Sugar-free eggs
A dentist in Trafford in Greater Manchester is giving out free 'Good Eggs' as a healthy alternative to Easter Eggs. The sugar-free Easter eggs contain a toothbrush, toothpaste and a guide to healthy brushing. Kailesh Solanki, of Kiss Dental Clinics in Flixton and Altrincham, has been giving out the eggs to patients who come in with children. He came up with the idea after wondering what to give his three-year-old daughter for Easter. The ‘Good Egg’ is similar to diabetic chocolate, and is hand-made using Belgian chocolate from a local chocolate manufacturer in Stockport.

**Dental Showcase**

More than 180 dental companies have already booked stands at BDTA Dental Showcase 2009, in a bid to provide dentists with a wide choice of products, services and technologies to assist day to day activity. Bookings continue to be received and the BDTA is expecting more than 500 companies to appear at the event in November. Tony Reed, Executive Director at the BDTA, said: ‘A trip to Dental Showcase will be a fantastic experience for all members of the practice. It is the only time you will see over 300 dental companies to appear at the event in one roof.’

BDTA Dental Showcase 2009 takes place 12-14 November 2009 at NEC Birmingham. To register in advance for your complimentary ticket visit www.dentalshowcase.com/visit, call the registration hotline on +44 (0) 1494 729959 or text +44 (0) 7995 020 276. Advance registration closes 8 November 2009. On-the-day registration: £10 per person.

**Karting competition**

Denplan has announced the launch of the 2009 Denplan Karting Challenge. Following the last two successful years the challenge has increased to nine heats throughout the UK. Regional heats begin in May in Edinburgh, where Denplan member dentists and other members of their practice team are invited to go head-to-head against other local practice winners to win a place in the September final.

www.dental-tribune.co.uk

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**Steele report exposed to all**

**Health minister, Ann Keen, has promised to publish the report on the independent review of NHS Dentistry in full.**

Professor Jimmy Steele, is leading the review, which has been asked to report on increasing access across the country and how to improve quality of services.

The review group has also been asked to come up with recommendations on how the government can work towards reducing oral health inequalities. In an exchange in the House of Commons, Mike Penning, the shadow health minister, asked if the report will be published in full and whether the government will accept all the recommendations.

In a slip up, Mrs Keen replied that the report, of course, would be accepted in full.

When we have made an error, any sensible government, we will look at the review when it is published.

The review is independent from the Department of Health and is being led by Professor Jimmy Steele of the University of Newcastle who, along with his team, will report directly to the Secretary of State in the summer.

Earlier on in the exchange, Conservative MP, Laurence Robertson, asked if the government will be taking steps to increase the number of NHS dentists in Gloucestershire.

Mrs Keen replied that NHS South West and Gloucestershire Primary Care Trust (PCT) is in the process of inviting tenders for dental services with a total value of £6m over the next two years—

**Dentist cuts patient's cheek**

A dentist in South London has been accused of cutting a patient’s cheek from her mouth up to the corner of her eye.

A General Dental Council (GDC) fitness to practise hearing, heard how NHS dentist Oscar Miguel Frauzo Alvim de Castro, formerly employed at Whitecross Dental Care surgery in Streatham, left his patient with the scratch from the instrument being used to do the filling, after his hand slipped.

Guy Nicklewright, who is representing the GDC, described it as ‘a quite extreme amount of travel (by the instrument) for an accident.’

The patient complained that the dentist did not apologise and carried on with the treatment as if nothing had happened.

She wrote a letter of complaint to the practice and took the matter to the GDC.

Mr De Castro, who is now living in Portugal, did not attend the hearing.

He claims he did nothing because the patient was wearing goggles, and did not show any pain during the remainder of the treatment.

Mr De Castro is also accused of giving the patient fillings without discussing or getting consent for the treatment, and keeping insufficient notes on the incident.

Mr De Castro, worked at the Streatham dentists surgery from May 2006 to April 2007 as a practiceitioner employed by Lambeth PCT.

The hearing continues.
Don’t miss CIC!

Better oral health solutions

Dental professionals are being urged to book their places now at the Clinical Innovations Conference and Annenberg Lecture 2009.

The joint endeavour from Smile-on and Alpha Omega is expected to be very popular.

The Clinical Innovations Conference (CIC) takes place on 15-16 May at the Royal College of Physicians, Regent’s Park, London.

Professor Nitzan Bichacho, a worldwide authority on aesthetic and implant dentistry and Dr Devorah Schwartz-Arad, a specialist in oral and maxillofacial surgery, will be presenting the lecture ‘Success factors in dental implantation: a multi-disciplinary approach between the surgeon and the prosthodontist’.

On 16 May, there will be an impressive programme of lectures including presentations and hands-on sessions from Professor Nasser Burghi, head of the division of aesthetic dentistry in the Department of Restorative Dentistry at the San Antonio Dental School, leading expert in tooth whitening technology Dr Wyman Chan and prosthodontics specialist Dr Siria Mirfendereski.

Other speakers include Professor Eddie Scher, Dr Chris Orr and Professor Liviu Steier.

Delegates will earn Continuing Professional Development hours, making this event an invaluable educational experience.

For more information and to reserve your place, call 020 7400 8989 or email info@smile-on.com.

Revitalising ageing teeth

NovaMin products revit- alise ageing teeth, decreases sensitivity, eliminates whitestains and decreases inflammation, according to research.

Dental treatment is undergoing a transformation worldwide and dental patients are more demanding and know what they want.

They are asking for minimal intervention therapies that conserve tooth and periodontal structures.

Since the late 1960s, more recently, researchers have adapted the same technology for tooth remineralization.7

She added: ‘NovaMin therapy is ideal for this function. Demineralization is stopped, white spots are eliminated, and the sealed dentin stops sensitivity. An added benefit of the NovaMin particle is its anti-bacterial effect on oral microorganisms, leading to enhanced gingival health.

Hager & Werken GmbH has launched two new products in their Miradent prophylaxis line that use the innovative NovaMin technology:

Miradent nanosensitive hca is a NovaMin containing dentifrice for at-home treatment. Clinical studies have shown a 90 per cent reduction in sensitivity, durable remineralization and long-term protection of hard tissue surfaces.

Miradent nanosensitive hca dental-kit was developed for in-office treatment of patients with acute sensitivity. This product delivers the same NovaMin technology at a higher dose for professional application. It is recommended after tooth cleaning and periodontal treatment when sensitivity often increases.

The extra £5.1 million is to be spent on increasing the number of NHS dentists in Wiltshire.

The new funding from the South West Strategic Health Authority will increase provision to an NHS dentist from the existing 43 per cent of the 457,490 population with access to an NHS dentist to 52 per cent.

The programme highlights the importance of communicating skills when treating patients and looks at interventions dental professionals should take to improve patients’ oral and general health.

It also looks at patient self-care and how practitioners can raise self-care issues with patients. This includes oral health messages as well as advising patients on healthy diets, sensible drinking, and smoking cessation.

The programme is for all dental professionals from dentists to orthodontists to hygienists.

For more information on the programme, call 020 7400 8989 or email info@smile-on.com.

GDC calls for views

The General Dental Council is calling dentists, wishing to become specialists, for their views on flexible training opportunities.

The General Dental Council (GDC) has this week launched a series of consultation documents on specialist lists, including presentations and hands-on sessions from Professor Nasser Burghi, head of the division of aesthetic dentistry in the Department of Restorative Dentistry at the San Antonio Dental School, leading expert in tooth whitening technology Dr Wyman Chan and prosthodontics specialist Dr Siria Mirfendereski.

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Fig. 1 Miradent nanosensitive hca dentifrice Priced by NovaMin

A spokeswoman for dental company, Hager & Werken GmbH, said: ‘This is an excellent opportunity for dental professionals to refer patients, check its website to see whether or not a dentist is a specialist.

The Specialist Lists indicate registered dentists who meet certain conditions and are entitled to use a specialist title. A dentist does not have to be entered onto a Specialist List to carry out the practice of any particular speciality; but may only use the title ‘specialist’ if they are on the list.

To ensure standards have been achieved, anyone on the lists must have appropriate training and experience – and they are the only dentists who are entitled to call themselves specialists.

A spokesperson for the GDC said: ‘Our goal is to provide guidance to training providers on allowing flexible opportunities for those wishing to train as specialists. So, we want to find out whether you agree in principle to making training more flexible. How could we do this? What limits are there? We would like to hear from as wide a range of people as possible, including professionals wanting to undertake training and those who will deliver it.’

The consultation opened on 18 March and will run until 10 June.

The consultation can be found on the GDC website at http://www.gdc-uk.org.

A copy of the consultation document and questions can be requested from Amanda Little on 020 7887 3812.

You can also email: allittle@gdc-uk.org or write to: Amanda Little, Consultation on Specialist Lists, General Dental Council, 57 Wimpole Street, London, W1G 8DQ.

More money for Wiltshire

The extra money will be used from April for the coming year.

In Wootton Bassett, the plan is to call themselves specialists.

The biggest increase will be in Chippenham where NHS Wiltshire plans to increase the coverage of NHS dentistry from the existing 22 per cent of the 457,490 population with access to an NHS dentist to 47 per cent.

In Calne, the number will rise from 59 per cent to 84 per cent.

The extra provision will be in towns in Wiltshire including Calne, Chippenham, Devizes, Malmesbury, Marlborough, Pewsey, Tidworth and Wotton Bassett.

