, a better chance of managing and treating autistic patients.

Medical questionnaires

On the basis that forewarned is forearmed, we include a specific autism question on our medical questionnaires. The question reads: "Are there any other details or conditions which it may be helpful for your dentist to know about but are not mentioned e.g. autism or Aspergers syndrome, physical or learning disabilities." This gives patient and carers a chance to prewarn us of a diagnosis or even prediagnosis.

We operate a helpline system for patients which asks broader questions. They include: "Does the patient have any medical condition which you feel has a negative effect on their dental health" and "Do they have any condition which affects their ability to care for themselves or seek care for themselves". These are two very crude questions but are specifically designed to capture autism so that those patients can be directed to an appropriate clinic.

Once we are aware of the fact that a patient has autism, we can then take measures to gain additional information to aid in our interactions with them.

Pre-visit questionnaires

Once it is known that a potential autistic patient will be attending for the first time, we send them a pre-visit questionnaire. We have two different versions, an adult

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There is unlikely to be any one major change which gives you a revolutionary step ahead

FIGURE 4
Gloves: "The dentist will wear gloves and use a small mirror to count my teeth"

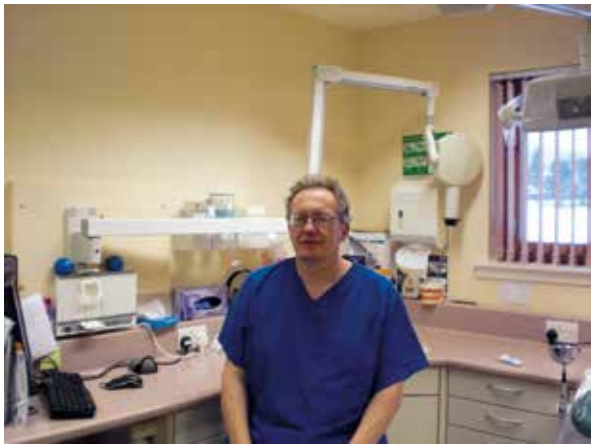

FIGURE 5
Dentist picture: "The name of the dentist who will count my teeth is Malcolm"

FIGURE 6
Reward stickers: "I will get a sticker after my teeth are counted and then I will go home"

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and a child. They basically ask the same questions but with slightly different wording. The questions ask about various aspects that would make visits easier: sensitivities, best time of day for an appointment, any expected difficulties, with communication and anything else that might help us.

The questionnaire is a single side of A4 which can be easily answered in as little or as much detail as a patient or carer wishes. However, the information contained can be invaluable in ensuring that a visit goes smoothly.

Pre-visit packs

As well as a questionnaire, we offer to send out a pre-visit pack to those attending for the first time. These can be especially useful to children. The contents of the pack can vary but essentially depend upon the ingenuity of the person assembling it. Our usual pack contains a pair of gloves, a mask, a disposable mirror, a cotton wool roll and a sticker. This has the value of being compact enough to fit within a standard envelope and thus keep postage costs down.

Appointment timing and length of appointments

Unsurprisingly, the timing of an appointment can have a significant impact on the success of an appointment. This can be due to the actual timing and how it fits into a patient's normal daily routine, but also how that person copes with change at different times of the day. Some autistic patients will be better first thing in the morning, while others may be better at the end of the day. This information will only come from direct contact and questioning. As such, blind sending out of appointments may not result in a success.

The other issue around timings of appointments is the impact a full or semi-full waiting room may have upon an autistic patient, as well as the physical wait itself. Ideally, there should be no waiting as this can cause stress and distress to many on the spectrum. It may be better to schedule such patients right at the start or right at the end of a session when there is unlikely to be many in the waiting room.

If the end of the session is chosen, then care should be taken to ensure that appointments are running to time. We encourage those for whom waiting is an issue to contact us shortly before their appointment to ensure we running on schedule. We also allow patients to contact us to tell us they have arrived but are waiting in the car park until we are ready, thus eliminating any need for sitting in a waiting room at all.

We usually allow a slightly longer appointment time for autistic patients, not necessarily for the treatment itself but to allow time for the patient to become comfortable in unfamiliar surroundings and because often communication can take longer.

Minimal arousal environment

When treating autistic patients we try to have a minimal arousal environment. One of the main issues with autism is a hyper or hyposensitivity, and this can be to external or internal sensations. This means there can be unusual reactions to lights, noises, tastes or movements. Therefore, we can turn off overhead lights, especially if they are fluorescent tube lights as these can cause hypersensitivity due to flicker. We also turn off the radio and we can turn off the ringer on surgery phones and place a notice on the door to prevent interruptions.

With regard to taste, plain water may be appreciated as a mouth rinse rather than mint, orange or thymol. Movement and balance is an often overlooked aspect of autism but we can help by having the chair in a reclined position thus preventing the need to have the patient moving in the chair.

Social stories

Social stories are a form of pictorial storyline often used in other fields such as education. I was, in fact, introduced to them by my wife, who is a teacher. They compromise of a series of pictures accompanied by short text. They can be photographs or cartoons and can be used to represent a variety of different topics from a general exam visit to a more specific treatment such as fissure sealants.

A simple example might be: "This is the dental clinic where I will go to have my teeth counted" with a picture of the building. "This is the room I will sit and wait until it is time for my teeth to be counted," with a picture of the waiting room. "This is the chair I will sit in to have my teeth counted," with a picture of the dental chair. And: "The dentist will wear gloves and use a mirror to count my teeth," with a picture of gloves and a mirror (this ties into the pre-visit pack). "This is the dentist who count my teeth," alongside a picture of the dentist and, finally: "After my teeth are counted I will get a sticker," with pictures of stickers.

USEFUL LINKS

NES Learning Resource
http://asd.nes.scot.nhs.uk/

Knowledge Network
http://www.knowledge.scot.nhs.uk/home/learning-and-cpd/learning-spaces/autism-spectrum-disorder.aspx

National Autistic Society advice for dentists
http://www.autism.org.uk/professionals/health-workers/dentists-info.aspx
http://www.autism.org.uk/dentist

British Society for Pediatric Dentistry Advice
http://bspd.co.uk/Portals/0/BSPD%20Advice%20for%20parents%20of%20children%20with%20autism%20Jan%2017.pdf

The principle is very simple, positive language with repetition reinforced by pictures. With modern cameras, they are extremely easy to produce by any member of the team and can be used for many different patients not just autistic ones.

Special interests

As a query on the pre-visit questionnaire, we ask about special interests. Often, autistic patients will have a favourite topic which they like to talk about or are interested in. If we know what this is then we can utilise it to our advantage with suitably themed rewards.

We had one such patient who liked lights, so we let them play with our dental light after an exam if they let us examine their teeth. Another required the procurement of a number of large elastic bands, but more often it is just suitable stickers or colouring sheets of favourite TV characters.

Distracters and comforters

Often, autistic patients will already be armed with their own objects for distracting or comforting them. This may be as simple as a set of headphones, either noise cancelling or playing music to more complex such as iPads or portable devices. It may also include favourite items such as toys, pieces of clothing, rope etc.

We should allow any patient who wishes to continue using any such objects – unless they directly interfere with treatment. Some autistic patients derive a degree of comfort during stressful periods from what is known as "stimming" – short for self-stimulation. This is basically any form of hand movement and may or may not involve an object of some sort. Therefore, it may be useful to have squeezy stress balls available that can be offered to those who might benefit from them.

Communication

We can help autistic patients by adjusting the way that we communicate and there are a number of simple strategies that can be of assistance.

Say the patient's name first to get their attention. So it is: "John, please open your mouth" rather than: "Please open your mouth John."

We may consider reducing our language, using only key words, such as: "Music off" rather than "Please turn off the music now."

We want to say things in the order that they will occur, so it's: "Glasses on, then sit on the chair, then teeth counting." The word "then" is a good link word that is easily understood.

Giving clear choices will help understanding, so a question such as "Which sticker would you like?" becomes far easier when it is reduced to "Barbie or Scooby Doo?"

We should always try to give positive instructions rather than telling patients what not to do, so instead of: "Don't run around the chair" it is preferable to say: "It's time to sit in the chair."

A concept that occurs frequently with an autistic patient is the importance of being told when something is over. For this, it can be useful to use the word "finished". If we use it consistently, this will help the patient understand the concept of time and help to keep them calm.

Summary

The above is a very brief summary of a large number of tactics that can be deployed to use when treating autistic patients. However, they are not always successful and, as such, we may have to refer the patient onwards for treatment under GA. This brings its own challenges but ultimately is often the only option for some patients.

But, by taking our time and adjusting how we prepare for our patients, how we change our environment and how we communicate we can have success and make visits to the dentist a lot less stressful that it might otherwise have been.

I wish you all the success in future dealings with this group of patients.

ABOUT THE AUTHOR

Malcolm Hamilton works as a senior dental officer in NHS Highland's Public Dental Service. He has worked there since 2009, prior to that he was a senior dental officer in NHS Orkney. He qualified from Dundee in 1989 and moved to Orkney after serving in HM Forces. He currently works in Sutherland and Easter Ross providing a range of dentistry to his patients there. He has a special interest in autism and in domiciliary dentistry.

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VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

1. To highlight where and when training in autism is appropriate
2. To highlight where training may be available
3. To understand that a range of tactics are necessary to help autistic patients.

LEARNING OUTCOMES:

1. To understand why it is important for all staff members to receive autism training
2. To know that there are a range of adaptations than can be made to facilitate attendance at a surgery
3. To know how to make a social story
4. To know what is suitable to include in a pre-visit pack
5. To know what steps may be taken to achieve a low arousal environment.

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HEALTH IS A TEAM SPORT

Mary Downie presents the second article in her two-part series on how psychological practice and knowledge impacts on the dental team

PSYCHOLOGY

This article seeks to look at chronic oral facial pain and the stress experienced by the dental team. This work will present evidence that in many cases both of these states are manifestations of the dis-ease in a divided mind. In chronic oral facial pain, we will examine the conditions of TMD, burning mouth and atypical facial pain from the mind body perspective. The work of John Sarno will be explored as he seeks to offer an explanation of how the brain diverts unconscious rage into physical symptoms without consulting the conscious rational mind.

The research by Goldthorpe et al (2016) offers an interesting complex intervention model based on CBT (cognitive behavioural therapy) which embodies many of the ideas proposed by Sarno. Linking the dis-ease of chronic oral facial pain and the pervading stress in our profession will be the Adverse Childhood Experiences (ACE) studies. Dr Robert Block, the former president of the American Academy of Pediatrics, purports that the results and implications of the ACE study, are the single greatest unaddressed public health threat facing America today. What is true in America is also true in the UK, as the ACE studies in Wales and England have demonstrated. The studies, which look at how adverse childhood experiences impact on all aspects of adult health, both physical and mental, is backed up by robust scientific evidence.

