Low fluoride children’s toothpaste fails to combat tooth decay

Children’s toothpaste that contain low concentrations of fluoride fail to effectively combat tooth decay, according to a recent study.

Researchers found that toothpaste containing fluoride concentrations of less than 1,000 parts per million are as ineffective as toothpaste with no fluoride at all.

For optimal prevention of cavities in children over age six, toothpastes should contain at least 1,000 parts per million of fluoride, according to the study carried out by the University of Manchester School of Dentistry.

The review, published in the latest issue of The Cochrane Library, a publication of The Cochrane Collaboration, examined results from 79 controlled clinical studies on 75,000 children, found the benefits of fluoride are reduced for toothpastes that contain less than 1,000 parts per million of fluoride.

“ Toothpastes with lower fluoride levels, in the 440 to 550 range, give results that are no better than the results seen with toothpaste that does not contain fluoride,” said co-authors Professor Helen Worthington and Dr Anne-Marie Glenny.

The study also found that brushing a child’s teeth with a fluoride toothpaste before the age of 12 months could lead to an increased risk of developing mild fluorosis.

Children’s toothpastes currently range from 100 parts per million to 1,400 parts per million.

Dr Glenny said: “From a public health point of view, the dentist, the benefit to health of preventing decay is likely to outweigh the risk of fluorosis.

“In such cases, careful brushing of their children’s teeth by parents with a small amount of toothpaste containing higher levels of fluoride would be beneficial.”

“If in any doubt, we would advise parents to speak to their family dentist.”

EARTHQUAKE APPEAL

We have all been shocked by the emergency situation in the Republic of Haiti after the earthquake which has claimed thousands of lives and left the survivors in turmoil. Dental Tribune is appealing to all readers who wish to help by donating much needed funds to help the relief effort to Médecins Sans Frontières (MSF), an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, healthcare exclusion and natural or man-made disasters.

What makes this all the more poignant is that the team at MSF responding to this disaster is still trying to account for colleagues who were already working in Haiti, and who may have not survived.

To help, go to www.msf.org.uk/supportus.aspx and click on the link to donate to the Haiti relief fund. Thanks in advance for your support.
£500k funding for tackling dental phobia

The Peninsula Dental School has been awarded £500,000 by the University of Plymouth to spend on research into dental anxiety, giving 12,000 patients access to treatment. Over the past four years we have doubled the level of NHS dental provision on the Island, which has almost 100% dental health, which is part of the Peninsula Medical School.

David Motes, professor of Oral Health Services Research and director of Postgraduate Education and Research at the Peninsula Dental School, said: “We have chosen three areas of research that require additional and focused study, and which will ultimately be beneficial to dental practitioners and their patients. “We are very grateful to the University of Plymouth for this funding and we look forward to working with researchers there to pursue these areas of study.”
Editorial comment
Always look on the bright side of life

It seems that the doom and gloom that has beset the country is slowly beginning to lift. No, I'm not talking about that bastion of British whinging – the weather, we'll need at least until May for that – rather the economic climate. Figures released by the Office of National Statistics has shown that the economy grew by 0.1 per cent in the last quarter of 2009. While it's not quite time to run about the streets cheering, this does mean that it may be time to quietly plan for more optimistic times ahead.

There has been more positive news in the profession as well – half a million pounds of funding into the use of virtual reality and nanotechnology in dentistry given to the Peninsula Dental School; a new dental school in Scotland; new dental practices opening in the Isle of Wight – it looks like a new year and a new decade has seen the turnaround into a more positive outlook, and long may it continue.

Also looking into the future, careers in dentistry are taking centre stage with the holding of a live Q&A session discussing careers in dentistry and the upcoming Career Opportunities in UK Dentistry conference next week.

Don't forget to visit my fundraising site – www.justgiving.com/bukumbibound to find out more about how I will be supporting the work of Bridge2Aid in the Tanzanian village of Bukumbi and to help by donating.

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6 Docimo R et al J Clin Dent 2009; 20 (Spec Iss): 137-143
Civil litigation report welcomed

Unsuccessful defendants should no longer have to pay ‘After the Event Insurance’ and success fees, according to proposals in a final report into civil litigation costs.

The Medical Defence Union (MDU), has welcomed the Right Honourable Lord Justice Jackson’s final report into civil litigation costs and claims it will improve the civil litigation process for claimants and defendants.

MDU head of claims, Jill Harding, said: “In our response to Lord Justice Jackson’s 2009 review of claims costs, we suggested a number of reforms which we believe are necessary to restore fairness and balance to the civil litigation procedures.

“We are delighted that many of these seem to have been proposed.

“We are particularly pleased that he has recommended unsuccessful defendants no longer have to pay for ‘After the Event Insurance’ and success fees which have contributed to the disproportionate costs faced by defendants, including MDU doctors and dentists.

“Lord Justice Jackson in his report accepted the need for wholesale reform of costs management including the time spent on a case and solicitors’ hourly rates.

“The report also recommends that specialist judges manage and try clinical negligence cases to ensure better cost and case management.

“For example, in the MDU’s experience, success fees can double claimants’ costs.”

Dental Protection communications manager David Groser commented: “Dental Protection welcomes the final report of Lord Justice Jackson on civil litigation costs.

“Lord Justice Jackson consulted widely during the consultation process and DPL together with its medical colleagues within MPS made two submissions and also provided data to the review team; we believe that the report represents a fair and balanced view of costs. The report includes specific recommendations for clinical negligence litigation including removing the obligation that the losing defendant must pay the claimant’s after-the-event insurance cover and success fees. Although DPL takes a firm stance when negotiating costs after settlement of a claim, these additional costs can sometimes double the costs which must be paid and this is necessarily reflected in the subscriptions charged to dental members.

“We would like to see the government bring forward legislation to implement these important changes. It would be a real shame if the momentum for reform of civil litigation costs was lost in the run up to a general election.”

‘Money-making’ dentist struck off

A dentist who conned patients out of thousands of pounds for fillings they didn’t need has been struck off by the General Dental Council.

Dr Constantine Saridakis, who worked at the Birchwood Dental Practice in Lincoln, was found guilty of 10 incidents of giving unnecessary treatment between May 2007 and March 2008.

In a number of cases, he recommended multiple fillings on patients who actually had no tooth decay. His partner gave a second opinion on some the cases, often finding no decay.

When confronted, Dr Saridakis allegedly said: “Sometimes I’m preventative, and sometimes I’m in a money-making mood.”

Dr Saridakis was suspended from NHS Lincolnshire’s dental performers list last April. However, he still treated two children then backdated the paperwork.

Two dental nurses voiced their suspicions when patients with healthy teeth were informed they needed fillings.
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New dental school for Scotland

Scotland’s First Minister has opened a dental school in an area where more than 51,000 people do not have a dentist.

First Minister Alex Salmond formally opened the £17m Aberdeen Dental School.

The school, which is affiliated to the University of Aberdeen, opened to students in 2008, with students transferring to the new building last November.

The school will produce 20 fully-qualified dentists every year.

The new complex includes units for radiography, restorative dentistry and consultant orthodontics, as well as dental laboratories, student laboratories and offices.

The Scottish government hopes the dental school will lead to a rise in the number of people entering the dental profession in Scotland - and in doing so reduce waiting lists. Recent figures showed that nearly 80,000 people in Scotland are still without an NHS dentist, with NHS Grampian having more than 31,000 on its waiting list.

North-east Tory MSP Nanette Milne said: “There have been a number of difficulties in recent years with regards to patient access to NHS dentists in the Grampian area and I hope that the opening of the Aberdeen Dental School will help increase the number of dental students in training and the number of dentists who remain in the Grampian area after training.”

SNP MSP for Aberdeen North Brian Adam also expressed hope that the dental school will make a difference and said: “The Scottish Government and NHS Grampian are investing in North East dentistry to tackle the long waiting lists and poor oral hygiene in Aberdeen and Grampian which this government inherited.

“Since the SNP came to power we have seen the number of dentists in Grampian rise to 504, with an increase of 21 last year and nearly 8,000 people have been taken off the waiting list.

“State of the art dental school will see 20 new dentists graduate every year from Aberdeen. Hopefully we can retain these dentists in Grampian and with their help make those long queues of people signing up to a dentist, a thing of the past.”

Rise in tooth whitening

Despite the economic downturn, there has been a rise in the demand for tooth whitening products and treatments, according to a recent survey.

A recent survey conducted by market research group Mintel found that around a third are concerned by the look of their teeth and 18 per cent do not like to show their teeth in photographs.

Tooth whitening has become a key reason for people to visit their dentists and sales of tooth whitening products rose to £57m last year and are predicted to increase by 86 per cent to £69m by the end of 2010.

The trend towards using tooth whitening treatments is being actively promoted by celebrities such as Simon Cowell who advocates Sonicare with all Factor finalists being sent a Philips Sonicare as part of their X Factor Profiles’ information cards and fact sheets to help dental professionals communicate better with their patients and show the benefits of its Sonicare HealthyWhite toothbrush.

The fact sheets can be personalised with a patient’s details and downloaded for free from the Sonicare website www.sonicare.co.uk/dp.
Dental nurses petition government

Nearly 600 dental nurses have signed a petition on the Number 10 website calling for the government to put pressure on the General Dental Council to reduce the Annual Retention Fee.

The General Dental Council (GDC) decided to freeze the Annual Retention Fee (ARF) of £96 for dental care professionals for the third year running.

However, dental nurses claim it is unfair that dental professionals on higher salaries pay the same ARF.

An online No 10 petition needs to get at least 500 signatures before it will reach the Prime Minister's office.

The petition lodged by Xy-anthe Lambert says: "We the undersigned petition the Prime Minister to reduce the annual Retention Fee for Dental Nurses to ensure a fair comparison against the higher salaries of hygienists/therapists and lab technicians, compared to Dental Nurses lower pay."

She adds: "I would like to highlight that dental nurses are on a lesser wage than hygienists/therapists and laboratory technicians, but are expected to pay the same annual retention fee as them."

However, Pam Swain, chief executive of the British Dental Nurses Association (BADN) believes that the most effective way of getting things changed is to join the BADN.

The BADN is currently gathering information about the salaries of dental nurses so it can highlight the low pay they get and present its case to the GDC.

