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Not long ago I was asked whether, if I could go back, I would do anything differently in my career and whether, knowing what I know now, I would perhaps even have followed a different career path entirely. Did I ever want to give up, run away, and start a whole new professional life?

I think everyone has moments of questioning the choices they’ve made, whether professionally or personally. I believe humans are hard-wired to wonder ‘what if?’. To a degree it’s what drives us forward as a species and allows us to achieve, collectively and individually. What struck me about this particular person though was the despair behind the question. They weren’t really asking me, they were asking themselves – a troubling rhetorical question camouflaged within an innocent conversation.

What made it even worse for this person was that their career was vocational. They have gone through years of education and training, professional exams and development. They have built a career from childhood and, here they were, questioning everything, questioning pretty much their entire life.

This person is not a dentist, but they were expressing thoughts and doubts that are becoming increasingly common in the dental world. More and more I hear people questioning their vocation or beginning to feel buried by the career they have worked so hard for.

The reasons for this are, of course, complex and multifactorial. They will vary from individual to individual, but it seems fair to say that the dental world has never been under such pressure, a perfect storm of social, political, ethical, legal and financial issues meaning that, for some, it can all simply become too much.

But what can we do? Well, the first step is perhaps to learn to recognise the warning signs of someone in crisis – whether this is in our colleagues, or in ourselves. It is also important to know what support is available.

Dental professionals can often work in isolation, and it is hard to know who to turn to in times of difficulty. At Ireland’s Dental magazine we can’t solve the problem, but we believe we can do something to help. Starting in this issue, and then in successive magazines, we will be investigating the theme of mental health and wellbeing, speaking to experts from many different professions and walks of life, and exploring the support available for the dental professional in crisis.

In my previous editorial I wrote that however bleak things may appear, dentistry remains full of wonderful people who are dedicated to advancing the profession, providing incredible patient care and finding ways to triumph over adversity.

I believe with all my heart that this is true, and the vast majority of people working in the profession will, thankfully, never experience the extremes of doubt and negativity that some have to face.

However, with more and more young people entering dentistry already expressing worries about the pressures they might face and questioning their ability to deal with them, surely it is incumbent on all to work together to support our friends and colleagues. And, as issues with mental health and wellbeing are not limited to dentistry, looking outside to see what dentistry can learn from other professions, and what it can teach them.

After all, I have to ask myself what would I have answered to my friend’s question, if it hadn’t been rhetorical? What would you?

Sarah Allen is editor of Ireland’s Dental magazine. To contact Sarah, email sarah@connectcommunications.co.uk
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Communication with your patients should begin the moment they set foot in your surgery, and that interaction has never been so important.

At recent conferences, I was struck by one common theme that appears to arise routinely – that of communication. It’s a broad theme, I’ll grant you, but I believe it is important in today’s modern dental practice to understand the necessity of improved communication skills at all levels of interaction with our patients.

**Front desk**
Traditionally, dentists have often linked the level of patient satisfaction directly with the quality of the dentistry that they provide and the patient receives. Increasingly, it is becoming evident that while the physical provision of dentistry and clinical outcomes are indeed central to content patients, it’s those first steps to arriving on the dental chair that are almost equally important.

Communication from the front desk is usually the first exposure the patient has with your practice. So, can you ask yourself: What impression would I have if I telephoned or called into my practice?

The front desk team has a crucial role in highlighting the strengths of your particular practice. Some customer training can often help.

Now, I realise that there is still some resistance to adopting the practices of the commercial sector, into the dental setting.

However, if you think about it from a healthcare stance, most patients will routinely only be exposed to general medical and general dental practice throughout their lives. So why not fly the flag for healthcare and keep the standards they enjoy with other services?

Some questions that might help here include: how well versed is your front-desk team in the Medical Card and PRSI services? Does your practice offer some specialist treatments? Have you recently extended your opening times or offer Saturday morning appointments? Critically – can your front desk team communicate this?

**Surgery**
A (since retired) colleague of mine often suggests that we spent five years learning the correct name for prosthetics, crown and bridge and oral surgery – to then spend the following 30 years translating them into: “plates”, “caps” and extractions.

The area of communication between dentist/hygienist and patient is becoming increasingly challenging. The old-style patriarchal standard of telling the patient what’s best is now being replaced by “co-discovery” and, most importantly, informed consent-making.

We are consistently reminded by our indemnity organisations in relation to accurate note-taking and, indeed, informed consent. Some questions for clinicians here that might help are: How informed is the patient of the choices we have offered? Is the patient aware of the choice they have accepted? The cost involved? The percentage chance of success? As always, the published literature is showing increasing examples that can help – and again customer training might be a solution here.

**Nursing**
Our dental nurses occupy a unique position in the dental team. They are often seen by the patient as the go-between – someone who speaks “dentistry” fluently and yet retains the ability to inform the patient in simple terms. This has been the hallmark of many successful practices throughout the years.

Building on this strength, it might be useful to spend some time asking your dental nurses what the most common queries are in that walk between chair and reception? The answers might surprise you – and help to improve communication in total.

A brief review of the above, and importantly linking it to what healthcare experts term “the patient journey”, can help to really let your practice and team shine.

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New environmental restrictions on dental amalgam use in specific patient groups came into effect in the UK and Republic of Ireland on 1 July 2018.

The use of dental amalgam for the treatment of patients under 15 years old, of pregnant or breastfeeding patients or of deciduous (primary) teeth in any patient is now only allowed when deemed strictly necessary by the dental practitioner, based on the patient’s dental or medical needs.

The restrictions, which are specified in EU regulations and applicable in UK and EU law, have been introduced to fulfil the requirements of the global Minamata Convention, to which the UK and Irish governments are signatories. This UN Convention aims to reduce use of mercury and mercury-containing products, including dental amalgam, on environmental grounds.

Why is there a need to phase down use of dental amalgam?

There is no evidence that mercury present in dental amalgam presents a direct health risk to individuals who have amalgam restorations or to dental staff. However, when released into the environment, the mercury within dental amalgam can be converted by aquatic microorganisms into a form that can accumulate to toxic levels in fish and other marine life and enter the human food chain. Therefore, by contaminating the environment, dental amalgam can contribute indirectly to the risk to human health from mercury. Phasing-down the production, use and disposal of dental amalgam will help to reduce this indirect risk.

What is the advice in Northern Ireland?

The four Chief Dental Officers of the UK requested that the Scottish Dental Clinical Effectiveness Programme (SDCEP) develop advice to support dental professionals in all four UK nations in interpreting and implementing the restrictions on dental amalgam use. The advice was developed following a rapid process that drew on elements on
elements of SDCEP’s accredited guidance development methodology. A short-life working group that included experienced dental practitioners and experts in restorative and paediatric dentistry, drawn from across the UK, was convened to develop the advice. UK-wide consultation was conducted to allow stakeholders to comment on and contribute to the development of the advice.

What is the SDCEP advice in a nutshell?

Early prevention – Prevention is at the core of many national policies and it is estimated that every £1 spent on prevention leads to £3 saved on later restorative work. The guidance refers to current UK guidelines around the prevention of caries in children, which make recommendations including behaviour change, dietary and toothbrushing advice, and the use of fluoride varnish and sealants.

Use of alternative techniques and materials – The advice recommends the use of alternative techniques and materials in the treatment of dental caries and restoration. For children and deciduous teeth this includes the use of methods such as the Hall Technique, sealant or infiltration and preventive only interventions. The advice states that many of the same approaches and principles can be used for caries management in adults and permanent teeth. It discusses the use of alternative materials such as resin composites and glass-ionomers. The advice is clear that extraction should not be considered as an alternative to the use of dental amalgam.

Minimum intervention dentistry (MID) – MID is an approach that aims to prevent
and control oral disease and encompasses oral health promotion, prevention and minimally invasive operative interventions.

Northern Ireland: new SDR fees and codes
The Statement of Dental Remuneration (SDR) for Northern Ireland has been updated for the provision of non-amalgam fillings for children aged under-15 and in pregnant and breastfeeding women.

Five new codes and fees have been created in Section V (Conservative Treatment) of Determination I of the SDR. Five new parallel item codes with the same associated fees have also been inserted into Section XII (Occasional Treatment).

Four of the new SDR codes cover “Composite, glass ionomer or resin fillings in permanent or retained deciduous teeth in patients under 15 years.”

The fee structure for these is displayed in the table below:

For pregnant/nursing mothers the new SDR code is 1471: “Treatment of any surface of a permanent tooth using composite, glass ionomer, or resin material in pregnant or breastfeeding women”.

This will be paid £15.71 per filling and £23.29 maximum.

The Republic of Ireland
In the Republic, the HSE has stated that it is “committed to the full implementation of the Regulations under the Minamata Convention, including the phase down of dental amalgam”.

As part of this commitment it has outlined six key areas to support practitioners and patients, which have either been delivered or are in train. These are:

- Policy with a preventive ethos to minimise the need for restorative or surgical treatment
- Guidance Statement for clinicians on the future use of amalgam
- Public Information for those attending HSE Dental Clinics
- Training on the use of alternatives to amalgam
- Safe disposal of waste amalgam
- Measurement and monitoring of phase-down.

In addition, the Irish Dental Council has issued a Code of Practice document, which lays out practitioners’ legal and ethical obligations relating to the phase-down.

We are aware that the last issue of Ireland’s Dental magazine contained incorrect information relating to the costs of dental care within Northern Ireland.

We want to make it clear that this information did not come from the cited report by Dental Booster, which related solely to the costs of care in the Republic, nor were Dental Booster in any way associated with the provision of the incorrect data.

Dental role in obesity policy
BDA Northern Ireland has welcomed the opportunity to nominate a dental representative to sit on the Obesity Prevention Steering Group for the first time.

BDA NI will join representatives from government departments and leading public health organisations.

The steering group has an important role in developing policy related to obesity prevention. Its current focus is the Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland – A Fitter Future For All.

Grainne Quinn, Chair of BDA NI Salaried Dentists Committee, said: “We welcome this opportunity to input the dental and oral health perspective to inform government policy around obesity prevention. For too long, the connections and relevance between oral health and wider public health have been overlooked.”

Dental Booster: a correction
We are aware that the last issue of Ireland’s Dental magazine contained incorrect information relating to the costs of dental care within Northern Ireland.

