**News in brief**

**Good Practice**
A dental surgery in Burton in Staffordshire was given the Good Practice Award by the British Dental Association (BDA). Dentist Yogi Savania, who owns Alexandra Dental Care with George Savva, attended a presentation evening in London with practice manager Michelle Cadd to accept the award from the BDA’s president Gordon Watkins. Mr Savania said: ‘We have always tried to provide excellent dental care and it is rewarding to be acknowledged as such by our British Dental Association.’

The award recognises practices that are committed to working to the high quality standards set by the BDA.

**Teeth worries**
Nearly half of all 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 spin-off company from the engine, also found that three quarters of the population would like to change something about themselves. Consumers are most worried about their teeth with 45 per cent wanting some kind of work, closely followed by a third wanting to change something about their body and 17 per cent who want to change their face or correct their eyesight through laser eye surgery.

**Alcohol abuse**
A retired dentist who lay dead in his house for weeks before being found, accidentally drank himself to death, a coroner said. William Hunter Gray Dodds, a retired dentist in Portsmouth was discovered by police at his home surrounded by empty beer cans and rotten food. Portsmouth coroner’s court heard how Mr Gray Dodds, who suffered from alcoholism, had not been seen for several weeks before police found him dead. His body was in an advanced state of decomposition and police said the death was not suspicious. He was known to be a ‘long term abuse of alcohol’. Mr Gray Dodds had no known living family. He had divorced from his ex-wife, who now lives in South Africa, many years ago. An autopsy revealed Mr Gray Dodds had cirrhosis of the liver and had consumed a lot of alcohol before he died.

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**MPs knock independent review**

MPs have criticised the independent review into NHS dentistry in England for failing to have a practising 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 Rosney, 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’s 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, or 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.
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% 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 mousy pap through the gaps in their teeth and Mr Thom had to feed some of these 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 ‘mis-treated’ by the local medicine man by boiling 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.

Examinations were performed where necessary as well as plaque removal and oral hygiene. Each patient was given their own hygiene pack and toothbrush were 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 pathology 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 new life. I removed my ‘rose coloured spectacles’ and found more to life than moving teeth!’

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

Credit crunch hits tooth fairy

The credit crunch will reduce payments left by the Tooth Fairy by up to 10 per cent for a third of children in the UK, according to a new survey.

New research commissioned by dental payment plan provider, Denplan, has revealed that children will be worse off this year with more parents deciding that the Tooth Fairy will not leave any money at all.

Thirteen per cent of parents already say the Tooth Fairy doesn’t leave money at their house, and that figure could be set to rise considerably next year as more parents feel the impact of the recession.

Over a third of parents said their children would definitely see a drop in the amount of money the Fairy leaves. It would be a shame to discourage such good practice, perhaps parents could consider an alternative reward that would encourage their child to continue their excellent oral healthcare habits.

Something that makes them feel important and justly rewarded. For some children staying up bit later than usual for one night might be appropriate or having an extra hour’s TV or video games.”

Free check-ups for Essex

Thousands of people in Essex who have not had a dental check-up in the last two years are being invited to receive a free check-up. NHS North East Essex has launched the initiative which includes a free check up and follow-up. A number of dentists have signed up to the initiative.

Kathy Flegg, dental lead for North East Essex Primary Care Trust (PCT) said: ‘One of our key objectives is to target people who have not been to see a dentist in the past 24 months to provide them with the necessary treatment so they are dentally fit.’

She called the campaign ‘a national first’ and said: ‘We hope as many people as possible take advantage of the offer.’

People are being sent a letter and voucher and are invited to contact one of the participating dentists for their free check-up and follow-up.

The trust is also organising street dentist events where impromptu check-ups will be on offer at public venues in Clacton, Dovercourt and Colchester.

The PCT is also carrying out a two-week ‘ blitz’ of students with dental teams visiting Essex University and Colchester Institute.

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 Boucott, the principal dental surgeon at Herbrandston Dental Health Practice in Herbrandston, has gone one step further and has a pot-bellied pig called Madita plus numerous ferrets, terrapins, rabbits and guinea pigs.

