Vandalised practice
A dental practice was vandalised, during an anti-Israel demonstration which ended in a violent rampage when a mob of angry looters rampaged through Kensington High Street in West London. About 200 protesters led the rampage after thousands had marched peacefully from Speakers' Corner, Hyde Park, to Kensington Gardens, near the US Embassy in Holland Park, London. The rioters smashed the glass frontage of Kensington Dental Practice, which was run by Dave James, and broke the windows of a nearby bank.
NHS Fife must ‘apologise’

The Scottish Ombudsman has told NHS Fife to apologise to a patient after fitting her with an incorrect denture. The patient’s own dentist had ordered the preparation of the denture before a community dentist, who was vulnerable to de- spite it being wrongly prepared.

The report upheld the patient’s complaint, agreeing that the denture fitted was not what was discussed, and said that the community dentist should have delayed treatment.

The Ombudsman stated that, although the patient had signed a consent form, she ‘was asked to make her decision under difficult and stressful circumstances without a proper chance to consider all the options’.

The Ombudsman recommended that the health board give a full apology and said that all dentists agree in future that a denture has been correctly pre- pared before a fitting takes place.

The report also recommended that, when a patient is under particular stress, guidelines should be drawn up to con- sider management and consent.

NHS Fife has accepted the recommendations.

‘Inspektor TC’ spots plaque

Scientists from Liverpool University have developed a dental product which identifies build-up of plaque in the mouth, before it is visible to the human eye.

The ‘Inspektor TC’ product is aimed at older people and young children, who are vulnerable to dental disease. The toothbrush-sized device features a blue light which, when shine in the mouth and looked at through yellow lenses containing a red filter, detects plaque as a red glow. Dentists currently use disclosing tablets which can stain the mouth and taste unpleasant.

‘It is extremely difficult to get rid of all plaque in the mouth’, said Professor Sue Higham, from the University of Liverpool’s School of Dental Sciences.

Dental Protection for Edinburgh

Dental director Kevin Lewis said, ‘This visible demonstration of the commitment of DPL and MPS to our members in Scotland, is something that many members have repeatedly asked us for.

But opening this new office in Edinburgh is only part of a much bigger picture, and we have already made several key appoint- ments to create an outstanding team that will be based in Edin- burgh.’

Their experience and spe- cialist local knowledge will strengthen and enhance what I firmly believe was already the best dento-legal advisory team in the world.

Our members in Scotland al- ready enjoy all the benefits of be- ing part of this large, strong and well-funded international organ- isation and now they will have the added benefit of this local service delivery and expertise.

New NHS dental surgery for Inverness

Patients in Inverness are to get a new NHS dental surgery designed to reduce waiting lists in the city.

There are currently 10,000 peo- ple on the waiting list for an NHS dentist in Inverness. The new sur- gery would be the third develop- ment for Inverness in recent years.

Mary Scanlon MSP, the Con- servative’s health spokesperson, said: ‘It will be a great boost to den- tal care in Inverness, which has had some of the lowest dental patient registrations of any health board in the whole of Scotland.’

While this will be welcome news for Inverness, I have writ- ten to NHS Highland to ask how they plan to make similar provi- sions for the Caithness, Suther- land and Easter Ross con- stituency, where only 15 per cent of people are registered with an NHS dentist.

She added: ‘In the Ross, Skye and Inverness constituency, the figure is not much better with only one in five people being reg- istered with an NHS dentist. Given that the Scottish average for NHS dental registration is 59 per cent, these two constitu- encies fail well below what is avail- able in the rest of Scotland.’

Political gripes, dental dilemmas, guest comments, general feedback...

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DTUK mailbox

We value your feedback, so email us at penny@dentaltribuneuk.com, or write to Dental Tribune UK, 4th Floor, Treasure House, 19-21 Hatton Gar- den, London, EC1N 8BA.
Many years ago, I shared a flat with a friend in investment banking. He had a standard answer when asked for advice about the stock market and it was, ‘It might go up; it might go down or it might stay where it is’. From that day to this to this, I have never heard any better investment advice. Couple that with the other simple lesson – namely that if it sounds too good to be true then it probably is – and you have all the information that you need to be an investor. Whether or not you are successful will depend on a host of factors that are completely outside your control. I don’t doubt that, if you make an in-depth study of a particular market sector, you might develop a level of knowledge that allows you to see potential opportunities and to take advantage of them. Or you can use experts, who have hopefully already gone through this process, and invest in emerging markets. Alternatively, you can spread your risk by using more traditional methods such as unit trusts, building societies and banks.

The chances of a significant return on your capital was never great in the latter cases, but they had the advantage of being safe. Unfortunately, recent events have forced me to add a third rider to my rules of investment and it is that there is no minimum price for anything. Sadly, there is virtually nothing left that has such intrinsic value that it will always be worth something.

So what can you usefully do with your money to protect it, and, potentially, to earn anything from it? In these uncertain economic times, it is very difficult to know who to trust or what to do for the best. However, there is one person that you can trust absolutely with your money and that is you. At least with money invested in you and your business, you are much more in the driving seat than you are with money invested in some stranger’s company.

There is a strong temptation to halt all investment during a down turn but it is the very time when investment can be most fruitful. Trying to update computer systems and install modern technology at a time when the appointment book is bursting can be very difficult. It is much more productive to do it when there is less disruption to surgery time and it will be in place ready to generate greater income in the future. Similarly, investing time in learning new techniques and skills will pay dividends in due course.

The recession will inevitably mean a reduction in the number of treatments delivered but it will not reduce the number of treatments needed. That need will still be there when the recession ends and those best placed to meet it will be those who suffer least from the current downturn. The only trouble is that, when you reap the rewards of your investment, there still won’t be anywhere safe to put it!

Tony Reed, executive director of the BDTA

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Dentsply sponsors dental aid programme

Dentsply, a manufacturer of dental products and dental instruments, helped to sponsor a dental aid programme in Kenya by providing free dental equipment.

Eighty final year Manchester University dental students travelled to Kenya to deliver quality dental care to those who otherwise have very limited, or no access to recognised dental treatment. The students carried out full dental checks on over 90 children at the Frances Jones Abandoned Baby Centre in Kenya.

Other patients received treatments which included scaling, extractions, single and multi-rooted endodontics and denture procedures.

A spokeswoman for Dentsply said: ‘Our donation of dental instruments, particularly the new Artio range, as well as other equipment, helped to make the expedition possible.’

GDC appoints new director for Scotland

The General Dental Council has appointed Ian Jackson as its new director for Scotland.

Mr Jackson, who has already taken up his post, now manages the General Dental Council’s (GDC) activities in Scotland and works with the Scottish Parliament, members of the public and the dental profession.

GDC president Hew Mathewson called his appointment ‘an important one for the GDC’.

He said: ‘The GDC is committed to providing regulation which is consistent across the UK whist relevant to the way in which healthcare is delivered in different countries, systems and contexts.

Ian joins us at an important time. His work will aim to further build and maintain effective GDC engagement in Scotland so that we can better—and respond better—to Scottish-based patients and registered dental professionals working in Scotland.’

Mr Jackson has previously held various roles at BT, where he has worked since 1990, and was most recently its partnership director.

He is also a member of the General Teaching Council in Scotland and was awarded an MBE in January 2005 for services to education in Scotland.

Mr Jackson said: ‘I am very pleased to have the opportunity to make a real impact on the GDC’s presence in Scotland by leading the development of the Council’s activities in the country.

I look forward to working with the many Scotland-based patients and professionals as well as the Scottish Parliament, other regulators and agencies in the country.’

‘International standards’ for academic staff

At least 90 per cent of staff at the UK’s dental schools have been judged as undertaking research of an ‘international standard’.

The findings of the 2008 Research Assessment Exercise confirm the high standard of dental research in the UK, with all 14 institutions recognised for their ‘world-leading originality, significance and rigour’.

Dr Ross Holohan, chair of the British Dental Association’s central committee for dental academic staff, said: ‘Today’s results confirm the excellence of the research that is being carried out by the UK’s dental schools, with the international excellence of their work enjoying just recognition.

He added: ‘What makes this success even more remarkable is that it has been achieved against a background of pressures on dental academic staff from a 25 per cent increase in student numbers and the opening of a number of new institutions.’

The 2008 Research Assessment Exercise was conducted jointly by the Higher Education Funding Council for England, the Scottish Funding Council, the Higher Education Funding Council for Wales and the Department for Employment and Learning, Northern Ireland.

Learning solutions at Dentistry Show 2009

Smile-on is to showcase the latest in its learning solutions at this year’s The Dentistry Show.

The show, which is being held at the NEC in Birmingham on 15-14 March, will include workshops and lectures from internationally recognised experts. Thousands of dental professionals care to those who are already registered, and attendees will be able to discuss the latest integrated learning breakthroughs with the Smile-on team.

Visitors to the stand are advised to ask about webinars, which enable dental professionals to take part in interactive lectures from the comfort of their armchair. Webinars can be replayed, to go over valuable points.

The team will discuss the innovative features of its three-module programme Communication in Interpersonal Interactions from the Practice, the Clinical Photography Course, DONTSTART and Clinical Governance Progress Management.

A spokeswoman for Smile-on said: ‘We understand the need for learning solutions that meet the changing needs of the industry.

With the latest technological innovations and forward-thinking approaches, Smile-on helps dental professionals develop their skills and knowledge, regularly refreshing their newfound expertise.’

For more information call 020 7400 9099 or email info@smile-on.com.

‘Highly interactive’ webinars

Dental care professionals were able to take part in two ‘highly interactive’ webinars focused on endodontics from their own homes.

Dr Julian Webber, director of the Harley Street Centre for Endodontics and faculty member of the Pacific Endodontic Research Foundation, presented the two-part series of webinars in December.

A spokeswoman for Smile-on and Dentsply Maillefer, which produces the Smile-on webinars, added: ‘Webber’s considerable expertise enabled delegates to improve their knowledge and confidence in rotary endodontics and heated obturation solutions.

Both of the webinars were highly interactive with delegates asking questions throughout by typing them into their computer. Dr Webber addressed these questions as they arose, allowing the delegates to really get the most out of the experience.’

Dr Webber covered a range of topics including irrigation, preparation with Nickel titanium files and heated obturation.

Dental care professional (DCPs) taking part in the webinars could earn a total of verifiable Continuing Professional Development points. These DCPs will also be able to access webinars again over the website.

The ‘Smile-on’ spokeswoman said: ‘The past webinars are also available to purchase but of course, the real benefit of attending the live sessions is having the chance to ask your own questions to Dr Webber throughout the presentation.’

For more information on any of our webinars, please visit www.dentalwebinars.co.uk, call 020 7400 9899 or email info@smile-on.com.

Fellowship award for Kevin

The director of Dental Protection has been awarded a fellowship from the Faculty of General Dental Practice (UK).

Kevin Lewis was awarded the fellowship during the first diplomats’ ceremony jointly hosted by the Faculty of Dental Surgery (Eng) and the Faculty of General Dental Practice (UK) to celebrate those awarded the MDFE (Membership of the Joint Dental Faculties) and the Diploma in Orthodontic Therapy.

Mr Lewis has been at the helm of Dental Protection since 1998, overseeing a major period of expansion in membership of the company which now has 52,000 members.

