MPs knock independent review

Mps have criticised the independent review into NHS dentistry in England for failing to have a practicing community dentist on its panel.

An independent team, to help improve access for patients who want to see a NHS dentist, was appointed in December by Health Secretary Alan Johnson.

The team led by Professor Jimmy Steele of Newcastle University is made up of Eric Rusney, consultant in Dental Public Health, Cumbria Primary Care Trust (PCT), Janet Clarke, clinical director of Salaried Dental Services, Heart of Birmingham Teaching PCT and Tom Wilson, director of contracts, Milton Keynes PCT.

Mike Penning, shadow health minister, expressed his concerns during the debate over the ‘lack of engagement between ministers and the professionals’.

He also questioned why no health minister attended the British Dental Association’s (BDA) conference last year ‘to speak on behalf of the government, given that the contract is so controversial within the profession’.

The BDA event was attended by the Liberal Democrats spokesman, Mr Penning and the Chief Dental Officer, Barry Cockcroft.

Mr Penning and the Liberal Democrats spokesman refused to debate with Dr Cockcroft in public as ‘he is a civil servant’ – he is not a minister of the crown and he is not elected; he is appointed by the Secretary of State for Health — and it is fundamentally unfair that a civil servant is there to represent the mistakes and problems that the government have got themselves into on dentistry’.

Mr Penning added: ‘As the process goes on and as this contract is reviewed, I am very concerned about whether the government will have the courage to admit how much of the contract they have got wrong and how much of it has affected people in this country.’

Mr Penning would like to see the length of contracts extended so dentists can invest in their practices.

‘If we want dentists to come back into the NHS, young dentists coming out of training schools — I have visited them and they are fantastic — to come into the NHS, we must give them the confidence to do so, especially in this difficult economic climate,’ he said.

The government has just published its further response to the conclusions and recommendations that were made in the critical Health Select Committee report last summer.

In the report, it accepted that ‘progress on improving access to dental services has been disappointing to date’ and set out the aims of the independent review.

Cirrhosis of the liver and had revealed Mr Gray Dodds had many years ago. An autopsy who now lives in South Africa, divorced from his ex-wife, known living family. He had be a long term abuser of alco-

Police said the death was not suspicious. He was known to have been going through eye surgery.

They worry not only about their teeth with 43 per cent wanting some kind of change their face or correct something about their body.

Consumers are most worried about existing treatments, closely followed by a need to improve access for patients who want to see a NHS dentist, was appointed in December by Health Secretary Alan Johnson.

According to a recent survey. Nearly half of patients believe they could have been offered a better service by their dentist, according to a recent survey.

The national survey carried about by RevalHealth.com, a specialist health research engine, also found that three quarters of the population would like to change something about themselves. Consumers are most worried about their teeth with 43 per cent wanting some kind of change their face or correct something about their body. A recent survey showed that three quarters of the population would like to change something about themselves.

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Pot-bellied pig calms patients

A dentist in Pembrokeshire is using a pot-bellied pig to help patients overcome their fears.

Many dentists have a colourful aquarium in their dental practice. But Dr Mark Boulcott, the principal dental surgeon at Herbrandston Dental Health Practice in Herbrandston, has gone one step further and has a pot-bellied pig called Matilda plus numerous ferrets, terrapins, rabbits and guinea pigs.

The pig wanders around the practice’s grounds, restricted only from the car park and clinical areas.

Dr Boulcott, believes the animals are effective in helping patients overcome their anxieties when visiting the dentist.

The children are taken to see the animals and ‘break the cycle of mistrust’ and to ‘show them that dentists can be nice people’.

A spokesperson for the charity, Facing Africa said: ‘These survivors are left with horrendous facial disfigurement, often with no cheek, lips, 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 pap 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 ‘misted’ 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.

During the trip, Mr Thom was part of the advance team whose duties were to carry out full medical, dental and social assessments, start a high protein feeding regime and a de-worming programme as well as clerking, photographing and assessing the degree of loss of jaw movement.

Extractions were performed where necessary as well as plaque removal and oral hygiene. Each patient was given their own hygiene pack and toothbrushing was supervised daily. Some had never seen a toothbrush and were used to using, on occasions, a soft twig. The children had come from remote villages. One had walked for two days just to get to the road where she could board a bus for the nine hour ride to the unit in Addis Ababa. They needed clean clothes, washing and to be shown how to use a lavatory. Each surgical team costs £40,000 in transport, materials and drugs and carries out over 50 facial reconstructions.

Mr Thom said: ‘I have seen pathologies the like of which I could only imagine; poverty one cannot comprehend and had the opportunity of giving something to lovely, grateful smiling children who can now look forward to a useful life. I removed my ‘rose coloured spectacles’ and found more life to more moving teeth!’

For more information about the work of Facing Africa, visit www.facingafrica.org

Reconstructing faces post Noma

A consultant orthodontist, has been helping to reconstruct the faces of children in Africa, who have survived Noma disease, and are horrendously disfigured.

Allan Thom, a past treasurer of the British Orthodontic Society, has recently returned from Ethiopia on behalf of Facing Africa. 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, also known as Cancum Ori.

Noma starts as a small ulcer in the mouth. A healthy, well-fed European child suffers a few days with a temperature. But the disease spreads rapidly in children who are malnourished, who have had measles and malaria and whose resistance is low.

Within a few days the cheek will be ulcerated and the teeth 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 per cent of the children will be dead from blood poisoning. The disease is prevalent in sub-Saharan Africa, where there is poverty and malnutrition.

A spokesman for the charity, Facing Africa said: ‘These survivors are left with horrendous facial disfigurement, often with no cheek, lips, 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 pap 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 ‘misted’ by the local medicine man by burning with hot coals and sticks.’

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GDPUK round-up

Tony Jacobs shares the latest from his forum as its members chew the fat about the latest issues on their minds, some dentistry-related, some not

GDPUK was off to a flying start with the usual infinite variety of topics related to dentistry at the beginning of 2009.

Reading the crystal ball always appeals to forum members. One such prediction was that as the pound becomes weaker and as the credit crunch continues to take hold, fewer dentists from abroad will find it beneficial to earn a salary in sterling, and the resulting shortfall in human resource will make achieving UDAs across the country more difficult. I was not convinced by this argument though. If the dentist lived in the UK, a pound is still a pound. The corollary to this argument is that Europeans will suddenly find that complex dental work is now suddenly cheaper in the UK, so their Euros will go much further. I wonder if any colleagues have seized on this and advertised their services to mobile Europeans? I certainly saw this effect in London over Christmas. Europeans were raiding the shops, with 70 per cent off in the sales and their advantage of 1 equal to £1.

Work woes

A popular thread was initiated when someone mentioned their terrible journey to work and asked about his peers’ journeys. This sparked varied answers, with some describing very scenic routes, some cyclists, some commuting on the motorway. My personal journey is about 2,000 metres against the rush hour traffic, so no queues for me, morning or evening. No, this isn’t a dentistry-related topic I know, but we all enjoy a topic which stimulates some discussion.

Clinical issues

Some clinical topics discussed (condensed) asked:

• Should we leave second molars off full dentures?
• Should articaine be used for nerve blocks?
• Which washer disinfector should we choose?

A practice manager began a discussion when asking about overtime for CPD for a DCP. A dental nurse who worked part-time attended a (free) radiography course during the day, but not in her contracted hours. She asked for time off in lieu. But her fellow team members often attend courses in evenings, but do not ask for comparable time off. So, what should the practice policy be, if we all agree team training is very important? If the practice allows this, will all time spent on education be part of the 40-hour week? This is a difficult one to answer.

Medical myths were de-bunked and dental ones were next. Should we add a few dental myths? My favourite being from quite a few of my lovely mums who insist: ‘They just came through like that’, when their two-year-old has rampant caries. Until next time.

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The Dental Defence Union (DDU) has given a suspended 18-month jail sentence, for claiming payment from the NHS for patients who didn’t exist, to a man who had failed to report to the Council conduct committee.

Mr Nolan was placed under supervision and ordered to do 300 hours unpaid work.

Mr Hoppenbrouwers called the consultation document ‘fundamentally flawed’ and said: ‘If, in the interests of protecting patients, you set minimum requirements for one type of provider, to ensure that patients will always receive appropriate compensation you must make consistent requirements of other types of provider. The GDC knows that a discretionary indemnity provider cannot agree to requirements that are consistent with those for insurers because to do so would ‘falsely claim to be holding themselves out to be insurers, which would be illegal’.

The DDU expressed disappointment that the GDC has not attempted to bring dentistry in to line with other healthcare providers such as opticians and chiropractors who have to have insurance and that it has not followed the example of regulators in other EU countries where insurance is either compulsory or recommended.

‘For each dental professional to have a contract of insurance and the certainty that negligence claims within the policy will be paid is indisputably in the interests of patients and dental professionals themselves,’ added Mr Hoppenbrouwers.

Robert Nolan, who has run a practice in the Lommer Street, Liverpool, since 1990, made up patients so he could falsely claim money and also claimed payment from the NHS for patients who didn’t exist.

Mr Nolan was convicted of 20 offences of obtaining money transfers by deception. Sixteen convictions related to fictitious patients with fake addresses while four related to overpayment for work.

The 56-week sentence was suspended for 18 months and Nolan was placed under supervision. Judge Morrow also ordered him to do 500 hours unpaid work in the community, pay £1,500 in costs and imposed a three-month curfew.

Mr Nolan will now appear in front of the General Dental Council conduct committee.

NHS dental fraud team manager Stephen McKenzie said: ‘Our thorough investigation showed that he was systematically defrauding the NHS. He claimed money for patients that did not exist and for work that was never undertaken on his registered patients. It is despicable that a person in his position, a position of trust in the community, should steal money from the NHS.’

He added: ‘Fortunately it is only a small minority of health-care professionals that abuse the system aimed at delivering NHS care. We were able to provide a clear trail that convinced the jury of his guilt. Any other dentist who considers the NHS as an easy target for fraud rather than a public service would be wise to consider how he would feel in Nolan’s shoes today.’


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The consultation recognises that there is an issue of 'enforce-ability' with discretion. As a mutual, non-profit making organisation which provides insurance alongside discretionary benefits - a detail missing from the consultation - we agree. In common with other discretionary providers, we cannot agree to any minimum requirements governing our exercise of discretion, because the very nature of discretion means we cannot give any guarantees.’