In the light of this evidence, Gabor Mate's (2003) seven A's of healing hold great relevance for 'health as a team sport' approach. The pains, ills and addictions of our modern society are a sign of the great disconnects that both health providers and patients are experiencing in their lives. When a boy child with Attention Deficit Hyperactivity Disorder would be president of a major world power it is time to sit up and pay attention.

THE COST OF CHRONIC PAIN

Let me begin with the potential cost to both the patient and the health service of ignored somatised pain. Late one Friday night, at an early stage in my career I was asked to attend an accident and emergency department at half past midnight. I had been awakened from my slumber by a young casualty officer who requested that I remove an anterior four-unit bridge from a very distressed lady. On entering the department, I was confronted by a 62-year-old anguished lady who had attempted suicide. Her mutterings were partly comprehensible and I learned that she'd had intractable pain in her anterior front teeth since the four-unit bridge had been fitted two years previously.

In a faltering voice influenced by her torment she revealed that no one would believe her when she had explained the intensity of the pain and how it was impacting on all areas of her life. In the last few months she had become fixated on her bridge and believed that if this was removed then the pain would disappear. She kept uttering "no one would believe me, no one would believe me". I gently said that I believed her and if it was her wish I would remove her bridge.

On clinical examination, it was an aesthetically and technically good anterior fixed appliance and my heart sank at the prospect of removing it. With her written consent, the bridge was finally set free from her oral cavity and she was released from the dental chair into the waiting care of the psychiatry department.

That whole episode has remained with me over the years and has informed my disposition to patients who present with pain but with no obvious organic cause. It can be difficult to resist intervening when a patient presents with intractable symptoms but in the absence of pathology, resistance is the better part of valour. In dental practice it is not uncommon to encounter patients who have chronic oral-facial pain of a non-odontogenic origin. This pain may take the form of tempero-mandibular dysfunction, burning mouth syndrome (oral dysathesia) or atypical facial pain.

After a careful and thorough history into the nature and distribution of the pain the patient is often referred to an oral surgery or oral medicine department. Within these departments, after thorough investigation which may include expensive tests, the patient is often given treatment in line with the biomedical model. For many patients with chronic pain, research now shows psychological factors play a role in the development, exacerbation and maintenance of their symptoms. Even though this is recognised by many clinicians, there are few psychosocial models in place to offer long-term resolution for this cohort of patients.

THE PAIN IS REAL

Dr John Sarno, an American physician, wrote a best-selling book on healing back pain, where he describes tension myositis syndrome (TMS). He proposes that the pain from this syndrome is caused by unconscious repressed rage and the diversion of

this rage into somatic symptoms. The pain, he states with great emphasis, is real, as demonstrated by eliciting tenderness on palpating the affected muscle groups. He goes onto describe how the pain experienced by the patient is mediated by the autonomic-peptide system often by way of a decrease in oxygen to the affected muscle group.

The somatisation of psychological distress has been described since the time of Charcot, Breur and Freud and was written extensively about in Studies on Hysteria. They describe the split between the conscious rational mind and the more childish primitive unconscious mind. The unconscious mind is often described in terms of the shadow and holds all the emotions that we fear to look at consciously. Take the parapraxis, also known as the Freudian slip, where the unconscious repressed wishes reveal themselves to the light of day. They can often be funny anecdotes but they do reveal part of what is repressed. For example, the slip of tongue that states "A Sale of Two Titties" instead of "A Tale of Two Cities" (see Fig 1).

The masseter muscle is the strongest muscle in the body, helping to exert upwards of 200 pounds of force when the molar teeth are clenched. It is also the holder of a great deal of tension with the unconscious nocturnal grinding of teeth and the diurnal clenching of teeth. The question is, what is the purpose of this grinding and clenching which can lead to micro fractures of the teeth and hypertrophy of the masseter muscles? The pain from this muscle tension can cause great distress to patients impacting on all areas of their life.

Patients often report that when their life is more stressful this pain increases in intensity. The Dr Sarno methodology counsels patients that this pain is real and, indeed it is, but the source of the pain is psychological as opposed to physical. If a patient can accept this fact and acknowledge that it is due to repressed emotions, then the conditions for the reduction in pain and even cure are set in place. Secondly, and just as importantly, it is essential that the patient familiarises themselves with the sources of their repressed emotions. Sources can include childhood events, high expectations of themselves, perfectionism, inner criticism, sensitivities, people pleasing, worrying, the need to be good, responsibilities – the list is endless.

The patient can be given instructions on jaw massage and exercises to ease the muscle tension but the definitive treatment is recognising the emotions that the patient is afraid to bring into the light of day. Techniques such as mindfulness are good to identify emotions but it is important that the patient becomes aware of the real source of these emotions. This would not only help to ease their TMD but their greater awareness could offer the opportunity to a far richer life.

COMPLEX INTERVENTION

The research by Goldthorpe et al (2016) offers an interesting complex intervention model based on CBT which may prove to be of great value to TMD and patients with chronic oral facial pain.

There are to date no clinical guidelines to offer definitive care pathways to patients suffering from chronic oral facial pain. This is perhaps because the true extent of the mind-body connection

Dr John Sarno

FIGURE 1
The image of an iceberg is often used to illustrates the conscious above the water, with the vast expanse of the unconscious below the surface

is not fully acknowledged. Future research in this domain is necessary in order to relieve the distress of this increasing number of patients.

The complex intervention model need not be complex at all, as the primary purpose of it is to gently educate the patient as to a plausible explanation for their symptoms. This education is based primarily on believing fully the extent of the symptoms and the impact they are having on the life of the individual. From this starting point of unconditional acceptance, the long-term management of the condition can be forged in a collaborative environment. There is much research work to be done in the mind body spirit connection in order to reach health and balance for this group of patients.

ACE STUDY

Epidemiological research connecting early childhood experience to the later development of physical and psychological diseases may offer answers to chronic oral facial pain, and the stress many of the dental team will experience in their lives. The

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ACE study was carried out in 1995 and 1997 in California by Kaiser Permanente, a private health company, and the Centers for Disease Control and Prevention. The 17,337 participants have been followed up regularly ever since and monitored for their experience of health and well being. The average age of participants was 57, with 74.8 per cent being caucasians and 75.2 per cent had a college education. All had jobs and good health care, demographics which would closely parallel the dental team in this country. The study asked 10 questions enquiring whether a person had experience of any of the following conditions during childhood:

- physical abuse
- sexual abuse
- emotional abuse
- physical neglect
- emotional neglect
- mother treated violently
- household substance abuse
- household mental illness
- parental separation or divorce
- incarcerated household member.

One adverse childhood experience was reported by about two-thirds of the participants. The number of ACEs was highly correlated with adulthood behaviours such as smoking, alcohol, drug-taking, obesity, promiscuity and ill health including depression, heart disease, cancer and chronic lung disease. The more ACEs the more likely a shortened life span in adulthood (Fig 2). The neurobiology of stress in childhood offers an explanation of how these negative consequences may occur. Under stressful conditions, neural networks are altered along with the biochemistry of the neuroendocrine system.

The scientific evidence to support how early deprivation alters neuro pathways is now firmly established and unless these deficiencies are addressed the damage acts like chaos theory later on in life.

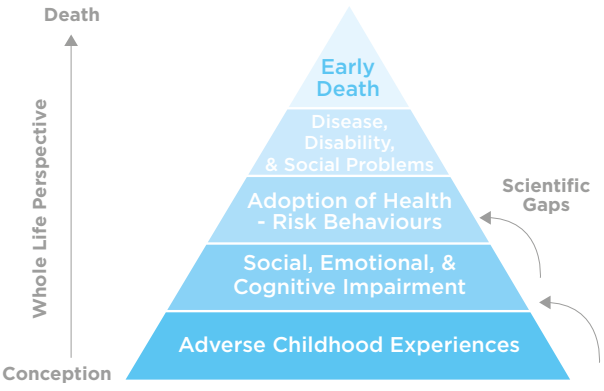


FIGURE 2
The number of Adverse Childhood Experiences correlates with a shortened adult life span

FORGING A NEW PATH

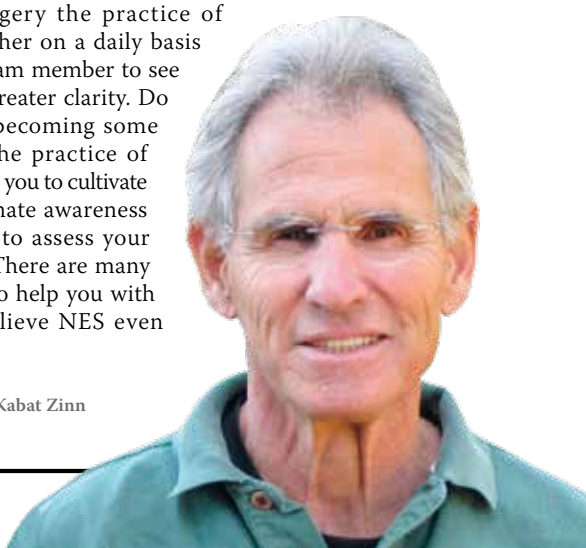
The good news for our patients and for our own personal wellbeing is neuroplasticity. The ability of the brain to form new neuro pathways can now be demonstrated by neuroimaging. The work of Lindon (2006) has shown how psychotherapy can alter brain pathways in conditions such as depression and post traumatic stress disorder. I am not advocating mass uptake of psychotherapy, but I am suggesting that the more conscious we become and the more aware of our lives we become then the richer our experience of life will be.

Socrates stated that the unexamined life was not worth living and, in fact, he was willing to die for that. But what is meant by that in our personal lives and indeed our professional lives? The GDC in its Standards for the Dental Team and their document Developing the Dental Team both mention reflective practice. Yet, do we know the physiological, cognitive and psychosocial skills necessary to truly reflect?

We live in very fast and furious times, connected day and night to cyberspace and external stimulation. Is it any wonder that many of us feel disconnected from what really matters in life? The good life or happy life has been the focus of philosophy and psychology from the beginning of time. Much wisdom has come to us from these sources but we have to slow down to listen to the wisdom of our own hearts. There is much to be said for finding a quiet time in our busy schedules to develop the art of mindfulness. Mindfulness has been born again from its ancient origins in the East. It can be thought of as a simple form of meditation which if practiced regularly has been shown to decrease stress and lessen the symptoms of depression.

At it simplest form, the practitioners of this art seat themselves in a comfortable chair with plenty of support for the back. If doing this in a busy day, it can be good to set the alarm on your mobile phone so that your are not distracted worrying about time. It is good to close your eyes and listen to the sound of your breathing and become aware of any sensations in your body. While doing this, you will notice that thoughts may arise; notice them with compassion, but do not become attached to them, as thoughts are passing. If you are tempted to dwell on the thoughts, return to your breathing, noticing your inhalations and expirations.

In a busy surgery the practice of mindfulness together on a daily basis can enable each team member to see the world with a greater clarity. Do not worry about becoming some Zen-like monk, the practice of mindfulness enables you to cultivate a deep compassionate awareness which allows you to assess your values and goals. There are many courses available to help you with mindfulness, I believe NES even facilitates one.