In 2007, he was awarded a fellowship by the Faculty of Dental Surgery of the Royal College of Surgeons of England.

He said: ‘I feel very honoured to have received this award, and particularly so because I still feel very much a general dental practitioner at heart. To have been the recipient of two fellowships in the same year does beg the question of whether the college knows something that I don’t – but I do hope to continue serving my profession for many years to come.’

‘Excessive regulation’ hits Wales

Tough, new regulations could put dentists off coming to Wales, according to the British Dental Association for Wales.

Under new Welsh Assembly regulations, every dentist offering non-NHS treatment has to register with the Healthcare Inspectorate Wales.

The HIW will have the powers to inspect practices and act on any complaints it receives.

This means that dental practitioners giving private dental treatment in Wales will be inspected to the same standards that are applied to NHS dental care.

Dr Stuart Geddes, from the British Dental Association for Wales, is concerned that regulation is too excessive and could deter dentists from coming to Wales.

He said: ‘This is unnecessary regulation on top of existing rules, it is over the top. This could put dentists off coming to Wales because of the extra regulation and cost and leave a shortage in Wales.’

However Health Minister Edwina Hart said: ‘It is important that there is uniformity of regulation between NHS and private care.’

Peter Higson, chief executive of HIW, claimed that the regulations will ‘act as a strong mechanism to encourage continuous improvement in the quality of private dental treatments and the improvement of clinical governance throughout primary dental care in Wales’.
When disaster strikes. . .

When a flash flood brought havoc to a London dental practice, the Group’s Operations’ Director sought help from the professionals and the team from Henry Schein Minerva rose to the challenge.

Juggling with all the normal run-of-the-mill, day-to-day problems that arise in every dental practice can sometimes be a headache. Multiply these issues by 4 practices, as in the case of Dental Arts Studio and you may think the job impossible, but when catastrophe strikes without warning, life can become very tough indeed. So when floods brought chaos to much of London and 45 minutes of rising water wreaked havoc with the Clapham branch of Dental Arts Studios, the practice was fortunate to have Operations’ Director Sharon Holmes at the helm. With the help and support of the team from Henry Schein Minerva, Sharon, who was voted Practice Manager of the Year 2007 by the BDMA, helped re-build the practice from scratch and establish it as the Group’s flagship branch.

Originally a trainee medical staff nurse, Sharon’s switch to dentistry was prompted by her need to merge her working and family life. She spent 14 years as a dental nurse in her native South Africa, gaining experience in all kinds of dentistry. Her move to the UK in 2002 further improved her knowledge and exposed her to life in both NHS and private practice. Finally, a chance meeting with founders of Dental Arts Studio, Dr Yogesh Solanki and Dr Sunit Malhan in 2005, forged a relationship that ultimately provided Sharon with the challenge of a lifetime.

Although at this point Sharon had little experience in practice management, she maintained an appreciation of the need for “procedure” and understood the importance of implementing systems within a dental practice. She now defines her role as “everything that makes the practice work,” and, as Operations’ Director, works with the individual Practice Managers in each of the 4 partnership practices, to ensure the systems that she has developed are rigorously followed in areas covering all elements of human resources, training, recruiting and practice procedures, all conducted in line with BDA guidelines.

So, when disaster struck and the water levels rose, Sharon was right in the thick of it. The Clapham practice was completely flooded from the basement upwards. The flood destroyed all the surgeries and the equipment in them, there was little choice but to gut the whole practice and refurbish from top to bottom.

“To see everything you have worked on for 4 years in ruins is a very emotional experience, I had put my heart and soul into helping develop the practice and was very committed to its success. When I received the phone call from the Practice Manager I was distraught and when I saw the practice for myself on the Monday, the reality of the situation dawned on me. There was so much to think about I didn’t know where to start.”

Dr Solanki and Dr Malhan were also devastated and along with Sharon they began to plan for the future. As a mixed NHS/private practice, one of their chief concerns was that whilst the practice was closed, patients might leave in search of care elsewhere, and despite trying to re-direct patients to the other practices in the Dental Arts Studio Group, Sharon knew they were working against the clock from the very beginning.

Work on the refurbishment began in the middle of July 2007 and choosing the actual equipment for the surgeries was one of the last parts of the project to be undertaken. In search of new surgery equipment, they visited several suppliers one of which was Henry Schein Minerva. There they met Dan Payne and Sue Borges and as Sharon says “it was one of the best conversations they’ve ever had”.

Dan and Sue worked closely with Dr Malhan, Dr Solanki and Sharon to provide them with the best deal possible on all the surgeries they needed to re-fit, offering options and advice at every stage. The final choice of chairs and cabinetry perfectly complement Sharon’s gentle and calming colour scheme of pale caramel, chocolate brown and oyster shell.

“Dan was amazing, he played an enormous role in the refurbishment, he was always on the end of the phone or willing to visit us, offering support, advice or just a friendly chat. I really don’t know how I would have managed the project without him. He became so much part of our team we even invited him to our Christmas party!”

The team at Henry Schein Minerva worked tirelessly to deliver exactly what we wanted from the refurbishment. They listened, understood our vision and interpreted our needs perfectly. Of course cost was a consideration, as was our ability to work in partnership with the suppliers and on all aspects Henry Schein Minerva came out top.”

It gave her a blank canvas on which to create a new practice, they have a new team, eager to deliver patient care of the highest quality and a future about which she and the rest of the team are very enthusiastic.

For more information email: me@henryschein.co.uk

Dental Arts Studio Clapham finally re-opened at the end of 2007 and Sharon is now able to think about the flood as something of an opportunity.
When you are dealing with a complete refurbishment, it’s really important to have the advice and support of a professional team. Henry Schein Minerva thought of everything, they helped with design, considered both the functionality and the look of each surgery and worked within our budget, delivering on-time, with excellent craftsmanship and attention to detail.”

Sharon Holmes – Operations Director, Dental Arts Studio, London

To develop your partnership
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For information please contact KaVo Dental Ltd

**European guide for dentists**

The Council of European Dentists (CED) has updated its guide on the training and work requirements for dental professionals wanting to work in other EU member states.

The latest edition of the EU Manual of Dental Practice looks at the legal and ethical regulations, dental training requirements, oral health systems and the organisation of dental practice in 52 European (EU and EEA) countries, including Croatia, which is due to join the EU next year.

Author of the guide, Dr Anthony Kravitz said: 'There has been considerable interest from dentists and government officials about the organisation of dentistry in the EU and we believe this guide addresses all the professional issues that dentists need to take on board to make the move to practise in another country as hassle-free as possible.'

The guide also compares the regulatory frameworks in the different countries and provides country specific information on the dental specialties that are recognised, along with details of where such training is available and its duration.

The guide also contains information on other dental care professionals, with a list of those which are recognised, their training, the procedures they are allowed to carry out, and the rules within which they can legally practise.


**BSDHT Oral Health Conference**

Nearly a thousand people turned up to the recent annual conference held by the British Society of Dental Hygiene & Therapy.

Delegates took part in over 14 workshops and visited 57 trade stands at the BSDHT annual oral health conference and exhibition held at the International Conference Centre in Edinburgh.

A BSDHT spokeswoman said: ‘This was the most well attended BSDHT conference to date reflecting UK dental hygienists and therapists’ passion and dedication for their profession.’

She added: ‘A very tangible two-day filling was sandwiched between the official opening by Margie Taylor, Chief Dental Officer of Scotland and General Dental Council president, Dr Ken Mathewson, whose closing clarified the Council’s role in dentistry and how its decisions would impact on the professional lives of this group of DCP (Dental Care Professionals) registrants.’

The seminars, which were spread over two days, included clinical workshops ranging from paediatric dentistry to dealing with the problems associated with an ageing population plus sessions on legal and ethical dilemmas and professional governance.

The 2009 conference will be on 16-17 October 2009 at the Bournemouth International Conference Centre.
Look into the future
When you are having your dream surgery designed and built, Chris Davies says that seeing a visual draft of the finished article is crucial.

Many dentists are frustrated with the layout of their practices. With most U.K. practices housed in buildings originally designed for domestic purposes, it can prove difficult implementing the required infection-control protocols and adjusting to the new demands in the practice. Spatial constraints can also prevent dentists from following their dreams and swooping on new opportunities. For example, if a competitor closes down, but the dentist does not have the room to increase the size of the reception area or set up an extra surgery, a chance to capitalise slips by. Such chances do not come along often.

Reasons to get involved
There are many reasons why a dentist might want to design his or her own practice. Experienced dentists will know what they need from their environment, and will have a good idea what sort of equipment they need, and how many patients they will expect in any given day. Having a bespoke practice that suits all of the individual dentist’s needs gives that dentist a tremendous edge. There is also the sense of pride and achievement a dentist feels when treating patients in their very own practice.

However, the construction of a tailor-made practice is an enormous job that requires real expertise and experience, and also an in-depth knowledge of the rules, regulations and assorted pressures at work on the modern dental industry. Fortunately there are companies that specialise in providing dentists with refurbishment, design and construction. When selecting one of these specialist companies, you need to bear certain things in mind.

Choose wisely
First of all, you need to make sure that the company you are working will offer a comprehensive service that includes design, execution and completion. It is also crucial that the company has a track history of working to time and budget limits, and that the service is supported by testimonials from dentists. Make sure that the company is independent from any particular manufacturer, so that you are guaranteed to get the most suitable equipment and furniture to meet your vision, at the best cost and to the highest quality. The company should also assist with project management, to ensure that everything runs smoothly.

It is vital that the company you select is able to present images, based on your discussions and the preliminary designs, of what the practice will look like when finished. That way, you can make changes during the early phases, rather than reach the conclusion of the project and get a nasty shock when the outcome is radically different to the way you originally envisaged.

The end result
The company should show you examples of what the completed project will look like, and also present you with samples of materials and textures so you can get an accurate idea of where you are heading.

These examples let you look into the future, identifying issues that might arise. By being able to visualise the finished practice before the project is complete, you can make sure that the project is steered towards your unique vision, providing you with your dream practice.
Many crucial words in the business vocabulary start with ‘P’: product, price, profit, promotion, performance, process, planning and people. Here, Lina Craven looks at several important P-words regularly neglected by practices and how this impacts overall performance.

**Performance management**

When I work with practices, one of the most common inefficiencies I come across is the lack of joined-up thinking. What I mean by that is that the team is driven by specific tasks rather than a common purpose. Usually the fault stems from undefined organisational goals: the management team has not clearly defined its vision for the practice and supported the achievement of the vision with a specific plan of action. What results is a whole host of goals, objectives and activities that bear little resemblance to one another.

If the goals of the practice are not clearly defined, it is impossible to set meaningful objectives for members of the team. You will recognise if this scenario fits your practice by considering this illustration: if every member of the team achieves his/her annual objectives, will that guarantee that the practice achieves its vision? If you can answer with a resounding ‘YES’ then you are on the right track but if you have doubts, you need to review how individual objectives are set. The solution is to ensure that the goals of the business and the goals of the team achieve overall success. This is known as goal congruence, in layman’s terms, everyone rowing in the same direction.

**Working towards a common purpose**

Often what I discover is that this fragmented way of managing is the result of a lack of a robust business plan, which in effect clearly defines the focus of the business by breaking goals down into segments of the business, for example, what must be achieved in marketing, customer service and with team resources. Subsequently, these goals must become the focus of the team, requiring their personal objectives to be the subset of the business objectives. After all, if no one owns an objective, it’s not likely to be achieved.