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What you rate the surface now? Certify your assessment in the Logicon assessment on page 21.

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Logicon can be applied immediately to a Kodak (Rtg) 9101/1100 radiograph. The features highlight the surface of interest in the radiograph. The program then runs automatically and produces three diagnostic aids.

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2. A plot of tooth density change across the site.
3. The percentage of mineral loss in the dentin based on a comparison to a database of normal and eroded dentin.

Logicon is an aid to the dentist’s own diagnosis. Since the eye can only resolve a maximum of 50 of the 250 shades of grey displayed on a conventional radiograph, while the capacity of the Kodak (Rtg) software is to capture 400 shades of grey, the potential for Logicon to reveal diagnostic information not readily visible to the dentist is considerable.

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Together, we can make a difference.
A lively debate on the value of endodontics, periodontics and orthodontics will be held at this year’s Young Dentist Conference. The event, which takes place at The Royal College of Physicians, in London, on 7 February, is organised by Dental Protection in association with the British Dental Association (BDA).

The first session, ‘Surgery 101 – Can we live without it?’, will pit three young dentists in specialist training against each other in a debate about the value of their chosen area of expertise.

The session will debate an imaginary scenario in which one of the three professions of endodontics, periodontics or orthodontics is to be scrapped on the grounds of cost.

The session will include a chance for questions and debate from the audience before a vote is taken on which of the three fields is the most dispensable.

The second session will explore one of the biggest challenges reported by young dentists, the discomfort they feel about discussing fees and charging an appropriate hourly rate for their services.

It will see a young dentist discuss with a young barrister and young business person their experiences in this area and debate how best this aspect of their professional lives can be managed.

The final session features three award-winning young dentists. Chosen for their very different approaches to establishing successful practices, the participants will describe their journeys to success and share insights into what they have learned from their experiences, before the session is opened to questions from the floor.

The sessions will be convened by three experienced figures from the dental community: BDJ editor-in-chief Stephen Hancocks, BDA chief executive Peter Ward, and VT adviser, NIS adviser and part-time dento-legal adviser for Dental Protection, Raj Rattan.

Tickets for the event, priced at £100 for DPL/BDA members, are available from http://www.dentalprotection.org.uk/news/events/events/young_dentists or by contacting Sarah Garry on 020 7399 1339 or emailing sarah.garry@mps.org.uk. Attendees will qualify for five hours verifiable CPD (Continuing Professional Development).

‘Scary’ dentists are a myth

A dentist in Essex is offering free check-ups for children to show that ‘visiting the dentist doesn’t need to be scary’.

Jane Jordan who runs a dental surgery, on the high street in Dunmow, Essex, is offering the free check-ups during February half-term - February 16 to 20.

The aim is to help children learn the right attitude to dental care from an early age.

Mrs Jordan said: ‘We want to actively encourage them to keep their teeth healthy and strong. During the week we will have free advice on foods and how to look after teeth, as well as giving out lots of free goodies such as stickers and toothbrushes.’

The surgery is hoping to attract more than 750 children of all ages during the week, and has an open book for any parents wishing to sign on for permanent dental care. The practice caters for both private and NHS patients.

Mrs Jordan added: ‘Hopefully events like this can give them, and their parents, a push in the right direction. In the process we can show them how visiting the dentist needs not to be a scary experience.’
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Hertfordshire’s primary care trusts have set up the helpline to help patients who have been having problems making an appointment with an NHS dentist.

The county’s dental chief Jane Robinson said: ‘It’s a popular misconception that NHS dental appointments are rare but that is simply not the case.’

In Hertfordshire there are 204 dental practices offering approximately 47,000 appointments every month. So there really are plenty of appointments out there.

Hertfordshire patients can call 01707 569645 or send an email to dentalappointments@herts-pcts.nhs.uk to find out the practice nearest which offers NHS dental appointments.

News & Opinions

Funding boost for Scotland

NHS boards in Scotland have pledged to spend millions on more dental facilities, after they were given an extra £82m by the Scottish government to spend on healthcare.

Health boards have pledged to make dental care a top priority and improve dental provision in their areas.

There are proposals for 15 new standalone dental centres as well as new surgeries and facilities upgrades.

The 15 new dental centres in Scotland are planned for: NHS Ayrshire and Arran; Cumnock, Ayr; NHS Fife: Levenmouth, Glenrothes; NHS Grampian: Fraserburgh, Huntly; NHS Highland: Oban, Campbeltown, Thurso, Inverness; NHS Orkney; Kirkwall; NHS Tayside: one planned (location to be confirmed); NHS Western Isles: Stornoway.

Health Secretary Nicola Sturgeon said: ‘In the tough climate we find ourselves in, capital projects are a crucial way for the government to stimulate the economy by providing local employment opportunities.

Since May 2007, this government has made NHS dentistry a top priority and these projects are further evidence of our determination to reverse the years of decline seen under previous administrations.

Already, we have seen the number of dentists rise and the highest ever number of dental registrations for both adults and children. And the opening of Scotland’s third dental school in Aberdeen in October last year will see more and more trained dentists entering the NHS.

I expect these new proposals from NHS Boards to further enhance dental access right across Scotland, as we strive to give Scots a dental service to be proud of.’

Andrew Lamb, the British Dental Association’s director for Scotland, said: ‘Today’s news provides recognition from the Scottish government of the significant problems that people in many areas face gaining access to NHS dentistry. For some of those people this investment will be good news, providing facilities for NHS dentistry where it wasn’t previously available. The new premises will provide high-quality environments for the practice of dentistry and that is to be applauded.’

‘However’, he added ‘there has been an ongoing problem of finding dentists to work in remote and rural sites and more will need to be done to address this. A significant number of people across Scotland will, unfortunately, continue to be without access to a dentist.

Today’s announcement is just one step in finding a solution to this problem. The Scottish government must also pay careful attention to the needs of the many independent dentists who will not be working in the new dental centres.

It was promised that some of this funding would be deployed to help high street dentists adapt to changing decontamination regulations and that is important that they are properly supported as they do this and continue to provide high quality care to the large numbers of patients they see.’

Colgate’s new Interdental Toothbrushes

The new toothbrush cleans the interdental surfaces of teeth.

Toothbrush manufacturer Colgate has produced an ‘innovative new toothbrush’ designed to clean the interdental surfaces of teeth.

The new Colgate Total Interdental Brushes have a triangular bristle shape designed for cleaning the interdental surfaces of adjoining teeth that can account for up to 40 per cent of the overall tooth crown surface.

A spokesman for Colgate said: ‘Every dental professional knows the importance of effective plaque removal for preventing caries and periodontal diseases. Interdental spaces are not easily accessible to most patients. Using a toothbrush alone can result in plaque accumulation in interdental spaces which remain undisturbed, potentially leading to caries and gingival inflammation. New Colgate Total Interdental brushes have been developed with this in mind.’

A patient recommendation pad is available from Colgate which enables dental professionals to highlight to patients the specific plaque retentive areas.

For further information or to request a Colgate Total Interdental brush patient recommendation pad call the Colgate customer care team on 01485 401 901.

Dental helpline for Hertfordshire

Patients in Hertfordshire will now be able to find the nearest practice offering NHS dental appointments by ringing a new dental helpline.

Hertfordshire’s primary care trusts have set up the helpline to help patients who have been having problems making an appointment with an NHS dentist.

The county’s dental chief Jane Robinson said: ‘It’s a popular misconception that NHS dental appointments are rare but that is simply not the case.’

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Taking over

In the second in the three-part series, Simon Hocken of Breathe Business considers various aspects of buying an existing practice.

The countryman who famously said to the traveller asking directions, ‘If I was going there, I wouldn’t start from here,’ had probably never met a dentist seeking his own practice. However desirable it may be to create a new business entirely in your own image, it’s often more practicable to buy into, or purchase outright, an established practice and progressively adapt its activities to fulfil your own ambitions.

Many of the basic criteria, which apply to creating a new practice, are equally relevant to acquiring an existing business. Location, and the surrounding demographic, must fit with the type of practice and treatment you aspire to provide; a rural community dominated by young families, for example, is probably not the ideal environment for an implant specialist. If the business is successful, and this is a safe assumption since you will naturally have examined the books before expressing a serious interest, it’s reasonable to assume that the service it currently offers is compatible with the needs of its core clientele, and a radical change of emphasis could be expensive.

Potential for growth?

Although your purchase target fits your present requirements, you should always consider its potential for future expansion; is it already working at capacity? Suppose you decide to open another surgery – is there parking for additional patients? Could the waiting area or the x-ray facilities cope with a higher throughput? More people on the premises may also have an impact on Fire, and Health and Safety regulations.

While taking over a going concern has obvious cashflow advantages, legal and professional advice is vital to assess and where appropriate renegotiate the existing contracts which govern its operation. Two of the most critical aspects are the tenure of the premises: when these are subject to a leasing agreement, and the practice’s relationship with its PCT where an NHS contract is involved. Bear in mind that an incoming owner will also assume responsibility for the existing staff contracts.

Read the lease

Practitioners frequently come to the market as the consequence of a retirement or the closure of a partnership, but these events may not coincide with the end of a leasing period. Even when this is the case, the seller may still need the approval of the premises’ owner before a change of principal can take place. Whatever the circumstances, a scrupulous examination of the terms of the lease should be undertaken by a specialist solicitor, with particular attention paid to who is responsible for maintaining the property, making good wear and tear, weather related or accidental damage and the funding of any alterations or improvements. Potential purchasers should also be aware that because commercial leasing agreements are normally longer than those covering domestic property, with up to 15 years and renewal options offering security of tenure, lessees are certain to insist on satisfactory bankers’ references before considering a new tenant.

When an NHS contract is involved, the attitude of individual PCTs to a change of practice ownership is notoriously variable, while some appear to be rela...
tively relaxed, others may take the opportunity to insist on a UDA renegotiation when the contract is transferred which effectively shifts the goalposts in their favour. Before making a commitment, at Breathe Business we recommend potential practice purchasers to inform the PCT management of their intentions, preferably in conjunction with the seller, who is in any case obliged to inform the PCT that a sale is in prospect.