We want to make it clear that this information did not come from the cited report by Dental Booster, which related solely to the costs of care in the Republic, nor were Dental Booster in any way associated with the provision of the incorrect data.
The Department of Health has confirmed that the planned national oral health policy for Ireland will take into account the recently launched Sláintecare Implementation Strategy.

A spokesperson said: “The national approach to future oral health service provision will be informed by the National Oral Health Policy, which is being finalised and which is expected to be published later this year. “The aim of the policy is to develop a model of care that will enable preventative approaches to be prioritised, improve access, and support interventions appropriate to current and future oral health needs. In developing the policy, cognisance has been taken of current Department of Health and broader government policies including the Sláintecare Implementation Strategy.”

The Sláintecare Implementation Strategy, which was announced in August, is the Government’s plan for delivering “a sustainable and equitable health and social care service over the next ten years”.

Services will be redesigned so that care is delivered based on population need and size. In the future, the majority of care will be delivered in the community.

The redesign will build on existing policy and work that is underway including the development of primary care teams, Community Healthcare Networks (CHN) and Community Healthcare Organisations (CHOs).

Notably, the spokesperson also said that changes in the way care is delivered will affect the health workforce, including dentists. The precise implications of this have yet to emerge.

The Strategy outlines actions to be taken in the next three years including:

- Development of a citizen care masterplan for the health service
- Actions to make sure the health workforce is supported to enable reform.
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Dentists in distress

Being a dentist has never been tougher. And it’s taking a serious toll. Burnout, anxiety, depression...worse. Ireland’s Dental doesn’t have the answers, only signposts to help. The journey starts here

Words: David Cameron, Tim Power, Stewart McRobert

When the envelope arrived from the GDC outlining the complaint, anxiety instantly constricted her chest. She felt slightly faint. But, after the third read, she felt balance returning. Wasn’t she certain she had done nothing wrong? Wasn’t the complainant being as unreasonable now as he had been when he was in her practice?

Ten months later, an intense inquiry was under way. But not just into the original allegation. The GDC probes were delving deep into other unrelated case files that had been requested. And with it, she had morphed from a competent, confident clinician into a nervous wreck, frantic about her professional future and the security of her young family. Until the morning of the breakdown, her husband had thought she was “simply” stressed, going through the type of difficult time that so many professionals face at some point in their careers. But when he found her weeping in the bedroom, unable to get dressed to go to work, their world almost collapsed.

The story is true but the dentist for whom this was a reality doesn’t want the world to know her name. She fears that what she went through would even now, despite vindication before the GDC and a full health recovery, damage her professional reputation in the eyes of her contemporaries and her patients. Worse, it could still put an even greater strain on the
viability of her small rural practice. The reality is that this is not one isolated, extreme case. It is absolutely typical of the increasing numbers of dentists all over the UK who are suffering in silence, some of whom do not make the recovery that the practitioner in our study was able to make. Some are forced to quit the profession forever because they just cannot take the strain.

Suicide is a reality in our society, particularly in some areas of the UK such as Northern Ireland and parts of Scotland, and tragically, in recent years, several dentists who have felt overwhelmed have taken their own lives. However, with wider recognition and public understanding of mental health issues, momentum is now growing within the dental profession for the radical change that is needed to tackle an insidious problem that is blighting the lives of so many professionals across the UK and the Republic of Ireland.

Ireland’s Dental magazine is committed to playing its part in supporting this work. Our aim is not to provide answers or solutions for individuals. Our key objective is to strive continuously to raise awareness of the issue and to provide, where possible, vital signposts for dentists to reach the professional support they need to help deal with the mental health issues they are facing.

We will be talking to the psychologists who are providing their expert help daily to professionals in difficulty, the organisations that are coming together to work towards a new way of helping those in trouble, and reporting on the stories that are impacting on this area of deep concern.

Passionate campaigner
Roz McMullan is currently chair of the BDA’s Northern Ireland Council and BDA President-Elect (2019/20), and she is a passionate campaigner on the issue of mental health among dentists. She has always been aware that stress was an issue for many of her colleagues, but the point at which she knew she had to act personally was when dentists and their families in Northern Ireland were struck by tragedy on a number of occasions. Not all of these were directly related to dental issues being faced by those who took their own lives but a number were. Enough was enough; something had to be done.

In Northern Ireland, Roz and her colleagues are now working within a framework that not only addresses the issue but also has an element through which outcomes can be measured. At its core is Probing Stress in Dentistry, a joint working group with representation from the BDA, the Deanery (Northern Ireland Medical and Dental Training Agency), the Northern Ireland Public Health Agency, the BDA Benevolent Fund and indemnity organisations. Recently, it has been powerful in producing guidelines on how to tackle the issue of mental health.

It has developed a range of access points through which dentists can get the help they need. It has created seminars and courses that they can attend to learn more about the problems and how to deal with them. It even has a small “roadshow” stand that is taken to events to raise awareness and offer guidance.

“We have to tap into the professional help that is out there and not try to be a panacea. We need to be signposts, guiding people to the proper help that they need. Access to occupational health services for dentists has been a great step forward in Northern Ireland,” said Roz.

“We see our role not in offering solutions for individuals. This is absolutely a job for the professionals. Our place is to offer to support and to raise awareness. We are bringing in the experts to help. And we are showing our colleagues where they can go to find the professional help they need,” she explained.

“We are also continuing to work with other stakeholders to improve timely access to professional help when dentists need it.”

HEALTH BOARDS NEED TO TAKE MORE RESPONSIBILITY. THE NHS NEEDS TO VALUE ITS WORKFORCE

ROZ McMULLAN
A measure of the success of this approach is the fact that the courses, which are run by Probing Stress in Dentistry, are always fully subscribed. “We see it all the time and that tells you just how big an issue this is and how important it is that we make this information available to all.”

Turning to the nature of the problem, Roz highlights a number of key issues facing dentists around the country. Stigma is a big one. “There is an issue of people not being prepared to put their hands up. They fear the real and perceived consequences of doing so. They are frightened of the increased risk of complaints, possible loss of income, loss of face, impact on their families and their colleagues. There are a lot of pressure points,” Roz said.

Another is money. Making a decent living in dentistry can be a very tough challenge. The reality is so different from much of the public’s perception. And so, regardless of how difficult or stressful the job has become, many, many practitioners are self-employed and simply cannot afford to take time off. The result can be perceived as devastatingly simple: No work, no income. No income, no future. No future, no life.

“I’m not certain what the answer is, but I feel that we have to be working towards some form of practical help for people running practices who are feeling overwhelmed and are needing to take time off. Health boards need to be taking more responsibility here and helping to find answers. The NHS needs to value its workforce.”

And for many, the trigger is the ever-increasing burden of regulation and governance. “It’s incumbent on everyone in leadership not to burden healthcare workers with more issues that provide more stress. There needs to be right-touch regulation. We can’t keep increasing pressure on people with more and more regulation. Recently I was talking to a very experienced dentist who had a complaint against him through a solicitor. When the reports were gathered, the solicitor said he felt that there were potentially no grounds for legal action. But, he suggested, the patient could, if they wished to continue to seek redress, pursue the matter through the GDC. And indeed this is what the complainant has done. The onus is on the GDC to make sure their responses are proportionate,” she said.

Roz McMullan believes that we are moving forward in tackling the problem, just perhaps not fast enough. She hopes that when the results of a major new study by the BDA and the University of Cardiff – about 2,000 dentists have been surveyed on the trigger points for their stress levels – are published, this important piece of work could be the springboard for greater action.

“We now know how many people are suffering so we know this is a very real problem and not just people talking. Soon, through the work that is being done, we will have the data that we need to identify the key triggers. This is crucial in taking us forward.

“Will we ever be able to prevent these issues? No. But could we help people to manage things better, I am absolutely certain that we could.”
Anxiety, good and bad

Barbara Gerber explains how a necessary human response can get out of control

Worries, fears and anxieties affect us all; most of the time, our responses to these are reasonable as well as being necessary for survival. In avoiding talking about or acknowledging that we are struggling with anxiety, we become increasingly more anxious. The purpose of anxiety is to warn us of danger, and to equip us to deal with it and allow us to remain alert until the threat has passed. Therefore, it is a crucial aspect of everyday living. We all need a certain amount of anxiety in order to focus the mind and to help to motivate and protect us.

Imagine you are crossing a busy road and you suddenly notice that a car is speeding towards you. You realise the danger and jump out of the way.

In the example above, a series of physical, mental, and behavioural changes take place, which leads to the flight, fight or freeze-startle response. This is seen throughout the animal kingdom. The adrenaline hormone and the involuntary nervous system send signals to various parts of the body, enabling it to respond immediately. This is self-preservation in action. When the danger has passed, the changes subside.

The problem arises when the brain misinterprets a situation as being dangerous when in fact it is not; it starts the fight, flight, freeze response which results in a body full of energy raring to go, but with few outlets. When we become over-anxious, worried, or stressed, this interferes with our ability to think clearly and act in a measured way.

Sometimes anxiety can be ongoing, lastin months, even years. Experiencing a number of stresses in our life and becoming preoccupied with worry can result in our everyday level of anxiety gradually increasing. Such long-term anxiety can result in exhaustion, irritability, having difficulty concentrating and can lead to bowel and sleep difficulties, leaving us feeling overwhelmed and low.

Impact on our lives
The impact of anxiety on us can be understood by considering the ways it affects different areas of our life. The Five Factor Model...
examines in detail five important aspects of our lives. These are:

- life situation, relationships and practical problems
- altered thinking
- altered feelings (or emotions or moods)
- altered physical symptoms in our body
- altered behaviour.

Our thoughts about a situation can affect our feelings or emotions, our physical wellbeing, and our behaviour. We can interrupt this vicious circle in a number of ways:

- understanding the body’s response when anxious
- challenging your own unhelpful thinking patterns
- challenging your own behaviours.

The most common physical symptoms of anxiety include tight painful chest, difficulty and shortness of breath, palpitations, trembling, shaking, headaches, nausea, sweating, dry mouth, tight neck and shoulder muscles, tired eyes, difficulties in concentrating, memory lapses and fatigue, and these tend to make us worry and often result in withdrawal into self, which in turn starts the vicious cycle. We often indulge in excesses, such as alcohol, food, recreational drugs and cigarettes, which make us feel better short term, but long term, increases anxiety.

