News in Brief

BAN founder dies
The founder member of the British Association of Dental Nurses (BADN) has died at the age of 89, Madeleine Lee, who was known as Bunny, suffered a fall before Christmas and had been recovering but died peacefully in her sleep. Ms Lee, who worked at a dental practice in Leyland in Lancashire during the Second World War, was inspired to set up the BADN when an American serviceman told her about a similar association in America. Despite wartime restrictions, Lee immediately set to work travelling around the British inviting nurses to join the new BADN. It held its first dental nurse examination, which was resided over by the newly created National Examining Board for Dental Nurses and Assistants, in November 1943. Lee was the first nurse to receive a certificate. She stayed on at the BADN as an honorary life member.

Most loved dentist
High Street Dental Practice in West Sussex has been voted the UK’s best loved dentist in a recent nationwide poll. The survey was carried out by the Which? and said that any practice in East Grinstead steered come top in the dental sector for its unbeatable customer service. It also came 20th Most Loved Business in all categories. Practice owner Jan Sandhu said: Our aim has been to create an environment in which people will feel relaxed and comfortable. We never forget how intimidating it can be to sit in a dentist’s chair, so every conceivable care has been taken to make sure they are completely at ease. We have invested in the latest dental technology to give them the ultimate in modern, pain-free dental care. It is fantastic to know that we are getting our customer care so right.

Dentist ‘accidental death’
An inquest into the death of a dentist in St Helena, Merseyside, has delivered a verdict of ‘accidental death’. The inquest was held at his flat in Sale in February 2008. Coroner John Pollard delivered a verdict of ‘accidental death’ due to the cause being positional asphyxia with alcohol intoxication. The inquest at Stockport Magistrates’ Court heard how he had been drinking heavily before his death and when he came home afterwards, it is believed he fell down the stairs.

Mhari Coxon details why looking at a patient's diet can be beneficial to their oral health.
Manchester dental student wins award

A student from Manchester University’s School of Dentistry has won the 2010 BDA/Dentsply Student Clinical Programme competition.

Lisa Durning won an all expenses paid trip to the Annual Session of the American Dental Association in Florida in October as Dentsply’s guest of honour.

As part of the trip she will be invited to present her winning project, titled ‘Analysis of a novel embryonic stem cell line exhibiting de novo promoter methylation of the metastasis suppressor E-cadherin.’

Ms Durning said: “I am delighted to win this award. It has been fantastic to be involved in research as an undergraduate and I am looking forward to presenting again in Orlando.”

Mark Gidley of the University of Sheffield School of Dentistry, won second place, for his presentation ‘Identification and quantification of periodontal pathogens in diabetic patients.’

He received a cheque for five hundred pounds.

A third prize, recognising professionalism and presenting skills, was awarded to Malveen Mann, a student at the University of Birmingham’s School of Dentistry.

The awards were judged by Prof Nairn Wilson of King’s College London Dental Institute, Prof Robert McConnell of University College Dental School and Hospital Cork, and Dr Susan Hooper of Bristol Dental School.

All entries in the competition have to be previously unpublished or presented.

Prof Wilson praised the ‘very high calibre of the undergraduates at UK and Irish dental schools’ and said: “Congratulations go to all of the entrants, who excelled at their own institutions to earn the right to compete in the final, and particularly to the winner, Lisa Durning.”

“The winning presentation reported a sophisticated analysis of a novel stem cell line, with the results indicating potential to control metastatic spread of cancer cells – exciting research of exceptional quality for an undergraduate student.”

Selection test favours private school boys

Boys from independent or grammar schools are more likely to get high scores in the aptitude test used to select students for dental schools, according to a new study.

The new aptitude test, was introduced in 2006 by 25 dental and medical schools and was intended to increase diversity and ensure fairness in the selection process.

However, it still has inherent gender and socioeconomic bias, although it is less subject to bias than A-level results alone, according to the study published online by the British Medical Journal.

The UK Clinical Aptitude Test (UKCAT) is an appraisal of skills such as verbal reasoning and decision analysis, and is designed to ensure that candidates have the most appropriate mental abilities, attitudes and professional behaviour for new dentists and doctors.

Prof David James, director of medical education at the University of Nottingham Medical School, who led the study, analysed data from the first group of applicants who sat the UKCAT in 2006 and who achieved at least three passes at A-level in their school leaving examinations.

They found a modest correlation between A-level and UKCAT scores, which confirms that the test can be used as a reasonable proxy for A-levels in the selection process.

However, the test had an inherent favourable bias to male applicants and those from a higher socioeconomic class or from independent or grammar schools.

“These findings lead us to be cautious about use of the UKCAT and the value of any one specific sub-test within an admissions policy. They also reinforce the need for further research to clarify the practical value of the UKCAT in a wider range of applicants and, importantly, its predictive role in performance at medical or dental school,” said the study.

In an editorial that accompanied the study, Prof David Powis from the University of Newcastle in Australia said: “Measuring cognitive ability is a step in the right direction, but it doesn’t tackle ‘widening participation’ - the admission of people from lower socioeconomic groups or whose education has been compromised by attending poorer schools.”

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Editorial comment
In like a lion...

Here we are already into March and where has the time gone? At Dental Tribune we are making our plans for the next few months; Dentistry Show, BDA, B2A trip to Tanzania... and if you haven’t supported me yet turn to page nine where you can find out more!

The access figures for NHS dentistry makes for some interesting reading, with a sixth successive quarter rise. Of course the cynic will say it’s about time that the figures got back to where they were three and a half years ago, and maybe they are right. But we are seeing an interesting time in terms of NHS dentistry and it will be fascinating to see how the pilots of the Steele Review impact on the current contracts and how the PDS+ agreements fit in with the current and developing situation. As they say, only time will tell...

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?
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Or email: lisa@dentaltribuneuk.com

Asbestos warning

Dentists are often at a high risk of developing mesothelioma, the cancer caused by asbestos, according to a new report.

An online report at www.asbestos.net claims that overexposure to asbestos makes dentists more likely to develop mesothelioma. Asbestos has been used in the field of dentistry, as a lining material for casting rings, since 1930.

Continued exposure to asbestos fibres in confined examination rooms can mean that dentists inhale a greater amount of the harmful substance unless they take precautions against it, said the report. Mesothelioma is the result of inhaled asbestos coming lodged in the soft tissue of the lungs.

The fibres damage the tissue’s DNA because they begin to replicate and divide. This cannot be controlled and tumours are then created. The tumour can be relatively symptomless and in some cases it can take 20 to 50 years for any sort of symptom to develop.

This means that when the mesothelioma is eventually diagnosed, it is already very advanced.

In most cases these tumours are then inoperable and are relatively unresponsive to chemo or radiation therapies. Most patients die just a few months after being diagnosed. Annually, 20,000 people die of mesothelioma around the world.

Dentists who believe they may have been exposed to asbestos should monitor their health and get themselves checked by a doctor.

Last month, an inquest found that a dental technician from Eastbourne, East Sussex, died from the cancer caused by exposure to asbestos.

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Scotland to go ahead with lifelong registration

Scotland is to go ahead with lifelong registration. From the beginning of April, the Scottish government will proceed with regulatory changes to introduce continuous registration.

The British Dental Association (BDA) has expressed its ‘disappointment’ at the decision, which it said could harm patient care as it does not encourage a pattern of regular attendance and is therefore not conducive to maintaining oral health.

Dr Robert Kinloch, chair of the BDA’s Scottish Dental Practice Committee, criticised the move and said: ‘Continuous registration sends all the wrong signals about the value of patients visiting their dentist regularly. It encourages neglect of personal oral health, undermines modern, preventive approaches to care and devalues the relationship between clinician and patient.

It also removes the responsibility of patients to comply with recall intervals advised by their dentist. Scotland already faces unenviable rates of oral cancers. The fear among dentists is that more cases will now go undetected.’

He called for the government to ‘work very hard to promote regular attendance to patients and ensure that the efforts of the profession in encouraging patients to visit them regularly are not undone’.

He added: ‘In the short term, dentists must be provided with the information they need about individuals who have not been seen in practice for the last three years to allow them to make a decision about whether the continued registration of those patients will affect the ability of the practice to care for its regularly-attending patients.’

Last year, the BDA carried out a survey of general dental practitioners from across Scotland, and found that 87 per cent were opposed to the introduction of continuous registration.

Dentists expressed concern that the scheme would undermine the importance of regular check-ups, fail to promote a strong dentist-patient relationship, and increase the chances of serious conditions such as mouth cancer going undetected.

Concerns were also expressed about the strain on NHS services that would be caused by patients who chose to attend less regularly as irregular attendance often results in more complex and time-consuming treatment being required. Catering for a greater number of emergency appointments would also increase waiting times for patients attending regular appointments.

The Scottish Government Health Directorates’ (SGHD) intention to introduce continuous registration stems from the Dental Action Plan developed by the previous administration.

The Scottish government’s policy approach is that there should be no automatic ending of registration after a given period of time and believes that continuous registration will help develop a more stable relationship between a dentist and a patient. SGHD cites that this fits with the need to plan care on a long-term basis and to monitor oral health over time.

With the new arrangements imminent, the BDA has called on SGHD to ensure that practitioners are provided with detailed information as a matter of urgency, so that practices can plan now for the change in registration arrangements.

This information should include a list of all patients for whom the continuing care and capitation fees are due to drop to 20 per cent on 1 April, due to the fact that they have not attended in three years.

Winter Olympic screening

Dentists are screening a fifth of all athletes taking part in the Winter Olympics for oral cancer.

The decision to screen 20 per cent of all athletes in the Games has been taken by the International Olympic Committee (IOC).

Around 800 athletes will sit in the dentist’s chair during the competition, with more than 70 dentists and their assistants on hand not only to fix their teeth and mouths, but also to practice preventative dentistry.

Dr Jack Taunton, co-chief medical officer of the Games, claims that athletes are so noxious they tend to put off having dental treatment.

He said: ‘Year-round, the alpine athletes follow winter around the world to train, and they are at higher risk of lip and mouth cancers because of the altitude and sun exposure. The skin on the lips is thin and poorly protected. The damage is cumulative and you have to consider they are exposed to these intense ultraviolet rays for up to 30 years, through their training and post-competitive coaching years in many cases.’

The damaging radiation largely occurs when the sun反射s off the surface of the ice and snow.