Is it worth it?
It’s possible, even likely, that the vendor’s valuation of the practice will not coincide with your own opinion, and an independent valuation undertaken by an industry specialist is essential. While the valuation of tangible assets such as the freehold of the premises or the lease, and the clinical equipment, is relatively straightforward, this is not the complete picture. In recent years, goodwill values have escalated beyond recognition, some would say to unrealistic levels, with figures of up to 150% being recorded in some instances. This trend has been particularly evident in private, urban practices delivering a high proportion of cosmetic treatments, perhaps reflecting the rapid and continuing growth of this area of dentistry. Even among experts, opinions about the importance and long-term value of goodwill differ widely.

Making it yours
From day one of your ownership you will become liable for all the business expenses – most immediately the staff salaries. It has been known for new, more expensive employment contracts to come into force on the very date of the sale completion, another motivation for the careful evaluation of all the paperwork! In any case, as well as the purchase price you must have working capital set aside to sustain the business during the handover or settling in period – it would be rash in the extreme to depend on cashflow alone to see you through the first few weeks. There are also bound to be some changes, however slight they may be, which you will want to make immediately to put your own stamp on the business – new stationery, for example.

Dental practices do not present in uniform shapes and sizes – at Breathe Business we have clients currently engaged in developing or purchasing practices whose locations, among others, vary from a brand new clinic, a stately home and a Georgian house, to a converted off licence. Practice owners are also individuals, and it’s this diversity that makes experienced, professional business and legal advice so important during the evaluation and purchase process.

In my next article, we’ll look at the basic nuts and bolts of running the business in the first few weeks.
Trust in uncertain times

Changing our behaviour and creating a high-trust environment in the workplace, leads to greater productivity and will help to retain and attract patients, says Dr Elaine Halley

**Practice Management**

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**Benefits of Trust**

**Individuals who demonstrate both integrity and intent of purpose do so by means of the following behaviours: straight talking, respect for others, transparency, making restitution when mistakes are made and showing loyalty.**

**In terms of competency, a trustworthy individual must be capable of doing the job, for example, have had the correct training, but also must deliver the results and live up to the level of training with the results actually delivered. The behaviours which demonstrate competency are delivering results, seeking continual improvement, facing or confronting reality, clarifying expectations and holding themselves and others accountable.**

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**Do you patients trust you?**

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**Dr Elaine Halley**

Qualified from the University of Edinburgh and has been clinically practicing dentistry since 1992. She set up her practice, Cherrybank Dental Spa in Perth, Scotland, in 1995. She lectures on subjects ranging from clinical excellence, to leadership and practice management. Her blend of experience combined with her own leadership skills in the UK dental community commend her as a proven dental professional with a timely insight into the day-to-day and fiscal operations of a dental practice. Visit www.cherrybankdentist.com.

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There’s no doubt about it – people are living longer. Old is the new young. Grey is the new black. Not all older women sit around knitting little socks for their grandchildren; not all older men potter around in the garden. Senior citizens are no longer retreating from life but engaging it head-on. They are travelling to places that their parents never knew existed. They are not just cruising; they are Sking (Spending the Kids’ Inheritance). They are filling the gyms. They are keeping their minds and bodies fitter than ever before. Older people keep their appointments (they have fewer alternatives).

Patients
Look at your patients: it used to be smooth pink jobbies (dentures), but now it’s dermal fillers, teeth whitening, implants, wall-to-wall veneers; that’s a huge market out there, and they no longer have to pay school fees or mortgages. It’s not just younger people, but their parents who want not only to be healthy but also to look healthy, so the pharmaceutical and cosmeceutical markets are booming like never before. They may be the market segment of the past, but they are also very much the market of the present.

Consultants
When older people get beyond the age that used to mean mandatory retirement, they become consultants. They’ve been there and done it all, so why shouldn’t the younger whipper-snappers learn from them? The wheel doesn’t have to be re-invented every generation. However, there is a downside. Perhaps the wheel isn’t what it’s cracked up to be. Having been there and done it all doesn’t necessarily mean that older people know it all. Indeed they sometimes seem as if they do not know it all at all. They may think they know it all, but what they know may be well out of date, redundant and irrelevant. What they did when they first learned to do it was the prevailing wisdom, but may no longer be so. In fact it is extremely unlikely to be so – the half-life of a fact has shortened dramatically. Think of the composition and placement of composites. By continuing to do things the same way they always did, they simply become better at doing things that have become outdated and are consequently irrelevant in the face of new ideas, knowledge and techniques. Continuing education is now mandatory, and not without good reason.

Nowhere is the notion of being left behind better seen than in the fast-developing world of Information Technology. Although some older folk have taken to IT like the proverbial duck to water, many cannot get their (grey) heads around concepts that kids in nursery schools are able to execute with total facility. Think of writing notes in longhand compared to using a word processor. Think of the apparent complexity of new-generation cell-phones. Think of CAD-CAM (if you don’t know what that acronym stands for, you prove the very point that is being made!). If you don’t want to be out of it, get with it. And we’re not just talking about dentists. Old age is not for sissies.
In my last article, I offered some insights into the nature and effect of charisma. Someone with charisma has the ability to make another person believe that they are both capable of extraordinary things. The most pertinent present example is US President-elect Barack Obama, who triumphed over John McCain by sheer dint of getting the American nation to buy into the idea that, together, they could effect meaningful change.

Not everyone is charismatic, but every individual, whether dentist, nurse or hygienist, is capable of increasing his or her own charismatic effort. ‘Why bother’, you may say, ‘I’m fine just as I am’. That may well be true, but if you have ever experienced the feeling of rejection because another person has not bought into an idea that you believe could benefit both of you, then consider this: the reason for the rejection might simply be because you were not able to convince that person that they would gain from your suggestion – in other words, you lacked conviction and were unable to influence them sufficiently.

In his book, The Charisma Effect – how to make a powerful and lasting impression, consultant Andrew Leigh defines the Charisma Effect as ‘the ability to use all aspects of yourself to achieve a strong, memorable impact on other people, influencing them emotionally, physically and intellectually, including their thoughts, attitudes and behaviour’. This does not suggest that you try to become someone else, rather that you learn to improve what is least effective in you, and to maximise the use of your best talents.

So, to build your own charismatic effect, the starting point is to raise your level of self-awareness:

1. List those issues that you would like to remedy, change or improve. In other words, create a list of aims that would benefit not only you but others around.
2. The next step is to work on eliminating your weaknesses and play to your strengths.
3. Consider what aspects of your personality might hinder your own personal charisma effect (you do have one) from shining through. The first batch of these might fit the general descriptive term of ‘victim’ or ‘poor me’.
4. Consider when you have blamed others for your own lack of progress.

To develop a stronger charismatic effect, you need to move from the position of ‘victim’ to that of ‘chooser’, where you can select more positive options to look for and seize opportunities to increase your personal influence. In part three of this mini-series, I will suggest (I have just deleted the phrase ‘I will humbly suggest’) a positive 10-point programme that you could build into your daily life.

If you would like to arrange a free telephonic consultation, Ed Bonner can be reached at bonner.edwin@gmail.com

The 10th dimension... the power of 10

The Charisma Effect (part 2)

‘People always interrupt me when I speak’

‘No one listens to what I say’

5.2 Consider when you have blamed others for your own lack of progress:

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The NHS prevents me from focusing on quality
People in this area can’t afford better dentistry
“I’m just an Associate and my boss isn’t interested”
At my university/college/practice I was never taught how to...

DT

Practice Management
Penny Palmer talks to Dr David Bloom, co-owner of the luxury Senova Dental Studios in Watford about his vision for the business and how a team effort is essential to achieving his goal

P icture this - the best high-end ‘luxury’ dental practice with nine practitioner studios to boot, and a spa ‘experience’ to die for. Then imagine where – Watford is probably the last place you thought of - but for David Bloom, the former British Academy of Cosmetic Dentistry (BACD) President, there’s no place like home to build a booming business.

Born and bred in Watford, Bloom, together with business partner, Jay Padayachy created their dream, and Senova Dental Studios was born.

Impressive is an understatement, and clients will agree. Have you ever had a check-up while watching Batman Returns? Or what about a new set of veneers to the beat of Jack Johnson? No? Then you haven’t lived yet.

In a nutshell the practice features a relaxation area, four massage chairs, music on demand, as well as DVDs to entertain patients during treatments. Spa treatments range from paraffin hand waxes to facials and massages, while the list of dental treatments is comprehensive.

As well as the nine dental studios, there is the dental operating theatre, a spotlessly clean sterilisation section, a very inviting complimentary refreshment bar, and an internet bar including free Wi-Fi.

The vision behind the business is pretty clear cut. Bloom explains: ‘We had no overflow area and wanted to provide an overall service with other facilities.’

With no spa in Watford, it seemed natural to expand beyond dentistry. ‘Clients can now come in and log on to emails while in the relaxation area, or they can book up other services – we simply wanted to take it to the next level,’ adds Bloom.

So what do the clients think of it all? ‘Clients are amazed, they love the space, they love the chairs, and they love the cleanliness of the whole place,’ says Bloom. Indeed, patients could ‘happily sit in the chair for up to four or even eight hours for a big treatment.’

Expansion is all well and good when it comes to vision, but to be recognised ‘as a centre of excellence’ is a much harder nut to crack. ‘We want to be seen as inclusive, and we want to help other dental professionals to perform any aspect of dentistry they desire.’ This is why the dual mentor dentists for simple restorative work upwards, and run corporo-secure five minutes of his time. But having worked in the NHS for 15 years, he is used to tight schedules. He joined his father in the business in 1990, with Jay turning up to take over from Bloom senior eight years later. Initially a ‘mixed’ practice, the duo converted to private practice in the late 90s, because ‘we could not perform the kind of dentistry we wanted to at health service rates.’

They continued to see children under the health service, but when the goal posts were ‘revised’, with the new contract, they said goodbye to the health service – but still provide free examinations for children less than five years old, ‘as long as a family member is seen at the practice’. Explains Bloom: ‘I just didn’t agree with negotiating for UDA dentistry. It’s not fair if one dentist has one UDA at £15, while the other next door has one at £30.’

As a restorative dentist, Bloom says he is ‘first and foremost a GDP, as well as the former president of the British Academy of Cosmetic Dentistry (BACD). ‘I need patients’ expectations on every visit,’ though he is quick to point out that a team effort is essential to achieve this goal. ‘We have a concierge, a front desk team, patient and treatment co-ordinators, hygienists, and a practice manager – we could never achieve what we do without them.’