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

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

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

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Credit crunch hits tooth fairy

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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 debunked 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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Suspended prison sentence

A dentist in Merseyside, has been given a suspended jail sentence, for claiming payment from the NHS for patients who didn’t exist.

Robert Nolan, who has run a practice in Wallasey, Bromer Street, Liverpool, since 1990, made up patients so he could falsely claim money and also claimed payment from the NHS for patients that did not exist.

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 36-week sentence was a result of Nolan’s dishonest practices, including labelling patients who were patients in his records as ‘non-attendees’.

Judge Graham Morrow QC told Liverpool Crown Court that it was ‘calculated, blatant and persistent dishonesty’. He agreed to suspend a prison sentence after hearing of Nolan’s personal circumstances and his ‘positive good character’.

‘Unworkable and illogical’ proposals

The Dental Defence Union (DDU) has criticised the General Dental Council (GDC) for its ‘unworkable and illogical’ proposals as holding themselves out to be a public service.

The DDU expressed disappointment that the GDC has not attempted to bring dentistry into 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 successful negligence claims within the policy will be paid is indisputably in the interests of patients and dental professionals themselves,’ added Mr Hoppenbrouwers.

Award-winning entrepreneur, Charan Gill, who featured on the TV show The Secret Millionaire, will be speaking at this year’s British Dental Conference and Exhibition.

Mr Gill, who sold his restaurant empire for £46m, will be giving the keynote address at the event, which takes place in Glasgow, from 4-6 June. Author and paralympic gold-medallist Marc Woods will also be a guest speaker at the event.

The conference and exhibitions Dentistry is transforming will bring together an extensive line-up of nearly 100 conference speakers who will explore the changing face of the profession today.

A range of exhibitors will showcase the changes in dental technology as the profession looks ahead to the challenges of the future.

California, Los Angeles, on aesthetic restorative practice; Nick Odpam, St. Bartholomew University Medical Centre, Nijmegen, The Netherlands, on the expanding use of posterior composites in clinical practice; and Mikael Zimmermann, Karolinska Institute, Stockholm, on infection control.

There will also be sessions covering clinical and practical business skills for dental care professionals and a selection of seminars hosted by leading dental organisations.

Also, new at this year’s event will be 50-minute exhibition hall seminars entitling delegates to additional verifiable continuing professional development.
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Dentistry debate goes live

A live 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 (DPL) 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: BDA editor-in-chief Stephen Hancock, 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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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 it 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

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

The new mouthwash style cleans the interdental surfaces of teeth.

The new Colgate Total Interdental brushes have a triangular bristle shape designed for cleaning the interdental surfaces of teeth. The bristles are angled to clean where adjoining teeth meet.

A spokesperson 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.

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

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

About the author

Is there room for growth?

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

During these months of economic instability, it is crucial to become seen as trustworthy. Whether your patient trust in your diagnosis, and do they also trust you to be the dentist who carries out the work for them. Our existing patients generally have a much higher level of trust with us – as they return to visit the hygiene department and receive dentistry, there is time for a relationship and trust to develop. New patients, however, do not yet have that level of trust, although there are significant steps that can be taken to speed up the time it takes to develop trust. This is particularly important if your patients come to you for single appointments, for example, cosmetics or implant work.

One of the main factors involved in the patient’s decision-making process is trust. Does your patient trust in your diagnostic skills? Do your patients trust you? Is the treatment you offer included in the results while decreasing costs.

The attributes of a trustworthy individual can be split into four areas, two pertaining to character and two to competency. The first area is that of integrity; meaning you do as you say, you live by your beliefs and values, for example, walk the talk. The second is intent of purpose, in other words, your intention is in alignment with your actions and values, and there is no ulterior motive you keep hidden. This reflects back to the earlier statement – you can’t have trust without trustworthiness. If your intent of purpose is not in alignment with the words you are speaking, others will detect it even if they are not entirely sure what in particular they are uneasy about.

