Easter dentist
Read why one dentist turned into an Easter Bunday when he gave his young patients Easter eggs containing a toothbrush, some toothpaste and a guide.

Lease holes
Are you a dentist looking to purchase either a practice with an existing lease, or set up a squat with a new lease? Beware of your statutory rights.

Maximum strength
If you have had adhesive failures, you probably don’t believe the success rates of the leading cosmetic dentists for their indirect adhesive restorations.

Kid’s hospital dental treatment ‘worrying’
Researchers have called the rise in the number of children having dental treatment in hospital ‘worrying’.

Nearly 50,000 children a year attend hospital to have teeth pulled out or be treated for decay, an analysis of hospital data has shown.

The findings, which were published in the British Dental Journal, revealed that children from poor areas were twice as likely to need treatment as those from more affluent areas.

He said general anaesthetics could be fatal to children.

The researchers wrote: ‘Caries (tooth decay) is a preventable disease yet the number of children being admitted for elective extractions of teeth due to caries was increasing yearly. Further investigation is required to determine some of the underlying reasons for this trend is required.’

A spokesman claimed that ‘there has been no increase in tooth decay in the period covered, which pre-dates the new dental contract.

He added: ‘Preventative oral healthcare has actually improved substantially thanks to the new dental contract.’

The Department of Health claimed the findings have been affected by changes brought in in 2001 which means that anaesthesia is now given in hospitals - rather than dental surgeries - for safety reasons.

The study found that children from poorer backgrounds were particularly at risk, being twice as likely to need treatment as those from more affluent areas.

Dr Paul Ashley, head of paediatric dentistry at University College’s Eastman Dental Institute, the second author of the study, said: ‘Two aspects of the study are particularly worrying - the rise in the number of general anaesthetics being given to children, and the widening gulf in dental health between social classes.

He said general anaesthetics could be fatal to children.

The researchers wrote: ‘Caries (tooth decay) is a preventable disease yet the number of children being admitted for elective extractions of teeth due to caries was increasing yearly. Further investigation is required to determine some of the underlying reasons for this trend is required.’

Peter Bateman, chair of the British Dental Association’s (BDA) Salaried Dentists Committee, called on water fluoridation to be used to address the gulf that has developed between the social classes.

He said: ‘This research highlights the stark inequalities in the oral health of England’s children. Those from socially deprived backgrounds are far more likely to have undergone extractions under general anaesthetic than their peers from more affluent backgrounds. The reasons for the apparent trends in this period are not clear and require, as the authors of the study acknowledge, further investigation.

He added: ‘What is clear though is that dental carries is a preventable disease and it is a tragedy that social class remains such an accurate predictor of oral health.

Water fluoridation, as the longstanding scheme in the West Midlands illustrates, has great potential to address this divide. The BDA was pleased to see the successful outcome of the consultation on the introduction of such a scheme in Southampton earlier this year and would like to see local people in other areas of the country given the same choice.’
This year’s Clinical Innovations Conference features a talk on three-dimensional imaging in implant and restorative dentistry, covering recent advances and how they impact on day-to-day clinical work.

Speaker, Dr Andrew Dawood, will explore the integration of the latest generation of digital imaging equipment into the dental practice, and how manufacturing technology has revolutionised cutting-edge dental treatments.

Dr Dawood has a wealth of experience in maxillofacial and craniofacial reconstruction, having been involved in the treatment of patients at St Bartholomew’s, The Royal London and University College Hospitals.

Having delivered lectures on a range of subjects that include dental implants, zygomatic implants, guided surgery and the best approaches to surgery planning, Dr Dawood is a knowledgeable speaker with a firm grasp of contemporary issues facing dentists.

A recognised expert in the fields of periodontology and prosthodontics, Dr Dawood’s passion lies in implantology, how the latest advances can assist today’s dental team.

The workshop will be held on 6 May at the Royal College of Physicians in Regent’s Park, London.

For more information, and to ensure your place, call Smile-on on 020 7400 8989, email info@smile-on.com or visit www.clinicalinnovations.co.uk.

BDA calls for nominations

The British Dental Association is calling for nominations for people wishing to sit on its Representative Body. There are currently vacancies in nine of its branches. If there are more nominees than vacancies, an election will follow in the branch concerned.

The Representative Body is the British Dental Association’s (BDA) most important committee. At its three meetings each year, the Representative Body receives regular reports including those from the Executive Board and the autonomous committees of the BDA, representing all the constituent parts of the profession.