NHS Wiltshire, which commissions dental services, is negotiating with existing practices in Calne, Devizes, Marlborough and Pewsey, to take on the extra NHS work. It is also hoping to attract new practices in Chippenham, Malmesbury, Wotton Bassett and Tidworth.

In Chippenham, where NHS Wiltshire plans to increase the coverage of NHS dentistry from the existing 22 per cent of the population to 47 per cent.

In Wotton Bassett the plan is to increase it from five per cent to 18 per cent and in Malmesbury from ten per cent to 27 per cent.

In Calne it will rise from 78 per cent to 84 per cent.

Janet Stobart, manager of The Market Place Dental Practice and the High Street Dental Practice in Devizes, expressed her delight at the extra funding and said: ‘We are pleased that NHS Wiltshire plans is closed but we are being asked on a daily basis by members of the public if they can join the practice.’

A new e-learning solution showing dentists how to give good oral dental advice to their patients has been unveiled.

The two-hour programme, Prevention in Practice: Using Delivering Better Oral Health, was launched by Smile-on at the British Association for the Study of Community Dentistry (BASCD) Conference in Manchester.

Janelle Montgomery, project manager at Smile-on, said: ‘The e-learning package can either be downloaded online or bought as a CD-ROM. It supports dentists in implementing the Delivering Better Oral Health toolkit, which was sent to all NHS practices in England in 2007, by the Department of Health.

The programme aims to improve knowledge and understanding, and help consistent and effective delivery of evidence-based health messages by the dental team.

With the programme, dental professionals will be able to provide evidence-based health care interventions that impact on oral and general health and promote behaviour change in patients to improve self-care.’

The programme is for all dental professionals from dentists to orthodontists to hygienists.

To find out more, email info@smile-on.com or call 020 7400 8989.
Guest comment
The way forward

Despite en masse criticism and anger about the new contract the government has described this transitional phase as merely ‘turbulent times’. Recent access data showing a 0.4 per cent (99,000) increase in access have been seized upon by the DH as a sign that the reforms are working, even though the number of patients seen was still 1.1 million (3.9 per cent) fewer than the 2.8 million seen in the two-year period immediately prior to the introduction of the new NHS contract in March 2006.

We all know the NHS is a budgeted system and that if we want to provide work outside of the NHS it must fall under the vain banner of being ‘cosmetic’, because surely if it is needed the NHS will provide it. DH literature aimed at both patients and dentists is filled with unspecific phrases such as: ‘In April 2006 the NHS introduced new rules which mean that orthodontic treatment is only given to people who need it for clinical reasons’ and my personal favourite is the term ‘clinically necessary’.

The words ‘clinically necessary’ and ‘clinical reasons’ seem to be an interpretation for ‘working within a budget’, so why is the DH reluctant to talk to patients and dentists about the reality of working within a budget? Are we now as a profession surely to be working within a budget? Are we working within a budget? Are we working within a budget?

In my recent interview with CDO Barry Cockcroft I asked him what NHS dentistry is aiming to provide. I was given a barrage of friendly sounding words such as clinical and cost effective and evidence and outcome-based treatment. But after probing a little bit further I was told ‘it’s about clinical and cost effectiveness and that’s a judgment dentists have to make.’ Initially this sounds like a nice non-specific phrase which with simple treatment makes a lot of sense; why should the NHS provide white fillings on back teeth when silver metal ones will suffice at a fraction of the cost? But what about more complicated treatments? Can we really have a situation where all treatments are both clinically and cost effective?

In many cases certain treatment options such as large span fixed bridges or implants can be very clinically effective but a removable partial denture may be the most cost effective option. So surely now is the time the DH opens a proper dialogue about how the NHS can provide more complex treatments or are we stealthily moving to a basic core system where the emphasis on seeing more and more patients to improve statistics is given priority over providing high level care to the whole population? Whatever the case lets hope the DH starts to give clear guidance as to the direction of NHS dentistry, maybe then NHS dentistry can deliver realistic aims based upon realistic aims.

About the author
Neel Kothari

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

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Contraindications: Hypersensitivity to the active substance or other components of the preparation. Do not use in children under the age of 6. Special warnings and special precautions for use: Do not swallow. Interactions with other medicines: None known. Unavoidable effects: Some cases of mucosal irritation and swelling of the oral tissues have been reported especially with high doses or in continued use. The symptoms will resolve on stopping treatment. For further information please visit www.colgateprofessional.co.uk.
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Mr SmartCem2 loves working with his indirect restorative team as he knows they always do a brilliant job together in preparing the tooth, to ensure the final restoration fits perfectly. When it comes to cementing the final restoration, the reliably strong Mr SmartCem2 uses his smart thinking and quick action to stick the crown in place. Mr SmartCem2 is so smooth, he turns to gel when setting to make the clean-up really easy. Give him a go!
Wii learning for dental students

Dental students in Glasgow have adapted the Wii, a gaming device, to simulate operating techniques on a virtual dental patient.

Their proposal has won first prize in the Dental Innovation Technology Ideas Award.

The competition challenged final year students to develop an idea for a new piece of technology or innovation in the dental field.

The students, due to graduate from Glasgow University dental school this summer, suggested adapting the Wii console so it could be used to simulate operating techniques.

The wireless controllers are used to replicate the use of instruments on a ‘virtual patient’ on the screen. The controller could also be used to provide sensory feedback to the user.

Dr David Watson, a lecturer at the dental school, said: ‘Simulation of clinical procedures is normally carried out in the operative techniques lab. However, dental students sometimes have limited opportunity to practise their techniques outside of the lab.

The use of Wii technology could be a really innovative and cost-effective solution which students could use to improve their manual dexterity. There is considerable research to back up the concept of using video games to improve dentist’s coordination and the Wii-based application would complement the simulation technology already used in dental schools worldwide.’

Mr Leaver said: ‘We are absolutely delighted that Glasgow Dental School has given us the opportunity to host this annual award. As more dental practices become reliant on digital systems, it is vital that students are up to speed with the latest technologies. We hope the award will inspire them to think about how technology can be applied in practice for greater efficiency and better patient care.’

Dental problems generate more calls

In Lincolnshire, emergency dental problems generated more calls to the NHS helpline, NHS Direct, than any other medical problem.

More than 7,000 patients called NHS Direct complaining of dental-related issues last year.

It was the second consecutive year that the issue came top in the calls made to the free advice and information service.


The figures, released to the Lincolnshire Echo under the Freedom of Information Act, show that 55,443 calls to NHS Direct were from Lincolnshire in 2007 and 2008. Last year they increased slightly from 81,316 to 83,786.

Rashes, abdominal pain, vomiting and fever made it into the list of top 10 complaints for both years.
‘Limit private dentistry’ says report

A thinktank wants a quota imposed, forcing NHS dentists to spend at least half of their time, on NHS dental work.

Dentists should be limited to the amount of private work they can do, said the New Local Government Network (NLGN), which specialises in public service reform.

Its report People Power – How Can We Personalise Public Services? claims imposing such a quota would help improve access to NHS dentistry.

The thinktank claims taxpayers are getting a poor deal as it costs £175,000 to put dentistry students through five years of training, after which they only have to spend the first year of their career as a qualified practitioner within the NHS.

The move would bring dentists into line with hospital consultants, who are not allowed to earn more than 10 per cent over their NHS salary in private practice.

In an open letter to Sir Jimmy Steele, chairing the Independent Review into NHS dentistry, Chris Leslie, director of the NLGN, said: ‘There is clearly a problem with a lack of basic NHS capacity on dentistry, despite valiant attempts by the government at a national level injecting an additional 8.5 per cent of resources this year following the extra 11 per cent increase granted in 2008/9.

When the typical dentist has received the benefit of around £175,000 of taxpayer investment in their training and development, we feel that there should be a greater obligation on those individuals to give more back to the community and dedicate a greater proportion of their time to NHS work. This should go beyond the current obligations for twelve months within the NHS context.

However, the British Dental Association (BDA) is against the idea and pointed out that is it the funding available to primary care trusts (PCTs) to commission primary care dentistry that determines the amount of NHS dental care available.

Susie Sanderson, chair of the BDA’s executive board said: ‘Since reforms to NHS dentistry were imposed in England and Wales in April 2006, care has been commissioned directly from dentists or dental practices by primary care trusts. Contracts are based on the completion of, and funding for, a fixed amount of care. This amount is expressed in a currency called units of dental activity (UDA).

She claims that many dentists would like to do more NHS work but are unable to and added: ‘The size of these contracts varies greatly, with some practices commissioned to provide significant amounts of NHS care and others holding much smaller contracts. Those with smaller contracts will normally also provide private care. This often opens up treatment options to their patients that are not available on the NHS.

In some instances dentists have either not been awarded NHS contracts at all, or been awarded NHS contracts that are for smaller NHS commitments than they would have liked.’

The BDA also pointed out that newly qualified dentists emerge from a five-year degree having incurred a significant amount of debt.

According to the BDA’s most recent survey of final year dental students, the average debt a new graduate owes is just under £25,000.

It is not the first time the idea of a quota has been floated.

Kevin Barron, chairman of the House of Commons Health Committee, has also backed the move in the past, saying dentists had a ‘moral obligation’ to treat NHS patients.

The government is also against a quota.

Dr Barry Cockerroft, England’s chief dental officer, said: ‘The NHS is now under a legal obligation to provide dental services for their local population.

‘We have also appointed an independent review team to help us understand what more needs to be done to ensure that every person who wants to visit an NHS dentist can do so and all NHS dental services meet the highest standards of care.

