**GDC vote for Direct Access**

New era for hygienists and therapists as vote allows patients to see them without dentist prescription

After months of research and consultations, the recommendation for Direct Access was passed on Thursday 28th March, with 20 votes for and two abstentions.

As a result of the vote at the GDC, dental nurses will also be allowed to carry out preventive programmes. This means that hygienists and therapists will be permitted to carry out their full scope of practice without prescription and without the patient having to see a dentist first.

Orthodontic therapists should continue to carry out the major- ity of their work under the pro- scription of a dentist, but can carry out Index of Orthodontic Treatment Need (IOTN) screen- ing without the patient having to see a dentist first.

Clinical dental technicians should continue to see patients direct for the provision and mainte- nance of full dentures only and should otherwise carry out their other work on the prescription of a dentist.

With Evlynne Gilvarry commenting that much has already been done in anticipation of the Direct Access vote being passed, 1st May has been confirmed as the implementation date.

Chair of the GDC Kevin O’Brien said: “This decision has been made with patient safety as an utmost priority. Registrants treating patients direct must only do so if appropriately trained, competent and indemnified. They should also ensure that there are adequate onward re- ferral arrangements in place and they must make clear to the pa- tient the extent of their scope of practice and not work beyond it.”

The British Association of Dental Nurses (BADN), the UK’s only professional association for dental nurses, welcomed the recent decision by the General Dental Council (GDC) to remove the barriers to Direct Access for Dental Care Professionals (DCPs).

For dental nurses, this de- cision means that, from 1 May 2013, they can participate in pre- ventative programmes without the patient having to see a den- tist first, providing that they are trained, competent and indemnified for any tasks they undertake, work within their scope of prac- tice and follow the GDC’s “Stand- ards for Dental Professionals”.

BADN President Nicola Do- cherty said: “BADN welcomes this decision to allow patients direct access to dental care pro- fessionals. We are particularly pleased that dental nurses with appropriate Oral Health qualifi- cations will now be able to make full use of their skills.

“However, we do draw dental nurses’ attention to the fact that if they are doing so they MUST be trained, competent and indem- nified for any tasks they under- take. It is a dental nurses’ own responsibility to ensure that s/he is fully indemnified, and BADN strongly suggest that this inden- nity includes cover of legal fees in the event of any professional misconduct charge. BADN Full members, whose indemnity cov- er is included in their member- ship, must inform our indemnity providers if they undertake addi- tional tasks. Non-members, par- ticularly those who are covered (or think they are covered) by their employers' indemnity cov- er (including so-called “crown indemnity”), should check that this cover is indeed in place and adequate (for both their own pro- tection and that of their patients) and, if they are in any doubt, con- sider joining BADN, their profes- sional association.

“It is also worthy of note that DCPs are not obliged to offer Di-
A new study published in the scientific journal Occupational Medicine has found that those who experience needlestick injuries can suffer persistent and substantial psychiatric illness or depression.

Needlestick or ‘sharps’ injuries are a daily risk to nurses, medical and health ancillary workers. The physical health effects of a needlestick injury are well known but this new research has demonstrated the mental health consequences of sharps injuries. The researchers found that those affected suffered psychiatric trauma that is similar in severity to trauma caused by other events such as road traffic accidents. This had a major impact on work attendance, family relationships and sexual health. The duration of the psychiatric symptoms were linked to the length of time the person injured by the sharp had to wait for blood test results.

Although sharps injuries mostly occur in healthcare settings, many other employees are also at risk including prison and police officers, park wardens, street cleaners and refuse collectors, tattoo artists and others who may come across carelessly or maliciously discarded hypodermic needles or other contaminated sharps. The risk causes worry and stress to the person injured by the sharp and to the employers oblige them to offer it.

“Although the majority of the thousands of bacteria found on the bib clips immediately after treatment were adequately eliminated through the disinfection procedure, the researchers found that 40 per cent of the bib clips tested had undergone standard disinfection procedures in a hygiene clinic.

Although the majority of the thousands of bacteria found on the bib clips immediately after treatment were adequately eliminated through the disinfection procedure, the researchers found that 40 per cent of the bib clips tested had undergone standard disinfection procedures in a hygiene clinic. Nevertheless, the presence of oxygen can allow bacteria to survive and grow in oxygenated environments. They found that 70 per cent of bib clips tested post-disinfection retained one or more aerobic bacteria, which do not live or grow in the presence of oxygen.

“The study of bib clips from the hygiene clinic demonstrated that with the current disinfection protocol, specific aerobic and anaerobic bacteria can remain viable on the surfaces of bib clips immediately after disinfection,” said Addy Alt-Holland, M.Sc., Ph.D., Assistant Professor at the Department of Endodontics at Tufts University School of Dental Medicine and the lead researcher on the study. “Although actual transmission to patients was not demonstrated, some of the ubiquitous bacteria found may potentially become opportunistic pathogens in appropriate physical conditions, such as in susceptible patients or clinicians.”

Led by Dr. Bruce Paster, Chair of the Department of Microbiology at the Forsyth Institute, microbiologists at the Forsyth Institute used standard molecular identification techniques and a proprietary, one-of-a-kind technology that can detect 500 of the most prevalent oral bacteria, to analyse the sampled bacteria from the bib clips. The analyses found:

- Immediately after treatment and before the clips had been disinfected, oral bacteria often associated with chronic and refractory periodontitis were found on 65 per cent of the clips.
- After disinfection, three of the bib clips (15 per cent) still had anaerobic Streptococcus bacteria from the oral cavity and upper respiratory tract.
- Additionally, after disinfection, nine clips (45 per cent) retained at least one anaerobic bacterial isolate from skin.

The main health implications of needlestick injuries is probably psychiatric injury caused by fear and worry.”

The Society of Occupational Medicine called for a much greater awareness of the psychosocial and physical effects of needlestick injuries. Workers who experience a needlestick injury need fast access to occupational health support, rapid results from blood tests and access to psychological support where appropriate. Occupational health specialist can help employers by undertaking a risk analysis and preventing and minimising exposure.

**Dental bib clips harbour oral and skin bacteria**

Researchers at Tufts University School of Dental Medicine and the Forsyth Institute have published a study that found that a significant proportion of dental bib clips harboured bacteria from the patient, dental clinician and the environment even after the clips had undergone standard disinfection procedures in a hygiene clinic. Nevertheless, the presence of oxygen can allow bacteria to survive and grow in oxygenated environments. They found that 70 per cent of bib clips tested post-disinfection retained one or more aerobic bacteria, which do not live or grow in the presence of oxygen.

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Researchers from the universities of Granada and Murcia have confirmed the effectiveness of a spray containing one per cent malic acid, which greatly improves xerostomia, or dry mouth, caused by anti-depressant drugs.

As the main author of this study, University of Granada lecturer, Gerardo Gomez Moreno, explains, one of the main causes of dry mouth is the consumption of different medications. “There are over 500 drugs, belonging to 42 pharmacological groups, which can provoke xerostomy as a side effect. Those that are most related are anti-depressants, the prescription of which has increased over recent years, thus leading to a higher number of patients with xerostomy from taking anti-depressive drugs, above all in 45-50 year olds”.