**What tools can we use to help?**

- **To help with the physical symptoms** we can adopt diaphragmatic breathing. If we have been breathing erratically for some time, it can be difficult to switch from hyperventilating to controlled or diaphragmatic breathing. To practice this, imagine you have a balloon inside your stomach and when you breathe in, you imagine the air going down into your stomach and thus your stomach expands — when you breathe out imagine the balloon deflating and thus your stomach goes in. Take a normal size of breath, because if you breathe too deeply, you will feel light-headed. Breathe slowly and in a controlled manner. It is worth practising daily, starting with lying down, then in a chair, then standing while in a relatively relaxed frame of mind. Being able to consciously change your breathing while anxious is an acquired skill and takes several weeks of practice, but if you are able to master this, you will find it reduces your anxiety within about 30–60 seconds. Alcohol, caffeine and excess sugar increase anxiety, so try to reduce these; however, exercise and relaxation help to reduce anxiety, so try to increase these.

- **To help with our thought process:** The way we think can contribute to the maintenance of our level of anxiety. We not only think in verbal terms, but also in visual terms. Many people who experience anxiety problems overestimate danger and underestimate their own ability to cope, e.g. overestimating the problem presented by the patient, and underestimating their ability and skill as a dentist. We anticipate problems based on predicted, extreme outcomes rather than basing them on realistic evidence. One of the problems with anticipation is that the thoughts generated are often inaccurate and fail to relate to actual events. Dwelling on these potentially unpleasant events in detail is time-consuming, distressing, and interferes with daily functioning. Anticipatory worries start with ‘What if...?’ questions. We can also become hypervigilant, seeing danger in every situation. And finally we often hold a post-mortem on situations we have just encountered, ignoring all the positives and only focusing on any perceived negatives. In order to challenge these ways of thinking, we need to focus on the evidence of our own personal experience — thoughts are not facts. We need to look at the thoughts that are making us anxious, e.g. from the example above “I will get into trouble” and ask yourself — Is there evidence to back this up? Has this happened before? And the evidence against — How many times have I been late and not got into trouble? And then come up with a more realistic thought and act accordingly, e.g. “I have been late many times before and nothing bad has happened so I won’t rush”.

- **To help to challenge behaviours.** The most important behaviour to challenge is avoidance — when we are anxious we often avoid facing up to whatever is anxiety provoking, e.g. not opening mail, not responding to emails, and not making “that phone call”. This only increases your anxiety, so challenge yourself to do whatever you are avoiding.
A problem shared...

The impact and continued growth of the Mental Dental forum on Facebook is an indication of the profession’s concern over wellbeing

If any further confirmation were needed about the depth of the mental health problem facing the dental profession in the UK today, then surely Mental Dental – A Group For Dentists in Crisis has provided it.

The Facebook forum was set up by dentists worried that there wasn’t enough being done to tackle the problem that many knew existed but were powerless to do anything to help address.

Within weeks of being launched by Welsh dentist Lauren Harrhy, almost 2,800 dentists had signed up. Today, that number has almost doubled, and new members are being added every day. There are also 15 administrators and moderators, who are all dentists volunteering to help during their spare time.

The forum is a platform for fellow dentists to share their thoughts, fears and experiences. But it is imperative to stress that it is not a mental health resource, and there are concerns among some of the profession’s leaders that the forum could exacerbate rather than help issues.

They strongly urge any dentist who is suffering stress or anxiety at work to contact their doctor or any one of the numerous professional mental health organisations and charities that exist to support people facing issues.

However, there can be no doubt that Mental Dental is a barometer of the depth of the problem. The number of members speaks volumes and, as one of its administrators argues, there is a place for it in the battle to tackle mental health in the profession.

Nicola McMillan is a Glasgow graduate who works as an associate in NHS general practice. She was installed as the first forum administrator after she and Lauren realised there were few places for dentists to go if they were feeling stressed or anxious.

She had known of dentists who had left the profession or, worse, taken their own lives, because of overwhelming pressures. Their shared concern led to Lauren setting up the group, despite the fact that she’s a practice principal with three young children.

As the forum has developed, so has the ability of its members to help each other.

“The aim is to provide support but never to advise. We, and forum members, are fellow dentists not professional counsellors,” she said.

She noted that certain topics crop up regularly – relationship issues between staff and principals, malicious complaints by patients, personal matters such as divorce, and general feelings of discontent with the profession.

One other area of concern is social media itself. “In our case, social media is a positive, but on many occasions it can help create or exacerbate negative feelings. We get lots of people suggesting that other forums where dentists’ posts show them leading apparently idyllic lives simply serve to make fellow professionals feel depressed and/or insecure.”

Notably, the forum has helped to demonstrate that fears about the mental health and wellbeing of dentists are not restricted to the UK. A past president of the Australian Dental Association Queensland was in touch with Lauren and Nicola in 2018 to ask about their experience and how Mental Dental operates.

As a result, that part of the world now has its own version called Mental Block.

Meantime, the effectiveness of Mental Dental can only be judged by its ability to provide support to its members. “We can never know for sure exactly what impact we are having,” said Nicola. “However, we have had a lot of positive feedback and there’s no doubt we have helped people – a number have taken the trouble to get in touch and say exactly that.”

To find out more, search for Mental Dental on Facebook.
‘I felt guilty if I found a cavity’

Nicola McMillan describes herself as a proud Glaswegian, GDP, member of the GDP subcommittee of the LDC, indoor climber, Harry Potter fan and empathetic listener. Here, she tells the story of her own struggles with mental health in the hope of inspiring others to seek help.

It started when I was studying for my Highers in fifth year. I was hyperventilating and felt I couldn’t breathe. I had what I now know to be panic attacks.

In first year of university, I struggled again: too much freedom, student loan money and a massive jump in difficulty from school. This led to what I’d now say was mild-moderate depression. I was tired all the time, and felt overwhelmed and prone to tears and frustration.

The next issue was getting a VT place. In 2011, in Glasgow, I didn’t place in the first or second round. I went to Shetland for a clearing interview and was unsuccessful. I genuinely thought of throwing the final year exam so I could stay in university another year and make myself the best candidate for the 2012 VT places.

When English clearing opened, I headed down to Wallasey in the Wirral for my first successful interview. However, during the race for VT positions and the run-up to practical finals I began to suffer from excruciating back pain. I was constantly tired. Living in a new city and working full-time for the first time was hard, and it was taking its toll.

Next I started DF2, six months maxfacs and six months PDS. I struggled with maxfacs. Five days in, I started crying in the middle of the ward in front of the consultant and the other SHOs. I was so stressed and also upset at seeing nice, kind people so unwell. The dark humour used by some of the SHOs and nurses didn’t work for me.

My back problems only got worse and my fiancé begged me to leave the job. But I stuck it out, and some
kind nurses and SPRs got me through. Then it was PDS for six months, then called community. I wasn’t used to its structure where administrators seemed to be given a lot of power, and I rebelled. Anxiety started when patients did or didn’t show up and I worried I couldn’t manage them. I think it was obvious that I didn’t want to kowtow to the politics that goes on in a hospital setting and I gave a pretty scathing review of maxfacs. I didn’t place as an SHO.

So, to general practice it was. But I lasted just three months in my first practice. The owner and practice manager made my life hell. I sought legal advice then bided my time until I had another position lined up. Not a great start to my associate career.

I stayed at my second associate position for 18 months. But I found it difficult to meet the high expectations of the Edinburgh patient base. They seemed to want private treatment for an NHS fee, and I found that very intimidating.

I was endlessly tired and I started getting so anxious that I would vomit my breakfast in the morning and consider pulling into oncoming traffic on the way to work. Not to kill myself, just to get injured enough so that I wouldn’t have to be a dentist for a bit.

I started seeing a life coach, also a dentist. She tried to assure me that it wasn’t my fault if my patients didn’t brush their teeth. But in my thinking, we’re professionals and we should be persuasive enough to convince patients of the importance of brushing their teeth daily. With that logic, it’s our fault they ever need treatment. I felt guilty if I found a cavity.

I locumed in a lovely practice for six months before starting in my current job. But there have been times, for personal reasons, that I have felt lonely and isolated. I knew I was fighting depression. The staff were kind and would ask if I was ok. But I was embarrassed. I felt it would come across as laziness and sometimes it was all I could do to drag myself to work in the morning.

I love being a dentist. Sometimes I hate the way patients treat us, but I truly enjoy my job. In the past year I’ve thrown myself into helping other people through Mental Dental. I’m truly honoured to be a part of it. It’s not been without its challenges. People are capable of saying some fairly dreadful things. Even in this day and age, and among fellow care professionals, there are those who simply do not understand or have any empathy for those who have to cope with their demons.

I have had some pretty unpleasant experiences online. But we believe that providing people with a forum, we are going some way to helping. We would always suggest that people who are suffering seek professional help, the sooner the better.

My GP, my fiancé and friends have helped me through some difficult times and for that I’m truly grateful. I believe in the kindness of our profession. Dentists will give up their time willingly to help others in need. What more can you ask for?
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Two GDC surveys find that patients take a harsher view of professional misconduct than those in the dental profession but are more tolerant when it comes to personal behaviour. Andrew Collier examines the figures.
A DENTIST ACCIDENTALLY PRESCRIBES/A DENTAL NURSE ACCIDENTALLY GIVES THE WRONG MEDICATION TO A PATIENT, AND THERE ARE SERIOUS SIDE EFFECTS

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A DENTIST REMOVES THE WRONG TOOTH/A DENTAL NURSE READS NOTES OUT WRONG AND AS A RESULT THE DENTIST REMOVES THE WRONG TOOTH

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A DENTIST/DENTAL NURSE GIVES A PATIENT A RUDE RESPONSE TO A COMPLAINT A PATIENT HAS MADE ABOUT THEM

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- Suspension
- Strike off register
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“If they’re a repeat offender, that’s different because they haven’t responded to a reprimand, so you need to move onto something else.”

And a dental nurse commented: “I’d personally suggest conditions. There may be more training that’s needed, whether in the sense of the racist comments or in the sense of how to use social media in a positive way without bringing our profession into disrepute.”

**Varying attitudes**

Another question relating to personal rather than clinical misconduct concerned a dentist or dental nurse being charged for drunk and disorderly behaviour on a night out.

In this case, attitudes varied dramatically between patients and registrants, with more members of the public feeling that no action should be taken against a dentist – 42 per cent, compared to 10 per cent among dentists and 13 per cent among dental nurses.