The first principle of trust according to Dr Stephen Covey, author of Seven Habits of Highly Effective People, is that “You cannot have trust without trustworthiness.” This is a natural law. Of course, there exists deceit and unscrupulous behaviour, but eventually honesty will be discovered. It is well worth reiterating – you cannot have trust without trustworthiness.

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. Nobody is perfect, and in dentistry as well as all walks of life, despite the best intentions, mistakes will be made. A trustworthy team or individual will own up to the mistake and apologise and go some way towards righting the wrong. They will not try to cover up mistakes or utilise blame to cover their tracks.

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. In the dental profession, we have a requirement to continually update our professional development, and it can be useful to communicate our commitment to education to our patients. For example, in furthering our skills in cosmetic dentistry, we can demonstrate commitment to competency and excellence by joining the British Academy of Cosmetic Dentistry and pursuing the Accreditation pathway. Further training that measures our results against high standards is an excellent tool to not only improve our clinical skills but also build trust with our patients.

Winning over cynics

There’s a lot we can learn when it comes to building trust with our patients. For example, in case presentation – having examples of our own before-and-after photographs can show how we deliver results. In the same way, testimonials from happy patients provide evidence of our capability and results. This is the fastest way to win over cynics. Clarifying the expectations of our patients lends itself to have a chance of being able to meet them. And don’t forget, seek first to understand before being understood. In other words, take the time to listen first. This is exactly what we do when we are diagnosing. If we didn’t first listen to the symptoms and expectations of our patients, we would be in danger of misdiagnosing.

Staying committed

The final two behaviours identified in trustworthy individuals, are those of making and keeping commitments, and extending trust to others. Making and keeping commitments no matter how small, is a measure of whether or not you can be counted on. An individual who is overly distrusting can waste a lot of energy double-checking and being suspicious, and this in turn will reduce the trust that is extended to them.

About the author

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 and experience of the 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.
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 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’.

3.1 ‘I’m not good at selling to others/speaking in public/putting across my ideas/working in groups/being a team leader… or whatever’

4. Consider those areas where you the game you play is the role of observer.

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.

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Why take a chance, when you can enjoy complete confidence?
Blooming marvellous

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.

Picture 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 waiting room, 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 a therapy with me.’

But then if we are being honest, there are not many people in the world like David Bloom either. An astute, extremely busy dentist, there are not many people in the world like David Bloom either. ‘Clients can now come in and log on to emails while in the relaxation area, or they can book a therapy with me.’

The press gave us a bashing five years ago but now they can see what we can do - the Hollywood smile can be 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’s part of my team and it is very important for any restorative dentist to have a close relationship with their ceramist.

‘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.’

David Bloom

Personality: Astute, innovative, focused

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

TV programmes: Desperate Housewives

Favourite book: The Celestial Prophecy

Star sign: Scorpio

Music: Pink Floyd

Sport programme: Rugby

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 Reconstructive Dentistry, The British Dental Association and is a sustaining member of The American Academy of Cosmetic Dentistry (AADC) and a fellow of the International academy of/Dental Facial aesthetics. Dr 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-OPRS seminars, and instructs and lectures on all aspects of cosmetic dentistry in the UK and the US.

David and Jay and their two fathers

Jenni Thomas, president of the Child Bereavement Charity with David and Jay
NHS Contracts – all change?
As the three-year, protected-income period for NHS contracts/agreements ends in March, Tim Lee offers some advice for NHS practitioners

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. 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 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.

Recent guidance from the Department of Health (DH) to PCTs suggests that it is possible for there to be ‘fixed term’ GDS contracts. I’m not convinced that’s right, except where the Regulations allow for temporary fixed term contracts in certain limited circumstances.

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 of 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 it wishes 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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About the author

Tim Lee is commercial law director and solicitor at Young and Lee Solicitors Limited in Birmingham. For more information, visit www.younglee.co.uk or call 0121 633 3233.
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 percent a year over 10 years, eight percent over seven years and 7.75 percent 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 poli-
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 US life assurance policies generally mature on the death of the life assured and so there is an element of uncertainty over mortality assumptions, although Keydata mitigates this risk through its high weighting towards older policyholders in the Plan portfolio.