The University of Granada research was carried out in a double-blind randomised clinical trial on 70 patients diagnosed with anti-depressant-induced xerostomy, split into two groups. The first group of 35 patients took a sialogogue mouth spray (one per cent malic acid), while the second group - also consisting of 35 patients - received a placebo. Both products were applied on demand over two weeks. To check the xerostomy both before and after applying both the product and the placebo, the researchers used a specific questionnaire, called the Dry Mouth Questionnaire (DMQ).

Dr. Gomez Moreno points out that there are various therapeutic possibilities for treating xerostomy (sialogogues, salivary substitutes, other general treatments), “although the effectiveness of many of them is controversial. For example, some studies have described citric and malic acid as salivary stimulants, even though, for years, their use was rejected due to the possible de-mineralising effect on tooth enamel”.

The results have been published in the latest edition of the Official American Journal on Depression and Anxiety.
Regular aspirin use cuts mouth cancer risk

Taking a regular low dose of aspirin could prevent head and neck cancers by almost a quarter, according to new research. The results of the study, published in the British Journal of Cancer, concluded that people were almost a quarter (24 per cent) more likely to avoid developing head and neck cancers if they took aspirin on a weekly and monthly basis. Throat cancers had the most benefit from regular aspirin use.

More than 16,000 people in the UK are affected by head and neck cancers every year. One of those is mouth cancer, a disease on the rise that affects more than 6,000 people and claims more lives than testicular and cervical cancer combined.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, stressed the importance of the findings but urged a word of caution.

Dr Carter says: “Mouth cancer cases are increasing, so this piece of research is encouraging. Regular aspirin use has been linked to preventing a number of cancers, and if it is a particularly successful practice for warding off mouth cancer, it should act as a springboard for more research.

“But as much as these results are encouraging, people should not be fooled into thinking that taking aspirin counteracts the dangers of mouth cancers such as the older people get, often the harder it can be to quit.”

Using data from the National Cancer Institute Prostate, Lung, Colorectal and Ovarian Cancer (PLCO), a large scale investigation of the effect of aspirin and ibuprofen on head and neck cancer risk was undertaken. For those aged 55-74, a “significant” reduction of head and neck cancer risk was undertaken. For those aged 55-74, a “significant” reduction of head and neck cancer risk was undertaken.

Tobacco display ban helps young people quit

One in four young people who gave up smoking last year said the ban on displaying tobacco products in large shops helped them quit, a survey has found.

Just over 25 per cent of ex-smokers between the ages of 18 and 24 said that keeping the products hidden had encouraged them to kick the habit.

On April 6 last year supermarkets and other large shops were prohibited from displaying cigarette packs to the public.

The poll of 1,000 former smokers, conducted by Ipsos MORI on behalf of ASH, found that of all smokers asked, 17 per cent of all smokers found the measure had helped them quit smoking.

Young smokers say display ban helped them quit

Different times for loading implants don’t determine success rate

A new study has been published by The Cochrane Library, exploring whether there is a difference in success rates between immediately and early loaded implants compared with conventionally loaded implants.

Twenty six trials including a total of 1217 participants and 2120 implants were involved in the study. This review looked at the effects of attaching artificial teeth either the same day that the implant was placed, or early (after only six weeks) compared to the usual delay of at least three months.

Some studies also compared the artificial tooth being attached so that it did not touch the opposite tooth (non-contiguous loading). The review found no evidence that attaching artificial teeth either immediately, after six weeks (early) or after at least three months (conventional) led to any important differences in the failure of the implant or the artificial tooth, the amount of bone which surrounded the implant (any bone loss would be an undesirable consequence).

The authors concluded that more research needs to be done in this area.

Twenty five types of bacteria found in biofilm

A team of researchers led by scientists from the J. Craig Venter Institute (JCVI) has published a study outlining the recovery and genomic analysis, using single-cell genomic techniques, of a periodontal pathogen, Porphyromonas gingivalis, from a hospital sink. This is the first time that a single-cell genome sequencing approach was used to isolate and analyse a single microbe from a biofilm in a healthcare setting. The team, led by JCVI’s Jeffrey McLean published their study in the April 5 edition of the journal Genome Research.

Understanding the community of microbes living in biofilms, especially those in healthcare settings, has been limited partially because pathogens can be in very low numbers and many other bacterial types are not easily cultured. A method for DNA sequencing from single cells developed by JCVI’s Roger Lasken group, is now allowing researchers to sequence the vast numbers of uncultured microbes in the environment. With this approach this team hopes to sequence many hospital pathogens that have been otherwise inaccessible.

In this study the team targeted bacterial cells in a biofilm sampled from a hospital bathroom sink. Using single-cell genomic sequencing combined with a new single-cell genome assembler, SPAdes, developed by Pavel Pevzner, University of California, San Diego, the team found 25 different types of bacteria within the biofilm. The bacteria represented environmental species, human commensals and human pathogens.

The team then reconstructed a near complete genome of one specific periodontal pathogen, P. gingivalis (designated as JCVI SC001) from a single cell. While this globally important pathogen is well known, only three other P. gingivalis genomes have been sequenced to date, and all of those were cultured from patients. This is the first strain sequenced from a single cell from the environment. The team was able to compare the JCVI SC001 strain to the cultured strains, finding it to vary by 524 unique genes, some potentially altering its virulence. The team believes that the JCVI SC001 strain could potentially contain adaptations relevant to survival outside of the host and to transmission to humans.

The scientists conclude that using single cell sequencing and analysis will open up new avenues of research into environmental samples, including healthcare settings where biofilms are critical in harboring pathogens that contaminate water sources, medical instruments and catheters. This has important implications in better understanding infectious disease especially modes of transmission as well as the spread of antibiotic resistance.
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**Dental cuts proposals deeply flawed, says BDA**

Proposals that threaten to set back the cause of improving Northern Ireland's oral health are deeply flawed and must be reconsidered, the British Dental Association (BDA) has warned.

Responding to the Department of Health, Social Services and Public Safety’s consultation on the treatment available in General Dental Services, BDA Northern Ireland has warned that the proposals will undermine dentists’ attempts to improve oral health in communities by placing restrictions on treatment.

The proposals would slash the funding available to dental practices, make many treatments – including bridges and some root canal work – subject to bureaucratic prior approval processes that will cause anxiety and uncertainty for patients, and undermine the patient-practitioner relationship.

The BDA has also warned that the proposals could, if implemented, have unforeseen economic consequences for dental practices and businesses that depend on their core service that puts health and patient care, jobs and the viability of dental practices at risk. They are based on saving money and put pounds before patient care. That is, quite simply, wrong. BDA Northern Ireland led a campaign of opposition against the proposals, encouraging dentists and patients to make their views on the consultation known. A BDA-organised petition against the proposals has attracted more than 5000 signatures.

**Lucky dental winners donate prize to charity**

A couple of patients from Queensway Dental Clinic, who won a £2,500 holiday with oral health care brand TePe, have decided to kindly donate their prize to charity.

