Pupils to get free toothbrushes in Wales

Children in Wales aged between three and five will be given free toothbrushes and toothpaste to stem unacceptable rates of dental decay. The programme called Designed to Smile will also teach children the right way to clean their teeth.

Schoolchildren in north Wales and parts of south east Wales will be targeted first in pilot projects. Launching the scheme Welsh health minister Edwina Hart said: ‘Rates of tooth decay in Wales are unacceptable for what is almost a totally preventable disease. Some of our children have some of the worst teeth in Europe. We need to reverse the trend if we are to meet our dental health and child poverty targets.’

The minister said the tooth-brushing schemes would provide children with the tools they need to develop and maintain good oral health from an early age. She added: ‘We intend to work towards every child being provided with free toothbrushes and fluoride toothpaste.’ Older children aged six to 11 will also be given advice on teeth cleaning. A total of £4.6m is being put aside for this project.

Professor Ivor Chesnutt, from Cardiff University School of Dentistry, said there was lots of evidence to show regular tooth-brushing was ‘crucial’ to good oral health. ‘We know that for many children at greatest risk of dental decay, cleaning their teeth or having their teeth cleaned does not form part of their daily routine,’ he said.

More than half of all five-year-old children in Wales have some tooth decay - rates are highest in deprived areas and experts say that some children in Wales have ‘never seen a toothbrush’. In Blaenau Gwent and Merthyr Tydfil, children have an average age of four, decayed and filled teeth by the time that they are five, compared to less than two areas in such Ceredigion and Monmouthshire.

But the British Dental Association said the scheme does not go far enough and children should also be taught how to use fluoridated mouthwashes properly.

The Brushing for Life project targeted the 21 health authorities with the highest levels of dental decay - 11 in the North West, five in Yorkshire and five in London. As part of the project health visitors gave out free packs including a toothbrush, toothpaste and leaflets to the parents and carers of young children, demonstrated correct tooth-brushing techniques and gave oral health talks in nurseries and playgroups.

In recent evidence to the House of Commons Health Committee chief dental officer Barry Cockcroft said: ‘We have a scheme called Brushing for Life which is linked to Sure Start where in some areas PCTs buy packs that we provide and then they are distributed through the Sure Start network with some oral health advice as well. The take up is very good in some areas and we need to do more of this. We re-launched the scheme a number of years ago and we are pushing that very hard in local communities.’

Access stories from around England
Greek solution

George Kiosses, a Greek dentist, believes he may have the answer to a shortage of affordable dentists in the Great Yarmouth area. He has set up a new private practice there but says his ‘subscription membership scheme’ is ‘very reasonably priced’.

Derbyshire rescue

New NHS dental practices are to open in Derbyshire as part of a £5.3m investment. Two new surgeries will be opening in April and May to treat patients who have previously struggled to find an NHS dentist.

Poor advice

Report comes from Maidstone of a patient seeing an ‘NHS dentist’. She was told the work she needed to a painful tooth would cost £250 even on the NHS (some mistake surely), but in any case the dentist did not have the skills to carry out the job, nor did he think any local NHS dentist would have the necessary equipment. He advised her to look for private treatment.

Turned away

A heavily pregnant woman was turned away from her dental check-up in Preston. When she arrived for her appointment, the six-months pregnant mum was shocked to be told her NHS dentist could no longer see her as the surgery had already dealt with too many NHS appointments and had reached its quota.

Devon despair

An Exeter mother is at her ‘wit’s end’ as she desperately searches for free dental treatment in the city for her young children. Samantha Harry has registered her four children with four dental practices over the last five years only to be told after about a year of treatment that they are no longer taking NHS patients.

Cancer sufferer

A cancer patient has been forced to pay for private dental treatment as there are no NHS dentist places left in Rochdale. He told a local paper: ‘The only advice (from the PCT) I was offered was to keep trying by constantly ringing around dentists randomly in the forlorn hope that they may have had a cancellation.’

Simply the best?

Don’t be fooled that there is such a thing as the ‘best’ profession plan. Retirement planning depends on your circumstances, says Ray Prince

Money matters

What do patients think?

There are many benefits to involving patients in research says Dr Susan J Cunningham from orthodontic department Eastman Dental Institute

Forensic dentistry

An interview with forensic dentistry specialist professor David K. Whittaker, of Cardiff University Wales

Who will pay your bills if illness or injury stops you working?

Flexible Income Protection

Easy way to bridge

To find out more, call 0845 244 9999 or visit www.dentalnews.co.uk
The new dental contract - full of holes and causing pain?

On March 6, the Patients Association launched a survey which asked Primary Care Trusts in England how they are responding to the new dental contract and the needs of their patients.

The Association sent a questionnaire to each of the 150 Primary Care Trusts (PCTs) in England, under the Freedom of Information Act. A total of 112 questionnaires were returned giving a response rate of 75 per cent. In summary:

• The majority of PCTs say they are satisfied with the level of funding and the latest increase. Most confirm that the funds are ring fenced.

• But: PCTs complain there is widespread lack of funds for orthodontics and other specialist treatments.

• There is increasing concern for the preventive role of dentistry in detection of oral health disease.

• Patients are confused about the new contract, new charges and NHS availability – complaints have risen.

• PCTs now commission dental services for their area, but the results reveal a lack of creativity in commissioning.

• There is confusion about the commissioning role of PCTs.

• The mixed bag of access to services, emergency and out of hours care, and preventative campaigns revealed in this survey ‘does not constitute a national health service for dentistry'.

The mixed bag of access to services, emergency and out of hours care, and preventative campaigns revealed in this survey ‘does not constitute a national health service for dentistry'.

Funding

All PCTs said that funding had either been ring fenced or floor funded – in practical terms the same thing, but two of them said funding had been transferred to other services, but less than ten percent of it.

Asked what services they found difficult to fund. Most cited orthodontics and other specialist care. Compared to the previous year, the vast majority of PCTs indicated an increase in their dental funding in 2007/2008 on average 4.4 per cent increase on the previous year. The majority of PCTs were generally satisfied with their dental funding (57.9 per cent).

The Patients Association were critical of the response that only just over a third (57 per cent) were using their funding to attract new dentists to their area, but out of the additional money the PCTs had to fund an increase in contact values which will have taken most of the increase. This also explains why nearly three quarters (70.2 per cent) of PCTs said that they used less than 10 per cent of their dental budget to attract new dentists.

Access to NHS treatments

The survey showed up some confusion about what ‘access to NHS dental care’ means. In answer to one question the PCTs said that, on average, 1.5 per cent of their population remained without access. On the other hand only around half of their population ‘were currently receiving NHS dental care’.

The Patients Association found these responses incompatible, but the discrepancy is probably due to the fact that not all people who are without a dentist actually want one.

For figures for dentists who have left the NHS reflect previously published Government data. The vast majority of PCTs (92 per cent) said that fewer than 10 per cent of dentists had left the NHS entirely; 81.9 per cent of PCTs indicated that they allocated less than 10 per cent of their dental budget to attract new dentists.

Treatments offered

PCTs were asked if they were aware of any particular treatments ceasing to be offered by NHS dentists and 51.5 per cent of PCTs confirmed they are aware that this was happening.

They reported reductions in the following treatments:

• Root canal work - 89.7 per cent
• Braces - 51.7 per cent
• Dentures - 57.9 per cent
• Crowns - 27.6 per cent
• Dental extractions - 5.5 per cent
• Other 17.2 per cent: included periodontal treatments and domiciliary care.

On orthodontic treatment, the Patients Association commented: ‘This is an area of dentistry which falls increasingly into private care despite its expense. Child patients requiring orthodontic treatment need it without delay. The NHS scheme, using a scale of severity, allows only the most severe cases to be dealt with. Yet nearly half (46.4 per cent) of PCTs indicated that they allocated less than 10 per cent of their dental funding to orthodontic treatment.

It ‘is open to question how the small sums allocated to orthodontic treatments square with the state- ment in the evidence that this was happening.

Other PCTs adopt a more informal approach, merely giving advice to new practice owners on the content of the contract.

The average Unit of Dental Activity (UDA) value is of £22.90. Asked if they anticipate harmonising UDA values across the PCT area in April 2009, 62.2 per cent of PCTs said they had no such intention.

About three quarters (76.5 per cent) of PCTs indicated that they permitted dentists to have child only contracts. Of those that did 55.5 per cent anticipated continuing permitting dentists to have NHS limited contracts after April 2008.

Only four per cent of PCTs had agreed any uplift of fees locally for endodontic treatments following the recent ‘single use in instruments’ advice.

The Patients Association have acknowledged an educational grant from Denplan, which made work on the survey possible. As a result of the survey the Patients Association has called on the Government to:

• Examine the co-payments system for dentistry as the basis for expanding the availability of treatments elsewhere in the NHS.

• Ensure early diagnosis of serious oral illness e.g. cancer by giving patients the same level of prevention and early detection abilities in the NHS. Primary Care Trusts (PCTs) must offer a full and complete NHS dental service to their population, which was intended to be a main benefit of the new contract.

• Remove the postcode lottery for patients which results from poor or weak commissioning by PCTs. Where PCTs offer an excellent, creative commissioning structure, they should take over the dental commissioning role of those that do not. Renewed guidance on best practice in commissioning should be issued.

• Require PCTs and dentists to ensure patients are fully aware of the important changes to their NHS dental care, thereby minimising patient anxiety and financial waste.

• Ensure the same level of coverage and availability of specialist treatments, e.g. root canal, orthodontics, as applies to other specialists in the NHS.

• Require PCTs to ensure dentists comply with latest infection control guidance.

The average Unit of Dental Activity (UDA) value is of £22.90. Asked if they anticipate harmonising UDA values across the PCT area in April 2009, 62.2 per cent of PCTs said they had no such intention.

About three quarters (76.5 per cent) of PCTs indicated that they permitted dentists to have child only contracts. Of those that did 55.5 per cent anticipated continuing permitting dentists to have NHS limited contracts after April 2008.

Only four per cent of PCTs had agreed any uplift of fees locally for endodontic treatments following the recent ‘single use in instruments’ advice.
Mr Justice Collins delivered his split verdict in this case at the end of February, finding in Eddie’s favour on one point, but against him on the other. The case has now stimulated comments from the Department of Health (DoH) and the British Dental Association (BDA).

The BDA was ‘delighted’ that Eddie Crouch had won his case against an unreasonable clause inserted into his Personal Dental Services (PDS) agreement with South Birmingham primary care trust (PCT). The PCT had changed the model contract to give it the right to terminate his agreement for no cause at any time and on notice that it could determine.

The BDA supported Dr Crouch’s case because of the consequences losing may have had for all dental contracts. It says it ‘committed significant resources’ in support of this element of the claim and believe that its submissions materially assisted his victory. The BDA did so because it believed not only that the PCT had misinterpreted the regulations, the model contract and the guidance, but that the clause ‘did not reflect the policy intention of the Department of Health’.

The DoH has also issued guidance to PCTs about the case. It said that Mr Crouch had ‘challenged the legality of a clause in his PDS agreement allowing the PCT to terminate the agreement at any time’. The DoH had supported the PCT in Court and continues to maintain that the PCT had always had the right to insert this clause but, in effect, the judge had moved the goalposts, by re-interpreting the PDS regulations.

The DoH says PCTs were ‘required’ to include such a clause allowing them to terminate an agreement without a reason provided they gave notice. There was, of course, no such talk before the contract started when the Department of Health was at pains to reassure dentists that contracts could only be ended by a PCT if there was a good reason. But of course in those days they wanted people to sign up to it.

The BDA did not support Eddie Crouch in his second point, which was lost, that the PCT had a responsibility to hold a public consultation exercise or needs assessment prior to awarding contracts. It took this action on the advice of a QC. The BDA’s Executive Board points to the ‘very significant costs the Association has devoted to legal review of the 2006 changes’. The Board did not consider that it would have been a ‘proper use of members’ money’ to have sought judicial review against the Department of Health for the whole of the 2006 changes and the way that they were implemented.

BDA members may well ask what is a ‘proper use’ of their money if it is not to support them in their struggles with the Department and challenge the legality of this unpopular contract even if there is little prospect of winning the case. At least the profession would know where it stands.

The Eddie Crouch case continues outside court

**Leading the way to a brighter future**

In the current economic climate of money market uncertainty, the ongoing PCT funding and contract saga, your practice management and business skills will need to be fit for the future.

Maximising your income and minimising your costs in every area of your practice will be key to success in the difficult times being forecast.

However, you can stay one step ahead of those additional challenges at the same time as improving your business and, safeguarding your future.

It’s so easy to do with our market-leading practice management and new business software.

**NEW**

**KODAK Back Office Business Software**

**&**

**KODAK R4 Practice Management Software**

Packed with more features than any other Dental Software, designed to make a significant contribution to the success of your practice and your business.

**Offering security in an uncertain world**

For further information or to place an order telephone 0800 169 9692 or visit www.practiceworks.co.uk
GDP-UK round up

Tony Jacobs rounds up the latest issues from his growing GDP-UK emailing list. The HSC inquiry has been widely discussed and illegal dentistry by beauticians continues to pose a worry.