GDC president, Angie McIlain claims that the GDC fails to take into account the fact that many dental nurses only work part-time and yet are expected to pay the same as hygienists and therapists (who are paid a minimum of £25,000 when newly qualified).

BADN want a complete revision of the registration fee to include lower fees for dental nurses, reduced fees for all part time registrants and payments to be spread across at least two instalments over the year, as well as for BADN to be consulted fully on all matters concerning dental nurse registration in the future.

Career opportunities event

The one-day event ‘Career Opportunities in U.K Dentistry’ celebrates its tenth year this February.

The event organised by the British Dental Association and UCL Eastman Dental Institute is being held on 12 February at a new and bigger venue – the Central Hall Westminster, located opposite Westminster Abbey and the Houses of Parliament.

The conference is aimed at vocational dental practitioners, young dentists, anyone considering a change of career or returning to dentistry after a career break, as well as dentists from overseas.

The day will consist of a programme of lectures by knowledgeable speakers. There will also be an exhibition with employers of dentists and organisations who support dentists throughout their careers.

Professor Jimmy Steele will be making the keynote address discussing challenges and opportunities that have arisen from the Steele Report.

There will also be a panel debate attended by Stephen Pur-

BDA's new president takes the reins

Edward Attenborough has been inaugurated as the new president of the British Dental Trade Association.

Mr Attenborough has taken over from Simon Gambold, managing director of Henry Schein Dental, who has served as president since 2002.

Mr Attenborough said: “Simon has served as president with immense dedication and commitment for more than two years and has achieved a great deal during his term of office.

“He has strengthened our links with the professional associations and worked hard to improve our lobbying capabilities and self regulation within the membership.

“I aim to continue with the focus on quality standards in both the surgery and laboratory sides of the industry as well as meeting the needs of the membership and very much look forward to working with members to achieve this.”

Mr Attenborough will be supported in his role by vice-president Karen Turner, managing director of Dentafix.

Mr Attenborough will be supporting in his role by vice-president Karen Turner, managing director of Dentafix.
GDPUK round-up

With the GDPUK online community remaining a continual bubble of activity over the holiday period, forum founder Tony Jacobs says there’s much to look forward to in 2010

GDPUK readers were busy through the December holiday period with the site even busier in early January when the snow meant more colleagues were at home with time to spare. The activity on the site suggested that catching up with the practice book-keeping was the last thing on their mind.

In the early part of the New Year, a topic was raised asking what dentists were talking about 10 years ago. I had a look back in the archives of messages posted in January 2000, and although I cannot promise it was a perfect and thorough review of all the postings at that time, some of the topics might jog your memory.

Debates from that time concerned the bleaching of teeth, the different methods, and the pros and cons of each style of treatment. Then there were discussions on the erosion of teeth, pregnancy, and NHS services in specific towns and holistic dentistry. There were also arguments as to why there are now, about the effectiveness of the British Dental Association (BDA) in representing the profession. Obviously this is a perpetual discussion point, and may always be.

Today’s hot topics
Back to the present, I will tell you about the hot topics now. The concept of the use of homeopathy in dentistry was raised with one or two proponents. This argument was attacked by a group of members, citing many reasons why this was unscientific. To give non-members a flavour of how severely debated these topics can be on GDPUK as a vibrant forum, this topic attracted 107 replies within a few days.

On a lighter note, there was an informal competition to post pictures showing the lowest temperature on a car’s external thermometer during the period of snow [I managed -11C in Manchester]. Travel in the snow, and some beautiful views from practice windows were posted, allowing for expressions of wonder and awe.

Other topics included advice on instrument washers, a discussion on lesser-known implant brands, section 63 courses and their organisation, as well as a small dental Christmas carol competition.

UDA claim campaign
Meanwhile, Ian Gordon started a campaign supporting NHS practices being able to claim some reduction in UDAs targeted for this year due to the disruption caused by the snow in early January. When the subject of the weather was broached, the whole country was unanimous in how much dental practices had been affected, with the public being given local or national advice not to venture out, with warnings of particular danger to the elderly and very young.

Has the campaign been successful? You will have to watch this space.

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February 1-7, 2010

8 News & Opinions United Kingdom Edition

临床治理

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临床治理
Clinical Governance has been gaining momentum in practice thinking over the last 18 months or so. With it being a requirement of the NHS contract, and the upcoming strategies that the Care Quality Commission will be putting in place, the reality is now for practices and PCTs to ensure their CG procedures are in order.

One of the PCTs who have been more forward thinking about how they ensure compliance with CG is Bromley. Starting in 2005, the PCT had been running a CG seminar programme as it believed Bromley dental practices Two years ago the PCT decided that what they then needed was a programme whereby they could measure consistently practises’ performance in the different areas of CG and identify the gaps.

**Ambitious project**

This is where Raj came in. Raj Rattan is a practitioner based in West Wickham and a dental advisor at Smile-on (a dental and a medical college to enable everybody to access a computer workstation so they could log on to the system and try it out. Raj said: “We had originally set up a series of workshops discussing the Clinical Governance CD. When CGPM went live, we ran another series of workshops. Before we introduced CGPM we went to a lot of trouble to engage with dentists throughout the programme; we also consulted with the LDC. The PCT told the practices ‘this is what we want to do’. There was resistance, there’s bound to be, but the majority said ‘ok if this is what we need to do, let’s find the nicest way in which to get it done’.

**Getting the picture**

Raj added: “From the touch of a few buttons the PCT can get a picture of what is happening in an individual practice in Bromley, they can aggregate. Where we are now is every practice in Bromley has completed the online assessment, and all will have been visited by the end of March 2010 – that’s approximately 60 practices.”

CGPM was then developed as a partnership between Raj and the team at Bromley PCT (Harry Goldingay - Associate Director Risk, Jill Webb - Assistant Director Primary Care Commissioning & Performance, Emma Wallis - Dental & Ophthalmic Commissioning & Performance Manager and Carol Adeleye - Dental Practice Advisor) and the development team at Smile-on. The development costs were borne by Smile-on with their Dental Practice Advisor) and the development team at Smile-on.

The development costs were shared between Smile-on and the PCT and the PCT then bought licences for all Bromley practices. The aim was to make the programme easy to use for both practices and the PCT, and make the requirements for each domain clear so that practices were informed about what they needed to comply with. Raj said: “There were two things I think that made our programme different at that time. One is that we scored practices against different at that time. One is that we scored practices against well-defined criteria but we also weighted the criteria. For example, if a practice hadn’t scored against item x, then we could say that we weren’t as bothered as item x was a minor protocol (eg the placing of a Health & Safety poster) that the practice could easily sort themselves. It’s important, but not as important as say not taking a medical history for a patient. So by having the criteria and weighting them we were able to get a score. Following feedback we then did some joint work on what is now called CGPM. The static product in the Clinical Governance CD was already in existence, so my work with the PCT on my spreadsheet was the bridge between what Smile-on had and what Bromley PCT wanted to do.

**Hands-on workshops**

In an effort to make it easier for practices, the PCT organised a series of workshops with groups of 12-15 attending; booking a local college to enable everybody to access a computer workstation so they could log on to the system and try it out. Raj said: “We had originally set up a series of workshops discussing the Clinical Governance CD. When CGPM went live, we ran another series of workshops. Before we introduced CGPM we went to a lot of trouble to engage with dentists throughout the programme; we also consulted with the LDC. The PCT told the practices ‘this is what we want to do’. There was resistance, there’s bound to be, but the majority said ‘ok if this is what we need to do, let’s find the nicest way in which to get it done’ and have a supportive way to do it.’

“The workshops ran over a period of six months at the end of last year. Because they were run in small groups, what we did was get the first cohort up to speed then they were the first group to be visited, then the second were the second to be visited and so on. So the whole programme was done in a very structured and supportive way because there was no rush to complete the visit until they had been to the workshop. And also at all times they had email access to people such as Harry and me to get help.

“Of course change is always hard and something on this scale has not come easily. Bromley PCT has had to work out a strategy to make the process easy and attractive for practices including an incentive scheme which offers a payment when practices achieve the required level. Raj commented that there had been some resistance to CGPM, but that it was a common occurrence when change of this scale happened. "What was very interesting was there were a number of people who originally said ‘this is more paperwork - this is more admin’.

“The interesting thing was after having completed the process these same people were saying ‘you know what, now I’ve done it I’m really glad I did as I am now more comfortable that I have now got all of these things in place’. It allows practices to comply with the contract and meets the PCT’s agenda.”

Before the programme was rolled out it was piloted on four pilot sites in the Bromley area. This allowed the development team to assess the usability of the system and gather feedback from real users who made themselves available as ‘guinea pigs’ to see if it worked. After these pilots, changes were made to refine procedures and make the system more user-friendly for both practices and the PCT.

**‘Ok if this is what we need to do, let’s find the nicest way in which to get it done’**

It has been a two-year journey for Raj and Smile-on to get to where they are today. For the PCT, Jill Webb and Harry Goldingay said: The PCT is delighted that all practices agreed to adopt the CGPM, which enabled all parties to build upon previous work. We also then move into the next development phase of the system which will be to review the current standards and adapt them, as necessary, in order to support Bromley providers to meet their CQC (Care Quality Commission) Registration requirements in April 2011.

Raj is deservedly proud of what has been achieved. “This has been terrific for me personally - I love working on new projects and I always felt where the hard bit of governance was actually doing the gap analysis; also measuring the improvement of practices. How I feel about it as an individual was probably the same as a photographer feels taking a series of photographs - it's fantastic. It then finds it hanging on someone's wall. I think actually seeing it, live and functional, having started to sketch it out literally on the back of an envelope - it's fantastic.

**Personal thanks**

“A personal huge thanks to the PCT who gave me the freedom to develop my idea and allowed me to see this develop properly. This has been a great example of teamwork between practitioners, a PCT and an IT company. Also we are running an IT support line - it’s been done remotely which saved time – we had no more than five face-to-face meetings.