Susan and James Williamson from Billingham entered the competition to win a £2,500 holiday when attending their regular appointment at Queenway Dental Clinic, where they have both been patients for more than 30 years. And while most people would be booking the first flight to somewhere hot and sunny, the couple have instead generously decided to donate the prize to a charity.

Susan shared her excitement after discovering they had won the competition: “We were delighted to win the prize and it was quite a shock, but we’re not big travellers so it was lovely to be given the option to donate the prize to a charity. We’ve both been patients at Queenway for decades and my husband uses the TePe brushes, so just to be offered the chance to enter the competition as a thank you from the companies was lovely, but to actually win it was great.”

The British Dental Health Foundation is looking for Buddies to improve children’s oral health.

The charity is asking dental care practitioners, oral health promoters and oral health promotion units to take up the challenge and visit local schools in a bid to increase oral health education in the classroom.

Latest figures reveal a third (35 per cent) of 12-year-olds have some kind of cavity while around one in seven (14 per cent) of eight-year-olds have signs of decay in permanent teeth, with one in 100 losing a tooth to decay.

Children who learn good oral health habits early are far more likely to carry them into adulthood – that is why the Foundation has launched www.dentalbuddy.org – a website with a range of free materials and resources to encourage more dental professionals to forge links with schools and deliver oral health messages to children in the community.

The symbol of the campaign is Buddy, a spaceman character who will set out to explore oral health in partnership with children.

Director of Educational Resources at the Foundation, Amanda Oakley, is asking for dental professionals to become a ‘Buddy’ themselves and take their expertise into the classroom. Amanda said: “Trainers have a lot of pressure to deliver education that meets national targets in literacy, numeracy and areas such as Personal, Health & Social Education, which oral health happens to fall under.

“By going into schools and nurseries, and sharing their knowledge and experiences, dental professionals and oral health teams can really make a positive difference for many children in the UK, particularly in more deprived areas where inequalities in health are more apparent.

“Oral health levels of children in the UK are generally very good but fundamental problems still exist. Children not being taken to the dentist, not being provided with toothbrushes and fluoride toothpaste and having imbalanced diets loaded with sugar. These are basic lessons we can pass on directly to the children themselves and teach them the value of good oral hygiene.”

Resources on the website include lesson plans, activity sheets and presentations, geared specifically towards Early Years, Key Stage One and Key Stage Two children.

**Do you have what it takes to be a Buddy?**

The BDHF is looking for Buddies to improve children’s oral health. Do you have what it takes to be a Buddy?
Bridgepoint acquire Oasis Healthcare

Oasis, one of the UK’s largest dental corporates, has been acquired by Bridgepoint in a transaction valuing the business at £185 million.

Founded in 1996, Oasis was de-listed from the Stock Exchange in 2007 by Duke Street who are now selling the business. Under the terms of today’s acquisition, Duke Street will rollover a portion of their proceeds to take a minority stake in the business.

BDA bids to raise £20K for charity

The British Dental Association (BDA) is encouraging the dental family to bid generously in an auction it is organising to raise money for two leading dental charities. The auction, which will be taking place at the 2013 British Dental Conference and Exhibition, is aiming to raise £20,000 to be split evenly between the BDA Benevolent Fund and the Bridge2Aid charities.

An array of prizes, including a Champagne City experience trip for two excellent charities auction and help us raise money for two excellent charities that are close to the heart of the dental family.

On course for occlusion success

Courses organised by the British Society of Occlusal Studies (BSOS) offer delegates the opportunity to attain a better understanding of occlusion for easier, more rewarding and more enjoyable dental practice.

Despite the critical importance of occlusion, dental schools cannot include comprehensive training in this subject in an already crowded curriculum. Recognising this shortfall, the BSOS has designed three complementary stages of learning to help dentists and dental technicians reap the greatest rewards from occlusion education:

1. Attending the introductory roadshow, Occlusion in Everyday Practice
2. The three-day Occlusion in Everyday Dentistry event
3. Completion of the follow-up hands-on course, Hands-on Occlusion Practical.

Successfully undertaking all three components is also a prerequisite to becoming a full member of the BSOS, since it is the only route available in the UK that allows you to meet criteria such as training in equilibration.

To find out more about the work of the BSOS, how membership of the Society can help you in practice or to book onto future courses, please visit www.bsos.org.uk or email info@bsos.org.uk.

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Call us now on 08456 123 434 or email us at team@ft-associates.com
Introducing the latest innovations at CIC 2015

Dr Adi Moran, specialist in endodontics, gives a sneak-peek at his lecture

Showcasing the latest innovations to hit the UK dental profession, Healthcare Learning: Smile-on are delighted to bring you the Clinical Innovations Conference 2015, in conjunction with the AOG and The Dental Directory. The impressive line-up of speakers will include a variety of internationally renowned professionals, all discussing the hottest topics, products and trends in dentistry. A DFT Conference will run alongside the main programme, offering London Deanery Foundation students an insight into the modern world of dentistry. Amongst the highly respected speakers will be Endodontic Specialist Dr Adi Moran. Having originally qualified with honours from Semmelweis University in Budapest, Adi undertook post-graduate training in Periodontology before going on to specialise in Endodontics. He is currently an associate clinical teacher in the Department of Endodontics at the University of Warwick, leading MSc courses and research, as well as a guest lecturer at universities around the world. He practices as an Endodontist on a referral basis at Harley Street Dental Studio and EndoCare.

“As I haven’t attended CIC before, I am looking forward to my first experience,” says Adi. “My lecture will focus on a brand new product to the UK. First introduced in the US in February 2015 and launched in Europe at the IDS 2015, I will discuss the many benefits of the new TF Adaptive NiTi system from SybronEndo. This twisted file system not only combines all the unique features of the current rotary TF systems, but also takes the advantages of the present reciprocation NiTi systems while eliminating many of their disadvantages.

Less pain
“For example, the TF-A system is designed for significantly reduced debris extrusion, a known issue with the reciprocation systems currently available. This in turn encourages less post-operative pain for the patient. Additionally, the older systems advocate the use of a single file, which sometimes isn’t the most efficient approach, especially on molar teeth. The new TF Adaptive supports up to three files, enabling the practitioner to complete a root canal treatment with one, two or all three files, depending on the canal dimensions and apical size. It utilises all the advantages of the current TF rota-

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Antimicrobial Tubing & Bottle!
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tion system, but adjusts to rotate or reciprocate in the canal based on the file load. The filing sequence is intuitive, easy to follow and highly efficient, and file matched obturation systems are also available. I am also very confident that it greatly decreases the risk of file separation in highly curved canals, and I will present interesting case studies demonstrating this. In addition, TF Adaptive is designed to work consecutively with EndoVac, the latest generation of negative apical pressure irrigation systems.

Broad understanding

“My lecture will serve as an introduction to the new product, and I hope delegates will leave with a broad understanding of the differences between the new system and older ones. I hope they take away all the advantages and disadvantages of each system and are then able to apply these in their practice, helping them to choose the most suitable file every time. I will also be using as much scientific evidence and clinical trials to illustrate my point as possible.”