The portfolio construction process
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.

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’s 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 — that is, 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 in value 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 closed, this is a signifier that the posteriorly misplaced condyle head is retrieving the disc, housing it within the bioconcavity, before the condyle falls back and off the disc. 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 pterygoid- 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.

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.

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If 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 overnight.

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 patient was left with toothache over night.

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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

Over the course of my last few articles, I have discussed some of the difficulties 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 patients, 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 implementing some of the changes set by the Health Select Committee (HSC), what we are seeing is a shameful onslaught by central Government, which is determined to make NHS dentists, follow suit, regardless of public and professional opinion. The problem 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 unethically profiteering from the system.

Combating unethical practice

This raises another important question: can we effectively regulate ourselves against unethical practice when most dentists feel the new UDA system is fundamentally unfair? The amalgamation of over 460 treatment codes into three bands has made the link between work done and remuneration extremely blurry. Rather than being given clear workable guidance, dentists have been left to practice within a difficult system. The spate of articles over the past few months criticising dentists over their current working patterns surely cannot be the right forum to regulate good practice. Catchy headlines about earnings and how frequently practice. Catchy headlines about the right forum to regulate good patterns surely cannot be the right forum to regulate good, amongst all dental professionals face being tarnished with the same brush, rather than just those unethically profiteering from the system.

PCTs in power

The key link between Government funding and dental treatment now lies in the hands of Primary Care Trusts (PCTs). While many PCTs are able to effectively commission NHS treatment based on local needs, the HSC has reported this is not happening nationwide. I know from experience in 2006, some PCTs gave dentists very little time to examine the details of their contract before having to sign them. This gross lack of organisation and communication from PCTs has acted to further alienate dentists worried about their future security, I guess we’ll never know whether this was a deciding 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 degree of fairness and transparency then seen in the past few years.

But let’s look at this in closer detail. Surely the disparity between a simple filling and a complex RCT is staggering, but as many molar root-treated teeth are subsequently restored with cast restorations instead of attracting three UDAs this course attracts 24 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 payments and treatments provided remains severed, it’s hard to envisage 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 areas, to help manage allocated funds. Currently we can see little indication that the DH has the desire to change or acknowledge the flaws in the system as put forth by the HSC.

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 Department consider increasing the number of payment bands from two to five or more. In particular, the HSC has raised concerns that there are disincentives to providing complex treatments.

The DH’s response offers a more positive interpretation of what the future holds in store. While acknowledging many of the difficulties during the transition period, the DH’s response offers us little new information as to the direction NHS dentistry is travelling 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 conclude 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 problems are merely teething errors from coping with a new contract, the evidence gathered as summarised by the HSC must be worrying for the profession and the Government. As dental services are increasingly being commissioned across the UK, what sacrifices 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 with what the future holds. Perhaps now, the DH can re-engage a good working relationship with dentists, by allowing us to plan for change rather than merely reacting to it.

About the author

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

Most dentists feel the new UDA system is fundamentally unfair

It is difficult to predict what changes, if any, will be made to nGDS.
A matter for debate
Graham Penfold and Dental Tribune discuss recall intervals

Last month dentists were accused of ‘exploiting’ the NHS system to maximise their incomes, denying thousands of patients access to treatment, by recalling healthy patients for checks 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 PFTs 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 frequently; they are far too many. Where do you stand on this?’

Dental Tribune: ‘Sure, any ‘irregularities’ should be exposed, but let us look at two key points. What evidence is there to support a one 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 societies views on this area. In addition, it has to be said that the deeply flawed new contract has put the need for commercial survival and best patient care in stark conflict with one another. But let’s place the finger of blame for that firmly where it belongs; the senior ‘policy’ makers at DoH.