“Finally, I'd like to acknowledge the pilot practices – their input was invaluable in the development of CGPM. I'd also like to acknowledge the LDC for their support during the rollout and a big thank you to all the practices of Bromley for their engagement.”
Considering risk assessment when planning treatment

Dental Protection looks at assessing facets of case preparation

Every treatment plan, from the simplest to the most complicated, employs a dual process of data collection. The initial input from the patient is enriched with information from past examination and any relevant investigations, so that a suitably informed diagnosis can then be made before a treatment plan is formulated for discussion with the patient as part of the prudent foundation for the consent process. All these stages raise questions that have to be correctly answered to ensure a correct assessment. Sometimes the ‘stations’ on this journey are passed through at a brisk pace. When the diagnosis is self-evident, and the patient’s wishes are clear, there is usually no great problem if the investigations are not exhaustive. For example, it is clearly not appropriate to take radiographs of every tooth when dealing with a chipped filling, or a biopsy of every mouth ulcer, or a sample for bacteriological investigation for every infected tooth or where there is some doubt over the logic or appropriateness of the original diagnosis and treatment plan, or perhaps when a diagnosis may have been ‘missed’. There are the occasions when third parties - often experts in the field instructed by the patient’s solicitors - will look very closely at each stage of the events leading up to an incident, and ask whether or not all the necessary and appropriate histories were taken, or whether all proper investigations relevant to the clinical situation were carried out, and if so, whether the dentist in question had acted upon and interpreted the results with the proper skill and care that could reasonably be expected of someone in that position.

As a corollary, other questions could then arise: • Why was some crucial aspect of the patient’s history or risk profile not recognised? • Why were certain investigations not carried out? • Could the harm subsequently suffered by the patient have been avoided, had the correct questions been asked? • Had the correct investigation(s) been undertaken and acted upon. Patient input can be elicited by What’s the problem? How can I help you?

Investigations Investigations and tests can take many forms, and the questions of Which?, When? and For Whom? are highly relevant.

Diagnostic phase What? (eg what is causing the patient’s pain?) Why? (eg why does this filling keep fracturing?) Treatment planning phase How? Is a question that is added at this stage along with considerations of What? And When? The prudent clinician will also be asking: Why not? When not? How not? Who? Etc.

In most clinical situations – including diagnosis and treatment planning – the clinician is faced with choices. As in any decision-making process, the quality of the decision tends to improve in direct proportion to the quality and accuracy of the available information.

Radiographs It is prudent, from a risk management perspective, to take pre-operative radiographs for extractions, in situations where the patient has reported previous difficulties with extractions, or where there is a risk of damage to other structures, (for example, in the tuberosity area, or when contemplating extractions in elderly patients) where the bone quality and quantity may be compromised and the risk of tooth or jaw fracture may be high. Third molars are another obvious area where knowledge of the root configuration, the overlying bone, and the relationship of the tooth to adjacent teeth, the inferior dental nerve bundle, and the lower border of the mandible, is essential. If radiographs are not taken, and a serious problem occurs, the dentist will be under pressure to demonstrate that the absence of the radiograph(s) could not have contributed to the problem in any way.

Radiographs are similarly an important investigation in cases where orthodontic extractions are contemplated (to confirm any congenitally absent teeth or other pathology), as well as serving as an aid to orthodontic diagnosis, treatment planning and case management. Similarly, in association with the diagnosis and treatment of periodontal disease, and endodontic problems, the absence of radiographs leaves a dentist highly vulnerable to the allegation that he/she had failed to carry out a relevant and material investigation. If a delayed diagnosis and treatment results from this lack of radiographs and has led to any further problems for the patient, the dento-legal problems for the dentist are compounded.

In endodontic cases, relatively common problems such as fractured instruments and under and over-root fillings, have all been attributed on occasions to the absence of relevant X-rays - perhaps no pre-operative X-ray was available to forewarn of a root curvature or sclerosis, or an exceptionally fine canal, or perhaps no working length x-ray was taken to assist in controlling the length of the filling (although in the latter situation, electronic apex locators are an alternative investigation which can be defunct successfully).

Cases where it is alleged that the ‘wrong tooth’ has been extracted or filled, or its pulp tissue has been unnecessarily extirpated, often hinge upon the evidence of proper investigations. In situations where the diagnosis is initially equivocal or inconclusive, cases may hinge
Occlusal investigations can take many forms, ranging from the use of articulating paper, wax, indicator spray or other occlusal ‘marking’ devices, through articulated study models, to a more detailed face-bow registration, pantograph tracing or devices which measure and record muscle activity. The use of a stethoscope also has its place in TMJ auscultation. The skill lies in knowing which investigations are appropriate, for which patients, and under what circumstances. The danger lies in erring on the side of too few, or too superficial, investigations.

Recording investigations

The key to the investigation process is to record what investigations are being carried out, and the findings so that, if necessary, one can demonstrate at a later date, a logical and carefully followed process leading to a diagnosis and treatment plan. It is much easier to defend a practitioner’s actions if supported by and consistent with a meticulously-recorded series of relevant investigations, (even if subsequently proved to be misleading or incorrect), than the commonly-encountered responses such as:

“I would probably have checked the tooth vitality and looked for any tenderness to percussion; I wouldn’t always write it down”.

or perhaps:

“I presume the periodontal condition must have looked better that day, or I would have done some further treatment and made a note in the patient’s records.”

The clinical records should make it possible to follow the clinician’s logical thought process through the stages leading to any particular course of treatment. All the relevant components of the case assessment process

on whether the investigations carried out were sufficient to support a given diagnosis and treatment. On the other hand, there is little point in carrying out full and proper investigations, and then failing to act upon the results.

In the case of some infections, taking the patient’s temperature can indicate the presence or absence of systemic involvement, and other specific measurements of the site, size and appearance of oral lesions (ulcers, swellings, white patches, and other dysplasia) - perhaps with the help of an intra-oral photograph - can make it much easier to monitor the development of resolution of oral pathology. The increasing frequency of cases involving missed diagnosis or oral carcinoma, stresses how important this can be.

Similarly, periodontal probing depth measurements are a valuable investigation whether in the form of a BPE screening, or a more extensive chart either around specific teeth, or all standing teeth.

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(consultation, medical history, dental history, social history, clinical examination, investigations, diagnosis and treatment plan) should be in evidence.

Reviewing the diagnosis
Correct diagnosis is the outcome of successful and appropriate investigation including history taking, visual and radiographic examination and any other clinical and pathological examination relevant to the patient’s condition. Sometimes only a provisional diagnosis can be reached which leads to further investigation. Each subsequent step/investigation/diagnosis leads to a definitive diagnosis which in turn will lead to a definite treatment plan. There are occasions when treatment itself forms part of the investigation. The outcome of such treatment is then fed into the diagnostic process.

Dental care is not static, it affects and is affected by the changing continuum in the patient’s general health and therefore consideration must always be given to the possibility of having to change the diagnosis and treatment plan as the patient’s condition alters.

Consent
When one or more treatment options have been identified, or a provisional treatment plan has been reached, it is necessary to involve the patient fully in a consent process which explains the nature, and likely outcome of each of the possible alternatives, compares their relative advantages and disadvantages, benefits, risks and limitations (and costs, where applicable). The consent process is only as good, however, as the quality of the information and treatment choices that the clinician invites the patient to consider. Consent may not be valid at all if one or more important and relevant treatment options have not been discussed with or offered to the patient (by referral, if necessary). Similarly, it is unwise to steer a patient too forcibly towards one particular treatment option without explaining its risks and limitations.

Summary
A typical scenario is the situation where a tooth becomes pulпитic very soon after a crown, bridge or veneer is placed and then needs to be root filled. In such a situation it is invariably difficult to persuade the patient that he/she should pay for a root filling, or for a new replacement restoration (if necessary). The clinician may well be asked whether:

- Are there any questions left unanswered by your records?
- Can you demonstrate the investigations you carried out?
- Do they now appear to have been sufficient or might it have been helpful to carry out and record additional investigations?
- Are you omitting to record investigations you do carry out (percussion/mobility testing is a familiar example of this), perhaps because you see them as a routine part of a clinical investigation? Many dentists tend to record only ‘positive’ or ‘abnormal’ findings, whereas ‘negative’ and ‘normal’ findings can be equally (or sometimes more) valuable - such as ‘no tenderness in sulcus’, or ‘normal response to ethyl chloride’.
- Is it clear from the records how and why the diagnosis and treatment plan reflected the patient’s history, the findings from the clinical examination and any discussions with the patient?
- Was more than one treatment option recorded?

The more experienced a clinician becomes, the greater the danger that their histories, discussions and investigations will be viewed by them in this light, with diagnoses made and treatment plans decided upon apparently by ‘instinct’. There is even greater room for criticism when the records create the impression that the clinician was determined to carry out the chosen treatment (whether or not it was justified in the light of the specific clinical circumstances of the individual patient concerned) and that no other treatment option was really considered at all. It is helpful, therefore, to carry out a periodic audit of one’s clinical records as described above, not only as a valuable self-assessment process, but also as a useful platform for constructive peer review discussions.

Simple audit
It is a useful exercise to take any ten record cards for patients who have had a significant amount of treatment, or an unusual treatment episode, and to ‘audit’ these cards just as a third party might do, were a problem to arise today.

- Are there any questions left unanswered by your records?
- Can you demonstrate the investigations you carried out?
- Do they now appear to have been sufficient or might it have been helpful to carry out and record additional investigations?
- Are you omitting to record investigations you do carry out (percussion/mobility testing is a familiar example of this), perhaps because you see them as a routine part of a clinical investigation? Many dentists tend to record only ‘positive’ or ‘abnormal’ findings, whereas ‘negative’ and ‘normal’ findings can be equally (or sometimes more) valuable - such as ‘no tenderness in sulcus’, or ‘normal response to ethyl chloride’.
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Tailor-made agreements

A properly drawn-up associates contract, although not entirely conclusive, may go a long way to avoid future challenges that a self-employed associate is actually an employee. Tim Lee explains.

Cases involving the employment status of ostensibly self-employed associates continue to come before Employment Tribunals (ETs). ETs are “first instance” tribunals, so the decision of one ET is not binding on others. However, in practice, tribunals often look to earlier ET decisions for guidance (and perhaps sometimes inspiration!).