A total of 34 per cent of dentists felt a reprimand would be the most appropriate outcome, compared to 37 per cent of dental nurses.

A smaller percentage of the patient cohort favoured the harsher outcomes compared to dentists – 10 per cent against 19 per cent for a dentist having conditions attached, 13 per cent against 26 per cent for suspension, and six per cent against seven per cent for striking off.

“You’ve got to have a certain level of professionalism,” said one dentist respondent. “If somebody is acting unprofessionally and has been charged, I think they are bringing our profession into disrepute.”

However, another responded: “The only way that drunkenness will affect anyone is if the dentist comes into work [still under the influence] the next day, and that’s a different thing completely.” Another remark was: “Until they’re actually found guilty, there should be no action.”

**Clinical scenarios**

Moving on to questions relating to clinical misconduct, one hypothetical scenario in the survey involves the case of a dentist prescribing, or a dental nurse accidentally giving, the wrong medication to a patient, leading to serious side-effects and an admission to hospital.

In this case, 2 per cent of dentists felt no action should be taken, with a further 13 per cent opting for a reprimand, 45 per cent the attachment of conditions, 26 per cent suspension and nine per cent striking off.

In the case of dental nurses, twice as many – 4 per cent – felt there should be no action, with 12 per cent favouring a reprimand and 39 per cent conditions. The figure for suspension was slightly
lower at 23 per cent, but for striking off, it was substantially higher at 13 per cent.

The public/patient cohort tilted more strongly to the harsher outcomes. Three per cent went for no action, but 8 per cent opted for a reprimand, 23 per cent for conditions, 42 per cent for suspension and 21 per cent for striking off.

Some respondents felt that the dentist or dental nurse should not necessarily be judged too harshly, particularly if it was an honest mistake or partly the fault of the patient in some way.

“If it happened, it would be a learning point to know that you can’t just rely on their medical history and you need to ask them every time,” said one dentist.

Another commented: “It’s a mistake... if this person is actively trying to do harm to someone then it’s different... the person may just need more training.”

Another view was that if the error highlighted a more serious failure, such as a practice not updating patients’ medical histories, then more serious action should be taken.

“If they never took a medical history, it should be a suspension, because they’re dangerous,” said one participant. “If they had a busy day and forgot to ask the patient, then it’s not as serious.”

And a dental nurse commented: “If it was a mistake, then it should be a reprimand, but maybe with some training but not with any restrictions in place. How can you restrict a dentist from writing prescriptions?”

In a different question on potential clinical error, respondents were asked about the case of either a dentist removing the wrong tooth, or a dental nurse reading the notes wrongly and the dentist extracting the wrong tooth as a result. Among patients, 3 per cent thought no action should be taken; 14 per cent opted for a reprimand; 31 per cent felt conditions should be attached; 36 per cent believed suspension to be the most appropriate outcome; and 13 per cent thought the professional should be struck off.

Dentists veered more towards the softer outcomes, with almost half – 45 per cent – believing the mistake should result in conditions being attached. Four per cent felt no action should be taken and 17 per cent believed a reprimand to be the best solution.

**Mitigating factors**

There was a notably softer response to the suggestion of harsher penalties within this cohort, with just 21 per cent believing in suspension and 8 per cent opting for striking off.

Among dental nurses, a dramatically higher figure – 14 per cent – felt no action should be taken. A reprimand garnered 23 per cent support, while 38 per cent opted for conditions. There was also lower support for the toughest measures among nurses than from dentists, with a figure of 16 per cent favouring suspension and just 3 per cent opting for striking off.

“It’s a training issue, potentially,” said one dentist, while another said: “If they had done it 10 times it’s different, but what if it’s a one-off?”

Yet another comment was: “I can imagine the younger dentists who have just come out of dental school would be quite scared. They would think it’s quite a serious thing to take a wrong tooth out.”

However, some professionals observed there could be mitigating factors, such as clinical decisions concerning extractions sometimes being complex.

It was pointed out that it isn’t always a simple task to determine which tooth should be removed, particularly when it is being taken out to try to ease pain on the basis of information provided by the patient.

“You could take one tooth out and the next day the patient still has pain and says you’ve taken the wrong one out,” said one dentist. “It could be that the pain was coming from both of them.”

And of the potential outcomes of suspension or striking off, one dental nurse remarked: “It’s so harsh!”

Further information is available on the GDC’s website www.gdc-uk.org
A DENTIST/DENTAL NURSE POSTS RACIST COMMENTS ON THEIR PERSONAL FACEBOOK PAGE

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A DENTIST/DENTAL NURSE IS CHARGED FOR DRUNK AND DISORDERLY BEHAVIOUR ON A NIGHT OUT

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Beth Bradley is an Irish, soon-to-be-final-year dental student at the University of Leeds and current BDJ Student editor. Following a tough fourth year of study involving significant clinical sessions, revision and exams, she was keen to explore what dental professionalism meant to her.

According to the General Dental Council’s (GDC) 2013 publication *Continuing Professional Development for Dental Professionals*, a dental professional will be “highly qualified and skilled whilst always accountable to a higher code of conduct”. Like any profession, dentistry possesses what the American College of Dentists (ACD) called, “a level of exclusive expertise”. Not only as qualified dentists but also as dental students, all behaviours should uphold the principles of the GDC Standards.

In this article I will explore dental student professionalism by discussing its ethical relevance, how we uphold professionalism within ourselves and with our patients, and how, in a world where teamwork is essential, we can attain the best professionalism possible.

By definition, a professional is governed by a higher standard of practice, and the 2013 GDC Standards outline the fundamental ethical principles that demonstrate how any dental professional must act. These standards, alongside the 2016 American Dental Association Code of Professional Conduct, represent a dental student’s obligatory behaviour. This obligatory behaviour can often be overlooked as we embark on university careers, where we are faced with a variety of new life choices and opportunities.

The Young Dentist (2017) indicated that to be deemed professional, the way in which a dentist/dental student acts should be deemed appropriate by members of the public and professional colleagues. Having felt this responsibility myself, I feel it is important to recognise the professionalism demonstrated by thousands of young dental students every year as we manoeuvre through the whirlwind of undergraduate training alongside peers, enjoying perhaps more frivolous carefree university experiences.

According to Trathen and Gallagher 2009, what sets a professional apart from others is a drive and devotion to strive beyond what they must do. It is important to consider that what an individual must do is often governed by fear of sanction or reprimand. However, what one ought to do is often controlled by a set of internalised and individual moral codes. So, as the ACD put it, a professional dental student should, throughout their scope of practice strive to pursue beyond what they must do to uphold the best interests of their patients. This may be through going the extra mile for a patient, booking in more clinical time or lab practice, or perhaps spending a few hours helping a colleague understand a specific lecture. It is these little extras which set a true dental professional apart from the rest.

Our own professionalism should permeate all aspects of our training, through interactions with patients, clinical team and peers and in our own personal professional development.
The Young Dentist (2017) highlights that a dental professional will demonstrate:

- attention to detail
- a desire to seek development and enhancement of their skills
- a willingness to acknowledge and learn from their mistakes.

To me, these traits are key elements of professionalism, and ones which I try to maintain throughout my studies.

As a young dental professional maintaining the patient’s and community’s confidence in myself and the dental profession is vital. I admire so many members of this profession and view preservation of its integrity as a key element of my own professionalism.

The GDC states that we should “maintain, develop and work within [our] professional knowledge and skill”. As a dental student I am responsible for my own learning and aim to have the necessary knowledge, skills and attitudes of a registered dental professional. This can be achieved by actively seeking opportunities to develop a skillset and enhancing capabilities in addition to the required studying and taking of exams. Continuous professional development will hopefully provide essential up-to-date care for my patients in the future.

According to the GDC, dentistry as a profession requires excellent and effective teamwork to deliver exceptional patient care. Universities offer a vast array of opportunities for professional development. Through dental societies, clubs and the many extracurricular activities on offer, there are countless chances to develop teamworking, communication and organisational skills. As dental students we should harness these chances to enhance our professionalism.

The GDC dictates that a true dental professional must communicate effectively with patients with uncompromising veracity. Optimal communication skills necessary to build a successful rapport with a patient are an essential proficiency of any dental professional, a skill which must quickly be learned by any young dental student. A report by the Parliamentary and Health Service Ombudsman in January, 2015, indicated that “Poor communication [was] at the heart of many dental complaints”, highlighting the importance of maintaining professionalism regarding patients by ensuring continuous effective communication with them on every level, thus maintaining the vitally important
patient satisfaction essential to a successful dental practitioner.

The best interests of the patient are central to any patient interaction and this concept is paramount to any treatment decisions. As you know, obtaining valid, informed consent from a patient for treatment is a vitally important facet of professionalism regarding patient care. As a dental student, by achieving sufficient consent for treatment, one exhibits a comprehensive knowledge of procedures, the ability to provide an unbiased presentation of the reasonable treatment alternatives and consequences, and the capacity to ascertain the level of competency of a patient.

I am sure every dental student knows that leadership qualities are an essential attribute for any dental professional, whether in a position of formal leadership or not. The Department of Health encourages a multidisciplinary approach to optimise patient management within dental school. This way all members of the clinical and educational teams engage to deliver the best possible patient care. We should have an in-depth knowledge of other disciplines’ skill set for appropriate referrals, hence working within our own skill set, and ensuring the best possible patient care by utilising connections within the service.

So, a truly professional dental student must abide closely to the laws and standards laid-down within the GDC’S Student Fitness to Practice and, as aptly described by Trathen and Gallagher: “A [true] professional must always seek to go [above and] beyond what one must do.”

Further reading


Top tips for practising evidence-based dentistry

Niall McGoldrick BDS, MFDS RCPS(Glasg), Derek Richards BDS, FDS, MSc, DDPh,FDS(DPh)

In the first of a series of articles focused on evidence-based dentistry, Niall McGoldrick and Derek Richards explain where to find the evidence and how to assess its quality.

Evidence-based dentistry

This article is the first in a series that aims to introduce the modern-day dental practitioner to evidence-based dentistry (EBD). After reading this series, you will be clearer about how to keep abreast of the ever-growing evidence base and the latest guidance. You will know where to look for evidence and learn how to maximise time spent searching for evidence to inform your practice.