With so many different ways now available for dental practitioners to gain further education and training, Adi discusses the benefits of attending events such as CIC.

“The set up of these events allows for personal interaction – delegates can ask the Specialists and experts specific questions and really get all the information they need,” explains Adi. “By name, this is the Clinical Innovations Conference, so it also presents a great opportunity for professionals to discover the very latest products and techniques to reach the industry. It’s a highly effective way for practitioners to keep up-to-date.”

Award

In addition to the conference programmes, CIC 2013 will also host the return of the Clinical Innovations Award. Recognising the newest and most influential developments and products in the profession, a panel of esteemed professionals will announce the winner during the course of the evening’s celebrations. Professionals in attendance will have the opportunity to make new acquaintances and catch up with old friends, while enjoying an evening of delicious cuisine and live entertainment.

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CIC 2013

The benefits of making gums bleed and finding out you have tooth decay

Neel Kothari discusses the hysteria behind bleeding gums

It has always bugged me that patients consider bleeding gums to be a bad thing. On the face of it, no one really wants to see their gums bleed, but if one only sees bleeding when they clean their gums is it not actually a good thing? At what point did it become acceptable to allow pharmaceutical companies to advertise that bleeding gums are bad and that their products provide a ‘total’ clean. Is the slogan ‘bleeding gums are bad’ an appropriate message or does it act to implant a suggestion that results in our patients becoming reluctant to make their gums bleed and therefore stay away from cleaning?

Television adverts from a well known toothpaste manufacturer (for legal reasons the actual brand name has been replaced with ‘Tooth-gate’ for the purposes of this article) clearly suggest that by using their products patients won’t see blood when they floss. Given that Tooth-gate claims to be used by more dentists than any other brand, I decided to investigate further.

In a poorly carried out scientific study, involving a sample of one (me) without any form of randomised double blinding, I used Tooth-gate and did not floss my teeth for four weeks in strict accordance with the manufacturer’s directions for use. No ethical approval was sought for this study on the grounds that it may infringe upon my human rights, which for the purpose of the experiment I have chosen to waive.

The results were astonishing. Four weeks into the study, I finally succumbed to flossing my teeth and found blood. Emotionally I was a wreck, having had the faintest glimmer of belief in Tooth-gate crushed out of me on the sight of blood. Thankfully I found strength through my wife Anya, who encouraged me to carry on with the study for the sake of science, however deep down I really don’t think I have fully recovered – I am told it will take time.

The presence of blood on my floss is unarguably a result of an ongoing inflammatory reaction designed to protect me against bacteria. Suggesting that a toothpaste is able to stop gums bleeding when you floss is akin to suggesting that one really does not need to floss at all, after all if there is no bleeding then surely

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About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2003, and currently works for Somerside, Cambridge as a principal dentist at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at Cardiff Eastman Dental Institute.

Comment

In a 2007 Cochrane review by Nield et al, the authors state that the results suggest that the addition of exercise alongside a reduced energy diet is the best way to promote better glycemic control in type 2 diabetes patients. Unarguably diet is linked to both diabetes and tooth decay. Anecdotally, it is interesting to note that type 1 diabetic patients tend to have low caries rates, presumably through a more carefully controlled diet. Similarly, many patients with type 2 diabetes do not present with active caries. Does this question, would they have had active caries without fluoride? And conversely if they had active caries at a younger age and consequently had changed their habits, would they have gone on to develop type 2 diabetes?

Hypothetically, if one was to find a cure for lung cancer specifically relating to smoking, would that result in an overall benefit to society as a result of reduced cases of cancer or would that result in more people smoking and accordingly dying of heart disease or other ailments? Sorry, I digress.

Until next time, remain sceptical!
Major changes to ARR makes pensions for dentists more transparent

Dentists working in the NHS should be aware of changes to the system for allocating pension entitlements. This is the advice of David Paul, a NASDAL member and an authority on dentists’ pensions in England and Wales. His remarks coincide with the issuing of the Annual Reconciliation Report (ARR), the paperwork relied upon by NHS Dental Services (NHSDS) at Eastbourne for the allocation of dentists’ pensions.

The first key change is that in future, all practice-owners must check with their associates that they have allocated the correct pension entitlement to them. The second is that the ARR for 2012/15 can be submitted electronically via the NHS portal. The electronic system requires the validation of the performer before the ARR can be submitted.

These changes have been designed to address the confusion that resulted from the 2006 Contract when the responsibility for pensionable earnings was transferred to the provider at practice level. Since no clear definition of what constituted pensionable earnings existed many performers, at least 5000, did not get their correct entitlement in the first six years of the contract.

As a result, says David, detailed discussions between NASDAL, the BDA, the Pensions Agency and NHSDS occurred during the summer and autumn of 2012. Since then, the Pensions Agency has updated its pension guide for GDS and PDS dentists. Practice-owners now have guidance to make sure the correct entitlements are allocated.

David believes that electronic submission of the ARR is the way forward, advising that dentists will find a new facility on the toolbar of the NHS dental portal enabling the ARR to be completed by the provider, authenticated by the performers and then submitted to NHSDS. Paper ARRs will be available for 2012/13, says David, but as electronic submission will streamline the whole operation, it is the NHSDS preferred option.

David added: “If dentists are concerned whether they were allocated their correct pensionable earnings between 2006 and 2012, or are confused about the current year, I urge them to talk to their specialist accountant, preferably NASDAL, who should be able to help them ensure they get the correct amount of pension.”

Finally, he reminds practice-owners that June 30 is the date by which the ARR should be submitted.

Information for dentists

Information for dentists:
The new NHS BSA guidance can be found at:

David recommends Chapter 4. These improved guidance notes clearly set out the steps to be undertaken by the provider (the contract holder) to complete the ARR.

NASDAL’s guidance written by David Paul is at: http://www.nasdal.org.uk/docs/
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Articulation papers & occlusion tips

Dr Ashish Parmar gives clinical tips for deal with occlusal contacts

All dentists have articulating papers as part of their armamentarium to make occlusal adjustments. However, we often don’t appreciate the subtle differences between the many papers and products that exist. The purpose of this article is to recommend a small number of well-designed products by one well-known manufacturer which will enable you to deliver a very high standard of dental care when assessing and adjusting occlusal contacts.

Clinical tips

Shimstock holds

The BK38 Arti-Fol® 8mm wide metallic uncoated Shimstock-film (12µ) is a high-tech test film made of metallic polyester-film. It is antistatic and can be easily held on the end of the Miller type forceps. The film is extremely tear resistant and is used for resilience testing i.e. making a note of “shimstock holds” before any treatment is carried out.

Always record a “shimstock hold” before a tooth (or teeth) is prepared. Then ensure this is re-established when the provisional restoration has been fitted. This also applies when assessing the laboratory made restoration on the master model (against the opposing model), and once the restoration has been cemented in the mouth. By making a simple note of the shimstock hold (on teeth that are not to be prepared) ensures time saving, accuracy and minimal adjustments to the occlusal surfaces of finished laboratory made restorations.