People he admires in the profession include his father, Mr Padayachy and his consultant ‘who is now a patient of mine’, as well as Roy Higson ‘who helped in my occlusion training’. Asked to describe himself, Bloom says he is an ‘astute, innovative, focussed’ professional who is ‘very important for any restorative dentist to have a close relationship with their ceramicist.’

‘I also couldn’t live without Collardam – a must for patient comfort, and I would also be lost without my digital SLR camera – it’s an absolute must-have.’

On the future of dentistry Bloom sees limitless potential. ‘With new materials, with implant dentistry and guided surgery, treatments can be a thing of the past, but it upsets me that people think that British people do not have nice teeth.’ He explains: ‘The press gave us a bashing five years ago but now they can see what we can do. The Hollywood smile is on its way out and the European smile could be round the corner.’

Competition, is not something to focus on according to Bloom. ‘There is more than enough dentistry for everyone, and our view is that we work together to educate the profession as well as our patients.’

Time though is the essence though, and running a practice like Senova is no easy task. How does he do it? I have a fantastic team, a very supportive wife and a brilliant business partner. Asked what he couldn’t live without when it comes to the business he says: ‘I couldn’t live without my ceramist, Luke Barnett, – he is part of my team and it is very important for any restorative dentist to have a close relationship with their ceramicist.’

David Bloom

Personality: Astute, innovative, focussed

Favourite destination: South of France

Hobbies: My family, snowboarding and swimming

Born: Watford

Family: ‘Two boys (eight and four years-old)

Favourite meal: Thai food

Drink: Wine

Car: Second-hand Porsche 911 convertible

Pets: Planning to get a dog

Best film: The Big Chill

Favourite book: The Celestine Prophecy

Star sign: Scorpio

Music: Pink Floyd

Sport programme: Rugby

Bloom sees anything from one to 10 patients a day, but the main goal remains the same, and that is to prevent dental disease and ‘ex- have a passion for cosmetic dentistry but personally think dentistry is general practice seeing clients from birth to older generations, and find it very rewarding.’

Bloom is on the editorial board of The Journal of Cosmetic Dentistry – the official journal for the American Academy of Cosmetic Dentistry. He is also the clinical director of CO-OPRA seminars, and instructs and lectures on all aspects of cosmetic dentistry in the UK and the US.

Standing outside the Watford practice on the day of the launch

Mini CV

A Newcastle-upon-Tyne Dental School graduate, Dr Bloom has been Principal at Senova Dental Studios since 1990 focusing on comprehensive restorative and cosmetic dentistry. A past president of the British Academy of Cosmetic Dentistry (2007-2008), David is also 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) and a fellow of the International academy of/Dental Facial aesthetics. Dr Bloom is also the editor in chief of The Journal of Cosmetic Dentistry – the official journal for the American Academy of Cosmetic Dentistry. He is also the clinical director of CO-OPRA seminars, and instructs and lectures on all aspects of cosmetic dentistry in the UK and the US.

Interview

14 DENTAL TRIBUNE United Kingdom Edition • February 2-8, 2009

David and Jay and their two fathers

Jenni Thomas, president of the Child Bereavement Charity with David and Jay

Jenni Thomas, president of the Child Bereavement Charity

Sport: Rugby

Favourite book: Pink Floyd

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In March 2008 the health minister, Ann Keen, announced that NHS funding for dentistry would be ‘ring fenced’ from 2009 for a further two years. Some think this means dentists’ protected income levels will also be extended to 2011; unfortunately, one does not necessarily follow the other, unless the Government makes fundamental changes to the two current Statements of Financial Entitlements (SFE).

New SFEs are due later this year/early 2009, and we’ll have to wait and see, but don’t be too surprised if there’s nothing in them to change the current timetabling for protected income – I’m assuming there will be no changes.

We’ll remain as we are at the moment then, for GDS contracts, Calculated Annual Contract Values (CACVs, based upon the baseline year) remain only in force until March 31 2009. After this time, CACVs will be replaced by Negotiated Annual Contract Values NACVs. For PDS Agreements, ‘Calculated Annual Agreement Values’ will be replaced by ‘Negotiated Annual Agreement Values’.

However, the PDS SFE is not very clear on the methodology by which CAAVs are to be replaced by NAAVs; it appears to suggest that NAAVs are to be calculated/agreed very much on the same basis as in 2006. Perhaps the new SFE will clarify the position.

Don’t hold back

The practical tip is to act NOW, (not at the end of March). Find out whether your PCT/LHB intends any significant changes to your contract/agreement. Speak to your LDC with a view to uniformity of approach in the process. Time is short – you need to move quickly.

If the PCT/LHB proposes unacceptable changes, remember that the Regulations require both sides to make ‘every reasonable effort’ to seek to resolve the dispute. If not, the matter can be referred for determination by the NHSLA.

By the time you read this, I expect that South Birmingham PCT’s appeal judgement in the judicial review case brought by Dr Eddie Crouch will have been heard. The High Court upheld Dr Crouch’s application for a review of the decision of the NHSLA to uphold a notice clause in his Agreement which allowed the PCT to terminate that Agreement without grounds, and on a date set out in the notice (as opposed to the agreement either continuing for its duration or only being terminable on the specified grounds of the agreement).
If the PCT’s appeal, against Dr Crouch’s successful application, is dismissed, then PDS contractors may be in a stronger negotiating position with their PCTs/LHBs.

Pre-contract disputes
On the subject of appeals to the NHSLA, there are still some pre-contract disputes rumbling on, virtually three years down the line.

Tip – there is a ‘time limitation’ on appealing pre-contract disputes to the NHSLA – the referral to the NHSLA must be made within three years from the beginning of the dispute. If you are involved in an ongoing pre-contract dispute, not yet referred to the NHSLA, then your time is rapidly running out!

Tip – now is the time (if you’ve not done it yet – and some have not) – to check that your contract/agreement paperwork is in order. I recently came across a case where the practitioner was unable to produce his PDS Agreement, and maintained that no such written agreement had ever existed. If he was right, both he and the PCT were in breach of the Regulations and the ‘contractual’ relationship might have been null and void. This is an extreme case, but does make the point that paperwork is not always in the state we imagine.

Tip – check your GDS Agreement. Ensure that Clause 16 (in the ‘standard’ form agreement) is correctly completed. The GDS Regulations state that a contract must provide for it to subsist until it is terminated in accordance with the terms of the contract or the general law. There are contracts out there, which are, nonetheless, expressed to expire on the March 31 2009 – this could clearly lead to problems, so it’s worth getting it corrected now.

Tip – now is the time to check that your contract/agreement paperwork is in order.

Tip – if your GDS Contract is incorrectly worded, get it corrected by agreement with the PCT/LHB – if the PCT/LHB won’t co-operate, then be prepared to refer to the NHSLA – bear in mind the time limits. You don’t want, at the end of March 2009, for the PCT/LHB, to claim that your GDS Contract has terminated!

Tip – PDS contractors should ensure that their PDS Agreement is correct as to term. PDS Agreements carrying on the old pilot scheme arrangements, should terminate no earlier than the end of the term for the original pilot scheme agreement. Orthodontists’ PDS Agreements entered into as from the April 1 2006 are required to have a duration of ‘not less than five years’ (Transitional Provisions Order Article 21).

Tip – PDS Contractors providing mandatory services should review their right, under Part 6 of the PDS Regulations, to ‘convert’ their PDS Agreement to a GDS Contract. Your decision will depend upon your circumstances.

Tip – the formalities include the contractor notifying the PCT/LHB ‘in writing’ at least three months before the date on which they wish the GDS Contract to be entered into. That notice also requires the contractor to give the date on which they wish the agreement to terminate ‘which must be at least three months after the date of serving the notice’. Might a PCT/LHB try to argue the invalidity of a notice if given less than three months before the expiry of PDS Agreement? Please make sure of your dates.

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It's becoming more popular for dental clients with disposable cash to invest, to consider alternative investments in a market where even banks don't seem safe.

A model investment portfolio typically includes a variety of equities, securities, bonds, deposit accounts, and gilts (Government-backed investments that were once gilt-edged, hence the name), as well as in some cases, property and commodities. This spread provides a reasonable amount of diversification. However, for any investors reading this, you'll most probably have found that your entire portfolio has fallen in the last few months, and your diversification strategy to avoid your entire portfolio falling has probably not worked as well as you would have liked it to.

US life settlement policies
Since the mid-1990s, we have noted growth in the market for traded US life settlement (life assurance) policies. In Germany and the US, there already exists a thriving traded life settlement policy market, similar in many respects to the traded endowment policy (TEP) market in the UK.

One of the plans we've researched that takes advantage of this market, is Keydata's Defined Income Plan which aims (but does not guarantee) to provide a full return of the initial capital invested at the end of the initial period. With headline yields of 8.25 per cent a year over 10 years, eight per cent over seven years and 7.75 per cent over five years, the investment has obvious appeal for investors seeking an attractive income over the medium term.

You can invest in this asset class through your ISA, as well as in pension arrangements, such as self-invested personal pensions (SIPPs) or directly in unit trusts.

Product structure
The Keydata plan invests in cash and a portfolio of traded US life assurance policies. The cash is used to maintain premium payments on the acquired policies and to pay income to investors. In addition, the insurance companies that issue the traded life settlement policies pay out a lump sum at maturity – that is, when the original life assured dies.

US life settlement policies are quite different from their UK equivalent. In most cases, these are effectively lifetime policies (US universal life contracts are written to age 100) and, therefore, there is a guaranteed payout on death. In the UK, life assurance is generally a fixed term product, with the exception of whole of life policies. The secondary market in US policies developed when it became apparent that many policyholders experienced a trigger event – retirement, for example, or a change in estate planning requirements – that made the protection policy redundant and a cash lump sum preferable. Before the development of the secondary market, the policyholder in this position had no alternative than to accept a surrender value from the issuer.

It is essential to appreciate that the life settlement secondary market is distinct from the earlier viatical settlement market, in which policies of the terminally ill (AIDS victims, for example) were purchased, based on what proved to be flawed mortality assumptions. Life settlement policies are uncorrelated with bonds, deposits, equities, commodities and crashing property values, and a good choice of investment, says Thomas Dickson.
cies are generally purchased where the lives assured have an expected mortality of between about two and 12 years and where the original policyholder is aged at least 65.

Importantly, the plan allocates about 80 per cent of the portfolio to policies where the life assured is aged 75 or over. This significantly increases the prospect of policies maturing within the term of the Plan, and hence the prospect of a higher yield or growth than is associated with standard portfolios.