Jon Kabat Zinn

Jon Kabat Zinn, emeritus professor of medicine and creator of the Stress Reduction Clinic and the Center for Mindfulness in Medicine has been credited with bringing this ancient art into modern medicine. He is quoted as saying that "You can't stop the waves but you can learn to surf". YouTube has many helpful videos to get you started on this life changing path.

FACE YOUR REALITY

In the quest to reduce stress it is good to remember the famous maxim: "If you always do what you've always done you'll always get what you've always got." There is great wisdom in this quote. If we are not prepared to look at ourselves, then things will continue as they are. It is not life that makes us stressed, it is the way that we respond to life. How we respond to life is chiefly influenced (as borne out in the ACE studies) by our early childhood conditioning.

Gabor Mate who wrote the book *When the Body says NO,* exploring the stress-disease connection, advocates what he terms the seven As of healing. These are: Acceptance, Awareness, Anger, Autonomy, Attachment, Assertion, and Affirmation. True reflection requires that we are able to accept ourselves as we truly are, not as we would like to be but as we are in this moment in time. Change is only possible after acceptance and acceptance is only possible if we are able to have compassionate curiosity about ourselves and other.

When I talk about acceptance I do not mean passive acquiescence but the ability to look at myself and my situation as it truly is. Facing and acknowledging our reality brings much greater awareness and means we can be fully present and responsible. We accept responsibility for ourselves and the experience we are having at this time whether it is a good or a bad experience.

Accepting yourself in the present moment means you learn to let go of the thoughts that say "you are bad or good, hopeful

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VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- Exploring a method of treatment for chronic oral facial pain.
- Looking at research that correlates early childhood experience with later psychological and health deficits.
- Looking at mindfulness and inner life enquiry as a means of relieving stress for the dental team.

LEARNING OUTCOMES:

- The divided mind – healing is where mind/body become one.
- How conscious and unconscious processes impact on psychological and physical health.
- Mindfulness as a way of life.

HOW TO VERIFY YOUR CPD

Go online to www.sdmag.co.uk and click on the CPD tab to access all our CPD Q&As and certificates

CONTINUED OVERLEAF>

or hopeless". You just are. You show up as you are letting go of all the things you fear to lose.

The second wish to a stress-free life is to become more aware. Awareness is the ability to recognise the physiological signals within your own body and the ability to interpret the emotional truth in the other. How many times have you had a gut feeling that you should have done one thing and only realised the cost of not heeding that after the event.

There is not enough space to go into the other As but each of them if engaged with sincerely offers a way of gaining greater understanding of our inner world. Carl Jung, the great Swiss psychiatrist, is quoted as saying "Who looks outside, dreams; who looks inside, awakes". It is only in the depths of our inner world that we will discover the wealth of our being. Mindfulness is a great starting point, but in order to undergo long-term change we must be prepared to explore the uncharted waters of our inner life.

CONCLUSIONS

Taking a more pragmatic stance, there are things we can do to reduce stress but they must be done on a consistent basis. It goes without saying a healthy diet, regular exercise, and sleep are essential to reduce stress. In fact one of the main signs of stress is that we give up doing the things that are good for us and the things that give us pleasure. In times when life is difficult it is often the wisdom of poets who help us to see new light.

I leave you with the words of Max Ehrmann and invite you to take a seat and slowly listen:

DESIDERATA: WORDS FOR LIFE

Go placidly amid the noise and haste,
and remember what peace there may be in silence.
As far as possible without surrender
be on good terms with all persons.
Speak your truth quietly and clearly;
and listen to others,
even the dull and the ignorant;
they too have their story.

Avoid loud and aggressive persons,
they are vexations to the spirit.
If you compare yourself with others,
you may become vain and bitter;
for always there will be greater and lesser persons than yourself.
Enjoy your achievements as well as your plans.

Keep interested in your own career, however humble;
it is a real possession in the changing fortunes of time.
Exercise caution in your business affairs;
for the world is full of trickery.
But let this not blind you to what virtue there is;
many persons strive for high ideals;
and everywhere life is full of heroism.

Be yourself.
Especially, do not feign affection.
Neither be cynical about love;
for in the face of all aridity and disenchantment
it is as perennial as the grass.

Take kindly the counsel of the years,
gracefully surrendering the things of youth.
Nurture strength of spirit to shield you in
sudden misfortune.
But do not distress yourself with dark imaginings.
Many fears are born of fatigue and loneliness.
Beyond a wholesome discipline,
be gentle with yourself.

You are a child of the universe,
no less than the trees and the stars;
you have a right to be here.
And whether or not it is clear to you,
no doubt the universe is unfolding as it should.
Therefore be at peace with God,
whatever you conceive Him to be,
and whatever your labors and aspirations,
in the noisy confusion of life keep peace with your soul.

With all its sham, drudgery, and broken dreams,
it is still a beautiful world.
Be cheerful.
Strive to be happy.

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ABOUT THE AUTHOR

Mary graduated from Glasgow University in dentistry in 1980 and from the Open University in psychology in 2001.

She obtained a postgraduate diploma in counselling and psychotherapy from Stirling University in 2013 and a postgraduate diploma in clinical education in 2017. She has enjoyed a plethora of experiences in dentistry, both in the UK and abroad. Mary is now in full-time psychotherapy practice. If you would like to contact her with regard to anything in this article, please email marybdownie1@gmail.com or call 07970 909 373.

AN AGE-OLD DILEMMA

CASE FILES

Aubrey Craig, head of dental division at MDDUS, presents another case from the archives

AUBREY CRAIG

A Scottish GDP contacted the MDDUS with the following query: "On occasion, children have attended my practice without an accompanying adult. I have, until now, waited to discuss the proposed procedure with a parent. However, this can lead to significant delays and I am wondering whether it would be defensible for me to commence treatment following consent from the child?"

MDDUS's response

Obtaining valid consent from a patient prior to any clinical intervention is an essential and sensible means of securing safe co-operation and maintaining a harmonious dentist-patient relationship. It is also a legal requirement which, if disregarded, could result in allegations of negligence or even assault.

Where the clinical notes demonstrate that suitably informed consent has been provided by a competent adult, such complications should not occur. However, where the patient lacks the requisite capacity or maturity, the situation becomes more problematic.

Your question relates to patients who may fall into the latter category. Is consent which has been provided by a child sufficient to permit the dentist to treat without fear of legal or regulatory repercussions?

If the patient is over the age of 16 (and mentally competent) then the answer is simple – validly obtained consent will render treatment lawful. At the opposite end of the scale, where children are very young and the implications of dental treatment are likely to be well beyond their comprehension, their consent is unlikely to suffice.

Certainly, an appropriately worded explanation of the planned treatment is an excellent means of engaging with a younger child. However, assuming that the dentist is not faced with a genuine emergency in which intervention simply cannot be delayed, obtaining the consent of the mother or, with certain exceptions, the father is essential before treatment can commence. It is in the intermediate cases, where the child has yet to reach the age of majority but is old enough to have an appreciable degree of insight into the procedure in question, that difficulties arise. Here, achieving a consensus from parent and child should always be the desired outcome.

However, where a parental contribution is unwanted or unavailable, you must judge whether the child is mature and intelligent enough to understand the proposed treatment. If so, then the consent which that child provides will be lawful.

In reaching this decision, you might wish to consider not only the age and astuteness of the patient, but also the nature of the recommended dentistry and whether that patient has received similar treatment in the past.

Thus, consent to the replacement of existing restorations in the upper first molars of a reasonably intelligent 12-year-old would, in all likelihood, be lawful, though the consenting process should be recorded with particular care.

Conversely, removal of these molars would probably be unwise unless the child was exceptionally retentive and perceptive. In such instances, it would be best to delay this procedure until all aspects of this treatment could be discussed with the patient's mother, father or legal guardian.

While this general guidance should inform your decision making, it is important to assess each case individually and, where there is any cause for concern, seek advice at an early stage.

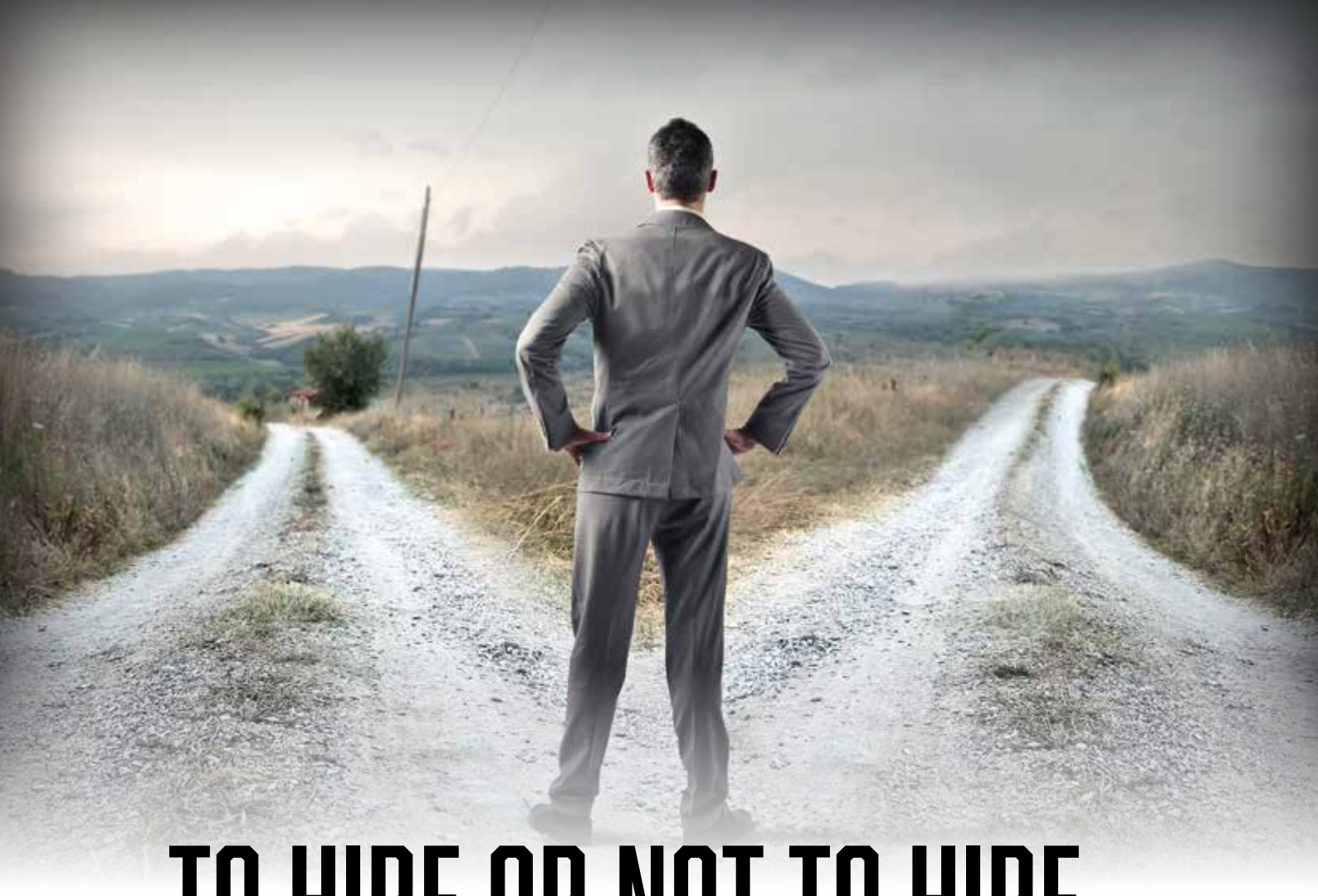
Management

PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

YOU'RE HIRED

WHAT YOU NEED TO THINK ABOUT WHEN RECRUITING NEW MEMBERS OF STAFF

See page 60



TO HIRE OR NOT TO HIRE...