Graham Penfold: ‘I believe that the most appropriate recall period is that agreed between the dentist and their patients based on best clinical practice, individual to each patient, and completely free from external influences particularly those which are politically driven. Happily, private practice does not have to face the PCT/NICE drumbeat of ‘you don’t need to see your dentist so often’ and long may that be the case. Long live clinical freedom.’

For further information, call Practice Plan on 01691 684135 or visit www.practiceplan.co.uk

‘Surely, it is for a dentist to decide in conjunction with the patient how and when they should be seen’

Graham Penfold has a degree in political science and a special interest in primary dental care policy making. He was director of finance and computing at the Norfolk family health authority and a partner in the firm of management consultants the Wilcox Penfold partnership who advised both Norwich Union Healthcare and the Royal Bank of Scotland. He was a director of Oasis Healthcare plc for four years and is now operations director with Practice Plan.
Does your back tell you a different story?

The only way for back problems to be minimised in the profession is by ongoing research and educating the dental team, says Dr RJJ Pilkington

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 region 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 your 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 posture 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 3.

The study showed how the vulnerable areas of the spinal tissues in the lower 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) 541295 or visit our website www.happybacks.co.uk.

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* Posture problems: risk or choice? DPR Medical, October 2007, Author: Dr B Andersen

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Each seat is manufactured to order so that they meet all the incumbent’s needs including specific requirements on colours and materials.

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CEREC from Sirona Dental Systems enables practitioners to use a high-tech yet simple to operate device to produce all-ceramic restorations in a single surgery visit, without the need for impressions or temporary crowns.

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The remarkable CEREC technology offers the very best in clinical excellence making dentistry a more enjoyable experience for the practitioner and patients alike. What’s more, patients love CEREC too!

For further information please contact Sirona Dental Systems on 0845 071 5040 or e-mail info@sironadental.co.uk.

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Ergonomically designed, it has a narrow back rest so that the operator can sit up straight in the most comfortable and ergonomically efficient way, with a clear view of the operating site.

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For further information please contact Bambach Dental Systems Direct on 024 7635 0901 or visit www.bambachdentrics.com.

NSK on 0800 634 1909 or your preferred dental supplier.

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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.

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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.

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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 designs 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 and convenience within every dentist’s reach. Each myray product incorporates a device, technology or simply an ergonomic feature that makes it unique. It also features HyperSphere technology so the full-arch ball- joint is revolutionary in every sense.

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

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To see for yourself, simply contact Bambach to arrange your 50-day free trial in your own practice.

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

For further information please contact Bambach directly on 020 8552 5100.
Perfect Saddle Stools enable incumbents to sit straight and comfortably relaxed - hour after hour - enabling incumbents to attain the same posture as when standing – the back muscles relaxed 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 featuring 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 that produces least stress on the vertebrae.

For further information please contact TRIDAC DENTAL EQUIPMENT LTD. Tel: 01923 242598 Fax: 01923 208084

Industry News

NEW TRIDAC ‘TRIONIC 5’ Delivery Units

The latest models of the highly acclaimed and reliable Trionic 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 are popular twin water bottle feature with remote switchover, also from the touch control panel.

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

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The Perfect Saddle Stool
The Art Of Sitting

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

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Molar Ltd are pleased to announce the introduction of the new G2, the latest generation of interdental brushes to the UK. When dental professionals and their patients were asked which brush they preferred the TePe G2 over the original brushes. Patients preferred the more comfortable feeling of TePe G2 when in contact with the teeth and gums.

If you would like more information on the new G2 Inter- dental Brush, or a sample, please contact Molar Ltd on 01954 710822 or email info@molarltd.co.uk.

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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 photomultiplier dye (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.

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Make The Transition

This year make sure you attend The Transition To The Tertiary Dentition lecture presented by the highly acclaimed Dr. Nik Sisodia and Dr. Martin Wane Aleya. The British Academy of Cosmetic Dentistry hosts the event at The Park Inn, Nottingham on Thursday 12th March 2009 from 7pm.