‘We feel that the measures we have taken are a better approach than a quota system for NHS dentists.’

Mr Leslie, director of NLGN, also said in his open letter to Sir Jimmy Steele, that PCTs should be encouraged to be far more innovative in the nature of their service commissioning.

He said: ‘For example, we would like to see a broader array of dental services so that particular hotspots can be targeted more intensively, perhaps with mobile dentist working, or periapatic dentistry. Opening hours should be considered so that, in time, the service can revolve more around the convenience of the patient than the profession.

And we would also like to see an extension of the “walk-in dentists” service which has proved popular in some areas. Further more, we believe the time has come for PCTs to pool resources and commission training facilities or even direct dental practices under the auspices of the NHS itself, hiring their own series of dentists rather than always “outsourcing” these contracts. A diverse market of provision should be the ultimate goal.’

The NLGN wants dentists to dedicate more time to NHS work.
Dental students are being told to use child-friendly language, and call the dentist’s chair a ‘rocket man’s chair’, in a drive to stop children being scared of the dentist.

The move comes after eight-year-old Sophie Waller died of starvation and dehydration after suffering from a phobia of dentists.

Professor Liz Kay, dean of the Peninsula Dental School in Plymouth focuses on teaching dental students a broad range of skills which encompass technical skills and communication plus psychology and sociological skills.

Dental students are encouraged to understand the root causes of a patient’s anxieties.

Professor Kay claims that learning the basics means 99.9 per cent of children would feel at ease.

She advises dental students to use the words ‘rocket man’s chair’ instead of dental chair and make it fun so instead of saying ‘open your mouth’ say ‘let’s count your teeth’.

She would like to see dentists making surgeries friendlier places by putting out games for them to play while they are waiting and added that parents could help by simply making sure their children cleaned their teeth and avoided sugary food.

Looming deadline for GDC fees

The deadline for all dental care professionals to pay the General Dental Council’s Annual Retention Fee is fast approaching.

The date for the fee has changed from December every year to 31 July.

The General Dental Council (GDC) has taken the decision not to increase the fee this year.

So it remains at £96 for dental nurses, dental technicians, dental therapists, dental hygienists, clinical dental technicians and orthodontic therapists.

GDC director of operations, Edward Bannatyne said: ‘This means a change for thousands of dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists, who are used to paying in December each year.

We are doing all we can to make sure people know about the deadline. Letters are being sent out and we’re also hoping you will spread the word among your colleagues. Please don’t ignore the deadline as you need to pay your fee in order to remain on the register.’

The deadline for dentists to pay their Annual Retention Fee (ARF) is still 31 December each year.

The GDC is hoping that dental care professionals will sign up to an annual Direct Debit.

They can do this by downloading a form from the GDC website via the ARF pages.

For those registered online, the GDC self-service website at www.gdc-arf.com can be used to set up a Direct Debit in April.

Dental care professionals who are not yet registered online need to wait for their ARF letter which will give them an ID verification code for the process.

Any questions, please contact the GDC Customer Advice and Information Team on 0845 222 4141.

Or email CAIT@gdc-uk.org.
A dentist from Dumfries in Scotland is flying out to a remote part of India to give people in the region free dental treatment.

Laura Kerr, a general dental practitioner, with ID Peacock, is going to Bisalpur, which also has a dental clinic. There is no permanent dentist based in the clinic and it is only in use when dental volunteers come from all over the world to work at the clinic for up to two months.

The lack of a permanent dentist can leave people in the area without dental cover for up to six months at a time.

Lack of oral hygiene led to Ms Kerr extracting 270 teeth and treating more than 500 patients, during her three week visit in 2007.

Many had walked over 10 miles to see her.

Fellow dentist, Beth Young, who works at Glasgow Dental Hospital is accompanying Ms Kerr on her trip.

The pair will have to raise money to pay for their flights as the dental volunteers pay their own expenses for the trip. They will also be working in temperatures of over 40 degrees centigrade.

Can you offer any sponsorship for Teeth for Life India?

Laura Kerr, a general dental practitioner, with ID Peacock, is going to Bisalpur, which also has a dental surgery room.

She will be spending two weeks based at the Eye Hospital in Bisalpur, which also has a dental clinic. There is no permanent dentist in this impoverished part of Rajasthan.

Ms Kerr went out at the end of 2007 and was given a 'thank you' trophy for her work. The trophy is now on show in Ms Kerr's Dumfries surgery room.

The project Teeth for Life India began in 2000.

They are also currently trying to raise money for specialist dental equipment as the only equipment the hospital has is a dental chair.

Ms Kerr is keen to hear from any organisations or businesses who would like to offer sponsorship or raffle prizes and is willing to give talks on her adventure. She can be contacted on 01587 288769.

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Lack of oral hygiene led to Ms Kerr extracting 270 teeth and treating more than 500 patients, during her three week visit in 2007.

Many had walked over 10 miles to see her.

Fellow dentist, Beth Young, who works at Glasgow Dental Hospital is accompanying Ms Kerr on her trip.

The pair will have to raise money to pay for their flights as the dental volunteers pay their own expenses for the trip. They will also be working in temperatures of over 40 degrees centigrade.

Can you offer any sponsorship for Teeth for Life India?

Laura Kerr, a general dental practitioner, with ID Peacock, is going to Bisalpur, which also has a dental surgery room.

She will be spending two weeks based at the Eye Hospital in Bisalpur, which also has a dental clinic. There is no permanent dentist based in the clinic and it is only in use when dental volunteers come from all over the world to work at the clinic for up to two months.

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You’ve all heard countless stories about the actress and the bishop, or about the judge and the blonde. What follows is a story that would have made Basil Fawlty, green with envy.

On a recent Saturday night, I went out for dinner. My Significant Other, hereafter referred to as my SO, had invited two of her friends of long standing (and, I might add, also of high standing) to join us at a restaurant where she had dined very satisfactorily on several occasions. The food, my SO said, was passing fair, the atmosphere good, the ambiance pleasant, and the prices reasonable. What I looked forward to most was getting to know her friends, the judge and the psychologist.

Tempers frayed

The SO and I arrived a couple of minutes late, to find a somewhat irate judge rising from the basement, where he had gone (unsuccessfully) to find a table in a position less drafty than that allocated on a freezing cold night. OK, the owners can’t control the weather, but they could improve on design and provide a two-door entrance hall – but hey, space is money even in cut-price London.

As the ebullient young blonde owner showed us to us our table, we offered our coats for hanging, to be told that they no longer did coat-stands because someone’s jacket had recently been stolen, and that was what backs of chairs were for – an unimaginative solution to a problem that required an innovative one. We were however luckier than our companions, whose coats were earlier accepted and unceremoniously dumped on the floor downstairs.

Or were we?

Due to the poor layout of fixtures, every time a waiter walked in the narrow space behind me to the service area, he knocked heavily into the back of my chair from where my coat was suspended, never once apologising. However, I was in a good mood and not about to allow such trivia annoy me. Not so the judge, who appeared testy, stating that one should not go to restaurants on a Saturday night. Little did he know that the best (or worst) was yet to come.

The waiter delivered us each of two quarter slices of bread which proved to be more than a little stale, proving that...
little of something had was worse than nothing at all. When the blonde arrived to take our order, the judge pointed out the bizarre problem at which she puckered her pretty nose and said in a grand tone: ‘Someone will be fired for this!’. My SO ordered a starter portion of risotto, to be informed that it could only be ordered as a main course, observing the disappointed look on SO’s face, the blonde remembered that it was her duty to please customers and said: ‘Ok, as a big favour, I’ll organise a starter portion for you.’ Gee, that will really stretch the chef, but thanks so much! She departed to speak to the waiter about the bread issue.

A few minutes later the waiter reappeared and put two more quarters of the same stale bread on our plates – explain that one!

Slim pickings
Our starters duly arrived, and tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them, tasty they were, although one needed binoculars to see them. Now, I know that small portions are the mode du jour, but these were microscopic. When the mains arrived, however, I was delivered a portion of fried fish whereas, like my SO, I had ordered the houllabaise. I pointed this out to the blonde, who assured me with a grimace that I had indeed ordered the fried fish, but then, momentarily replacing the glued-on smile, said they would bring me the houllabaise even though I had not ordered it.

At this point the judge, whose patience had already been severely tested, peremptorily demanded (as judges do) that his empty wine glass be replenished, and the blonde went into hyper-actress mode, taking an eternity to dry the bottle, again to show us what good service was really about. The judge then lost it and bellowed: ‘Are you going to serve me, or not?’

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The judge then lost it and bellowed: ‘Are you going to serve me, or not?’
Marketing – does it work?

Getting your practice known takes more effort than just advertising in the Yellow Pages, says Andy Acton

The UK dental market is changing rapidly with more practices looking to develop the private element of their practices significantly. These practices are targeting patients that have the choice of where to spend their disposable income. Your job is to convince them to spend it with you. Try and relate it to your own life, where do you shop for groceries and why? Is it because the quality, price or a multitude of reasons? Then look at the marketing that influences you.

In this changing environment, the practices that want to continue to be successful or become successful need to keep a constant review of their promotional activity. It’s not just about getting new patients, but also retaining your existing ones. Here’s a prime example: if you offer tooth whitening but don’t tell your patients you do, don’t be surprised when they go to another practice, which has advertised this service.