SUSIE ANDERSON-SHARKEY TACKLES THE THORNY ISSUE OF RECRUITMENT IN HER LATEST MANAGEMENT ARTICLE

In this issue I want to delve in the minefield that is recruitment, and ask the question: "Can we really get it right 100 per cent of the time?" Hopefully, by the end of this article we shall come to some sort of conclusion.

In the business of business (if you follow what I mean), I have always felt that the whole area of recruitment is the trickiest of all. Over the many years I have been in the dental profession, I have lost count of the number of people I have interviewed for various positions, and I can say that a lot has changed in the recruitment front since I entered the wonderful world of dentistry way back in 1991.

In those days, you could ask someone how old they are, how many kids do they have, are they planning on having any more kids, what does your husband do for a living (totally irrelevant to the position of dental nurse but nosiness sometimes gets the better of us all!). Nowadays, there are very strict criteria on what can be asked at the time of interview and, to be honest, I don't think it has made much of a difference. With the emergence of social media over the years, everyone is "out there" and it's relatively easy to find the information you are looking for.

When looking for a candidate, it's important to ask yourself several questions such as:

- Am I looking for a trainee or a qualified nurse?
- Am I looking for part-time or full-time?
- What duties do I want the candidate to be able to perform?

> "NOWADAYS, THERE ARE VERY STRICT CRITERIA ON WHAT CAN BE ASKED AT THE TIME OF INTERVIEW AND, TO BE HONEST, I DON'T THINK IT HAS MADE MUCH OF A DIFFERENCE"

These are just one or two questions, but from there you can begin to put together a job specification and match CVs against the job specification (how closely does this CV match all of my requirements? Does it tick all the boxes?).

How are you going to advertise? There are various ways and means, and, like me, you've probably tried most of them over the years. Word of mouth can be very useful and we've had a few excellent candidates from this method. Dentistry is a fairly small pond, and every nurse knows a nurse who knows a nurse who's interested in a career move. However, ideally you would like to have a few candidates and online advertising tends to be the most popular way to kick start the selection process.

We were recently advertising for a new member of staff and I put an advert in what I thought was a popular site for recruitment. However, I got fewer replies that I expected, so I then went onto a lesser known recruitment site (lesser known to myself) and the replies came flooding in. Keep up to date with where

people are looking and it can save a lot of time and money.

Next up are what I call the three Ss: screening, shortlisting and selection.

SCREENING

This is where you look at the CVs and match them up with the job specification as I mentioned earlier. Honestly, this isn't too hard a job. You will get CVs that in no shape or form come close to your job specification, therefore I would reject these immediately.

SHORTLISTING

You've hopefully got a number of CVs that match up fairly closely to your job specification. How many people do you want to interview? Do you want to interview everyone on the same day, or over a few days? I tend to try to interview about four or five candidates for a position, and also try to interview them quite closely together. Make up a list of questions, keep them relevant to the job and ask each candidate the same questions. At least two people should be in on the interview process, one asking the questions and the other to note down the answers.

SELECTION

Hopefully, from the interview process you will have a couple of candidates who are potential future employees who you can get back for final selection interview and, at this stage, you would follow through on their references.

On our most recent recruitment drive, we had two equally good candidates and it took three interviews with each of them to make a final decision. We felt that both candidates would have fitted well with our team and our ethos, and in the end it came down to how one of the questions was answered.

To summarise all of the above:

- Write a job specification
- Advertise the position
- Screen CVs
- Shortlist
- Select.

So, let's go back to the question at the beginning. Is it possible to it right 100 per cent of the time? Honestly... no.

You can go through the process of job specification, advertise, screening, shortlisting, selection, jumping through all the recruitment hoops (haven't even mentioned psychometric testing, group work etc) and at the end of the day the candidate you have selected for one reason or another just doesn't work out.

When this happens (and it will), don't beat yourself up. Reflect on your processes, ask yourself is there anything you could have done differently and then move on. I've worked in the industry long enough to know that we are just not going to get it right 100 per cent of the time and, at the end of the day, if we have done our absolute best then we acknowledge that on this occasion it hasn't worked out, we use it as a learning experience and move on with the job in hand. Good luck!

ABOUT THE AUTHOR

Susie Anderson-Sharkey has worked in various capacities in the dental industry since 1991 and has been practice manager at Dental fx since 2006.

PFM Dental

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*PFM Dental have registered "Priority Buyers" who will pay the agency fee in addition to their offer on behalf of our clients. All payments are sent to our client's solicitor and fees are charged as normal

HOW TO AVOID NASTY SURPRISES WHEN BUYING A PRACTICE

HIGH PRACTICE VALUES MEAN BUYERS SHOULD BE EXTRA WARY OF A PURCHASE THAT COULD BECOME A LONG-TERM LIABILITY, SAYS PFM DENTAL'S MARTYN BRADSHAW

There is no doubt that the values of practices are at their highest ever. Because of this, buyers need to undertake extra due diligence when purchasing a dental practice as otherwise they may find themselves committed to a 15 to 20-year liability that doesn't meet their expectations.

VALUATIONS

There are a number of ways in which a practice should be valued but always on a multiple of profitability. The beauty of using a profit multiple is that this gives the truest representation of the potential profits going forward. The first option is to consider an "associate-led" position, where all income is met by associates (known as EBITDA). The EBITDA stands for earnings before interest, tax, depreciation and amortisation, and therefore all personal items and tax reducers are removed from the practice expenses, but an associate cost would be added in for the principal's gross fees.

The second route is a "principal-led" model which would benefit anyone who is looking to work in the practice – a corporate style structure would not benefit from this. This is the same as the above except the principal income is left in (without an associate cost relating to this). One thing that a buyer should consider is whether they can replicate the level of gross fees that a principal is generating.

In my experience, anyone trying to do this alone, rather than getting an expert valuation (generally costing under £1,000), will probably cost themselves tens of thousands in overpayment.

PROJECTIONS

Once you are comfortable that the valuation is correct, this is the most important step of all. You need to consider what profitability the practice will generate for you based on your projected turnover, any proposed changes to the practice, tax and finance costs. This will potentially be a practice that you are going to own for the rest of your career – you do not want any nasty surprises with the profits.

Let us assume that a valuation has been based on a principal-led model and the purchaser is going to replace the principal (it could even be that the buyer is an associate at the practice and they are looking at a role reversal with the principal). However, the principal generates £250,000 in gross fees but the buyer feels that they will only be able to generate £150,000 in gross fees. This would hugely impact on the profitability, bearing in mind that the value has been based on a multiple of this profit.

If, for example, the projections depleted by £50,000 and a three-times income multiple was being used, they would be paying £150,000 more for the practice (with fewer profits to repay the loan) than was estimated on the financial model. This does not necessarily mean the practice is overvalued but that, based on the price, it may not suit this particular buyer's needs.

PARTNERSHIPS

Partnerships (buy-ins) are where I probably see the most mistakes with people estimating values. There are a number of different partnership types and each of these would have a different valuation figure put on them. For example, if you are buying into a true profit share, which is quite uncommon, then as the profit is being split, the value of each share of the practice would be equal.

However, on the more common expense sharing routes, the partners would have a different income levels. Should the turnover be £500,000 with one principal generating £300,000 (60 per cent) in turnover and the other £200,000 (40 per cent) in turnover, the values would need to reflect the relevant percentages – as the profits of each would be different.

FINANCE

Once the above has been considered, it is time to put the financing in place. Approaching one bank or a local bank is not the way to go. A number of banks should be approached with a full report of the practice, your personal profile and the projections based on your circumstances. This way you can ensure that you get the most competitive interest rates.

Just a 1 per cent difference in interest rates on a £500,000 loan is an extra £5,000 in cost in the first year alone.

ABOUT THE AUTHOR

Martyn Bradshaw is a director of PFM Dental, which offers a number of services including dental practice valuations, accountancy, finance negotiations, finance projections and financial advice. It has offices in Edinburgh and York. Go to pfmdental.co.uk for more information.

Achieve your personal goals

SOFTWARE OF EXCELLENCE'S IAN HAMILTON EXPLAINS HOW TO USE YOUR DATA TO TRANSFORM PRACTICE PERFORMANCE

The definition of a 'great' practice is down to the personal ambition of practice owners and what they want to achieve. SOE is not prescriptive about what any owner should strive for, but we do have data-led models for setting targets and benchmarking. These help dentists to understand what's possible and facilitate the creation of a financially sound business underpinning their life choices.

OBJECTIVES

Setting objectives and making these known to the whole team is the starting point for every successful practice. Every team member should be able to articulate what the practice's objectives are and, furthermore, understand their role in helping to achieve them.

Core business targets are generally concerned with finance, such as revenue and patient satisfaction, for example the practice's online reputation, patient referrals and in-practice reviews.

Whatever targets are set they should be ambitious, but realistic.

TRACKING DATA

Assessing business performance based on gut feel is simply not good enough when you want to maximise the potential in your practice. Using software tools now available, principals and managers can track data and understand exactly how their practice is performing.

It's important to act on what your data tells you, as immediate action can solve potential problems. For example, if one measurement for patient satisfaction is patient referrals, there must be a process by which this data is consistently captured. This process must be understood, and followed, by every team member.

PERFORMANCE MANAGEMENT

Team 'buy-in' is crucial to achieving targets, as this is how you create accountability for the success, or otherwise, of the practice. If targets are occasionally missed that isn't the end of the world; rather the reasons can be understood so continuous improvement transpires and overall targets can still be met. In similar fashion, rewards when targets are achieved will enable the team to celebrate success together.

If you want to ensure you achieve your personal goals with your practice, this is an area deserving of your attention.

ASDP
ASSOCIATION OF SCOTTISH DENTAL PROFESSIONALS

MORE INFO
For further discussion on this, feel free to contact Ian on 07814 370 797 or call SOE and ask to speak to one of our Best Practice Consultants.