Managing advanced periodontal disease with a hopeless prognosis is never easy. It is understandable that patients wish to hold onto their teeth and fear the removal of such den- tures! The lecture concentrates on clinical management of advanced periodontal disease from diagnosis through to final restoration. It will discuss the lack of evidence and often conflicting conclusions in the liter- ature for the management of such cases.

Learning objectives include:
- Periodontal diagnostic dilemma
- Psychological aspects

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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 prospect.

Using this device is the natural starting point when beginning full mouth 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.

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The CEREC new user dates for 2009 are as follows:
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- June 16th and 20th
- July 17th and 18th
- August 14th and 15th
- September 16th and 19th

Numbers on these CPD accredited courses are restricted so please book early to avoid disappointment. To reserve your place or for further information please contact Sirona UK directly on 0845 071 5040 or e-mail mark.buckland@sirona-dental.co.uk or visit www.sironaaceducationsolutions.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 Donal 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

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

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

Put 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 narrowed for 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 disabilities. The rugby-themed event runs on 15th & 14th of February, and attendees will also receive dinner on the Friday, lunch on the Saturday and complimentary ticket for the Six Nations Championship match to England vs Wales, which is also on 14th February.

Other key features of the conference will include a Q&A session with a team of former rugby stars and a comprehension 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 306 6522 or email milly@eclipse.co.uk.

Raise your game with the Wooden Spoon Rugby Conference!
and mild orthodontic relapse cases.

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.

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Take It To The Next Level Visit Practice-Works at the The Dentistry Show 2009

The Dentistry Show will be its third year conference at the NEC Birmingham from the 13th and 14th of March 2009. Leading companies within the dental market will be demonstrating their products and services.

For more information contact PracticeWorks on 0800 169 9692 or visit www.practice-works.co.uk

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 BSS Dental Postgraduate Deaneary to enable practices to meet Clinical Governance care requirements.

KSS Postgraduate Dental Dean Stephen Stephen-Humble analysed feedback from the first stage, and Dental Clinical Governance Lead Bernard Swithern described the two-year journey of the 150 practices involved. Chief Dental Officer Barry Cockcroft celebrated the programme's significance before Dental Adviser Ray Battan provided strategies for continual improvement.

Because the responsibility for implementing a practice's Clinical Governance lies with the PCTs, Smile-on has provided CGPM which allows practices to upload progress details to http://www.cgpmuk.com for easy monitoring by PCTs. Key features of CGPM include a free-of-charge messaging system and resources from the KSS Deaneary and PCTs that are constantly updated. Practices that had already uploaded their information were awarded with Plaques, valid for one year.

For more information please call 020 400 8980 or email info@smile-on.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 BSS Dental Postgraduate Deaneary to enable practices to meet Clinical Governance care requirements.

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Laser With KaVo

KaVo Dental Ltd is one of the world’s leading dental manufacturers dedicated to achieving excellence in all their products. KaVo continues to provide exceptional products based on the needs of its customers. The extensive range offers dentists 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 lesions in an accurate and non-invasive manner.

The DIAGNoDent ensures a precise measurement detecting incipient lesions on the surface. Customers 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 01494 757 000, email: sales@kavo.com or visit www.kavo.com

UCL Postgraduate Certificate in Dental Sedation and Pain Management

The UCL Eastman Dental Institute will next deliver their Dental Sedation and Pain Management Course on 6th, 7th, 9th and 10th May 2009 with practical training. Further didactic teaching being delivered over the following six months.

Professor James Boelofse, Professor of Anaesthesiology, is Programme Director and is supported by Dr Yusuf (Joe) Omar and Dr Andre du Plessis and a faculty of experienced teachers. Some of the topics to be covered include:

• Treatment planning and pain management
• Behavioural management techniques
• Patient assessment and clinical examination
• Introduction to paediatric sedation
• Practical aspects of setting up a sedation service

Course participants will administer conscious sedation to patients under the close supervision of experts. They will be encouraged to demonstrate this in their own practices, seeking advice from their course mentors when necessary.