In our day-to-day lives we have become accustomed to using search engines such as a Bing or Google to help answer simple questions, but, when it comes to our clinical work and professional life, we need to take a more formal approach in our search. There are a number of web-based scientific databases that catalogue evidence. The databases can be thought of as massive online libraries, but like any library, if you don’t know your way around it or the cataloguing system used, then you are likely to get lost and spend hours searching for what you need. Therefore, having an awareness of the different scientific databases available and understanding how to use them is a good starting point.

An example of a well-known database, and one you may have already used, is PubMed. Simply typing the word ‘dental’ into the search box on PubMed results in more than half a million hits – 516,870 to be precise. These 516,000 hits are spread over 25,844 pages, which makes for a lot of reading. Clearly, we need a more focused approach. So, what then if we pick a subject within dentistry such as fluoride varnish? This search still returns 1,293 hits spread over 65 pages.

The point we are demonstrating here is that there is a wealth of information and publications that we can make use of, but there is some skill required to negotiate databases and identify quality evidence. A busy practitioner needs access to high-quality evidence quickly and easily.

The American Dental Association describe EBD as “an approach to oral healthcare that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise and the patient’s treatment needs and preferences.”

As dentists we want to do our best for each and every patient we treat, and this is at the heart of EBD. Most dentists will be confident in their clinical skills and will listen to patients but not all will be confident in the strength of evidence behind how and what they practice. The evidence should be a constant go to for a modern-day dentist.

Developing an evidence-based approach can be thought of in five stages:

1. Asking the right question
2. Searching for the best available evidence
3. Critically appraising the evidence
4. Applying the evidence
5. Evaluating the outcome

In your life outside of the surgery, you will already be using this approach, whether you realise it or not. Take buying a new car, for example. Let’s say it is a used car; you may not want to rely solely on the sales person’s word that the shiny car on the forecourt really is the best one for you. You will need to think about what it is you really need from the car – is a sporty convertible with two seats and no boot space going to suit your...
lifestyle? Maybe it is.

Most people will search the internet comparing various cars on independent websites; they will look in magazines or speak to friends and family beforehand. So, when you arrive at the showroom you already have an idea of what you are looking for and what you need from a car. At this point you have carried out the first stage of an evidence-based approach: Asking the right question.

You have also begun the second stage: Searching for the best available evidence.

When you have identified a potential car, you will want to continue your search for evidence to support your decision to buy. You will want to know more details about the service history, you might inspect the paint work, check how many miles it has done and ask about previous owners. You will combine this information with what you found out previously and check the quality of the evidence before you. This is stage three: Critically appraising the evidence.

Next comes the big decision; whether to go ahead with the purchase. After carefully considering all the evidence you have available, you may or may not decide to buy the car, this is stage four: Applying the evidence.

The final stage is evaluating the outcome. This will take place in the months and years to come when you will be driving the car. If the car keeps breaking down and needs multiple new parts, you might question your approach and the evidence upon which you based your decision.

In this article we will cover stages one and two of the evidence-based approach.

**Asking the right question**

Evidence-based dentistry starts with a clinical question. You need to be clear about what it is you are trying to find evidence for. A good technique to help develop your question is to use PICO.

**What is PICO?**

PICO is an acronym for Population, Intervention, Comparator and Outcome. It is used when developing a question regarding a clinical scenario. Say, for example, you are a general dental practitioner; you suggest that the five-year-old patient in your chair should have fluoride varnish applied to her teeth. The patient’s parent questions this; he asks you “what good will it do?”, and at this point he does not provide consent.

Using the PICO approach, we can build our question and start our search for the evidence. First of all, we need to establish the key population group that we want to find evidence about. In this case, it is children.

Next, we need to think about what treatment we are proposing and what the alternative might be. Here, we are proposing fluoride varnish application and the comparison would be no fluoride varnish. You could also choose an active treatment for comparison, such as fluoride mouthwash or toothpaste. Having an alternative prevention option might help win over the parent in this scenario.

Having a clear idea about what outcome you want from the treatment is important. Here, our key outcome is the caries rate in the child.

As a result of this process, we now have a PICO question we can use in a database search:

- **Population, patient or problem:** Children
- **Intervention or treatment:** Fluoride varnish
- **Comparison:** No treatment
- **Outcome:** Caries.

**Searching for the best available evidence (AQUIRE)**

We now have a clear PICO...
question for moving forward with and have completed stage one. In the next stage, we need to think about the types of evidence there are and where we can find them.

This section will aid you in the search for the best available evidence. It has two parts. In the first part we will explore the hierarchy of evidence and the uses for each type, while the second part published in the next article, will take you through the practicalities of different databases.

Types of evidence
First let us think about the different types and levels of evidence available. The most common and easy way to think about evidence is as a pyramid or hierarchy as shown in Figure 1 on the previous page. It is quite intuitive, with the highest levels of evidence found at the top of the pyramid. Each type of evidence has a role to play in shaping healthcare. We will work our way up the pyramid discussing each of the types of evidence in turn while exploring the pros and cons of each.

In vitro/animal research
Animal and in vitro research can be useful in the initial stages of developing treatment, for example when exploring causes behind disease or investigating an early idea or hypothesis. The dental materials we use are initially tested in the lab. If they fail at this stage then there would be no point in testing the material in humans without overcoming the initial flaws identified.

With animal experiments there can be an issue when it comes to translating or replicating findings in humans. Some treatments may never work or they may actually be harmful to humans. The process of getting from the lab bench to chair side can take decades of refinement.

In this article, our focus is on what works best in the clinical situation and therefore this type of lab-based study is not immediately transferable into practice.

**Ideas, editorials and opinions**
Initially, most people think their own ideas are great, but do they stand up to the scrutiny of others? As we mentioned above, ideas need testing. Personal opinions and written editorials often only provide one view point. Therefore, it would not be a good idea to change your practice based on a discussion over a cup of coffee or on a single editorial on a website, magazine or journal.

There are occasions when a combined opinion can be useful though. Sometimes professional groups come together to give an opinion or stance on a particular issue. This often involves bringing together a range of currently available evidence. The downside is that the opinion will include some of the group’s own biases.

A recent example of a professional group summarising evidence is the Scottish Consultants in Dental Public Health Group, *Recommendations on the use of fluoride toothpaste and fluoride supplements in Scotland 2017*. The document is clearly referenced and has been produced in consultation with a renowned guideline development group. This type of opinion holds more weight and can be taken more seriously.

**Case control studies**
Case control studies are retrospective observational studies. They do not test an intervention but are used to help find out what might cause a disease or be associated with it. As the name suggests, they are made up of two different groups, cases and controls. Cases will have the particular disease of interest and will be compared to controls that do not have the disease of interest. Researchers will take extensive histories from both groups and compare factors such as lifestyle. They are useful for establishing risk factors that are associated with a disease.

Recently there has been a lot of interest in understanding the causes of dementia. With an ageing population, if we could find out how to prevent dementia then this could have a great impact on the health of the population. One hypothesis queries whether periodontitis has any association with dementia. A research group in Granada carried out a case control study to find out if there was such an association. They compared 180 people with cognitive impairment to 229 without any impairment. After controlling for known risk factors they found there was a statistically significant association between...
As mentioned before, case control studies are useful for establishing if associations exist between risk factors and disease. A lot more evidence is required in order to prove causation and establish the sequence. In this example, one might question whether the periodontal disease came before the dementia or whether the patient developed dementia and then stopped brushing as well as before?

If you want to learn more about causation, then a good starting point is to read about the work of Sir Austin Bradford Hill.

Hill was an epidemiologist during the 19th century. In an after-dinner speech he set out a number of considerations that should be taken into account when trying to establish causation.

**Cohort studies**

Cohort studies are another form of observational study and are much more useful in establishing causes of disease. As the name suggests, they include a cohort of people with all the subjects included in the study initially free from the disease of interest. Detailed histories and in some cases examinations take place at the beginning of the study. The cohort is then followed up, often over a number of years, and observed for signs of the disease.

One of the most famous cohort studies took place in the US in a town called Framingham. The town in Massachusetts was to be the centre of a study that has now lasted 69 years. It focused on understanding the causes of cardiovascular disease as public health specialists recognised this as a major threat to the population of the US. People in the town who were free of cardiovascular disease were enrolled in the study and observed for many years.

Detailed information on behaviour, lifestyle and other characteristics were recorded. Investigations including blood pressure monitoring and ECG’s were carried out as the study progressed. It took 10 years for the first key finding to emerge. The researchers were able to show that as blood pressure increased, the incidence of coronary heart disease also increased. The study produced the foundations of preventative medicine and discovered many of the causes for heart disease that we aim to prevent today.

**Randomised controlled trials**

A randomised controlled trial is the study of choice for testing new interventions in dentistry. They are experimental in nature and use randomisation techniques to reduce risk of bias and confounding factors that may influence outcomes. Patients are selected against strict inclusion and exclusion criteria ensuring they have similar baseline characteristics. There are then randomised into two arms, treatment and control. In the treatment arm, the subjects receive the new treatment under investigation. This is compared to the subjects in the control arm who will receive either placebo or current standard therapy.

Using a randomisation process to allocate patients to the different arms of a trial reduces the risk of selection bias, which is present when there are systematic differences between baseline characteristics of the groups being compared. Randomisation is best done using a computer-generated sequence that is independent of influence from the investigators. A trial that conceals group allocation from both the patient and the investigator is described as double blind, in that neither know if they are receiving the new treatment or the alternative be that a placebo or standard care. At the end of the trial, the outcomes from each arm are then compared for any differences and inferences drawn on whether the treatment is effective.

There have been many randomised controlled trials (RCT) in dentistry, all of varying standards. Although an RCT is high in the hierarchy of evidence, it is still important to critique how the research was carried out and to what standard. We will cover that in article two.

**Systematic reviews**

The highest level of evidence is a systematic review. They bring together all the existing evidence on a particular question. Systematic searches of the literature are initially broad and can result in thousands of hits on databases such as PubMed. The review team will set criteria to focus the review down to include studies that answer specific questions. They then carry out critical appraisal of the studies to assess quality. If the studies all measure similar outcomes then the results of the trials can be compared by extracting the data and using statistical techniques in a meta-analysis. This gives more weight to the studies.

**Guideline development groups**

Guidance documents aim to bring together the current best available evidence on a given topic and make recommendations. National Guidance Groups such as Scottish Dental Clinical Effectiveness Programme, Scottish Intercollegiate Network and the National Institute for Clinical...
Excellence comprise a team of expert researchers and clinicians. They have a formal methodical approach to appraising the evidence; they combine this with expert opinion to arrive at their recommendations. We will look more at guidance and the influence they have on practice in the next article, which will feature an interview with Dr Doug Stirling from SDCEP.