Putting on a show

JAMES WILSON, A QUALIFIED DENTIST AND SPECIALIST DENTAL ACCOUNTANT, REFLECTS ON ANOTHER SUCCESSFUL SCOTTISH DENTAL SHOW

We've just returned from another highly successful Scottish Dental Show which was held at Braehead Arena, Glasgow on 19 and 20 May. I was there to represent Stark Main & Co Dental. It was an unique experience to attend the show with my 'accountant's hat' on rather than, as in previous years, when I was a practising dentist.

The show was, as always, a great opportunity to re-connect with contacts in the profession and, as our firm only acts for Scottish dental professionals, the show provides us with an annual chance to stay abreast of developments in the profession.

This year's hot topics included a great deal of enquiries from vocational trainees and new associates looking for specialist accountancy services as they become self-employed and attempt to navigate through the intricacies of HMRC compliance. They were, not surprisingly, mostly concerned about their tax affairs, and our best advice remains to engage a specialist dental accountant as soon as possible, so that your tax liabilities can be mitigated and scheduled to avoid any future cashflow problems.

Other hot topics this year included:

1. Limited company versus sole trader/partnerships for associates and practice owners
2. Making Tax Digital – we had a lot of enquiries about this impending change, and what implications it has for dentists. (Tip – if you haven't heard of it – don't sleepwalk in to the process and open discussions now.)
3. Raising finance and constructing business plans for practice acquisition.

All of the above are core specialisms of our firm and therefore we are well placed to help.

I really enjoyed connecting with my dental colleagues in my new accountancy role, and could feel that they appreciated that, as a dentist, I understood their challenges. It gives me an unique perspective of the dentist/accountant client relationship as I know what a dentist wants from their accountant having been 'on the other side of the fence' for a number of years.

If you want to enquire about any of the accounting topics in this article, or feel you need a more specialised dental accountant, please do contact us.

ABOUT THE AUTHOR
James is a key part of the Stark Main & Co Dental Team. With more than 25 years' experience as a practising dentist and principal allied with his accounting qualifications he is able to offer a unique insight to Scottish dental practitioners.

Make sure you get the best value when it's time to sell

DECIDING TO 'GO IT ALONE' AND SAVE A SPECIALIST AGENT'S FEE COULD PROVE TO BE AN EXPENSIVE FALSE ECONOMY

PAUL GRAHAM

I recently completed on the sale of Partick Dental Care, two high-quality dental practices made up of a five-surgery practice and a four-surgery practice, based two miles west of Glasgow city centre. The sale attracted 19 interested parties, from corporates to expanding multiple operators, and the practice sold off an asking price of £2.1 million for the leasehold interest.

After the sale went through, I spoke to Alan McClure, the founder and co-owner of the practice to discuss the sale. Alan and his co-owner Chris Stafford decided to sell to step back from practice ownership. The decision to use Christie & Co, Alan says, was made because: "Christie & Co's approach wasn't aggressive, they knew the market and Paul kept the deal going when different parties changed their outlook".

One of the key pieces of advice Alan shared for prospective sellers was: "Don't try to save the fee and do it yourself, you'll get a lesser price and possibly lose the sale."

I couldn't agree more with this sentiment. During the course of a year, many thousands of people sell their businesses with the great majority using a specialist business agent like Christie & Co. But some 'go it alone' and, while a proportion of those who succeed in finding a buyer and closing the sale might console themselves with the thought that they saved the agent's fee, the crucial questions arise; did they achieve the best price? Would someone else have paid them more? And might an alternative purchaser actually have been a better fit for their business?

Besides price, going it alone means that an owner will be lacking the comparative insight of knowing whether they have managed to negotiate the most preferential terms in the share purchase or asset purchase agreement.

When it comes to selling a business, particularly in respect of 'value', you simply cannot judge the worth of a dental practice by comparing it with one up the road. No two practices are alike.

Expertise and services, of course, cost money and there lies the justification for specialist agents' fees. Selling privately may be cheaper. But is it worth the risk, the time involved and the danger of not achieving full market value? We are convinced that it is not, and fortunately for Alan and Chris, neither did they.

MORE INFO

To discuss how Christie & Co might help you achieve your future plans in Scotland, contact Paul Graham, associate director at Christie & Co, on 0131 524 3416.

Principals with principles

IF PRACTICES HAVE PRINCIPALS, DO YOUR PRINCIPLES WORK IN PRACTICE?

FRANK MORTON

Most business success comes from people. Whether they are principals, associates, nurses or receptionists, identifying and retaining good people is critical to competing well in your chosen field.

Here is a recent industry report card that highlights the importance of identifying and growing the next generation of practice principals.

Dental practice owners are, on average male, 50 years of age, have owned their practice for 16 years and are likely to have fewer than three dentists.

Twenty per cent of practices are fully private, fewer than 7 per cent serving only NHS patients.

No real surprise therefore, when principals tell us that 'future-proofing' their practices, attracting good associates and exit or succession planning keeps them awake at night.

Have you identified the next generation of owners for your practice? What plans are in place to make this happen? Have you established a financial exit strategy that works for both parties? What does 'life after work' look like for you?

Putting pen to paper on this may provide nights that are more restful.

At AAB, our business is planning. We help business people to start up, scale up and ultimately sell up. We help people to understand their options around profit extraction, acquisition, and planning for succession or sale. We understand the value of efficient exit strategies for those leaving and those taking over.

AAB Wealth specialises in planning now for what happens next. We use cash-flow modelling as part of our conversations, helping people see and plan their futures with confidence.

When asked "With hindsight, what would you have done differently?", most principals will say "Start planning my exit much earlier and take more time to do things properly."

Perhaps it's time for a check-up?

ABOUT THE AUTHOR
Frank Morton is director of wealth services at Anderson Anderson & Brown Wealth Ltd, Chartered Financial Planners

Blue sky thinking

COULD THE CLOUD BE THE PERFECT CHOICE FOR YOUR DENTAL PRACTICE?

ANNA COFF, EQ ACCOUNTANTS

You may be aware that the Government has postponed any decision on Making Tax Digital (MTD) until after the General Election on 8 June. Although most expect it to continue, there is deliberation over when MTD will come into force and which businesses report first (based on turnover).

As it is expected to eventually impact all businesses, now is as good a time as ever to make the move to a computer-based package, but MTD isn't the only reason to make the move. Cloud accounting provides up-to-date, precise information with multi-user access for ease of use so you can spend more time focusing on running your business.

Cloud accounting packages, unlike traditional computer-based packages, store their information on a secure website, allowing data to be accessed and processed from anywhere and at any time. They are flexible packages that can be tailored for your dental practice in terms of setting up departments and code lists for NHS income and non-NHS income.

They also offer a host of other attractive features and functions including:

- Automatic bank feeds: which means your records will reflect your current bank balance without the need to download or input a list of transactions from your bank
- Cashflow control: the system will track invoice expected pay dates and can show when monies are due in or are payable
- Invoicing: they can generate sales invoices which can subsequently be printed or emailed to patients
- Debtors and creditors: invoices are logged on the system to ensure that the running total of amounts receivable or payable are tracked.

Users do not have to worry about keeping their version up to date as any new functions or updates are automatically applied to the system, so all users are on the same version.

The cost for these systems are based on a monthly subscription, with no large up-front cost and no minimum subscription period, so users are not tied to the package if it doesn't suit their needs.

MORE INFO

If you wish to find out more about Cloud based accounting packages, please contact Anna Coff on 01307 474274 or e-mail anna.coff @eqaccountants.co.uk

CREATING A WELCOMING ENVIRONMENT

NEW ORTHODONTIC PRACTICE AIMS TO FILL THE GAP IN PROVISION IN GLASGOW'S EAST END

Entering East End Orthodontics' new practice on the busy Shettleston Road in the east end of Glasgow is like entering an oasis of calm. The double doors open into a wide entrance, which leads into a spacious waiting area where dental nurse Cherie Fitzsimmons welcomes patients at the reception desk. The double-glazing on the glass-fronted practice hushes the noise from the busy street, and the teal and grey colour scheme, air conditioning and overhead lighting feature provide a calm and comfortable environment for patients and staff.

This is the welcoming, light and friendly atmosphere that orthodontists Colin Lennox and Janet MacKinnon wanted to create for clients at their newly opened orthodontic referral practice.

Colin and Janet, who have worked together for over 10 years as associates in specialist orthodontic practice, decided to go into partnership together to start up their new practice in Shettleston after Janet's husband complained about the lack of orthodontic facilities in the east end.

Janet explained: "My husband has a dental practice in Ruchazie in the east of the city and he was aware of the struggle that people from this area have to access orthodontic treatment locally.

"We could see that there was a real need for an orthodontic service in this area and that the demand would likely grow as there is a great deal of new housing being developed in the east of the city and beyond."

After the first site they looked at in the east end fell through, their second option was a former housing association office in a row of buildings on Shettleston Road, which at first sight looked a bit too large for their needs.

However, they both decided that the extra space would provide room for expansion so they followed the courage of their convictions and decided to take a lease on the property and plan for a four-surgery practice.

Janet said: "We felt the extra space would help future-proof our business and allow us to expand as our referral business developed. At the moment we have two fully equipped dental surgeries, but have

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two other rooms to become surgeries when required."

Janet said the site is perfect for them as it is on a major thoroughfare with regular bus routes and only a 10 minute walk from Shettleston station, plus there is plenty of off-road parking.

They applied for planning permission in August 2016 and by the end of year they were ready to move the builders in.

Janet said: "The building was a complete shell so we had a blank slate to work with, but we went through many designs to make sure we got it right. It was great working with SAS Dental Solutions, as they understand the needs of modern dental surgeries, and were flexible enough to accommodate our changes as the design developed.

"You usually take the layout of the practice you work in for granted but when it is your own you have to be sure every aspect of the design is right.

"The planning was critical, and we spent a lot of time walking up and down the proposed layout in the empty building to imagine how we were going to work and move about in our surgery and the rest of the building.

"For example, we installed a window in one of the internal walls so that a nurse working with a patient in our dental hygiene area could also monitor the reception if it was unmanned.

"It's all these little things that are important."

Building work started this year and

East End Orthodontics opened its doors to the public in May.

Janet said it was a relief to get the practice finally opened, but this was short-lived by a flooding in the back of the building in the first week because of blocked drains.

She said: "It's certainly not what you want to happen when you've just opened, but we got it fixed quickly so it was only a minor setback in the end."

They are both delighted with the final design of the practice and their two air-conditioned fully equipped surgeries, which feature Belmont Voyager III chairs.

Colin said: "We've used them in our other surgeries and we like their simplicity. We need chairs that are comfortable for our patients and these are perfect for us."

Next to the surgerys is the roomy OPG room, which houses the X-ray equipment, which is networked to the practice management system.

Colin added: "The practice management system was a big expense in both installation and training, but it's indispensible as it helps us run the whole business, from the day-to-day appointments and updating patient

records to collating information on patients for the referring dentist."

Joining Colin and Janet at the new practice is manager Michelle Connelly, and dental nurses Cherie Fitzsimmons and Jemma Blaikie, who have all undertaken training in the practice management system.