The British Dental Health Foundation has welcomed the increased oral screening campaign that will also educate athletes on the importance of applying sun-cream to help prevent mouth cancers.

Scottish health minister opens new dental clinic

The Scottish health minister has opened a new state-of-the-art dental clinic in the Borders.

Shona Robison officially opened the facility at the site of Hawick Community Hospital.

The Hawick Dental Centre (HDC) is part of a £1.8m NHS dental development, and is being tipped as the UK’s top decontamination facility for dental equipment.

Ms Robison said that she was delighted to be opening HDC and added that it would increase access to dentistry for local people.

HDC has been treating patients for a round about a year but was officially opened this week.

It contains six surgeries, has specialist X-ray equipment, and the government hopes it will reduce NHS dental waiting lists at Borders General Hospital.

A similar project has also opened in Coldstream as part of the development.

It’s about YOU and YOUR VISION...
The unique Cleo II ‘Surgery System’ with folding and extending legrest permits multiple dental procedures in the most comfortable working conditions. Technically advanced, hygiene-conscious and very versatile to fulfill the expectations of the elite surgery. Aesthetically superior too, we think.
Hitler’s chronic bad breath

The Nazi dictator, Adolf Hitler, suffered from severe halitosis, gum disease and tooth decay, according to a new study.

The study ‘Dentist of the Devil’ by German dentist Meinecke Deprem-Hennen found that Hitler’s dental records revealed he had poor oral healthcare and had to have his molar tooth removed after periodontal problems. His health also suffered through eating very badly which also exacerbated his oral health problems.

Despite the Führer’s alleged sensitivity to pain, the study also details how Hitler was treated eight times for root canal work by his own private dental practitioner, and had a likely dental phobia.

Bad breath is one of the main symptoms of poor oral hygiene, according to the UK’s National Dental Helpline, which deals with numerous enquiries concerning bad breath.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter said: “Persistent bad breath is usually caused by gases released by the bacteria that coat your teeth and gums and back of the tongue.”

“Correct and regular brushing can help keep your breath fresh. It is important to ensure that plaque is removed from around the gum margins by regular brushing and from between the teeth by using interdental brushes or dental floss daily. You can also use a tongue scraper or brush to remove bacteria from the back of the tongue.

“Mouthwashes with antibacterial agents can also help eliminate bad breath but it is important these are not just used to mask an underlying problem.”

He added: “Poor oral hygiene can lead to gingivitis, which can progress to gum disease. Subsequent recession of the gum and bone, and eventually tooth loss, can also occur if not stabilised. It is very often the bacteria in these gum pockets that leads to persistent bad breath.”

The BDHF is urging people in the UK to improve their oral health by cutting down on the frequency of sugary foods and drinks.

People wanting further advice about dental concerns and oral health issues can contact the National Dental Helpline on (0845 065 1188) or visit www.dentalhelpline.org. The Helpline offers free and independent expert advice from oral health educators on many oral health issues.

A series of free ‘Tell Me About...’ leaflets, covering topics such as diet, bad breath, gum disease and dental decay, are also available.

BDTA sponsors BSDHT event

The BDTA is pleased to announce that it will be a major sponsor of the BSDHT Conference and International Symposium on Dental Hygiene in July 2010.

Delegates from across the world who will be attending the event at the Scottish Exhibition and Conference Centre in Glasgow will benefit from a motivational presentation by world-class speaker Warren Greshes, who has been commissioned by the BDTA to educate and entertain the attending hygienists and therapists.

Warren is an expert in the areas of sales motivation and personal and professional development. He served on the board of directors of the National Speakers Association and in 1998 was inducted into the Speaker’s Hall of Fame. His talk at the BSDHT event will be designed to leave the audience feeling positive and empowered as he links his practical examples and experiences to the dental environment. You can find out more about Warren Greshes before the event at www.greshes.com.

BDTA Executive Director, Tony Reed, comments, “This important event will attract a worldwide audience and the BDTA is delighted to be able to present a world class speaker to match the occasion. The fact that the UK has been chosen to host the International Symposium is an accolade for the BSDHT and we are proud to be playing a part in making 2010 a conference to remember.”

For further information on the BDTA visit www.bdta.org.uk or for more information on the BSDHT Conference and International Symposium on Dental Hygiene 2010 visit www.bsdiht.org.uk.

GDC: go online for CPD

The General Dental Council (GDC) is asking all dentists to fill in their continuing professional development (CPD) returns ahead of the 30 March 2010 deadline. 1,353 dentists are at the end of their five-year CPD cycle and will need to ensure they complete and return their end of cycle declaration before the closing date.

Those whose five-year cycle ended 51 December 2009 need to return an end of cycle declaration of the hours they have completed in that time. Dentists who do not meet the deadline will be required to take further action, including submitting CPD evidence, such as certificates, to support their CPD hours.

New chair of the Scottish Dental Practice Committee elected

Robert Kinloch has been elected as the new chair of the Scottish Dental Practice Committee of the British Dental Association.

Dr Kinloch, who practises at Alexandria, near Loch Lomond, was elected unopposed and takes up the post with immediate effect.

He succeeds Colin Crawford, who resigned from the committee to take up an appointment in the salaried dental service.

Dr Kinloch called it an ‘honour to be elected to represent Scotland’s high street dentists’ and said: ‘I look forward to continuing the good work of the Scottish Dental Practice Committee (SDPC). We have unresolved issues with changing decontamination requirements and plans to introduce lifelong patient registration. We are also pressing for the introduction of an oral health assessment and a revised Statement of Dental Remuneration. All of these issues must be tackled against a backdrop of uncertainty in public spending and a Scottish Government election in just over a year’.

Dr Kinloch graduated from Glasgow Dental School in 1977. He has dedicated his whole career to general dental practice, working initially as an associate then establishing his own practice in 1981. He provides predominantly NHS care.

Dr Kinloch has a special interest in the role of information technology in dentistry, and has been an advocate of the extension of the NHS national broadband network to dental surgeries in Scotland, which it is hoped is a building block to full electronic systems.

He has also provided dental care to people in the upper reaches of the Amazon in Peru, as part of his work for the Vine Trust, a medical charity of which he is a board member.

He is also a current member of the British Dental Association’s (BDA’s) Executive Board, chair of the BDA’s Scottish Council and chair of the BDA’s UK and Scottish Policy Health Groups.
Royal visit to CPD training facility

It was pomp and ceremony time at 125 Grays Inn Road as the UCL Eastman Continuing Professional Development team prepared to welcome HRH the Princess Royal, Princess Anne.

The visit was to officially open the new state of the art clinical teaching facility and unveil a plaque to commemorate the occasion.

The new facility is based on the fourth floor of the UCL Eastman CPD building and comprises five new dental chairs equipped with microscopes and digital radiography, a cone beam scanner, a skills laboratory and a lecture facility.

There was a great presence from the dental community for the visit from academics and lecturers to students and dental suppliers who had fitted out the facility.

The official part of the day began with a programme of speeches to put the new facility in the context of furthering knowledge and stimulating excellence in education. Prof Andrew Eder, director at UCL Eastman CPD, began the programme with a presentation of the background of what the school had achieved since its establishment in 1999 with regards to continuing professional development and the focus on a quality educational experience.

Prof Eder said: “Much as Anton Chekhov’s character Trofimov is described as a ‘perpetual student’, dental professionals are now finding themselves in an arena where it is necessary to constantly learn and update their skills.

“Since its inception in 1999, the CPD facility here has strived to maintain a level of intellectual stimulation for students and create a highly sought after quality learning experience. We are confident that the recent investment into the new clinical facility will enable us to continue fulfilling that aim.”

Prof Eder was also keen to point out the practical applications the facility would be having, announcing the fact that UCL Eastman had been appointed by the IOC (International Olympic Committee) to provide dental care to the 2012 London Olympic Games.

UCL Eastman Dental Institute director Prof Stephen Porter then spoke about the importance of collaboration in the development and delivery of preventative measure for patients not only of today but also tomorrow. Commenting on the challenges facing the dental profession, Prof Porter spoke about the need for education and the implementation of innovative programme to meet the needs of a diverse population.

The Chief Dental Officer Dr Barry Cockcroft CBE also said a few words, highlighting the synergy between the visions of both the Department of Health and UCL Eastman CPD in focusing on education and prevention, and applauding the universities for their investment in research, training and care which enhances the level of patient care and the experience for the dental professionals delivering that care.

Then it was the turn of HRH Princess Anne. Known for her dislike of long speeches, she spoke of the need to stay up to date with the latest thinking, and rising above the challenges armed with the best information possible. She also spoke about the need to sell the good news to patients about what they need to maintain great oral health, while also recognising that one fundamental challenge is to get the people who could benefit most from dental care to access it appropriately.

Wrapping up the speeches was Prof Malcolm Grant CBE, UCL President and Provost. He emphasised the importance of the joining of UCL and the Eastman together, especially in the field of interdisciplinary research. He stated that they all had a mission to make a difference to patients, and it was the universities that held the key to driving investment and recovery in the UK.

The Princess was then taken on a tour of both the old and new clinical skills facility, meeting with staff and graduates before unveiling the commemorative plaque and signing the visitor’s book. She was then presented with a posy by Deborah Eder as a token of appreciation from UCL Eastman CPD.

It was a great day for UCL Eastman CPD and having visited the new facility I was extremely impressed with the quality and attention to detail in the design. Even the skills laboratory had made the highest use of space with student’s needs in mind (although being in there did allow me to rediscover my fear of phantom heads). I look forward to visiting the facility again and hearing about the work UCL Eastman CPD are doing for dental education.

One of the new dental training surgeries Princess Anne speaks to members of staff

HRH the Princess Royal unveils the commemorative plaque
Satisfying the ‘girly swot’ in me

Elaine Halley begins her blog as a student on the inaugural online MSc in Restorative & Aesthetic Dentistry from Smile-on and The University of Manchester

Three children, a private practice, a new practice opening imminently and having just finished my year as President of the British Academy of Cosmetic Dentistry – what more do I need than the opportunity to take on an MSc?