The higher courts (whose decisions may be binding) have said, time and time again, that decisions involving employment status depend entirely on the facts of each case. The courts stress that a simple “checklist” approach to the problem is not sufficient. Each court or tribunal has to look at all the circumstances of each case.

Grotepass v Singh

In the recent case of Grotepass v Singh (which came before the Southampton ET in July 2009), the Claimant who had been an associate of the Respondent principal, claimed he had actually been employed. There had been no written associate’s agreement.

The ET found that the Claimant had been treated as self-employed for tax purposes. Fees were made up of private patient fees per item charge, and the associate’s arrangement was tailored to the needs of the practice. The ET also felt that the facts of this case, that the Claimant was not an employee for the purposes of bringing a claim for unfair dismissal (a similar finding to Grotepass).

Lessons to be drawn

In dealing with practice acquisitions and sales, I am often surprised at the number of practices that I encounter where there are no written associates contracts in place.

One important lesson to be drawn from these two recently reported cases, is that a properly drawn-up associates agreement, although not entirely conclusive, may go a long way to avoid future challenges that a self-employed associate is actually an employee.

It is important to remember that associates’ agreements are not “one size fits all.” Each situation should be properly and individually considered, taking legal advice where necessary, and ensuring that agreements are tailored to particular circumstances.

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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 655 3255.
Confirmed speakers at Clinical Innovations

Dr Julian Webber

After qualifying from Birmingham Dental School, UK in 1974, Dr Webber worked as an Associate in a National Health Service Practice for two years before continuing his education at Northwestern University Dental School, Chicago, Illinois, USA. As the recipient of the prestigious Charles Freeman Scholarship of the American Dental Society of Europe he was the first UK dentist to receive a Master of Science Degree and Certificate in Endodontics and returned to the UK in 1978. Dr Webber has held teaching positions both at Guy’s Hospital and Eastman Dental Schools in London whilst maintaining a practice limited to Endodontics in central London since 1978. In October 2002, he opened the Harley Street Centre for Endodontics, a purpose built state of the art clinical teaching facility. Dr Webber devotes much time to teaching and writing having contributed to numerous journals and textbooks on Endodontics and extensively lectured around the world. Dr Webber is a former President of the British Endodontic Society, a member of the British Association of Endodontists, European Society of Endodontology, a member of both the American Dental Societies of London (past president) and Europe (current vice president), a member of the Pierre Fauchard Academy and a Fellow of the International College of Dentists. He is a faculty member of the Pacific Endodontic Research Foundation in San Diego, California, where he has perfected and taught techniques on Microscope, Conventional and Surgical Endodontics. He is a visiting Professor at the University of Belgrade, Serbia and Montenegro.

In 1998, he became Editor-in-Chief of Endodontic Practitioner, a clinical endodontic journal. Julian will be speaking on Management of Endodontic Failure

Dr Trevor Bigg

Dr Trevor Bigg has been working in private practice in West Oxfordshire for nearly 40 years and has treated up to four generations of some families. He operates a general practice and take referrals for cosmetic dentistry, the non-invasive restoration of the worn dentition and treatment of Temporomandibular Dysfunction (TMD). He was a tutor at the Central London Study Group for five years with MGDS students and mentor practitioners who are taking the FFGDP(UK). Dr Bigg lectures at home and abroad on crown and bridge updates, posterior and anterior composites, bleaching and Minimal Intervention Dentistry. He also runs day ‘hands-on’ courses for Denplan and Dentistry and presenting a Smile-on webinar on Bleaching. Dr Bigg holds a membership in General Dental Surgery at the Royal College of Surgeons, London and Fellowships from the College of Surgeons in Edinburgh and London and is a Past-President of the British Society for General Dental Surgery.

Trevor will be speaking on Progressive Tooth Whitening

Dr Wyma Chan

Wyma Chan, C.H. at Guy’s Hospital Dental School, London. He set up the first dedicated teeth whitening spa smilestudio in UK in 2002, and then a licensing network of smilastudio outlets a year later.

He is the founder of smiles studio Teeth Whitening Academy, which began training the dental team on teeth whitening processes in 2005 with his hands-on format. He has trained more than 1500 dentists, dental hygienists, dental therapists, dental nurses and other dental team members.

Wyma has worked with all major home and power whitening systems and has performed more than 5,000 whitening procedures. His innovative research in the field of teeth whitening led to five UK granted patents and several more pending. Wyma won the prestigious Procter and Gamble Investigator Award at the 2008 International Association for Dental Research meeting in Toronto, Canada. He is a part-time PhD research student at the Centre for Materials Research and Innovation, University of Bolton, United Kingdom. Through his research and experience of treating thousands of patients, Wyma has discovered some important phenomena in the texture of teeth, and utilised them to establish some important protocols and metrics that have contributed to the understanding and improvement on safety and efficacy of teeth whitening processes. He has many articles published in dental journals and is well regarded as an expert in this field.

Wyma is a wet-handed teeth whitening dentist and treating around 1,000 patients every year in his dedicated teeth whitening Centre, and spend the rest of his time on research. He lectures internationally and runs regular hands-on power whitening seminars in London.

Dr Edward Lynch

Edward is Head of Restorative Dentistry and Gerodontology at Queen’s University Belfast and is also Consultant in Restorative Dentistry in the Royal Hospitals. A specialist in endodontics, prosthodontics and restorative dentistry, he is also on the editorial board of numerous international journals and has published more than 450 publications. Professor Lynch is very much a ‘wet gloved’ academic, treating many specialist referrals every week.

Edward will be speaking on Making pretty teeth is the easy part

Dr Basil Mizrahi

Basil graduated from the University of the Witwatersrand, South Africa in 1989. In 1995, he obtained an MSc in Dentistry, majoring in Periodontics. After five years in general practice, he moved to the USA to specialise in Prosthodontics at Louisiana State University, School of Dentistry.

In June 1998, Basil graduated from a three-year full time Prosthodontic program at LSU under the leadership of Dr Gerard Chiche. During this time he also completed a Masters Degree in Education at the University of New Orleans.

In 1999, Basil started his own referral based practice in Harley Street. He is also a clinical lecturer at the Eastman where he runs hands-on courses for dentists.

He is on the GDC specialist register for Restorative Dentistry and Prosthodontics and has been awarded Fellowship of the American College of Prosthodontists.

Basil will be speaking on New Scientific Advances in Teeth Whitening Processes

Clinical Innovations Conference (CIC) will be held on the 7-8 May at the Royal College of Physicians in Regent’s Park, London. For more information call 020 7400 8989 or email info@smile-on.com

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Sticking to your resolutions

If you keep just one of your New Year’s resolutions this year, says Peter Dunn, make sure it is the one to be more financially efficient

If you keep one New Year’s resolution this year, make it the vow to be more financially efficient. There’s no denying 2009 was tough. Many dental professionals have experienced a difficult market where patients have come off dental plans, lengthened the time between examinations, veered off course with their treatment plans or deferred big-ticket treatments.

In times like these it is tempting to bury our heads in the sand and leave everything as it is, but it is quite the opposite that is required – and that’s action. Don’t put off your spending decisions: now is the time to become really proactive with your personal and practice’s finances.

**Questioning your finances**

When was the last time you questioned your finances or took a good, hard look at where your money is being spent? Are all your expenses necessary? Are you getting the best value from them? Many people start out with good intentions. They re-search the best life assurance, income protection cover or pensions when they originally take them out, then sit back and hope the decisions and investments they made three, five, 10 – or even 20 years ago will do them proud. But the truth is, as your circumstances change, so should your portfolio.

Take income protection cover as an example. Changes are you took out income protection cover when you were younger, possibly when you first started out in dentistry. You were probably sold it by someone whose primary basis for suggesting that particular policy was their commission – but is it right for you now?

Have your profits and income changed since you first took out the policy all those years ago? Does the policy actually reflect your situation today and even more worryingly, if you have a claim, will they pay out?

**New Year’s resolutions**

Each New Year we make decisions to plan aspects of our lives differently. We decide to stop smoking, to cut down our drink-ing, to exercise more, to get a better work-life balance, to spend more time with the family – we plan all sorts of new approaches that we hope will make us feel better, perform more effectively and allow us to enjoy our lives more. I have no doubt that everyone reading this article will potentially break each year, make new financial resolutions and embark on a financial health assessment on your financial portfolio. Times have changed. Many other industries, including dentistry, financial advice has changed considerably over the decades. From a commission-based sales job in the 1970s and 1980s, to a specialist consultant with supporting educational credentials; when you seek financial advice from a reputable firm, the experience will not reflect anything like the one you may have had 10 or 20 years ago. In the same way that you would recommend I visit your practice if I had not been to a dentist for more than 12 months, if you have not had a comprehensive review of your financial position for many years, you are risking your financial health and the repercussions can be catastrophic.

You perform a 15-point dental health assessment on your patients to check for signs of dental disease and we undertake our 10-point financial health assessment to ascertain the crucial decisions that will drive your financial security. We will help you to identify your vision of the future, without the limitations of any financial constraints, and work back from that desirable position to plan a solution that seeks to achieve it.

**Driving your investments**

It is your vision of the future combined with expert financial management that drives the investment process. Using a targeted risk profiling methodology, an asset allocation model will be designed that reflects your attitude to risk. Then by modelling different scenarios and quantifying their impact, you can be steered towards a decision making that finds a suitable balance between your appetite for risk and the achievement of your aspirational life.

The question is how many of us plan to build a suitable financial programme by the time 2010 has been and gone! A New Year is a good time to become really proactive with your personal and practice finances.

When was the last time you reviewed the best life assurance, income protection cover or pensions when you originally take them out, then sit back and hope the decisions and investments you made three, five, 10 – or even 20 years ago will do them proud. But the truth is, as your circumstances change, so should your portfolio.

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You perform a 15-point dental health assessment on your patients to check for signs of dental disease and we undertake our 10-point financial health assessment to ascertain the crucial decisions that will drive your financial security. We will help you to identify your vision of the future, without the limitations of any financial constraints, and work back from that desirable position to plan a solution that seeks to achieve it.

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In the same way that you refer to specialists when the need arises, many reputable financial advisers will work in partnership with globally recognised and respected wealth managers. They are best placed to provide sophisticated portfolio management and related financial services but the overall responsibility and management of your finances will firmly remain the responsibility of your financial adviser.