The Health Select Committee (HSC) inquiry into dentistry has been an excellent place for thought and comment on GDP-UK of late. In the past, colleagues have shared insights and read the pages of dry evidence, questions and answers between committee members and the inquiry group. It’s always sought to improve the evidence base and its part purchase of IDH made a practice where there was a unique CDO contract not piloted elsewhere. In evidence, the Department of Health continues to state that the pilot PDS schemes were used to draw conclusions. As a result, some of the features of the features are being discarded.

Colleagues in the GDP-UK group also discussed the pros and cons of running an in-house payment plan for their practices. Many colleagues have done this themselves, and continue to manage the processes, while others are happy to use a service provider.

A further issue highlighted was a very carefully worded debate about ‘highly profitable associates’. Colleagues were cautious in how they addressed money saving benefits to being a member, which is free. GDPUK is always seeking to improve the benefits to members.

High costs and long waits are forcing patients to go abroad says survey

Record numbers of British patients are travelling abroad for medical and dental treatment because of the high costs, long waits and infection risks of care in Britain, according to a survey conducted by the agency Treatment Abroad. The growth in medical tourism is being fuelled by cut-price private treatment, offered in combination with package holidays to exotic destinations including South Africa, South America and Malaysia. An estimated 100,000 people travelled abroad for treatment in 2007, up from 70,000 in 2006.

High costs and the difficulty of finding an NHS dentist have made dental tourism the fastest-growing category of medical tourism, with Hungary the most popular destination for dental treatment, offered in combination with package holidays to exotic destinations including South Africa, South America and Malaysia.

Almost two thirds said they had chosen to go abroad to avoid NHS waiting lists and more than half said they were worried about hospital infections.

British medical and dental organisations warn that providing follow-up care for patients treated abroad is more difficult and complain that British doctors are increasingly having to sort out complications from treatment provided elsewhere. They say standards of training, regulation and infection control may all be lower than in the United Kingdom.

The European Commission is expected to publish draft plans which would open its borders to medical tourists, allowing citizens of any of the 27 member states to seek treatment in a neighbouring country with their home country, in certain circumstances, picking up the bill. If the proposals are approved, the expansion of choice will focus on the performance of the health systems on the Continent.

A spokesman for the Department of Health said: ‘The vast majority of those who travel abroad for treatment do so for genuine medical reasons, not because of the NHS, and the numbers doing so are a tiny fraction of the 550 million patient treatments the NHS carries out each year.’
Denplan receives Sunday Times award

For the fifth consecutive year Denplan has risen through the ranks of the ‘Sunday Times 100 best companies to work for, 2008’ listing, for mid-sized companies. At the awards dinner held at Battersea Park Events arena, London, hosted by the BBC’s Fiona Bruce (on February 28) Denplan again moved up the listings to secure sixth position – a rise of two places from 2007.

Steve Gates, managing director said: ‘These awards are a real testament to the team here at Denplan, which continually rises to meet the exciting challenges facing UK dentistry today. As the organisation’s leader it’s hugely gratifying to know that Denplan commands such high levels of commitment and loyalty from its employees without compromising their work-life balance. This winning attitude is the key to our success as a leading provider in our field.

‘Dentists nationwide recognise how they too benefit from this ethos, which makes us the number one choice for those looking to move into private practice. Five years ago we entered on year on year we’ve continued to rise. This is our highest position yet and a great achievement. My thanks go to everyone at Denplan for expressing their views so positively and making it such a great place to work.’

The ‘Sunday Times 100 best companies to work for’, for mid-sized companies, is open to all companies in the UK employing between 250-5,000 people and is designed to distinguish between ‘the good and the most outstanding companies’.

Based in Winchester, Denplan employs over 300 people and provides products and services to over 6,500 member dentists and 1.8 million patients, nationwide.

Hove practice faces massive clawback

B osses of an award-winning dental surgery say they may have to close because of their NHS contract problems. The Toothsmart surgery, in Portland Road, Hove, has stopped treating NHS patients. Colette Murphy, who runs Toothsmart with husband Zoy Erasmus, says the practice has been struggling to break even since the Government introduced the controversial dental contract in April 2006.

Mrs Murphy told a local newspaper that the primary care trust (PCT) had told them that there is no problem with access to dental care, yet the figures show fewer people are visiting the dentist. ‘We have been working flat out and have not had a holiday, yet are struggling to break even. It cannot be right,’ she said.

Mrs Murphy is in dispute with the PCT, which says the practice owes £90,000 over work which has not been carried out. She said: ‘The PCT pays surgeries for the work at the start of the year, but because our targets are unrealistic we simply cannot do all that work. If we have to pay those clawbacks we will eventually have to stop treating NHS patients and close half the surgery, because it is simply costing us too much to keep treating people on the NHS.’

About 6,000 fewer adults and 900 fewer children have visited NHS dentists in Brighton and Hove since April 2006. A spokesman for Brighton and Hove City Teaching PCT said: ‘There are NHS dental places widely available in the city now, and if this practice moves away from NHS dentistry we would use the money to provide replacement NHS places at other practices instead. The NHS dental contract gives practices an agreed amount of money in exchange for an agreed quantity of treatment. This quantity was agreed with each practice on the basis of the activity levels it had been delivering previously.

‘When a practice delivers less activity than it had contracted for, we ask it to refund the money it has been paid for the proportion of work it has not done. The Toothsmart practice provides excellent care to its patients and we want to see that continue. We have been working intensively with the practice to help it find a way forward, but have not yet agreed a solution.’

Rogue salesmen using scaremongering tactics

The local Strategic Health Authority (SHA) has taken the unusual step of issuing a statement reassuring patients that NHS dental services remain widely available in the North-East. It follows reports that door-to-door sales staff have been trying to get members of the public to sign up to private dental policies by telling them that it is difficult to get an NHS dentist in the region.

According to the SHA, access to NHS dentists in the north-east is the best in England. A recent report from the Information Centre found that 61 per cent of adults in the north east had visited a dentist in the last two years compared with 52 per cent nationally, while 59.5 per cent of adults and 75.9 per cent of children in the region had seen an NHS dentist at some point in the 24 months leading up to 30 June 2007. A spokeswoman for the SHA said: ‘If people are approached, they are advised to get in touch with Trading Standards.’

Professor Jimmy Steele, of Newcastle University Dental School, said: ‘That is quite shocking. It seems that people have been employed to generate business in this way. They are scaremongering, playing on people’s fears.’ While there was a ‘widespread belief’ that it was difficult to get an NHS dentist in the North-East, Prof Steele said he thought this was untrue.

The North-East SHA’s dental adviser, David Landes, said it appeared there was a ‘rogue’ sales agent or salesman who had been operating in County Durham and South Tyneside. While Mr Landes conceded that in some areas of the region NHS dentistry was ‘not as good as the NHS would like’ and that some people in rural areas had to travel to get treatment, he said people were still able to see an NHS dentist.

A spokesman for the Association of British Insurers said the sale of any form of insurance was strictly regulated and advised anyone who was unhappy not to sign any documents and to get in touch with their insurance company’s head office.
Minister lightly grilled by committee
Minister and CDO perform an unusual double act before the Health Select Committee

Traditionally the responsible minister gives the final evidence before a select committee, to answer or avoid questions that have arisen in other evidence sessions.

As health committee chair-man, Kevin Barron, told the minister Ann Keen, when she appeared before him on March 6, ‘Most of the questions that are going to be asked today are going to be directed you,’ although he said she might wish to ‘field them on occasions’.

Taking the catches that day were chief dental officer (CDO) Barry Cockcroft and civil servant, David Lye. Despite the chairman’s wishes most of the questions were ‘fielded’ by the minister’s supporters rather than by her. This gave the unfortunate impression of a minister unsure of her facts and not in charge. This was compounded when the CDO referred to her as ‘Ann’ rather than ‘Minister’.

One committee member challenged the minister to accept that ‘some PCTs are actually currently incapable of properly commissioning dental services’. Ann Keen thought ‘incapable’ was a bit strong but she agreed that there was ‘very, very strong evidence that some PCTs need much more support’.

Another raised the issue of a quarter of a million fewer patients received NHS care in the first year of the contract; which meant the new the new arrangements were a failure. The minister deflected this to the CDO who said that the full effect of opening new practices would not show for two years after their opening. There was much questioning about access, waiting lists and workforce planning. The CDO said there was ‘no workforce shortage and there are enough people who want to provide services if the PCTs offer them for tendering’.

Another issue raised by a quarter of a million fewer patients received NHS care in the first year of the contract; which meant the new the new arrangements were a failure. The minister deflected this to the CDO who said that the full effect of opening new practices would not show for two years after their opening. There was much questioning about access, waiting lists and workforce planning. The CDO said there was ‘no workforce shortage and there are enough people who want to provide services if the PCTs offer them for tendering’.

Another issue raised by committee members was the department’s relationship with the profession which had ‘certainly not been good’. The minister said she had had a very good meeting with the BDA. She wanted to work with the BDA along with other professions related to dentistry in ‘the same way as I work with every other part of the NHS’. She continued: ‘We do recognise the professionalism of a dentist, the quality of the work they do and also, by us having regular oral checks, other more serious conditions can be diagnosed by the dentist and the rest of the oral health care team’.

The independent MP Dr Taylor feared he was living on a different planet from everybody else’. Dr Cockcroft had said he got no negative vibes, but the MP found that every time he sat in the dentist’s chair he got negative vibes all the time, mainly centered around Units of Dental Activity (UDAs). The committee had heard suggestions for change in the system, but the CDO said what was needed was to ‘let it settle down as it is’.

There was much questioning about UDAs and also the removal of patient registration, something that the committee appears to believe should be re-instated. Whether such ideas appear in its final report however, remains to be seen.

Take the future into your own hands
Sirona’s new XIOS intraoral sensor system

• Precise digital image quality within seconds
• Slim sensor design with smooth contours
• Innovative XIOS sensor holders are smaller than the sensor
• Comfortable for the patient, easy for the practice team

XIOS is fully portable between treatment rooms

Telephone: 079 507 51040
e-mail: info@sironadental.co.uk
www.sironadental.co.uk

The Dental Company

Sirona.
Concern grows in USA over lead in crowns from China

A n Ohio woman has claimed that high levels of lead were found in her dental crownwork, which, she says, was made in China. She had received a three-unit dental bridge and after having an adverse reaction to her dental work, and having it removed, her dentist disclosed that the work had been sent to a dental laboratory in China.

The patient then had the restoration sent to a chemical laboratory for analysis. The documentation of the dental material analysis of this patient's restoration showed unsafe levels of lead in the porcelain on the restoration. In the wake of this report, the American Dental Association (ADA) has issued a warning.

The ADA says there is no appropriate use for lead in manufacture of dental prosthetics, and the association is working with the federal regulatory agencies and the dental laboratory industry to 'determine the specifics' of the incident and determine 'whether it is an isolated case or indicative of a larger problem.'

In a statement, the ADA says it is informing all member dentists about the news reports, and it has contacted appropriate federal authorities, including the Food and Drug Administration and the Centers for Disease Control and Prevention. 'We have begun our own investigation into the safety of both foreign and domestically produced dental crowns and other dental prostheses,' it says. 'However, our investigation should not be viewed as a substitute for necessary oversight and enforcement by the federal and state government agencies responsible for protecting the public's health and safety.'

The ADA adds that it is taking the reports 'very seriously,' but there simply isn’t enough information available to presume that the presence of lead in dental crowns or other prostheses is widespread. Only 15 to 20 percent of dental prostheses used in the U.S. come from foreign labs, and China accounts for only part of that share. The Association advises patients to discuss any concerns about the safety of their dental crowns or other prosthetic devices with their dentists and suggests questions that could be asked.

UK response

The story aroused the interest of the UK media. Richard Daniels, the chief executive of the Dental Laboratories Association, (DLA) told the press that the number of potentially dangerous imports was rising. 'At this point nobody knows what the health risks are,' he said. 'The fact is the majority of NHS work will be coming from China or India in the next five years. We need to be moving towards proper regulation of the industry. It isn't just a matter for the NHS either - many of the big corporate groups also have agreements with factories in China to make their fixtures.'

David Smith, a board member of the DLA, said: 'The worst case scenario is we'll end up with a large number of people in the UK with mouths full of lead and they've got no idea that that's the case. In theory what happened in America should never happen here as there are regulatory bodies which should prevent these problems in the UK.

'But the truth is, if the situation isn’t addressed then it is only a matter of time before there is a similar case as in the States. We’ve watered down all the rules in such a way that you could drive a bus through them. In the end, the whole system is profiteering. Any savings made by outsourcing the work to China are never passed on to the patient.'