The underlying portfolio aims to contain an appropriate number of policies to create a robust risk pool. The selection of policies, therefore, is based on:

- Diversification across policyholders by age, health, and by region and across issuing insurance companies.
- A minimum policyholder life expectancy of two years which avoids the distressed sales associated with the viatical market and avoids 'contestability' issues on early death, which in the US can arise if the death occurs within two years of the policy being taken out.
- A high portfolio weighting to older policyholders.

The portfolio construction process

The underlying portfolio is constructed to avoid contestability issues by ensuring that the life assured has a minimum life expectancy of two years and by maintaining a high portfolio weighting to older policyholders. The selection of policies is based on:

- Diversification across policyholders by age, health, and by region and across issuing insurance companies.
- A minimum policyholder life expectancy of two years which avoids the distressed sales associated with the viatical market.

Conclusion

The secondary market in life settlement contracts provides a new asset class for UK private investors, which helps to diversify their portfolio. There is a low correlation with traditional income-yielding assets such as bonds, gilts and deposits, and also a low correlation with growth assets, such as equities and property.

How much of your portfolio should be allocated to this new asset class is really decided in a financial review with your IFA, but the institutional market and the rule of thumb is that a five per cent weighting is required for genuine diversification.

It is as applicable to the more adventurous investors with private equity and commodities in the portfolio mix, as it is to those with a more traditional spread of equity and bond funds.

For growth investors, a carefully constructed portfolio would seem to be far less volatile than stockmarket investments. Of course, for both groups there is the inherent risk that medical advances, as yet unknown, could prolong the lives of the original policyholders, while a change in US legislation and regulation could also affect the value of the policies.

However, as the funds are weighted towards the traded policies of the 75-year-old+ market, they would seem to be well immunised against any unforeseen change. Finally, while the investment offers private investors a transparent vehicle and the opportunity to diversify risk with an investment that has a low correlation with traditional markets, it is important to appreciate that the Plan is designed to be held to maturity—either five, seven or 10 years depending on the option chosen. Investors who encash their holding before maturity may get back less than the original investment.

NOTE: The figures in this article are for guidance only and reflect the position at the time of writing. The value of investments can go down as well as up. It is therefore important that you understand the risks and commitments.

About the author

Thomas Dickson, director of Essential Money Limited, formerly a partner of Money4Dentists, has a wealth of experience in advising the dental industry. Beginning as a financial advisor, Thomas recently launched Essential Money, providing expert independent financial advice dentists throughout the UK can rely on. For a copy of the Merlin Stone report which explains the attractions, risks and ethical issues of the above investment or for further information, please contact Essential Money on 0121 685 5060 or email thomas@essentialmoney.co.uk
Raising awareness of temporo-mandibular disorders
Dr Andrew McCance explains how orthodontics can help spot the telltale signs before treatment begins

With new systems on the market that enable and empower GDPs to offer orthodontic treatments to patients, it is important that everybody is able to spot the telltale signs of temporo-mandibular disorder (TMD). The vast majority of tooth movements carried out will affect occlusal function, so it is vital that the state of the patient’s temporo-mandibular joint (TMJ) is accurately appraised before treatment begins.

Orthodontics can help
The benefit of orthodontics over alternative ‘smile solutions’ is that a specialist in this field can take the entire skull into account during diagnosis and treatment planning. It may be expedient to focus just on the teeth, but this can cause the clinician to miss important data pertaining to the TMJ. Any loss of vertical resulting from treatment can lead to considerable suffering for patients who are on the brink of operating ‘off the disc’. Simply by making themselves familiar with TMD, GDPs can safeguard the wellbeing of their patients and avoid carrying out treatments that are detrimental to the TMJ.

Common symptoms
There are a number of common symptoms associated with TMD. When a patient hears a click when opening their mouth, followed by another click when the mouth is close, this is a signifier that the posteriorly misplaced condyle head is retrieving the disc, housing it within the pterygo-tympanic plate. Any swelling in the area can cause dizziness, or even nausea, as the middle ear is affected, and tinnitus has been known to be present in many chronic cases. The internal derangements caused by TMD could also be associated with trigeminal neuralgia.

Other symptoms include occurrences of locking, which require intervention and cause a great deal of misery for the patient. Remodelling can also take place, as surrounding muscles become hyper-activated to prevent the disc-making a hole in the pterygo-tympanic plate. Any swelling in the area can cause impact on the chin can cause trauma of the retro-discal ligament, as the jaw is pushed back and forced off the disc.
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:

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- SIMPLY DENTAL
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Earn up to 12 hours CPD through attending the conference!

*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
I f you are responsible for the reception desk in a busy practice, sometimes it can be tempting to resolve a situation as quickly possible simply by being in a position to deal with the next one when it comes along. You only have to look at the customer service desk in a busy supermarket to see the technique in action where refunds are given and the goods are taken back with no questions asked; customers are directed to the bathroom; parking is validated and leaking cartons are replaced with a smile; anything to avoid a queue of people waiting, the ferocity of their enquiry escalating by the minute.

Such levels of frenetic activity are not really appropriate to a dental surgery, but there are some similarities particularly when the customer is given conflicting advice by different members of staff.

Consider the case

A principal dentist has received a complaint about one of his associates who was away on leave. The complaint centred on the patient's appointment being cancelled at short notice, which had left the patient with toothache over night.

The principal apologised and indicated that the appointment had been cancelled due to the illness of the associate. Unfortunately, this was not correct. The associate had spoken to the patient independently and said that the reason for the cancelled appointment was due to a lack of staff in the clinic.

The patient was now confused and raised a further complaint. The associate's version of events turned out to be true, while the principal had acted in haste without seeking the views of the others involved and in so doing had made the situation worse.

When a complaint arises, apologise, but don’t be in too much of a hurry to give an explanation. Consider the views of all the others involved before making a definitive response. The definitive response should only be given after an assessment of all the relevant facts, circumstances and issues pertaining at the time.

Look out for another Learning Curve from Dental Protection in future editions of Dental Tribune UK.
A solid foundation?

In the fifth article in the series, Neel Kothari asks whether the Department of Health will engage a better working relationship with dentists for 2009.

O
er the course of my last few articles, I have dis- cussed some of the diffi-
culties faced by NHS dentists on a day-to-day basis. Since the start of the new contract, we have seen an almost universal condemnation of the system from groups representing dentists and pa- tients, but little recompense from central Government.

More recently we have seen an abhorrent use of the media to finger point and impart blame on dentists who the Government feel are not living up to their end of the contract. Rather than im- plementing some of the changes set by the Health Select Commit- tee (HSC), what we are seeing is a shallow onslaught by central Government, which is deter- mined to make NHS dentists, fol- low suit, regardless of public and professional opinion. The prob- lem dentists are now facing is that by using the media in this way, all dental professionals face being tarnished with the same brush, rather than just those un- ethically profiteering from the system.

Combating unethical practice

This raises another impor- tant question: can we effectively regulate ourselves against un- ethical practice when most den- tists feel the new UDA system is fundamentally unfair? The amalgamation of over 460 treat- ment codes into three bands has made the link between work done and remuneration ex- tremely blurry. Rather than be- ing given clear workable guide- ance, dentists have been left to practice within a difficult sys- tem. The spate of articles over the past few months criticising dentists over their current work- ing patterns surely cannot be the right forum to regulate good practice. Catchy headlines about earnings and how frequently dentists recall patients do very little to build constructive dia- logue between dentists and the Government. Instead, this can be interpreted as a pre-emptive strike aimed at those dentists who disagree with the new den- tal system.

At a time when our patients have real worries about the econ- omy and their jobs, what the NHS can do to help our patients is offer stability. Another mass exodus of dentists after April 2009 has been predicted by some and denied by others across the spectrum of popular opinion. If the NHS wants to offer stability to our pa- tients, those dentists who may potentially leave the NHS must be offered guarantees that if there are to be changes to the cur- rent system, these are to be made in consultation with dentists and show a greater degree of fairness and transparency then seen in the past few years.

PCTs in power

The key link between Gov- ernment funding, and dental treatment now lies in the hands of Primary Care Trusts (PCTs). While many PCTs are able to ef- fectively commission NHS treat- ment based on local needs, the HSC has reported this is not hap- pening nationwide. I know from experience in 2006, some PCTs gave dentists very little time to examine the details of their con- tract before having to sign them. This gross lack of organisation and communication from PCTs has acted to further alienate dentists worried about their fu- ture security. I guess we’ll never know whether this was a decid- ing factor for those that left the NHS back in 2006, or merely the final straw in a long line of broken Government promises. Nonetheless, let’s hope PCTs learn quickly from the past and show greater transparency in their future negotiations.

Predicting the changes

Looking towards the future, it is difficult to predict what changes, if any, will be made to nGDS. But if changes are to be made, what guarantees can we expect the Government to make that these will be piloted? Or even having a two-way dialogue with the dental profession? The HSC has recommended as a short-term measure that the De- partment consider increasing the number of payment bands from three to five or more. In par- ticular, the HSC has raised con- cerns that there are disincenti- ves to providing complex treat- ments.

Let’s look at this in closer detail. Sure the disparity between a simple filling and a complex RCT is staggering, but as many molar root-treated teeth are sub- sequently restored with cast restorations instead of attracting three UDA this course attracts 12 overall. If band two was split into an upper and lower level would this actually encourage more dentists to restore teeth? Or could this be seen as a way for paying dentists less for simple fillings? As long as the link between pay- ments and treatments provided remain severed, it’s hard to envis- age reactionary measures, such as this, as long-term solutions.

What the profession is looking for is fairness and equality across the board, and defining how much work should be provided per course of treatment would go a long way, particularly with those dentists working in high need ar- eas, to help manage allocated funds. Currently we can see little indication that the DH has the de- sire to change or acknowledge the flaws in the system as put forth by the HSC.

Differing responses

Both the BDA and the Depart- ment of Health (DH) have written formal responses to the main concerns raised by the HSC and these can be found on the BDA website. Not surprisingly, we can see both reports differ in their re- sponse to the HSC report. The BDA’s response seems to agree with the fundamental flaws in the system as pointed out by the HSC and in my opinion offers a fair and balanced view of the system in its current form.