**Take control in 2010**

When you consider the complexity of your financial portfolio, you may find it all a bit too much and put off doing something about it. But that would be the wrong approach. For all the resolutions that you make and potentially break each year, make 2010 the year you actually take your finances by the scruff of the neck and do something positive about them.

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Even if you begin with a comprehensive analysis of your current situation, which is always the first approach of any good financial adviser, just take that initial step. Think about all the policies you probably have: critical illness cover, life assurance, pensions, savings and investments, loans and mortgages; the list goes on. Get them working for you! Make sure that your financial decisions are informed and focused on an end goal that realises the life goals you most desire. Everything is possible when you combine action with purpose.

Half-hearted plans to do more exercise, drink less alcohol or eat more healthily – they are all well and good, but none of them will help you achieve your long-term aims - goals and aspirations that really matter. Make sure your New Year’s resolution for 2010 really counts – make an appointment with a financial adviser, ask around and see who comes highly recommended. Enjoy the peace of mind that comes with knowing your future is planned, your affairs are in order and your financial success is secure.

**About the author**

Peter Dunn is director and senior consultant for Heritage Financial Advisers, a team of independent, fee-based financial planning specialists dedicated to the dental sector. Peter has over 20 years experience of working within the dental industry in financial services companies allied to Dental Business Solutions and Practice Plan. In 2001, he relocated to Northwards with what is now Heritage Financial Advisers and assumed joint control of the company in 2006. To contact him, call 01855 862727 or email info@hfadvisers.co.uk.
Closing the gap

Dr Edward Young shows how the Clearstep method has helped a young lady gain her confidence and a beautiful new smile

Our patient, a 25-year-old female, had no history of orthodontic treatment and she came to us with concerns with the appearance of her upper anterior teeth. In particular, she felt that both her UL2 and UR2 were moving backwards and UL1 and UR1 were moving forwards.

At that particular point, she was beginning to be very self-conscious with the appearance of her teeth. Her interest was principally in Clearstep as they are invisible and unobtrusive; she works as a primary school teacher and felt this would be a perfect choice. Although her lower teeth are also crowded, she sought only to have upper arch teeth treatment.

Closer examination of her teeth revealed that both her UR2 and UL2 were instanding and that she was tending to favour a Class III edge-to-edge incisal relationship. Her upper arch was also somewhat narrow and her overbite decreased.

Taking impressions

Relevant intra-oral and extra-oral photos, x-rays and accurate impressions were sent to OPT for analysis. On receipt of the detailed report, it was explained to the patient that in order for the perfect result she would need to consider having lower arch treatment too.

However, in order to address her problems, we would first have to expand out her upper arch using the Clearstep Orthodontic Dentofacial Aligner (CODA system), thus making her upper arch wider and then finally use Clearstep positioners to align. The CODA is a removable lateral expansion device made with very light elgloxy wire and soft esther acrylic. It is highly discreet and has a minimal affect on speech. I find the appliance encourages more effective lateral movement of teeth than a box of positioners.

Treatment recommended

We advised the patient to wear two CODAs for 14 weeks in order to expand out her upper anterior teeth, particularly UR2 and UL2. Prior to fitting the CODA, Clearstep enclosed composite templates to allow placement of material on the palatal surfaces of her UR2 and UL2. This allows the acrylic portion of the CODA to be inserted snugly underneath them to encourage gentle, consistent, favourable forces. It was also noted earlier that the patient had a decreased overbite and this could be made worse by a potential appliance propping open her bite.

In order to address this issue, posterior bite raisers were fitted in her UR7 and UL7. The CODA can be worn at all times and typically patients adjust to the appliance very well. The patient was advised to return after 14 weeks to monitor her progress and to take fresh impressions for the move onto Clearstep positioners.

Long-term retention

After nine months of clear positioners, the case came to an end, and again, three retainers were given to the patient to ensure long-term retention.

The above case uses a number of techniques and appliances, systematically implemented in order to encourage favourable tooth movement to full effect. Clearstep positioners alone would have taken a little longer.

Throughout treatment, the patient had been able to continue her busy working life looking after a classroom of children as well as live her active social life while her smile continued to improve with no obscurities or problems.

The patient is delighted with the results and the tooth movement is apparent from the occlusal views in the images.

The Clearstep System

The Clearstep System is a fully comprehensive, invisible orthodontic system, able to treat patients as young as 7.

It is based around 5 key elements, including expansion, space closure/creation, alignment, final detailing and extra treatment options such as functional jaw correction.

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Accreditation Seminar

This accreditation seminar is aimed at General Practitioners, providing you with all the knowledge and skills required to begin using The Clearstep System right away.

Personal Accreditation

Receive a visit from a Clearstep Account Manager, providing a personal accreditation in your practice at a time convenient to you.

Accreditation Seminars for 2010

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Further Courses

Once accredited, further your orthodontic expertise with our Hands On Course, where you will learn sectional fixed skills and other methods to reduce your costs and treatment times.

Clearstep Advanced Hands On Course dates for 2010

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Cutaneous sinus tracts: An endodontic approach

Diagnosis and treatment for a successful outcome

Misdiagnosis of an extra-oral sinus tract usually leads to a destructive invasive treatment of the local skin lesions that is not curative and often mutilating (Fig. 1). Attempting to treat such lesions with a circular incision of the orifice of the cutaneous fistula and excision of its entire tract with all the ramifications is not consistent with the present standard of care. Unfortunately, cutaneous fistulae are sometimes treated as though they are independent dermatologic lesions with the pathogenic characteristics and treatment prognoses typical for mucosal fistulae. However, even skin biopsy may produce unnecessary scarring.

Correct diagnosis is the key to treating this kind of lesion. A gentle digital finger pad pressure on the apical region of the area suspected can create a discharge of pus. A dentist can provide useful information that will help with the final diagnosis and the subsequent treatment plan. A correct diagnosis will lead to a simple, yet effective treatment—the removal of the infected pulp canal tissue from the root canal space—resulting in minimal cutaneous scarring.

Cutaneous sinus tracts of dental origin have been well documented in the medical literature, dermatological literature, and dental literature. However, these lesions continue to be a diagnostic dilemma. Patients suffering from cutaneous fistulae usually seek treatment from a physician or a plastic surgeon instead of a dentist and often undergo multiple surgical excisions, multiple biopsies and antibiotic regimens with eventual recurrence of the cutaneous sinus tract because the primary dental cause is frequently misdiagnosed.

The evaluation of a cutaneous sinus tract must begin with a thorough patient history and awareness that any cutaneous lesion of the face and neck could be of dental origin. The patient’s history may include complaints of dental problems. However, patients may not have any history of an acute or painful onset. There may also be complaints of episodic bleeding or drainage from the cutaneous site with persistence of the cutaneous lesion. Occasionally, there is a history of injury to the tooth.

Correct diagnosis of the cutaneous sinus of dental origin should be suspected by the gross appearance of the lesion. These cases typically present as erythematous, symmetric, smooth, non-tender nodules of one to 20 mm in diameter with crusting and periodic drainage in some cases. The most characteristic feature of the nodule is its depression or retraction below the normal surface. This cutaneous retraction or dimpling is caused by the fixation of the tract to the underlying tissues and may be secondary to the healing process or a late finding in active disease. Lesions that previously underwent biopsy and treatment are usually characterised by the absence of at least part of the nodule and frequently by an orifice of draining sinus at the base of the fixed depression.

Endodontic infection, the product of cellular degeneration—bacterial toxins—and, occasionally, the bacteria themselves within the canal spread through the apical foramen into the surrounding tissue. Thus, a slow inflammatory process begins in the tissue contained within the peri-odontal ligament. Left to itself, it may manifest in a variety of ways, ranging from simple widening or thickening of the ligament to granuloma or cyst. Sometimes a fistula may develop, with the patient reporting intermittent discharge of pus.

The fistula provides a means of continuous drainage of the lesion. The opening of the fistula may be found on the mucosa overlying the tooth that sustains it, but often it may also be found at a considerable distance from the diseased tooth. In some cases, the fistula may run in the space of the periodontal ligament of the same tooth. It may even traverse the periodontal ligament of the adjacent healthy tooth, thus stimulating a lesion of periodontal origin. In such cases, negative pulp tests performed on the crown of the tooth, indicated by a gutta-percha cone inserted into the fistula, assist in making the correct diagnosis.

If the drainage of the fistula is not continuous but intermittent, it is preceeded by a slight swelling of the area as a result of the increased pressure of pus behind the closed orifice. When the pressure becomes strong enough to rupture the thin wall of soft tissue, the suppurrative discharge issues externally through the small opening of the fistulous orifice. This orifice may heal and then re-close, only to re-open later. The discharge of pus is never accompanied by intense pain. At most, the patient will complain of slight soreness in the area prior to reopening of the external orifice. The pus creates a tract in the surrounding tissues, following the locus minoris resistentiae. It may exit, at any point, in the oral mucosa or even in the skin. It is not uncommon, particularly in young patients, to find a cutaneous fistula at the level of the mental symphysis, if lower incisors are involved, or in the sub-mandibular region, if a lower first molar is involved. Also, it may be found in the floor of the nasal fossa, if a central incisor is involved.

Attempts to treat cutaneous fistulae with a circular incision of the orifice of the cutaneous fistula and excision of its entire tract with all the ramifications cannot be considered to comply with the present standard of care and should be regarded as highly undesirable. Most of the time, root canal therapy is the ideal treatment for such lesions. However, Grossman states that such tracts are lined by granulation tissue. In his study, Grossman was unable to identify any epithelium at all. Bender and Seltzer also conducted histological studies of numerous fistulous tracts without finding an epithelial lining. Given the current state of knowledge and scientific data, there is no reason to recommend surgical removal of such tracts, just as there is no reason to believe that even epithelium-lined fistula tract should not heal after appropriate endodontic therapy.

Obviously, these fistulae must be distinguished from congenital fistulae of the neck, both lateral arising from the second brachial cleft—and medial—arising from rests of the thyroglossal duct—which are lined by an epithelium. Such fistulae are of a different pathogenesis and definitely do not resolve spontaneously but only after careful surgical excisions of the tract.
The differential diagnosis of the case in question included the following:

- Localised infection of the skin, such as pyoderma, pimples, ingrown hairs and obstructed sweat glands;
- Traumatic or iatrogenic lesions;
- Osteomyelitis;
- Tuberculosis; and
- Actinomycosis.