News from ADA at San Antonio, Texas

Debuting at the 2008 ADA Annual Session in San Antonio, Texas, the ADA is building an interactive, educational center at the San Antonio convention center for its attendees. The Live Operatory Center, will take place in the Gallery; a 15,000 sq. ft. area located in the exhibit hall, adjacent to registration. In the Live Operatory Center, attendees experience emerging technology in a hands-on environment that will provide them with assistance in their daily diagnosis and treatment planning.

The Live Operatory Center is a unique blend of product training and continuing education. This high tech environment is the first of its kind in the dental meeting arena and will allow attendees to earn up to 3.5 hours of continuing education (CE) credit for their attendance in three disciplines, while being exposed to the latest technology and products on the market. The ADA's goal is to provide attendees with knowledge that they can use as consumers on the exhibit floor, and skills they can take back and implement in their practice.

All dental procedures and patient demonstrations in the area are displayed on multiple 60-inch flat screen monitors, featuring detailed images collected from inner-oral cameras and hand-held camera operators. This high-tech, cutting-edge center will be divided into three distinct educational disciplines:

- The Laser Pavilion
- The 3-D Imaging Center
- The CAD/CAM Stage

The Laser Pavilion: Working together, the ADA and the Academy of Laser Dentistry, have designed a new model for educating dental professionals on the safe and effective use of laser technology and the benefits of adding lasers to their practice. The Laser Pavilion takes up roughly one-half of the Gallery and is divided into two separate rooms: a lecture room; and a workshop room. Forty participants at a time will attend a 45-minute lecture, immediately followed by a 75-minute hands-on workshop. This design will allow the Annual Session to accommodate 500 attendees between Wednesday afternoon and Sunday. The cost per person to attend the course will be $895.

The 3-D Imaging Center: In 2007, the ADA conducted live patient scanning with four 3-D imaging machines in one of the Education in the Round (EIR) classrooms. This was the first time this type of demonstration had ever been done at a major medical meeting.

For 2008, the ADA is expanding this program and moving the 3-D imaging to the Live Operatory Center. The 3-D Imaging Center will encompass ½ of the Gallery and feature four of the companies that participated in 2007, along with two new companies for 2008. Lead lined glass protection shielding will be built in the Gallery and will remain up during the duration of the Annual Session. This will allow for a five-day exposure to 3-D imaging for attendees, as opposed to one day in 2007. In addition, the ADA will have the opportunity to accommodate six machines, as opposed to four in 2007.

CAD CAM Stage: The remaining ½ of the Gallery will have two mini-theaters with seating for 40 people in each. One theater will house the equipment for the CEREC system from Sirona and the other will have the E4D system from Schein. Attendees will have the opportunity to attend a 30-minute presentation on CAD CAM dentistry from each company, which will include full demonstration of the making of a crown from the point that the prep is done and conclude with the delivery of the crown on a typodont.

The Preliminary Program and online registration and housing for the Annual Session will both be available in April at www.adaa.org/goto/session. International dentists who join the ADA as affiliate members received a special discounted registration to the Annual Session. Contact the ADA by e-mail, international@ada.org, or call +1.512.440.2726 for more information.

For Patient Treatment, there is only ONE place to go.....
The importance of induction

Induction can be defined as an introduction or initiation, or the act of carrying these out. Unfortunately it is observed more often in the breach than in the act. It gives a great deal of thought about selecting a person to fill a vacancy, but not enough to ensure the right person's attendance and entry to the practice is a smooth comfortable process. Is it sufficient to say, ‘Welcome to the practice, I hope you will be happy here’ – if you have any problems give me a call? I don’t think so!

I’ve recently read a management handbook called Excellent Employment, but regrettably the author fully bears out my point. More than a hundred pages are dedicated to the selection process, and then a half page to induction, which, even if the ultimate in brevity, is worth quoting in full: ‘Once you have found your amazing new recruit with the fabulous attitude and all the skills you required, don’t abandon them. Finding great people is only a small part of the employee equation; you have to find a way to retain them. Think back to those times when you took on a new job. Was there an induction programme or were you just left to work things out for yourself? Were you given a buddy or mentor, someone to look after you during that first week or so, or were you left to get on with it alone? Did anyone sit with you at regular intervals during your first three months to tell you how you were progressing, or were you left to guess?’ That was it.

In writing a skill required by you average dentist in practice? Not really. If one doesn’t have the necessary skill, one can buy it, but it don’t come cheap! Being able to write decently however is a great gift, and used intelligently, can be invaluable in disseminating information. At its best, we need to be able to write up our treatment plans in a legible and coherent manner so that our patients will be encouraged to take up the treatment offered.

As Bonner says, “A common failure is the not treatment carried out in a manner not only legible and coherent manner so that our patients will be encouraged to take up the treatment offered. Very good, but only a hint of a taste, let alone even one course of a meal.

Who needs induction?

All of the following should be subject to an induction programme:

- All full-time, part-time, and temporary employees
- Those returning to work after a lengthy absence
- Temporary staff
- Work-experience students (with one should do a risk assessment with school or education authority)
- External contractors such as builders

Purpose of induction

1. Should never assume levels of competence in respect of skills, including infection control, health and safety, personal protection, managing radiation, and managing emergencies.

2. Effective integration
3. Retention of new staff
4. Creates opportunities to communicate and establish policies and procedures
5. Demonstrates who is responsible for what, sources of advice, and lines of responsibility
6. Demonstrates the mission and values and objectives of the practice
7. Creates an understanding of organisation culture
8. Assists with managing attitudes and behaviours
9. The induction period enables the new employee to learn quickly whether he/she wishes to remain in the job
10. By complying with legislation, which a proper induction process obliges one to do, the risk of later litigation and prosecution significantly reduced.

Structuring induction

Pre-employment starts with offer-of-employment letter, involves learning, enables preparation; health & safety policy statement;

Initiation and employment on probation: One should appoint a competent “buddy” to mentor the newcomer, who should also be encouraged to shadow other employees. Induction includes a specified probationary period during which the new employee has a formal opportunity to learn enough about the practice in order to become a fully-functional member of the team in the shortest time possible. It begins with assigning the ‘new’ employee the responsibilities of becoming familiar with the practice manual (assuming this exists!). The purpose of the manual is to provide the foundation and principles on which the practice is established and defines the boundaries or scope of its operation, its policies and procedures. During this period the employee will learn the likes and dislikes of the employer and other members of staff and also of the patients.

Post-probation: this is based on periodic reviews – are aims and objectives being achieved? The purpose is to identify further training needs.

Lack of induction leads to

1. Lack of understanding and responsibility
2. Low motivation
3. Low morale
4. Increased complacency
5. Inefficient, ineffective and unsafe work practices
6. Failure to work to full potential
7. Mistakes leading to accidents
8. Unsafe practices leading to ill-health
9. Employees leaving, leading to increased recruitment costs
10. Risk to protection of patients.

It is apparent from the foregoing that proper induction of members of temporary and permanent, full- and part-time staff is an essential part of the process of successful employment, and is ignored at one’s peril.

Part of the content of this article follows the approach of Jane Bonehill, a former dental nurse who now runs DenMed, and I would like to thank her for allowing me to refer to her methods.

Information via the written word

The fourth in the new managing information series of articles, by Ed Bonner

I am the most consistent finding in negligence cases.

Creative writing is a boon in marketing your practice, whether via brochure, leaflet, website, advert or advertisement. Here again, your average dentist gets lost up his own fundamental as he tries to include every last detail within a limited space: trying to pour a quart into a pint bottle. One should heed the words of one of our most illustrious playwrights, Alan Ayckbourn: “A common mistake in beginners is to be so obsessed with content that they are in danger of creating something to heavy to move anywhere!” If you remember nothing else from this article, do not forget that if you expect your patients to spend more than a couple of minutes reading your brochure or website you are probably being wildly optimistic, as probably am I thinking that you are still reading this article.

If I cannot say what I want to say in 600 words, be it in an article, website, or brochure, I am not writing about being a bore, I am spending more time filtering out superfluous words than writing them in the first place. Not everyone is or should be a comedian, but a touch of humour never goes amiss, especially when dealing with as serious a subject as dentistry! The length of sentence should vary: long sentences mixed up with shorter ones make a tastier salad than sentences of uniform length.

What is important however is the message you are trying to sell to your reader or patient. The writing technique I employ is the same as that which I apply in my consultancy, The 10th Dimension: distil everything essential into no more and no less than 10 points. Some of that content to condense from, say, 25, at other times you may struggle to find 10 points of interest. What we do with this can be a highly disciplined and creative way of disseminating information. To illustrate the point, I have highlighted an important word or phrase in the above text.

Ed Bonner can be reached at bonner.edwin@gmail.com
So how important is the practice name? On a scale of 1 to 10, is it a 1 or a 10? Let me illustrate my point by using the experience of a well-established and very successful practice, based in Hertfordshire, U.K.

This practice was set up in 1957 by Bernard Bloom. In 1990, Bernard’s youngest son David joined and persuaded his father to move to new premises and call the practice “Bloomsbury Dental.” Jay, a contemporary of David’s from Newcastle Dental School, joined in 1998, and Bernard retired shortly thereafter.

As the reputation of the practice grew, it became clear that with a name like “Bloomsbury” many potential customers mistakenly thought the practice was in Bloomsbury, London, or was an offshoot of a practice based in London, with the same name. It was therefore difficult for David and Jay to accurately assess how well they were doing with so much confusion. Nor could they measure the effect of all their marketing efforts. They soon realized that “Bloomsbury” said nothing about the ethos and culture of their practice. It was clearly time for a change.

Obviously, the change encompassed more than just the “name.” David and Jay readily understood that they needed to have a clear, concise and consistent message expressed and implemented by everyone in the practice. Their rebranding exercise had to sum up the complete customer experience. It had to establish their unique identity. It wasn’t just the direct branding: name, logo, business philosophy, and website. More importantly, it had to do with the way that their customers, and potential customers, would think about their practice.

So why do David and Jay feel that it’s a 10? While undergoing the rebranding exercise, David and Jay appreciated that customer loyalty arises not so much out of rational considerations but more on the basis of emotional affinity and personal connection. For them, customer retention and referral had always been a key part of their success. They needed to build on this by ensuring that the customers felt even more welcome and valued. They wanted to do more for their customers than anyone else did and even more than their customers would expect. They wanted to show their customers that they meant a great deal to them.

They had introduced the spa concept to the practice in 2005; recognizing that few people look forward to a trip to the dentist even though they know that the end result is going to leave them looking and feeling so much better than before. During long, and often messy procedures, David and Jay’s patients are cocooned in their own soothing and calming world with a choice of music and films to watch, booties and blankets to keep them warm, hand treatments to aid their relaxation and crucially, dental bibs that keep them dry and their clothes completely protected.

Remember when I said they wanted to do more for their customers than anyone else? Yes, they have invented dental bibs that offer total protection and comfort. The idea was sparked by David’s wife who, while undergoing a smile-lift, was unnecessarily distressed by having the neckline of her outfit and hair soaked in the process. She advised David, that the spa concept was let down by the inadequacies of their dental bibs. David challenged her to come up with something better, so she did – CollarDam.TM

Remember, small business branding is about getting your target customers to see you as their preferred choice. Building a brand isn’t just about what you do; it’s about what you do to differentiate yourself from everyone else. Your brand should articulate the total experience of doing business with you. It should be a dependable, consistent and yet special experience every time.

What's in a (practice) name?

By Sheree D. Whatley

Sheree D Whatley is managing director of Le Verdon Consulting which advises companies, largely in the medical and dental fields, on their global distribution strategies. She can be contacted at sheree@wanadoo.fr

About the author

Sheree D Whatley

Hague Dental Supplies Ltd, Trident Business Centre, 29 Elizabeth Road, Tolworth Broadway, London SW17 8SH 000 000 6666

www.hague-dental.com

SPECIAL OFFERS

- Excel Enigma H Autoclave with printer £1450
  Including free Tower 100 water pump

- Excel Enigma S Autoclave with printer £1050
  Single cycle vacuum
  Including free Tower 100 water pump

- Excel Enigma E Autoclave with printer £2450
  2-cycle vacuum
  Including free Tower 100 water pump
Simply the best?

Don’t be fooled that there is such a thing as the ‘best’ pension plan. Retirement planning will be different for everybody, depending on your circumstances, says Ray Prince

Like many of our clients, we are constantly updating our levels of Continuous Professional Development (CPD). As part of some recent CPD, we read a report called ‘Advisers Have Vital Role As Persuaders’. It was compiled, based on the results of a survey carried out by investment group Fidelity, which asked both individual investors and advisers to rank five factors in retirement planning success in order of importance, ‘1’ representing the most important.

The survey aimed to identify how well educated financial advisors are about a looming pension crisis, so it’s vital investors are given the right advice.

Looking at some of the results of the survey below, we can see that although individuals understood the importance of the amount saved over a lifetime – the most important factor according to financial advisers – they still rated ‘finding the best pension plan’ their top priority.