Setting objectives is one thing, but delivering them is another. We need a system that keeps people on track, as ultimately keeping people eventually deviate from the set path and find “better” ways of doing the task. I find in many practices that what managers think is happening in terms of a process is not the same thing as what is currently being undertaken by team members and this is where error creeps in.

Inefficient processes can attract unnecessary costs to a business and the only way to identify processes that are wrong is by the quality of the measurement you put in place.

When I work with practices, one of the most important, because without them you can’t do much about the rest.

**The solution is to ensure that the goals of the business and the goals of the team achieve overall success**

**‘If no one owns an objective, it’s not likely to be achieved.’**

Process improvement

Invariably following this method of running a business, we end up looking more closely at processes. Even if you have set processes up in the past, what usually happens is that working practice and they become more proactive in identifying areas of weaknesses and proposing solutions. In other words, they participate in the change process and take ownership of issues, which is a saviour for managers.

So what constitutes a good process? Well in the main, it’s one that maintains a simple approach. Why do something in ten steps if the same outcome can be reached in five? One caveat, it must be legal and it must deliver superb customer satisfaction. In the main, costs and efficiency driven, while others may exist to comply with legislation. It is good practice to review all processes at least annually to ensure they remain as efficient as possible, are meeting their purpose and are being correctly followed by those who use them.

**All about people**

Ultimately it’s a people game; the right people doing the right things in the right way. It seems so simple, so why does it often seem so hard? When we get to the final chapter, we realise that there are many of these Ps are interrelated. They are not discrete activities, they are all joined and the central joining point is people. No wonder the one time legendary CEO of Chrysler said, ‘There are many Ps in business but of them all people are the most important, because without them, you can’t do much about the rest.’

**About the author**

Lina Craven is the founder and director of Dynamic Perceptions. Over the past 25 years, she has assisted dental practices to realise their vision of success through the achievement of a customer-driven culture that focuses on delivering an exceptional patient journey. Lina’s qualifications and experience as an orthodontic therapist, treatment co-ordinator and practice manager in the US have given her a unique insight into the day-to-day practical problems faced by dental practices. Visit www.orthodontic-management.com or call 01844 275527.
Caveat venditor!

From buyer beware to seller beware – a sign of the times?
A cautionary tale by Mike Hughes of the ASDP

Long-established custom in commercial transactions has placed the onus on the buyer to ensure that the prospective purchase is what it appears to be and that the price is fair. But today’s sellers also need to be aware that the buyer may be a wolf in sheep’s clothing.

There is at present much activity in the dental practice transfer market, driven in part by the corporates’ determination to increase their market share, and many dentists are now encountering the professional negotiators employed by these corporate bodies. I was recently asked for an opinion, fortunately before the papers had been signed, on one such transaction.

A promising situation
At first glance, the figures seemed reasonable. The principal was keen to sell his mixed practice, operated by himself and three associates, which had a nominal turnover of £700,000. The initial offer of £420,000 was not overly generous in the current climate, but given the location of the practice and other limiting factors was at least worthy of consideration.

However, under the contract the initial price to be paid was only 80 per cent of the agreed total, for example, £336,000, with the remainder being paid in instalments over a three-year period subject to the practice achieving year-on-year growth of 11 per cent. Effectively, after three years of hard work by the principal, anticipated turnover would rise to £897,741, thus reducing the percentage paid for goodwill from 60 per cent of turnover to 45.8 per cent. Suddenly the deal is not looking quite so attractive.

Naturally the prospective purchaser promised high-powered management support and other assistance to develop the practice, but, as they say, ephemeral promises butter no parsnips. Even supposing the promises were kept, no one could guarantee the results.

Loss of earnings
Closer examination revealed that the principal’s personal earnings were a gross of £180,000 and the practice’s net profit was £140,000. At the end of the three years he would become an associate paid 45 per cent of his present earnings, or £81,000 before tax compared with the £145,000 current net profit within the business, representing a personal loss of earnings of £192,000. If the 11 per cent growth is not achieved, deducting £192,000 from £336,000 means that in effect the principal will receive only £144,000 for the goodwill.

A further issue emerged regarding the associates. If the deal was agreed the existing associates’ percentage of growth-related earnings would be reduced immediately the practice was sold. Our vendor and principal would have entered a commitment to achieve 11 per cent year on year growth in a practice where his trusted and experienced associates have arbitrarily suffered a pay cut, and will almost certainly leave. Although the purchaser would be responsible for finding replacements, in real terms the vendor could not possibly fulfil the earn-out provisions within the contract without continuous chair occupancy.

Appearances and first impressions can deceive. Whether buying or selling, study the small print, or risk getting caught in the strings that may be attached.

About the author
Mike Hughes has been fully committed to the dental sector as a business consultant specialising in various aspects of dental practice financial management, the creation of business plans and in providing advice and valuation to practitioners on sale and purchase, since 1992. Mike is also the Chairman of the ASDP. ASDP members offer professional, objective and practical advice and services, based on experience within the industry, to dental practices and other businesses within the dental sector. ASDP members include solicitors, accountants, banks, financial advisers, valuators and sales agencies, insurance brokers and leasing and finance companies.

The Association of Specialist Providers to Dentists (ASPD)
Your First Stop for expert independent Business advice

The ASPD is a group of highly respected companies, located throughout the UK, who specialise in the business aspect of dentistry.

ASPD members include:
- Accountants
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The primary objective of the ASPD is to provide you with reliable, practical advice.
When you pause to take stock of how technological innovations have benefited dentistry, it really is amazing. Dentists are able to make the most of their talents and offer a range of different treatments to meet the needs of their patient base. However, without effective communication, these needs may not be met.

With many dentists investing in GDP-friendly invisible orthodontic solutions and services such as tooth whitening and veneers, communication is the key to selling these to patients. In short, if the patient is not aware that a treatment is available, the patient will not seek that treatment at your practice.

In an ideal world, dentists would be able to spend as long as necessary with each patient, talking them through the numerous treatment options and discussing their needs and concerns, before detailing every step of the procedures involved. In the busy modern practice, this is rarely possible.

Dreams a reality

New technological innovations have, in a sense, made this ideal scenario a reality. Systems are now available that integrate easily into waiting rooms, either as kiosks, wall-mounted or desktop units, and with touch-screen interaction these are easy to use for all patients. As an information resource, these systems are highly flexible, with regular, nightly updates via broadband internet connection to keep the information current and to inform patients about new treatments as soon as they become available in the practice.

The main benefit of such a system is that it lets patients access information at their own pace while they wait to see the dentist. This means that when the patient sees the dentist, less time is required for explanation as the patient is already familiar with the basics of the procedures involved.

Easily integrated

When it comes to the latest technology, communication does not end there. These new systems are integrated easily into the practice’s broadband internet connection, enabling patients to request information by email so that they can go through it with friends and family in their comfort of their own home, and make informed decisions.

The dentist can also use the device to effectively market the entire treatment list, focusing on different treatments at different times—for instance, increasing the exposure of whitening treatments in the run up to Christmas.

About the author

Amy Rose

Amy has over six years experience in the dental profession, and currently heads up the design and marketing team at Dental Design Ltd. Visit www.touch-ed.co.uk to find out what the leading system offers, call 01202 677277 or email contact@touch-ed.co.uk.
Most dentists graduate with the intention of one day becoming a partner and owning their own practice. Usually after a few years as a corporate employee or an associate gaining experience, the time seems right to make a move towards independence.

Clinical expertise, however, is no guarantee of business acumen or organisational skills. Having been there myself, and more recently offered advice to many others with similar ambitions, I’ve had ample opportunity to identify the pitfalls and devise methods to circumvent or overcome them.

After starting from scratch myself in 1989, I eventually sold my practices and in the last seven years as a business advisor, I have assisted a number of new principals achieve their ideal scenario, the creation of their own practice from scratch. For many associates, this represents the Holy Grail, to work in an environment designed in converted Edin\-wardian high-street premises and staffed from day one, or your practice will need to be advertised in advance and equipped to the next phase. Your fine new practice you have designed yourself, but without the financial commitments of ownership and ongoing property maintenance.

It’s important to set targets, and to stick to them. Give yourself a realistic time-frame, say 12 to 18 months to be up and running, with achievable interim goals to keep you on track. To be successful for working for yourself, you must be disciplined. Keeping things moving is no easy task when in all probability you are still working full time in someone else’s surgery. Know from my own experience, the days are never long enough. Whether you’re converting or building a new practice, a competent and experienced site manager is vital.

Even while you’re embroiled in the creative stress of building works, you need to look forward to the next phase. Your fine new practice will need to be advertised in advance and equipped and staffed from day one, or your investment will quickly cost more than it earns, which will not impress the bank manager or your development partner. It’s a good idea to engage a receptionist a month before you open to start booking appointments; you won’t just hit the ground running, it will crystallise the mind in those last weeks and you’ll open on time!

You may have chosen the option of renting premises, of course, which may be less than ideal but will usually reduce your capital outlay, although many of the same strictures still apply.

New practice kit
A new practice means new equipment, which today offers a bewildering choice and purchasing errors can be ruinously expensive for the unwary. The temptation to invest in the very best from the beginning should be resisted unless you really need the absolute, state of the art digital imaging system for the type of treatment you are offering. Better to stick within budget and look for kit, which can be upgraded later if necessary, when a cashflow has been established and the costs can be offset against tax payments.

Don’t skimp on ‘front of house’ spending – reception and waiting spaces are not only the practice’s shop window, most patients will spend more time here than in the surgery and the more pleasant their experience the more likely they will be to return or tell their friends about you. With a little imagination the décor can reflect the practice’s brand image – use the same colours as those of your logo, for example. And remember, you’ll still need a buffer of working capital after you’ve opened for business.

Many of the details involved in setting up a new practice, such as choice of equipment supplier, laboratory, management software, even opening hours, will depend on individual preferences and circumstances, but there are still two more pieces of advice which are universally relevant; take some time to visit other practices and glean ideas – fellow professionals are usually delighted to show off how they work.

About the author
Simon Hocken BDS has owned two private practices and is an accredited coach. He has recently joined forces with Chris Barrow to form a new business training and coaching company called Breathe Business. Simon can be contacted at The Breathe Business Group by emailing simon@nowbreathe.co.uk, calling 01326 377078 or visiting www.nowbreathe.co.uk.
The case for... and against
Staff turnover

The case against

All we know how disruptive and expensive losing a member of staff can be. Patients feel more comfortable with someone they know and have come to trust; they often feel more aggrieved when a loved receptionist leaves than when a dentist does. From the employer’s perspective, think of the cost of advertising or employing the services of an agency. Think of the time spent conducting interviews. Consider the time spent on induction and training, and the slow-down in productivity while the new worker grows into the job. Work-flow gets disrupted; employer, employee and other employees get frustrated. Don’t forget the effect on other members of staff of acquiring a shadow and having to go through all the required routines yet again, procedures that can be extremely draining on team morale.

As a rule, established members of staff do not take kindly to a new kid on the block until that kid can prove its worth. Within the dental world, it can take anything from two to four weeks for a new person, even one with experience, to become acclimatized with practice policy and culture and the same time-span again to become efficient and effective. It has been estimated that almost 50 per cent of new employees leave their new job within the first month, the reasons ranging from poor selection to overstating the positive aspects of the job while understating the downsides.