**Case presentation**

The patient was referred to me from overseas with a large mandibular fistula, which had previously been misdiagnosed as an infection of the submandibular gland. Surgery had been performed and his submandibular gland had been extracted. The wound had not healed and the clinical situation was fast worsening. Thus, the wound had opened and subinfected with a heavy discharge of pus.

A dentist invited to see the patient immediately telephoned me and sent a photo of the wound to me via his mobile phone. Following my recommendation, the patient was immediately put under double antibiotic therapy (Amoxicillin 1000mg twice daily, Metronidazole 500mg twice daily). The patient presented to my clinic the following day, where we started with a detailed questionnaire to collect all the information about the history of the wound. The patient reported that he had been suffering from this fistula for quite some time already with intermittent phases of discharge of an exudates and numbness of the lower lip. No dental pain was reported.

A panoramic X-ray showed some bone rarefaction under teeth 47 and 46, but no invasion of the mandibular nerve tract was evident (Fig. 2a). A dental scan with 0.5 mm increment was performed in order to gain a better idea of the clinical situation. One of the sagittal slides (015) clearly shows the lesion around the distal root of tooth 47, surrounding the apical part and destroying the cortical bone invading the lower soft tissue (Fig. 2b). Furthermore, the mesial root of tooth 46 showed apical radiculency, invading the tract of the lower mandibular nerve (014; Fig. 3). This pathology explains the numbness of the lower lip, while the pathology around the distal root of tooth 47 explains the extra-oralfistula.

Careful review of the axial slides in the area of tooth 47 (006) offers an idea about the amount of bone destruction in the lower lingual area. The axial slide under tooth 46 reveals the communication between the lesion under the mesial root and the mandibular nerve tract (Fig. 4).

Next, we established a clear diagnosis that the lesion was an extra-oral cutaneous fistula of dental origin. The patient was suffering from a large, infected open wound and a suitable treatment plan had to be established quickly. The following solutions were presented:

1. **Extraction of the teeth and curettage of the area**, with extra attention paid to the mandibular nerve: This plan could provide the patient with a solution for eliminating the infection and allowing the wound to heal. Yet, two strategic molars would be lost with this solution and a replacement would not be an easy job with this amount of bone destruction in the infected area.

2. **More conservatively, a root canal treatment in order to clean and disinfect the root canal systems of the two molars, followed by an internal medication and a 5-D obturation capable of blocking the bacteria from reaching the apical part and trapping the remaining bacteria inside the root canal system.** This approach would allow the patient to keep his molars and would provide an environment in which the healing process could begin. The risk would be the establishment of an external biofilm that cannot heal by itself and may require microsurgical removal.

The patient and I decided to preserve the two molars. Immediately, root canal treatment, cleaning and shaping of the canal space using TF files (SybronEndo) with copious and alternate irrigation of Chlorhexidine, SmearClear (SybronEndo), distilled water, and sodium hypochlorite with ultrasonic activation in a well-established sequence, was performed. An apical enlargement to size 40 in .04 taper was performed after crown down with K3 files (SybronEndo), to disturb the biofilm mechanically and to help reduce the colony formation unit (CFU).

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An intermittent paste was injected inside the shaped root canal system. The paste of two different antibiotics (Augmentin and Metronidazole) was manually mixed and injected with a paste filler. A hermetic temporary filling was placed for a week. The wound was covered with a dressing of steroids and antibiotic paste to prevent further external infection. A week later, the patient was already showing good progress. The wound had started to close and less inflammation and swelling were observed (Fig. 5). The root canal was reopened and cleaned, and no internal fluids were coming from the periapical region. RealSeal material was used as obturation material in a vertical condensation using RCPISL (Hu-Friedy) and an immediate build-up was performed. Therefore, the patient was invited for regular control check-ups. A few weeks later, a post-op X-ray (Fig. 6) and photos were taken. The wound seemed to be in good condition and some skin and fibrous tissues were forming.

While I was writing this article, the patient visited Beirut and decided to come in for a check-up. He complained of a muscle disturbance of his lower lip, but all the previous numbness had disappeared. He agreed to perform an i-Cat scan in order to find out what was going on and to detect any pathology. I was amazed by the bone formation and complete healing (Figs. 7-9). The wound had also healed very well (Figs. 10a & b). I contacted a plastic surgeon and asked his opinion regarding the muscle disturbance. He posited that such symptoms may be caused by the tremendous loss of structure.

**Discussion**

An important diagnostic modality is the determination of the nature of fluid draining (if any) from the cutaneous sinus. During palpation, an attempt should be made to milk the sinus tract. Any discharge obtained should be scrutinised to determine its nature (saliva, pus or cystic fluid). Culture and sensitivity testing should be performed to rule out fungal and antibiotic paste contamination. A hermetic temporary filling was placed for a week. A few weeks later, a post-op X-ray (Fig. 6) and photos were taken. The wound was covered with a dressing of steroids and antibiotic paste to prevent further external infection. A week later, the patient was already showing good progress. The wound had started to close and less inflammation and swelling were observed (Fig. 5).

A pustule is the most common of all purulent draining lesions and is readily recognised by its superficial location and short course. Actinomycosis exhibits multiple draining lesions and characteristic fine yellow granules in the purulent discharge. The tooth is often not involved radiographically. If a sinus tract does not close after appropriate removal of the primary cause, the most common alternative cause is actinomycosis. (Fig. 5)

**The challenge in these kinds of cases is to assemble all the pieces of the puzzle and build up a full idea of the clinical situation.** Assembling the pieces means that all the diagnostic materials, such as a history questionnaire, X-rays, CT scans, and sometimes biopsy and bacteria culturing, must be provided in order to establish a correct diagnosis. Most of the time, the solution will only be a simple routine that must be performed in certain conditions. Turning to solutions that are more complicated—and that certainly can be more profitable—is not always the right choice, nor the most ethical one.

The author would like to thank Yulia Vorobyeva, PhD, interpreter and translator, for her help with this article.
Aesthetically speaking

Dr Bob Khanna discusses the benefits of offering non-surgical facial aesthetic treatments dental

Every dentist has the ability to offer non-surgical aesthetics. A dentist's underlying knowledge of the head and neck region, as well as the skills and dexterity required to be able to perform everyday dental tasks offers a solid grounding from which to build a career in this fast-paced industry.

As well as technical skills, I believe that dentists by nature have to be personable, and possess excellent communication skills to help alleviate any stress and anxiety within patients. This calming influence is hugely beneficial when working with patients who may not have had facial aesthetic treatments before, and may not be sure of exactly what to expect. After all, a calm patient is much easier to work with.

Desired v required

There are many benefits to performing facial aesthetics within a practice. For example, being able to combat pre-conceived ideas about what happens in a dentist's chair. In the course of a normal day in surgery, dental phobia is a hurdle many practitioners have to overcome. However, I have found that patients are not as nervous when they are having a cosmetic procedure – despite being in a dental environment. I believe this is due to the ‘desired v required’ phenomenon.

When a patient is informed that they require a procedure, the concept is not a desirable one. If a patient desires aesthetic treatment, regardless of how long it will take, or how painful it is, people find strength to temper their anxiety in order to benefit from having the treatment.

Having an appealing facial aesthetic treatment in a dental environment also helps alleviate the general fear of visiting the dentist. They realise that the environment is not as scary as they may have imagined, and understand that they are safe in the hands of someone they trust. The environment is then associated with a pleasurable experience; their practitioner after all has provided them with something that they desired, so the fear of returning lessens considerably.

Boosting your client base

As well as helping patients face their phobias, I have found that I have also inherited a lot of dental clients from the facial esthetics side of my business – one of the major benefits to offering the service. If your practice is set up well, patients should be able to get their hands on information about the cosmetic dentistry procedures you offer while in the practice for facial aesthetics treatments. I find patients who are interested in facial aesthetic surgery are generally more open to alternative forms of cosmetic procedures, and may be more likely to enquire about dental options. After all, nobody wants a rejuvenated face let down by a non-aesthetically pleasing smile.

A good earner

Financially, the facial aesthetic market, as a stand-alone modality, is highly profitable. Products such as Botox are defying the recession as consumers are choosing to opt for longer-lasting cosmetic treatment instead of short-lived expensive non-medical-based high street skincare routines. Also, a growing acceptance of such cosmetic procedures means that the demand for non-invasive procedures is increasing, and being able to offer patients such a service has the potential to increase revenue.

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Doing the right thing
Caroline Holland reports from the tenth anniversary Dental Law and Ethics Forum

Changes in the processes, culture and tone of the profession’s regulator, the General Dental Council, were laid bare by the outgoing Chief Executive and Registrar, Duncan Rudkin, in a frank and illuminating talk to the Dental Law and Ethics Forum, currently marking its tenth anniversary.

Just two weeks before his departure from the General Dental Council (GDC) and taking up his new role with the General Pharmaceutical Council, Mr Rudkin looked back on his 11 years with the council. He analysed critically the approach the GDC had taken in the past. ‘Sometimes we might have appeared to give the impression that we must protect the public from the profession, and that would be a big mistake.’

This valuable insight was partly attributable, he said, to former GDC member, Joe Rich, partly attributable, he said, to the public from the profession, impression that we must protect might have appeared to give the impression that we must protect the public from the profession, and that would be a big mistake.

He continued: ‘The relationship between the professional team and the patient is a special one to which the regulator is not a party and it seems to me that our role as regulator is as much as anything about facilitating or underpinning professionals themselves in providing protection.’

Mind over matter
Fitness to Practise, or disciplinary issues, came into the category of things that keep him awake at night, he said, ‘How can a regulator work effectively and fairly to deal with the small number of rogues and villains without sucking into the system those who are not rogues and villains but maybe having a bad day or anUnfortunately set of circumstances?’

He said the GDC need to make Fitness to Practise a more clinical in 1 day

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A cause for celebration
BACD enjoys a triumphant sixth annual conference in Edinburgh

The British Academy of Cosmetic Dentistry is celebrating one of its most successful annual conferences. Entitled ‘The Future of Dentistry’, Edinburgh played host to a wealth of prominent dental professionals from around the globe.