The practice offers a wide range of orthodontic appliances including clear aligners (Invisalign), invisible/lingual braces (Incognito), ceramic braces and standard stainless steel braces.

The pair have also invested in kitting out a large LDU room, which houses a washer-disinfector and autoclave supplied by Eschmann as well as plastic-clad walls and corian worktops to ensure the highest quality of hygiene.

Janet said: "We were keen to ensure that this room and its facilities were completed to the highest spec we could, and that we had room to accommodate more equipment once the other surgeries come on stream."

Beyond the LDU are the staff facilities, which include toilet and shower room – for those adventurous to cycle into work – and a cosy staff kitchen. Beyond the kitchen is the compressor room, which also features a Dencomp

Systems compressor to power the chairs and dental equipment.

Colin and Janet both work two days a week at East End Orthodontics, which is closed on Wednesdays, while also working as part-time associates at their current practice as the new referral business builds up.

Now that the surgery has been open a few weeks, Colin and Janet are enjoying the experience of running their own practice.

Janet said: "Our staff have been absolutely brilliant at helping us to make this a success and to create such a nice welcoming environment.

"We will be hosting a welcome event at our practice on 22 June to introduce our services and to show off the facilities at our new premises. All are welcome."

TACKLING DENTAL PHOBIA

BASED IN BROOMHILL IN GLASGOW'S WEST END, BUTTERCUP 7 DAY DENTAL WORK HARD TO CATER FOR NERVOUS AND ANXIOUS PATIENTS

Almost half of UK adults have a fear of the dentist. That's an awful lot of people that are either slightly worried, extremely uncomfortable, scared, or terrified to come and see you.

It's our responsibility as dentists to make sure that our patients' teeth are in top condition, to offer professional advice on good oral hygiene, to help our patients when they need us, and to provide a service that exceeds expectations! At Buttercup 7 Day Dental, there's more than that.

Gerwyn Rowlands, one of our founding dentists, was (and still is) a nervous patient. Gerwyn is our guy on the inside, and we've worked hard to identify the things with which a nervous patient struggles. Because we know first hand what it's like having a fear of the dentist, we're doing everything we can to make sure our clinic is helping our patients to overcome theirs.

Here are a few of the things that we're doing to change our practice for the better, we hope you can take a few golden nuggets away with you and improve your practice.

MAKE YOUR DENTAL PRACTICE, THE PERFECT DENTAL PRACTICE

When we established Buttercup Dental, we sat down and wrote a list of things that we would want from our perfect dentist.

That list became the foundation of our business plan. Because we built our clinic from the perspective of a patient, our clinic is a nice place to be, and it's 100 per cent focused on making the whole journey as easy and convenient for the patient as possible.

We wanted easy access with free parking, flexible opening hours, a quality service, no pain, a modern waiting room, different price options and a place where you genuinely feel welcome. Our "wish list" became our "must haves" for when we started Buttercup, the dental practice that has all the things we'd want from our perfect dentist.

CREATE A RELAXED ENVIRONMENT

We've found that the space of the clinic is incredibly important to the overall patient experience. Dental clinics are often… well, clinical. They're sterile, white, have clean lines and often come with a very specific smell.

We've tried to take the clinical out of our clinic. By making our waiting room a comfortable space, much like a cafe, we've created a relaxed atmosphere where our patients are able to relax before their appointment.

A clean and sterile clinic is of course a must, but try your best to make the waiting room as relaxed as possible. Old magazines and uncomfortable chairs don't exactly send the message that you care an awful lot about your patients.

SLOW DOWN

From our relaxed environment to the way we move, to the way we talk, we've slowed things down at Buttercup!

In a lot of practices, patients want to get in and out as quickly as possible because they don't see any of it as a pleasant experience. Going to the dentist is just another "job to be done", and frankly not the most fun! At Buttercup we've changed that and we've slowed everything down; this has taken the stress out of everything.

BUILD TRUST, AND LONG-TERM RELATIONSHIPS

We believe that a big portion of the fear comes from encountering unknown places and people, so we've set aside time to get to know our patients. Building trust is one of the most important things we do in our clinic.

We know our patients, and they know us. That's one of the things that makes Buttercup special.

If you want your patients to come back again and again, act like it. Work on building local and long-term relationships. People care whether you remember their name or not, and they appreciate when you ask how the dog that broke its leg last summer is doing.

BE OPEN ABOUT DENTAL PHOBIA

Sometimes part of the reason why people fail to attend visits to the dentist is because they're embarrassed by their fear.

The idea that only a kid is afraid to go to the dentist is utter nonsense, and it's important to let your patients know that you take them seriously.

Your patients are your most important assets, and you should be treating them that way. If anyone is nervous, book them in for a little longer, talk to them, make sure their questions are answered and that you're coming across as approachable and friendly. For some people, being caring and respectful comes naturally. For others it takes a bit of work. But it's so important. Train your staff, so that everyone knows the value of being kind.

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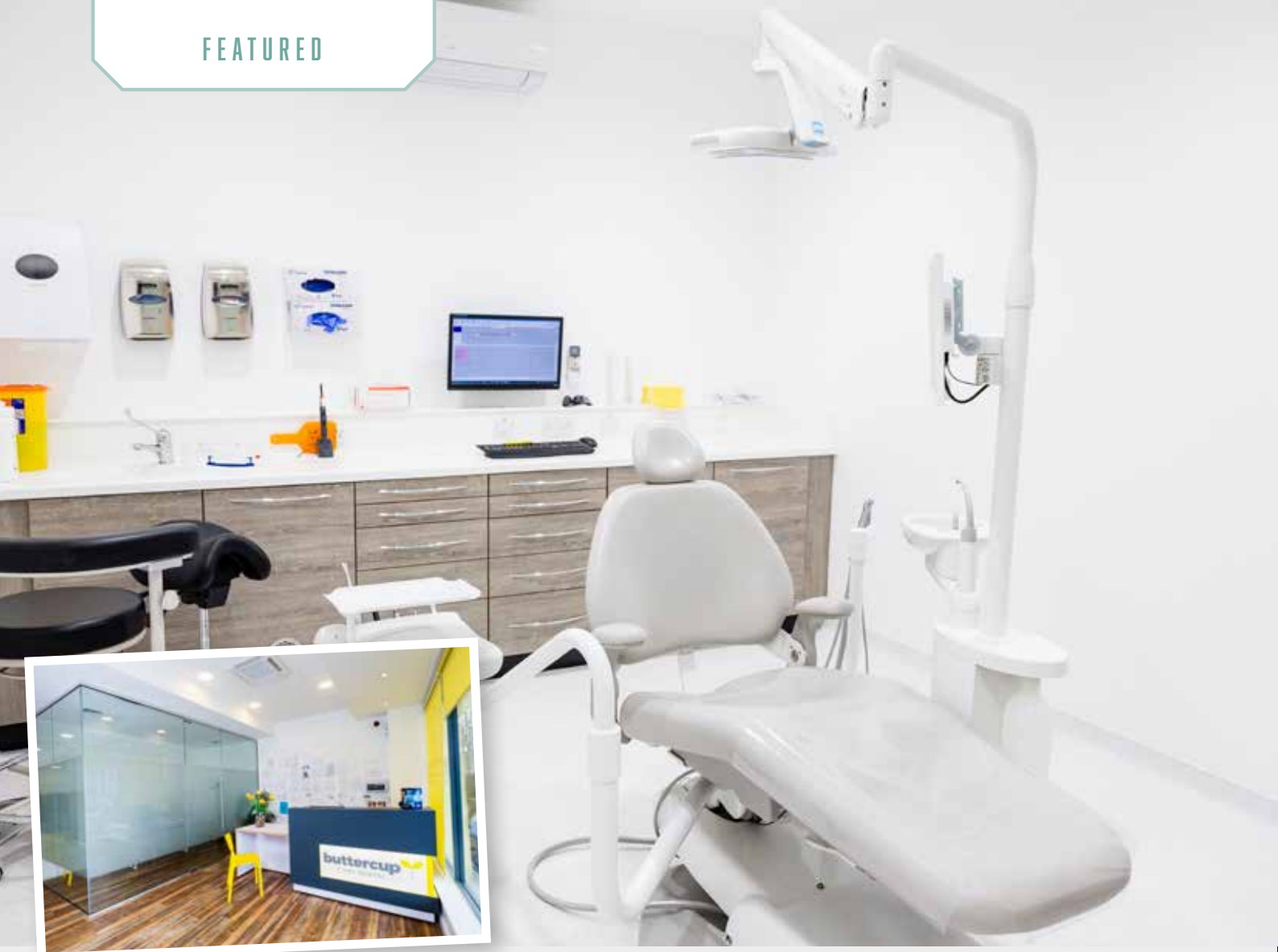

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USE A STOP SIGNAL

We all know that talking when someone else has their hands in your mouth is tricky business. Make sure you've got a signal for "stop" when the patient is in your care, and make sure they know what the sign is. For example, right arm up means stop!

Giving the patient full control of when you start and stop is incredibly powerful, and it'll hopefully make it easier for them to undergo treatment. By empowering them, you'll almost certainly make them feel more relaxed which will mean that they are unlikely to require you to pause during treatment very often, if at all. Going to the dentist is not supposed to hurt, and we all do everything in our power to make the patient experience as smooth and painless as possible. But sometimes, it does hurt, and sometimes having your mouth wide open for a long time can be uncomfortable. And then it's time to take a little break and reassess what you're doing, and how you can make it more comfortable.

POSITIVE REINFORCEMENT

No matter how old people are, they never get tired of being praised. If your patient is doing a great job brushing his/her teeth – tell them!

We're not saying give your patients a lollipop after every successful visit, that would be contradictory. But a little encouragement never hurt anyone.

OVER AND OUT

Those are some of our main priorities at Buttercup Dental. We're always looking for ways to make our practice better, and to improve our patients' journey. We're keen to hear from you if you've found your own way to calm down nervous patients and make their trip to the dentist easier.

All the very best of luck from Gerwyn and Angela Rowlands, and the rest of the Buttercup 7 Day Dental team.

MORE INFORMATION

Dental Sky is a keen supporter of Buttercup 7 Day Dental and one of the fastest growing dental supply companies in the UK. Based in Ashford in Kent, the company supplies the dental profession with 'practically every dental product you need to run a successful practice

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EDINBURGH DENTIST EXPLAINS HOW HE HAS MODERNISED A SUCCESSFUL AND POPULAR DENTAL PRACTICE SINCE TAKING OVER SIX YEARS AGO

Taking over a well-established dental practice that has been operating in the local community for more than 30 years is a daunting task. Add to that the need to renovate and completely transform the look and layout of the building to accommodate an LDU, then Duddingston Dental Practice principal Stuart Banks has had his work cut out for him.

Originally from the west coast of Scotland, Stuart qualified from Leeds University Dental School in 2004 and completed his vocational training year in Pontefract, West Yorkshire. He continued to work in Yorkshire until 2009 when he made the decision, with his then fiancée Lisa, to move to Edinburgh just before they got married.