The positive side

Yet there are positive aspects to staff turnover, providing the frequency is not excessive.

Job turnover tends to be self-selective, for example, it is usually the weaker individuals, the ones you are not unhappy to lose, who leave. The stronger person stays in a job, the less they focus on being creative and flexible, preferring instead to do what they know well and what comes easiest to them: this is called taking the path of least resistance. What begins as an exciting job eventually ends up as just a job.

Liberties begin to be taken, such as arriving a bit late or leaving early, or taking extended tea breaks or holding long phone conversations with non-patients. They have learned what they can get away with and will push this to the limit.

The longer a person stays in a job, the more annual leave they are entitled to: a new employee may be entitled to two or three weeks per annum, whereas a person who has been there for say five years might feel entitled to five weeks. Wage increases are a similar issue: an employee would expect to have her salary increase annually at least in line with the rate of inflation, but without necessarily becoming more productive with the passage of time. It is not unusual for an employee with 10 or 15 years of experience to be earning 50 per cent to 100 per cent more than an individual with say two years of experience, yet not being more productive. Thus, staff turnover can be beneficial to a practice by keeping labour costs down or it can lead to rising, and indeed many business companies, including General Electric and Microsoft, pursue an active ‘functional turnover strategy’ when they perceive established members of staff becoming too established.

Staff turnover, especially of more senior individuals, increases promotional opportunities for others lower in the ranks that stay. For example, a nurse can become a receptionist, and a receptionist a practice manager.

In an ideal world, we would like to select successfully, train thoroughly and employ productive, efficient and effective workers who behave impeccably. But life is not like that: forest fires are necessary to clear away dead wood, and the best we can hope for is that new growth can take place quickly and with minimum cost to the forest.

Are you for or against the notion that staff turnover can be beneficial? Email jury@dentaltribuneuk.com and let us have your views.

Dogs can turn

An ancient intonation states ‘know thine enemy’. Problem is, they are not always easy to spot, and the worst are often the least expected. An example is a woman whom I know well has in recent years become a chronic claimant. In fact, she is addicted to claiming/suing since she found out that many individuals and groups would rather not charge or even give money back than deal with this beautiful but very viciousrottweiler. This is because when she first presents, she does so as a pos- dole, but as time goes by her canines lengthen, her curls straighten and shorten, and before you know it you are being savaged. The question is, how do you spot the rot- twailer within the poohle?

Do all dogs turn?

One simple solution is to assume a priori that every poohle has the potential to turn. If you follow this philosophy, you must trust no one, get every patient to sign every disclaimer and indemnity document possible, and contact your indemnity insurers at the first sniff or nasty bark. You must collect your fees in advance, because you will not be able to claim in arrears once the foam is on the mouth. Such a mentality will substantially diminish your ‘at risk’ profile, but unfortunately also proves unpalatable to the poohles that are real poohles. So, rather than preparing for confrontation, work to create co-operation.

How can you pre-empt turning?

Sometimes people are diffi- cult when a situation is stressful for them, and it doesn’t get much more stressful than at the dentist. Rather than enhancing the fear factor, offer encouragement and reassurance to prevent a difficult person becoming more difficult.

One way is to spend time talk- ing to and observing the doggies before you get into any serious treatment. Sooner or later, they will give clues about who they really are. Ask why they left their last dentist. Inquire about their appre- ciation or otherwise of work done in the past. Note give-away cues such as ‘very expensive’, ‘...didn’t listen to me’, ‘...got the colour wrong’, ‘...had a difficult recep- tionist’, ‘she hurt me, so I never went back’, and the most obvious of all, ‘he was a butcher’. Beware racial/religious/age prejudice to- wards others, because it will not be long before it is towards you.

Ten tips to achieve resolution without pain:

A sign of emotional maturity is the ability to create positive outcomes from negative situations by developing necessary and practical techniques. These will help you to anticipate problems and find the best solutions for challenging situations.

1. One must practice working way from conflict and to- wards co-operation.
2. One must enlist one’s patients rather than engage them.
3. One must learn to cope when conflict arises, and especially learn not to take every com- plaint personally, even if it ap- pears personal.
4. Remember at all times that the problem may lie more with what’s going on in your pa- tient’s head than in your hands.
5. Gather as much information as possible to try to analyse the conflict situation.
6. You may improve your results by moulding your own be- haviour and attitudes rather than trying to change those of your patients.
7. Respect the rights of others and be prepared to compro- mise when appropriate.
8. Plan your approach, and use positive communication skills to negotiate the best outcome for all parties.
9. Try initially for co-operation rather than conflict by aiming at a solution that benefits you both equally.
10. But if this doesn’t appear to be working, bale out sooner rather than later and leave it to the professionals to resolve.
Money Matters

Transforming poor performance

If you’re having a difficulty managing and financing your practice, Andy McDougall says there are options to consider before signing away your business

Technically I’m broke. Physically I’m tired. Emotionally I’m drained. Sound familiar? You would be surprised by how many principals are in this position and struggling with all that goes with managing a business. The bank manager is highlighting your precarious financial position; a tax bill is looming; you are not fulfilling your contractual obligations; claw back is on the horizon; new patients just aren’t arriving as quickly as you needed or hoped they would.

In such circumstances it’s no wonder that the offer of taking all that stress off your hands with the purchase of your practice can seem tempting. You could still work in the practice and receive a decent salary but someone else would own it and run it their way leaving you with very little of the sale proceeds and no entitlement to the profits that would inevitably be generated in the future. So before you sign away your business, consider the other options available to you.

Determining the worth of your practice

If it is a corporate, the purchase offer is most likely based on what we call EBITDA – Earnings Before Interest and Taxation, with depreciation and amortisation added back. The magic number is then grossed up by a multiple to give you your offer. The question you have to ask yourself is would you accept their offer if you could see the same future as them?

The same vision

Ever stopped to think why someone would offer you good cash for a business that in the technical sense is broke? The answer of course is that the intended buyers can see a very different future to the one you envisaged. The question you have to ask yourself is would you accept their offer if you could see the same future as them?

If the future results of your business are attractive to others, why aren’t they just as attractive to you? The difference of course is that while you are clinically superb, you may not be as adept commercially. The people acquiring your business will run it with you in mind, and because of business knowhow, they will reap the rewards that you once believed would be yours. If only you had that business knowhow you could transform the performance of the practice and reap the profitable rewards yourselves.

Transforming a vision

Yes every business must have a vision but having a vision is easy and fades quickly after the ‘rah rah’ away day. What many owners seldom tell you is how to actually turn your vision into something tangible and profitable. There are no new truths. The way to deliver it is the way it has been done for many years, by every successful business under the sun – it is just new to dentists. Regardless of whether you want to take your business to the next level; plan your exit to maximise your payday; rely on something more tangible than luck, or turn debt and uncertainty into a planned and profitable future, business planning offers the solution.

Transforming poor performance

You may not get all your cash from the sale straight away. Some may follow at a point in the future and may even be dependent on you delivering some specific targets (but at least you will be able to sleep without worrying about any further debt).

• Having sold the business you may not be able to simply walk out as in many cases it is you the investment is being made in. The investor may expect you to stay on for an agreed period to ensure your clients don’t disappear with you.

Planning is the secret

Business planning requires a bit more thought than a budget spreadsheet based on last year plus 10 per cent and needs to be more specific than some generic business planning software from PC World. Your business plan is akin to incorporating fingerprints because it is unique to you and your circumstances. It will help you to identify the key drivers that underpin your success and align your resources to focus on those things that will make the difference to you.

The results of sound business planning don’t result from luck; it’s a methodology that works. Why not consider business planning as a viable alternative to the offer you’ve just had on your practice – at the very least it will help you to clearly see what your intended purchasers can see and give you some scope for negotiation so that if you want to sell, at least you get the sales value you truly deserve!

Would you accept their offer if you could see the same future?

Andy McDougall

Andy McDougall has over 25 years experience of business planning and brings to his business and expertise from a wide range of commercial and competitive business sectors. Andy now delivers business planning services to help members of the dental community to respond to the dynamics of an increasingly commercial and competitive environment. He helps businesses reach the next level and to turn around poor performance. To find out more on our business planning services, contact info@spotonbusinessplanning.co.uk or call 07710 962559.

About the author

Trionic 5S Delivery Units

NEW

Trionic 5S Delivery Units

- Wide range of equipment options
- Dual water bottles
- Touch panel controls

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Touch Panel Controls with additional features

- Chair position movements
- Chair Programmes 1, 2 & 3
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- Rinse & return programme
- Programme memory control
- Micro Motor speed limiter
- Scaler power control
- Water Bottle A
- Water Bottle B
- Spilltoon cup filler
- Spilltoon rinse
- Operating light switch
- Radiograph viewer
Vigilance is vital

If you take care of the pennies, the pounds will take care of themselves, an idea that shouldn’t be dismissed in this time of financial upheaval. Ian Stead explains

It’s not much fun counting beans in or out; but with the credit crunch and inflation sweeping through every sector of the economy, and having particularly negative effects on the pound in the patient’s pocket, now more than ever it’s vital to keep an eye on the practice expenses.

The more hours you spend in the surgery pursuing prosperity, the more frustrating it is to see the bottom line eroded by a burgeoning debit column.

Of course, every business and every practice suffers from fixed costs over which their principals have very little control. There’s the rent or the mortgage, utility bills, wages, bank interest, bad debts, local taxes... all these and more must be paid just to stand still. That’s why it’s so important to have systems in place to control the costs you can influence without having to waste valuable chair time checking the details.

Watch your spending

A policy of regular expenditure reviews ensures that seemingly insignificant increments in the cost of small, everyday items do not pass unnoticed. It’s a competitive market, and changing suppliers is easy. When annual contracts are due for renewal, for insurance, fire extinguisher maintenance or clinical waste disposal for example, the laziness of maintaining the status quo may not be the most economic. Shop around; knowing that a new agreement is not a forgone conclusion should also mean a keener quote from the supplier.

Don’t overstock

A prudent purchasing policy, which eschews impulse buying and stock levels as well as keeping a brake on disproportionately routine spending. Suppliers frequently announce supermarket-style, time-limited special offers on everyday clinical necessities, and the temptation is to ‘stock up’ at bargain prices while the offer is available. It seems a good idea at the time, but storage is also a cost and do you really need thousands of wipes when you use only a few dozen a week?

On the other hand, a monthly stock check will indicate with reasonable accuracy the volume usage across the practice of clinical and office essentials, and a commitment to regular delivery puts you in a strong position to negotiate discounts with the supplier.

The adage ‘Take care of the pence and the pounds will take care of themselves’ is easy to dismiss as irrelevant when the purchasing power of the pound is under threat and the business turnover is a six or seven figure sum; but dentists who do, do so at their peril.

For more information on finding the very best practice valuation and sales advice, contact Frank, Taylor & Associates on 08456 123434, email team@ftassociates.com or visit www.ftassociates.com.