Having joined General Practice as soon as I qualified, and having spent tens of thousands of pounds and travelled the world in search of CPD, I was disappointed to find that when the Faculty of General Dental Practitioners launched their Certificate in Aesthetic Dentistry, I didn’t qualify to take part. ‘Academically’ I didn’t have enough points for entry onto the course. By choosing to educate myself as was appropriate for the development of my practice, not through the hospital system or having a part-time MSc to my name and despite the fact that I have been teaching, writing and lecturing for years on many aspects of restorative ‘cosmetic’ dentistry, I wasn’t eligible.

Ego

Maybe it was just my ego that was hurt. The course in its original format was abandoned and I carried on with life. I briefly researched the options for an MSc but nothing excited me and the financial burden of having to leave the practice part-time with all the other plates I had spinning just didn’t seem worth it. I live on a farm in Perthshire. I travel a lot for the sake of my family and like all working parents, need to spend my time wisely.

A distance learning MSc in Restorative and Aesthetic Dentistry utilising IT was right up my street. I must confess to a certain amount of excitement – I’ve always been a bit of a girly swot. I had a job to do in committee and despite the fact that I have been teaching, writing and lecturing for years on many aspects of restorative ‘cosmetic’ dentistry, I wasn’t eligible.

‘Three children, a private practice, a new practice opening imminently and having just finished my year as President of the British Academy of Cosmetic Dentistry – what more do I need than the opportunity to take on an MSc?’

Online MSc’s allow people to study wherever they are, whatever they’re doing – are those real dead people? – with the cries of ‘Mummy – are those real dead people?’ – are those real dead people? That’s disgusting! My husband walked in, shook his head and went back out on his tractor to fix things.

Meanwhile, two months into the course and I have been on a journey back to wonders of second year gross and dental anatomy – Sharpey’s fibres, Striae of Retzius, acellular and cellular cementum – all these wonders of nature that 18 years on a journey back to wonders of second year gross and dental anatomy – Sharpey’s fibres, Striae of Retzius, acellular and cellular cementum – all these wonders of nature that 18 years of general practice had harmed into the dark recesses of my mind!

There have been a few technical and administrative hitches with the technology along the way – but the concept is amazing, and Smile-on should be congratulated for embracing technology to allow those of us who live outside the major educational regions to access learning in this way.

Action list

I must confess, even at this early stage to being a tad behind with the lectures and self-evaluations. Half-term skiing holidays and the new practice opening haven’t helped. But, I have my online action list at the University of Manchester web portal (I wonder if I can get a student railcard again?). My plan is to intensively study and catch up... I’ll let you know how it goes!

About the author

Elaine Halley BDS (Hons) DGDP (UK) is the BACD Immediate Past President and the principal of Cherubbank Dental Spa, a private practice in Perth. She is an active member of the AACD and her main interest in cosmetic and advanced restorative dentistry and she has studied extensively in the United States, Europe and the UK.
Bukumbi Bound

Dental Tribune gives an update to the forthcoming visit to the village of Bukumbi to build a community centre with Bridge2Aid

With the trip just under two months away my mind has really been getting focused on what I need to organise before the team travels out to Bukumbi. I am already well on the way to becoming a pincushion after getting the majority of the jobs my doctor has recommended – only one left to have now!

The main thing that has brought home how soon we will be travelling is the excellent volunteer confirmation pack sent to me by B2A. Reading through it, it is surprising how much information you need to take in before you go! But I’m sure that the preparation we need to do beforehand will enhance our experiences while we are out there, as well as keeping us out of trouble.

Words and phrases
As someone with a fascination with language (remember I do work with words allegedly?) the bit that interested me most was the list of words and phrases in Swahili that could come in handy. Always willing to give a new language a try (although Greek was a bit of a challenge), I looked through the list and thought I would share some of them. I will put the English first, then the Swahili:

• Hello (polite form) – Shikamoo
• Yes – Ndiyo
• No – Hapana
• Why? (for those with small kids this one is for you!) – Kwa nini?
• My name is – Jina langu ni
• I don’t speak Swahili well (if there was ever an essential phrase, this will be it!) – Sizungumzuki Kiswahili vinuri
• Thanks for a wonderful time – Asante kwa wakati mizuri

To help me learn some of the phrases I am enlisting the help of a very clever four-year old girl (my daughter Emily) as she likes the sounds of the words as I say them out loud and can remember them faster than I can!

Schulke
The Team at Schulke (Andrew Thurston, Andrew Scott, Cornelius O’Mahoney, Julie Taylor, Nicola Furniss and Jackie Entwistle) are now really looking forward to making the trip to Tanzania and starting work on the Community Centre we are helping to provide for the people at Bukumbi. Andrew Thurston commented: “With lots of fundraising events behind us, I would like to thank everyone who has contributed both within the industry and beyond, your generosity has been astounding!”

“Thanks again to everyone who has supported me through my Justgiving site especially Smile-on, Practice Plan and Denplan and my friends and colleagues. If you would like to donate to B2A, please go to my fundraising page - www.justgiving.com/bukumbibound - and give your support. To help raise more funds, the team at Schulke are participating in a sponsored walk at Bewl Water in Kent April 10-11, and I will be joining the walk on April 10 so please support my leg!”

The Clearstep System

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Breaking the habit
With No Smoking Day on March 10 encouraging people to get free from smoking, Lil Niddrie, Denplan Sales Trainer, discusses how the dental team can not only help patients quit, but can also build relationships in the process.

I am sure that, as a dental health professional, you are aware of the physical risks of smoking, such as periodontal diseases, premature tooth loss and oral mucosal conditions, and come across them regularly in practice. What you may not be aware of is that a smoker’s lifespan can be shortened by five minutes for every cigarette smoked and that around 50 per cent of all regular cigarette smokers will eventually be killed by their habit.

Smoking is also linked heavily with major general health problems such as strokes, coronary heart disease, ulcers, low birth weight babies and, of course, cancer. All these issues – as well as the sensory effects such as stains on hands and fingernails, premature aging, and smelly hair and clothes – can leave the non-smoking population wondering what possible reasons are left to justify this habit.

However, for many people, giving up smoking is about far more than overcoming the physical addiction to nicotine. It is also about breaking through the psychological aspect of smoking and the habits surrounding it. The following guidance is designed to help you assist your patients to quit smoking.

Things to read
Providing a range of literature for patients is all very well and good, but different people will respond to different messages. Therefore, it is really important for a treating dentist or hygienist to talk to their patients and provide appropriate literature to suit their particular issues.

Rather than ‘scare mongering’ and producing long lists of diseases with shocking images of blackened lungs or stained teeth, it can often be more appropriate to provide literature educating patients about why they have an addiction. For example, nicotine is a stimulant which releases adrenaline into the body, which leads to increased stress levels. Stress releases sugars which create energy, so the body begins to rely on nicotine to feel good or to get going. As a result, some smokers may replace food with cigarettes and withdrawal may result in feeling weak and dizzy.

Withdrawal symptoms
The withdrawal symptoms experienced by patients will vary greatly, as you can see from the chart below. It can be a real comfort for some smokers to know that the majority of withdrawal symptoms they are experiencing or have experienced in previous attempts will subside within a matter of weeks. (Table 1)

It can also be really helpful for patients to know that from almost the first moment they stop smoking their bodies start to adjust and begin reversing the damage. (Table 2)

(Source - QUIT 2005 The UK Charity Which Helps People to Give Up Smoking)

Smoking cessation aids
While smoking cessation aids cannot make a patient want to quit or make the process easy for them, they are proven to lessen the urge to smoke as well as boosting confidence and easing nicotine withdrawal. Holding samples of the different forms for cessation aid in practice, so that smokers can see them and ask questions, can be a valuable service and patients are far more likely to respond positively if they feel well informed.

Some patients may choose to deal with the physical withdrawal and the habit at the same time, while others choose to use nicotine replacement therapy, which takes care of the nicotine addiction so that the smoker can work on breaking the habit. You should also have details of your local NHS Stop Smoking Programmes and other workshops designed to tackle the psychological aspects of quitting smoking.

Past experience of quitting
Unfortunately, two-thirds of people, who stop smoking, start again and the most common reason for this is over confidence. The person thinks that they have control over the habit and therefore can easily smoke the odd cigarette with no repercussions. This is possible for a few people, but the neural pathways which developed and created the smoking habit in the beginning are dormant and have not disappeared. One cigarette, therefore, is enough to reactivates the pathway and so smokers who relapse find themselves smoking just as many if not more than before.

It is important however, to never reproach a patient for relapsing. By re-assessing the patient’s goals and motivation and exploring their smoking triggers, you can remind them that they can still successfully quit. Patients who have stopped smoking in the past and then relapsed can more accurately prepare themselves to successfully quit this time, by recognising their triggers and creating appropriate strategies in advance for those difficult times, for example, the first cigarette of the morning is with a cup of coffee, the patient may find that changing where they drink the coffee will reduce the craving for a cigarette.

It is important also to recognise that a person who stops smoking may not just be changing a simple behaviour – they may have to make changes to their entire lifestyle. For example, if a patient associates smoking with drinking at the pub, they may have to avoid the pub in the short term!

It is clear that encouraging patients to quit smoking is anything but simple. It is a complex issue with both physical and psychological aspects to tackle. Some payment-plan providers offer tailor-made training days, which are specific to your practices needs and can incorporate modules focused on Smoking Cessation. Some of these courses can also count towards verifiable Continuing Professional Development (CPD) when undertaken in accordance with GDC requirements. This type of training can not only give you the confidence to offer guidance and support to your patients, but the means to build mutually beneficial relationships to last long into the future.