<table>
<thead>
<tr>
<th>Advisers</th>
<th>Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount saved over a lifetime</td>
<td>1 2</td>
</tr>
<tr>
<td>Date at which saving started</td>
<td>2 4</td>
</tr>
<tr>
<td>Getting the right asset allocation</td>
<td>3 5</td>
</tr>
<tr>
<td>Picking the right funds</td>
<td>4 3</td>
</tr>
<tr>
<td>Finding the best pension plan</td>
<td>5 1</td>
</tr>
</tbody>
</table>

The main point this survey brings to light is the idea that individual investors believe that there is a ‘best pension plan’ out there. We do not have space to reiterate our investment process here, but in short, while the pension wrapper is important (as it is tax efficient), the investments within the pension that really matter.

A second opinion

When we first looked at the results of the survey, we remembered a recent experience, where a new dental client contacted us for a second opinion. When my colleague met him, it became clear why he wanted another viewpoint. The first IFA he visited recommended that he invest over £2,600 per month into a personal pension, because it would allow the client to retire earlier, and was the ‘best’ pension he could recommend.

Despite this advice, the client wasn’t asked for any of the following information: what his life goals were; what risk questionnaire/assessment was used; the result of the cash flow forecast; whether the NHS pension and state pensions been taken into account; where the expenditure template was showing what you need at 60; whether the sale of the practice had been taken into account; whether any possible inheritances been considered and if existing investments been built in?

Many things concern us here, including the probability (based on many clients’ case work) that if such planning were implemented, the client would possibly have ‘too much’ for their needs at age 60 or over, and in a wrapper, which restricts what you can do with it (75 per cent of the proceeds would possibly have ‘too much’ for their needs at age 60 or over, and in a wrapper, which restricts what you can do with it (75 per cent of the proceeds have to be used to provide an income – 25 per cent is available as a tax-free cash lump sum). This can of course also be at the cost of the client’s life – what’s wrong with enjoying life and spending money now if more money does not need to be invested?

To cap it all, for the few hours work that had been carried out for the client, £18,452 was to be paid as a lump sum when the client signed up! This money would be paid to the adviser through deductions from the pension plan.

Key learning point

Be aware that there is no ‘best pension’ and if anyone says there is it’s probably time to take a step back and ask the adviser what form of measurement they have used to arrive at the decision they have.

The next step

If your adviser has not taken into account the above factors as a minimum to your overall retirement planning, we recommend you do so now. Retirement planning is not just about pensions – building in all factors and having a life now is quite important, too. Even if you intend to simply buy policies instead of comprehensive planning, be aware of advisers who charge large amounts of commission and talk about the ‘best pension’.

For a free copy of Rutherford Wilkinson’s Audio CD: How To Avoid The Three Most Common Retirement Planning Mistakes, call Catherine Lowes on 0191 217 5540 and a copy will be posted to you (please quote ref: DT).

Contact

Ray Prince
is an independent financial planner with Rutherford Wilkinson plc and helps dentists get the best deals on mortgages, protection and investments, as well as helping them achieve their financial objectives. You can contact him on 0191 217 5540 and ray.prince@rwplc.co.uk.
Praying on weakness?
As the US dollar further loses its strength, now is the ideal time for UK investors to buy into the United States property market. Or is it? Dr Paul Hanks explains

Bob Cummings tax specialist for National Association of Specialist Dental Accountants (Nasa) told Denal Tribune that there was some good news amid all the gloom of the budget. He said: ‘We are also pleased to give dentists a speck of good news that the budget will put a few additional hundreds of pounds into their pocket. However, some team members might end up paying more tax and employers might like to find ways to prevent them from being penalised.’

He explained that the basic rate of income tax was being reduced from 22 per cent to 20 per cent. The benefit of these changes is in the region of £790 for a higher-rate taxpayer. A higher earner will also pay more in National Insurance Contributions as a result of the raising of the upper earnings limit, which will cancel much of the income tax cut, but still leave the average wage dentist better off by about £400.

However, there is a loss of the 10 per cent basic rate tax on lower earnings and this means that someone with a salary of up to £15,000 could be worse off. Employers could consider introducing flexible benefit schemes which are a way of boosting pay without incurring a tax liability. Talk to your Nasa accountant if you want advice on implementing schemes to support and reward your staff.

Finally, said Bob, there is a reprieve for dentists who incor up to $300,000. Thus the mortgage payable over the lifetime of a loan of $300,000 will be $205,000, which is bought in US$400,000. Examples of UK homes that are priced in the same range that are for sale in the USA include a house in California for US$400,000, which is bought in the UK at £150,000 before US$400,000, which is bought in the UK at £150,000 before 

The US economy
The US Federal Reserve (FED) is under pressure to reduce US interest rates to help boost the struggling housing market amid signs of weakness in the wider economy. Against a background of weak growth, sagging consumer confidence, lower corporate earnings and grim data on the housing industry, forecasters predict that the FED will reduce the key federal funds rate to 4.5 per cent. With UK house prices rising sharply in October, it is more likely the Bank of England will keep UK rates on hold at 5.75 per cent. This makes the pound more lucrative than the dollar for investors.

The sub prime story
Many of you will have read about the sub prime mortgage problems in the US. Essentially, sub prime mortgages are those mortgages given to people of low income and low credit histories. A few years ago, lenders had loads of money and wanted to give it out as fast as they could. They introduced things like stated income, stated loans, where someone could apply for a loan and state they had a job for £15,000 could be worse off. Lower earnings and this means that someone with a salary of up to £15,000 could be worse off. Employers could consider introducing flexible benefit schemes which are a way of boosting pay without incurring a tax liability. Talk to your Nasa accountant if you want advice on implementing schemes to support and reward your staff.

Finally, said Bob, there is a reprieve for dentists who incor--dentists a speck of good news that the budget will put a few additional hundreds of pounds into their pocket. However, some team members might end up paying more tax and employers might like to find ways to prevent them from being penalised.’

He explained that the basic rate of income tax was being reduced from 22 per cent to 20 per cent. The benefit of these changes is in the region of £790 for a higher-rate taxpayer. A higher earner will also pay more in National Insurance Contributions as a result of the raising of the upper earnings limit, which will cancel much of the income tax cut, but still leave the average wage dentist better off by about £400.

However, there is a loss of the 10 per cent basic rate tax on lower earnings and this means that someone with a salary of up to £15,000 could be worse off. Employers could consider introducing flexible benefit schemes which are a way of boosting pay without incurring a tax liability. Talk to your Nasa accountant if you want advice on implementing schemes to support and reward your staff.

Finally, said Bob, there is a reprieve for dentists who incor...
Practice under construction

Flooding, staff and patient complaints and a clean-up operation are enough to put any practice manager to the test. Sharon Holmes triumphs in the face of adversity

S
ome time back in July 2007, the Dental Arts Studio's Clapham Junction branch suffered a blow during one of the summer storms. It was Friday morning, and I was at our other practice in City Road with practice owners Dr Malhan and Dr Solanki, when I received a phone call from Clapham Junction's receptionist. 'Hello Sharon. We're stuck in the building and the practice is filling up with water!' I thought the worst. If they were stuck, the flooding had to be bad. But as it turned out, the staff couldn't get out because it was raining outside, and they had nowhere to go. I wasn't sure whether I should laugh or cry! You can either get wet in the rain or drown, the choice is yours,' I replied.

Picking up the pieces

And so the long and winding road to rebuilding our crushed practice began. First we had to get the insurance assessors in. This was a slow process, seeing as so many other buildings had been damaged in the recent floods all across England. Your best option here is to hire an independent assessor who will work in your best interest, when it comes to dealing with your insurance company.

My first task on the Monday morning was to get my nurses to pack all dental instruments into containers for safe storage. This was not an easy task. All the staff wanted to go home on full pay, as they didn't feel it was their problem that the practice wasn't functional.

I called the HSE and told them what had happened. I also explained to them what I needed to do to start the clean-up process. As it was rainwater, it would be safe for the staff to remain in the building, so long as they wore barrier clothing – gloves, aprons and protective eyewear. Their day clothes were to be sent to the dry cleaners and they were not to eat food on the premises. I carried out all of the above instructions as informed.

A formal complaint

Despite my vigilance, one member of staff contacted the HSE officer to report me for putting their health at risk. Luckily, the complaint came to nothing, as I had followed the required procedure.

In the days to follow, trying to stay positive and focused, knowing all the staff were unhappy, was emotionally draining. After the professional cleaners came in and removed all the contaminated dental materials, they placed extractor fans downstairs in the basement surgeries to dry the floors, walls and ceilings. This also helped to remove the terrible damp smell.

All the damaged patients' archived records had to be sent to a professional restoring company, as records less than eleven years old could not legally be destroyed.

Home and dry?

The practice was now clear of water, but a strong stench of damp lingered, which would dissipate as the day wore on with doors and windows left open. I was also at the practice all day, which the nurses aren't used to and found difficult, especially as they call me 'the whip', something I found out recently. The Old Street practice manager was away on holiday when this happened, and I soon realised the staff were lazy and uncaring so I was constantly motivating them to get anything done. After two weeks, the practice manager

simple fixed orthodontic therapy to improve your cosmetic dentistry

Monday 21st and Tuesday 22nd April 2008

The Speaker

Dr Derek Mahony

The Lecture

If you do nothing else this April, make sure that you book yourself a place on Sydney based Specialist Orthodontist Dr Derek Mahony's latest lecture 'Making your restorative and cosmetic dentistry more predictable, using simple fixed orthodontic appliances', helping you achieve the Perfect Smile.

The lecture is to be held at the BDA in Wincheap Street, London EC1A 7HR, on Monday 21st and Tuesday 22nd April 2008, and will include a lecture and question and answer session. The lecture will also explain the use of simple fixed appliances such as a TED and T-Screw to help you achieve the perfect smile.

Venue

The British Dental Association
center, 64 Wincheap Street,
London EC1A 7BD

Please return this form to:
CS Courses
Cott Road
Sudbury
Suffolk
Tel: 01787 379779
Fax: 01787 375289
Email: info@fulfillglobal.com
www.fulfillglobal.com
www.esdo.com

For further information regarding this course please contact Dr Derek Mahony directly on info@derekmahony.com
returned, so I could focus on meeting the needs of our patients.

On the day of the flooding, I had just finished working out a plan to accommodate our Clapham Junction patients at our London Bridge practice. This was because one of my associates was taking a six-week holiday. I emailed the new plan to each associate and practice manager which we carried out until we were able to hire a surgery local to our practice. Once this happened, I then set up a rota list with associates who were each allocated one day surgery time.

These sessions were purely for emergency care only. Some of our associates chose to do one session daily so that everybody had the chance to work. We had to liaise daily with our PCT who supported us, as we were now falling behind in our UDA target.

Money matters

With Clapham Junction patients at our London Bridge practice, a separate spreadsheet had to be created to ensure our accountant understood what was happening. Each day when a problem arose, a system had to be implemented to avoid a disaster further down the line. It sounds a lot very stressful but I found I rather enjoyed sorting out the short-term problems.

Of course, our patients were not happy about having to go to another practice which was further for them to travel. So on top of dealing with disgruntled staff, we were also trying to keep our relationship with our patients on a good level. In between all this chaos I worked closely with Solanki and I were dealing with dental suppliers for quotes for replacement of all the dental equipment. I was dealing with finding us a good reliable builder who could undertake the refurbishment of a seven-seater practice.

Rebuilding the practice has been extremely trying. First the lack of space to store existing equipment that could be salvaged tried every one's patience, as we had to keep shifting it from surgery to surgery. This is one area that I would recommend that if you could do a total clean out and find a local storage unit for the interim it would be much easier to work clean and fast and will also avoid further damage to your small equipment as when these were packed in haste ours was badly damaged especially our telephones which we now face a further cost of replacing.

Adapting to problems

At this point I was no longer the business development manager, but instead site manager. I came into work dressed in jeans and trainers with my hair tied up and got stuck in with the builders and my new practice manager Rebecca Berry to replace one who had walked out amid the chaos. We worked late nights and weekends. We ran up and down to hardware stores and to IKEA. Eventually the practice took shape, and in the process I learned so much about IT, media technology and dental equipment. I also learned that a dental surgery does not just have a chair, materials and hand pieces there is so much more that is hidden that goes into setting up a dental surgery.

We planned to open up on 26 November 2007. But I was worried we wouldn't make the deadline, but we managed. We booked long-term agency nurses and ensured all our dentist had chair-side assistants. I begged, borrowed and stole staff from my other three practices and covered our reception area. Up and running and we now have a full team of staff. Most of the agency approached me for full-time positions, which I awarded them. We are a strong team now and I look forward to the days to come with Clapham Junction. As Winston Churchill Hill once said: ‘This is no time for ease and comfort, it is a time to dare and endure.’

Clearly different … it’s amazing!

Introductory Seminars

As the first event in the Clearstep Educational Continuum, this introductory seminar is aimed primarily for General Dental Practitioners, whatever your expertise and experience.

By the end of the program you will understand the benefits of ‘connect treatment plans’ and feel confident about treating any patient with the Clearstep system, together with traditional orthodontic techniques.