The DH’s response offers a more positive interpretation of what the future holds in store. While acknowledging many of the difficulties during the transi- tion period, the DH’s response offers us little new information as to the direction NHS dentistry is traveling in or any concrete plans to get out of the mess we are already in. While the DH has made an effort to respond to most of the concerns raised by the HSC, I was unable to find an adequate response to point 26 (HSC conclusions): ‘We con- clude that the contract is in fact so far failing to improve dental services measured by any of the criteria’.

Sacrificing quality?

Although the DH would like us to believe these current prob- lems are merely teething errors from coping with a new con- tract, the evidence gathered as summarised by the HSC must be worrying for the profession and the Government. As dental serv- ices are increasingly being commissioned across the UK, what is sacrificed to quality is the DH prepared to accept as this happens? And when will the DH tell us if there are to be changes to the current contract? As April 2009 draws ever closer, dentists are still in the dark about what the future holds. Perhaps now, the DH can re-engage a good work- ing relationship with dentists, by allowing us to plan for change rather than merely re- acting to it.

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cam- bridge 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 gradu- ate 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 fu- ture holds within the NHS and as such, he appreciates some of the difficulties in providing dental healthcare within this wildly criticised system.
A matter for debate

Graham Penfold and Dental Tribune discuss recall intervals

L ast month dentists were accused of ‘exploiting’ the new NHS contract to maximise their incomes, denying thousands of patients access to treatment, by recalling healthy patients too frequently. Chief Dental Officer (CDO), Barry Cockcroft, told The Times: ‘A few dentists seem to be calling in patients inappropriately. The Primary Care Trust (Primary Care Trust) must sort this out at a local level.’

Dental Tribune: ‘So Graham where do you stand on this? There are a lot of ‘conspiracy’ theories going around. The Government got a bloody nose over the Health Committee report and is trying to deflect the criticism on to dentists. It’s coming round to Review Body evidence time of year. Or is it just that the figures from the new FP17s happen to be coming in now, showing that dentists are seeing patients too frequently?’

Graham Penfold: ‘I do not really like terms like ‘a few’ or ‘too frequently’; they are far too vague! Exactly, how many is a few? It does not sound like very vague! Exactly, how many is a few den-

Dental Tribune: ‘But two of the measures collected by the NHS are percentage of forms for the same patient, re-attending within three months and the percentage returning between three and nine months. The National Institute of Health and Clinical Excellence (NICE) guidance on dental recalls clearly stated that many patients with low risk of disease could come back in two years (adults) or one year (children). When the second quarter results came back in September they showed that some dentists were recalling at three month intervals, surely these irregularities should be exposed.’

Graham Penfold: ‘Sure, any ‘irregularities’ should be exposed, but let us look at two key points. What evidence is there to support a three or year recall interval for adults or one year for children? I meet with many dentists and I am yet to find one who would support a recall interval of two years for adults; one year is the maximum and that is not suitable for all adults. An awful lot can happen and change in two years. As for children, their teeth can undergo dramatic changes in a short space of time due to a wide variety of factors. For me, under the NHS, all longer recall intervals are really about are freeing up dental capacity to sort out the access issue; it would be interesting to hear the defence soci-

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About the author

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A bad back in dentistry is something that most of the profession will experience. Why does the profession suffer so much? You only have to look at their working posture with distortion occurring at cervical and lower lumbar regions with thoracic rotation and shoulder abduction. A colleague, who works on my back care courses, refers to it as the “static golfer’s posture”. However, that’s before you even factor in the strains of day-to-day living. So if spending all that time in your surgery bent over the patient, followed by 18 holes of golf, two hours weeding the garden and continuously poor lifting of the children in the wrong way hasn’t already taken its toll, then it’s only a matter of time before your back starts to tell you a different story.

Biomechanical research over the last few years has started to shed light on what happens to backs when they fail and then you the sufferer can end up as a chronic back pain sufferer. Chronic back pain sufferers usually have poor body/spinal awareness and have let their backs take the brunt of everyday living. The body’s tissues have viscoelastic properties, tissue creep and muscle memory. So if you can no longer put your hands behind your head it is probably because the muscles have shortened too much and their muscle memory is therefore set to move only at that range of movement.

Some interesting results

I initiated at the Biomechanical Engineering Department, University of Newcastle a pilot study into the poor working postures of dental students and to date the findings have been enlightening. The results of the pilot study performed on a group of dental students’ pre and post ergonomically trained are to be published later this year.

In the picture above (Fig. 1), the operator is performing the dental task by direct vision as a means to perform the dental procedure more easily. Unfortunately, this is placing considerable stresses on the spinal tissues. How many procedures will it take for the practitioner to work like this before musculoskeletal symptoms are experienced?

Therefore the pilot study is basically a computer motion analysis. The computer motion analysis of the posture can be recreated throughout the time it takes for the practitioner to perform the dental task. This can be compared to postures where ergonomic interventions are integrated so that the practitioner performs the same task but this time in a better posture and sparing the delicate spinal tissues.

To give an idea of the posture the students typically adopted in the study pre ergonomically trained is in Fig 2.

For the students performing the same task with ergonomically designed equipment and teaching their posture is shown in Fig 5.

The study showed how the vulnerable areas of the spinal tissues in the cervical region and lumbar spine are spared and hopefully may prolong your career without having to prematurely retire due to musculoskeletal symptoms.

For more information on the research at the University of Newcastle or to learn more about ergonomic teaching and back care courses for the dental team contact Dr Pilkington at “Happy Backs Limited” for more details either of (01672) 541293 or visit our website www.happybacks.co.uk.

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*Posture problems: risk or choice? DPR Medical, October 2007, Author: Professor Oene Hokwerda*
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Ergonomic Surgery Considerations and Design

If you are planning a surgery refurbishment, or are looking to expand your treatment room – consider A-DEC and their extensive network of Equipment Specialists. With a level of experience that generates over 400 surgery designs in the UK every year, you can guarantee you’re in safe hands.

As a typical dental surgery in the UK is expected to be in service for around 11 years (on current replacement cycles), at A-DEC we recognise there is much more to your refurbishment than just choosing a line of quality equipment, the ergonomically operating and design of a dental surgery should also be carefully considered and applied.

A-DEC’s professional, highly trained Equipment Specialists are available to visit your practice well in advance of the project commencing to listen to your needs and share in your vision.

For more information about the A-DEC product line or to discuss your project ideas contact A-DEC today.

Freefone: 0800 255285
Tel: 024 7655 9901
E-mail: info@a-DEC.co.uk

Is Your Spine S-Shaped?

A high proportion of dental surgeons suffer from back, neck and/or shoulder pain at some time during their working lives and this has been shown to be the most common cause of early retirement in the UK.

One of the most effective ways to prevent such musculoskeletal problems is to maintain the normal spinal curves when seated. The correct seating position using the Bambach Saddle Seat can alleviate many of the problems associated with muscle fatigue by encouraging an improved sitting posture.

The Bambach Saddle Seat helps to align the spine whilst maintaining the natural s-shape thus preventing the discs from being put under pressure. The hips are kept at the optimum angle of 45°to the spine so back and thigh muscles are at their most relaxed.

Designed with you in Mind

Your comfort is primary importance when performing clinical procedures. With this in mind, NSK have designed the Ti-Max X Series to deliver an unrivalled combination of comfort and performance.

Prolonged, repetitive use of your handpiece can put increased strain on the hand and wrist, causing discomfort and ultimately affecting your performance and compromising your ability to deliver the best clinical results for your patients.

Ergonomically designed, the Ti-Max X Series boasts an extremely lightweight Tita- nium body which is on average 50% lighter than the equivalent stainless steel version.

Making an important contribution to the overall success of your practice, the Ti-Max X Series demonstrates the highest levels of excellence in comfort and design, making procedures easier and stress-free for the benefit of you and your patients.

To start practicing in comfort, please contact Jane White at NSK on 0800 654 1909 or your preferred dental supplier.

Dental Services Direct

Dental Services Direct pride themselves on offering a range of equipment to help their customers work more effectively and efficiently. Two ergonomically designed products that do just that are the myray x-ray system and the Stern Weber TR series of integrated delivery systems.

The CEFLA Dental Group has spent a decade developing technologically advanced imaging technology to design products specifically for dentistry, their aim has been that of taking technology a step further. By creating unique features for each device they have been able to bring digital imaging comfort to every dental practice.

As endorsed by the Australian Physiotherapy Association the Bambach Saddle Seat offers more than just a seat.

To see for yourself, simply contact Bambach to arrange your 30-day free trial in your own practice.

For further information please contact Bambach directly on 020 8532 5100.

Ergonomics
The Perfect Saddle Stool
The Art Of Sitting

Support Chairs' Perfect Saddle Stools have solved lower back problems for thousands of people. Consequently, they are regularly recommended by Orthopaedic Specialists and Physiotherapists.

Perfect Saddle Stools enable incumbents to sit straight and comfortablere-axed 1-hour hour – enabling incumbents to attain the same posture as when standing – the back muscles re-axed and spine following a soft, natural curve.

Compact, they allow incumbents to move around freely and are available in Classic and advanced versions. The latter featu-ring a front indentation and groove across the seat for better ventilation and to relieve pressure on the vertebrae.

When seated, the occupant automatically assumes the position of a sleeping position – relaxed.

For further information contact your regular Dental Dealer or Support Chairs on 01296 581764, fax 01296 580658, email sales@supportstool.co.uk or visit www.supportstool.co.uk.■

NEW TRIDAC ‘TRIONIC 5’ Delivery Units

The latest models of the highly acclaimed and reliable Tridac Delivery Units, now include a redesigned touch control panel incorporating chair movements and programme selections, plus remote switching of the operating light. The new white finish further adds to the appeal of these attractive units.

Available in three formats; Chair Mounted, Cabinet Mounted or as a modern Cart Unit, all with popular twin water bottle feature with remote switcher, also from the touch control panel.

Within these neatly laid out units, there is ample space for the installation of a wide range of equipment options to meet individual clinicians’ requirements. This attention to detail, together with ease of access for maintenance, and high build quality, make the Tridac units so well appreciated by opera-tors and engineers alike.

For further information please contact TRIDAC DENTAL EQUIPMENT LTD. Tel: 01923 242958 Fax: 01923 250864 ■

Dead Stools have solved lower back problems for thousands of people. Consequently, they are regularly recommended by Orthopaedic Specialists and Physiotherapists.