Conclusion

So now we have reached the top of the pyramid, and it should be becoming clear that there is a wealth and variety of information out there. We should be mindful of what evidence exists for the treatment we are providing our patients. Each type of study or research has its own pros and cons. The next article will focus on the practicalities of where to find the evidence, how to get the most out of databases and, importantly, how to critique the evidence you find.

Bibliography


References

A rare intraoral presentation of lymphomatoid papulosis

Background
Lymphomatoid papulosis (LyP) is defined as a chronic, recurrent, self-healing papulonecrotic or papulonodular skin disease.¹

- It is very rare, having an estimated incidence rate of 1.2-1.9 cases per million, with intraoral involvement even rarer with very few cases reported in the literature.²
- It displays a spectrum of histological appearances with its most concerning presentations suggestive of malignant lymphoma. Despite its potentially alarming histology, the lesions tend to follow a benign clinical course resolving spontaneously within 3-12 weeks, sometimes leaving superficial scars.¹
- It is characterised by recurrent crops of skin lesions, predominantly on the trunk and limbs.
- It tends to affect adults and can last for years or decades.
- It has no curative available treatment, but patients have a good prognosis with a 100 per cent five-year survival rate.¹

Despite this, physicians tend to have a guarded approach as these patients have a small but increased risk of developing malignant lymphomas such as Hodgkins lymphoma or primary cutaneous anaplastic large-cell lymphoma.¹

A case of intraoral LyP at Glasgow Dental Hospital is presented below, highlighting the challenges of diagnosing and managing this incredibly rare presentation.

Case description
A 72-year-old male was referred urgently by his consultant dermatologist to the Oral Surgery department at Glasgow Dental

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Hospital with regard to concerning tongue ulcers. He gave a four-day history of a tender and swollen tongue, which he associated with the onset of a new medication, sacubitril/valsartan. The lesions arose two days after he started this medication. The sacubitril/valsartan was discontinued by the referring practitioner when he reported the tongue lesions. He had an extensive medical history including COPD, heart failure, myocardial infarctions and lymphomatoid papulosis affecting his skin, as well as polypharmacy. He was a heavy smoker and had a history of alcohol abuse.

Extraoral examination was unremarkable. Intraoral examination revealed two large raised, firm ulcers on the left dorsal surface of the tongue crossing the midline. The larger ulcer measured 1.5cm in diameter. The acute onset of the lesions was unusual. Oral lesions are not listed as a side effect of sacubitril/valsartan in the BNF. Their concerning characteristics led to the provisional diagnosis of a squamous cell carcinoma and consequently an urgent incisional biopsy.

**Histopathology**

Histopathological analysis, from the incisional biopsy of the tongue suggested a CD30 positive lymphoproliferative disorder.

**Discussion**

Without the availability of previous skin biopsies for comparison, a more sinister diagnosis may have been suspected, potentially leading to more aggressive and debilitating management.

The differential diagnosis included mucosal/cutaneous anaplastic T-cell lymphoma, mucosal/cutaneous involvement by systemic anaplastic lymphoma, transformed mycosis fungoides and lymphomatoid papulosis. Fortunately, identical cellular changes were seen in previous skin biopsies and the unusual and correct diagnosis of lymphomatoid papulosis of the tongue was given.

Oral involvement of LyP is incredibly rare, with fewer than 20 cases reported in the literature. In these cases intraoral lesions predominantly affected the dorsal surface of the tongue, similar to this case, but lesions on the commissures and the uvula were also reported. For these cases, most of the patients already had a diagnosis of LyP affecting the skin prior to oral involvement, which would have greatly facilitated the diagnostic challenge.

The patient was under the care of Dermatology regarding his LyP skin lesions. Past management of his skin lesions included:

- a conservative approach – allowing time for spontaneous resolution
- excision
- topical steroids.

Further treatment options suggested in the literature for LyP skin lesions include:

- a low-dose of oral methotrexate – the most effective treatment available to suppress the development of new LyP skin lesions
- PUVA (psoralen ultraviolet
- A light therapy)
- chemotherapy.

Unfortunately, there is limited guidance in the literature on how to manage intraoral LyP lesions. However, as these lesions often resolve spontaneously, treatment is not always advocated.

After liaising with Dermatology, a topical betamethasone mouthwash was prescribed for symptomatic control and the lesions were monitored until they resolved within a three-week time period without incident.

**Learning points**

- Diagnosis and management of this rare condition and even rarer intraoral presentation proved challenging due to the lack of cases and guidance in the literature.
- As the condition can be easily misinterpreted for something more sinister, it is important that clinicians and pathologists are aware of this, to prevent unnecessarily aggressive management.
- Formal reporting of intraoral cases of LyP is crucial to build up a reference base for future clinicians.
- Long-term follow-up is important as these patients are at risk of developing a malignant lymphoma.

M.D. 2000.

Available at: [https://profiles.nlm.nih.gov/ps/access/NNBBJT.pdf](https://profiles.nlm.nih.gov/ps/access/NNBBJT.pdf)
Fig 1: Clinical photograph of the tongue ulceration at initial examination

Fig 2: Low-power view, X20 magnification, H&E stain

It demonstrates:
• heavily stratified squamous epithelium towards one edge
• an area of ulceration towards the other edge
• diffuse infiltrate of lymphoid cells in the underlying skeletal muscle bundles

Fig 3: Medium-power view, X100 magnification, H&E stain

It demonstrates:
• the squamous epithelium overlying the lymphoid infiltrate
• there is no epidermotropism of the large lymphoid cells

Fig 4: High-power view, X400 magnification, H&E stain

It demonstrates:
• the lymphoid infiltrate
• large, pleomorphic lymphoid cells with vesicular nuclei and prominent nucleoli

Fig 5: High-power view, X200 magnification, CD30 immunostain

It demonstrates:
• the large lymphoid cells stained positively with CD30 immunostain in a membranous and cytoplasmic pattern

Fig 6: Clinical photograph of the tongue at two-week review appointment. There was some firmness on palpation. The lesion had improved dramatically

References


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dentistry is tough. Treating conscious patients by carrying out procedures to a technically high standard in a sensitive area is never going to be easy. Practicing professionally with an overarching atmosphere of fear of potential litigation and the need for compliance with sometimes abstract rules makes for a challenging life.

Little wonder then, that problems with stress and burnout are growing, and I have had many painful conversations with individuals following my presentation, “Is dentistry making you sick?”

There is clearly a need for an improvement in individual resilience, but that will be wasted if the organisation where you work does not take its own resilience seriously. In this article I want to discuss the “Resilient Dental Practice”, what it means, why it is important, how to build one and most important, how to maintain it.

“All things should be kept as simple as possible, but no simpler.” These wise words from Albert Einstein reflect my views on building the resilient practice which I define as “The ability of a dental organisation to quickly absorb and adapt to the impact of an external or internal stressor or disruptor without a noticeable drop in its level of patient care and service.”

We live in a world often described by the acronym “VUCA”. It’s Volatile, Uncertain, Complex and Ambiguous. The rate of change both within and outside dental practices is increasing; the pressures of running a successful dental business grow higher with every passing day. In order to succeed there is a need not only to be able to cope with the daily challenges that life and business are going to throw at us but also be ready for whatever the future will bring.

The four facets of resilience have been defined as preparedness, protection, response and recovery; I will reflect these in the following eight characteristics of a resilient dental business.

1) They have standard operating procedures. These can be defined as a set of step-by-step instructions for each process within the business. These individual sets build one on the other to produce a manual of “how we do things”. From decontamination to marketing and answering the telephone.
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to giving a perfect local anaesthetic, all processes are examined and described. Building these small steps into larger blocks means they can be regularly examined and amended in the light of experience, new knowledge or business demands.

2) They understand that change will happen, they do not resent it, but rather, they embrace it. They understand that change is the only constant and that any (dental) business which wants to be and remain successful must be ready for changes and the challenges they bring. A resilient business has a competitive edge in the marketplace.

3) The people are trained and ready. From owner to apprentice, there is an emphasis on constant training. That can be in clinical procedures, where they are always seeking to look round the next corner for coming advances in procedures, materials or equipment, or business ideas and practice.

4) There is a clear “Purpose of the Practice”. Often overlooked or allowed to lapse, it is important everyone understands that in addition to “what we do and how we do it” all can embrace, “why we do it”. Simon Sinek’s book Start with Why is a great source of inspiration.

5) There are clear plans for action in the event of necessary change. I should point out that too often change is viewed as a negative, and certainly we must be aware of threats to the smooth flow, success and profitability of the business but change can be a power for good.

6) The people talk to each other. There are routine and regular meetings and conversations between all team members. These are not “top down” sets of instructions, or monthly moans rather they are opportunities to look, listen and learn from each other.

7) They are proactive rather than reactive. Most of the changes in the business happen because they have seen the need ahead of time rather than waiting for the worst to happen. Even when the unseen or unexpected occurs there is a discipline within the organisation that understands what is most important and what has to be prioritised. In dentistry, this of course is patient care so that, no matter how trying or testing the challenge, the patient will not be inconvenienced or any disruption will be kept to a minimum.

8) Finally, the leaders lead effectively. In his excellent book about his life as a restaurant entrepreneur, Danny Meyer wrote, “The hallmarks of effective leadership are to provide a clear vision for your business so that your employees know where you’re taking them; to hold people accountable for consistent standards of excellence; and to communicate a well-defined set of cultural priorities and non-negotiable values. Perhaps most important, leaders hold themselves accountable for conducting business in the same manner in which they have asked their team to perform.”

In an ideal world, all change would be incremental with as few shocks as possible. The practice that works on and builds its resilience is prepared for change, it operates in a state of constant “Flow” and, instead of an atmosphere of crisis, always keeps its calm. No matter what the threat – or opportunity.
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New!
What does practice growth mean to YOU?

Understanding the difference between sales, margin and strategic growth will help you to achieve what’s best for you, your practice and your patients.

Richard Pearce

Growth is talked about often, whether in relation to a dental practice or the economy as a whole. But do we properly understand it and know what sort of growth we want? Here, we will consider different sorts of growth and make observations in relation to a single practice and consider growth to create a small group of practices.