Expand your range of treatments and further your skills. Book onto the Clearstep introductory seminar today.

LOCATION    DATES

Bristol    27th March
London    22nd April
London    27th May
Lisburn    30th June
London    31st July
Dublin    16th August
London    29th September

The course is approved by RPS(I) Ltd, UK Medico-legal CDT accredited, as equals with DCS (validated CDT requirements).

An email alerting you to join the Clearstep system is sent with an introductory seminar flyer to confirmed attendees.

BOOK ONLINE FOR THE INTRODUCTORY SEMINARS:

www.clearstep.co.uk or contact info@clearstep.co.uk

My patients kept asking me for an inevitable, comfortable way to straighten their teeth. I knew I had found the answer. My private practice is booming one to two new patients.

Dr Andrew McClure, Mail, New York, NY 10016, USA
Clearstep Chairman & Founder.
Much of the research undertaken by myself and research colleagues in the Orthodontic Unit over the last five years would be classified as ‘patient centered research’ – investigating what is important to the patients rather than just what is of interest to clinicians.

The traditional approach to the assessment of orthodontic treatment (‘braces’) has been to look at measurements on radiographs or on study casts of patients’ teeth. These measures are relevant to clinicians; however, do not necessarily reflect what is important to the patient. As a result of these issues, there has been an increased interest in so-called ‘patient-centered measures’, which are best described as measures expressed, or experienced directly, by the patient.

The concept of patient-centered measures has been well developed in medicine (Lipscomb et al., 2007) and research in dentistry is now closely following this lead. In the field of Orthodontics, these outcomes include, for example, patients’ experiences of treatment; patient satisfaction following treatment; changes in quality of life and changes in psycho-social measures such as body image and self-esteem.

1. Do patients and clinicians have the same views?

Many of the changes described above have been driven by the perception that patients and clinicians have different views on treatment need, outcome etc. In order to establish whether this was actually the case in orthodontics, a study was undertaken at the UCL Eastman Dental Institute and the John Radcliffe Hospital Oxford in which patients were asked to rate their own need for treatment and this was then compared with the views of a number of experienced clinicians (Juggins et al., 2005). Interestingly, there was a clear difference between the two groups and this highlights the importance of seeking patients’ views when considering provision of treatment and policy making.

2. Psycho-social assessment

A major focus of this on-going research area is the group of adult patients undergoing orthognathic treatment, a form of treatment involving orthodontic treatment and jaw surgery for patients with severe dentofacial deformities in whom orthodontic treatment alone would not produce optimum function or dental/facial aesthetics. The psycho-social impact of having a severe dentofacial deformity has been investigated and additionally, the changes in psycho-social measures such as quality of life, self-esteem and body image have been studied during and after treatment (Cunningham et al., 2001, 2002). The significant improvement in quality of life found following orthognathic intervention is important information to have available when policies are being made and health care provision planned.

Interventions (such as orthognathic treatment) which changes someone’s appearance, even in a positive way, may well have psychological implications and the Eastman Dental Hospital UCLH is fortunate in having the expertise of a liaison psychiatrist on the Orthognathic Clinics in order to facilitate communication between patients and clinicians and to support patients in the treatment process. This has opened up a whole new area of research. For example, recent studies have looked at clinicians’ perceptions of the value of offering orthognathic patients for psychological support (Juggins et
More recently this research area has extended into those patients undergoing conventional orthodontic treatment and quality of life has also been assessed in children and adolescents with multiple missing teeth (Laing et al., 2007 Submitted for publication). The impact of such conditions is often underestimated and it is important that patients have the opportunity to put their own viewpoints to those involved in policy making and provision of care.

3. Information provision
One of the most important factors in achieving optimal results from orthodontic treatment is patient co-operation. In order for this to occur, patients need to fully understand the treatment process and what is expected of them and this is clearly one of the most important factors in the informed consent process. A recent study compared two methods of information provision: printed leaflets and a computer based visual presentation. The computer based program showed significantly better information retention than the leaflets and adolescent patients appeared to prefer the computerised form of information provision. Therefore, the recommendations were that information provision using a computer program should be considered in hospitals and orthodontic practices as it appears to be preferable to more conventional information leaflets (Patel et al., 2007 In press).

4. Process of treatment
One issue of concern to most dental patients is how much pain they are likely to experience and a recent collaboration between UCL Eastman Dental Institute and the John Radcliffe Hospital Oxford looked at this very issue (Pringle et al., 2007 In press). The traditional fixed brace system was compared with a new fixed brace system, which is more expensive but purports to cause less pain. Patients completed questionnaires monitoring the pain they experienced in the early stages of treatment and the two systems were then compared. Although, the new system showed statistically less pain, it was doubtful as to whether the differences were large enough to be of clinical relevance to the patients themselves. These findings have important implications when orthodontists are choosing which system they choose to use and the research allows them to draw on the experience of previous patients when making such decisions. There are also economic consequences, which are clearly of importance in the NHS setting.

These are just a few illustrations of the types of patient-centered research, which have been undertaken recently and these examples clearly illustrate the importance of involving patients in research.

To celebrate its 60th Anniversary, the Eastman invites you to join them for what will be a truly inspirational event on the 2008 dental calendar. Taking place on April 5-6 2008 in central London, the Eastman 60th anniversary celebration programme is not to be missed. To register and for more information, visit www.eastman.ucl.ac.uk.

The Eastman at 60
Eastman Dental Institute and Hospital, London UK
Thursday 3rd April 2008 12:00pm - 5:30pm and Friday 4th April 2008 9:00am - 5:00pm

To celebrate its 60th Anniversary, the Eastman invites you to join them for what will be a truly inspirational event on the 2008 dental calendar. Taking place on April 5-6 2008 in central London, the Eastman 60th anniversary celebration programme is not to be missed. To register and for more information, visit www.eastman.ucl.ac.uk.

Eastman 60th Anniversary Congress - Synopsis
Thursday 3rd April 2008
Research and Clinical Case at the Eastman
Lunch will provide an opportunity to network and discuss papers from 12.00pm to 1.30pm
Parallel Session Options 1A: Research at the Eastman
The Eastman’s research is focused upon Clinical Dental and Oral Health Sciences. This area of research has adequately documented the impact of orthodontic treatment on patients, their quality of life and on their psychology and the provision of healthcare. The research programme is based on evidence-based research, which demonstrates its wide application, translation and sustainability.
Parallel Session Options 1B: Patient Care at the Eastman
This session will provide an over-view of the advances in the care of orthodontic patients, the improvements of orthodontic techniques and the provision of care. The patients and their parents will be involved in the decision-making process and the patients’ involvement is essential.

Friday 4th April 2008
Natural Teeth or Implants?
Decision making in clinical practice
Lecture programme from 9.00am to 5.00pm
Parallel Session Options 2A: Prognosis for Teeth (CFD, Implant and Conservative)
This challenging programme will present the latest advances and developments in the management of dental implants. It will enable delegates to appreciate and apply the evidence-based approach to decision-making for successful treatment with dental implants.
Parallel Session Options 2B: Programme for Dental Care Professionals
Caries Prevention, Hygiene, Therapy and Technology
This one-day programme is designed to support Dental Care Professionals and advanced dental therapists in their role in the dental implants. The course will be presented by a well-recognized course director and the responsibility of the course is based on the evidence and the evidence-based approach to decision-making.
Complex cases

Another article in our series on risk management provided by Dental Protection: this week precautions to consider before launching into a complex case

Fig. 3: Diagnostic wax-ups are a useful tool in case assessment and are an important part of your records.

Fig. 4: ‘Biscuit Bake’

Fig. 5: Try-on of a partial denture.

Fig. 6

Fig. 7

There can be few of us who have not benefited from the wisdom of hindsight in the course of our clinical career. Spotting the ‘problem’ patient before it is too late, or drawing back from the procedure which is doomed to fail, or resisting the temptation to provide treatment against our better judgement occasionally derives from inspired intuition or is gleaned from years of hard experience! More predictably it is the result of a conscious decision to take every opportunity to ‘test the water’ before committing yourself to extensive or irreversible treatment.

One Step at a Time

An obvious example of this cautious approach arises when treating young children or exceptionally nervous adult patients. Starting a treatment plan with procedures that are as short or simple as possible gives the clinician an opportunity to assess the patient’s ability to cope with treatment procedures, before embarking upon longer or more challenging procedures.

Always try to decide on a fall back position during those first appointments so that the situation can be recovered if the patient’s co-operation does not prove to be as complete as that which had been hoped for. This can be particularly useful when there are grounds for concern over whether a patient will be able to keep their mouth open, for sufficient periods of time, to enable complex or intricate work to be carried out on one or more posterior teeth.

A similar approach needs to be adopted when complex treatment is deferred while you check a patient’s ability to maintain adequate oral hygiene, or willingness to attend for treatment.

Dentures

In denture work of various kinds, there is the obvious advantage that most of the decisions that are taken are also reversible. The try-in stage of a denture is a classic example of this, allowing both the clinician and the patient to assess the various aspects of the denture before jointly committing to the finished product (Fig. 1).

At an earlier stage in the process of denture construction, ‘training bases’ are another tried-and-tested approach to assessing, for example, how much palatal coverage or lingual pouch/tuberosity extension the patient can tolerate. A proposed change in occlusal height or in tooth position relative to the edentulous ridge and soft tissues can also be tested out in a way which still allows easy and inexpensive modification and adjustment if necessary.

For patients who have a severe gag reflex or intolerance to palatal coverage, one is never quite sure how they might cope with a transition to full dentures, or partial dentures with extensive palatal coverage. A prudent exploratory stage—undertaken before any teeth are extracted—is to construct a ‘mock’ upper acrylic plate, and to adjust this in stages until acceptable to the patient.

The relines procedure is yet another proven means of establishing whether a denture can be made satisfactory by correcting any deficiencies in the fit surface. Often this can prolong the life of an existing, otherwise satisfactory denture.

Chairside, soft reline and ‘tissue conditioning’ materials are entirely reversible, but can still yield valuable information about problems with existing dentures, and potential problems that might arise when making new ones.

Denture Clasps

One frustratingly familiar source of dental-legal problems is the visible clasp of a chrome cobalt denture, which the patient discovers for the first time after the finished denture has been fitted. Usually the patient’s dissatisfaction is based on aesthetic grounds; sometimes the clasp creates problems with comfort or function. On occasions, the clinician accedes to the patient’s wish and removes the offending clasp only to find that the patient can no longer wear a denture which is now hopelessly loose.

It is tempting to believe that there are times when you just can’t win. What you can do, however, to head off some of these problems, is to use a black wax pencil (at the design stage) to mark on the tooth itself exactly where the proposed clasp(s) would sit. This gives the patient the opportunity to raise any concerns before the denture is ever constructed.

Temporary Crowns & Bridges

Temporary (provisional) crowns provide an opportunity to preview a proposed tooth length/appearance/colour before proceeding with the final restoration. Despite the relative ease and simplicity of this treatment approach, it seems to be a surprisingly under-used clinical tool when dealing with those patients who clearly have high aesthetic expectations and demands. Quite apart from its intrinsic value as a procedure within the overall process of crown construction, it can allay the concerns of the patient who lacks confidence in the outcome, reassuring them that you are doing everything that you possibly can to secure an optimal outcome for them.

Another very useful ‘check’ procedure along the same lines is to try in crowns and bridgework at the ‘biscuit bake’ stage of porcelain build-up, letting the patient see how things are progressing, and allowing any adjustments to be made before glazing and finishing the restoration (Fig. 2).

Using temporary (provisional) bridges to try out the shape, size, pontic width and colour of bridge-work is a variation on this same effective technique. A temporary bridge can also provide a timely indication that the proposed bridge abutments are undercut or divergent, and will not allow the insertion of fixed-fixed bridgework without further preparation.

Where anterior bridgework is replacing a denture, which has been worn over many years, problems can arise with speech because of the altered shapes and dynamics of the spatial relationships of the tongue, teeth and palate. The provi-
The provisional restoration provides an ideal opportunity to resolve these potential problems, while adjustments remain easy to make.

The provisional restoration can highlight potential problems with the occlusion and, on occasions, can point to previously unsuspected parafunctional activities which have the potential to compromise the success of the final restoration. Also on the subject of crown and bridge or veneer restoration, a common cause of dento-legal problems is the under-prepared tooth, resulting in an over-built restoration which either has an excessively bulky appearance, or emergence profile (leading to periodontal problems), or height (leading to occlusal problems).

The simple expedient of having a clear vacuum formed slip made before commencing any tooth preparation, allows the clinician to check that sufficient tooth reduction has been carried out, in all dimensions, to allow for the thickness of the restorative material. Unless teeth are adequately prepared, the subsequent restoration is often a compromise, either aesthetically or functionally, or both.

A common outcome is that the technician decides that the available occlusal clearance is only sufficient for a thickness of metal and not for bonded porcelain as well. The resulting metal visible on the occlusal surface or metal ‘islands’ (Fig. 7) often comes as a considerable disappointment to patients who are expecting a tooth coloured restoration. Here again, a relatively simple extra stage introduced at the appropriate moment can save a lot of patient dissatisfaction, and subsequent time and expense in remediating the situation.