The course will focus on equipping clinicians with precise knowledge, skills and practical training. Once they have attended, participants will have the confidence to administer effective and safe sedation to their patients.

The course is suitable for both dental and medical practitioners as well as hospital based clinicians from all specialities.

For more information contact Colin Howells, or visit the admin-istrator, on 0207 905 1251, email c.howells@eastman.ucl.ac.uk or visit www.eastman.ucl.ac.uk/cpd

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 from the 15th 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.dentalwebinars.co.uk and watch the informative showreel).

The team will discuss the innovative features of its three-module programme Communicating in Dentistry: Stories from the Practice, the Clinical Photography Course, DN START and Clinical Governance Progress Management.

Smile-on understands the need for learning solutions that meet the changing needs of the industry. With the latest technological innovations and forward-thinking approaches, Smile-on helps dental professionals develop their skills and knowledge, regularly refreshing their newfound expertise.

For more information please call 020 400 8989 or email info@smile-on.com
Young Dentist Conference 2009

Don’t miss this one-day programme taking place on February 7 at the Royal College of Physicians and the chance to boost your CPD

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 specialty:

• 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.

The Dental Awards

24th April 2009 • Royal Lancaster Hotel • London

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United Kingdom Edition • February 2–8, 2009
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 2008 (download at 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. In addition: treatment planning, surgical and restorative observation of all course patients.
- Guest speakers:
  - Dr Henri Thuau, Consultant Maxillo Facial & Oral Surgeon
  - Dr Jo Omar, Medical Emergencies and CPR

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

Implant Courses
with Dr Mark Hamburger

42 Harley Street
London W1G 9PR
Tel 020 7631 1488
Fax 020 7631 1646
Mobile 07944 970 140
marian.harley@hotmail.co.uk
sleeplessness can be a symptom of TMD

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 supporting musculature, and facial tics or trembling fingers are possible indicators of advanced stage TMD.

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 diarthrodial 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 pediatric 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 systematic diseases like arthritis may also have their part to play in TMD.

Torn ligaments, leading to swelling and bruising, can facilitate dislocation. Therefore, lengthy procedures that require the patient’s mouth to be wide open can be causative of TMD, as can the bruxism caused by malocclusion and the brain trying to compensate for an off-bite. Other potential factors include certain hobbies or professions. For instance, brass or woodwind musicians often require decompression splints and people who often have their head or neck in an awkward position – like a car mechanic – are also heading for TMD.

Impact on the chin can cause trauma of the retro-discal ligament, as the jaw is pushed back and forced off the disc. Trauma to the condyle head and housing fossa occurs when the jaw is moved back, forcibly, into the bilaminar zone’s superior stratum and the roof of the glenoid fossa. In such cases, lasting damage can occur without the condylar process sustaining fracture.

Long-term wellbeing
In order to give patients the very best treatment – in effect, treatment that produces excellent, natural results that do not cause discomfort or damage, whether now or in the long term – it is crucial that general practitioners are able to spot the signs, and effectively diagnose TMD. With the patient’s long-term wellbeing at stake, and more patients becoming interested in the benefits of a straight and healthy smile, clinicians cannot afford to shirk their responsibilities, not when all it takes is a little extra study to unlock the secrets of the TMJ.

For more information on orthodontic diagnosis and treatment, or to find out more about the Clearstep system, contact the OPT Laboratory and Diagnostic Facility on 01342 557910, email info@clearstepbrace.com or visit www.clearstepbrace.com.

About the author
Dr Andrew McCance
Since qualifying in dentistry from Glasgow University, Dr Andrew McCance has gained a wealth of experience in multi-disciplinary practices. He has held several distinguished positions including senior house dental surgeon at St George’s Hospital, Tooting, and then the post of senior lecturer at Great Ormond Street, he continued to develop his expertise culminating in a PhD at University College London. In the mid 1990s, Dr McCance began to develop the Clearstep brace, based on the demands of the 4,000 patients treated annually in his specialist practices. He is currently taking his Clearstep vision to a worldwide audience.
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.

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