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 photodiodine (TBlue) 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™ £622.78 plus VAT Pack of 20 Vizilite Plus™ £50.55 plus VAT

Optergo

Optergo solutions for better posture now also available at Opticians in Bushey, Leeds, South West London and West-class-on-Sea.

Visit Designer Dental and they will demonstrate how effective dental marketing can be. This clinical conference fo-cuses on three exceptional growth areas – implantology, medical facial aesthetics and cosmetic dentistry. Designer Dental can help you maximise the marketing of these areas.

Designer Dental is one of the UK’s leading marketing compa-nies that is exclusively within the dental profession. This highly trusted and award winning company has an im-pressive reputation and portfo-lio that is widely recognised.

The expert team will be on hand at the conference to pres-ent the full range of marketing services available to dental practices. The team will be able to advise delegates on welcome packs, promotional material and image/branding.

Optergo understands that opticians should be provided by op-ticians, in the same way that teeth should be treated by den-tists. Therefore, our unique posture of enhancing dental services and not being spectacu-larly only through opticians. We train our optician partners in dental orthodontics as well as the requirements dentists have of optics. This combination makes sure that an Optergo user gets a pair of loupes (or spectacles) that enables both optimal vision and optimal working posture.■

For more information, please call 01642 206 106 or email enquiries@designer-dental.co.uk ■

TePe G2™ – The best just got even better!

Molar Ltd are pleased to an-nounce the introduction of the new G2 model, the second gener-ation of interdental brushes to the UK. When dental profes-sionals were asked what they were looking for, in the smaller-sized interden-tal brushes to be made with even stronger, longer wires, TePe rose to the challenge and the TePe G2 was developed.

The TePe G2’s new soft, hol-low, flexible tip is design-pro-tected. This exciting and inno-vative design allows the brushes to be inserted further between the teeth and the flexi-ble neck also increases the brushes durability. Testing by dental professionals and their patients reported 94% saying they would choose the TePe G2 over the original brushes. Pa-tients preferred the more com-fortable feeling of TePe G2 when in contact with the teeth and gums.

If you would like more infor-mation on the new G2 Inter-den-tal Brush, or a sample, please contact Molar Ltd on 01935 710822 or email info@molarltd.co.uk.

NEW TePe G2™ – The best just got even better!

We continue to build up our network of optician partners across the UK, and the additional area that Harvy Rose & Sons (Bushey & Westcliff-on-Sea), Tolley & Partners (Southwest London) and Simon Falk Opticians (Leeds). Contact details of these and our other optician partners could be found on our web site www.optergo.co.uk

Drs. Nik Sisodia and Martin Wanendeya are partners at the private practice, Tendental in Clapham Common South Lon-don. For more information contact Suzy Rowlands on 0207 612 4142 or visit www.bacd.com ■

Dr. Suzy Rowlands on 0207 612 4142 email sr@bacd.com or visit www.bacd.com ■

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Designers Dental Moving you forward at the Aesthetic Dentist 2009

For further information please call 01642 206 106 or email enquiries@designer-dental.co.uk ■

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Pack of 40 Vizilite Plus™ £622.78 plus VAT Pack of 20 Vizilite Plus™ £50.55 plus VAT

For more information, please contact Panadent 01808 881788 or visit www.panadent.co.uk ■

New Velopex Aquacut ‘Superfine’ Sodium Bicarbonate Cleaning and Polishing Powder

Velopex are delighted to an-nounce the arrival of the new Velopex Aquacut ‘Superfine’ Sodium Bicarbonate Cleaning and Polishing Powder.

This product is packed in the standard Aqua cut clear plastic ‘pots’ and will work in any Aqua-cut model.

This ‘superfine’ powder of-fers some major benefits over the powder that it replaces. Due to the smaller particle size and reduced angularity there is less soft tissue tingling for the pa-tient, making treatment more pleasant.

Sodium Bicarbonate re-mains the powder of choice for Stain Removal and Polishing as well as for the removal of soft decay. The advantage of using Sodium Bicarbonate (at low pressures and low powder flow) for the removal of soft decay is that there is no chance of an ex-plosion.

The ‘Superfine’ product will replace the current product on a stock turnover basis over the coming Months.

For more information or to ask any questions, please contact: Mark Chapman Medicines Investment Ltd Barretts Green Road LONDON NW10 7AP Tel 07734 041877 ■
Great offers available on PracticeSafe refill disinfectant spray.

Surgery professionals appreciate the versatility of PracticeSafe spray. Not only can it disinfect the alcohol resistant surfaces of a Dental Practice but medical products such as hand and angle pieces can be cleansed and disinfected to a very high standard.

PracticeSafe disinfectant spray is alcohol based and highly effective against MRSA/ HBV/HIV/HCV/BVDV, vaccinia, tuberculocidal, hospitalism prophylaxis, bactericidal, fungicidal.

Kemdent have successfully introduced PracticeSafe spray in 500ml spray bottles and want to ensure Dental Professionals are aware that PracticeSafe spray is available in 5L and 10L refills. If you buy a 5L refill before the end of March you will receive a 10% price discount and on a 10L refill, 15% discount.

For further information on special offers or to place orders call Helen on 01795 770236 or visit our website: www.kemdent.co.uk

PracticeWorks Kodak Dental Systems’ Online “Backup Recovery Service”

Every business, and especially those in health care, needs access to its records. From anywhere in the world, re-accessing critical records, all current practice management systems, the PracticeWorks Online Backup Recovery Service offers complete peace of mind to you and your patients, with instant data recovery guaranteed.

To safely back up your practice records and day by day data call PracticeWorks on 08001099692.

The Kois Deprogrammer

The British Academy of Cosmetic Dentistry invites you to attend the Kois Deprogrammer lecture presented by Dr. Ken Harris at the British Dental Association on Thursday 19th March 2009 from 7pm.

The accurate recording of Centric Relation (CR) is a daunting process for many clinicians. Despite numerous de-programming devices and techniques, it often proves difficult to achieve correct results in the practice.

The de-programming device described by Dr. John Kois eliminates confusion and simplifies the process making the recording of CR a more predictable process.

Using this device is the natural starting point when beginning full molar reconstruction cases in Dr. Harris’ practice. The step-by-step process is demonstrated in the lecture providing reference to numerous treated cases of varying difficulty.

Dr. Ken Harris maintains his private practice in Sunderland concentrating on cosmetic dentistry and complex reconstruction cases with particular emphasis on thorough treatment planning based on sound occlusal principals.

For more information contact Suzy Rowlands on 0207 612 4106, email: info@bacd.com or visit www.bacd.com

The Non-Alcoholic Solution to Surface Cleanliness

Citrox Bio™ is the 100% natural way to met infection control protocols. Extracted from orange pith, this natural and organic microbial agent gives you the edge you need against MRSA, Clostridium Difficile, Hepatitis B and Streptococcus.

Due to its residual effect, Citrox Bio™ keeps working long after it has been applied and since the range of Citrox products includes hand gels, waste cleaner, cleaning & disinfectant liquid and surface wipes, you have an option for every surface in the practice.

By breaking down biofilm and destroying cell walls, Citrox Bio™ is even effective in the presence of organic matter. Lethal against up to 99.9998% of dangerous pathogens (that’s 100 times more potent than products boasting 99.8% effectiveness), Citrox Bio™ provides valuable peace of mind in the busy modern practice.

Non-volatile, non-toxic, environmentally friendly and biodegradable, Citrox Bio™ is an effective line of defence against bacteria, viruses and fungi.

For more information please call 01480 862080, email enquiries@oraldent.co.uk or visit www.oraldent.co.uk

Learn More from Sirona!

Never has the demand for CEREC been greater. With CEREC now becoming the first choice for ceramic restorations this mainstream treatment is now taking its place in many dental practices up and down the UK.

With over 22,000 systems worldwide, Sirona has been able to produce an even higher level of training with a blueprint of over 20 years in training CEREC users of all levels whether you are an experienced CEREC user or someone who has just taken delivery of their CEREC for the first time.

The CEREC new user dates for 2009 are as follows:

- February 20th and 21st
- March 20th and 21st
- April 17th and 18th
- June 16th and 20th
- July 17th and 18th
- August 14th and 15th
- September 18th and 19th

Numbers on these CPD accredited courses are restricted so please book early to avoid disappointment. To receive your further information please contact Sirona UK directly on 0845 071 5040 or email mark.buckland@sironadental.co.uk or visit www.sironaacadcomolutions.co.uk

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 combined, both in Classical and in the 3D system. User friendly and easy to learn, with Easyshade™ Compact, you can read one single shade or 5 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 remixes!

Other key features of the conference will include a Q&A session with a team of former rugby stars and a comprehensive selection of lectures on some of the most important elements of dental leadership and enterprise.

This fantastic event offers people interested in the world of implant dentistry and the "beloved game" a chance to really take something from the course and also give to those who need it most.

For more information please contact Donna Wraith on 0775 065 6522 or email millyks@eclipse.co.uk.

Hands-On With The Inman Aligner

The British Academy of Cosmetic Dentistry invites you to get stuck in with the Inman Aligner Hands-On Certification Course in association with Straight Talk Seminars. The ITI Centre, Straumann UK Ltd in Crawley, Sussex will host the course on Friday the 13th of March 2009.

Invented in the US by Donn Inman CDT, the Inman Aligner was used to treat orthodontic relapse. Dr. Tif Qureshi presents the course as the first UK dentist to pioneer the appliance.

Having had a particular interest in simple orthodontics for a number of years, Dr. Qureshi has completed over 500 cases using the Inman Aligner. Delegates will see how the appliance can be used to treat crowding, some diastemas, cross-bites

Raise your game with the Wooden Spoon Charity Rugby Conference!

As you may remember from last year, Valentine’s Day isn’t the only important date you need to remember in February, it is also the month of the much loved ‘Wooden Spoon Rugby Conference’, sponsored by Straumann. All of the proceeds from the event will be directed to its illustrious combination of dentistry and rugby, are donated to the Wooden Spoon charity. The associated charity supports disadvantaged children and young people with mental, physical and social needs around the UK. The rugby-themed event runs on 15th & 14th of February, and attendees will also receive dinner on the Friday, lunch on the Saturday and a complimentary ticket for the Six Nations Championship match to England vs Wales, which is also on 14th February.