About the author

Ian Stead

After graduating from Imperial College London, in 1980, with a degree in Zoology, Ian Stead joined Rentokil PLC Pest Control Division in a graduate recruitment scheme and soon progressed to sales manager of its West London branch. In 1995, Ian established an independent pest control company in London, which was sold in 2004. As the son of a dentist, Ian possessed some empathy with dentists and dentistry. It was with this understanding and his excellent knowledge of running a successful business that Ian joined Frank Taylor & Associates in April 2006 as managing director.
Management of dental plaque to reduce disease

Dental hygienist Mhari Coxon gives an overview of dental biofilm

**Diagram One: Four Stages of Biofilm Cycle**

With kind permission of Professor John Thomas, West Virginia University

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This article is intended to give an understanding of the structure of biofilm and its role in periodontal disease. Its role in dental caries will also be discussed.

**Introduction**

It is without doubt that bacteria, and the by-products of their life cycle, are the primary etiological factor in the chronic disease of periodontitis.

The bacterium in the mouth can be split into three groups – planktonic or free floating, those attached to the oral epithelium, and those attached to the tooth or other inert surface. The interaction of the planktonic and epithelial-based bacteria with the microbes attached to the tooth surface enables the complex biofilm that is dental plaque to develop. It is this plaque that triggers the host’s response, in susceptible persons, causing periodontal tissue degeneration to begin.

**Dental biofilm**

Dental biofilm was described well as ‘a microbially derived sessile community, characterised by cells that are irreversibly attached to a substrate or interface or to each other, are embedded in a matrix of extra- cellular polymeric substances that they have produced, and exhibit an altered phenotype with respect to growth rate and gene transcription.’

**Formation of the dental biofilm**

Microbially generally prefer to develop in an attachment (sensu) formation. The microorganisms found to be pathogenic to humans can thrive as planktonic (free-floating) and biofilm states as well as sessile. Recent research shows there to be over 500 microbial strains present in oral biofilm.

Formation of the biofilm can be separated into four stages.

**Stage One**

Once the surface of the tooth has been cleaned, a conditioning film of proteins and glycopolymers is adsorbed rapidly to the tooth surface. This is the saliva pellicle forming and starts immediately after the surface has been cleaned.

Debris such as protein, fragmented bacteria and amylase found in saliva are embedded in the film, acting as receptors, allowing the attachment of the microbes to begin. These can involve protein-protein or carbohydrate-protein (lectin) interactions, and this process contributes to determining the pattern of bacterial succession.

**Stage Two**

Attachment can be defined as a slime layer forming around the colonizing pioneer bacteria, which consist mainly of gram-positive cocci and rods that divide and form microcolonies.

These initial colonising bacteria connect to the pellicle and each other with hundreds of fine, hair-like structures called fimbriae. Once they stick, the bacteria begin producing substances that encourage other planktonic bacteria to join the community. This is the recruitment phase. It is thought that the act of attaching to the pellicle stimulates the bacteria to excrete an extracellular slime layer that helps to anchor them to the surface and provides protection from the microbes already attached.

The biofilm then grows primarily through cell division of the already attached bacteria, rather than through the adherence of new bacteria. Next, the proliferating bacteria begin to grow away from the tooth. Plaque doubling times are rapid in this early stage of development.

**Stage Three**

**Bacterial blooms** are periods when individual species or groups of strains grow at a rapidly accelerated rate. More microbes are sent, in the form of quorum sensing, and a second wave of bacterial co-aggregate with bacteria that are already locked to the pellicle.

**Stage Four**

The bacterial colony will degrade itself of waste and dead bacteria and some planktonic bacteria will be released to continue the growth cycle.

**Disruption of the biofilm**

The key weapon against this maturation that is unable to professional patients and patients remains regular disruption, and where possible, removal, of the biofilm and saliva pellet causing a break in the cycle. This tends to inhibit the metabolic growth. We know that, if left untouched for up to 12 weeks, pockets will be colonised and so the need for maintenance care remains as valid as it always has.

**Mouthwash**

Chlorhexidine, Cetyl pyridinium Chloride and Essential oil mix mouthwashes have all shown some penetration into a biofilm of varying percentage in research. These in conjunction with good toothbrushing and interdental cleaning can be useful in the reduction of incidence of the chronic diseases of periodontal disease and dental caries. No antimicrobial can disrupt the biofilm significantly without mechanical intervention.

**Photodisinfection**

Pertows are a Photodisinfection system developed by Ondine that utilizes low-intensity lasers and wavelength-specific, light-sensitive, available to specifically targeted and destroy microbial pathogens and reduce the symptoms of disease. The compounds are generally topically applied and one or more lasers are used to activate the compounds and complete the disinfection. Research is ongoing in this field.

**Probiotics**

There was a probiotic launch this year specifically aimed at supporting a healthy dental plaque. There is some early research available but more in-depth study is needed.
Dental Practices nationwide are benefiting from the advantages of adding Periowave to their treatment regime.

Dr David Africa of Elm Dental Practice, Cheshington, Surrey, has noted Periowave’s virtues. “The inclusion of the Periowave method in our armamentarium in the fight against periodontal disease has been a fantastic choice,” he says. “The ease of use and the acceptability by patients of the new technology, as well as the predictability of the results, makes everyone confident that we can significantly reduce the risk factors for periodontal disease.”

“In my experience with Periowave when combined with splinting,” Dr Africa continues, “I have seen amazing results, especially in the lower anterior region in patients of all ages. During their follow-up visit, patients immediately tell us about the significant improvement in the feel of their gums, and the disappearance of bleeding that was there before treatment.”

Philip S Burns & Associates Dental Practice, Sheffield, are happy with the results of Periowave. “There is considerably less bleeding after treatment and the pocket depths are reduced. Patients have noted that any bad taste has disappeared and there is far less tenderness in the gums. Patients have been delighted with the treatment.”

Tony and Lisa Appleton of Church Street Dental Practice appraise the commercial decision to take on board Periowave.

“We looked at each of the areas of dental care we were providing and highlighted and researched those areas we felt we could improve. Fortunately for us our research coincided with the UK launch of Periowave and we were lucky enough to secure one of the first Periowave machines in the country.”

“Patients appreciate the pro-active treatment Periowave offers and are happily paying for it. The ease of the treatment is a winner with both patients and practitioners alike! Initial data of pocket depth reductions suggest decreases of up to 3mm at the 6-week post-op review. We are currently looking to expand our periodontal team and firmly believe that Periowave has given us this welcome boost to the practice.”

Dental biofilm and caries
In dental caries, there is a shift toward community dominance by acidogenic and acid tolerating species such as mutans streptococci and lactobacilli, although other species with relevant traits may be involved. Strategies to control caries could include inhibition of biofilm development (for example, prevention of attachment of cariogenic bacteria, manipulation of cell signaling mechanisms, delivery of effective antimicrobials, etc.), or enhancement of the host defenses. Additionally, these more conventional approaches could be augmented by interference with the factors that enable the cariogenic bacteria to escape from the normal homeostatic mechanisms that restrict their growth in plaque and out compete the organisms associated with health. Evidence suggests that regular conditions of low pH in plaque selected for mutans streptococci and lactobacilli. Therefore, the suppression of sugar catabolism and acid production by the use of metabolic inhibitors and non-fermentable artificial sweeteners in snacks, or the stimulation of saliva flow, could assist in the maintenance of homeostasis in plaque.

Summary Box
Reducing the caries forming biofilm
- reduce sugar intake in clients diet
- improve oral hygiene
- increase saliva flow

Dental biofilm is a complex group of communities which, when allowed, will create a suitable environment to thrive at the detriment of the host. Oral hygiene ensuring good plaque control still remains a major control element in maintaining a healthy dental biofilm. Diet and lifestyle are also important factors in determining the quality of dental plaque.

Dental biofilm is a complex group of communities which, when allowed, will create a suitable environment to thrive at the detriment of the host. Oral hygiene ensuring good plaque control still remains a major control element in maintaining a healthy dental biofilm. Diet and lifestyle are also important factors in determining the quality of dental plaque.
Full Dentures
the dento-legal implications

Although new techniques and new materials are creating new opportunities, and new challenges for clinicians to meet and overcome— not to mention new dento-legal risks to deal with—there are still plenty of familiar 'old chestnuts' that crop up with monotonous frequency in claims and complaints against dentists. One such problem is the provision of newly-provided dentures, or even the indigity of having to remake the dentures on one or more occasions, only for the patient to send back, declaring the new dentures to be unwearable. Most of the complaints and claims associated with full dentures can be categorised into three groups:

- the oral cavity
- the patient
- the clinician

The Oral Cavity
Although it may seem self-evident, an essential prerequisite of successful full denture construction is a properly detailed assessment of the patient’s mouth—the quality and suitability of the edentulous ridges and the soft tissue of the denture-bearing areas, the occlusion and vertical dimension, the musculature, and any complications introduced by the lips, tongue or cheeks, for example. Additionally, the quality and quantity of the patient’s saliva may have a direct impact on the retention and comfort of the denture.

Dry mouth or significant changes in the content/quality of saliva is commonly found in the elderly, and often compounded by certain medical conditions and by many different types of medication. A careful medical history and assessment of the saliva can alert a clinician to possible problems arising from this area.

Recording the Assessment
Surprisingly few dental records for complete denture cases confirm that these essential first steps have been taken, so it becomes easy for patients (or their lawyers) to argue that the clinician has failed in his/her duty of care to carry out a full examination and assessment prior to constructing the dentures.

When things go wrong in the later stages of denture construction, it is easy to be wise after the event and not uncommonly a dentist will say 'this was always going to be a difficult denture because of the patient’s bite' (or the lack of edentulous ridges, or dry mouth etc.). This then invites the question of whether these problems were ever discussed in sufficient detail with the patient before proceeding.

If you do anticipate problems for any reason, then take the time to warn the patient, and record these warnings in a dated entry in the clinical notes. Without such record/card entries, the way is left open for the patient to argue ‘I would never have gone ahead with these dentures if the dentist had only explained to me that...’

This is essentially a consent issue, although it may not have appeared so at first sight. That same line of thinking begs the question that ‘had the patient been appropriately and adequately warned, would he or she preferred a referral to a prosthodontic specialist, or perhaps to someone with special expertise or experience in full denture construction?’ In short, if the initial examination reveals anything about the patient’s mouth that would limit the prospects of constructing full dentures successfully, then discuss these constraints with the patient in advance.

The Patient
As we all know, different patients present with different problems. Some are extremely demanding and difficult to satisfy, others seem impossible to deflect from unrealistic expectations of treatment outcomes. Some talk too much and are apparently determined to control the treatment at every stage, while others talk too little and fail to give us crucially important information about their previous history or current problems. With some patients we are on a hiding to nothing from the outset—because of our age, or sex, or appearance, or ethnicity, and because they come to us with preconceptions and perceptions of what they want, what they expected, and what they need.

Clinical Confidence
All of these problems—and more—can prejudice the prospects of success when providing complete dentures. A patient, who is confident in the clinician providing the dentures, is more likely to be happy with the dentures; conversely once a patient loses confidence in the clinician who is providing the dentures, the prospects of a successful outcome can be slender or non-existent.

Getting to Know Them
It’s short-sighted to focus exclusively on the dentures themselves; an important aspect of the equation in full denture construction is to maintain the relationship between

Fig. 1

An irregular maxillary alveolar ridge together with a tendency to a dry mouth and an existing stomatitis could be a challenge, particularly when opposed by the natural anterior teeth and a lower partial denture.