<table>
<thead>
<tr>
<th>Withdrawal symptom</th>
<th>Duration</th>
<th>Proportion of those trying to quit who are affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability / aggression</td>
<td>Less than 4 weeks</td>
<td>70%</td>
</tr>
<tr>
<td>Depression</td>
<td>Less than 4 weeks</td>
<td>60%</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Less than 4 weeks</td>
<td>60%</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>Less than 2 weeks</td>
<td>60%</td>
</tr>
<tr>
<td>Increased appetite</td>
<td>Greater than 10 weeks</td>
<td>70%</td>
</tr>
<tr>
<td>Light-headedness</td>
<td>Less than 48 hours</td>
<td>10%</td>
</tr>
<tr>
<td>Night-time awakenings</td>
<td>Less than 1 week</td>
<td>25%</td>
</tr>
<tr>
<td>Coughing</td>
<td>Greater than 2 weeks</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Duration</th>
<th>Proportion of those trying to quit who are affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 minutes</td>
<td>Oxygen levels in your blood return to normal.</td>
<td></td>
</tr>
<tr>
<td>48 hours</td>
<td>Carbon monoxide has been eliminated from your body. Your lungs start to clear out mucus and other smoking debris.</td>
<td></td>
</tr>
<tr>
<td>72 hours</td>
<td>Breathing becomes easier. Your heartbeats begin to relax and your energy levels increase.</td>
<td></td>
</tr>
<tr>
<td>2-12 weeks</td>
<td>Circulation improves throughout the body, making walking and running a whole lot easier.</td>
<td></td>
</tr>
<tr>
<td>5-9 months</td>
<td>Coughs, wheezing and breathing problems get better as your lung function is increased by up to 10%.</td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>Heart attack falls to about half that of a smoker.</td>
<td></td>
</tr>
<tr>
<td>10 years</td>
<td>Risk of lung cancer falls to half that of a smoker. Risk of heart attack falls to about as someone who has never smoked.</td>
<td></td>
</tr>
</tbody>
</table>

Table 1
Withdrawal symptom
Duration
Proportion of those trying to quit who are affected

Table 2
Duration
Proportion of those trying to quit who are affected

...that keeps your patients coming back
Letting off steam, but not boling over

Roger Levin looks at useful steps to keeping control of stress in the workplace, and how successful stress management can benefit team morale in so many ways

What's the leading cause of stress? Is it even possible to pinpoint one cause when so many variables operate in busy dental practices? It's safe to say that every dental practice experiences too much stress at one time or other. Some practices accept it as a fact of life, while others want something better. For them, total success includes having a low-stress practice. Levin Group consultants have observed that stress usually results from a combination of factors. The most common problems are a lack of well-defined business systems, ineffective leadership skills and teams that are not as committed as they should be. All of these issues can be solved. The final result is a low-stress practice, which is the goal of every dentist who has ever gone into practice.

The Levin Group Method for Total Practice Success includes five steps clinicians can take to have an immediate and positive impact on stress:

1) Empower the team
2) Hold morning meetings
3) Revise the schedule
4) Improve communication
5) Become a better leader

Empower the team

The clinician’s best resource for reducing inefficiency and lowering stress is the dental team. Involve as many team members as possible in examining your systems. Everyone on the team will have valuable insights to contribute. Special staff meetings can be held to review the major systems such as scheduling, case presentation, hygiene, practice financial management and patient finance. Some strategies include:

• Ask team members to bring a list of 10 possible improvements to the next staff meeting.

• Organise an off-site, all-day retreat to focus on current issues and strategic planning for the practice. This approach creates an opportunity to bring people together, forge a team spirit and identify problem areas and solutions.

• Send your practice manager to regularly scheduled continuing education courses to gain new perspectives and ideas on dental management.

Task the practice manager with the project of creating a written operations manual for every major business system in the practice. These manuals must include a step-by-step analysis of each system so that a person not trained in dentistry can quickly learn how the practice operates by following the manuals.

Hold morning meetings

Once the team has been empowered, it is a valuable asset to have a daily morning meeting. Conducting morning meetings before patients arrive is a sure-fire method of proactively organising the day and minimising stress. During these meetings, the clinician and the
team must identify times during the day when:

- Emergencies can be seen
- Time crunches are likely to occur
- New patients will need extra attention from the dentist
- Any special situations may affect the day

Making preparations for what's ahead on a given day will greatly reduce stress in the practice.

Revise the schedule
The backbone of the practice is the schedule, and it affects nearly every aspect of practice operations. Poorly constructed schedules can have chaotic results – frustrated patients, cancelled appointments, lost production and a stressful work environment for the staff. When this situation is left uncorrected, the practice risks losing good team members, thus creating even more stress for the remaining staff.

Examine how your practice schedule is constructed. For example, are there too many holes in the schedule? That's a sign that appointments are spaced too far apart. This scenario increases stress for the dentist and the team.

Levin Group recommends to its clients Power Cell Scheduling, a high-performance scheduling system using 10-minute units to accurately schedule appointments and allow more scheduling flexibility. Fifteen-minute units can result in under- or over-scheduling patients.

For example, if a procedure takes 20 minutes, the practice using 15-minute units would have to schedule this as a 15-minute or a 30-minute appointment.

From one day to the next, the schedule's format should be very similar. Mornings should be reserved for longer, higher-revenue procedures that make up most of the day's production goal. Afternoons can then be scheduled with simpler procedures. Within this framework the dentist and dental team are less stressed. This type of schedule keeps everyone on a steady, but not overwhelming, pace while allowing the practice to meet daily production goals.

Improve communication
Look at any successful practice and you will see an office that communicates extremely well. Communication affects every aspect of the patient experience, ranging from scheduling an appointment to case acceptance. For the dentist, the first step in improving communication is cultivating clear, positive and well-understood interactions with team members.

Throughout the day, the dentist has opportunities to coach team members, respond to questions and concerns, and motivate the team. Dentists should be providing positive feedback to team members throughout the day. Don't wait to recognize good performance until a staff meeting. When team members perform well, tell them that day.

Clear communication and supportive coaching become more critical as the practice grows. The dentist needs to inspire team members, individually and collectively, to achieve the highest levels of success.

Become a better leader
A mismanaged practice is a stressful place to work. Efficiency, productivity and communication are all reflections of your leadership skills. Therefore, dentists who work to improve their leadership skills can measurably reduce the stress in their practices.

Good leaders have learned to work through their teams – not around them. The most successful dentists have figured out how to delegate responsibilities to team members. Delegating responsibility accomplishes two things: dentists reduce their stress and team members gain a sense of empowerment. Staff members want to feel they play an important part in practice success.

Leading by example is another facet of leadership. Team members learn how to act by watching the leader's behaviour. A dentist who is positive and motivational inspires team members to act in the same way. Lead the way and your team will be sure to follow!

Conclusion
Chronic stress indicates that some vital elements of leadership are underdeveloped on the clinician's part. Dentists can remedy this situation by taking more proactive measures as leaders of their practices. Team members are relying on the dentist to set the tone, solve problems and identify strategies to get control of problem areas that are sources of stress.

Yet paradoxically, dentists who are working to become good leaders learn to empower their teams as much as possible. Dentists become better leaders by tapping into team member's insights, abilities and skills. These five steps can help dentists become better leaders, build better teams and achieve total success.
Contract complexities, a real plus?

ASPD member Andrew Lockhart-Mirams discusses four particularly important aspects of the recently launched PDS+ Agreement

On November 16, 2009, the Department of Health launched the new model PDS+ Agreement for improving dental access, which has since prompted much debate.

The main concerns are that the agreement seems very prescriptive, one-sided (favouring the PCT) and requires robust management systems to be in place, to the extent that fulfilling the requirements may be difficult for the big dental corporations and to a greater extent, the small dental practice.

Changing times

The new agreement sees a shift from the standard GDS contracts and PDS agreements that dental contractors are familiar with, to more of a short-term contract based on the APMS (Alternative Provider Medical Services) model contract favoured by the Department for General practitioners.

PCTs will shortly commence procurement and contracting the new agreement and have, in some instances, already begun testing early model documentation.

If dentists are thinking about bidding, we would suggest that they first read carefully the agreement being tendered, the requirements being imposed, the viability of achieving the targets and whether any initial outlay can be recouped within the term of the agreement.

Unfortunately, it is an unduly complex agreement and before time and money is spent going through any tender process, it is advisable to seek the advice of specialist accountants and solicitors.

Termination of PDS

Most dentists are aware of the ‘Crouch’ judgement regarding a PCT’s right to terminate a PDS agreement. The case concerned a clause inserted into Dr Crouch’s PDS agreement, which apparently gave the PCT a freestanding right to terminate his agreement without cause, merely notice. The PCT claimed the clause derived from paragraph 67 (Termination by the Relevant Body; notice) of Schedule 5 to the NHS PDS Agreement Regulations 2005 (‘the Regulations’).

The case was argued before the Administrative Court, who found in favour of Dr Crouch. The clauses complained of were ordered to be removed, but the Secretary of State appealed this judgment.

The Court of Appeal held that the right to terminate by notice under PDS is not a ‘standalone’ right. The power argued for by the PCT was described as ‘exorbitant’ in the judgement, although the Court did allow the inclusion of clauses reflecting paragraph 67 of the Regulations. They ruled, however, that these must be interpreted as a procedural provision to be read in conjunction with those instances in the Regulations/Agreement where the PCT does have a specified cause to terminate (untrue information, grounds of suitability, etc.).

Reversion from PDS to GDS

Under Regulation 21 of the National Health Service (Personal Dental Services Agreements) Regulations 2005 (‘the Regulations’), a contractor is entitled to revert from a PDS agreement to a GDS contract. The contract value of a GDS contract awarded pursuant to Regulation 21 is a difficult obstacle as the Regulations are silent on this issue. As such, a contractor cannot rely on an express right to have the same value they retained under the PDS Agreement.

The reversion to GDS is technically considered the award of a new contract and any provisions that are not pre-prescribed by the Regulations must be agreed between the parties. Thus, where a PCT issues a GDS contract pursuant to regulation 21, the contract value must be agreed between the PCT and the contractor. Guidance (dated January 2009) issued by the Primary Care Commissioning in respect of PDS to GDS transfers makes it clear that it envisages the contract value to be agreed between the parties.

In a NHS LA (NHS Litigation Authority) decision from August 2009, the contractor disputed the Negotiated Annual Contract Value (NACV) offered to it by the PCT, which was less than the contractor’s Negotiated Annual Agreement Value (NAAV).

The NHS LA determined that the risk profile of the PCT and the contractor under the old and new arrangements needed to be examined as to whether it was reasonable for the contractor to offer a NACV which was lower than the NAAV under the existing PDS Agreement.

In this case, it was determined that moving from a short-term to an open-ended contract did change the risk profiles for both parties as the contractor had greater security and the risk to the PCT grew as a result. The NHS LA determined that “it would not appear to be unreasonable that where the overall risk profile for the contractor has been reduced for the PCT to propose that the contract value to be decreased as part of the negotiations.”

This indicates how the NHS LA is handling cases where the value is being decreased should the PCT fail to offer an equal or acceptable value.