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

Dental Tribune United Kingdom Edition • February 2-8, 2009
Dr. Qureshi realised the technique had potential to have a huge effect on the traditional techniques of veneer-based cosmetic dentistry. Dentists and patients now have an astonishing alternative treatment option to perform smile transformations without the aggressive preparation with teeth aligned quickly and safely.

For more information contact Suzy Rovens on 0207 612 4166, email: info@baed.com or visit www.baed.com.

Isoplan

Stewart Angus is the UK Director of Sales for Isoplan, one of Britain’s largest practice membership plan providers.

Dental Centre to discuss the vital second stage of the Clinical Governance Programme. Smile-on's programme was selected by the Dental Governance Committee (representing three local Primary Care Trusts) and the KSS Dental Postgraduate Deanery to enable practices to meet Clinical Governance core requirements.

KSS Postgraduate Dental Dean Stephen Humb-humble analysed feedback from the first stage, and Dental Clinical Governance Lead Bernard Smith examined the two-year journey of the 150 practices involved. Chief Dental Officer Barry Cockcroft celebrated the programme’s significance before Dental Adviser Bar-Ba-Ba-Ba-Ba provided strategies for continual improvement. Then, Smile-on’s Noam Tamir introduced the Clinical Governance Performance Management (CGPM) system.

Because the responsibility for implementing such a programme is shared, Smile-on understands the needs of its customers. The Company has a dedicated team of professionals an elite selection of laser technology.

The GENTLEray 980 diode laser offers a large touch screen display with intuitive user interface. It is the first perfect step into soft tissue surgery and can be used in a variety of applications. This particular laser therapy reduces bleeding and pain during the procedures and after. It is easy to disinfect and lightweight so it can be transported easily.

The DIAGNoDent laser caries detector is the perfect device for finding hidden caries and erosions. Smile-on’s DIAGNoDent ensures a precise measurement detecting incipient lesions on the surface. Clinicians now have the choice of the DIAGNoDent Classic or the Pen version.

All the laser equipment from KaVo is user-friendly, compact and portable. Whatever your needs, KaVo will find a laser product to suit the individual needs of your practice.

For more information please contact KaVo on 0141 775 0000, email: sales@kavo.com or visit www.kavo.com.

V.Banks@Eastman.UCL.ac.uk

Smile-on Showcases Learning Solutions to Inspire and Involve at The Dentistry Show 2009

Smile-on is proud to announce that it will be exhibiting at The Dentistry Show at the NEC Birmingham on the 13th and 14th of March 2009. This event will include rewarding workshops and lectures from internationally recognised experts.

Thousands of delegates from across the dental team have already registered, and attendees are invited 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 the armchair. Webinars can be replayed, to go over valuable points (visit www.dentalewise.co.uk and watch the informative showreel).

For more information please call 020 400 8998 or email info@smile-on.com.
This programme for this year’s Young Dentist Conference features contributions from a number of successful young dentists with their own businesses, others in specialist and a group of well-known figures who have achieved success in business beyond dentistry.

The speakers this year include Shaheen Rahman a young barrister from a well-known London chambers, and Anna Heyes, founder and Managing Director of Liverpool-based Active Profile marketing and PR agency. Shaheen and Anna will speak during a session entitled ‘Because you’re worth it; offering a practical approach to recognising and managing your worth.’

This exciting one-day programme has been organised by Dental Protection together with the BDJ and BDA. As in previous years, delegates can expect challenging ideas and facts as well as lots of practical tips which are particularly relevant to recently qualified dentists.

The programme

Surgery 101 – Can we live without it
Some take the view that endodontics can never compete with implants. Others believe that extractions and implants are more predictable than long-term periodontics. And a few argue that orthodontics is a beauty treatment, not dentistry at all. If one of these three branches of dentistry had to be discontinued by NICE on the grounds of cost-effectiveness, which would it be? Three young dentists in specialist training will make a case for the preservation of their speciality:
• Phil Thomson (endodontics) • Claudia Wellman (periodontics) • James Grant (orthodontics)

Then you get the chance to vote, consigning one of them to the clinical waste.

Because you’re worth it
One of the challenges frequently reported by younger dentists, are the issues of cost, price, worth and value. One minute we are dental students with a debt – but overnight we become a professional person with earnings that many other young graduates can only dream about. Many young dentists find it difficult to discuss fees, and to feel comfortable about charging an appropriate amount for their services. An articulate trio:
• Neal Raval (dentist) • Shaheen Rahman (barrister) • Anna Heyes (Young Business Person of the Year 2007) will debate the issues, share their experiences and suggest ways to manage this aspect of a professional career.

Are you ready for this?
Three UK dentists, who aimed for success early in their careers, and have set up successful (but very different) practices, describe their journey and what they have learned from the experience.
• James Hamill (Blueapple in Northern Ireland) • Chris Barrowman (Infinity Blu Dental Care in Pitlochry) • Saaqib Ali (Sherwood Dental Practice in Birmingham).

Tickets are £100 (inc VAT) and include five hours verifiable CPD. Contact Sarah Garry on 020 7399 1339 or email sarah.garry@mps.org.uk

Please call Celine Peacock for your entry brochure on 01689 899170 or email celine.peacock@purplesms.com

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British Dental Nurses’ Journal

Denplan

Member of the Global Group
Will you sell us your practice?

Spadental is looking to acquire high quality dental practices across England and Wales for its principals.

If you are interested in selling your practice as a ‘whole’ practice, either immediately or in the not too distant future, we would very much like to hear from you.

It is our policy when we acquire and invest in a practice to ensure the healthy continuity of the services you provide both for your patients and staff. At the same time looking at ways of supporting and developing the growth and future potential of the practice.

In absolute strictest confidence and without obligation, if you would like an informal discussion on your thoughts, ideas and options with us, with possibly an indication outlining a competitive offer for your practice from us, then please contact Paul Massey - Acquisitions Partner on 01600 891560 or 07836 701522 or by emailing paul.massey@spadental.co.uk

www.spadental.co.uk

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 College of Surgeons, England.
- In the document entitled ‘Training Standards in Implant Dentistry for GDP’s 2009’ (download of GDC.gov.uk).
- Compliance 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.
- Treatment planning, surgical and restorative observation of all course patients.
- Guest speakers:
  - Dr Henri Thuau, Consultant Maxillo Facial & Oral Surgeon
  - Dr Jo Omer, 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 370 140
marian.harley@hotmail.co.uk

Hague Dental Supplies offer sales, design and engineering services to the dental industry.

In London, Hague have one of the largest showrooms in the UK, viewings are available by appointment (inc out of hours).

Hague also offer engineering and maintenance service packages on your equipment at agreed intervals to suit your needs. At the depot, in Surrey, Hague stock a huge selection of parts and equipment – in order to get you back up and running fast in an emergency.

Trident Business Centre, 89 Bickersteth Road, Tooting Broadway, London SW17 9SH
0800 298 5003 www.haguedental.com

DENTAL TRIBUNE United Kingdom Edition · February 2-8, 2009 Classified 51
What if it’s left?

If TMD is untreated, this can lead to bone-on-bone attrition as the joint deteriorates, producing a crunching sound, and unpleasant sensations resulting from the presence of crepitus. If TMD is not diagnosed before treatment, then the patient can undergo procedures that may be unnecessary, or cause them greater discomfort. Because nocturnal bruxism, another phenomenon associated with TMD, can damage dentition, it is possible that TMD can lead to treatment that is planned without the TMD even being diagnosed!

Other clues that might indicate that the patient is suffering from TMD include sleeplessness (caused by pain and/or discomfort, or nocturnal bruxism) and depression (caused by the combination of sleeplessness and discomfort, over a period of time). Sufferers have also been known to suffer from aches located in the neck, head, jaw, and back. Providing necessary treatment

The GDP should also be suspicious of patients exhibiting muscular para function and facial compression in the lower third - pain, after all, is difficult to hide. Armed with this knowledge, dentists should always be able to spot TMD, so that they can provide beneficial and necessary treatment that actually improves the patients’ quality of life, as opposed to causing them greater discomfort. In children, TMD is far from common, unless associated with trauma or a congenital developmental defect, such as Treacher Collins or Golden Hars syndrome – in any case, since children under 12 years old do not yet have a fully formed diarthroidal capsular joint at the temporal bone and mandibular junction, general practitioners should always refer these cases to the appropriate specialist (although it is unlikely that such a case would reach the dentist before the cranio-facial trauma unit or paediatric ward).

So what are the causes of TMD?

Unfortunately, there is no straightforward answer – at least, not at the moment. Without conclusive evidence, Orthodontists cannot be expected to wholeheartedly accept the theory that malocclusion is the main causative factor. However, causative factors may include overbites, malposition of dentition including crowding, loss of teeth and any orthodontic treatment that leads to mandibular retrusion. Developmental disorders and systemic diseases like arthritis may also have their part to play in TMD.

The ideal anterior incisal vertical relationship would be a “one eighth” upper to lower overlap with the condyle on the disc.

A specialist in this field can take the entire skull into account during diagnosis and treatment planning.

Other conditions can also lead to TMD.

The GDP should also be suspicious of patients exhibiting muscular para function and facial compression in the lower third - pain, after all, is difficult to hide. Armed with this knowledge, dentists should always be able to spot TMD, so that they can provide beneficial and necessary treatment that actually improves the patients’ quality of life, as opposed to causing them greater discomfort. In children, TMD is far from common, unless associated with trauma or a congenital developmental defect, such as Treacher Collins or Golden Hars syndrome – in any case, since children under 12 years old do not yet have a fully formed diarthroidal capsular joint at the temporal bone and mandibular junction, general practitioners should always refer these cases to the appropriate specialist (although it is unlikely that such a case would reach the dentist before the cranio-facial trauma unit or paediatric ward).

So what are the causes of TMD?

Unfortunately, there is no straightforward answer – at least, not at the moment. Without conclusive evidence, Orthodontists cannot be expected to wholeheartedly accept the theory that malocclusion is the main causative factor. However, causative factors may include overbites, malposition of dentition including crowding, loss of teeth and any orthodontic treatment that leads to mandibular retrusion. Developmental disorders and systemic diseases like arthritis may also have their part to play in TMD.

The ideal anterior incisal vertical relationship would be a “one eighth” upper to lower overlap with the condyle on the disc.

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Septodont has dedicated 75 years of innovative product development and manufacturing exclusively to the Dental profession. Our production expertise has earned the approval of Dental professionals on 5 continents and from 150 government health agencies, making us the world leader in local anaesthetics.