Successful promotion

The principles of marketing are easily adaptable to dentistry of which there are six components that make up the promotional mix:

- Advertising
- Direct marketing
- Sponsorship
- Public relations
- Personal selling
- Sales promotions

These components are integral to a marketing plan as they are all interlinked and interdependent. There is little point in advertising your practice if all you then sent out to interested patients was a tatty, photocopied piece of paper. This is counterproductive and only creates a negative picture of your practice.

Next steps

- Decide what type of practice you want and what type of patients you want to attract – remember successful marketing is about getting the patients you want not just lots of patients.
- Review your image and literature – you don’t see Harrods sending out poor-quality letters and brochures, for example. A quality presentation will make the patient perceive a quality practice.
- Set a budget – marketing doesn’t need to be expensive, it could be as simple as a practice newsletter.
- Engage a professional who can match your ambitions to your budget.

Once you have done all this you need to make sure that you instil in your practice team the importance of marketing and how to effectively use the literature.

Marketing is important to you and it doesn’t have to be expensive. If you want to develop your practice or even protect them you need to immerse yourself in all aspects of marketing for your practice.

Andy Acton

is director of Frank Taylor & Associates, independent valuers and consultants to the dental profession. Andy has helped a number of dental specialist banks develop their services to the dental profession, including NatWest and Bank of Ireland. Call 08456 123454 or email andy.acton@ft-associates.com.
Critical decisions are being made, but information is not readily available. It’s not unusual to see divisions between clinical and business staff, between groups of the favored employees and the rest of the workers, or between the longtime personnel and the new recruits. Regardless of the makeup, staff cliques can be a powerful undertow in your practice manifesting in poor morale, ongoing conflict and increased staff turnover—all of which compromise practice productivity and profitability.

Take the case of Liz, Ellen and Tom. They’ve been with the doctor since day one. They feel that because of their seniority in the practice, they are the ones to run the show, and that would be how the other employees see it as well. The doctor doesn’t make a change unless the “Three Musketeers” are on board. The Three Musketeers eat lunch together, have coffee together, socialize together and think nothing of the message of exclusion they send to the other employees, who, by the way, turn over pretty regularly. They justify their failure to include new employees by claiming it is “just too much of a burden on the rest of the staff.” The expense of perpetual employee turnover, the inability to effectively address shortcomings in key systems, and their own loss of credibility as the leader of the practice and CEO of the business.

Cliques are costly.

Certainly, strong relationships among long-time employees can be tremendously beneficial for practices that rely on small cohesive teams. However, staff cliques can be extremely counterproductive and, consequently, expensive. These non-productive units of exclusion reject key messages, making it impossible to establish a true team that works together effectively.

The problem becomes particularly serious if critical practice decisions are being made without input from those who are not part of the clique, or if essential information is not shared with “outsiders” who need that information to effectively carry out their job responsibilities and duties, or if the treatment of some staff is tactfully different than the treatment of others.

Teams, not cliques, make a dental practice successful. While personalities, work styles, and interests may differ, each member of the team needs to be given the opportunity to contribute fully.

It’s up to the dentists, as leaders, to set the example for the team and to steer clear of behaviors that can unwittingly strengthen cliques or create divisions among staff. For example, allowing a few to monopolize the conversation in staff meetings rather than insisting on input from all team members can send the message to certain staff members that their input either isn’t valued or has a lower value than the “chosen” participants.

Sharing information with a select few members of the team conveys to the rest that only the favored are ‘in the know.” Also, socializing with certain members of the staff outside of work also conveys the message of favoritism and encourages a sense of exclusivity among those who see themselves as part of the doctor’s social circle.

These similar and behavioral do nothing to build a sense of camaraderie and team work. Rather they create divisions among staff. For example, allowing a few to monopolize the conversation in staff meetings rather than insisting on input from all team members can send the message to certain staff members that their input either isn’t valued or has a lower value than the “chosen” participants.

Pay attention to the lines of demarcation that may be drawn in your office and take steps to erase them promptly. Those quietly war- ring factions are chiseling away at your practice infrastructure and subtly undermining your every effort to establish a practice that is built on excellence. Read on.

Out with the ‘in’ crowd

Cliches can be particularly challenging in practices lacking job descriptions and/or systems of employee accountability. Naturally, where there is no common-ality among employees, alliances and friendships are likely to be re- sult. But there’s a difference between friendships and factions. For example, a clique might:

• Critical decisions are being made or pushed by a select few and are not shared with other team members.
• Team members are complain- ing that their views don’t mat- ter, or they are shuttling down and refusing to offer input.

• Information is not readily shared unless employees are directed to do so.
• Certain staff members are openly cool to others.
• Whisper campaigns seem to be more prevalent.
• Some employees openly ex- clude others in social or profes- sional activities.

If any of those rings true in your office, take these steps to unite and conquer:

• Recognize that individual person- alities can and do make a signifi- cant difference in how individuals react and interact with one another. Invest a small amount of time and resources in personality testing. Staff members who un- derstand the personalities of their colleagues, including the dentist, tend to get along much better prepared to work with them effectively. Employee online testing at www.mcken- ziegmmt.com or employee test- ing.htm is an excellent tool.

• Clearly define job responsibili- ties. With job descriptions, all team members understand their individual roles on the team. Moreover, they recognize who is responsible and accountable for which systems.
• Hold regular staff meetings to address issues that arise in the practice. Dynamic teams are going to have disagreements. In fact, constructive conflict is essen- tial; it’s fundamental to growth and the pursuit of excel- lence. Encourage staff to work together to resolve issues and address matters that they feel should be addressed.
• Create an environment that en- courages teamwork. For exam- ple, if appointment breaking is wreaking havoc on your day, dis- cuss the matter in a staff meeting and urge input and ideas from all staff members. Then assign two or three employees to develop a strategy to address the problem. Be sure that the “task force” crosses any ‘clique lines’ that ap- pear to have been established.

• Insist that clear information be shared among the team. For ex- ample, hold a brief staff huddle each day to make sure that the front desk staff know exactly where to place emergency pa- tients to ensure there are no surprises. Give front desk staff a ready knowledge of procedures for the charges associated with those procedures. Staff members can dismiss patients efficiently.

• Establish clear standards for of- fice behavior and policies and spell it out in an employee hand- book or policy manual. Then fol- low those policies. If you routinely make exceptions, you send the message that the policies are ir- relevant and everybody can sim- ply do their own thing without re- gard for how it will impact the pa- tients, the team and the practice.
• Don’t look the other way. If an employee is engaging in nega- tive behaviors that are poten- tially damaging, don’t ignore it. Doing so implies that you ap- prove and further encourages a culture of distrust and division.

• Reward teamwork and make an effort to acknowledge the success and positive contribution of every employee. Doing so will promote a team that not only appreciates working well together, but also enjoys succeeding together.

Finally, remember that although dental staffs are typically small in number, dental teams are often complex microcosms of the world in which we live. It’s not uncommon to have staff members with very different backgrounds, experiences and personal values. As a result, any attempt to achieve cohesion rather than division.

**About the author**

Sally McKenzie, Certified Management Consultant, is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides highly successful and proven management services to den- tistry and has since 1980. McKenzie Management offers a full line of educa- tional and management products, which are available on its Web site, www.mckenziemgmt.com. In addi- tion, the company offers a vast array of Practice Enrichment Programs and team training. Ms. McKenzie is the edi- tor of the *Management newsletter* and The Dentist’s Network newsletter.

**Dental Tribune** United Kingdom Edition - April 6-12, 2009
On February 5, 2009, the Bank of England cut interest rates from 1.5 per cent to just 1 per cent. Never in the institution’s 315-year history had such a low been reached, and considering that the interest rates stood at 5 per cent last October, it is evident that drastic action has been taken to head off the worst economic crisis since the Great Depression.

Combined with the Government’s tax cuts and the weakened position of the pound, this latest reduction should provide ‘considerable stimulus’ to the UK economy, according to a statement from the Monetary Policy Committee (MPC).

At some point over the last few years, many principals will have borrowed money at 1 per cent-1.5 per cent above this base rate and will now be enjoying savings of thousands of pounds per month. For example, principals who borrowed £750,000 at 1 per cent above base rate last year would have been paying £5,750 per month. Now, those monthly interest rate payments would be down to £1,250, constituting a saving of £4,500 per month.

The MPC pointed to a severe and synchronised downturn, partly characterised by job cuts and weakness in consumer spending, so this saving in interest payments could well be crucial when it comes to keeping private practices afloat, especially if patients start deferring treatment, or stay away altogether.

Essential Money has noticed that the experience of many clients, including private, NHS and mixed practices, is that turnover has not been affected and the appointment book is still full. In fact, in addition to patient payment plans like Medenta, which helps to spread the cost of treatment over several months, the new rate reduction provides several new opportunities.

For instance, now might be the time to borrow some money cheaply and expand the practice with an additional surgery— or even buy another practice. Alternatively, the monthly savings could enable you to safely put some money aside in high interest savings accounts, pay off your residential mortgage or increase your pension. Or, you could enjoy having the extra cash, and simply spend it!

It is worth noting, however, that while most clients hardly need the cautionary advice, you should never forget that all markets move in cycles, and you can never be sure what is around the corner. Also, caution in the past is not necessarily being rewarded today: those dentists who sought financial security by fixing some or all of their loans have actually taken the expensive option, with rates as low as they are now.