Hot topic: incorporation

Undoubtedly one of the hot topics at the moment is incorporation and although it may not be true in every case, specialist dental accountants advise that not pre-prescribed by the Regulations must be agreed between the parties. Thus, where a PCT issues a GDS contract pursuant to regulation 21, the contract value must be agreed between the PCT and the contractor. Guidance (dated January 2009) issued by the Primary Care Commissioning in respect of PDS to GDS transfers makes it clear that it envisages the contract value to be agreed between the parties.

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About the author

Andrew Lockhart-Mirams is co-founder of Lockharts Solicitors and leads the firm’s commercial team, which is a member of the Association of Specialist Providers to Dentists (ASPD). ASDP member companies work together to provide comprehensive solutions, each member of the ASPD network is a dental industry specialist committed to overcoming challenges faced by dental professionals. For more information call 0800 458 6773, visit www.aspd.co.uk or email andrew.lockhart-mirams@csd@lockharts.co.uk.

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Ceramic restorations—What is the key to success?

Robert Michalik shares with readers his experiences in creating successful ceramic restorations.

The issue I would like to address in this article is one well known to many readers. However, occasionally it can be beneficial for us to consolidate and evaluate our knowledge. So, I would like to set out my own experiences acquired over many years of work as a dental technician. I hope that the majority of readers will share my opinion that in order to guarantee a successful ceramic restoration it is important to choose the right material and construction and to ensure that it is properly made. Prosthetic work carried out in this way ensures an aesthetically pleasing appearance, perfect marginal seal and durability for the entire restoration.

Naturally, it cannot be expected that crowns set on a non-pre-cious metal will look beautiful and provide a natural distribution of light.

Technicians will always face a dilemma when it comes to choosing the right coping and, only a skilful consideration of all the arguments for and against any specific solution will guarantee a successful outcome. My observations primarily concern the materials and technologies that I have most frequently used to make ceramic crowns.

The firing method used for a ceramic mainly depends on the material of the coping. In turn, the aesthetic quality of the prosthetic restoration (transparency, opalescence, fluorescence) is mostly influenced by the type of coping used.

Ceramic prosthetic crowns differ both in the technology used to construct them and in the materials from which the restoration is prepared. Porcelain can be fired on:

- Alloys: precious metals (alloys with high gold content—above 75 per cent, medium—50-70 per cent, low—up to 50 per cent) and non-precious metals (chrome, cobalt)
- Galvanic structures
- Transparent zirconium dioxide (ZrO2) (nanoceramic—size of grain below 50 μm, purity of material 99.999 per cent, and opaque zircon—grain value above 50 μm)
- Aluminium trioxide (Al2O3)
- Press porcelain
- Feldspathic porcelain

I will briefly outline the pros and cons of the crowns we use most frequently in our office.

Porcelain fired directly on refractory die

Advantages
- Natural distribution of light in finished restoration
- Optimal cohesion of material
- Excellent aesthetic effect when making individual crowns for anterior non-discoloured abutment teeth or veneers and inlay/onlay restorations
- Physiological wear with the antagonist
- Chameleonic effect

Drawbacks
- A difficult restoration technology, as no adjustments can be made once the refractory material is removed
- Not possible to control and monitor individual stages of the work
- Limited application for making individual anterior crowns to be placed on non-discoloured abutments or for inlay/onlay restorations
- Preparation is possible only with a simple, relatively even shoulder around the entire circumference

Porcelain fired on zirconium dioxide (ZrO2)

Advantages
- Reproducibility and accuracy of restoration (only in CAD/CAM system)
- Good light dispersion
- Covers dark abutments and metal posts and cores (opaque zircon)
- Wide range of applications (crowns, bridges, bars and implant abutments, telescope crowns, leads)
- Possibility of preparation with limited shoulder and chamfer/bevel
- Individual stages of the work can be monitored, even in the patient’s mouth
- Construction retains shape when ceramic is fired

Drawbacks
- Construction has limited elasticity
- Micro chipping on active surface
- Construction cannot be repaired
- Liners must be used

Porcelain fired on metal

Advantages
- Chemical bonding of construction with porcelain
- Construction can be repaired
- High elasticity
- A wide range of applications (bridges, crowns, telescope prosthetics, posts and cores, bars and implant abutments)
- Individual stages of the work can be monitored, even in the patient’s mouth
- Oligodynamic effects (in the case of gold)

Drawbacks
- No transparency in substructure
- Oxidation necessary
- Risk of margin deformation when firing ceramic
- External factors may influence construction (temperature, proportion, refractory material)

Porcelain fired directly on metal

Advantages
- A wide range of applications (crowns, bridges, bars and implant abutments, telescope crowns, leads)
- Construction retains shape when ceramic is fired
- Wide range of applications
- Good light dispersion
- Covers dark abutments and metal posts and cores (opaque zircon)

Drawbacks
- Construction cannot be repaired
- Liners must be used

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I will present several cases in which various kinds of substructures were used to achieve the most natural appearance possible.

**Case 1 (Figs. 8–17)**

A 28-year-old patient presented with pronounced discoloration of the teeth, which was a result of medication from the tetracycline group taken during her childhood (Fig. 8). There was also significant damage to the enamel of the patient’s teeth. The uneven cervical line had damaged the aesthetic appearance of her dentition. The patient wished to change both the shape and appearance of her teeth.

The first task was to ensure a proper cervical line and achieve an effect of longer teeth without changing the occlusal line. Owing to the skilful work of the dentist and the ideal construction of the temporary crowns made by the technician, it was possible to achieve excellent results in the red aesthetic zone. Figures 16 and 17 show that the gingiva formed in accordance with our expectations.

As I mentioned earlier, in order to guarantee success, it is important to choose the right technology for crown fabrication. In this case, I considered two possibilities for making the restorations: either on a coping using press technology or fired directly on the refractory material. I was
faced with such a dilemma because I was unsure whether the crowns made using feldspathic porcelain would cover the dark abutments of the patient's teeth. After the preparation, however, it turned out that the stumps of the teeth were not as drastically discoloured as the colour prior to the preparation had indicated.

The effect of the reconstruction is left to the appraisal of the readers. The use of a metal coping and even a zircon solution would not have achieved the desired aesthetic result.

Case II (Figs. 18–21)
A 26-year-old patient presented with a discoloured tooth 11 (Fig. 18). Previously, the operations performed by the dentist on the patient had involved making composite veneers, which had changed colour over time. The first stage of the work involved changing the fillings in teeth 21 and 22, then making the preparation and taking the impression. In this case, I considered three variants for the substructure: made using the press method, a zirconium dioxide coping or a galvanic structure. The patient wanted a natural restoration identical to the one on tooth 21.

The press method would have been too risky, as the stump of the tooth was severely discoloured. I was concerned that the dark colour would show through the cemented crown. A crown inserted on a galvanic gold coping, in spite of its warm tone and its ability to cover the dark abutments, would not have dispersed light in such a way that when looked at from any angle it would be impossible to notice any features distinguishing it from a natural tooth. Hence, I decided to make a crown based on a zirconium dioxide substructure.

Case III (Figs. 22–25)
A patient visited our surgery for a typical dental check-up. After a preliminary examination, caries was found to be present in several teeth, including the patient's two lower premolar teeth (secondary caries reaching the pulp chamber). Unfortunately, in cleaning the zone affected with caries the dentist had to devitalise the tooth and perform endodontic treatment. On completion of the treatment, the remaining dental tissue was found not suitable for partial restoration. Hence, the dentist decided to make ceramic crowns and place them on stumps strengthened beforehand with gold alloy posts and cores. The stumps prepared in this way were subjected to analysis that showed that the optimal solution in this case would be porcelain crowns made on a zirconium dioxide substructure. This would ensure an aesthetically pleasing appearance and durability. Such characteristics could not be achieved with crowns made using the press method or fired on a refractory material or a metal coping. Only using zirconium dioxide as a substructure guaranteed the intended effect, which is left to the readers to judge.

In conclusion, I would like to thank the dentists who helped me prepare the work presented here. I would also like thank Robocam for providing the zirconium dioxide.

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The fluoride debate

Are health ministers really concerned with the public’s oral health when it comes to water fluoridation, or is it an easy way to lessen the burden on the NHS?

Neel Kothari discusses

For many within our profession, water fluoridation needs little endorsement, but among the general public, some of the more talented mass media strikes fear and anger in their hearts. They perceive it as an erosion of their autonomy, rather than appreciating the widespread benefits it may provide.

We have all come across a patient whose medical beliefs fly in the face of science and, while it is easy to label these patients as crackpots, for some the fixation to their beliefs can be as strong as seen within religion. Many anti-fluoridation activists quote a range of reasons against fluoridation, which include throwing doubt on its proven efficacy and the potential health risks proven or perceived, nevertheless the Government still seems keen to push ahead with water fluoridation for those areas at high risk of dental carries.

The most recent case which attracted controversy was that of South Central SHA’s decision to push ahead with water fluoridation in and around Southampton, which, despite a 72 per cent opposition (10,000 respondents) and the County Council opposing the plan in a local consultation, still went through.

My fear here is not that water fluoridation has been pushed through against the will of the local population, but whether this has decayed local democracy in doing so?

Pros and cons

Trying to gather more evidence to way up the pros and cons, I looked at why the British Dental Association (BDA) had decided to endorse South Central SHA’s decision to introduce water fluoridation.

In a statement on this decision, the BDA presented its case by stating: Fluoridation will play an important role in reducing the worryingly high levels of dental decay in Southamp ton where as many as 42 per cent of five-year-olds have experienced tooth decay.

Studies of people’s teeth in fluoridated and non-fluoridated areas demonstrate the beneficial effect fluoridation has on dental health over time. For instance, a survey of five-year-olds by the British Association for the Study of Community Dentistry (BASCOD) in 2003-05 found that six of the top ten places in Britain for children’s dental health all receive fluoridated water. Five-year-olds in South Staffordshire have the best teeth, while South Birmingham ranks eighth best.

Caries in the deciduous dentition of young children in South Birmingham is two to three times greater than the average in the county. South Central SHA’s decision to push ahead with water fluoridation in and around Southampton, which, despite a 72 per cent opposition (10,000 respondents) and the County Council opposing the plan in a local consultation, still went through.

Pros and cons

Five-year-old children from Southampton have over twice as many teeth affected by decay as those from South Birmingham and around three times more than those from Staffordshire. During 2007, over 320 children in Southampton had a general anaesthetic to have a total of 2,940 teeth extracted.