Bite registration & Shimstock holds

An excellent tip is to hold Shimstock-film between the posterior teeth (where there was a hold) during bite registration. As the bite registration material (e.g. Luxadite from DMG) is setting, resilience testing is carried out to verify with certainty the accuracy of the bite registration. This can then be recorded for the dental technician.

Help from the dental assistant

Let your dental nurse help by holding two articulation forceps bilaterally each time, as well as using gauze (to dry the occlusal surfaces), blow air from the “three in one” syringe and saliva aspiration to ensure a dry field and maximum efficiency when checking for markings.

The dentist can then concentrate more with the fine adjustments using the fast hand piece bur and avoid stopping too many times. This will make the procedure more efficient and also make it easier for the patient.

The “two phase articulation system”

I advise you make the first occlusal contact markings with BK51 paper (Progress 100 blue paper (109µ)). This paper is recommended to use initially for fixed restorations. It is a smooth fibre reinforced paper with progressive colour transfer. It can even mark well on wet surfaces due to the translucent® bonding agent. The paper also marks difficult surfaces such as highly polished crowns.

It is better to use two articulation forceps placed bilaterally. This paper is thicker and unilateral use may not be ideal due to imbalance caused in the occlusion system (including the TMJ).

This is then followed by using the BK51 Arti-Fol® metallic red paper (12µ) which marks clearly the middle of the relevant blue marks. The red spots will then be the exact spots to remove in the occlusal adjustments. Thereafter, one typically sees a blue larger zone, with a clear halo in between and a red spot in the middle.

The BK 51 paper affords a unique combination of a high-tech metal foil (Shimstock foil 12µ) and a two-sided colour coating with microfibre ground colour pigments which enable clear visible marking of all occlusal contact points. The paper also marks moist occlusal surfaces.

Interproximal tight contacts

The BK55 Arti-Fol® 8mm wide metallic red (one sided) Shimstock-film (12µ) is useful for checking approximal contact points when fitting dental bridges, crowns or veneers. Since the back of the film is metallic, it is obvious which side is colour-coated and which is not.

Articulation forceps

There are two different articulation forceps that are useful for everyday practice: the BK152 Articulating Paper Forceps and the BK 145 Arti-Fol forceps. The former is a high quality forceps with excellent fixation of the paper, as well as the ability to firmly hold the 8mm Shimstock film on the end due to a strong grip. The latter will hold the BK55 8mm test film for approximal contact area assessment.

I normally have two of the BK152 forceps ready with the Progress 100 paper and also two of the forceps with the BK51 red paper ready on each of the procedure trays. Although this results in a higher initial outlay for articulating forceps, I have found this to be time saving and therefore better in the long run.

Articulating paper to check denture contacts

One of the best papers for checking denture occlusion is the BK 81 Bausch micro-thin Articulating Paper (60µ) which is thin and tear resistant and is coated with liquid colours on both sides. The paper is also available in the horseshoe shape. This paper is useful for marking dentures; the two colours can be used for centric and excursion markings.

The horseshoe-shaped articulating papers are also especially useful for patients who tend to bite unilaterally during the occlusion test due to diminished resilience.

The dentist can immediately detect the preferred side of the mouth. Symmetrical marking of all contacts is desirable especially when testing the occlusion of full dentures which are primarily adjusted according to the concept of bilateral balanced occlusion.

Even marking of the full dental arch is essential when adjusting an occlusal device. In this respect, horseshoe-shaped papers provide a welcome relief especially when testing occlusal contacts on moist artificial surfaces.

Checking crown fits and denture clasps

Articulation papers & occlusion tips

Dr Ashish Parmar gives clinical tips for deal with occlusal contacts
I use the BK86 Arti-Spot® Highspot-Indicator (red) which is a contact colour for testing the accuracy of fit of crowns, inlays, onlays, telescopic crowns and clasps. It is applied to the test surface with a brush. The solvent evaporates in seconds, leaving a thin film 3µ thick. Every contact destroys skin colour exactly at the point of contact. The base material then shines through and high spots can be easily detected.

Arti-Spot® can easily be removed after use. Hot water, mechanical friction (eg toothbrush or floss), alcohol, isopropyl alcohol and steam ing will also loosen residual colour deposits. Marking on dental plaster can also be removed with a fine brush.

Checking interocclusal clearance during tooth preparation

The Fleximeter-Strips (BK 253) are a useful innovation

By understanding the design and differences between articulating papers allows the dentist to make accurate and precise markings. This will then help more accurate adjustments to be made rather than “just chasing the blue marks”.

The combination of Bausch PROGRESS 100° Articulating Paper, 100 microns, and Arti-Fol® metallic, 12 micron, articulating film offers considerable advantages, especially on occlusal surfaces like gold or ceramic which are difficult to examine. The first test should be made with blue articulating paper. Markings are immediately evident since the bonding agent of PROGRESS 100, Transculase®, is transferred as a fine coating.

The next step is to use a thin film (preferably red) because of its intensity and excellent contrast with blue. The colour transfer properties of the film are considerably enhanced by the PROGRESS 100’s bonding agent. This method offers the utmost reliability in accurately identifying high spot markings.
for the dentist and technician alike. These strips are flexible measuring instruments in three different thicknesses. They are very useful to assess the inter-occlusal space when preparing a posterior tooth for a crown or bridge. In addition, it is possible to paint some Arti-Spot® on one side of the Fleximeter-Strip and place this coloured side against the prepared tooth. The patient is then asked to bite up and down. Where there is inadequate clearance, the occlusal aspect of the prepared tooth will mark red, and this can then be accurately adjusted. The thicknesses of the Fleximeter-Strips 1.0mm, 1.5mm, and 2.0mm can also be used to enlarge the vertical dimension (bite height). They are made from a special silicone rubber that can be sterilised up to a temperature of 200°C.

Use of T-Scan

T-Scan is a computerised occlusion software system. Used in conjunction with the “two phase articulation system” of occlusal markings is the most precise way to make occlusal adjustments and equilibrate an occlusion.

Summary

By understanding the design and differences between articulating papers allows the dentist to make accurate and precise markings. This will then help more accurate adjustments to be made rather than “just chasing the blue marks”.

About the author

Ashish B Parmar (Ash) is a private dentist and has a unique state-of-the-art practice in Chigwell, Essex called Smile Design By Ash (www.smiledesignbyash.co.uk). Ash is a national and international lecturer and was one of the main dentists on the three series of Extreme Makeover UK. He offers an outstanding 8-day Course which includes training on leadership, vision creation, goal setting, step by step techniques in doing Smile Makeovers, treating advanced cases (e.g. wear cases), lasers, fibre-reinforced composite dentistry, photography, communication, case presentation skills, team development, occlusion, etc. Ash has written numerous clinical articles in dental journals and is well recognised for his passion in cosmetic dentistry – using both composite and porcelain techniques. To review many other informative articles and FREE TRAINING CLINICAL VIDEOS, and to find out more about the unique training Course run by The Academy By Ash, visit www.theacademybyash.co.uk or send an email to training@theacademybyash.co.uk. Alternatively, you may phone Ash personally on his mobile number 07971 201180.