Following the latest base rate cut, some mortgage lenders announced that they would be passing it on in full to their SVR (Standard Variable Rate) customers. The Government is putting pressure on lenders to reduce their standard variable rates in line with the cut, and lenders such as Nationwide, Britain’s biggest building society, have been quick to commit to passing on the full half-point base rate cut to borrowers on variable rate deals, to rates as low as 3.5-3.75 per cent. Other lenders committing to this include Skipton Building Society, Lloyds TSB, Cheltenham & Gloucester and Halifax (part of the Lloyds Banking Group), Woolwich (owned by Barclays) and Abbey, Government-owned Northern Rock, however, appears to be consistently failing to pass on the rate cuts, with a

In light of the recent Bank of England base-rate reduction, Thomas Dickson shows how you can use the situation to your benefit.
Standard Variable Rate of 4.84 per cent.

If you are nearing the end of an introductory rate with your current lender, and have between 25 per cent-40 per cent equity in your property, there are some fantastic fixed rates available (now as low as 3.49 per cent). Those of you not in this position could be better served by staying on the standard variable rate, at least for the short term.

This is also the first time that a mortgage lender has been forced to reduce the interest on their home loans to zero. If you are one of those 1500 customers who took out a tracker mortgage pegged at 1.01 per cent below the base rate with Cheltenham & Gloucester (C&G), then you will be paying no interest at all on your home loans from March 2009.

Savers are hit

There is a downside to these cuts. The attempt to revive the economy by slashing interest rates is leaving pensioners and those others dependent on savings with a lower standard of living. Savers – who outnumber borrowers – have seen their interest payments drop by a massive 83 per cent since July 2007.

Figures published by the Bank of England in January 2009 showed that interest paid on notice accounts, tax-free ISAs and bonds in December 2008 was at its lowest since records began in 1995. The average return on instant access accounts was just 0.81 per cent.

Many self-employed dentists have significant cash savings, in preparation for their annual tax bills in January and July. Those with a mortgage as well can benefit from offset mortgages, which are an excellent way to take advantage of additional savings, because the money is guaranteed; the rate is higher than usually offered by deposit accounts, and no tax will have to be paid.

The economy and house prices

The UK economy officially shrank by 1.5 per cent in the fourth quarter of last year. This was the biggest contraction in nearly 30 years. Yet the Government is confident that the latest announcement, previous rate cuts and the weakness of the pound will combine to have a ‘significant impact’, eventually aiding the economy.

A recent report from the Halifax announced that house prices had risen by 1.9 per cent unexpectedly in January 2009, ending 10 consecutive months of falls. This brought hope that the worst was over in terms of declining house prices. However, Nationwide reported that house prices had fallen by 1.5 per cent over the same period, and the Halifax itself warned that the rise was likely to be a statistical blip because the market remained under severe downward pressure.

Conclusion

Although the economy does appear to be spiralling downward uncontrollably, with investors likely to be nursing some heavy stock market losses, the recent base-rate cuts are on the whole excellent news for the majority of dentists. This year 2009 really could be the year to use the savings made on any borrowings to take full advantage of some under-priced assets.
Managing your investments

To make sure you get the maximum return on the hard-earned money you’ve invested, you need to make sure your IFA is proactive, says Suzanne Allen

If you hold a private pension, ISA or savings policy of any sort, can you recall when it was last reviewed? If you have a good financial planner, the chances are it was looked at fairly recently—certainly within the last 12 months. But otherwise you will fall into the bracket of many clients we come across who remain invested in the same funds they started out with maybe five, 10 or even 20 years ago. When you consider what you went through to earn that amount: studying, exams, and years of professional hard slog, don’t you now wonder whether it is working as hard for you as you did for it? Investments don’t manage themselves and in today’s increasingly complex financial markets, maximising them requires the combined skills of proactive IFAs and their chosen team of specialists.

Your hard-earned cash

If your pension is invested with a company that no longer actively transacts new business, there’s a good chance that you are still invested in the original funds. That means your investment in that pension is not being proactively managed and therefore you may not be getting the best return. As it is most unlikely that you have the same mortgage with the same lender, or save for tax in the same building society account that you took out all those years ago, why is your pension still invested so unwisely? Many dentists have invested tens or hundreds of thousands of pounds into personal pensions, ISAs and insurance policies at the recommendation of their professional advisers, and most continue to delegate that investment responsibility. There’s no problem with delegating responsibility but abdicating it is a different issue entirely.

Complex money management

Historically most financial planners have viewed managing clients’ money as an integral part of their role. Today though, as the range of investment products becomes more complex and reactive to economic factors, managing clients’ investments effectively is becoming increasingly complex and requires a lot more research and time, and different levels of expertise.

The processes IFAs take to ensure each client’s money is managed in line with their ever-evolving requirements are pretty complex:

1. Agree with the client the purpose of the investment, the timescale, flexibility needed, the client’s tolerance to investment risk and current and future tax position.

2. Select the most appropriate investment vehicle, perhaps a personal pension, unit trust, ISA or insurance bond.

3. Agree the spread of investments between the different asset classes, such as equities, bonds and commercial property. There are a number of asset allocation models available and the importance of getting the asset mix right cannot be overstated. Investing in a poor-performing UK equity fund when equities are rising as a whole is generally better than putting money into a well-run commercial property fund when that sector is falling and offers a compelling case for the importance of market timing!

4. Ensure the most consistent investment funds are selected. This is achieved by comparing the fund manager’s rating with his/her peers, the strength of the research team, the investment processes, the fund manager’s views for future opportunities and of course how that manager...
An investment needs to be reviewed regularly to ensure the asset allocation remains appropriate, the selected funds are doing what they say on the tin and the client's needs haven't changed rendering the original advice inappropriate.

So you can see how complex it can be for IFAs to effectively manage clients' money. Add to that the not insignificant administration and regulatory burden and your financial planner has significantly fewer hours in the week to look after each client.

The modern approach

More and more financial planners are recognising that their skills and experience are more about the ‘big picture’ in managing clients' financial planning rather than the day-to-day aspects of investment management. A good financial planner prefers to spend more time face-to-face with the client, developing creative solutions to improve the clients' finances e.g. to save them tax, to introduce them to other specialists who can add value such as specialist accountants, solicitors and banks.

The result is that many financial planning firms are now developing links with discretionary fund management companies to outsource the investment management side of their business. These companies invest heavily in research and the clients are appointed a personal investment manager who monitors the clients' portfolios on a daily basis.

Once a fund manager is given their remit they will manage the portfolio on a discretionary basis and make investment decisions without recourse to the client. The advantage of this approach is clear; the fund manager has the authority to respond dynamically to investment opportunities that would otherwise be missed if authority had to be constantly sought. These managers also have access to investment areas not readily available to individual investors, such as hedge funds and structured products, adding to the opportunities available to the client.

Monitoring performance

The financial planner will monitor the performance of the portfolio manager to ensure the chosen mandate is followed and they will recommend changes whenever the client's circumstances alter, for example, when reaching retirement age there will be a need to draw an income from investments.

Most discretionary management groups will look after all areas of a client's investments, including pensions, unit trusts and OEICs, ISAs and bonds. They will take a cohesive approach to their clients' investments and working alongside the client's financial planner, will use the tax status of each investment to its best advantage.

Your financial planner is not abdicating responsibility by passing the investment of your money to a professional fund manager – quite the opposite. As a great dentist you take full responsibility for the care of your patients' mouths by ensuring it is looked after to the highest professional standards. However, you will also refer your patients to a specialist for complex treatments. In the same way, a good financial planner will take overall responsibility for your finances and will take advantage of specialists, such as discretionary managers, to ensure you achieve your financial goals and aspirations.

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Evidence-based efficacy of ozone for root canal irrigation

Guest expert Edward Lynch and Edward Swift discuss evidence-based efficacy of ozone for root canal irrigation

Question: As a follow-up to the recently published information on ozone as a means of carries treatment, how can we provide some information on the use of ozone in root canal therapy?

Answer: Ozone has been proposed as a dental antiseptic agent based on its antibacterial effects in both gaseous and aqueous forms. Ozone is effective when used in high concentration, used for a adequate time, and delivered correctly into root canals after the traditional cleaning, shaping, and irrigation have been completed. Ozone will not be lethal to the viable bacteria in spite of being used in gaseous or aqueous forms. Ozone has been proven to have antimicrobial activity against all dental biofilms, contain many molecules such as iron, which can increase the antimicrobial effectiveness of ozone in teeth and can help reduce cariogenic microorganisms in vivo to further increase the antimicrobial effectiveness of ozone.

Ozone is a potent oxidizer and immune-modulatory capacity. Ozone has been proven to help reduce cariogenic microorganisms and this could be beneficial to the professionals involved with the healing process.

Recommended use of ozone in root canal therapy

Ozone works best when there is less organic debris remaining. Therefore, the recommendation is to use either ozonated water or ozone gas at the end of the cleaning and shaping process. I personally still use my conventional irrigants during this earlier phase and I finally irrigate with ozonated water (Thermozone, Santa Monica, CA, USA) using ultrasonic. I also have used ozone water when treating teeth with limited access cavities using mineral trioxide and sterile roots with open access cavities and containing a paper point were carried by one volunteer in the oral cavity for 1 week.

Comparison of the use of ozone and sodium hypochlorite in root canal irrigation

Ozone has been proven to be one of the most powerful oxidants and immune-modulatory capacites that blow ozone into root canals, but manufacturer’s directives must be followed in order to prevent any potential lung inhalation. Lime Technologies also sells ozonated oils for use as root canal medicaments.