BDA in favour

From this it is clear that the BDA is in favour of water fluoridation and on a personal note, I too can see its preventative benefits, but at what point does this become an issue of consent? And are we ever justified in imposing a treatment solution on an unwilling patient?

In a consultation such as in Southampton, 72 per cent of respondents are in opposition to water fluoridation and the local SHA still goes ahead with water fluoridation, what is the point of the consultation? Does the taxpayer really need to prop up a pantomime concerned with the sake of due diligence? And at what point does the Government stop having small local consultations and start enforcing this policy nationwide? After all it seems, rightly or wrongly, that it has already made its mind up.

On the issue of local consultations on water fluoridation, Conservative Shadow Health Minister Mike Penning says: “There are differing views on both sides of the argument in terms of fluoridation, and local communities should have a real say in decisions relating to the water supply – rather than have a decision imposed on them by the Government.”

We need to ensure that local consultation processes are meaningful, and the Conservatives have pledged a review of these practices in Government.

Lack of foundation?

When reading through some of the literature presented by anti-fluoridation campaigners, clearly some of the arguments have a lack of foundation and verge on scaremongering rather than drawing from a solid evidence base. But some of the arguments presented are harder to deconstruct, such as from those people who on principle object to mass medication or from those people who simply do not want it in their drinking water. One other factor to consider is the effects of dental fluorosis on our patients. For some this is a minor cosmetic trade-off for having healthy teeth, whilst for others there is an expensive future of whitening and veneers of the horizon, all of course currently not freely available under the NHS!

The opponents of water fluoridation also point out that there are other ways to reduce levels of decay among high-risk children and that decay rates have been consistently decreasing in both fluoridated and non-fluoridated areas. Although I can see that there are other ways to reduce decay, in my opinion water fluoridation offers us a considerable advantage in helping high-risk children to avoid unnecessary dental intervention, however I accept that not everyone holds this view and that not everyone will stand to benefit from fluoridation.

As more SHAs look at the need for water fluoridation in the years to come, this will no doubt lead to numerus public consultations with more opposition to fluoridation to deal with. Whether water fluoridation is beneficial to the public or not, I question whether health ministers are really concerned with this issue or if this is seen as an easy way to lessen the burden on NHS dentistry? If ministers were really concerned with the effects of decay on those from socially deprived areas then why not tax sugar, along with alcohol and tobacco?

While it would be convenient for the Government to disregard opposition to water fluoridation as mere scaremongering, this issue clearly raises a very strong opposition. In my mind, the arguments for water fluoridation in high-risk areas do outweigh the arguments against it. It is also clear that this argument has not been won in the court of public opinion and as such, while water fluoridation may help its desired demographic, a small segment of democracy has clearly been traded off in making it happen.
Care Quality Commission
- By Seema Sharma

All NHS and private dentists have to register with The Care Quality Commission (CQC) in 2011. Simply having a set of policies and procedures in place is not going to impress the authorities. Practices will be expected to demonstrate outcomes to prove that they meet a fairly extensive set of regulations which can be grouped into six broad sections:

1. Patient involvement and information
2. Personalised care, treatment and support
3. Safeguarding and safety
4. Suitability of staffing
5. Quality and management
6. Suitability of management

Do or die
If you’ve got somewhere to go, this may the time to book a ticket, but if you own a practice and have to stay and face the music, then there are only two options – to take the bull by the horns and slog through getting compliance systems in place grudgingly, or turn the problem into an opportunity and use it to attract and retain patients and develop your practice. Doing nothing is not an option. Non-compliant practices face being shut down, and there is a lot to do for CQC compliance between now and next April.

Demonstrating Quality
We all have an inherent understanding of the difference between a good quality and a poor quality service, but imagine being offered a once in a lifetime year long holiday on a Caribbean island, or a couple of weeks in a Mumbai slum which was the only travel invitation I’ve received recently.

What information would you want your team to gather and send to you, so you can be reassured that all your patients will still be returning, the practice will meet CQC regulations and, if you have an NHS contract, your commissioner will still be talking to you when you return?

Management ecosystems
Do not be daunted by the new buzz phrases in dentistry – quality and key performance indicators. To the entrepreneurial practice owner and manager, they provide an opportunity to build a set of integrated clinical and financial practice management systems which prove that they run a high quality practice, and to market their pioneering activities for growth.

As a successful practice grows, there comes a point where every dental practice owner finds the balance of growth and a personalised service difficult to maintain. At this stage one of three things usually happens:

- Clinicians who prefer clinical dentistry to practice management choose to run boutique or niche practices, concentrating on specialist care or a smaller segment of the more affluent population.
- Others step up from being a manager to a leader and empower other team members to take on some of the services that contributed to the original growth, putting appropriate checks and balances into place to ensure that quality does not slip.
- Some do neither and try to fit management in a piecemeal fashion around clinical work, which can lead to stress and disenchantment.

Eleven Entrepreneurial Tips

1. Measure qualitatively
   Put some qualitative measures in place as soon as you can eg start using a comments book and audits to assess if the practice is meeting patients’ needs and expectations.

2. Meet
   Team meetings serve multiple purposes. By brainstorming the strengths and weaknesses in your practice, you are likely to find that there are some weaknesses that you had not considered and be pleasantly surprised at how some of your team members have the skills and interest to help you take your work forward during the year.

3. Appraise
   Spend a couple of weeks conducting staff appraisals to develop a baseline assessment of each team member’s level of understanding in areas like safety, safeguarding, patient involvement, communication, evidence based preventive strategies and personalised care pathways.

4. Delegate
   Not only is assessment of fitness of workers one of the CQC regulations, you can share out the workload by using the opportunity to get “buy in” from each member of your team to take on an area of responsibility and tailor their personal and professional development to meet associated CQC outcome targets.

5. Motivate
   Define your vision, praise those who are already working towards it and explain the benefits of working as a team to achieve targets by distributing responsibility to those who are not – after all registration is required to stay in business, so it’s in everyone’s interest to join hands and do their bit.

6. Monitor
   Use standard risk assessments and audits to assess the practice is meeting regulations, to create improvement plans and to keep an eye on whether your practice is meeting patients’ needs and expectations.

7. Measure quantitatively
   We use common quantitative measures every day – we count how many people come through the door, how many procedures are offered a once in a lifetime opportunity to join hands and do their bit.

Seema Sharma, founder of Dentabyte, is a joint shareholder in 4 successful start-up practices which between them have 10 general and 5 preventive & specialist chairs. That may not sound like much but when you factor in she has the time to collect her kids from school, take a holiday at least 4 times a year and run her charity, The Sharma Foundation, it becomes apparent that lifestyle is certainly her yardstick.

Seema says “Successful practice management isn’t about the separate components it is about building an eco-system that integrates and optimises those components to the point that they become perpetually self-sustaining.”

Whether you need to get more from your practice management systems, prepare for CQC, meet your PCT’s KPIs, balance your practice financials, build more effective teams or continue professional development, Dentabyte can help.

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What makes a successful practice? How do you define “success”? Ask most practice owners and you are likely to hear quite a range of replies - after all, each individual has his or her own personal yardstick or measure of success.
Planning for success
Mistakes can be made when carrying out guided surgery, but they can be easily be avoided if you plan accurately, insists Dr Riz Syed

Guided surgery is an aspect of implant surgery that has gained popularity over the last 10 years, allowing surgeons to plan implant placements with a high degree of accuracy. The idea behind guided surgery is to perform a complete evaluation of the patient, from the surgical to the restorative point of view, and then to translate this information into a surgical guide for optimal implant placements.

In 2005, the Food and Drug Administration (FDA) approved a guided system from Nobel Biocare known as NobelGuide. Having used NobelGuide since 2005, I have enjoyed a high success rate. I have however, come across problems based solely on the inaccurate planning, which has inevitably led to complications.

Avoiding common pitfalls
The planning involves many stages before the surgery and each stage is vital to ensure success.

The first stage occurs during the consultation where the patient is carefully assessed. Their desires and final outcome have to be taken into account along with the patient's medical history.

If the patient is wearing a prosthesis, it is crucial to check if the patient is happy with the position and look of the teeth. The fitting surface, vertical dimension and lip support should all be assessed.

It is then important to decide if the patient's prosthesis is to be used as a guide for the CT scanning. The alternative is to produce a new stent. It is vital to ensure that the fit surface is accurate and verified before sending the patient for a scan. The occlusal index must be worn during the first scan with the radiographic guide in place to ensure this does not move during the scanning procedure.

Words of warning
One problem I have seen on many occasions is the use of radioactive relining materials. These materials show up on the scan and can interfere with the bony ridge and it is very difficult to assess the crestal position. If a new stent is made for the scan, radio opaque materials should not be used.

The second problem in planning arises when the Gutta Percha markers are not placed in the correct position. For the software to match the prosthesis to the CT of the patient, at least six markers are needed on different planes away from the occlusal surface. Each marker should be at least 1.5mm in diameter x 1mm deep. Some scanning centres are happy to place the gap markers into the stent or denture. Having a good relationship and communication with the scanning centre is important.

Know your software. The guided software has many different functions available to the user and it is very important to familiarise yourself with using demo cases before you plan a live case.

Once the scan has been sent back and reconstructed on the Procera software, the implant-planning phase begins. This is where the Nobel Biocare software comes into its own. The patient's anatomy can be assessed with a high degree of accuracy, allowing the surgeon to view vital structures including the mental and inferior dental nerve, maxillary and nasal sinuses. Implants can then be placed with great precision.

Each implant placed has a yellow halo of two mm surrounding the implant site that has gained popularity over the last 10 years, allowing surgeons to plan implant placements with a high degree of accuracy. The idea behind guided surgery is to perform a complete evaluation of the patient, from the surgical to the restorative point of view, and then to translate this information into a surgical guide for optimal implant placements.

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Each implant placed has a yellow halo of two mm surrounding...
Finding your vocation

Although it can be a time fraught with tension, it’s also a time for you to decide exactly where you want to head, says Sarah Armstrong, who offers some essential, yet calming advice.

The time of year is approaching where final dental students across the country are beginning the application process for their Vocational Training (VT) positions commencing in August 2009.

The VT application process can be stressful business. For the first time since you all met back in first year, you and your friends will be competing against each other for the same jobs and employers can get a little fraught, especially when you are often competing against not only friends but housemates too!