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The effectiveness of toothbrushing

Fridus van der Weijden*, Dagmar Else Slot*
*Academic Center for Dentistry Amsterdam, The Netherlands

Plaque control is the cornerstone for the prevention and control of periodontal disease and caries. However, although salivary flow has some limited potential in cleaning debris from interproximal spaces and occlusal pits, it is less effective in removing and/or washing out plaque and natural cleaning of the dentition by physiological forces – ie, movement of the tongue and cheeks – is virtually non-existent (Lindhe & Wicén, 1969). Therefore, to be controlled, plaque must be removed frequently by active methods, and evidence from large cohort studies has demonstrated that high standards of oral hygiene will ensure effective plaque removal (Van der Weijden & Slot, 2011). There is substantial evidence showing that toothbrushing can control plaque, provided that cleaning is sufficiently thorough and performed at appropriate intervals. The underlying factors influencing the effectiveness of toothbrushing include toothbrush design, its mode of action, ease-of-use and patient compliance.

Systematic reviews

evidence. In addition, the American Dental Association (ADA) has launched a website called ‘Center for Evidence-Based Dentistry’ (http://ebd.ada.org/SystematicReviews.aspx) that currently contains more than 1600 clinically relevant systematic reviews.

PICO(S)-question

The protocol for a systematic review is developed beginning with a carefully formulated question using the ‘PICO(S)’ rule – patient, intervention, comparison, outcome and study design. The manner in which this question is formulated is

Systematic Reviews (http://www.cochrane.org/training/cochrane-handbook) declares that reviews are needed to help ensure that healthcare decisions can be based on informed, high-quality, timely research

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The use of mechanical devices for the routine cleaning of teeth dates back to the ancient Egyptians, who made a brush by chewing on the end of a twig to fray it. Today, there are literatures with bristle patterns that are designed to hard-to-reach areas of the dentition, particularly proximal areas. Much emphasis has also been placed on new ergonomic designs, for example handle sizes appropriate for the hand size of the prospective user. Nevertheless, even adults, despite their apparent efforts, appear not to be as effective in their plaque removal as might be expected.

The effectiveness of manual toothbrushes in a systematic review brushing exercise studies are commonly used for toothbrush evaluations, serve as a useful indication of the plaque removal ability of a toothbrush and facilitate the control of confounding variables such as compliance. A recent systematic review evaluated the efficacy of manual toothbrushing with respect to toothbrush design and brushing duration following such exercises (Slot et al, 2012). The literature search yielded 2079 titles and abstracts, of which 59 papers with 212 brushing exercises (as separate legs of the experiments, and including 10,806 participants, met the eligibility criteria for inclusion. The mean pre- and post-brushing plaque scores found in the papers were used to calculate an overall weighted mean percent plaque score reduction. The sheer magnitude of the number of participants and the heterogeneity observed in the various study designs gives the results particular value, because they reflect what may be generally expected from routine oral hygiene. For the studies with data assessed according to the Quigley & Hein plaque index, the weighted mean reduction in plaque scores was 50 per cent (95 per cent CI: 27 per cent to 55 per cent), while in the studies using the Navy plaque index a weighted mean plaque score reduction of 55 per cent (95 per cent CI: 50 per cent to 56 per cent) was observed. Sub-analysis between the different bristle tuft configurations illustrated variation in plaque removal ability (24 per cent to 61 per cent), with the angled bristle design demonstrating the highest mean plaque reduction with either index. A sub-analysis on the influence of the duration of brushing revealed a mean plaque reduction of 27 per cent after one minute of brushing and 44 per cent after two minutes.

Therefore it was concluded that the efficacy of plaque removal resulted in an average plaque score reduction from baseline of 50 per cent, with a range of 50 per cent to 55 per cent depending on the plaque index used. The available evidence indicates that bristle tuft arrangement (flat-trim, multi-level, angled) and brushing duration are variables contributing to efficacy, irrespective of the index used, it appears that there is room for improvement for the efficacy of manual toothbrushes.

Powered (electric) toothbrushes The first successful electric toothbrush (the Brosa SA) was
conceived in Switzerland in 1954 by Dr. Philippe-Guy Woog, and the first generation of electric toothbrushes had a brush head designed as a manual toothbrush that moved in a (compound) horizontal and vertical motion. Since the 1980s, tremendous advances have been made with numerous electric toothbrushes have been developed to improve the efficiency of plaque removal. Powered brushes currently available vary in their mode-of-action. Oscillating-rotating brushes are designed with a round head that moves back and forth, with alternating turns clockwise and counter-clockwise. In contrast, brushes with a circular mode-of-action rotate in one direction only, counter-oscillation brushes have tufts of bristles that rotate back and forth independent of the directions of other tufts, and other brushes move from side-to-side (including sonic brushes). At different times, individual studies have been conducted on the efficacy and safety of these powered brush categories and the collective evidence has been summarised in systematic reviews.

Powered brushes versus manual toothbrushes
An early dental systematic review, performed in collaboration with the Cochrane Oral Health Group, compared manual and powered toothbrushes in everyday use, principally in relation to plaque removal and gingival health (Heanue et al, 2002). Five electronic databases were searched to identify randomised controlled trials comparing powered and manual toothbrushes (up to the middle of 2002) where the participants were members of the public with uncompromised manual dexterity who brushed unsupervised for at least four weeks. The criteria for selection were that the studies were randomised, compared at least two powered brushes with different modes of action, involved at least four weeks of unsupervised brushing and where the participants had no impairment of manual dexterity. The toothbrush modes-of-action represented by these trials were: oscillating-rotating, counter-oscillating, side-to-side, circular ultrasonic, multidimensional and ionic (electrically active).

Comparison of different powered toothbrushes
The most recent Cochrane review assessed the comparative efficacy of powered brushes with different modes of action and their effect on oral health (Deacon et al, 2011). Five electronic databases were searched up to July 2010, resulting in a total of 17 eligible trials, with more than 1,500 total participants. The criteria for selection were that the studies were randomised, compared at least two powered brushes with different modes of action, involved at least four weeks of unsupervised brushing and where the participants had no impairment of manual dexterity. The toothbrush modes-of-action represented by these trials were: oscillating-rotating, counter-oscillating, side-to-side, circular ultrasonic, multidimensional and ionic (electrically active).

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“Evidence-based dentistry is important for decision making, however it has to be noted that clinical outcomes may not be the only decisive factor to come into play”

*Source: GfK and SDM market data 2010 for LuxaCore
Based on seven trials of up to three months duration, with no significant heterogeneity, oscillating-rotating brushes were found to result in statistically significantly greater plaque reductions in the short term (one - three months) compared to side-to-side powered brushes. The standard mean difference (SMD) for plaque reduction was calculated to be SMD = 0.24 (95 per cent CI: 0.02 to 0.46). Clinically, the relative superiority of the oscillating-rotating mode of action to the side to side motion of action would equate to a seven per cent reduction in the Turesky modified Quigley - Heinz plaque score. The short-term gingivitis reduction of SMD = 0.55 (95 per cent CI: -0.04 to 0.74) missed being statistically significant. As only one trial was available of more than three months duration, and with only a limited number of participants, no firm long-term conclusions could be drawn.