Ozone systems available for use in root canal therapy

KaVo produces the HealOzone, which delivers 2.10ppm ozone at a flow rate of 615 cc per minute and has been proven to be safe.

Other reports also reported a high biocompatibility of aqueous ozone. Irrigation of the root surface of avulsed teeth did not reveal a negative effect on periodontal ligament cell proliferation. A clinical report regarding the healingaccelerating effect of ozonated water did not show any detrimental effects on cells.

Effect of aqueous ozone on the NF-κB system

The transcription factor NF-κB plays a crucial role in inflammato-immune processes and apoptosis. NF-κB is also thought to be of importance for the development of the maternal immune response and is involved in the regulation of periodontal/periapical inflammatory reactions and the production of cytokines and apopitotic. Huth and colleagues38 reported that ozone is one of the most powerful oxidants on cells and that ozone can help reduce cariogenic microorganisms in vivo to further increase the antimicrobial effectiveness of ozone.

Biocompatibility of ozone in root canals

A high level of biocompatibility of aqueous ozone on human oral epithelial (BHY) cells, gingival fibroblast (HGF-1) cells, and periodontal cells has been published.

Huth and colleagues38 investigated whether gaseous and aqueous ozone exerted any cytotoxic effects on BHY cells and HGF-1 cells compared with established antisepsics (2 and 0.2 per cent sodium hypochlorite [NaOCl]; 3 per cent chlorhexidine [CHX]; 5.25 and 2.25 per cent sodium hypochlorite [NaOCl]; 3 per cent hydrogen peroxide [H₂O₂] over 1 minute and compared with the an-tioxidant potentials of ozone. Ozone gas was found to have toxic effects on both cell types. Essentially, no cytotoxic signs were observed for aqueous ozone. CHX (2 per cent, 0.2 per cent) was highly toxic to BHY cells, and 3 per cent NaOCl and nontoxic (0.2 per cent) to HGF-1 cells. NaOCl and HClO resulted in markedly reduced cell viability (BHY, HGF-1), whereas monera-zole displayed mild toxicity only to BHY cells. Taken together, aqueous ozone presented an excellent result of biocompatibility of the tested antisepsics. Nonetheless, ozone gas performed well compared with the established endodontic irrigants, which showed equal or even higher cytotoxic potentials than ozone gas.

Use of ozone to manage the intracanal in the access cavity

Ozone has been proven to help reduce cariogenic microorganisms and this could be beneficial to reduce potential contamination of the root canal systems during instrumenta-tion.

Enhanced healing associated with ozone use

Ozone also plays a key part in the healing process, which decreases inflammation by acting on the NF-κB system and can help reduce the response of periradicular tissue to infection.

Clinical 17

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DENTAL TRIBUNE
Conclusion

Of course, more research on the use of ozone in root canal therapy will add to our knowledge in endodontics.

Thousands of dentists worldwide use ozone in root canal therapy and it is claimed that millions of teeth have received root canal therapy with ozone having been used as the final irrigant. No adverse event has been recorded after use of the HealOzone or ozonated water in root canal therapy.

Ozone is an effective, easy, cheap, and fast treatment to help disinfect root canals. Ozone is much stronger than chlorine and acts 5,000 times faster without producing harmful decomposition products. As ozone is the most powerful antimicrobial and oxidant we can use in endodontics, and as aqueous ozone revealed the highest level of biocompatibility compared with commonly used antimicrobials, then it is fairly obvious that ozone should be used to help combat the microorganisms associated with infected root canals. Ozone has a place in the 21st century oral health care, and we should use its proven powerful antimicrobial efficacy and potent oxidant ability to reduce microorganisms during root canal therapy.

Disclosure

Professor Edward Lynch is a consultant and principal investigator for research grants from CurOzone USA (Aurora, Ontario, Canada) administered by Queens University, Belfast, Northern Ireland, UK.

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References


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Enjoy total independence
High standards

In part one of this two-part exclusive interview, Neel Kohthari talks to Chief Dental Officer Dr Barry Cockcroft to find out how well he thinks the NHS system of dentistry is working and what standards it should be aiming for.

NK: Since Labour has come into power, funding for the NHS has almost doubled. In your opinion, how well is NHS dentistry currently doing?

CDO: The way we describe it at the moment is that it’s turning the corner. It’s certainly been a very turbulent period over the last three years and it’s obviously a very high priority for government and ministers. What we know now is that the amount of NHS dentistry being commissioned, being purchased from dentists, is now above the level it was in April 2006 and that’s continuing to rise. We increased spending by 11 per cent in 2008/9 and we will increase it overall by 8.5 per cent next year, which is a massive level of investment. According to Information Centre data the number of dentists providing treatments is up, and the NHS is already commissioning more dentistry than it was prior to the introduction of the new contractual arrangements in 2006, but the access data which has stubbornly so far gone in the wrong direction we are absolutely confident will begin to move in the right direction.

NK: When do you feel this will become a reality?

CDO: Very soon, we know it’s retrospective data, so the data we publish towards the end of the year will already turned around, but isn’t reflected in the retrospective data, so the data we publish towards the end of the year will already turned around, but isn’t reflected in the retrospective data yet.

NK: But that’s not really the case everywhere. After all, PCTs also have to make ends meet.

CDO: Now they have made a commitment to grow services, as you can see in our response to the HSC, they have got more money to grow services, and that’s what it’s about. The overall difference in PCR pales into insignificance compared to the money they now have to grow.

NK: What is the standard is NHS dentistry aiming to set for patients; should it be a basic core service or a world-beating healthcare?

CDO: It’s certainly been a turbulent time. Under the old system, they had an SDR. But dentists are highly trained professionals who have spent five years at university. If they can’t work out professionally what is clinically and cost effective, then it’s a pretty raw deal really.

NK: If NHS dentistry is aiming to provide more than a basic service, has the government fairly allocated funding for complex treatments?

CDO: Well I think first of all the funding for individual contracts, for example, it’s quite right that the NHS pays for cosmetic treatment in that situation.

NK: What I mean by that is, as you are well aware, dentists and PCTs have to budget themselves within a certain level...

CDO: Yes, but the whole health service has to do that. I think the point is that the ring-fenced budget for dentistry has vastly increased now.

NK: So should dentists on the NHS be providing a basic, core service and how does this compare to what’s available within private dentistry?

CDO: It sets out in the regulations that dentists are being paid in advance to provide treatment that is clinically and cost effective. We are providing them with extra money, dentists’ incomes have gone up. I think the comparison between the NHS and private sector is not something I want to go into. I think there are things that the patient may want which are not clinically effective and it’s right that the NHS doesn’t pay for that. At the same time, if someone’s got a developmental defect and has hypoplasia for example, it’s quite right that the NHS pays for cosmetic treatment in that situation.

NK: Have you given dentists any guidance to help them decide what is clinically and cost effective? Because it seems that across the board there is wide range of opinion on what is cost effective.

CDO: It’s certainly been a turbulent time. Under the old system they had an SDR. But dentists are highly trained professionals who have spent five years at university. If they can’t work out professionally what is clinically and cost effective, then it’s a pretty raw deal really.

NK: But if you take a simple procedure like a small composite filling, there are numerous ways in which this can be provided. Surely in a budgeted system, the onus on the dentist is to provide it in the most cost-effective way. This doesn’t always mean the best way, does it?

CDO: Part of quality is about messaging to patients. If you’re giving poor quality messages to patients, such as ‘we can’t provide you with a scale and polish under the NHS unless, but we can provide you with this privately’, then that’s wrong. The NHS is aiming to provide a quality service, not a quality service, then the PCT needs to sort it out. The treatment of choice for a very small single surface cavity, according to Pickard, is a composite restoration and that should be the starting point for the NHS. It is not just “cost” but clinical effectiveness as well. Access is starting to improve now and PCTs are very also need to be focused on quality of care. Dentists need to work with their PCTs and we can see up and down the country dentists are working much better with their PCTs, but it’s a big cultural change and I accept that.

NK: What do you think of Lord Darzi’s report?

CDO: It’s certainly been a turbulent period over the last three years and it’s obviously a very high priority for government and ministers. What we know now is that the amount of NHS dentistry being commissioned, being purchased from dentists, is now above the level it was in April 2006 and that’s continuing to rise. We increased spending by 11 per cent in 2008/9 and we will increase it overall by 8.5 per cent next year, which is a massive level of investment. According to Information Centre data the number of dentists providing treatments is up, and the NHS is already commissioning more dentistry than it was prior to the introduction of the new contractual arrangements in 2006, but the access data which has stubbornly so far gone in the wrong direction we are absolutely confident will begin to move in the right direction.

NK: When do you feel this will become a reality?

CDO: Very soon, we know it’s retrospective data, so the data we publish towards the end of the year will already turned around, but isn’t reflected in the retrospective data yet.

NK: Has the increase in NHS dentistry spending gone towards commissioning new services or has this been funded by a deficit in PCTs’ budgets from a reduced patient charge revenue (PCR)?

CDO: No, not at all, the two things are not connected. The reduction in PCR I wouldn’t say is significant, it was there in the first year of the contract, but is certainly getting better. But the 11 per cent certainly being used by PCTs to commission new services which you can see all over the place.

NK: But that’s not really the case everywhere. After all, PCTs also have to make ends meet.

CDO: Now they have made a commitment to grow services, as you can see in our response to the HSC, they have got more money to grow services, and that’s what it’s about. The overall difference in PCR pales into insignificance compared to the money they now have to grow.

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NK: What do you think of Lord Darzi’s report?