Endodontics

A ‘working length’ or ‘diagnostic’ x-ray to provide reliable length control (Fig. 5) as a guide to subsequent instrumentation—or alternatively, the use of an apex locator—is a perfect illustration of risk management achieved through a simple expedient in everyday working routines. Many endodontists take this a stage further by introducing one final check at the ‘master point’ stage to ensure that the optimal length control has been maintained.

The corollary here is that if a completed root canal treatment (RCT) does not have an optimal apical seal, being either overfilled or underfilled, and no x-rays or other steps have been taken to maintain effective length control during the procedure, then it becomes difficult to resist the argument that the failure to implement well-recognised and simple steps to establish the correct root length, has led directly to the problem with the RCT (Fig. 6).

Summary

When things go wrong in dentistry, it is often tempting to wonder if the outcome might have been very different, if only an extra intermediate step had been taken along the way. Effective risk management need not be complex, costly or time consuming—indeed, quite the reverse when one considers the time and money that has to be invested in remediating a situation when things have been allowed to go wrong, it is always cheaper and quicker to spend some time and effort in getting things right the first time.

A less obvious consideration is that of patient confidence. If the clinician takes deliberate steps throughout treatment to communicate to the patient all the things that are being done to ensure a successful outcome, the patient is much less likely to lose confidence in the dentist's ability. Once a crisis of confidence has arisen, it can be very difficult to recover from the situation.

On the other hand, if all available opportunities to maximise the treatment outcome have been seized by the clinician and communicated effectively to the patient, not only is the treatment itself likely to be successful, but the patient will probably attach a higher value to the service provided and will be less questioning of the cost of their treatment.

Innovative equipment solutions for performance beyond the expected

The digital design and superb quality of A-dec equipment is close to new—yet as you would expect, it provides all the functionality and reliability required for efficient and rigorous working. A-dec also believes in developing products which improve the expected and offer improvements to the normal ways of working. Think differently about the clinical side of the business by A-dec. A-dec products provide an extra value added to the installation that ensures you think differently as well. So to explore the possibilities and seek a better way, give us a call and make sure you are one of the first to brush the handpiece.

Think differently • • • • • For details call 0800 233 285 or contact your local authorised A-dec dealer

A-dec is a leader in the dental industry. A-dec products are designed, manufactured and distributed worldwide through a network of dealers who are independent businesses. A-dec is not responsible for, nor do we control, the products or services provided by our dealers. This is the world's largest specialist provider of dental professional indemnity and risk management for the whole dental team. This article comes from our risk management library based upon Dental Protection's 100 years of experience, currently handling more than 8,000 cases for over 48,500 members in 70 countries.

Dentaltown United Kingdom Edition March 31–April 6, 2008

Risk Management 21
A new highly aesthetic layering ceramic—also for zirconium oxide

New technologies have established themselves on the dental market, particularly for fabricating aesthetic restorations. With the introduction of the CAD/CAM technique, materials which were not available before, such as zirconium oxide, can now be used in the dental laboratory. Compared with all-ceramic systems that are already available on the market, this material can be used for a wider range of indications in fixed denture prosthetics. Therefore, it is now possible to fabricate long-span bridges. Restorations made of zirconium oxide offer a decisive advantage due to their high stability. As both systems can be inserted using the conventional technique, these restorations represent a good alternative to metal-ceramics for dentists.

Indications

These new framework materials require a new generation of high-performance ceramics in order to maintain their advantage over metal-ceramics. The new IPS e.max Ceram layering ceramic from Ivoclar Vivadent is a nano-fluorapatite glass-ceramic with optical properties that are similar to those of the IPS d.SIGN metal-ceramic. It is part of a new all-ceramic system, which comprises two different types of glass-ceramic ingots. One type of ingot is used to fabricate pressed restorations, while the other is used to press onto zirconium oxide frameworks. Moreover, the system includes glass-ceramic and high-strength zirconium oxide blocks that are processed by means of the CAD/CAM technique. The integrated layering ceramic is suitable for veneering zirconium oxide frameworks and glass-ceramics alike. The material can also be used for fabricating veneers on refractory dies. Consequently, a variety of all-ceramic indications can be covered. The advantage of this system compared to metal-ceramics can be described very easily, as all advantages of light dynamics can be fully exploited. Opaque base materials have to be used to cover the dark oxides on metal frameworks. Light transmission, which is very important, is interrupted. The IPS e.max system enables virtually unlimited light transmission, which endows the restorations with an even more lifelike appearance. Hence, restorations that come very close to their natural counterparts can be fabricated (Fig. 1). The author would like to provide a closer look at this ceramic and show how reliable the material is to work with based on impressive images.

Liner

The zirconium oxide frameworks are cleaned under running water or with a steam jet (Fig. 2). The IPS e.max Ceram ZirLiner generates a sound bond between the ceramic and the framework. However, it is different from the liners of other systems, since it does not mask the framework like an opaquer but it is applied in a thin layer and remains translucent even after firing (Fig. 3), similar to fired stains. This liner, in the present case the IPS e.max ZirLiner 1, is applied only once.

Zirconium Oxide–White Gold Refined with IPS e.max Ceram

CDT Horst Polleter, Nuremberg/Germany

Fig. 1: Cross-section of a zirconium oxide crown by transmitted light.
After firing, a silky-matte glass is visible. The liner is available in different shades—based on the IPS e.max shade concept. In contrast to opaque like liners that act as a light blocker, the IPS e.max Ceram ZirLiner supports light transmission in the cervical areas and thus improves the true-to-nature effect of zirconium oxide crowns.

Proven layering and shade system

After this step, IPS e.max Ceram is layered. As with all ceramic systems, it is advisable to build up the basic shape of the reconstruction with the respective Dentin shades (Fig. 4) in order to control the size and shape. In the present case, a mixture of Dentin A2-A3 is. The incisal area is cut back down to the framework on the labial surface (Fig. 5) to gain information on the layer thickness. In addition, all the different layers, such as effects and translucencies are located within the crown. The framework is covered with Deep Dentin in A2 in order to prevent the coping from shining through in the incisal area. The reduced area is subsequently built up with the respective Dentin materials. This build-up serves as the basis for further layering procedures. The incisal proximal aspects are reduced and a mamelon structure is designed. The incisal edge is built up with Opal Effect 1. Transpa Blue is used for the sides. Mamelon Light is used for face. Mamelon Yellow-Orange. This material is used to lengthen the incisal area and to frame the incisal edge. Next, dentin firing is conducted according to the instructions of the manufacturer. Once the contact points have been adjusted, the crowns are finished and their shape and function is adjusted, the crowns are finished (Fig. 9).

Essence and Stains materials

After finishing the crowns and bridges, it is very important to check the shape and surface. For this purpose, I use silver powder, which blocks the shade and thus pushes the shape to the fore (Fig. 10). Once the surface and shape have been designed, glaze firing is conducted according to the manufacturer’s instructions. For characterization, 10 Essence materials and 7 Shade stains are available. The advantage of the Essence materials is that they feature the “1-for-5 effect”. These materials can be mixed with all the other IPS e.max Ceram powder materials or they are used for internal characterization or surface staining. Various characteristics can be applied, if required. In total, there is a variety of possibilities to design crowns individually. Finally, the restoration is mechanically polished and a glaze firing conducted (Fig. 11). The new layering ceramic is ideally suitable to imitate the natural play of light.

Conclusion

The new IPS e.max Ceram ceramic material is ideally suitable for veneering zirconium oxide frameworks. The material is easy to process. In addition, the material exhibits a life-like fluorescence and opalescence due to its specific composition (nano-fluorapatite). The restoration in situ fulfills everything we expect of a state-of-the-art ceramic (Fig. 12 and 15). I am sure that I have made the right decision to use this ceramic, as it allows me to produce true-to-nature restorations.
Dentists were able to identify approximately 95 percent of the British tsunami victims from their teeth

An interview with forensic dentist specialist Professor David K. Whittaker, UK

David K. Whittaker is Emeritus Professor of Forensic Dentistry at Cardiff University, Wales. He is the author of a standard text on forensic dentistry in the UK ("Colour Atlas of Forensic Dentistry", Wolfe Medical Publications) and the author of more than 100 publications. As a practising expert witness for 50 years, he has written more than 450 reports and statements and regularly appears in Crown, Appeal, Magistrates and Coroner Courts. Over this period, he has built up a close service to the police, home office pathologists, lawyers and forensic scientists. In his role as an expert witness he acts for both the prosecution (CPS) and the defence throughout the UK. He has also attended court in the USA, Australia, Norway and Trinidad. During the 2007 FHD World Dental Congress in Delhi, Dental Tribune International editor Claudia Salwiczek had the opportunity to speak with him about his fascinating work in forensic dentistry.

Claudia Salwiczek: What are the main principles and procedures of identifying a dead person using dental information?

Prof. Whittaker: It is quite complicated to go into all the methods in a short time, but in principle you try to investigate the teeth in detail, eg, take x-rays and photographs and/or make casts. In other words, the goal is to find out as much information as you can from the dead person’s mouth, as to height, type of dentistry they have had done over the years and unusual anatomical features. Most people’s teeth differ slightly, even if no fillings have been put in. There are slight differences of position, of angulation, of size and shape.

When you have a dead body to deal with and you do not know anything about it, you start by collecting all that information. In my opinion, it is best to do that first, even if you already have a set of dental records or a set of x-rays the police have produced from somewhere thinking it could be this person. It is to better ignore all of this information, put it aside, seal it in an envelope and even say to the police “do not give it to me” so you are not trying to fit what you see in the mouth to some dental record. It is the other way around. You are trying to describe what the person’s mouth and face look like. It’s not just the teeth you are looking at. It’s also the shape of the face and lips. Dentists are trained not just to look at teeth but to look at palates, tongues and the mouth in general, the shape of the jaws, the growth, etc. All of this is part of the professional training.

So you sit down with a blank pad, as if you were going to write a detective novel. You start with names and no knowledge whatsoever. And then you start building up little bits of information.

You will look at the body as a whole, if you got the whole body, and firstly determine whether this is male or female. Even if it is decomposing or just a skeleton you can usually determine if its male or female because of the pelvis, but even from the shape of the skull. For example, most men surprisingly have a forehead that slopes backwards a bit. Most women have one which is vertical. Men’s jaws tend to be much squarer and they tend to flare at the back. Also, the big bones under the ear, called the mastoid that has muscles attached to it, is usually bigger and more marked in male bodies. I can go on, but there a quite a lot of differences. It is usually not very difficult to determine if the body you are looking at is male or female. That way you are not wasting your time looking for the wrong sex.

Then you start to look at the age of the person, when they died. As I said in my lecture, you can do that because the teeth actually start to develop when you are still in the womb—only six weeks after conception. The human foetus is only about a centimetre and a half long and its teeth are beginning to form. By the age of about 2/3, all the baby teeth will have erupted into the mouth. Then there is a kind of plateau, nothing seems to be happening, but in fact the permanent teeth, which also already started to develop in the womb, come through when the baby is about 6 years old, and they go on erupting through the age of 18 and they are still growing until the age of 21. These are approximate figures. So from six weeks after conception to the age of 21 you can look at these teeth developing, either under the microscope or on x-rays or by just looking in the mouth. It is a sequential pattern that we know a lot about.

So the real problem is the determination of the age after 21 years of age when everything sort of shuts down. We usually do that by taking one tooth out of the body and slicing it under a machine, usually lengthwise, and we put that under a microscope and measure certain changes in the root of the tooth. The older you get, the root of the tooth becomes transparent, because the mineral that deposits in it makes it translucent. In the early 1970s, this transparency starts to develop around the age of 25 and it spreads through the tooth until old age. So we can measure the extent of that and we can work out how old they were when they died.

If we want to have it more accurately than that, we can do the determination of the age from the biochemistry of the tooth. We do the analysis of the help of the amino acids, the building blocks of life. In the teeth they appear in Crown, Appeal, Magistrates and Coroner Courts. This period he has built up the service to the police, home office pathologists, lawyers and forensic scientists. In his role as an expert witness he acts for both the prosecution (CPS) and the defence throughout the UK. He has also attended court in the USA, Australia, Norway and Trinidad. During the 2007 FHD World Dental Congress in Delhi, Dental Tribune International editor Claudia Salwiczek had the opportunity to speak with him about his fascinating work in forensic dentistry.

John Ricci, PhD in Associate Professor in the Department of Forensic Science at National Institute of Standards and Technology (NIST), has many recently published papers, one of which is the development of computerised microscopes for dental analysis that provide high, accurate, precise and reliable information. He is the developer of the Laser-Lok microchannel technology.

Participating Faculty:
John Ricci, PhD in Associate Professor in the Department of Forensic Science at National Institute of Standards and Technology (NIST), has many recently published papers, one of which is the development of computerised microscopes for dental analysis that provide high, accurate, precise and reliable information. He is the developer of the Laser-Lok microchannel technology.