The safety of powered toothbrushes.

A systematic review was recently conducted on the safety of powered toothbrushes. The safety of powered toothbrushes may play a role in a patient's decision to change over to powered brushes with a side-to-side mode-of-action, while insufficient evidence is available for other powered brushes. Systematic reviews also provide evidence for the safety of an oscillating-rotating brush.

Other considerations

Evidence-based dentistry is important for decision making, however it has to be noted that clinical outcomes may not be the only decisive factor to come into play. For instance, the increased cost of powered toothbrushes may play a role in a patient's toothbrush choice, while a powered toothbrush may offer ease-of-use and improve patient compliance with brushing. It is the toothbrush in the hands of the user that determines the efficacy of plaque removal. The role of the dental professional is to coach and motivate the patient. Features such as a timer and visual signals on a brush help to increase engagement of the user to perform an adequate job and have been found to result in improved brushing and patient compliance.

Conclusions

Based on the available evidence, oscillating-rotating brushes have been shown to result in greater plaque and gingivitis reductions compared to the use of manual brushes. Additionally, based on short-term data, oscillating-rotating brushes compare favourably to powered brushes with a side-to-side mode-of-action, while insufficient evidence is available for other powered brushes. Systematic reviews also provide evidence for the safety of an oscillating-rotating brush.

References


Center for Evidence-Based Dentistry. http://cled.edu/eff/?SystematicReviews.


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David Cross (Greece)

“I have received my certificate as a peri-odontist specialist by the Dutch Society of Periodontology. Since 1986 Prof van der Weijden dis- solves his time between the Clinic for Periodontology, Utrecht and the Aca- demic Centre for Dentistry Amsterdam. Furthermore he works on regu- lar occasions as an implant dentist in a private devoted to implantology in Drachten. He is a frequent lecturer in postgraduate courses and the au- thor of the book entitled, ‘The Power of Ultrasounds’ and the co-author and editor of the book ‘Preservat Dentistry’. He has also authored and co- authored approximately 60 national and 150 international publications. The Ivory Cross, awarded him early 2005 with the Carl Willnau Medal of honor for his work on prevention and propagation of oral health. Early 2010 he has been appointed a chair as pro- fessor at the University of Amsterdam with ‘Preventive dentistry and peri- odontal infections’ as main focus for his research. This chair has been an initiative of the Dutch Society of Peri- odontology.
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Just call me Michael
Michael Sultan tackles the contentious issue of the title ‘Dr’

There’s been a lot of talk of late regarding the title ‘Dr’, and whether as dentists, we should be allowed to use the title before our names, and even if we should encourage our patients to refer to us as doctors at all.

Some colleagues find themselves incensed by this issue. If patients and staff members don’t refer to them as doctor, they take great offence – they feel that somehow their position is undermined. After all, they’ve done five or more years training in a medical discipline and expect their hard work to be recognised!

You know, I really do have to wonder why some members of our profession find themselves getting so wound up by this. To me this whole debate is completely anachronistic. If a patient comes to me and calls me ‘Dr Sultan’ I don’t feel flattered or delighted that they’ve called me doctor – if anything I feel disappointed. As dentists, aren’t we supposed to be a bit warmer than that?

Attitude
In years gone by as society we’d always insist people call us ‘Dr’ or ‘Mr’ – any sort of title really. But now our attitude to people has shifted. Our attitude to healthcare has also shifted. It’s no longer a ‘you do as I say’ approach, but more a ‘let’s discuss together what we think is best’. Ultimately our aim is to build relationships with patients – to show them that we care. In this context I do think that insisting that we are called doctor acts as a barrier with our patients. As a profession we shouldn’t be so arrogant to think that unless someone calls us doctor they don’t respect us. Instead we should have enough selfconfidence as a profession to say well, it doesn’t matter what they call me.

Of course, a lot of this debate goes back to the very early days of what we would now refer to as the medical profession. Back in the day, medical doctors were highly qualified, studied at prestigious universities and were awarded a title at the end of it. This was in contrast to surgeons, who weren’t seen as being anywhere near so prestigious. Back in those days you were part-barber, part-butcher, part-surgeon and rampant elitism meant that as a surgeon (a predominantly male occupation) you were always...
referred to as ‘Mr’.

Perceptions

But perceptions then changed. Doctors were still called doctors, but it then became the norm that if you were a particularly qualified and knowledgeable doctor you might be referred to as a surgeon, or consultant. As a medical doctor then you looked forward to the day where you went from being a ‘Dr’ to being a ‘Mr’ again because you were somehow higher. A strange circle! But while all this was happening dentists weren’t called doctor at all as they weren’t seen as being as ‘worth’ as doctors. Naturally this claim caused some affront at the time, and the dentists of the day fought hard to receive equal recognition with their medical colleagues.

Nowadays however, none of this makes any difference to anybody. Gone are the days when you could phone up an airline or a restaurant and expect an upgrade on account of your title. Nowadays you pay for what you want. So this debate really is very anachronistic and irrelevant. When I first started working, nurses were told not to call me by my first name. Did it make any difference to their attitudes to me? Absolutely not – they either liked me or they didn’t like me. It’s the same with the patients. I certainly don’t think they respect us any more by calling us doctors or anything else. We should be aiming to break down barriers, not build up even more of a wedge between ourselves and the general public!

Debate

This brings me back to an old saying I was told many years ago now. That is, ‘people don’t need to know you’re clever – they need to know you care’. For me this saying cuts right to the very heart of the whole doctor debate. Should we be respected? Yes of course, just as every single individual should be respected. Do we deserve special treatment? Of course not! In my experience, people with an ego hide behind a title. If we want to really form excellent professional relationships with our patients we need to drop this insecurity and start focussing on what we do best – providing the very best levels of patient care that we can. So, when a patient comes to me and says ‘Can you help me Dr Sultan?’ I pause, and I reply: ‘Of course I will do everything in my power to help you, just don’t call me Dr… call me Michael.’

About the author

Dr Michael Sultan  BDS  MSc  DFO  FICD  is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPD, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practices.
Mentoring strategy in dental teams
Glenys Bridges discusses mentoring

The concept of senior colleagues supporting the work of more junior colleagues, by sharing the benefits of their hands-on experience is a time-honoured activity. To take this a stage further as part of their induction processes, an increasing number of practices are creating buddy relationships. Their aim is to formalise a skills transfer process which previously happened in an ad hoc style. In many cases guidance from a senior colleague has been very much valued by employers and employees alike. This article explores ways to build a mentoring strategy for your practice, which will secure increased benefits from these beneficial interactions.