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NK: When do you feel this will become a reality?

CDO: Very soon, we know it’s retrospective data, so the data we publish towards the end of February will indicate what happened in the two years ending last August. In our view, it’s already turned around, but isn’t reflected in the retrospective data yet.

(JC data published in February showed access increased by 109,000 in the two year period ending August 2008.)
not actually come true. There is no shortage of vocational trainers, there is no evidence of a mass exodus of dentists. There is significant increase in the amount of preventative treatment going on. The amount of NHS dentistry commissioned has gone up, the number of dentists working in the NHS has gone up. One thing that has not turned round yet is the retrospective access data and if we are right, we expect that to turn around; then we will have evidence that everything we said would happen would have actually happened.

NK: In 2009, the three-year term for the current contract expires, what changes can dentists expect to the current system?

CDO: Current contracts do not expire. This is a complete misunderstanding about what will happen after April 2009. Nothing changes, other than the gross income guarantee. So everything else remains the same. GDS contracts are open-ended and can only be terminated if there is a breach of contract.

NK: So dentists can expect no changes to the current UDA system, not even an increase in the number of bands as advocated by the HSC?

CDO: No, nothing like that. We would need to consult on any of that, and in the statement of financial entitlement which we consulted on widely recently we made the point that contract values, if nothing happens, will for next year remain the same, just up-rated. The only thing that changes is the gross income guarantee. The PCT does not have the power to change a contract unilaterally. But if somebody had a contract value for £200,000 and for the last three years has only delivered £100,000 worth of contract, then the PCT now has the opportunity to say you have underperformed for three years and we propose that your contract value be reduced.

NK: Nationwide PCTs have provided a mixed service, have the PCT staff received adequate training with commissioning or is more needing to be done?

CDO: We completely accept that the quality of PCT’s commissioning has been variable, as has the engagement of clinicians. What we’re now able to say is that 50 per cent of PCTs have already increased access since the new arrangements, but others have not, and that’s why we announced in the HSC that Mike Warburton, who helped implement the equitable access for GPs last year, is going to help the PCTs that are having the most difficulty. In our final response to the HSC, the strategic health authorities (SHAs) have said: ‘We will work with our Primary Care Trusts to make sure that all our PCTs’ commissioning plans enable us to deliver health dental services to anybody who seeks them by April 2011’, at the latest. I think this puts together a nice little package to help support our PCTs. But it’s been very difficult over the past two to three years getting clinical engagement. But things are clearly moving in the right direction now.

In part two to be published in a later issue, Neel Kothari talks to Barry Cockcroft about how the system has affected the balance between performers and providers

About the author

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

Dr David Bloom and Dr Jay Padayachay offer their advice on the best equipment to use for cross-infection control

1. Central sterilisation area (Fig.1, 2): it will eventually come into force that all practices must have a central sterilisation area away from the surgery itself. Such areas need to be thought through so that there is a flow from the ‘dirty’ or non-sterile area to the ‘clean’ or sterile area. So, from the sink into which the instruments are initially placed, to the autoclave where the bagged instruments are sterilised, protocols need to be created so that the chain is not interfered with and non-sterile comes into contact with sterile. To aid this, differential lighting can be used so that the non-sterile areas are lighted with a red bulb, and the sterile areas have a green bulb.

2. Ultrasonic bath – the instruments should be placed into an ultrasonic bath for 15 minutes to loosen any debris, for example, instruments are not scrubbed manually at this stage which thus reduces the risk of injury to the nurse.

3. Washer-disinfector (WD) (Fig.5). These are great for removing any remaining debris from the instruments prior to them being bagged for the autoclave. While discretionary at the moment, the Care Quality Commission will be aiming to register all healthcare facilities including dental practices (NHS and Private) within the next two years. Implementation of washer disinfectors will come into force over the next three years and will replace ultrasonic baths. Once out of the WD, the instruments should be visually checked and only then scrubbed or burr brushed to remove any remaining debris (usually cement) prior to bagging.

4. Handpiece cleaner (Fig.4). Where a handpiece manufacturer does not recommend a washer-disinfector for cleaning the handpiece, use of a dedicated handpiece-cleaning machine may be considered. Not only does this clean out the handpiece prior to sterilisation, it also lubricates it to the ideal. This will also prolong the life of the equipment as well.

5. Autoclave: The two types of sterilisers found in General Dental Practice are the vacuum (wrapped instrument) sterilisers (classified as Type B) and unwrapped instrument and utensil sterilisers (classified as Type N).

Vacuum Benchtop Sterilisers Type B are suitable for wrapped and unwrapped solid items, hollow items and porous loads, and as such are particularly suitable for sterilizing dental handpieces and this technology is increasingly becoming the standard for use in dental practice. Wrapped items processed in a vacuum benchtop sterilizer can be readily transported, remain sterile up...
to point of use, and can be stored for use at a later date, minimising the risk of cross contamination. The provision of suitable stocks of wrapped steriliser instruments can enable continued patient care while WD, steriliser and water treatment plant are unavailable through repair, maintenance, and testing.

Benchtop Sterilizers Type N are suitable for solid devices that are not wrapped. Provided that the proper irrigation and cleaning of lumens and internals of handpieces has been achieved in combination with a WD, handpieces may also be processed in a Type N steriliser. Where remaining hollow items used in the practice are not single-use, a Type N steriliser may be the appropriate solution, although as mentioned previously, this type of technology is being increasingly overtaken with the vacuum type steriliser. Dental practitioners should also be aware that instruments processed in a Type N steriliser should ideally be used directly from the steriliser as transportation and storage of sterilised items may pose a risk of re-contamination, and should be risk assessed and controlled to minimise the risk.

6. Disposable items. These are useful when it is not practical to sterilise. Examples include three-in-one tips (we have found the Kerr tips to have no water contamination compared to some others), and can include burs, cups, aspirator tips and saliva ejectors. The list is potentially endless as there are now even disposable handpieces and a risk/cost analysis should be undertaken.

7. CollarDam (Fig.6). With the move to disposables, CollarDam provides the missing link when it comes to bibs. Traditional plastic bibs that are wiped down between patients are no longer acceptable. Thus disposable bibs with daisy chains have now come into use, but remember that if doing this the chain also needs to be autoclaved. This is fine if the chain is made from metal but not so if it is plastic. CollarDam uses an adhesive strip avoiding the need for such chains, and the premier version of it has a built on head cover avoiding the need for a separate one. The everyday bib doesn’t have this useful function but all types prevent water seepage at the neck preventing patients getting wet in this area.

8. Handwashes. The use of alcohol-based handwashes can dry and irritate the skin with prolonged use. Continus alcohol

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• How to diagnose a healthy joint from a problem joint
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Dr David Bloom
a graduate of the Newcastle-upon-Tyne Dental School, has been a prin- ciple at Senova Dental Studios since 1998 focusing on comprehensive restorative and cosmetic dentistry. A past president of the British Academy of Cosmetic Dentistry (2007-2008), David is also an accredited member of the BACD. He is a member of The British Society of Occlusal Studies, The British Society of Restorative Dentistry, The British Dental Association and is a sustaining member of The American Academy of Cosmetic Dentistry (AACD). He is also a fellow of the International Academy of Den- tal Facial Aesthetics, David is on the editorial board of the journal of Cosmetic Dentistry – the official journal of the American Academy of Cosmetic Dentistry, and clinical director of CO-OP.R8 seminars and instructs and lectures on all aspects of cosmetic dentistry in the UK and the U.S. (www.coopr8.com).

Dr Jay Padayachay,
a graduate of the Newcastle-upon- Tyne Dental School, has been a prin- ciple at Senova Dental Studios since 1998 focusing on comprehensive restorative and cosmetic dentistry. A full member of the British Academy of Cosmetic Dentistry, he is a mem- ber of The British Society for Oc- cusal Studies, The British Society of Restorative Dentistry, The Pankey Association, The British Society of Periodontology and the American Academy of Cosmetic Dentistry of which he is a sustained member. He is also a director of CO-OP.R8 semi- nars and lectures in all aspects of cosmetic dentistry in the UK. (www.coopr8.com).
Decontamination – it’s the detail that counts

This note sets out in a practical way tips on how to bridge the gap between the idealised expectation of HTM 61-4 and the reality of the limited space available in typical dental practices for LDU development. The perfect LDU lecture presentations with miles of worktop often don’t translate into the reality of compromise when back at home base.

A person to advise for confidence is needed to develop a vision of the facility, starting with a compromise to demonstrate to any audit that at first you care, and have a planned schedule which you can prove.

Origins
Where did it all start – in Brussels? Or was it the Maidstone effect where C.Diff claimed around 90 hospital patients. With the national hospital audit central government was eventually bound to run scared of the political risk of upsetting the voting families with relatives in hospital and long term care.

Dentistry is not alone. All other practices will be drawn into the surveillance not from podiatrists right down to tattooists and beauty. Someone had to be first and it happens to be dental as the well identified profession in the public view.

Clinical water from reverse osmosis
This clinical-quality water is created from tap water in a ‘posh’ filter membrane system with the nickname of R/O - reverse osmosis – and is used as a clean supply to the steriliser. This water is fresh for each sterilisation cycle and dumped to drain after each use.

The steriliser
In the steriliser chamber air pockets prevent steam molecule access. The vacuum feature dilutes trapped air in tube or crevasses prior to the autoclaving temperature cycle. The vacuum cycle also assists moisture removal and drying. For pouching vacuum is essential using a closed pouch in the whole cycle.