Prof. David K. Whittaker, Photo: (Gloucestershire Constabulary)
Clinical Case Studies

out bodies to find out what happened to them. People like me see a lot of dead bodies—I mean I've seen hundreds and hundreds. Each one of them is somewhat unique and you cannot assume that one change won't necessarily occur in another and vice versa, so you have to try to compromise.

What have been the most interesting and challenging criminal cases you have worked on?

It is difficult to say because some of them are very interesting from the legal point of view. Some of them are very interesting because the situation is very unusual and some because they are very challenging scientifically and set new problems. So it is almost impossible to pick one. In terms of murder, the biggest one I have worked on was the Frederick and Rosemary West murders in Gloucester in 1994, sometimes also called the Cromwell Street murders. Back then, I had to set up a special laboratory to deal with that because of security reasons and because of the amount of work. I worked more or less full-time for one year most of the day and sometimes most of the night on that case and almost nothing else.

What made it so difficult?

The sheer number of cases and dead bodies. We were dealing with a serial killer and a lot of female victims. They were all fairly young and we had no idea who they were. You can read about the Cromwell Street murders, there have been at least three books written about it. We thankfully do not have many serial killers in the UK. There were about 10 in the whole of the 20th century and not really one yet in this century.

Do you normally work on criminal cases only, or are cases like the mentioned also common in your everyday praxis?

I work on both, but the majority of cases are criminal cases like murder and rape and grievous bodily harm (GBH) cases. These are cases were the victim survives, but has been badly injured. Those are the three main types of cases that I work on.

In the UK we have the adversarial system of law. When a person is arrested, the crown prosecute that person, so they bring in their lawyers and then of course you have the defence lawyers on the other side. And they argue the case in court. About half the cases I do, and I have done about 800 of them, I would be instructed by the Crown. So I am in on the case from the beginning, advising the police and the Crown prosecution service and so on. And then in court, of course, you have the other expert on the defence side. So half the cases I have done have been for the Crown, but the other half for the defence. So I have experiences on both sides, which I think is very important so you don't get biased.

DNA identification methods have become more important in the recent years. Do you think that this will have an impact on the field of forensic dentistry?

It already has. Many people, myself included, actually thought that this would do us out of the job in the long run. DNA identification was discovered in Britain by the geneticist Prof. Jeffreys in the 1980s, and so we are pretty advanced on DNA technology in the UK. We are now able to pick it up from low copy numbers at very, very low levels. And of course the teeth can tell DNA. In my lab we do quite a bit of work on extracting this and looking at it, so actually DNA identification is part of forensic dentistry. Plus, DNA from teeth is pretty good, because it is well protected and not contaminated. And even then, in something like the tsunami, as I mentioned before, the victims were identified through their teeth and not their DNA. As you see, we still rely on forensic dentistry quite a bit.

Is there something a general practitioner/dentist can do to make your work easier?

The keeping of full and accurate dental records including x-rays and study models, and making these available to people like myself is the best help all.

Thank you very much for taking the time to sit down with me for this interesting interview!
Galileos 3D Scanner

Take a look at Galileos and see what it can do for you!

The NEW Galileos 3D cone beam digital x-ray system offers Practices the power of integrated diagnostics and treatment planning via a single imaging system. It enables them to reduce risks, plan surgical interventions, coordinate treatment planning with colleagues and explain treatment to patients with even greater clarity, certainty and ease.

Galileos 3D is intuitively controlled by its EasyPad Touchscreen and is an all-in-one diagnosis and planning system which offers a very short, low dose scanning cycle for optimum speed and efficiency.

For hands on demonstrations of all their equipment in their new purpose built Chertsey showroom and training facility or for a representative to visit your practice please call Sident Dental Systems on 01932 582900 or email sales@sident.co.uk.

Make the Right Connections!

You can experience an NSK Ti-Max series turbine whichever connection you have, as these hi-tech handpieces connect to all major manufacturers’ couplings including Kavo®, W&H®, Bien Air® and Sirona®.

First for innovation and hi-tech manufacturing, NSK continues to bring new and exciting developments to the dental market helping to make procedures easier and stress-free.

At the pinnacle of handpiece technology, NSK’s Ti-Max X Series offers unmatched versatility and quality, featuring the latest technology to provide exceptional benefits in terms of speed and precision and deliver powerful cutting when you need it most. NSK consider how every element of a handpiece affects your performance and have ensured the Ti-Max X Series is ergonomically designed to sit comfortably in the hand, thanks to its lightweight, well-balanced Titanium body.

For more information please contact NSK on 0800 6541909 or your preferred dental supplier.

Digital Dental

Independent advice you can trust

Digital Dental provide unbiased advice to enable Dentists to choose the right products for their individual digital imaging needs.

With over 10 years experience, they appreciate every Practice is different and has individual requirements. Therefore they offer a range of options enabling their clients to make the best choice for them in order to integrate the latest and most appropriate digital tools into their Practices. Not restricted to one or two manufacturers, they believe they supply the best products on the market that can integrate with all Practice Management Software or deliver seamless integration and paperless Practices.

Their technically trained advisers are the same people who demonstrate, install and train their customers on the equipment they select. Ensuring their clients get exactly what they were promised. These advisers can demonstrate all their products at one visit and at a time to suit the Practice. This includes “live” demonstrations rather than mock ups on dummy systems, enabling Practices to evaluate the actual performances of different options. Then install the equipment and provide comprehensive free hardware and software training until all the staff are fully trained.

Should a problem arise they can provide loan equipment to minimise disruption.

Proud of their reputation, Digital Dental have testaments to prove it.

For further information telephone Digital Dental on 0800 027 8595, email sales@digitaldentalco.com or visit www.digitaldental.co.uk.

Minerva Dental

Galileos 3D x-ray system

For unparalleled functionality in diagnosis, planning and treatment

Part of Sirona Dental’s XG family of digital radiography units, which also includes the Orthophas XG 2D imaging system, Minerva Dental’s NEW Galileos 3D cone beam digital x-ray offers unparalleled functionality in diagnosis and treatment planning.

Galileos 3D gives operators the power of integrated diagnostics and treatment planning via a single imaging system. It is particularly appreciated by anyone involved in implantology, periodontology, oral maxillofacial surgery and orthodontics. Enabling them to reduce risks, plan surgical interventions, coordinate treatment planning with colleagues and explain treatments to patients with greater clarity and certainty.

With its innovative Cone Beam technology, Galileos 3D calculates a large volume 3D image set (over 200 exposures) in a single low-dose 3D scan of 15 seconds or less. The image set is then processed and presented using GALAXIS software, an advanced version of Sirona’s SIDEXIS XG imaging software.

Galileos 3D not only shows 2D displays in perfect image quality, but also enables clear navigation and diagnosis in traditional Pan, CEPI and T3A displays. For Dentists’ unmatched flexibility and diagnostic potential.

Intuitively controlled by its EasyPad Touchscreen, it is an all-in-one diagnosis and planning system which offers a very short, low dose scan cycle for optimum speed and integrated workflow.

For further information ask your local Minerva Representative or telephone 029 20 442800.

Retained for future success

The British Orthodontic Society (BOS) has published an information leaflet aimed at patients who have concluded the main part of their orthodontic treatment and had their fixed brace removed. The vast majority of patients are then fitted with retainers – either fixed or removable - which are designed to prevent the newly corrected teeth from drifting back towards their original positions, which makes additional correction difficult, if not impossible.

Top ten

The leaflet provides answers to ten of the most frequently asked questions patients ask about retainers and is designed to provide an easy to follow guide, and of course encourage patients to see the importance of keeping up the good work by wearing and looking after their retainers.

1. What is a retainer and how important is it that I wear it?
2. How long will I have to wear the retainers?
3. How might the retainer affect my speech?
4. Can I eat normally?
5. Will I get caries?
6. Can I take it out for sports?
7. How do I remove the brace?
8. Will I be able to go on holiday?
9. What do I do if I play contact sports?
10. Will my bite change?
Optergo Prism Spectacles and Loupes - bending light instead of your neck

New refracting prism spectacles and loupes from Optergo can help put an end to neck and back problems.

Rather than bending towards a patient Optergo prism spectacles and loupes change the angle of image projection to the eyes. This allows the wearer to see below the normal line of sight and sit upright while working normally. There is no loss of vision, a straighter neck and back, and a reduced downwards-rotation of the eyeball resulting in less fatigue.

The prism is part of the lens, incorporating an individual's prescription and sitting in tilted, ultra-lightweight titanium frames. The latter improves patient experience – maximum, deep and stress-reduced polymerisation.

The patient chair features an adjustable headrest and an automatically correct backrest with a compensating movement. Combining operator ergonomics with patient comfort, it features smooth and easy-to-maintain upholstery in a choice of colours.

Other features include an easily adjustable double articulating headrest and an automatic leg rest with movement synchronised to the backrest. The latter improves patient entrance and exit and facilitates closer face-to-face positioning between the dentist and patient. This feature especially benefits elderly patients.

An intraoral x-ray unit, flat LCD monitor and Delight operating light can be integrated if required.

For further information please ask your local Minerva Representative or telephone 020 29 442800.

Pegasus H-Dent Needles are a key product from Astek Innovations. This well established product offers dentists a safe and reliable choice of needle.

For more information contact your local Representative, visit www.astekinnovations.co.uk or telephone 0161 284 7800.

Minerva Dental Planmeca Compacti for unmatched user and patient comfort

Minerva Dental are distributors for the Planmeca Compacti Treatment Centre, which integrates the dental unit and patient chair into a comprehensive floor-mounted unit.

The Compachi offers a spacious environment, balanced instrument delivery and every alternative plus unmatched user and patient comfort. Absence of a base leaves exceptional operator legroom and allows easy-to-maintain clear floor surface.

The patient chair features an adjustable headrest and an automatically correct backrest with a compensating movement. Combining operator ergonomics with patient comfort, it features smooth and easy-to-maintain upholstery in a choice of colours.

Other features include an easily adjustable double articulating headrest and an automatic leg rest with movement synchronised to the backrest. The latter improves patient entrance and exit and facilitates closer face-to-face positioning between the dentist and patient. This feature especially benefits elderly patients.

An intraoral x-ray unit, flat LCD monitor and Delight operating light can be integrated if desired.

For further information please ask your local Minerva Representative or telephone 020 29 442800.

Chlorhexidine Gluconate – Ideal Before and After Surgery

As we all know Chlorhexidine Gluconate is an exceptionally well-proven antimicrobial agent, which reduces the formation of plaque and combats gingivitis and oral candida infections.

The Chlorhexidine gluconate formula has been universally recommended by GDPs for the maintenance of good oral health for decades, which is a testament to its efficacy.

Chlorhexidine Gluconate Mouthwash is also recommended for both pre and post-operative use in the rapidly expanding areas of endodontics and dental implants, where leading dental specialists are increasingly exploiting its qualities to reduce infection and minimise patient discomfort and helps speed the healing process.

For more information please call John Jesshop of Blackwell Supplies on 07971128077 or email john.jesshop@blackwellsupplies.co.uk

BDEA can find permanent and locum Practice Managers, Dentists, Nurses, Hygienists and Receptionists, and even provides emergency locum placement at short notice.

With some recruitment agencies, you are never sure how the new team member will fit in, or whether they will be as good at their job as they say they are. With BDEA you know you will get the right person for the right job. Candidates are given in depth interviews over the telephone by an experienced Dental recruitment team, and are thoroughly assessed to find out their skills and qualifications.

BDEA obtain previous employment references and, when locum assignments come to an end, sends a quality control questionnaire to the client, to ensure that their temporary staff are reliable, knowledgeable and confident.

To contact Browns Dental Employment Agency, call 0845 150 5848, or email info@brownslocumlink.com
Sirona names their new UK Managing Director

Minerva Dental’s SIRONA Laser is the maintenance free diode laser which is so compact it fits in your pocket. With a clearly laid out menu which lets the operator navigate easily step-by-step, by following the menu, it is now available with an optional SIRONA docking station which makes it even easier to use. Suitable for use on any treatment centre, SIRONA incorporates a moveable fibre management system and hand-piece holder for maximum efficiency and operator convenience.

Operating at 980nm wavelength, SIRONALaser is small, powerful and light. This makes it easy to transport between surgeries or practices. SIRONALaser can be used for soft tissue surgery, dentine tubule disinfection in endodontic treatment, crown lengthening, disinfection of periodontal pockets and peri-implant sites, and teeth bleaching applications. In surgical applications it offers high precision tissue removal with minimal thermal damage to surrounding tissues, minimised bleeding for clearer visibility in the operating site, protection against post-operative infection, minimised scar formation, reduced need for anaesthesia and virtually no post-operative pain.

Easy and comfortable to hold, SIRONALaser’s ergonomically designed, fully autoclavable handpiece is operated using a choice of either removable finger switch or foot control. There are various tips to facilitate easy use throughout the mouth.