I am often asked if mentoring is just another name for coaching. The answer is that although there is significant crossover in these interactions, essentially mentors must have actual hands-on experience and expertise in the work role of their mentee. Whereas, in coaching the expertise is coaching rather than applied skills. In this way many business coaches have not ‘walked in the shoes’ of the client. Because the dental team mentor’s skills are in the delivery of dental care, to support their work the practice needs to create a mentoring strategy and provide training and support. In this way all parties are able to secure measurable benefits through mentoring.

Mentoring success depends upon numerous factors, not least finding a best fit mentor and mentee match. A structured mentoring process must be managed in exactly the same way as all other practice activities. This begins with a clear vision to create the design, implementation, support and evaluation processes for your mentoring scheme.

Successful mentoring is dependent upon the participation of senior colleagues as mentors and also as mentees. This is a prime example of leading from the top. The best mentoring schemes start small and grow gradually, stimulated by enthusiasm, positive examples and organisational support. Here is some guidance for the creation of an effective mentoring scheme at your practice:

• Establish the purpose of the scheme - Define who will be involved, what they will do and the expected results. Begin by finding out what mentoring is already happening on an informal basis and assess how valued this format of learning and development is at present.
Appoint a mentoring lead – someone with responsibility for managing and helping to sort out difficulties within the mentoring scheme and its relationships. This person will need to be able to measure and assess personality types and learning styles to find mentor-mentee matches.

Define mentoring activities. Mentoring to introduce new employees to practice routines is the relatively brief, phase one of the mentoring process. On completion of this phase the more enduring phase two begins. This ongoing stage is where mentors help colleagues focus on their challenges, choices, cause and effect to help them to find creative solutions, learn from experience and decide how to apply learning to their working practices.

Consider what factors will help and hinder mentoring in your team – do you have top management support, top support and refreshments are people willing to participate, do they have time? Once people start to see tangible benefits from mentoring it becomes easier and the relationship built becomes enduring during challenging times.

Ensure you have support in place for mentors – Training and skills development are the mentor’s initial needs. But who mentors the mentor? It is important that every mentor has the chance to reflect on their mentoring practice with a mentoring supervisor, who has the chance to reflect on their mentoring practice.

After the Initial stages
As with all relationships, mentoring relationships grow and develop. New employees will inevitably look to established colleagues for practical information to help them find their way around in their new workplace. Once those pragmatic needs have been met, innate learning styles will take over and input of a particular mentor may not be appreciated. In such cases this should not be viewed negatively, simply as recognition a progression of needs and the way forward to building the next level of mentoring relationship.

Define mentoring activities. Include mentoring and learning styles and assess personality types and input of a particular mentor.

Appoint a mentoring lead – someone with responsibility for managing and helping to sort out difficulties within the mentoring scheme and its relationships.

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Table 1

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<th>What kind of things will be talked about?</th>
<th>What PAs have to say about mentoring?</th>
<th>What is the current state of private dental practices?</th>
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**About the author**

Glenys Bridges is an experienced management trainer and assessor with 20 years experience of working with General Dental Practitioners and their teams. In addition, she has expertise and qualifications in Counselling and Life Coaching. Her first book, Dental Practice Management and Reception was published in 2008 her second book, Dental Management in Practice was published during 2012.

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Lingual masters in London
Angela Auluck review the BLOS Spring meeting

Six different lingual systems were showcased at the BLOS Spring Meeting by some of the world’s leading innovators. The prestigious Four Seasons, Canary Wharf was the perfect backdrop for a day of presentations on the latest advances in lingual orthodontics.

Joint Session
Dr. Patrick Curiel from Paris, the inventor of Harmony, started the day in a joint session with colleague Dr. Adrien Marinetti talking about his self-ligating fully customised lingual appliance. Although the appliance was launched in the UK almost two years ago this was the first public presentation and the audience was keen to hear what the system had to offer.

The key message was that Harmony is comparable with labial orthodontics in terms of mechanics, treatment time, chairside time and finish. To demonstrate this, the speakers showed a number of cases and highlighted how the constant development of the appliance is embracing new technology such as a fully digitised set-up.

Interactivity
Next up was Dr. Woo-Ttum Bittner, Sure Smile QT’s biggest user from Berlin. Dr. Bittner explained to the audience the versatility of the system - the brackets are bonded directly to the teeth and then scanned to produce electronic files. The treatment goals are then simulated on the scanned plaster models prior to producing customised wires as well as fixed retainers. Dr. Bittner described how Sure Smile has empowered his practice and was thrilled with the level of ‘interactivity’ that took place between him and the laboratory.

Dr. Vittorio Cacciafesta turned his attention to the ‘art of orthodontics’. He presented case after case treated with 2D lingual brackets. Dr. Cacciafesta showed cases with

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impacted canines, segmented mechanics and demonstrated how torque control was possible with 2D brackets. He concluded that the 2D lingual technique can often simplify lingual treatment although it does have its limitation and art is certainly the sentiment.

eBrace
The last speaker for the morning session was Dr. Silvia Geron from Israel. Dr. Geron commonly uses eBrace in her clinical practice and wanted to share with the group her experience of the appliance. eBrace is a fully customised lingual appliance with a self-ligating option. The uniqueness of the appliance is:

• its small size
• comfortable fit
• ease of early engagement of all the brackets
• the built-in torque in the bracket base and slot which reduces need for bending the archwire

Dr. Geron highlighted that the key to success is to manage your patients’ expectations and to think like an orthodontist not like the system!

Dr. Didier Fillion was next to take the centre stage and he took the time to show how new advances were being incorporated into the Orapix system with the use of CT scans and intra-oral scanning. He discussed openly his way of ‘less is more’ and doing it ‘my way’. His passion for a straightwire system came across strongly and this is what he is working towards in his practice.

Advances
Last but not least was Dr. Giuseppe Scuzzo, whose passion and expertise in the lingual technique thrilled the audience. Dr. Scuzzo, in his talk, set out to debate why more orthodontists are not using lingual appliances in their everyday practice. He discussed the advances of appliances, where we now have aesthetics, comfort and biomechanical ef-

ficiency and demonstrated this with the amazing clinical results he achieves with lingual appliances. Along the way he dropped in clinical tips such as distilisation of upper first molars using the modified Pendulum appliance and concluded that lingual appliances should be the appliance of choice in every orthodontic practice!

The BLOS Spring meeting was a success. We were in awe of the new technology being incorporated into lingual appliance systems and left feeling motivated and enthused to try it out!
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Also taking centre stage at the show will be the company’s new 900 Series LED operating light. As with their treatment centre concepts, these are both built to last and provide excellent light output over their projected lifetimes, which is a staggering 40,000 hours or around 25 years for the average user. The ten shrouds are all colour matched immediately making it ideal for colour matching as well as reducing eye fatigue. As individual requirements and preferences vary the light can be easily adjusted between 4,500 and 32,000 lux.

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The Waterpik® Water Flosser: “considerable improvement in plaque control”

Miss Julie Toll RDH is a Dental Hygienist based at The High Street Dental Practice in East Grinstead, West Sussex. She has been recommending the Waterpik® Water Flosser to patients for over six months.

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