Fig. 2

Daunting Dentures
Most clinicians will have experienced the humbling and soul destroying experience of multiple retries (trial insertions) of full dentures or endless adjustments/eases, destroying experience of multiple occasions, and new challenges for clinicians to meet and overcome—not to mention new dento-legal risks to deal with—there are still plenty of familiar ‘old chestnuts’ that crop up with monotonous frequency in claims and complaints against dentists. One such problem is the provision of newly-provided dentures, or even the indigity of having to remake the dentures on one or more occasions, only for the patient to send back, declaring the new dentures to be unwearable. Most of the complaints and claims associated with full dentures can be categorised into three groups:

- the oral cavity
- the patient
- the clinician

The Oral Cavity
Although it may seem self-evident, an essential prerequisite of successful full denture construction is a properly detailed assessment of the patient’s mouth—the quality and suitability of the edentulous ridges and the soft tissue of the denture-bearing areas, the occlusion and vertical dimension, the musculature, and any complications introduced by the lips, tongue or cheeks, for example. Additionally, the quality and quantity of the patient’s saliva may have a direct impact on the retention and comfort of the denture.

Dry mouth or significant changes in the content/quality of saliva is commonly found in the elderly, and often compounded by certain medical conditions and by many different types of medication. A careful medical history and assessment of the saliva can alert a clinician to possible problems arising from this area.

Recording the Assessment
Surprisingly few dental records for complete denture cases confirm that these essential first steps have been taken, so it becomes easy for patients (or their lawyers) to argue that the clinician has failed in his/her duty of care to carry out a full examination and assessment prior to constructing the dentures.

When things go wrong in the later stages of denture construction, it is easy to be wise after the event and not uncommonly a dentist will say ‘this was always going to be a difficult denture because of the patient’s bite’ (or the lack of edentulous ridges, or dry mouth etc.). This then invites the question of whether these problems were ever discussed in sufficient detail with the patient before proceeding.

If you do anticipate problems for any reason, then take the time to warn the patient, and record these warnings in a dated entry in the clinical notes. Without such record/card entries, the way is left open for the patient to argue ‘I would never have gone ahead with these dentures if the dentist had only explained to me that...’

This is essentially a consent issue, although it may not have appeared so at first sight. That same line of thinking begs the question that ‘had the patient been appropriately and adequately warned, would he or she preferred a referral to a prosthodontic specialist, or perhaps to someone with special expertise or experience in full denture construction?’ In short, if the initial examination reveals anything about the patient’s mouth that would limit the prospects of constructing full dentures successfully, then discuss these constraints with the patient in advance.

The Patient
As we all know, different patients present with different problems. Some are extremely demanding and difficult to satisfy, others seem impossible to deflect from unrealistic expectations of treatment outcomes. Some talk too much and are apparently determined to control the treatment at every stage, while others talk too little and fail to give us crucially important information about their previous history or current problems. With some patients we are on a hiding to nothing from the outset—because of our age, or sex, or appearance, or ethnicity, and because they come to us with preconceptions and perceptions of what they want, what they expected, and what they need.

Clinical Confidence
All of these problems—and more—can prejudice the prospects of success when providing complete dentures. A patient, who is confident in the clinician providing the dentures, is more likely to be happy with the dentures; conversely once a patient loses confidence in the clinician who is providing the dentures, the prospects of a successful outcome can be slender or non-existent.

Getting to Know Them
It’s short-sighted to focus exclusively on the dentures themselves; an important aspect of the equation in full denture construction is to maintain the relationship between

Fig. 1

An irregular maxillary alveolar ridge together with a tendency to a dry mouth and an existing stomatitis could be a challenge, particularly when opposed by the natural anterior teeth and a lower partial denture.
dentist and patient. Time spent at the outset in getting to know the patient and understanding any expectations, is seldom wasted. If nothing else, it can alert you to situations where the best option is not to become involved in the treatment at all, or where the additional experience of a specialist is advisable.

The emotional component associated with full dentures is not often appreciated. It is worth considering why the patient has chosen this particular moment to seek the replacement of the dentures they have been wearing for so many years. An understanding of the patient’s motivation often provides the key to understanding his/her needs and expectations. It may also alert the clinician to the potential difficulties.

Getting Used to Them

A patient’s ability to adjust to new dentures that are different in some ways from others worn over a long period, may be influenced by events in his/her life that are quite unrelated to the dentures themselves. The dentures become a convenient scapegoat for an unhappy patient to focus his/her problems on. Adapting to the new dentures simply represent one challenge too many for a patient who is already under stress for one reason or another, and whose ‘coping’ mechanisms are already compromised for reasons outside the clinician’s control.

The Clinician

There is still a lot of wisdom in the old adage that an extra five minutes spent at each stage of the construction of a denture, saves ten minutes at the next. Anyone who has accepted a less-than-optimal impression, or who has rushed the ‘biting’ stage of a full denture, will probably relive a few nightmare cases upon reading this. Similarly, adjustments that are easily and inexpensively made at the wax ‘try-in’ stage, are a costly and time consuming frustration once the dentures have been completed.

Easy Does It

‘Eases’ and other adjustments of the type already described require skills and a fine judgement. They are quick and easy enough to achieve, but each successive removal of acrylic may be considered very carefully. Before removing any acrylic from a completed denture, it is worthwhile asking yourself what it is designed to achieve, and for whose benefit the material is being removed. After several cases, there is a danger you will have removed much of the retention initially achieved by denture flanges or the accuracy of the fitting surface. Adjustments in the ‘post-dam’ area should be approached with caution. Many such adjustments made at the patient’s insistence have eventually led to the need for a complete remake.

When to Stop

If patients return time and time again, complaining that they are unable to wear their dentures, it is tempting to dismiss them as patients who will never be satisfied, whatever is done for them. It is salutary to remember that the majority of these patients subsequently go on to have perfectly satisfactory dentures constructed by another dentist.

Dentists who have remade dentures on one or more occasions, or who have invested a great deal of time over many visits, may feel that they have done everything humanly possible to achieve a satisfactory outcome for the patient. This makes it all the more frustrating and hurtful when patients throw all this commitment back at the dentist, saying that they had attended twenty times, and allowed the dentist to have three attempts, but the dentist was still unable to make a denture that they could wear.

A New Start

One learns with experience when that stage has been reached. This is the time when it makes more sense for the patient to make a fresh start with another dentist, than to persevere with a case when the confidence and patience is wearing very thin on both sides.

About the author

We are the world’s largest specialist provider of dental professional indemnity and risk management for the whole dental team. The articles in this series are based upon Dental Protection’s 100 years of experience, currently handling more than 4,000 cases for 51,000 members in 70 Countries. Visit us at www.dentalprotection.org

A complete set of 56 risk management modules can also be ordered from Lynne Moorcroft at mmps.org.uk.
Minimal intervention, best results

James Goolnik insists you needn’t drill your patients teeth away to create the perfect smile, when you can use Durathin porcelain veneers

Think about it. You carry out smile-design principles and remove healthy enamel for the labial surface of your patients’ teeth. No matter how good your clinical skills, your patient is likely to have transient sensitivity during the temporisation phase and for a brief period after final cementation of your new restorations. Even in the most conservative preparations 10 per cent of the teeth you have prepared will lose vitality in the future. You are also relying on fifth-generation bonding agents, so there is a possibility of debonding in the future.

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1. Diagnostic wax-up. Using a technician who also thinks in the same field. An additive technique allowing a realistic smile. Then using silted matrix to copy this into a provisional smile (Luxatemp) in the mouth.

2. Direct composite mock-up (my preference). Adding composite and sculpting it to get a beautiful smile. Take an alginate to send to the laboratory to copy.

Ask the patient to return a few days later to check the appearance and speech. Flick the restorations off and take accurate silicone impressions and send to the laboratory. There’s no need for further temporisation unless the patient cannot wait to show off their new smile.

On the fit appointment, no anaesthetic is necessary, you may choose to use a small amount of anaesthetic to make the rubber dam placement more comfortable. The seating protocol is slightly different as the restorations are more delicate until cemented so a delicate touch is advised. No drills, no sensitivity, no anaesthetic and they can be removed with almost no changes to the enamel.

If you want to find out more, Dr Dennis Wells, Dr James Goolnik and Mark Wallis will be presenting Minimal Intervention Dentistry, otherwise know as ‘you are not going to drill my tooth down to a stump!’ on Friday June 26. They will also be offering a hands-on certification course.

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* The Dental Advisor 2006, Vol 23, No. 6, S. 8/9
Tips for carrying out occlusal treatment

David Bloom and Jay Padayachy of Senova Dental Studios offer their top 10 tips on assessing your patient for occlusal problems

1/ In an ideal occlusal scheme, Centric Relation (CR) is coincident with Centric Occlusion (CO). See fig 1. This occurs naturally in only 10 per cent of the population.

CR can be defined as ‘when the heads of the condyles are in their most superior position within the sockets, with the discs properly aligned and full neuromuscular release’.

CO can be defined as maximum intercuspation of the teeth and is otherwise known as habit bite.

2/ Assess any discrepancy between CR and CO, as this may result in a slide with the potential for occlusal disharmony.

3/ Assess the static occlusion to evaluate the overbite and overjet. The overbite will help determine how much incisal length can be increased with or without opening the vertical dimension and will help the diagnosis of a traumatic palatal occlusion or anterior open bite. The overjet will help determine the teeth that will be involved in the excursive scheme. It is essential that the teeth as far away from the hinge axis that the skeletal pattern will allow take the excursive loads.

4/ Assess for wear facets and abfraction lesions. Use Shimstock and articulating paper to assess holding contacts before doing any restorations. See figures 2 and 3 — these show poor guidance in right hand excursion.

5/ Assess anterior and protrusive guidance — ideally there is a canine protected occlusal scheme with posterior discussion in all lateral and protrusive excursions. Failing this, anterior group function is acceptable but there must be NO working and/or non-working interferences and no posterior interferences in protrusion. See figs 4 to 6.

6/ Do I work in CO or CR? CO or conformative dentistry is most commonly used in single tooth or quadrant dentistry while CR or reorganised occlusion is most commonly used in rehabilitation cases. Reorganising an occlusion can be as non invasive as an equilibration or can involve a full arch or even a full mouth reconstruction.

7/ Assess bitewing radiographs for the presence of any vertical bony defects, which may be associated with poor function — see fig 7.

8/ Believe your patient — if they say that the bite ‘feels high’ after placing a restoration (direct or indirect) it probably is!

9/ Triple trays work well for single tooth or quadrant dentistry but check patient is in CO.

10/ Learn how to use a face bow as articulators are essential for larger cases or smile cases.

And remember to attend an occlusion course to help your understanding of the basic principles and the diagnosis of occlusal disease and their potential consequences.
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- How to use photography to treatment plan
- How to apply the principles of occlusion for longevity of your restorations
- How to take the perfect Centric Relation bite
- Why and how to take a face bow
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About the author

Dr David Bloom, a graduate of the Newcastle-upon-Tyne Dental School, has been a principle at Senova Dental Studios since 1996 focusing on comprehensive restorative and cosmetic dentistry. A past president of the British Academy of Cosmetic Dentistry (2007-2008), David is also an accredited member of the BACO, one of only 10 in the world. He is a member of The British Society of Occlusal Studies, The British Society of Restorative Dentistry, The British Dental Association and is a sustaining member of The American Academy of Cosmetic Dentistry (AACD). He is also a fellow of the International Academy of Dental Facial Aesthetics. David is on the editorial board of the Journal of Cosmetic Dentistry – the official journal of the American Academy of Cosmetic Dentistry and is a clinical director of CO-OP.R8 seminars, instructing and lecturing on all aspects of cosmetic dentistry in the UK and the US. (www.coopr8.com).