For further information please log on to www.sironacadem-solutions.co.uk or call Sirona Dental Systems on 0845 071 5040 e-mail info@sironadental.com.

Testimonial by Dr Amarjit Gill

With aesthetic dentistry on the increase many of us upgrade the materials and techniques we use to get better results. How many have upgraded the instruments though? I suspect very few have. I know of no lecturers that talk about this and struggle to recall articles that are written about them.

But could you be tempted with Nova’s composite instruments with tips coated with a special Titanium Nitride. This creates an ultra-smooth non-surface enabling quick placement and easy carving of composites. This really pays off when you are sculpting composite veneers! There is a choice of handles that make them lightweight and perfectly balanced to help prevent hand fatigue too.

The British company is Nova and their MD, Karen Turner, says she has a range of high quality instruments that are totally dependable, at prices that eliminate the need for dentists to look for lesser quality alternatives. If you take into account their optimal reliability and long life the price won’t worry anyone.

To see the full range please call DentalFax on 01276 691 821 or visit www.nova-instruments.com.

Sirona Laser

Minerva Dental SIROLaser New Docking Station ensures optimised efficiency and operator convenience

The Sirona Dental Group is pleased to announce that in February 2008 Terry Patuzzo was appointed Managing Director for their UK subsidiary, Sirona Dental Systems Ltd, the CEREC CAD/CAM division.

Terry has held various positions within Sirona Dental Systems since 2003 and has been an integral factor to the success of the business in the UK.

“In the last three years I have seen CEREC become the product that many dentists have on their wish list!” commented Terry, “Following the emphasis on implementing training programmes coupled with huge attention to after sales service and support this has, as a consequence, seen our business go from strength to strength.”

“I am honored to have the trust of Sirona and very proud of this assignment to take Sirona Dental Systems Ltd onto the next level here in the UK. Our company focus is on fulfilling our customers’ needs by providing outstanding service. Only this will ensure the continued growth of CEREC now and in the future.”

For further information please log on to www.sironacadem-solutions.co.uk or call Sirona Dental Systems on 0845 071 5040 e-mail info@sironadental.com.

Ivoclar Vivadent Ltd

NEW AdheSE One Promo Pack With “Click & Bond” VivaPen

Ivoclar Vivadent’s NEW AdheSE One featuring the innovative “Click & Bond” VivaPen dispenser is currently available in a Special Promo Pack containing a 0.5ml syringe for just £21.17 plus vat, the perfect way to evaluate this exciting new product.

This years speakers are Dr Malcolm Levinkind and Raj Battran.

This year sees the CEREC CAD/CAM division.

Minerva Dental

Talking Points in Dentistry 2008 set to be a sell out success!

The GlaxoSmithKline Consumer Healthcare (GSK) Talking Points in Dentistry lecture programme 2008 is set to be a sell out success with 2 venues already full. Dental practice teams who wish to attend are urged to book now to avoid disappointment.

The event is free to attend and offers the entire practice team the opportunity to gain CDP (Continued Professional Development Certificate) accreditation. Registration will promptly start from 6:30pm at all 11 UK venues, with the evening drawing to a close at around 10pm. Buffet refreshments will be provided throughout the evening.

This years speakers are Dr Malcolm Levinkind and Raj Battran.


Minerva Dental

Sirola MultiMotion Headrest

Now you can see more!

Minerva Dental Ltd, the wise choice for equipment and supplies, are pleased to announce the availability of the New MultiMotion Headrest from Sirona.

In Sirona’s Ergonomics Program, correct positioning and optimum access are absolute essentials if the operator and their assistant want to maintain concentration and precision throughout the day. It centres on three key areas – the operators sitting position, positioning of the patient, and optimum visibility of the treatment site. The MultiMotion headrest performs an important role in this program.

Designed for use with any Sirona Treatment Centre, MultiMotion is a fully adjustable headrest that enables you to position the patient’s head in the precise location for optimum access and visibility whilst maintaining their comfort. It features both upper and lower jaw positions, plus tilt and rotation.

MultiMotion facilitates optimum viewing of inaccessible areas, with the patient’s head inclined towards you and not visa versa. With simple one-handed operation it securely positions the patient’s head, eliminating any risk of lateral displacement.

For further information please ask your local Minerva Representative or telephone 029 20 442800.

Periodontists in line for behavioural change

Behavioural change is the theme of the British Society of Periodontology meeting on 28 June 2008 at the Digital World Centre in Manchester. The event, which is supported by Philips Oral Healthcare, will be addressed by internationally renowned keynote speakers including:

Professor Steve Rollnick, Clinical Psychologist, Primary Care and Public Health Department of General Practice at Cardiff University will demonstrate how behavioural management psychological models can be used in dental practice.

Ivoclar Vivadent Ltd

NEW AdheSE One Promo Pack With “Click & Bond” VivaPen

Ivoclar Vivadent’s NEW AdheSE One featuring the innovative “Click & Bond” VivaPen dispenser is currently available in a Special Promo Pack containing a 0.5ml syringe for just £21.17 plus vat, the perfect way to evaluate this exciting new product.

This years speakers are Dr Malcolm Levinkind and Raj Battran.

This year sees the CEREC CAD/CAM division.

Minerva Dental

Talking Points in Dentistry 2008 set to be a sell out success!

The GlaxoSmithKline Consumer Healthcare (GSK) Talking Points in Dentistry lecture programme 2008 is set to be a sell out success with 2 venues already full. Dental practice teams who wish to attend are urged to book now to avoid disappointment.

The event is free to attend and offers the entire practice team the opportunity to gain CDP (Continued Professional Development Certificate) accreditation. Registration will promptly start from 6:30pm at all 11 UK venues, with the evening drawing to a close at around 10pm. Buffet refreshments will be provided throughout the evening.

This years speakers are Dr Malcolm Levinkind and Raj Battran.


Minerva Dental

Sirola MultiMotion Headrest

Now you can see more!

Minerva Dental Ltd, the wise choice for equipment and supplies, are pleased to announce the availability of the New MultiMotion Headrest from Sirona.

In Sirona’s Ergonomics Program, correct positioning and optimum access are absolute essentials if the operator and their assistant want to maintain concentration and precision throughout the day. It centres on three key areas – the operators sitting position, positioning of the patient, and optimum visibility of the treatment site. The MultiMotion headrest performs an important role in this program.

Designed for use with any Sirona Treatment Centre, MultiMotion is a fully adjustable headrest that enables you to position the patient’s head in the precise location for optimum access and visibility whilst maintaining their comfort. It features both upper and lower jaw positions, plus tilt and rotation.

MultiMotion facilitates optimum viewing of inaccessible areas, with the patient’s head inclined towards you and not visa versa. With simple one-handed operation it securely positions the patient’s head, eliminating any risk of lateral displacement.

For further information please ask your local Minerva Representative or telephone 029 20 442800.

Periodontists in line for behavioural change

Behavioural change is the theme of the British Society of Periodontology meeting on 28 June 2008 at the Digital World Centre in Manchester. The event, which is supported by Philips Oral Healthcare, will be addressed by internationally renowned keynote speakers including:

Professor Steve Rollnick, Clinical Psychologist, Primary Care and Public Health Department of General Practice at Cardiff University will demonstrate how behavioural management psychological models can be used in dental practice.
Novabone: Dental Putty – Uncommon Handling, Uncompromised Results

With his seminar ‘Novabone Dental Putty – Uncommon Handling, Uncompromised Results’, Novabone Product Manager Srinivas Katta can show you how to make the most of this superior osteostimulative material.

Composed of minerals naturally found in the human body, Novabone Dental Putty is proven to promote rapid regeneration of bone. With optimum ease of handling, and offering outstanding results, Novabone has over 20 years of clinical use and a wealth of studies behind it.

Novabone has been observed to promote solid bone formation and high material resorption at 6 and 12 weeks. It does not require mixing, has unparalleled adaptability, and unlike other graft materials, stays in place and conforms to the defect.

The seminar takes place on the 1st of April at the British Dental Association, 64 Wimpole Street, London, from 18:30-20:50 and constitutes an hour of Continuing Professional Development.

The first 20 respondents to the seminar invitation will receive a FREE 0.5cc sample of NovaBone.

Contact Oraldent on 01480 862080 to book your place

New toothbrush promises up to 2 shades lighter in 2 weeks – and healthier teeth too

Healthier, whiter teeth, up to two shades lighter in two weeks – that’s the dazzling prospect anyone looking to transform their smile can expect from the new Sonicare Clean & White toothbrush.

With his product, the traditionally black-and-white bristles will be replaced by white bristles loaded with thousands of tiny teeth-shaped particles. This means that Sonicare cleans in just one go, getting into those hard to reach areas and along the gumline. Building on Sonicare’s patented sonic technology, the innovative ProResults brush head, and a dedicated whitening mode, HealthyWhite ensures that you can achieve visibly whiter teeth without the hassle of whitening strips and gels.

The toothbrush is ideally suited to all daily brushing needs and is suitable for sensitive teeth.

For more information please call 0800 895115 or visit the website www.sonicare.co.uk.
Every dental professional is now eligible to enter 2008 Premier Awards

Building on the success of the last seven years, Dental Protection and Schülke announce the return of The Premier Awards which has been expanded to include entries from all dental professionals.

With a total prize fund of £6,000, the Awards offer one of the largest cash prizes for dental risk management projects in the UK. The three competition categories now include all members of the dental team at any stage of their career.

• Dental care professionals (DCPs)
• Dental undergraduates
• Dentists

The new categories mean that all dentists and DCPs are eligible to enter their own work for this prestigious award. Dental Protection, the world's leader in indemnity and risk management advice for the dental team has renewed their longstanding partnership with Schülke, the European leader in infection control, to sponsor The Premier Awards for 2008.

The event recognises achievements in developing awareness and the effective management of risk within clinical dentistry. Candidates can submit projects or assignments in one of the following topic areas:
• Infection control
• Health and safety
• Consent
• Record keeping, or
• Team working and skill mix

This year's awards will be presented during The Premier Symposium to be held 29 November 2008 at Kings College, London.

An application form and full terms and conditions are available by contacting Sarah Cunliffe at Dental Protection on 020 7399 1339 or by emailing sarah.cunliffe@mps.org.uk

Further details of the Premier Awards and Premier Symposium are available on the Dental Protection website, www.dentalprotection.org

The British Academy of Cosmetic Dentistry (BACD) together with the British Society of Cosmetic Dentistry (BSCD) is delighted to take the year into a very special BACD Anniversary Meeting in Edinburgh on 18th - 20th June 2008.

Speakers who are still:erating research and practice are from all around the world to make presentations at the BSCD's meetings and meetings of the BACD - the two non-academic World famous societies including Dental Aesthetics, Anand Magan, James Briscoe, Earle Tilson and Erich Winkler all attend, helping to deliver a totally unique course combining the ethos of both organisations and aesthetic dentistry.

The meeting will be held at the Royal College of Physicians, Green Motor, Cafe in Edinburgh, and the society will enjoy an evening dinner reception at the historic Grassmarket.

For more information or to join them and the BSCD in the stunning surroundings of the Scottish Capital for this fantastic three-day course, please visit www.bacd.com

And the winners last year were…

Last years winners were:

Undergraduate
1st Nathalie Chamary: Microbial contamination of removable prosthetic appliances and cross infection control
2nd Joanna Christou and Mishal Sachdev: A review of consent for dental anaesthesia

Postgraduate
1st Chetan Kaher: The evaluation of advice given to health care professionals to pregnant patients regarding dental radiography
2nd Neil Subhash Nathwani: Clinical record keeping audit

DCPs
1st Lisa Simmons: Infection control and blood/body fluids policy
2nd Alison Lane: Cross infection - have you got it under control?
SMILE DESIGN 2008
THE ULTIMATE EXPERIENCE

A hands-on seminar teaching the concepts of smile design and functional esthetics to cavity-free patients, by expert practitioners, from eminent, practical workshops. Increase patient productivity, enhance office environment and further your practice and professional growth.

Friday 10th October 2008
Saturday 11th October 2008
Friday 7th November 2008
Saturday 8th November 2008

Venue:
Savoy Dental Studios, 16 Bowchurch Grove, Watford, Herts, WD17 2AD

Presented by:
Dr David Bloom EDS N’dle
Dr Jay Pardipch EDS N’dle
Melanie Prebble BDT EDD

SPEAKER FREQUENCY
• Course Synopsis
• Course Orientation
• Course Conclusions
• Course Evaluation

Course Fee:
Dental or TMJ Management
£495 + VAT

Additional fees include:
- Course Fee:
- Course Materials:
- Course Handouts:
- Course Notes:
- Course Videos:
- Course Manuals:
- Course Guides:
- Course Books:
- Course Texts:
- Course Manuals:
- Course Guides:
- Course Books:
- Course Texts:

For any further information, please call:
Heidi Keene
07887 774 466
email: info@co-ops.co.uk

To place recruitment or Courses/Seminar ads please contact: Joseph Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com