The opening ceremony saw a spectacular performance from The Red Hot Chilli Pipers, an incredible show of rock bagpipes and blistering drumming that had the audience up on their feet; an unforgettable introduction to the conference.

Over the course of the three days, world-renowned speakers shared their knowledge and expertise on a range of subjects. Mr Khaled Shahbo, who talked about his successful business in a lively presentation, gave the opening address. Dr Lynn Jones gave her advice on how to best manage the treatment of patients with occlusal and TMJ problems, while Dr Lorne Lavine revealed some interesting thoughts on digital progress made towards a paperless office.

While Mr Shahbo spoke about his business, Dr Khaled Shahbo had the audience on their feet.

Knowledge bank

In his presentation on adhesive systems, Professor Paul Lambrechts gave an overview of some of the current options dental professionals have at their disposal for minimally invasive tooth preparations.

Dr David Bloom gave an in-depth look into the theory and practice of photography necessary to achieve BACD accreditation.

The aesthetic zone

Achieving Ultimate Aesthetics was the theme of Dr Tidu Mankoo’s address; a full-day lecture that provided attendees with a wealth of information and understanding on the interdisciplinary management of the aesthetic zone.

In another full-day course, Dr Ryan Swain and Dr Barry Buckley outlined the treatment philosophy behind short-term orthodontics, so that attendees could be confident to offer this orthodontic alternative in their own practices.

Dr Bhavna Doshi provided an enlightening address on the fundamental strategies for a successful practice, with step-by-step guidelines for creating a profitable business.

Two of the programmes offering hands-on elements that were popular during the conference provided very different knowledge for the attendees.

Although considered entry-level treatment for many patients, tooth whitening requires dental professionals to demonstrate they have undergone appropriate training in the techniques. Dr Dominique Kanaan and Dr Zaki Kanaan gave a full-day certification course in the techniques required for successful treatment.

Dr Julian Caplan’s presentation, entitled ‘Beautiful anterior porcelain restorations are now possible in a day’, provided the

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page 30

BACD enjoys a triumphant sixth annual conference in Edinburgh

Don’t read this...
 seeing as the financial market is still depressed financially and patients aren’t keen to part with their hard-earned cash, the Dental Arts Studio has been developing a marketing campaign. Each month there has been a deadline to meet and a panic to get our marketing material ready to meet print deadlines.

A lesson learned
Out of this panic, and as a New Year’s resolution, I have decided to be proactive. To avoid this mad panic, I’ve devised a special events calendar, as a way of staying on top of these deadlines throughout the year. It reminds my practice managers to prepare the marketing material two months in advance, to allow time for adjustments and for the ordering and printing of the adverts or leaflets. In doing this, it avoids disappointment for the patients and also stops them from thinking that we are inexperienced and unprepared.

The second calendar is in relation to clinical governance. Seeing as I manage a mini-corporate group, it is very difficult to monitor whether all essential documentation is on record for each member of staff, so it helps me to keep tabs on what we have and are missing. I have now made the decision to carry out an audit across the group twice a year due to the staff changes that take place from time to time and due to this paperwork is often overlooked which can lead to legal implications due to negligence.

Meeting patients’ needs
The third task that I have set is aiming to meet the needs and desires of our patients. I have completed a patient survey throughout the group in relation to patient care and services. I will use the data to devise a better service. The forms show that patients are uneducated when it comes to oral health, many stating that visiting the oral hygienist was not important or the health of their gums.

Yes, I know this is going to entail major in-house training for staff and close monitoring to ensure that they implement what is being taught, but I’m willing to give it a shot. Knowing this has made me more determined to train my staff to better educate our patients, because what the surveys are telling me is that the patients have not been previously educated in relation to the most important aspects of oral care. Where are we failing our patients?

Better education
It is vital that time is taken to discuss dental care with patients. The more we educate them, the better they will respond to treatments, without thinking we are trying to extort money by trying to sell cosmetic dentistry privately. This was another point apparent from the patient survey, that patients did not see it important to have a cosmetically enhanced smile.

However, whatever was very high on the list of importance was, the dentists’ skill, pain control, trust and clarity with knowing the costs prior to the start of treatment which brings me back to the importance of writing up treatment plans that have been discussed openly with the patient prior to starting treatment.

As John D Rockefeller said: ‘I believe in the dignity of labour, whether with head or hand; that the world owes no man a living but that it owes every man an opportunity to make a living.’

Dates to remember
There’s no better time than the new year to implement change, says Sharon Holmes

About the author

Sharon Holmes has worked in dental practice management since 1992. Arriving in the UK in 2002, she took a post in a mixed NHS and private practice in Wembley, eventually taking over its management, converting it to a fully private practice. In 2005, she moved to London City Dental Practice, where after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is a member of a dental group called the Dental Arts Studio, to which she has been instrumental in its creation. She holds the position of operations director and manages every aspect of the group alongside her principal dentists.
Positive impact, positive results!

It's important to make a positive impact from the start, to entice dental patients back. Success coach Adrienne Morris offers some advice to help get on the right track.

1 Promise less, deliver more. Expectations are always high and it really pays to undersell what you are giving and then over-deliver: the end result, a client who is thrilled to have gained a truly valuable product/result which exceeded their expectations. At the same time you will have built an initial brief and hopefully have an extremely satisfied client who will be happy to recommend you and use your services again and again. Whatever you have gained profit-wise, you will have vastly exceeded as far as your reputation for performance, delivery and reliability is concerned.

2 Play full out. You know this isn't a dress rehearsal. Treat each and every opportunity as if it's the most important in your life and give everything you've got. You never know who is watching to see how you're performing. Even if they don't sign up this time, it may take just one more occasion for them to see you or the results of your work in action to convince them to sign up next time or whatever you want. Don't be disappointed if they don't give you an order or booking at the first meeting or the next – you have to build up trust and confidence. And if you're always giving of your best, this will be enhanced each time they meet you or hear about you.

3 Pay attention to detail. Don't be sloppy – attend to even the smallest detail because all those minute details add up to a great professional finish and that's always going to make a good impression. Check spellings of names; check titles and how people like to be addressed.

4 Know your subjects. If you're trying to reach someone, get names of the ‘gatekeepers’ ie, secretaries, personal assistants, receptionists – establish a rapport with them – they’re the ones who might just get you through the door when they’re rejecting everyone else (Peter Thomson, the renowned business consultant, refers to receptionists as 'rejectionists' with good reason).

5 Follow up good contacts. Always follow-up when you meet someone new with whom you feel you have really connected – drop them an email and remind them of what it was you had in common or had chatted about, remind them what it is you do, and for whom you have done it. If you have to write a thank-you, a handwritten note will always leave a good lasting impression, as long as it's legible.

6 Be positive and put on a happy face. Sure it's hard to remain positive when you’re feeling overwhelmed, but having an attractive and good-natured and friendly attitude is important. The Tony Robbins mantra ‘attitude is everything’ really does have validity. Whenever you're facing a setback, do a mental checklist of what IS working in your life right now, what DO you have going for you, what CAN you cheer you on, and give thanks for your good health, for a roof over your head, for your friends and family, for the fact that you're alive and encouraged that you have to be striving to do better. Lift up your head, put your shoulders back and smile – you should feel better straight away.

7 Focus on solutions, not problems. You have to switch your focus to solving the issues preventing you from getting to where you want to be. During the process every step will be a learning exercise and will encourage you to make a significant difference to you in the long run. Facing a seemingly daunting task but breaking it down into manageable chunks and dealing with each of these, one step at a time, will make it seem much more approachable. The learning you get will put you in a position to turn your biggest weakness into your biggest strength.

8 Walk the walk. Spend time with the peer group you want to be in – in other words, hang out with people already living the kind of life you want, doing what you want, who have what you want. Don't be nervous about asking for advice. You must have noticed how people love to give it, even when you haven't asked for any. Copy their behaviour, their style, dress the part, talk the talk – but only if it feels right for you. Because if you don't feel relaxed, it will show in your body language. Be a 'player' and remem-ber the coaches’ adage – ‘fake it till you make it’.

Focusing on the solutions rather than the problems is a much more positive approach.

About the author
Adrienne Morris is a success coach, helping professionals and small business owners reach new heights of success. She can be reached on 07956 514714, email coach@alplifecoach.co.uk or visit http://alplifecoach.com.

Company Feature
Is The Joke on You?

Is it possible for dental practices to attract more patients without spending more money on marketing?

A young dentist was starting his career. He rented a beautiful practice, engaged an interior designer and in-vested a fortune in the latest in customer care, comfort and convenience – concepts not tra-ditionally associated with the healthcare industry but which are now vital investments in the pursuit of success.

So how can you reduce your rates and still make money?

A woman phoned her den-tist when she received a huge bill. “I’m shocked,” she com-plained. “This is three times more than usual.”

“I know,” said the dentist, “but you yelled so loudly during surgery you frightened away my next last-taxpayer.”

There are many, relatively inexpensive, ways of improving customer care, but how can a dentist offer patients genuinely better value without damaging practice profitability? Solving this conundrum in isolation can be difficult, but with a little in-formed guidance and an innova-tive but proven patient plan now becoming available in the UK, dentists can again enjoy the lux-ury of being rushed off their feet!

In the US, creative and uni-versally accessible dental plans are helping practices to enjoy the best of both worlds: improved cash flow and more new patients.

With more than seven million Americans participating, US dental practices are invited to join the Dental Network and benefit from this vast pool of potential new patients. Patients find the US’s largest network of national member dentists and their specialisations in a number of ways, including:

• Daily database updates with agents and groups
• Via the distribution of printed directories
• An online provider search

(more than 250,000 hits in the US every month)

• Multi-lingual assistance to help patients find their ideal treat-ment provider.

Devised and designed by a dentist, Munroe Sutton’s Patient Referral Plan is the culmination of 50 years’ experience in the field of dental marketing and is now available to dentists through-out the UK, bringing the same proven benefits to both patients and practices as those enjoyed in the US. Treatments are made more affordable for the patients, and practices experience the ad-vantages of direct marketing at no cost to themselves. Acceptance rates rise steeply as the financial pressures ease for the patients, and with the option of receiving immediate payment prac-tices’ cashflow is also enhanced. The scheme allows for bespoke reimbursement arrangements to ensure that participating prac-tices are never out of pocket and payment is guaranteed.