Data logging
What about records? As an essential part of practice procedures the cycle statements for the washer and steriliser can be paper or paperless – valuable evidence for your own assurance of correct working to deal with client criticism and not forgetting the routine audits soon to come.

Space-saving tower
These accoutrements – R/O, washer, steriliser, and recorder – go to make up the hardware for safe decontamination. They are bulky and need bench top space. To retrieve this valuable space is worth the consideration to stack the washer and steriliser in a vertical tower with printers and R/O water – saving around 1500mm of worktop.

Any of your existing equipment could also be rehoused in a tower and printers added for facility upgrade. The wheeled unit can be moved for cleaning and simply couples to services for power, water, and a hook drain.

Transfer boxes
A very useful box transfer and storage facility will also help in the jigsaw of small areas. They are colour-coded green and red with lids and are stackable with a small footprint.

Matching the workload
What about capacity sizing to deal with average and peak loads. For very large practices the speed and capacity, the infection control tower, single or duplicated will service a wider range of practice size. The single tower for decontamination will size well for the single chair upwards saving the space of spread about separate units.

LDU room detail
And the LDU room itself! There is a lot of detail to make this a safe haven for the physical routines of decontamination. The older the premises, the greater the risk of hidden anti-infection control – draughty, gaps at skirtings, badly fitted windows, neglected fan ducts to name but a few.

The style of new furniture is important – to be designed for infection control, DIY type is not safe. Totally moulded doors, shelves and cabinet walls, are a priority. Worktops must be continuous without joints and double postformed. Space above wall cabinets should be closed up to the ceiling and wall and ceiling surfaces clad with PVC extrusions and a tanked floor with altro type covering to complete the cocoon for easy wipe-down routines.

And your best friend?
The silicone sealant gun to close bug traps of such as toe boards and worktop runs as well as air leakages. What on earth is all this going to cost! There is no golden rule. Individual area assessment, with debate to refine to joint opinion, will yield the best safe layout. The smaller the LDU the greater the jigsaw for sound decontamination without compromising patient and staff safety.

What next?
Find a competent LDU adviser who understands the complete picture and your problems may well be halved.
Simply squeeze a small amount into the palm of your hand. Rub all over hands, paying attention to the back of your hands and in between the fingers, until dry. Ortho-care Pro-\text{tect} requires no water and no drying with paper towels and leaves your hands feeling clean and fresh with the scent of spearmint. Available in 500ml pump dispenser bottles or handy100ml flip-top bottles ideal for pocket or handbag.

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A-dec 500 allows unprecedented integration of technology and is well-positioned to fit small spaces and conservative budgets. The new A-dec 500 system is designed with a mid-level platform choice that’s lower in cost than the A-dec 500®, yet maintains the high performance, service, and support that distinguish A-dec products.

Everything about A-dec 500 is designed with efficiency and well-being in mind: from the ultra-thin 1” (25mm) thick backrest that provides optimal access to the oral cavity, to the 54mm to 75mm vertical range that allows doctors of all heights to sustain posture and position arms at sides.

To learn more about A-dec 500, contact your local dealer, visit www.a-dec300.com or call the UK headquarters on 02476 550901.

About A-dec

Headquartered in Newberg, Ore., A-dec is one of the largest dental equipment solutions providers in the world, with a global network of customers and authorized dealers in more than 100 countries.

For more information about A-dec, visit www.a-dec.co.uk or call 02476 550901.

From Vita, the world leading expert in shade determination, the new Easyshade™ Compact is a fast and reliable way to take shade at the push of a button. High measuring accuracy due to spectrophotometric measuring, this cordless, mobile and lightweight unit reads up to a potential 97 shades combination, both in Classical and in the 5D system. User-friendly and easy to learn, with Easyshade™ Compact you can read one single shade or 5 different areas in the tooth and check restorations. Up to 25 shade taking results can be stored in memory. No more waiting to enter conditions or costly remakes!

For further information please contact: Sirona Dental Systems Ltd 0845 07 450 info@sironadental.co.uk

The DAC Universal combination autoclave, cleans, lubricates and sterilises 6 instruments in 12 minutes!

The DAC UNIVERSAL supports the practice staff by automatically cleaning, lubricating and sterilising handpieces intended for non-critical, semi-critical and critical applications. The function of the NITRASEAL unit is to wrap instruments prior to sterilization in the DAC PROFESSIONAL.

According to the hygiene guidelines of the Robert Koch Institute, “non-critical” applications do not involve any contact with the mucous membranes.

The Sirona DAC PROFESSIONAL autoclave handles large sterilization loads quickly and reliably. The DAC PROFESSIONAL is the ideal complement to Sirona's DAC UNIVERSAL and NITRASEAL systems.

With the introduction of the new DAC PROFESSIONAL Sirona Dental Systems has closed a gap in the sterilizer market. Firstly, this autoclave can accommodate up to six trays. Secondly, it can be pre-heated, which significantly reduces cycle times. The rapid sterilization program can be completed in as little as ten minutes. The DAC PROFESSIONAL is a “Class B” sterilizer in accordance with EN 15060 – in other words, it fulfills the stringent requirements laid down for large-capacity sterilizers deployed in hospitals.

For more information please contact: Nobel Biocare 0845 07 450 info@nobilascope.com

Nobel Biocare, the world leader in innovative restorative and esthetic dental solutions is delighted with the response to the recent ‘Aesthetic Treatments of Complex Cases by the world-renowned Dr. Patrick Palacci.

Held on the 13th of March at the Crown Plaza Hotel, Glasgow, delegates were unanimous in their praise of the multidisciplinary and in-depth assessment into aesthetic implant dentistry and intricate cases including bone grafting, sinus lift, raising the flap and flagless with Nobel Guide. Dr. Palacci also explored advanced and complex surgical procedures including soft tissue management incorporating papilla regeneration and soft tissue grafts.

Having developed several techniques in optimal implant placement, papilla regeneration technique and aesthetic implant dentistry, Dr. Palacci also expressed his approval on his acclaimed methods and theories.

Continuing its dedication to U.K dentistry, Nobel Biocare has a number of outstanding courses and events taking place in 2009.

To guarantee your place on a Nobel Biocare course this year please email: tanyawade@nobelbiocare.com or call: +44 (0) 1895 452921 for more information.

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With the Clinical Governance Performance Management tool, practices can upload their progress so that PCs can quickly see what has been achieved, and what re-

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For more information, contact Dental Design on 01202 677277 or email contact@dental-design.co.uk, www.dental-design.co.uk
Top steps at CIC

In the lead-up to the forthcoming Clinical Innovations conference we talk to the prestigious symposium’s lecturers in a sneak preview of the much-anticipated two-day event in central London.

Dr Sia Mirfendereski’s lecture - Key Steps to A Successful Whitening Centre - is, in his own words, the brief history of his 17 years experience of tooth-whitening. His talk will incorporate a ten-step plan on how dentists can bring the technique into their practices order to extend their business.

He says: ‘Tooth-whitening is an opportunity for dentists to expand their practices, which they can add on to their existing services. I have learned from experience that the only way to incorporate tooth-whitening successfully is to offer patients a money-back guarantee. ‘I am not competing with tooth-whitening packages which can be purchased over-the-counter or off the Internet. It is true that manufacturers do sometimes offer a money-back guarantee, but if the process does not work, it is usually down to the operator. It is also really important that the patient also plays their part in the treatment.’

In the session, he will go through the ten-point plan, including; choosing the correct bleaching method, the right levels of concentration and associated issues, chemical activation and restorative implications to new regulations, patient communication and marketing.

Dr Sia, who is a Gold member of the British Dental Bleaching Society, says it is essential for dentists to be trained properly in the method. He says: ‘They really have to know what they are doing. Tooth-whitening can be a good adjunct to other treatments.’

But he says it is vital for dentists to be on hand during the treatment. ‘Dentists should not be carrying out major operations next door, while the patient is having tooth-whitening treatment. Dentists need to be on hand to monitor quality control, so it is best if they do basic work, which they can leave at a moment’s notice if necessary.’

Dr Sia’s main practice is in Wimpole Street, central London, (www.msdentistry.com) where he works with, Prof Liviu Steier. The practice also offers dental training, particularly in Implantology.

He says: ‘We are a referral-based practice which gives CPD training in second-stage Implantology.’

Dr Sia also has practices in Dulwich and Oval, plus the use of dental facilities in Cobham, where he does dental consultancy for the Chelsea Football Team.

Another gem in his cap was his commission as dental consultant in an artistic project, for which he advised on the meticulous dental restoration of a skull! The life-size cast of an 18th century human skull in platinum, was encrusted with over 8,000 diamonds by artist, Damien Hurst. Entitled, For the Love of God, it was on show at Hoxton’s, White Cube gallery last summer, as part of Hurst’s exhibition, Beyond Belief. It allegedly sold for £50 million to an unknown purchaser, the highest amount ever paid for a work of art.

Dr Sia is frequently invited to lecture on tooth-whitening at conferences both in the UK and beyond including, Newcastle, Belfast, Dubai and Chicago. He is also visiting honorary lecturer at the University of Florence, Italy.

He qualified in 1991 at the London Hospital, now the Royal London Hospital, where he also gained an MSc distinction in Gerodontology. He was honorary lecturer there in Restorative Dentistry, as well as Oral-Maxillo surgery from 1995-2002. In December, he was appointed Honorary Associate Clinical Professor, at, University of Warwick’s Postgraduate Dental Education Unit.
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