Dr Jay Padayachy, a graduate of the Newcastle-upon-Tyne Dental School, has been a principle at Senova Dental Studios since 1998 focusing on comprehensive restorative and cosmetic dentistry. A full member of the British Academy of Cosmetic Dentistry, he is a member of The British Society for Occlusal Studies, The British Society of Restorative Dentistry, The Pankey Association, The British Society of Periodontology and the American Academy of Cosmetic Dentistry of which he is a sustaining member. He is also director of CO-OP.R8 seminars and lectures in all aspects of cosmetic dentistry in the UK. (www.coopr8.com).

Fig. 2: pre-op right lateral excursion
Fig. 3: pre-op left lateral excursion
Fig. 4: post-op right lateral excursion
Fig. 5: post-op left lateral excursion
Fig. 6: post-op protrusion
Fig. 7: vertical defect associated with a non-working interference.
Feeling the pinch?

In the fourth in the series, Neel Kothari suggests that the harsh reality of the new system means that for some people, dental healthcare is no longer an affordable necessity, freely available to all, but rather a difficult choice to make that will have a direct impact on their wallets.

Over 60 years ago on July 5, 1948, the National Health Service was launched with the proud expectation that it would make the UK the ‘envy of the world’. Prior to its introduction, healthcare services were at best patchy and the level of care received was linked very closely to one’s wealth. The introduction of the NHS revolutionised the way healthcare was provided in the UK. For the first time, hospitals, doctors, nurses, pharmacists, opticians and even dentists were brought together under one umbrella organisation with the caveat of being ‘free for all at the point of delivery’.

From the very start, its central principles were clear; the NHS was to be available to all and financed entirely from taxation, which meant people paid into it according to their means. Today, the NHS still operates with many of its core principles intact, but it now faces a different set of challenges. Words such as ‘credit crunch’ and ‘recession’ play heavily on the minds of those who are most affected by the economic downturn and for some, the NHS was not freely available to all. The idea that the average majority of people were being looked after in dental care and finding value for money. Meanwhile, the fringe minority that the NHS relatively smoothly, whereas the fringe minority seem to be the biggest burden, both in terms of accessing dental care and finding value for money.

The economics of dentistry in recent months, it has become clear that people are feeling poorer, and when I have quoted £198 for treatment, some patients have asked me, ‘is that the NHS price?’ While the majority of people still opt to have their treatment, I am particularly concerned about those that feel they cannot afford to do so. If we look at how this affects our elderly population, we can see that the cost of day-to-day living is rising at an alarming rate and many elderly people are struggling to make ends meet. Although there is financial help available towards dental costs, many people who are feeling the pinch of inflation do not qualify for this help. Surely having some patients struggling to find £198 for necessary dental treatment is not well enough.

Failing our society?

It is now clear that the introduction of banded courses of treatment has not effectively addressed the needs of society’s most vulnerable and this may indeed be the area where the system has failed the most. The link between work needed and patients’ fees has been messily severed many crucial links, such as patients’ registration and the links between patients paying according to the amount of treatment they need. Further to this, the much-needed constructive dialogue between the Department of Health and the dental profession seems to be missing. While some patients have benefited from this new system, others are not so lucky. As the nation begins to tighten its belts, we may find more patients struggling to pay for NHS dental treatment as many feel it is becoming beyond their means. The harsh reality is that for some people, dental health care is no longer an affordable necessity, freely available to all, but rather a difficult choice to make that will have a direct impact on their wallets.

Shoving true colours

So, in a time where the burden of the economy is affecting people for the first time, we perhaps here where failures of the dental reforms are most visible. The dental reforms have blindly severed many crucial links, such as patients’ registration and the links between patients paying according to the amount of treatment they need. Further to this, the much-needed constructive dialogue between the Department of Health and the dental profession seems to be missing. While some patients have benefited from this new system, others are not so lucky. As the nation begins to tighten its belts, we may find more patients struggling to pay for NHS dental treatment as many feel it is becoming beyond their means. The harsh reality is that for some people, dental health care is no longer an affordable necessity, freely available to all, but rather a difficult choice to make that will have a direct impact on their wallets.

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About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds for the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

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Dentistry is about helping people and you have probably already found that people ask you all sorts of things about their teeth and mouth. This can be difficult if you haven’t studied the subject yet. They may see you as an expert despite your protestations that you are not. No matter what your level of knowledge is, it is important to listen to the person, otherwise we can’t help them. It also helps us. As Sir William Osler said in 1904: ‘Listen to the patient; he is telling you the diagnosis’.

Your amazing brain

Have you wondered why it is so hard to concentrate on what someone is telling you? Why does your mind drift off in lectures and seminars even if they are interesting? It is because you have such a mighty brain (but be careful how you tell the lecturer that if they catch you not concentrating). You can process spoken words at about 400 words a minute, but people speak socially at 110 words per minute, or often slower if they are speaking formally as in a lecture. This means that even when your brain has taken in the visual stimulus of slides or other visual aids you still have a lot of spare capacity. That is how mighty your brain is.

Clear your head

To really listen to a patient you need to clear the other stuff out of your head. This is much easier said than done. You will be wondering what they are thinking about you, what you will be doing with them, and may well be conscious of a colleague working with you who will be watching and listening to you. You may also be mindful of time and the need to get a move on. The good news is that it takes no longer to listen to the patient than it does to ignore them.

You can try to focus not only on what the patient is saying, but also on how they are saying it. As will be shown in a future article, people reveal more about themselves and how they perceive their health or problems in how they speak, than what they actually say. If we can tune into this, we can gain masses of information and keep our brains fully occupied. Often their choice of words and their expression together tell us far more about how they feel than their words alone. If we can get in touch with their feelings, we are in a much better position from which to be able to help them.

The patients give even more information about their feelings and thought processes through their facial expression and body language. We will look at these in more detail in another article, but remember that it is easy for someone to disguise their words to give an impression of self-assurance, but telltale signs of apprehension will usually be readily detectable through voice tone or body language – even to those of us who do not have the little grey cells of Hercule Poirot.

Mike Wanless says that to really hear what your patient is saying, you’ll need to clear your head and look for the signs

Mike Wanless

qualified as a dentist in Manchester in 1977. He took an MSc in health education and a PhD in dentist-patient communication. He has spent most of his career in the community dental service but now works as the Head of the Greater Manchester School for Dental Care Professionals in Salford. He is also a dental tutor for two PCTs and is an examiner for NBDSN.

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Dental Services Direct is renowned for its impartial advice and first-rate service. In particular, the Dental Services Direct team has a wide knowledge of the latest in chair and delivery unit technology. As suppliers of many major equipment manufacturers including; Anthis, Belmont, Dentalez, Heka and Stern Weber, the com...
The main benefit is that each brush has a flexible handle and brush to increase control and access to difficult areas. Unlike other brushes, the tip has been especially designed with a unique pivot technology enabling it to bend easily and minimise potential breakage.

Denti-Brush is available in 4 sizes in packs of 6 brushes. Each brush has its own hygienic protective cap making it ideal for travel as well as at home.

To find out more about the promotions we are running areas including Acid Erosion, Dentine Hypersensitivity, Caries for Dentures, Smoking Cessation and Gingivitis, and are available to all practices. Each module contributes to 1 hour’s verifiable CPD.

For more information please contact your GSK Representative or call 0208 047 2700.
Vizilite Plus™ Screening Test for Oral cancer

Vizilite Plus™ is a simple technology to assist in the early detection of oral abnormalities including premalignant lesions and oral cancer.

Vizilite Plus™ comprises of a chemiluminescent light source (Vizilite) to improve the identification of lesions and a blue phototherapeutic dye (TBliue) to mark those lesions identified by Vizilite. Carried out as part of a general check up, Vizilite Plus™ is a simple, low cost, pain free and 100% sensitive test that can help save lives or give patients peace of mind.

Pack of 40 Vizilite Plus™ £62.78 plus VAT Pack of 20 Vizilite Plus™ £50.55 plus VAT

For more information, please contact Panadent 01689 88 17 88 or visit www.panadent.net

GlaxoSmithKline Consumer Healthcare (GSK) - Products for all of your patients

GlaxoSmithKline Consumer Healthcare (GSK) offers oral hygiene products for patients at all stages of their dentition, ranging from milk teeth to the care of dentures. Brands include Aquafresh, Corsodyl, Sensodyne, Sensodyne Pronamel and Poligrip.

The World's Best Dental Implantology Diploma Course

Developing the best skills requires access to the best courses and teachers. Perio-Implant Europe Ltd provides this access, and its courses are world-renowned.

Perio-Implant Europe Ltd’s strong reputation has attracted internationally recognised experts to teach modules as part of the Diploma Course in Dental Implantology (April 24th 2009 to February 15th 2010). The impressive list of names includes Apollo-nius Allen, Andre Saadoun, Roger Levin, Pascal Valentin and Perio-Implant Europe Ltd founder Nadeem Zafar, with venues in the UK, Sweden, France and Brazil.

Other modules include:
- Head and Neck Anatomy
- Digital Photography
- Periodontology
- Implant Design and Immediate Placement
- Creating a Cosmetic/Implant Referral Practice
- Implant Treatment Planning
- Medico Legal Aspects
- Prosthetics Complications
- New Concepts
- and more...

With hands-on sessions and residencies in Brazil, as well as the Advanced Bone Grafting Course involving valuable work in Europe, the course is regularly oversubscribed and it is crucial to book early to avoid disappointment.

For more information call 01276 469 600 or email info@implantsuccess.com.

Easyshade™ Compact

From Vita, the world leading expert in shade determination, the new Easyshade™ Compact is a fast and reliable way to take shade at the push of a button. High measuring accuracy due to spectrophotometric measuring, this cordless, mobile and lightweight unit reads up to a potential 97 shades combination, both in Classical and in the 3D system. User friendly and easy to learn, with Easyshade™ Compact, you can read one single shade or 3 different areas in the tooth and check restorations. Up to 25 shade taking results can be stored in memory. No more worries about lighting conditions or costly remakes!

Panadent 01689 88 17 88 or visit www.panadent.net

Howard Gluckman – London Workshop

The evening of 18th of February 2009 will find an audience in Fulham taking part in the second Velopex London Aquacut and Laser Workshop – presented by Dr Howard Gluckman. As a Specialist Periodontist, Dr Gluckman has made extensive use of both his Velopex Laser and Aquacut.

At the Workshop, we encourage owners to bring case presentations for discussion. The venue is Fulham Dental Care on the Fulham Road – so numbers are limited.

Costs for the evening are £25 for existing Velopex Laser owners, £55 for new Velopex Aquacut units and £275 for those who do not own a Velopex Laser or Laser.

The seminar qualifies for 5 Hours CPD and can be booked by contacting Mark Chapman at Velopex.