The independence of the prac-tice and any existing patient pay-ment plans are unaffected, and a 24-hour automated voice deliv-ers professional, efficient patient confirmation. The referral system puts dentists in touch with an ever increasing strength and expertise of dentists who know they can do their job but to whom they cannot give an order or booking at the first meeting or the next – you have to build up trust and confidence. And if you're always giving of your best, this will be enhanced each time they meet you or hear about you.

With their discretionary income at a higher level than ever before, many dentists are never out of pocket and practices' cashflow is also enhanced. The referral system puts dentists in touch with an ever increasing strength and expertise of dentists who know they can do their job but to whom they cannot give an order or booking at the first meeting or the next – you have to build up trust and confidence. And if you're always giving of your best, this will be enhanced each time they meet you or hear about you.

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Incorporation... isn’t that just a ‘trendy business’?

There are many myths surrounding the issue of incorporation. Michael Lansdell looks at some of the biggest ones and gives the business facts.

Ever since the General Dental Council amended the regulations to allow dentists to trade through limited companies from July 2006, (incorporation) the profession has been awash with conflicting advice and opposing opinions. In this article, I will try to dispel some of the specific misconceptions which have grown up around the issue.

It’s often stated that any potential tax savings after incorporation will be cancelled out by increased accountancy fees. True or false?

False. Accountancy costs will rise, as there is more work accounting for a limited company, but this is only a minor element in the overall equation. Before incorporating, the annual net benefits should be weighed against the additional costs. Reputable accountants will usually agree to fix their fees in advance to facilitate an informed decision.

Incorporation allows you to withdraw from the company an amount equal to the value of your practice’s goodwill with an effective tax rate of only 10 per cent (on the first £1 million); if other family members are also shareholders, or work in the practice, further tax benefits accrue, and tax-efficient borrowing becomes possible which many dentists have used to reduce or eliminate their domestic mortgages.

It will be a nightmare when I come to sell

False. The practice can either be sold by the limited company, which you can then wind up or not as you please, or you can sell your shares and the purchaser takes over the limited company.

The first option is less tax-efficient, but the second is normally chosen as it’s usually beneficial for both parties. The new owner is able to immediately take over existing bank accounts and any other business arrangements, as the company is a separate legal entity and continues to exist, and to trade, whoever owns the shares. In fact, many incorporat-
Impression materials

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Kerr announces an unprecedented breakthrough in Vertise™ Flow, the self-etch, self-adhering flowable composite.

This new category in composite technology revolutionizes the need for a separate bonding application step with composites for direct restorative procedures. Powered by Kerr’s renowned OptiBond adhesive technology, this product will greatly simplify the direct restorative procedures for today’s time-challenged dentist by incorporating the bonding agent into the flowable. Over the years, Kerr has become a leader in resin restorative dentistry due to decades of dedicated research in composites and expertise in adhesives – both of which come together in Vertise Flow.

In recent years Kerr has worked with leading European and US universities to validate the in-vivo and in-vitro clinical performance of Vertise Flow and its launch has revolutionized clinical performance. Vertise Flow is a new opportunity for the dentist to perform specific procedures easier and with more predictable results. Kerr is looking forward to providing the dental world with an innovative product.

For more information or for a free in-surgery demonstration and sample, please call 01733 892 292 or e-mail kerm@kerr.com.

**Hi-Tray Light**

Hi-Tray Light is a range of extra rigid plastic impression trays. They are split into "Large" for normal preparations and "Small" for micro-cavities and endodontic procedures. Kerr is looking forward to launching the new product after enough clinical evidence confirmed its clinical performance.

For more information or for a free in-surgery demonstration and sample, please call 01733 892 292 or e-mail kerm@kerr.com.

**Hydrosystem**

Hydrosystem is a proven solution for reducing voids in A-Silicone impressions. Hydrosystem reduces the surface tension on the preparation, therefore reducing the flow of air. Hydrosystem is used to coat the preparation to further enhance detail. The hyper-hydrophilic formula of the "meatier" interior flexibility and therefore detail for the ultimate impression a heavy body is available to be used instead of the putty & comes in the new water to disperse 360ml hard cartridges that fits any of the available mixing machines.

Hydrosystem has a sweet mint flavour to help relax patients. Samples are available, call 037970 690811 or email uk@kerr.com.

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Make your budget go further
Looking for a way to save your practice money in 2010? Perhaps you want to make your budget go that little bit further? Thousands of dentists worldwide have already registered (for FREE) on InventoryCircle since it launched just months ago. Why not check it out too? You too can benefit from the way that www.inventorycircle.com connects dentists and equipment dealers who want to buy and sell:

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Extra large Microfibre & 4-way cleaning provide Effective protection against plaque-plaque
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viruses (RT-111) – viruses (pathogens of swine flu). These wipes can be used for daily disinfection of surfaces close to the patient/frequently touched surfaces (e.g. dental chair armrests, the light, handpieces).

The disinfection of hands and surfaces and also contaminated instruments play a major role in preventing the human-to–human transmission of the currently circulating swine-flu virus which belongs to the group of influenza A viruses, type H1N1.

All equipment/metallic devices in direct contact to the patient can be disinfected and sterilised after use and before use on another patient. Kentmed Instrumentsafe is suitable for the safe disinfection of instruments at the respective concentration rates and exposure times of the product.

This is an excellent time to try the Extra Large Microfibre or Economy wipes. Any orders placed before March 31st will have a 20% discount. For further information on special offers or to place orders call Helen on 01793 772216 or visit our website www.kentmed.co.uk

septodont

Septodont is the specialist in safely delivering dental anaesthesia. The Ultra Safety Plus is a remarkable single use patient safety syringe with a sliding sheath. With recent studies showing 48% of all nurses having been injured by a needle stick injury and many therefore having been made aware of the risk, it is remarkable that an American testing institute has awarded a European product with the “This is a great light!”

The cordless high-performance LED light with polywave® LED has supported all competitors – many of them newly-launched products – also in the second year.

The testing institute describes bluethroat as follows:

- “This is a great light!”
- “It’s great to have one light that does everything”
- “The sleek design and power are great!”

An award we are proud of! Thank you to the “Dental Advisor” award for specifying us as a unique writing proposal and design of bluethroat marketingsubject. One thing, only one product per category receives the award, and for another, it is remarkable that an American testing institute has awarded a European manufacturing contact

Incorporate ChairSafe and PracticeSafe solutions into your practice’s workflow. The company’s key values of partnership, imagination, innovation, creativity and potential have helped facilitate the products from simple to complex and efficient to what you would expect from a world-class technology company.

Happy birthday Smile-on!

The Smile-on team celebrate providing expert training solutions.

There was cause for celebration at the Smile-on headquarters, as January 2010 saw the company break through 100,000+ visitors per month.

The Smile-on team are always working to ensure that the programmes are responsive to the needs of the dental sector, and continue to offer expert guidance and help boost standards in the UK dental industry by promoting excellent patient care and practice satisfaction through education and training.

For more information call 020 7400 8989 or visit www.smile-on.co.uk
opportunity for attendees to gain hands-on experience in re-contouring Empress crowns to give the correct aesthetic from of a central incisor.

Among the panel presentations held during the conference, the Complex Case Management discussion provided a great opportunity to consider how to provide optimum care for a patient, giving practical advice on sequencing treatment, clinical techniques and communication with both the dental team and the patient.

'Simple Orthodontics For You and Your Patient' brought together four of the orthodontic treatments that are easily accessible to the GDP for treating patients. Each speaker, representing Invisalign, Clearstep, Six Month Smiles, and Inman Aligner, had the opportunity to present the advantages as well as some of the limitations of their systems.

A chance to network

As well as the wealth of learning opportunities at the conference, delegates were also able to network with suppliers and to explore the latest in equipment and materials to enhance their dentistry.

The conference also provided the current BACD President, Dr Elaine Halley, to wish her successor, Dr, the best of luck for the future.

For information on the 2010 BACD conference, please contact Suzy Rowlands on 020 8241 8526 or email suzy@bacd.com.
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“I thought it was a cavity… I didn’t want to deal with it.”

Asher Burrell, dental patient, Battersea, UK.

Approximately 1 in 3 adult patients suffer or have suffered from dentine hypersensitivity, and over 50% of sufferers don’t mention it to their dental professional.¹ This may be because they fear it requires major dental work, the pain may be variable so they don’t report it or because they may be using techniques to try and avoid the pain.

These findings highlight the important role that dental professionals play in actively diagnosing dentine hypersensitivity.

Recommending daily brushing with Sensodyne Total Care F is a simple, effective solution which is clinically proven to reduce the pain of dentine hypersensitivity.

“There are no issues anymore, no barriers. I can do what I want and eat what I want.”

Asher Burrell, dental patient, Battersea, UK.

¹ Addy M. Int Dental J 2002; 52: 367-75

Potassium nitrate, Sodium fluoride

Advice that’s appreciated

Product Information

Sensodyne Total Care F Toothpaste. Presentation: Potassium nitrate 5.0% w/w, Sodium fluoride 0.306% w/w. Uses: Relief from the pain of dentinal sensitivity, an aid for the prevention of dental caries. Dosage and administration: To be used 2-4 times a day, in place of ordinary toothpaste. Contraindications: Sensitivity to any of the active ingredients or excipients. Precautions: For children under 6, use a pea-sized amount and supervise brushing to minimise swallowing. Side effects: Very rarely, isolated cases of hypersensitivity type reactions such as angioedema, oral and facial swelling have been reported in patients using potassium nitrate containing tooth pastes, particularly in patients who are predisposed to hypersensitivity type reactions. Legal category: GSL. Product licence number: PL 00036/0103. Product licence holder: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. Package quantity and RSP (excl. VAT): 45 ml tubes £2.09, 75 ml tubes £3.11, 100 ml tubes £3.65 and 100 ml pumps £3.65. Date of preparation: August 2009. Sensodyne is a registered trade mark of the GlaxoSmithKline group of companies.