Final years have an amazing knack of winding each other up into a frenzy and the VT application process is certainly no exception. Every year rumours fly about candidates who have jobs before the release date for VT positions or practices who are interviewing weeks in advance. The majority of the time these are false, so try and ignore these and focus on your own application.

Get in early

Prepare your CV/application form early. Even if the deadline is months in advance, it’s best to get cracking now as once the deadline is imminent, you will be caught up other pressing matters – that small matter of revision for finals!

Your VT application is not just a one-way process; this is also you, so take the opportunity to assess where you want to go to. Are you interested in working in a large or small practice? Are you interested in a particular dental specialty? Do you want to work in a particular location? Of course being fresh out of dental school – you’ve got no real way of knowing which direction your career will take, but this is the critical time to start thinking. Where do you see yourself in five years?

Ask for advice

Contact your peers in senior years. Their advice is absolutely invaluable having gone through the process already. Where did they choose to work? Are they happy with their decision? They may even be able to help you with your application and advise on practices to consider applying to. Often clinicians and visiting GDPs will be happy to help you with your application too.

There is huge variation in the application process depending on the Deanery you apply to. It’s vital you find out exactly what form the application process will take, and the deadlines involved. Deadlines often vary widely between Deaneries; as yet there is no nationwide release date for VT posts. Some areas adopt an online application system, whilst others use the more traditional method of CV’s submitted to individual trainers. The best place to find out this information is on the individual Deanery websites.

Meet the trainer

In some areas you are required to attend a ‘Meet the Trainer’ event. These are arranged to enable you to meet trainers and find out about their VT practices, but is also for the trainers to gain an idea of potential candidates for their vacancy. The day is an ideal opportunity to create a good first impression so dress smart, engage in conversation with as many trainers as possible, ask intelligent questions and take copies of your CV – often these events are the first port of call to arrange an interview.

Matching processes are being increasingly used to match candidates to trainers. These vary in their format depending upon the Deanery, but generally they involve applying to a number of available positions and attending interviews, then once the round of interviews has been completed, the trainers rank the candidates in order of preference, and the candidates rank the trainers. After this first round of matching, some candidates/trainers may remain unmatched and a second round of matching is then carried out.

When ranking trainers you need to think very carefully, you must be prepared to work with each trainer you have ranked. You need to consider which practices/trainers would best suit your needs but be careful to not limit your choices too much eg only listing a few trainers or listing only practices based in city centres – the application process is highly competitive and you run the risk of not getting matched at all.

Although the VT application process can be a stressful and time-consuming process, don’t lose sight of the other major task ahead of you, passing finals! Good luck and enjoy your VT year.
Eating for better oral health

When it comes to treating oral hygiene, it’s best to treat the whole patient which includes a look at their diet, says Mhari Coxon

Yes, it’s that time of the year again. After six weeks or so of excessive eating and drinking and general merriment, my body clearly told me no more. And so, the annual healthy diet and ban on alcohol has been in full swing since January 1 2010 – and don’t I feel the benefit. I’m sleeping better, my skin looks healthier, eyes brighter (I’m in danger of sounding like a dog) and my energy levels are up (I’m in danger of sounding like a sup). And so, the annual healthy diet and ban on alcohol has been in full swing since January 1 2010, perhaps our diet analysis questionnaire in practice can be particularly helpful for both the clinician and patient. We use a three-day plan, where they record everything they eat and drink for three consecutive days, one of which is a weekend day. The inclusion of a weekend day is important as we can be quite structured during our work or school week, but completely different in our leisure time. It is important to update your treatment appointments, which we do with great support and maintenance. What I am saying is that we need to remember to treat the whole patient and not rely on oral hygiene alone.

Sometimes the management of the disease can seem overwhelming, so discussion about diet as a support instead of another interdental cleaning lesson may provide a reprise for the patient in terms of the monotony of management. Now, if you will excuse me, I have some fresh figs, natural yoghurt, and mixed seeds which my name on them (and we won’t mention the chocolate cake yesterday; well it was a birthday, it would have been rude to say no).

References
(1) Bone and nutrition in elderly women: protein, energy, and calcium as main determinants of bone mineral density. 
(2) Diet and periodontal disease: a critical time for action. 
(3) Diet and periodontal disease: a critical time for action. 
(4) Diet and periodontal disease: a critical time for action.

A sum of all parts

Please do not take the wrong meaning from this piece. I am not saying that a good diet is all that is needed to treat periodontal disease. It is a blend of good daily oral hygiene, good diet, elimination of the highest risk factors such as smoking and a lot of good support and maintenance. What I am saying is that we need to remember to treat the whole patient and not rely on oral hygiene alone.

The benefits

Bone density is very important to us dentally, for maintenance of the healthy periodontium, and when that is no longer the case in supporting an implant for prosthesis. Research shows that those that have diets with good levels of dairy, fresh fruit and vegetables, especially green leafy ones containing boron, and vitamin D in the form of daylight or supplementation have better bone density.

There is also evidence to suggest that excessive intake of vitamin A could be detrimental to bone density. So, it is reinforced that it is a question of balance.

Tissue quality in the periodontal and gingival sites could be improved by the increase of vitamin C in the diet as it has been proven to increase collagen growth. (4) This would be beneficial in the initial healing stage and over the first year as the tissues repair the damage.

About the author

Mhari Coxon is a dental hygienist practicing in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSH) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPD
tedCP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@toddshygiene.com.

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A sensible alternative

Michael Lansdell offers advice on avoiding involvement with tax schemes

The state of the nation’s finances continues to deteriorate, with national debt at staggering levels, revenue collection in the form of taxes much reduced, and Government expenditure soaring.

The Government seems to think that tax rises for the “wealthy” are politically popular, despite the fact time after time, it is clear that the very “wealthy” tend not to bear the brunt of these increases.

From 6 April 2010, top rate tax is increasing from 40 per cent to 40 per cent on taxable income between £150,000 and £170,000, and from 40 per cent to 50 per cent on all taxable income above £150,000.

From 6 April 2011, National Insurance is doubling on all profits above £130,000, with very few exceptions.

High rate tax relief for pension contributions is now already restricted to £20,000 per annum for those with incomes in excess of £150,000, with very few exceptions.

All that glitters…. With all of this gloom, entering into a “tax scheme” appears to have its advantages – principally that your tax rate can be reduced to zero, and it all seems so easy with a few signatures on some papers that are brought around to your home or your practice by that friendly-faced person who introduces or sells “tax strategies”.

With the Chancellor under intense financial pressure, and desperate to protect revenues of state, the Government is clear about their position on tax schemes: We will identify activities which….are not likely to have the legal effect desired by those thinking of using them. Where they are discovered….we will make a challenge and seek full settlement of liabilities through enquiry and litigation. (www.hmrc.gov.uk/avoidance/spotlights.htm)

And pursuing these tax schemes the Government is certainly doing: harshly, mercilessly and with the full force of the law, to root out the avenues where taxpayers seek to avoid what they should pay. Recent tax schemes attacked by the Government have started with criminal investigations into the schemes, before moving to the other aspects of reclaiming tax, interest and penalties incorrectly claimed.

The front page story of the Mail on Sunday on 14 February 2010, which ran to several of the inside pages as well, detailed one of the schemes under investigation, including naming the people who had participated: many schemes operate as Limited Liability Partnerships (LLPs) and details of all participants are a matter of the public record at the Registrar of Companies and can be downloaded from the internet by anyone for just £5!

This article is, of course, terrible publicity for the participants. What is more important is the Inland Revenue’s position as documented, which is that because the arrangement was principally aimed at tax avoidance, and was not trading on a proper commercial basis, then the participants in the scheme are not entitled to tax benefits, and to the extent that they have had tax benefits, these should be repaid to the Inland Revenue with penalties and interest.

The Mail on Sunday then went on to report that the firm that developed the scheme had problems of its own: a loss of £6.5m for the year to April 2009, and that two of its executives were later charged last year in connection with a £210m tax scam for wealthy clients. Not the most tasteful company for a dentist to be keeping.

A more sensible solution

On the one hand, you have taxes skyrocketing and you feel that you must take action. On the other hand, you want to avoid dodgy tax schemes because deep down you know that they will cause you trouble and emotional and financial distress later: is there an alternative?

Yes. The solution is the incorporation of your dental practice, ie converting from a sole trader or partnership to a limited company, an arrangement which has been allowed by the GDC since 2006.

Some initial points are relevant about what incorporation is NOT:

• A tax scheme
• A tax loop hole
• Illegal
• Will not reduce your tax bill to 0 per cent

If we know what incorporation is NOT, then what IS it?

• It is the arrangement of your trading structure from a sole trader or partnership to a limited company
• It is a legitimate restructure of your affairs into an arrangement that has been legally recognised in the UK since 1844
• It is allowed for dental practitioners, with a GDC restriction on this type of trading entity having been lifted in 2006

• It is a mechanism that may significantly reduce your tax bill, usually by between 50 and 50 per cent, depending on individual circumstances.

What about some of the more popular misconceptions about incorporation out there?

• Incorporation takes away your flexibility – on the contrary, the opposite is true.
• There will be loads of extra tax to pay when you sell or retire – this seems very unlikely, and to the extent that it may be true, it should be quantified and compared to the tax that you will save until retirement or sale to work out whether you will be better or worse off overall.
• Your practice gross, staff wages and profits will be a matter of the public record – if your gross annual turnover is less than £6.5 million, this does not apply and your private information about these things remains private.
• Limited companies are subject to inspections from PAYE auditors – in fact, all employers are subject to inspections from PAYE auditors, sole traders, partnerships and limited companies alike – your trading structure makes no difference.
• Your PCT won’t agree to it – many PCTs do and many don’t; if they don’t, there are ways of benefiting from the tax savings without disturbing your arrangements with the PCT.

Conclusion

It is impossible for any professional – accountant or otherwise – to say whether incorporation is a good or bad idea without fully understanding your own circumstances and working out the savings available in your particular circumstances. It may be right for you. The next step is to consult a dental incorporation specialist and see if you could benefit, and if you could, by how much.

About the author

Michael Lansdell was brought up in South Africa, receiving his honours degree there in 1981. He completed his training with international accounting firm Ernst & Young in 1984, and went on to become a founding partner at Lansdell & Rose Chartered Accountants (SA) a year later. Based in Kennington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner managed clients, generally dentists and doctors, and specialising in the incorporation of dental practices.
our UDAs, we cash up, we check how many new patients came in and we look at our expenses.