Stuart explained that he had always wanted to be a practice owner, but he knew it might take time to find the right practice and in the right location. Fortunately, the position of associate at Duddingston came up with a view to buying the practice. After meeting the current principal Johnny Muir, it turned out that they had previously met many years ago on a family holiday so a connection was immediately made.

Stuart worked alongside Johnny for 18 months and took over the business when he retired in April 2011. He said: "The practice had been in its current location for 30 years, was well established as an NHS practice and had a very strong reputation both in the local community and further afield. A lot of our patients travel from the Borders and East Lothian for their dental care.

"There were pros and cons to being an associate first but, overall, I felt it was the right way to do it as I could build rapport with patients and the team and see how the business ran before becoming the principal."

In the six years since taking over, Stuart admits that the practice itself has changed significantly, but the team has also expanded as well. Staff numbers have doubled and

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they are due to take on their first VDP in August. He said: "The business always had a strong focus on family dental care and we have continued to build on this. We have put prevention at the forefront and are pleased to be able to offer our patients sessions with our Childsmile nurse and our hygienist-therapist. We have a visiting implantologist which has been a fantastic addition to the practice.

"While the approach of relaxed, family-friendly dental care hasn't changed, we have made sure that our systems, protocols and procedures now meet the high standards expected in modern dentistry."

Stuart explained that, when they took over the practice it was beginning to look a little dated and some of the equipment was needing frequent maintenance. Over the years, the building had been converted in stages from a flat and two small shops, to the combined building that Stuart and Lisa bought over. This had worked perfectly well for many years but, with the changes to compliance and regulations, such as the need for an LDU, the building became less and less fit for purpose.

Stuart said: "We always wanted to expand to three surgeries from the existing two and improve our facilities. It was a case of working out the best way to do that without actually moving premises."

A large reception and waiting area welcomes patients

The planning process began in 2013, not long after the couple had their first child, with the architect Kenneth Reid keen to explore the possibility of using the piece of land next to the practice that was, at the time, being used for bin storage and general dumping by the neighbouring flats.

However, the process was not quick, as Stuart explained: "The acquisition of the land and subsequent planning process took a lot longer than we could have imagined. We were very fortunate to

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When it comes to viruses, I like to show mercy. I kill them quickly.

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have some great advice, not least on the financial side by Condies.

"However, the number of things to think about when redesigning and expanding a dental practice was huge. There's not only your own use of the space, interior design and planning but of course the health board and council and many other rules and regulations to take into account.

"During the planning process, we had our second child and moved house which took our focus off the build project somewhat!"

The builders, Gordon Guthrie Contracts, were finally able to get started on 1 August 2016 and Stuart explained that it was almost as if the building knew it was getting an overhaul, as handles were starting to fall off cupboards, equipment was breaking down regularly and the place was looking more and more tired.

However, Stuart explained that the builders managed to keep the practice open and running for the whole time, only losing a few sessions. He said: "They felt like part of the team, they were great."

When Stuart and Lisa took over, the practice had two surgeries and a small LDU, a joint waiting/reception area, small staff kitchen/office area, patient and staff toilets and a back room used for storage and casting models. Now the renovation is complete, they have a light and spacious, practical building offering three surgeries, fully compliant LDU kitted out by Eschmann, disabled access toilet with baby change facilities, a large waiting and reception area and much better staff facilities. The main entrance to the building, which previously was accessed from a side street, was awkward for disabled, the elderly or parents with children. Now, the practice has a ramp and automatic door situated on the main street, which is much more user friendly.

Stuart explained that, now the building work is finished, he hopes to continue to run a happy and successful practice. He said: "We have a team that works very well together but are also very good at welcoming new members and bringing them on board with our ideas and systems. They are a team to be proud of and our patients enjoy the continuity of care that a great team offers.

"Professionally, we hope to provide our VDP with a similar experience to the one that I had. We hope that, by the end of the training year, we have a dentist who is ready to be an associate and has learnt that dentistry is not just about being good clinically but about building relationships with patients and your team.

"Personally, we are ready for some good quality family time after living and breathing the building project for so many months!"

The Belmont tb Compass chair with suction motors supplied by Durr Dental

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DENTAL TECHNICIAN AND LABORATORY OWNER GRAEME LITHGOW EXPLAINS WHAT NEARLY 30 YEARS OF EXPERIENCE IN THE DENTAL INDUSTRY COULD PROVIDE FOR YOUR PRACTICE

No matter how limited you think your knowledge of digital dentistry is, Ivoclar Digital will provide comprehensive training and support that will give your laboratory team the training, understanding and confidence to manufacture a consistent workflow with excellent aesthetics and predictable outcomes for all of your digital work.

Dental Logic has been in business since 1988. Established alongside Kirkliston Dental Surgery, we provide a comprehensive in-house service to our four surgeries and private crown and bridge work to local dental practices.

Until recently there had been little change in how we manufactured our appliances. Three years ago I started to seriously consider what CAD/CAM and CNC milling could add to our business. This took me on a journey across Europe to look at different scanners and milling systems on the market.

ONE-TO-ONE SUPPORT

We took the decision to purchase the D800 scanner, 3Shape software and Zenotec Select Hybrid milling machine. One of the key reasons for using Ivoclar Digital is the tailor-made customer support and training provided as an integral part of the package, which, to date, is still on-going. This has been invaluable to us as we had no experience of the digital world.

Today's technicians need to fully understand their systems and processes in order to get the results they want and to meet the expectations of their clients. Dental Logic has benefited from the initial five days of intensive, in-house, one-to-one training followed by 12 months of bite-size coaching. This level of support and training has enabled us to be fully confident on how the system works and technical issues or queries can be easily resolved, remotely or over the phone.

THE DIGITAL FUTURE

I have introduced the digital process to my lab in a very measured way so that we had time to understand how the CAD/CAM and CNC milling systems work and had the benefit of working with our own in-house dentists.

Some labs will buy a scanner to start with and then send their work to a milling centre. At Dental Logic, it has always been important for us to have full control of each of the processes in the manufacturing of all our appliances. Therefore, we do not send any of our lab work to third parties.

The educational and training resources from manufacturers such as Ivoclar Digital are second to none and designed to assist technicians, no matter what stage of their career, to take on new digital challenges.

Milling machines such as the Zenotec Select Hybrid save time and money, and allow the technicians to concentrate on delivering highly aesthetics results. The set parameters produce results that are incredibly accurate in terms of both fit and predictability.

Having been an established dental laboratory for 29 years, we are now a fully digital one-stop shop for our patients and local dentists, providing a very personal and unique service offering. The service and support we have received from Ivoclar Digital has been hugely important to us and we couldn't have done it without them.

MORE INFORMATION

For more information on the Ivoclar Digital product portfolio and technical support, please contact a digital specialist or visit www.ivoclardigital.com

Alternatively, visit www.dentallogic.co.uk

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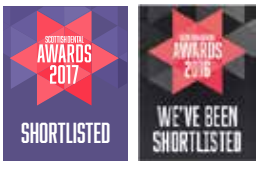

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Dr Shubham Mittal, a senior partner of Clifton Moor Dental Centre, uses the ONE COAT 7 UNIVERSAL one-component bonding agent from COLTENE. He said: "It is a very good all-in-one bonding system. Whether I need to use the Self-Etch technique, Total-Etch or Selective-Etch, I can rely on ONE COAT 7 UNIVERSAL to provide effective bonding to a number of materials, including gold, titanium, ceramic, zirconium oxide and composite. For me, having that level of freedom and flexibility has been invaluable to my restorative work.

"With the same product, I could also get a good bond on a non-vital tooth using Total-Etch – there really is no limit to how ONE COAT 7 UNIVERSAL can be used.

"As such, I would definitely recommend to other practitioners, especially those that are already using other COLTENE products."

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ZIMMER BIOMET DENTAL ANNOUNCES NEW PARTNERSHIP

Zimmer Biomet, a global leader in musculoskeletal healthcare, is pleased to announce the distribution of NovaBone Dental Putty in more than 40 countries within the Middle East, Africa (except South Africa), Latin America, Asia Pacific and select markets in Europe (except Italy and France). NovaBone is a fully synthetic bone-graft engineered for enhanced handling and improved performance. In addition to being osteoconductive, the calcium phosphosilicate particles within the product's formulation promote osteostimulation. NovaBone Dental Putty has over 20 years of well-documented clinical efficacy. It offers unique consistency, with no mixing or thawing required prior to placement.

To learn more about Zimmer Biomet dental solutions, visit www.zimmerbiometdental.com

COMING FACE TO FACE WITH DENTISTS

Progressive dentists who want to offer patients facial rejuvenation to complement their dental restorations will appreciate the treatments offered by Sinclair Pharma, an international aesthetic dermatology company with a portfolio of next-generation collagen stimulators.

Sinclair Pharma recently appointed two dentists to join its roster of trainers and both lectured on behalf of the company at the Dentistry Show.

Dr Ian Hallam's lecture focused on non-surgical jawline and midface lifting with Silhouette Soft sutures. Dr Tim Eldridge's presentation looked at full-face rejuvenation with Perfectha dermal fillers.

Please visit www.sinclairpharma.co.uk or email NSR@sinclairpharma.com for more information about new Sinclair Pharma training courses.

SMART MOVE

Philips Sonicare reveals a flagship innovation – the DiamondClean Smart – dubbed the world's most intelligent toothbrush. The brush uses unique connected technology to inspire and motivate patients to take better care of their oral health.

It delivers exceptional oral care results by harnessing built-in smart sensor technology in both the toothbrush and brush heads and personalised coaching within the platform to help improve patient's brushing technique.

The new brush seamlessly syncs with the Philips Sonicare app, giving users real-time data, feedback and guidance to empower them to proactively manage and improve their oral health.

