“The question is: Are clinics going to allow time for change?”

An interview with dental hygienist-therapist Theodora Little, London

About six months ago, London-based dental hygienist-therapist Theodora Little spoke openly about an issue that many dental clinics are facing right now: how are dental hygienists able to undertake essential care and thorough oral hygiene instructions in 20- to 30-minute appointments? In an interview at the BDHA Dental Showcase in London in the UK this year, Theodora introduced to a new prevention concept, individual training of oral prophylaxis, that will empower patients to maintain their oral health and thereby ultimately prevent dental disease.

Dental Tribune: Theodora, you graduated from King’s College London in 2013 with a diploma in dental hygiene and therapy. Why did you see a need to speak up for a change in oral hygiene instructions among dental professionals?

Theodora Little: We all want to do the best for our patients, but unfortunately, owing to time constraints that we have implemented here in the UK, it is not possible to carry out effective and thorough oral hygiene alongside education. During my time at university, our oral hygiene instruction training was very theory-based, with a few representatives visiting to demonstrate and provide different products. Unfortunately, we did not receive any interactive practical training on brushing with an instructor, which was a shame. I learnt more about the different techniques that have been used and recommended over the past years. This is why individually trained oral prophylaxis, or the iTOP programme, has become more important than ever. iTOP involves visual education on the techniques and products, all of which help motivate and empower patients. You say that iTOP changes the way patients are treated—both personally and clinically.

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Yes, because one goes back to the basics and prevention is, after all, the main priority. We do not want to be seen as contributors to this drill, fill and bill philosophy. iTOP combines relationship building through thorough communication and education, including touch to teach. If we can take dentistry back to the basic aspect of prevention based on this philosophy, then we can help prevent dental disease and empower our patients to then implement preventative measures on a daily basis at home.

Do dental practices really have the time to implement this plan?

In the UK, most dental hygienists have 20- to 30-minute appointments. I have worked to this pressured schedule in the past, so I understand how difficult it can be to educate, carry out thorough oral hygiene and answer any questions a patient may have. I was left feeling empty at the end of each day and questioned whether I was really helping and making a difference to my patients. I am now fortunate, as I work in a clinic where we have hourly appointments in order to provide a unique and tailored preventative service. Communication is key to successful education and oral hygiene; therefore, it should be a priority and hygiene should be given adequate time for delivery thereof. If one can educate the patient, prevention will follow and subsequent conveyor belt appointments will be eradicated. Unfortunately, many people do not like change, but it is sometimes necessary for long-term benefits.

A while ago, Chief Dental Officer for England Dr Sara Hurley said that one does not need to visit the dentist twice a year. What do you think about this?

As a hygienist-therapist from a prevention perspective, I prefer to see a patient on a regular basis. We are all human and it can be difficult sometimes with life’s twists and turns to continue with a daily habit. I find habits can easily be broken when something of greater importance pops up. Therefore, many patients need regular super-

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Could you tell us more about the state of oral health in the UK?

It certainly depends on the region and age group of patients one is treating. I have found that, since working in the Curaden clinic in London, I have treated more patients with tooth surface loss and recession rather than periodontal disease. This may be because of the age group, combined with the fact that they appear to be extremely health conscious. This, in turn, involves a very acidic diet, owing to the consumption of fruit on a regular basis in different forms, constant sipping when exercising and using many of the in products, but in the incorrect way, or perhaps using what is not right for them. Over brushing with potentially abrasive whitening toothpaste can contribute too. Tooth surface loss can then lead to hypersensitivity, which can be unbearable for some patients. Therefore, we continue to proceed with itOP, together with high-quality products, such as CURAPROX’s CS 5460 toothbrush.

Which do you recommend: dental floss or interdental brushes?

Every patient and his or her mouth is different, so one size does not fit all. I tailor recommendations based on the individual. Some patients may have larger interdental spaces and in general I would then recommend interdental brushes, as one can use theseatraumatically if the right size is selected and the correct technique has been demonstrated. Flossing can cause trauma if used incorrectly, and the time to teach is needed. As with every dental aid, the technique, quality and training given with that aid and for that individual patient are of most importance. However, if my patients prefer one product over the other and refuse to use interdental brushes, for example, then I would rather have them using floss than nothing at all. Still, the important thing is taking the time to discuss the different products with the patient and their benefits and then demonstrate the technique through touch to teach. However, this is where we need time, and the question is: are clinics going to allow time for change?

Thank you very much for the interview.