Normally we think in terms of growth in revenue, not least because this does tend to lead to growth in margin (profit). But you could be more interested in the growth of you and your family. This may mean that the practice affords you a three-day “clinical” week, crucial time out of the practice, but still provides your minimum income requirements.

Let’s consider three types of growth within a practice:

1) Sales growth – more revenue, fill the appointment book, do more per hour

2) Margin growth – increase prices/reduce costs

3) Strategic growth – increase opening hours, add more surgeries, add specialisms, add practices.

Practices have traditionally focused on sales growth – with offers, for instance – but more recently, some have started to realise that brands sell faster. This is evident by the rise in significance of reviews. Reviews don’t dwell on how cheap the appointment was (see FREE consultation), but on the friendly staff, the dentist who didn’t hurt and a great “experience”.

Videos sell a brand and therefore some are realising this. Going to the dentist (and receiving significant dental treatment) is an emotional journey for...
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[Images of toothpastes and restorative products]
Connecting with patients’ emotions can lead to real margin growth.

So, if your practice is not delivering what you want in terms of income and/or non-clinical time then it needs to change – to grow. So be clear about this to begin with. Create a brand and then promote it consistently through your staff and then through every part of how your patients ‘meet’ you. This means that your website, with videos, the practice kerbside appearance, the entrance and the marketing collateral are all consistent with a brand that connects with the patients you want.

**A word on strategic growth**

Top down works faster!

This means that if you started with a vision that you would have 10 practices (key criteria: less than one hour’s drive between any practice), then you can organise operations so much more effectively from the outset. Therefore, achieving your aim so much quicker.

And don’t forget the ‘Rule of 150,’ referred to by Malcolm Gladwell in his book, *The Tipping Point*. Put simply, with more than 150 people in an organisation, communication breaks down, cohesion is lost and convergence of goals is very hard to maintain.

If I was a 35-year-old dentist, currently working as an associate (who wanted to sell a business and potentially retire at the age of 50), I would consider the following strategic growth plan:

- Decide on the geographical area I want to be in for the next 10-15 years.
- Target where my first Practice will be – which town(s).
- Be able to list what it will have (no fewer than four surgeries might be one requirement).
- Start looking – it could take a while!
- Acquire the first Practice and think ‘10 Practices working as a coherent Group’ from Day 1.
- Hire the best (associates and support staff, particularly a business manager).
- Develop operational standards that you can keep replicating.
- Become known throughout the area as a great dentist and practice owner (you want nearby practice owners to come and ask you to buy them).
- Be ready to acquire ad-hoc – practices won’t become available just when it’s right for you.
- Think group/integration/economies of scale at every step.

But remember, nothing goes according to plan! So, you need to maintain some flexibility and be ready for the unexpected.

Growth is a very over used and misunderstood term. Understanding the difference between sales, margin and strategic growth might help you achieve the most important type of growth – growth for you and your family.
The process of getting straighter teeth can be a daunting prospect to patients, particularly those who previously had metal braces in their childhood and don’t feel comfortable going through that process again. Add into the equation the shift to a world where we are living our lives online, travelling frequently and are used to receiving everything instantaneously and the traditional process of getting braces is not an attractive option.

Cosmetic dental company Your Smile Direct is working to change that by bringing cutting-edge orthodontic technology directly to consumers. Focusing on minor or moderate concerns like gaps, crookedness and overcrowding, Your Smile Direct uses clear aligners to straighten teeth in an average of 20 weeks. The aim is to make straight teeth more accessible and more affordable for customers worldwide.

The process is simple; following a free 30-second smile evaluation taken on their website, customers can choose between a brief 30-minute visit to one of Your Smile Direct’s Smile Clinics to get a 3D scan taken, or ordering a Home Smile Kit to create their dental impressions themselves from the comfort of home.

Clinics are currently based in Glasgow, Dublin, London, Manchester, and Paris. A personal 3D treatment plan is then created by a registered and licensed in-house dentist and put into place for each customer. Once the customer is happy with the suggested treatment, custom-made aligners are delivered straight to their door.

Your Smile Direct has a dedicated smile care team on hand, which includes in-house licensed dentists across six countries, through every stage of the process to make the process as smooth, safe and timely as possible for patients. They are available by phone, email or social media to answer any questions clients may have about treatment before starting. At the click of a button they can be on the way to achieving their perfect smile.

Treatment costs £1,399 upfront or 36 monthly payments of £41 with a £185 deposit. This includes a final retainer sent at the end of treatment that helps maintain the results.

With customers embracing technology and seeking greater value and convenience, innovation continues to thrive. The technology is advancing, the expertise of the professionals involved is progressing and the processes are being streamlined to offer the customers the best service possible.

Please visit their website www.yoursmiledirect.com/gb and social media channels @yoursmiledirect (Instagram, Facebook, Twitter), for more information.
Invisible braces for visible confidence.

Find out how Your Smile Direct can complement your business through partnership.

yoursmiledirect.com/ie/partnership
Dental Roots concentrates on education and keeping qualified dentists and dental students in contact. Naturally, we cover many topics, and one that comes up very often is the question of loupes. We receive a variety question:

1. When should I buy dental loupes?
2. How much should I spend?
3. What magnification should I get?
4. Which company should I go to?

A poll we ran on our platform recently showed that 41.6 per cent of the students use dental loupes, which is very impressive.

I could say that one of the benefits of loupes is that you see better, but I think that is a bit obvious! It is much beyond that.

The use of loupes, in my opinion, is about caring for your patients; if you can’t see well, how can you provide them with the best quality of care?

In fact, when signing up associates for our clinics, one of the requirements we have is that they should wear loupes. We all treat our patients to the highest level possible, and if we are to get another dentist on board who could potentially be seeing our patients, they would need to be able to see the same picture!

Loupes are eye openers – literally. When you first start using loupes it hits you – what did you do all the time when you were not wearing loupes? You almost get scared to know how much you did not see.

We all want to do our best for our patients and follow the golden rule: Do good to others as you would like good to be done to you.

So if you prefer to see a professional treating you with magnification, there is no reason that you would not do the best for your patients.

Patients are very observant. After all, remember that for most of the time that they are in your surgery their mouth is open, which leaves more time for other senses to pick up on everything. They will know if you care for them, and using loupes, in my opinion, and a good make, means you cared to invest in your patients for their wellbeing.

If you asked me for straight advice without going round in circles, which is my style of giving advice, I would say you should never underinvest in your career.

1. Get loupes as soon as you can. If you can in university that’s the best idea.
2. Spend enough money to get a good pair of loupes that you would use for many years to avoid extra expense.
3. Get loupes with which you can change the magnification, or at least get one with high enough magnification that will serve you for a few years. For example 3x for check-up, 4x for crown preparations and 5x for endodontics.
4. Choose a company with a good track record, good customer service and good reviews.

Dr Saeid Haghri is a multiple-award-winning dentist. He is the founder of national organisations and communities such as Dental Roots, Make a Dentist, ToothWise and Future of Dentistry Awards. He has always been closely in contact with the young dentist and dental students to help them with their education. He owns multiple private practices and has created a diverse business portfolio.
WHY CHOOSE JUST ONE?

Why limit yourself to just one magnification power? With interchangeable telescopes you have the power to select the optimal magnification for each procedure. Offering a range of magnification powers from 2.5x-5.5x, the OmniOptic™ system is your ideal solution for simplified magnification upgrades. A lighter weight option when compared to adjustable magnification loupes, the OmniOptic system gives you a customized comfort from start to finish.

Discover the power of interchangeable magnification today.
THE SCD IMPLANT BUNDLE
Our best bundle. Without any compromise.

Our SCD Implant Bundle now offers quality components, greater compatibility with popular implant systems and the assurance of an all-inclusive price. The new Titanium Nitride (TiN) coated screw ensures reliable retention, better torqueing, and even better results for your patients.

ALL-INCLUSIVE bundle at only €299/£249

*Semi or high precious alloy extra * Standard Titanium screw available **T&Cs apply see website for details

New available with Titanium Nitride TiN coating

Every implant case is unique. Therefore we are giving you the choice. Select between Titanium or our new Titanium Nitride (TiN) coated screws. The TiN coating is an important upgrade to our product as this special surface treatment improves the performance of the screw.

- The improved, harder TiN surface provides a more stable and reliable connection with the implant.

Screw- or Cement- Retained PFM Crown
All our products are manufactured following globally recognised processes and our restorations are made under a quality management system that is certified under ISO 9001:2008 and ISO 13485:2003.

Custom Milled Abutment
For our custom, titanium milled abutments we use Grade 4 or Grade 5 quality. All components are tested under ISO 14801:2007 and we use CAD/CAM precision milling to ensure high accuracy.
**IMPLANT** COMPONENT SUMMARY

<table>
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<th>Brand</th>
<th>System</th>
<th>Platform</th>
<th>Digitek® Abutment</th>
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*Only titanium available
*One-piece design, precision machined in titanium, CoCr
Torque - recommended screw torque
*Angle, for bridge, max angle between two implants axis
For a complete list of supported implant systems, please visit our website.
THE REALITY OF EARLY ORTHODONTIC THERAPY

A short observation by Dr Skip Truitt

For more than half a century the profession has been divided over the issue of early interceptive orthodontic therapy versus delaying treatment until the patient is in the permanent dentition. In my experience it is not an issue of early versus later treatment, but rather evaluating the true underlying cause of the malocclusion in question. If, for example, the patient is experiencing an imbalance in normal skeletal growth then early interceptive orthopaedic therapy is the treatment of choice.

Unfortunately the dental literature is full of “valid research” proving early interceptive orthodontic is of no value. The documented proof is that one can take a Class I Division One malocclusion, extract bicuspids in both the mixed dentition and the permanent dentition, and obtain the same clinical results. What this research actually proves is the same incorrect diagnosis and treatment creates the same clinical result regardless as to when it is performed.

The Meredith & Rubin study of cranial facial growth showed that 40 per cent of facial growth occurs by four years of age, and more than 90 per cent by nine years of age. The classic view of this study is to consider all malocclusions to be dental in origin, and only minor tooth movement can be initiated until the patient matures into the permanent dentition at around age eleven. Therefore the patient has less than 10 per cent of the growth potential remaining when fixed orthodontic is initiated.

This is a gross misinterpretation of the Meredith & Rubin study. The study actually proves that malocclusions caused by incorrect growth should be treated as early as they can be diagnosed. If left untreated one can expect to see 90 per cent of the damage to natural facial balance by age nine.