Consider using key performance indicators to attach quantitative measures to qualitative processes. For example:

- How much diary time gets wasted?
- What are the outputs from each clinician in £ or UDAs?
- Which high importance, low fee items (check-ups, reviews, advice, denture check-ups etc) clog up the appointment book?
- How can this be managed without alienating patients?
- How many high risk/high needs patients are plugged into a “preventive programme” with the hygienist?
- How many low risk patients are on a “maintenance programme” keeping the patients as lifelong supporters and leaving you free to do dentistry?

Not only will you be meeting outcomes around CQC requirements to demonstrate personalised treatment, care and support, you will be freeing up your time to concentrate on treatments and the skilled technical dentistry you spent years in training for, you will ensure you have a tailored partnership with each and every patient which they will tell others about, and you will be picking up those patients who are falling through the net in your practice, and the resultant lost revenue.

8. Plan your strategy
Take a little time out to work out what you are doing well and what needs attention, then create an action plan for the next 12 months.

9. Allocate resource
Decide if you are going to sacrifice clinical time and revenue to work on CQC registration, or if you are going to engage your team and send your practice manager on the right training courses to do the work for you, or a bit of both.

10. Reorganise your finances
Assess where your practice expenditure goes. Broadly speaking, rent rates, utilities and compliance related costs are fixed and almost impossible to trim. Variable costs are related to activity. As a rule of thumb, materials, lab fees and infection control typically use up 12 per cent of turnover – more and you need to have more control, less and you may not be meeting standards.

Personnel costs and profits are the only areas which allow room for manoeuvre – this is why it is so important to get “buy in” from the team and arrange team training. The only other way is to engage expensive professionals to help you, and there may need to be cut backs in personnel costs to fund this. Beware those who tell you to cut back on staff... you may end up doing a lot more work than if you invest in their training!

11. Stay calm
Most problems have solutions, even if it takes some time to find them. Consider a positive approach and seek assistance if necessary.

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**About the author**

An impassioned advocate of mixed practices, Seema is a successful dentist who owns 4 practices, including a 6-chair multi-disciplinary centre in the heart of Docklands, and a practice management consultancy, Dentabyte Ltd. Attributing her success to sound management and investment strategies, she recently visited the slums of Mumbai to give away £50,000 to underprivileged communities living in absolute poverty, and established a philanthropic charity, The Sharma Foundation.

If you would like to know more about her humanitarian efforts, email info@seemasharma.co.uk.

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The specialist division brings together minimally invasive protocols and training, with experience and in-depth knowledge of the industry’s latest products and techniques. In addition Henry Schein Minerva are also organising a programme of education courses throughout 2010 designed to help you maximise the potential of your new equipment. Henry Schein Minerva is your specialist in digital and laser dentistry.

Hi-tech dental has a vital role to play in driving the profession forward to meet the ever increasing demands of patients. Now you can meet these demands with the help of one company – Digital Dental will provide specialist advisors, installation and service support for the full range of equipment and Henry Schein Minerva’s finance packages can help ease the process of funding.

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2010 DENTSPLY / BDA Student Clinician Programme

The 3rd DENTSPLY / BDA Student Clinician Programme Award has been another successful event and an opportunity to celebrate the investment being made into the future of dentistry.

DENTSPLY is proud to sponsor this prestigious programme, which gives students a valuable opportunity to gain research experience in this field of dentistry.

The winning entry came from a student who is studying at Manchester Dental School. Lisa Drummond is working on a new embryonic stem cell line exhibiting de novo promoter methylation of the metastasis suppressor E-cadherin. She will be the first in an all-access paid trip to Orlando, Florida, to attend the American Dental Association’s Annual Conference. She also becomes a member of SCADA, an international association of student clinicians.

Both the BDA and DENTSPLY would like to extend their gratitude to the contributors made to the lottery networking event. Professor Davis, President of the Student Clinicians of the American Dental Association (SCADA); Dr Linda Henderson, DENTSPLY’s Vice President & Chief Clinical Officer; and Dr John Drummond, President of the BDA.

For more information, or to book an appointment with your local DENTSPLY Product Specialist, call 0800 072 3313 or visit www.dentsply.co.uk

Another new ultra-slim insert innovation from the UK’s leading manufacturer

The THINsert™ insert is 40% slimmer than the Slimline inserts. It is to remove biofilms and is suitable for use on smooth surfaces and with light tissue attachments without losing any tactile sensation.

DENTSPLY’s currently offering a promotion on Cavitron inserts, buy any 4 and get 1 free (send a copy invoice to DENTSPLY – please see web site for address). Why not try the new THINsert?

For more information, or to book an appointment with your local DENTSPLY Product Specialist, call +44 0800 072 3313 or visit www.dentsply.co.uk

Topdental Donate 120,000 Wipes

Topdental (Products) Ltd, one of Europe’s leading manufacturer of high level disinfection wet wipes has donated 120,000 of those surface disinfection wipes towards existing the plight of the unfortunate people of Haiti. The wipes will be used to help combat the growing concern for the spread of the infection in the area.

The goods are being sent on a special cargo plane via Luxembourg to Cap-Haïtien in the North of the Island. Fortunately this hospital was not badly affected by the earthquake and it is now helping to treat the wounds of the current population of 1,000,000 people.

The steps were of particular interest as they have been tested to new Phase II guidelines which enables them to be used in surgical operating theatres as well as general areas requiring high level disinfection as per HTM 01-05 from the Department of Health.

For more information contact Tara at 01733 779706 or visit our website www.kemdent.co.uk

Dental haha - One of the British Dental Care Practice has received today that PCTs to clear part or all of a minor oral surgery waiting list within a fixed period.

The organisation can arrange for a state-of-the-art mobile dental operating theatre® to be up and running in a suitable location within 6 weeks to allow PCTs to help ease the pressure of the waiting list.

The service can be set up with minimal trouble to the PC as Dentsply’s and Vuceran’s hospital grade operating theatres can be set up at any time of the year. The area is required to accommodate the mobile unit until the service is established. The service will be available as part of a temporary or interim service while a longer-term solution is being commissioned.

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Phonic®, which has been nominated for the ‘Top Curing Light of the year 2010’ by the independent US testing institute “The Dental Advisor". This is the second award within a year for Phonic®, which has been awarded the “Top Curing Light” title.

The testing institute describes Phonic® as follows: “This is a great light!” “It’s great to have one light that cures everything!” “The light design and power are great!”

An award we are proud of

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Managing your reputation
We’ve been reviewing hotels and appliances for some time but only recently have we started to review our visit to practices. Patients are going to review you and your practice using the Google review tool and there’s nothing we can do about it – is there?

Yes and no. Whilst we can’t stop patients leaving feedback, we can recover some control. Last year, Dental Design launched www.dentistfinder.net – an online review site. By embracing the concept and registering on DentistFinder not only can you e-mail review requests to patients, you are advised when a review has been left – allowing you to respond. The more positive reviews you receive, the better your online reputation.

Staying ahead of the game
Madeira Dental Practice has been a loyal customer for almost 10 years. During this time we have undertaken three redesigns, a re-brand and several search engine optimisation reviews. Whilst you may argue that you can’t afford a re-design, to update literature or increase your SEO spend, the truth is, you cannot afford not to.

20% discount
We are offering a 20 per cent discount off all our services to celebrate our 10 years in business. This offer is only available in March so don’t miss out. Call now on 01202 677 277 or visit www.dental-design.co.uk and benefit from a discount on all our services.

29 Advertorial March 8-14, 2010 United Kingdom Edition
Orthodontic Week
This new annual event organised by the British Orthodontic Society launches in London

The British Orthodontic Society has announced that the first-ever National Orthodontic Week (NOW) will be launched on March 22, 2010. The aim of the week is to create a cohesive vehicle for all providers of orthodontic treatment to come together and communicate a strong and well-informed message about orthodontics to the public and to the wider dental profession.

This will be an annual event, which it is hoped will encourage enquiries and dialogue about orthodontics; will highlight the expertise of the orthodontic profession; will educate patients about the various types of treatment and will clarify what can be expected from treatment.

The launch of NOW will take place at The National Portrait Gallery on March 22, 2010. NOW initiatives will be announced during a private viewing of the Irving Penn celebrity portrait exhibition. Penn was famous for taking the photos of the most glamorous faces in Hollywood and he worked for many years for Vogue magazine creating some of the most iconic images of the 20th century.

Do it NOW
The BOS is making the announcement of NOW to give the profession plenty of time to gear up for the event and make preparations for local and practice initiatives which will benefit them and their patients. A new website www.nowsmile.org has been created and dental professionals are being encouraged to log on to NOW to find out how they can get involved with the campaign; download free material for their local press. Also available will be an expanding menu of suggestions about ways in which practices might want to run NOW promotions in their area.

Promote the week
A range of more than 20 promotional items and clothing featuring the NOW logo for practices to use to promote the week are available from the NOW website and five per cent of all sales will be donated to the BOS charitable Foundation, which supports research and education in orthodontics.

In January 2010, a YouGov survey was conducted, which aims to discover consumer attitudes to their mouths, their smiles and the potential of orthodontics and the results will be announced at the launch.

A large part of the site is aimed directly at informing the public. It provides the opportunity for patients, potential patients and their families to find an orthodontist in their area; to access 12 information leaflets produced by the BOS; to read some inspiring stories about how orthodontics has changed peoples lives and to win a digital photograph frame (on which perhaps to display their beautiful new smiles!).

To cap it all, the new and burgeoning group of Orthodontic Therapists has been encouraged to join forces to launch a charity initiative at the start of NOW week, which it is hoped will benefit the wider community who need special dental and orthodontic treatment.

Chairman of the British Orthodontic Society Dr Nigel Harradine commented: “This is the first time that a campaign has been created in the UK to encourage all providers of orthodontic treatment to act together to communicate the current scope, current treatments and real potential benefits of orthodontics to a wider audience. I would urge BOS members and the wider dental professional to find out how they can get involved with NOW and benefit from the creative range of initiatives which have been developed by the BOS to help them and their patients”.

To participate in National Orthodontic Week or to find out more, visit www.nowsmile.org.
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