For further information on the latest Philips innovations, please call 0800 0567 222 or visit www.philips-tsp.co.uk

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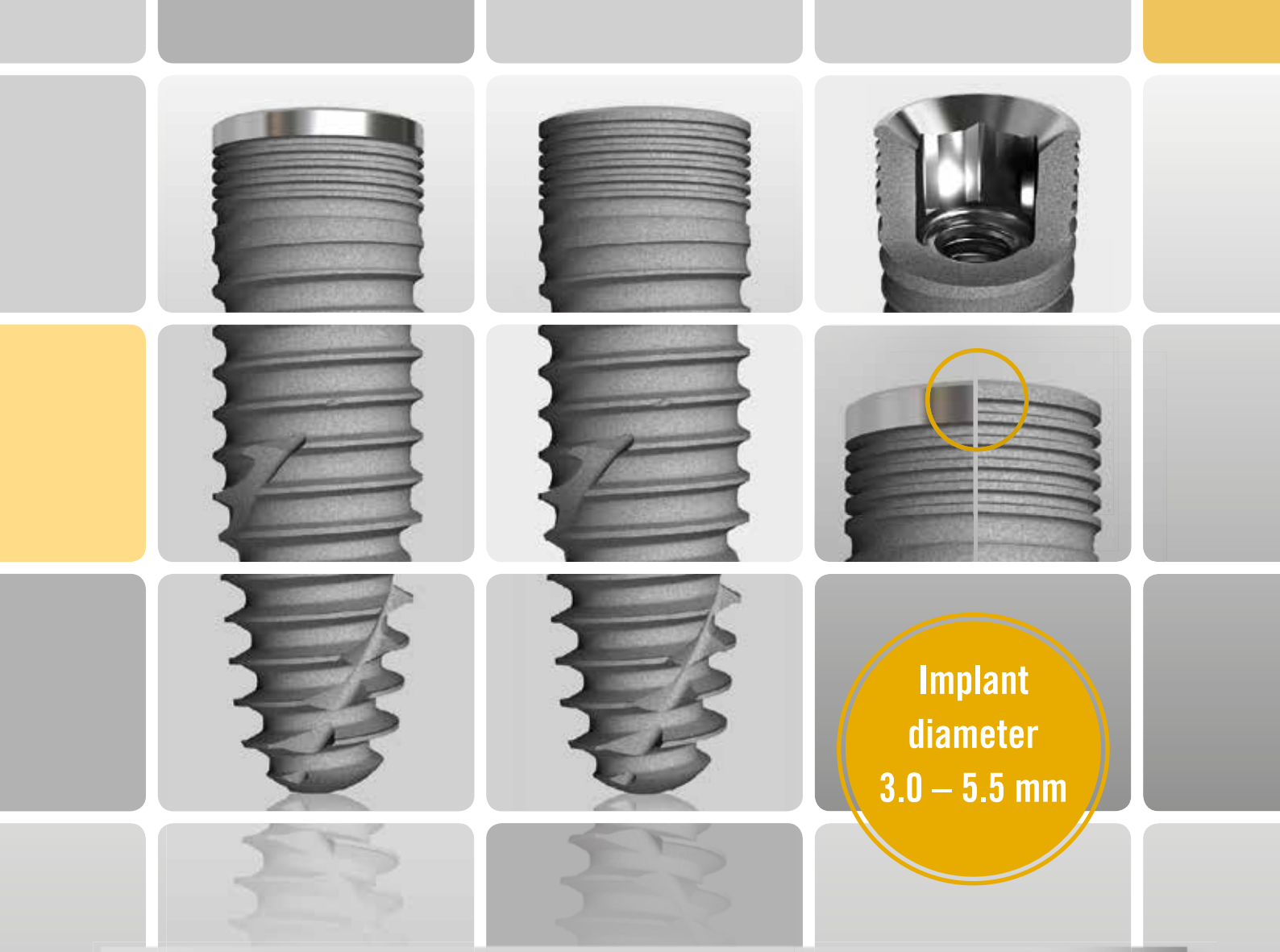
In 2017, Planmeca has been showcasing the next generation of dental solutions at shows and events around the globe. The latest range of digital innovation includes pioneering products in almost all of our categories.

Introducing unique patient positioning, free FOV adjustments and intelligent patient movement correction, the new Planmeca Viso X-ray unit is the next step forward in the evolution of cone beam imaging. In addition to evolving its CBCT imaging range, Planmeca is expanding its CAD/CAM product range with a new light intraoral scanner, the 183 gram Planmeca Emerald. Planmeca's new entry-level milling unit, Planmeca PlanMill 30 S, has been developed for efficient, accurate, and cost-effective milling.

To explore these and other products, call 0800 5200 330, email marketing@planmeca.com or visit www.plandemo.co.uk



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REALITY REVEALED

Most people think they're brushing their teeth for the recommended two minutes, twice a day, but now, thanks to the Oral-B App 4.1 we can see for how long those using Oral-B's Genius electric toothbrush, are actually brushing.

More than 1.5 million people have downloaded the app globally since the Genius brush was launched last year, showing that the average time dedicated to brushing is a whopping 2.22mins.

Designing an app to sync the camera function of a mobile with the unique technology in

the Genius toothbrush was not without its challenges. Initial concerns were that some people might be reluctant to take their phone into the bathroom; however, research had indicated that 74% of people do, and 24% of people would even answer a call while in the bathroom!

FLEXIBILITY WITH ONE BASE, ONE TIME

For tissue-level implant restoration with maximal soft tissue preservation, discover the innovative On1 concept from Nobel Biocare.

An exciting new product that has already received fantastic feedback from the profession, the On1 system provides workflow flexibility while encouraging quality and longevity of implant treatment.

The unique On1 Base raises the restorative platform of the conical connection from bone level to tissue level. With two heights available to suit different soft tissue thicknesses, both

short- and long-term aesthetics are optimised. Once placed, the On1 Base needn't be moved again.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com

IT'S CALLED BRILLIANT CRIOS FOR A REASON!

For the fabrication of quality indirect single tooth restorations, the BRILLIANT Crios from COLTENE is an ideal choice for anterior and posterior teeth alike.

To ensure first-class results, the BRILLIANT Crios material combines all the advantages of COLTENE's innovative submicron hybrid composite material technology with those of a CAD/CAM fabrication process. The result is a reinforced composite bloc that guarantees high flexural strength for maximum resistance as well as low abrasion. With the addition of a tooth-like modulus of elasticity to offer a shock-absorbing effect,

BRILLIANT Crios is recommended for use in bruxism patients or implant-supported crowns.

To discover for yourself how BRILLIANT Crios lives up to its name, call 01444 235 486, email info.uk@coltene.com or visit www.coltene.com

ENDURING BEAUTY WITH BRILLIANT EVERGLOW

To provide first-class restorations to your patients, you need products that guarantee effortless and enduring results. You need BRILLIANT EverGlow next generation universal composite from COLTENE.

Using an innovative mix of submicron barium glass fillers and pre-polymerised fillers identical in content to the resin matrix, the sophisticated and pliable universal composite can be easily applied to all cavity classes in both anterior and posterior teeth.

BRILLIANT EverGlow also offers increased bonding strength for higher scratch resistance against

intense chewing and abrasion stress, as well as longer gloss retention.

To discover the brilliance of COLTENE's restorative technology, call 01444 235 486, email info.uk@coltene.com or visit www.coltene.com

THE FUTURE IN THE PRESENT

All of us wish we could take a peek into the dental future. This wish can come true at Dental Showcase 2017, at the NEC in Birmingham (19-21 October).

For the first time, Dental Showcase will include a dental surgery of the future on the show floor. The purpose-built practice will include a reception area, patient information zone and a fully functioning surgery.

Presentations will include keynotes on the future of dentistry, live demonstrations on how to handle medical emergencies, ergonomics, innovations in x-rays, 3D printing,

how to make the right purchasing decisions, IRMER and much more. The focus will be on providing practical, effectiveness-boosting advice.

To register your place at Dental Showcase, log onto www.dentalshowcase.com/register

IVOCLAR DIGITAL LAUNCHES AT IDS

The 37th International Dental Show (IDS) was the ideal occasion for Ivoclar Vivadent to announce the launch of their new Ivoclar Digital brand. The leading manufacturer impressed an eagerly awaiting audience at the "Rheinterrassen Köln", the day before IDS officially opened.

Robert Ganley, CEO of Ivoclar Vivadent AG, opened the event and captivated the audience by announcing plans to enhance its customer-focused market strength significantly with Ivoclar Digital, a new digital portfolio providing dentists and technicians with state-of-the-art professional

expertise throughout the entire digital process journey.

For more information on the Ivoclar Digital product portfolio and technical support, please contact a Digital Specialist or visit www.ivoclarvivadent.co.uk/laboratory-professionals

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- Complex and Non Complex treatments provided
- New patient consultations within two weeks

Dr Stuart Lutton

BDS MJDF MSc Implant Dentistry

Dental Implant Surgeon

Stuart holds a Masters degree in Implantology and is a co-founder of New Life Teeth with Robert Leggett.

Stuart qualified from Sheffield University in 2000 and has been practising in Edinburgh ever since. His particular focus is on dental implants, specifically the ground-breaking full arch dental implant procedure. His Masters degree was completed under the personal tutelage of Professor Edward Lynch, head of dentistry at the University of Warwick.

Already responsible for over a thousand dental implants, Stuart is a member of the UK ADI Association of Dental Implantology. He now practises alongside Rob Leggett at New Life Teeth, providing full arch dental implants for patients referred from practices across the country.

Robert Leggett

RDT Dip CDT RCS Ed

Clinical Dental Technician

Rob is co-founder of New Life Teeth with Dr Stuart Lutton. His focus is on the creation of dentures and dental implant solutions, including full arch dental implants, which he constructs from zirconia using ground-breaking technology from Zirkonzahn.

After qualifying as a dental technician from Edinburgh's Telford College, Rob worked in both the private and public sector, spending 10 years in the NHS including Glasgow Dental Hospital and Edinburgh's Dental Institute.

In 2009 Rob qualified as a Clinical Dental Technician from the first CDT course to be run in the UK. In January 2013 Rob began Scottish Denture Clinic in Edinburgh, and now practises alongside Dr Stuart Lutton at New Life Teeth, where they work with both NLT and referral patients.

Dr Arvind Sharma

BDS (Dund), MSc Endodontolgy, MJDF RCS (Eng), MFDS RCPS (Glas)

Dental Surgeon (Limited to Endodontics)

Arvind qualified in 1996 from the University of Dundee. Arvind has completed a Master's degree in Endodontology at the University of Central Lancashire, passing with Merit and has gained membership through examination of the Royal College of Surgeons of England in 2012 and Glasgow in 2016. Having worked many years in general practice he has now limited his work to Endodontics providing his services in Edinburgh, Aberdeen and Glasgow. Using contemporary equipment, (including a microscope), materials and techniques.

Arvind accepts referrals for all aspects of non-surgical endodontic treatments from first primary treatments to re-treatments and includes management of cases with complex anatomy, sclerosis, open apices, perforation repair and removal/retrieval of fractured posts and separated instruments.

Stuart Campbell

BDS (Dund), MClinDent (Pros), MSc (Implant Dent), MFDS,RCS , PGCert (Oral Surgery)

Prosthodontist, Dental Surgeon

Stuart qualified as a dentist from the University of Dundee in 2001. Following his undergraduate study he was awarded Membership to the Royal College of Surgeons Edinburgh (MFDS) in 2005. In 2013 he completed a three year part time Masters degree in Dental Implantology with distinction from the University of Central Lancashire. During these three years he also completed a Postgraduate certificate in Oral Surgery with Merit.

In 2014, following 10 working in general dental practice, Stuart began full-time specialty training in Prosthodontics at the Edinburgh Dental Institute. In 2016, he completed his Master of Clinical Dentistry (MClinDent) in Prosthodontics with distinction, being awarded the University of Edinburgh medal for clinical and academic excellence.

His main clinical interests in practice are surgical and restorative implant therapy, management of the failing restored dentition and management of toothwear.

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*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany, FEB 2016