Unfortunately, doctors treating children are forced to go outside of the teaching institutions that are dominated by classic archaic orthodontic concepts in order to obtain the appropriate information.

For more information on course one, please see the advert on the opposite page.

“IF IT IS LEFT UNTREATED ONE CAN EXPECT TO SEE 90 PER CENT OF THE DAMAGE TO NATURAL FACIAL BALANCE BY AGE 9”
Course 1

Early Interceptive Orthodontics

This superb course has led to thousands of general dental practitioners developing a thriving Orthodontic side to their practice

Presented by the world’s foremost Ortho lecturer

Dr. J.W. ‘Skip’ Truitt DDS BS

You will learn the benefits of early interceptive treatment, how to correctly diagnose and then treat developing malocclusions that you see every day in your practices.

This is the first course in a series of six courses, all lasting three days. The remaining courses will cover Fixed Appliance Therapy, Cephalometrics, Advanced Orthodontic Techniques and T.M.J. Therapy

We guarantee that your only regret after the course will be that you did not attend sooner!

Friday 30th Nov - Sunday 2nd Dec 2018

Hyatt Regency Hotel - Birmingham

This 3 day course qualifies for 21 hours of verifiable CPD.

Cost

£999

Courses sponsored by Triple O Dental Laboratories
Excellence in Orthopaedic and Orthodontic Appliances

To register or for more information on courses please contact John Marchant

Tel/Fax +44 (0)121 702 0450  john@tripleodontallabs.com
www.tripleodontallabs.com
Bupa’s growth in the dental market continues at pace, with the acquisition of four further practices in Ireland. The news means that Bupa now operates 46 practices in Ireland – 21 in Northern Ireland and 25 in the Republic of Ireland. The recent announcements include: MyDental in Ballsbridge, Dublin; Fortwilliam Clinic in Belfast and Ballymena; and Church Road Dental Care in Carryduff.

These latest acquisitions are key to Bupa’s strategy to provide high-quality dental care to customers in the UK and Ireland. In 2017, Bupa acquired Oasis dental care, and now operates more than 470 dental practices across the UK and Republic of Ireland.

Speaking of the news Catherine Barton, General Manager for Bupa Dental Care, said: “With steady forecast growth, we’re confident in the long-term success of the dental market. As such we’re keen to expand our network so that we can offer quality care to even more customers, and so I’m delighted to welcome these new practices.

“As part of the Bupa family they’ll be able to broaden their referral network and also benefit from a range of support functions, such as clinical governance and support, marketing, HR and IT. With these benefits, we’re confident that the practices will be able to grow, while maintaining their commitment to top-quality patient care.”

Bupa continues to grow its dental presence with a focus on mixed and private practices providing a high standard of patient care. In November 2017, it announced the acquisition of Avsan Holdings with 16 practices across Scotland and England, while in December it purchased Metrodental, adding two premium practices in the City of London.

Bupa now has more than 2,000 dentists and over 4,000 practice staff, providing a wide range of dental services, from general dentistry to cosmetic and specialist treatments.

With no shareholders, Bupa reinvests profits into providing more and better dental and healthcare for the benefit of current and future customers.

THINKING OF SELLING your practice, now or in the future? Contact Bupa today:
Call: +44 (0)1454 771 575
Email: M&A@bupadentalcare.co.uk
Visit: bupa.co.uk/sellingyourdentalpractice
Sell your practice and be part of something exciting

As one of the leading providers of dentistry in the UK and Ireland, we can bring a wealth of experience and expertise to help your practice build on its success. And while we take care of the day-to-day running of the practice, you can dedicate more time to your patients, family or even yourself.

Talk to us today about:

☑️ selling your mixed or private practice
☑️ our range of support services from clinical governance, marketing, HR to IT
☑️ indemnity insurance, with access to legal advice
☑️ CPD packages and training
☑️ personal clinical support

For a free, no obligation valuation
📞 +44 (0)1454 771 575
✉️ M&A@bupadentalcare.co.uk
🌐 bupa.co.uk/sellingyourdentalpractice
**EXPANSION FOR MC REPAIRS**

Maddalena and Carl Wise’s mission to offer dental practices the very best in equipment support has been a huge success… and that’s good news for customers, as the business goes for growth.

MC Repairs Ltd was formed in 2009 by husband-and-wife team Maddalena and Carl Wise. Their vision was to create long-term relationships with practices throughout the UK and help practices to understand how to get the most from their repair bills.

Carefully selected components from around the world ensure repairs stay in practice for the optimum amount of time, and maintenance advice helps to keep equipment in tip-top condition. Customers then benefit over the long term when they see their average spend declining over the years.

Due to their success, the Wises are now about to move their two business brands and the teams to a new state-of-the-art workshop facility and warehouse to further aid the growth and provide even more to the industry.

Carl has now been in the industry 20 years and knows handpieces, scalers, motors, couplings etc. like the back of his hand. All makes and models can be catered for, and no particular brand receives priority. The teams at MC are trained to recommend the best options/brands for the practice in question. Talk to anyone on the team and you will be tapping into a combined knowledge of well over 50 years in the dental industry.

MC Repairs Ltd is independently verified to ISO 9001:2015 on an annual basis. Components are selected carefully from around the globe or customers can opt to have only OEM components fitted to their equipment. All quotations are provided totally FREE of charge by using either our FREEPOST repair packaging or arranging a collection online. Equipment repairs are quoted upon receipt and 99 per cent of the time can be returned within 24 hours, as we know you can’t be without your instrument for too long.

MC Dental Equipment Ltd is the brand used to showcase the wide range of products the team recommend and have on offer, including handpieces, scalers, motors, implant units, autoclaves, scaler tips, lubrication – there is so much to choose from. You can view the complete catalogue online or request a regularly updated offer brochure spotlighting the best offers from the best brands around the world.

Follow Maddalena and Carl and their team on all of the social media outlets. From tips and news to offers to keep you always up to date, you will not be disappointed Contact 01253 404774 or visit www.mcrepairs.co.uk or www.mcdental.co.uk
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Progressive approach in everyday oral health care

At this year’s EuroPerio9 congress, Zendium from Unilever showcases a remarkable set of data that demonstrates how daily use of this unique toothpaste improves gingival health by balancing the oral microbiome.

Results are perfectly aligned with the evolving view of the pathology of periodontal disease, which puts microbial balance, rather than microbial elimination, at its heart.

Zendium is a toothpaste that works differently. In addition to fluoride, its unique SLS-free formulation contains natural enzymes and proteins which boost the natural salivary defences and balance the oral microbiome. A study in 2017 showed that over 14 weeks’ use, Zendium significantly increased health-associated bacteria and significantly reduced disease-associated bacteria. These findings complement a growing expert consensus which recognises that the overall balance of the oral microbiome is key to oral health.

To find out more about Zendium visit www.zendium.com

International leaders share implant dentistry expertise

In recent years, dentistry has experienced development and health care innovations that have changed the way in which dentistry is performed.

BioHorizons, which provides education tailored to the ever-changing needs of dental professionals, is presenting two courses featuring leaders in the implant field.

On 13 October, Professor Tiziano Testori, Head of the Implant Dentistry and Oral Rehabilitation at the University of Milan, will talk about ‘Immediate Loading: State of the Art’ in Dublin.

‘Communication-Based Implant Dentistry with Dr Lincoln Harris’ is scheduled for 18 October in London. Dr Harris, a clinician in a private practice, will share his expertise and develop understanding on how to communicate effectively with patients suitable for implant treatment.

Further information and registration will be available via www.theimplanthub.com/education, email educationuk@biohorizons.com and call 01344 752560.

Durable crowns made easy

Ideally suited for the elderly who do not want to invest in more expensive longer-lasting restorations, patients with a limited budget and children requiring a space maintainer following tooth loss, DMG’s new LuxaCrown enables simple, quick and cost-effective chairside fabrication of long-lasting crowns. The result is an incredibly precision-fit, aesthetic and long-lasting restoration, which can be worn for up to five years.

As well as excellent flexural strength, it possesses outstanding fracture toughness that ensures long-term stability of semi-permanent restorations. With a Barcol hardness of 54, in-vitro studies have confirmed its high mechanical strength. Its unique indication as a semi-permanent crown and bridge material with outstanding wear allows for a wide range of indications.

For further information contact your dental dealer or DMG Dental Products (UK) Ltd

Outstanding cement that blends in

DMG has launched a temporary luting cement that stands out by blending in!

TempoCemID is a translucent, dual-cure composite luting cement for temporary luting of all kinds of temporary restorations.

Invisible, but detectable it can be used for temporary and semi-permanent luting of temporary crowns, bridges, inlays and onlays; and temporary luting of temporary veneers. It is also ideal for luting implant-borne restorations.

It is specifically formulated for optimal transparency so that it is invisible underneath a restoration and never impacts upon its shade. TempoCemID has a high bond strength, which is designed to prevent leakage, but still allows it to be removed easily when required.

Perfect for long-lasting restorations, it enables clinicians to see their aesthetic worries vanish before their eyes.

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Quintess Denta are delighted to announce their distributorship for MICRO-MEGA. MICRO-MEGA, whose history dates back to 1905, has always been at the forefront of technology and holds internationally recognised know-how in the design, manufacture and marketing of medical devices for use by dental specialists around the world (root canal instruments, obturation, handpieces and instrument hygiene).

“We are thrilled to supply the superb range of products from MICRO-MEGA including the One Curve. This innovative product is loved by dentists around the world for its efficiency and value,” said James Hamill, CEO, Quintess Denta. One Curve is a smart, efficient and conservative instrument that simplifies canal preparation, reduces time for canal shaping, respects the original anatomy of the tooth, has proven cutting efficiency and uses a simple protocol with a direct downward movement to the working length. Its variable cross-section means less ‘dragging in’ and better centring of the file. C-wire is 2.4x more resistant to cyclic fatigue fracture. This very cost-effective rotating system comes with a risk-free trial from Quintess Denta.

For more information and to avail of some introductory offers, visit www.quintessdenta.com

From left: Stephen Wilson, Sales Manager; James Hamill, CEO, Quintess Denta; Florian Donnard, Area Sales Manager, MICRO-MEGA; Ian Creighton, Implant Sales Manager, and Peter Greene, Managing Director, Quintess Denta
Quintess Denta
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Programme details and registration is available on asm2018.ie