To book or for more information or to ask any questions, please contact: Mark Chapman Medivance Instruments Ltd Barretts Green Road LONDON W3 10 AP UK Tel +44 7754 044877 mark@velopex.co.uk

FREE Book and Beautiful II from Shofu

Shofu are offering the first 10 readers to call the opportuni ty to win a fabulous colour glossy educati onal book. This fascinating 252 page book entitled A clinical Guide to Direct Cos metic Restorations’ written by Sushil Koirala and Adrian Yap clearly illustrates actual case studies. It takes you through smile design, demonstrating the principles and protocols all the way through current restorative materials, bonding to enamel and dentine, the gioner concept all the way through to techniques, clinical applications culminating in pa tient communication.

As an extra incentive, Shofu will be sending you a generous sample of Beautiful II gionier. This state of the art composite restorative material is based on Pre-Reacted Glass Ionomer technology.

To claim your free Cosmetic Restorations book and Beautiful II sample, which includes 5 x single dose A2, 5 x single dose A5 and instructions for use or for further information please contact Shofu on 01892 870000 – hurry, stocks are limited!

Orthodontist Faces Africa

Consultant Orthodontist Al- lied Thom, a past Treasurer of the British Orthodontic Society, has recently returned from a charity mission to Ethiopia on behalf of Facing Africa (www.facingafrica.org). Mr Thom helped set up the charity, which sends surgical teams to Northern Nigeria and Ethiopia to reconstruct the faces of children who have survived Noma disease (which in English text books, is known as Cancum Oti).

Noma starts as a small ulcer in the mouth. In a healthy, well fed European child it would be no more than a few days of temperature. But in a child who is malnourished, has probably had measles and malaria and whose resistance is low, it spreads rapidly.

Within a few days the cheek will be ulcerated and fungating (malignant swelling). The tissue will loosen. The child will have a fever and be unable to eat. Within five days it will spread to the lips. Within seven days to the nose, palate and/or eye. Within two weeks 95% of the children will be dead from overwhelming sepsis (blood poisoning). There is nothing that can be done for these children.

It is the survivors of Noma for which Facing Africa cares. These survivors are left with horrendous facial disfigurement, often with no lips, cheeks, palate and nose. They have ankylosis of the TMJ (loss of jaw movement) from scar tissue and are unable to open their mouths. They feed by pushing a mushy pat through the gaps in their teeth and Mr Thom had to feed some of the children a high protein “mush” through a 50 ml syringe. Because of the facial disfigurement and local village taboo the children have no friends, no schooling, no socialising – no life. Some are “mislitected” by the local medicine man by burning with hot coals and sticks. Facing Africa seeks out these children, assessing them as suitable for surgery (taking into account other medical conditions) and brings them into a rehabilitation unit prior to surgery.

If you would like more information about the work of Facing Africa, visit www.facingafrica.org. More information about the BOS is available from www.bos.org.uk.
Core CPD Update Conference

With CPD now mandatory for the whole dental team, here’s a chance to boost your CPD by seven hours in Watford, London and Gatwick.

As you are no doubt aware CPD became mandatory for all DCPs from August 1 2008 and this conference has been designed to comply with the GDC requirements for verifiable CPD and will cover the latest developments for the dental team in the following areas:

- **DENTAL RADIOGRAPHY, TODAY’S REQUIREMENTS, TOMORROW’S POSSIBILITIES**
  Speaker: Dr Colin Cook

- **LEGAL AND ETHICAL ISSUES: RISKY BUSINESS-AVOIDING THE BANANA SKINS**
  Speaker: Dr Len D’Cruz

- **DENTAL DECONTAMINATION IN THE 21ST CENTURY**
  Speaker: Dr Martin Fulford

- **DEALING WITH COMPLAINTS PROFESSIONALLY**
  Speaker: Stephen Henderson

- **MEDICAL EMERGENCIES IN DENTAL PRACTICE**
  Speaker: Dr Yusof (Joe) Omar

Professional Conferences comply with the GDC requirements and the conference will provide:

- Clear learning objectives
- Certification of the verifiable CPD
- Topical subjects which not only satisfy CPD requirements but are also of direct relevance and use to delegates in their day-to-day work
- Speakers who are acknowledged experts in their field and who will present their talks in an informative and interesting way
- Accessible venues with good conference and catering facilities
- Refreshments and course documentation
- Optional two-course seated lunch with wine
- Seven hours verifiable CPD

Dates and venues

The conference takes place at three different venues on three separate dates:

- **Monday March 30 2009 – Hilton Hotel, Watford**
- **Wednesday May 6 2009 – Hilton Hotel, Gatwick**
- **Monday May 11 2009 – Kensington Town Hall, London**

Professional Conferences has been providing highly respected courses for the legal and surveying professions for over 16 years and is established in offering top-quality, but realistically priced conferences in these professions, with over 18,000 delegates attending our conference annually. Now, with the help of highly respected lecturers from the world of dentistry we are bringing you excellent and affordable courses in topics relevant to your practice.

Book your place

Tickets cost £99 + VAT excluding lunch, or £114 + VAT including lunch. For more information, contact Michelle Tobias at Professional Conferences on 01923 859626 or email info@proconferences.com. You can also book online at www.proconferences.com.

For additional venues and more information, visit www.proconferences.com or call 01923 859626.
IDT Dental Products Ltd is seeking a Dental Lab Technician to assist in preparing computer datasets for stereolithographic models and surgical drill guides. These are custom made for each patient starting from a CT scan. Your job will be to liaise with dentists to optimise the guide design, read and manipulate patient datasets, generate reformatted images and 3D views, and create computer files for automated guide production. Knowledge of dental restorations including implants is essential, but no hands-on bench work is required.

If you are interested in a change please call +44 (0)20 8600 3540, fax +44 (0)20 8600 3549 or email rar@ctscan.co.uk for further information. Also please visit our website www.ctscan.co.uk.

Dental Tribune
United Kingdom Edition
January 26–February 1, 2009
Classified 31

Ayub Endodontics
www.ayub-endo.com

Wimbledon
- Assistance with Buying & Setting Up Practices - Incorporation Advice
- New PDS/GDS Contract Advice - Particular Help for New Associates
- Tax Saving Advice for Associates and Principals - Help for Dentists from Overseas
- National Coverage - We act for more than 550 Dentists

Please contact:
Nick Ledingham BSc, FCA
Tel: 01244 328301
Email: mail@moco.co.uk
Website: www.moco.co.uk/dentists

SPECIALIST DENTAL ACCOUNTANTS

IDT Dental Products Ltd is seeking a Dental Lab Technician to assist in preparing computer datasets for stereolithographic models and surgical drill guides. These are custom made for each patient starting from a CT scan. Your job will be to liaise with dentists to optimise the guide design, read and manipulate patient datasets, generate reformatted images and 3D views, and create computer files for automated guide production. Knowledge of dental restorations including implants is essential, but no hands-on bench work is required.

If you are interested in a change please call +44 (0)20 8600 3540, fax +44 (0)20 8600 3549 or email rar@ctscan.co.uk for further information. Also please visit our website www.ctscan.co.uk.

Libran supports principals who:
- Think their practices could be run better
- Wish to reduce this admin/management workload.
- Considering retirement and want to get ready to sell
- New principals who feel lost and in need of help.

To find out if we can be of help you please call Lyndsay on 07721 627765 or 01792 510112

Frank Taylor and Associates

Valuations
- purchase, sale, buying in, retirement
Sales
- practices available countrywide
- totally confidential service for vendors

Libran helps principals who:
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- New principals who feel lost and in need of help.

To find out if we can be of help you please call Lyndsay on 07721 627765 or 01792 510112

Implantology Mini Residency
One year Surgical & Restorative Implantology Course
with Dr Mark Hamburger, Specialist Prosthodontist
An implant course to provide you with the necessary knowledge and skills to start a successful career in implants. The course is aimed at general dental practitioners looking to integrate implant dentistry into their patient care.

The course provides:
- All necessary education to comply with the GDC guidelines as set out by the Faculty of General Dental Practitioners, UK and the Royal Collage of Surgeons, England, in the document entitled: Training Standards in Implant Dentistry for GDP’s 2008 (download at GDC.gov.uk)
- Compliant with GDC guidelines for 185 verifiable CPD points.
- Benefit from over 20 years of clinical knowledge & experience.

The course:
- 18 full days spread over a 14 month period, located in Harley Street, London.
- Maximum of eight candidates per course.
- Each candidate will place and restore at least two implant cases under the direct supervision of Dr Mark Hamburger. In addition: treatment planning, surgical and restorative observation of all course patients.
- Guest speakers:
  - Dr Henri Thuau, Consultant Maxillo Facial & Oral Surgeon
  - Dr Jo Omar, Medical Emergencies and CPR

For further information and to request a brochure/registration form, please contact:

Implant Courses with Dr Mark Hamburger
42 Harley Street
London W1G 9PR
Tel: 020 7631 1488
Fax: 020 7631 1646
Mobile: 07944 970 140
marian-harley@hotmail.co.uk
One of the five conference programmes running will be the ‘Aesthetic Dentist’ which is now in its 3rd year.

The main scientific programme brings together eminent international speakers, distinguished clinicians and guru’s from every facet of dentistry, business and facial aesthetics. Creating a remarkable opportunity to see the cutting edge clinical techniques that together form the basis of total facial and dental rejuvenation.

The show has been split into 5 different sections aimed at different areas of the dental profession:

- **AESTHETIC DENTIST**
- **SIMPLY DENTAL**
- **DENTAL INSIGHT**
- **HYGIENIST SYMPOSIUM**
- **AESTHETIC TECHNICIAN**

*Programme/speakers subject to change*

**CONFERENCE TICKETS £495+VAT**

**AESTHETIC DENTIST CONFERENCE PROGRAMME**

**FRIDAY 13TH MARCH**
- 08.15 - 09.00 Registration and Exhibition
- 09.00 - 10.30 Jason Kim + Peter Kouvaris  
  The Function and Art of Predictable Aesthetic Dentistry
- 10.30 - 11.15 Exhibition
- 11.15 - 13.15 Michael Wise  
  Aesthetics for Tooth and Implant Supported Restorations
- 13.15 - 14.15 Lunch and Exhibition
- 14.15 - 15.15 Bob Khanna  
  Modern Dental and Facial Aesthetics – Strategies for Success
- 15.15 - 16.15 Sia Mirfendereski  
  10 Steps to Create the Leading Whitening Centre
- 16.15 - 16.45 Exhibition
- 16.45 - 17.30 Tracey Bell  
  Integrating Aesthetic Medicine with Cosmetic Dentistry

**SATURDAY 14TH MARCH**
- 08.15 - 09.00 Registration and Exhibition
- 09.00 - 10.30 Ashok Sethi  
  Aesthetics - Decision-Making for Predictable Outcome
- 10.30 - 11.15 Exhibition
- 11.15 - 13.15 Nicholas Davis  
  Dentistry and the Aging Face
- 13.15 - 14.15 Lunch and Exhibition
- 14.15 - 15.00 David Bloom  
  Visual Diagnostic Try-in’s - Beyond Dental Imaging
- 15.00 - 16.00 Bhavna Doshi  
  How to do Cost-effective Marketing
- 16.00 - 16.30 Exhibition
- 16.30 - 17.15 Ash Parmar and Rahul Doshi  
  Smile Design Techniques with “hot tips” on Clinical Procedures

*Programme/speakers subject to change*