There will also be key issues for decision-making at each meeting, including reports and papers on policy issues. In June each year, the body decides the subscription fee for the next membership renewal.

The Representative Body elects the majority of members of the Executive Board, in turn has closer scrutiny of the day-to-day activities of the Association. The reports from the Executive Board at each meeting of the Representative Body include updates in regard to the strategic direction of the Association, operational planning and topical matters affecting the profession.

Members of the Representative Body also have the opportunity if they wish, to work in other areas of the BDA’s work.

NHS Leeds has proposed to provide dental care for an extra 8,000 patients across west Leeds.

Plans were put forward for consultation to increase dental services throughout the whole of Leeds with several areas benefitting from an enhanced service. It is expected that new patients in Pudsey, Wortley and Farnley will be able to sign on from September 2009.

More dental services to benefit Leeds

Richard Lewis, a Pudsey councillor, has welcomed the move.

He said: ‘The current situation has put a huge amount of pressure on existing NHS dentists.

The problem of dental waiting lists has been ongoing for many years with hundreds of people unable to access dental care simply because dental practices have opted out of NHS-led services and have gone private instead.

BDA’s Associate Day

The British Dental Association is holding an Associate Day to give recently graduated associates the opportunity to date information on NHS rules and regulations, recruitment and the legal aspects of their career.

The workshop will be held on 5 May at 9am in the Royal College of Physicians in Regent’s Park, London.

For more information, and to ensure your place, call Smile-on on 020 7400 8989, email info@smile-on.com or visit www.clinicalinnovations.co.uk.
GDPUK round-up
There was a mixed bag of comments on GDPUK last week, reflecting the variety of topics encouraging discussion on the forum.

Professor Jimmy Steele continues with his review of NHS dentistry. Eddie Crouch says he has confidence in this investigation. Do you? You can read the Professor’s blog at http://tinyurl.com/d152q4u. It certainly makes for interesting reading, although the conundrums discussed are the same as topics that have been mulled over for years on GDPUK. An example would be a debate about a patient with problems from a molar. The tooth had an honest and reasonable standard root treatment provided under NHS contract, and the patient chose a crown that could only be provided under private contract. Subsequently, problems from the root treatment were diagnosed, and the conundrum became apparent — seeing as it was a repeat of root treatment which should have been in the hands of an endo specialist, who should pay?

Another topic colleagues like to discuss on a web forum, which they don’t get a chance to discuss in other media formats is about the value of precious metals, and how best to turn these assets into a different more tradeable commodity. Colleagues have shared ideas on how best to do this. Some keep any waste until they retire, some sell small amounts regularly. Some use one of the Assay Offices for the smelting and assessment. Some use travelling scrap dealers. The relative merits of those two approaches were discussed.

Postgraduate education to improve one’s understanding of orthodontics for younger dentists was aired. Younger colleagues realised they had had little experience on qualification. Notes were compared on how to go about gaining more knowledge and experience.

There was much unprompted happiness from the grass roots of the profession when the result of Eddie Crouch’s poll win as the UK’s most influential dentist was announced. Eddie is genuinely popular, and continues to take his stand against the Department of Health (DH) to the brink. Many dentists get their heads down and get on with making a living, Eddie has really stuck to his principles, and kept up his battles.

The impending closure of the Paternoster lifts at Birmingham Dental School attracted comments, many colleagues remember these potentially dangerous lifts. A search of YouTube found many videos to illustrate the thread on the forum. Apparently a similar system is still working at Sheffield University, so perhaps they are going strong at other academic institutions around the world.

About the author
Dr Anthony V Jacobs, 52 is a GDP in the suburbs of Manchester, in practice with partner Steve Lazarus at 406Dental (www.406dental.com). He has had roles in his LDC, local BDA and with the annual conference of LDGs, and is a local dental adviser for Dental Protection. Nowadays, he concentrates on GDPUK, the web group for UK dentists to discuss their profession online, www.gdpuk.com. Tony founded this group in 1997 which now has around 7,000 unique visitors per month, who make 55,000 visits and generate more than a million pages on the site per month. Tony is sure GDPUK.com is the liveliest and most topical UK dental website.
Simplified digital impression-taking

As the only system in the world that uses the principle of triangulation for intra-oral measurements, the Cerec system is setting higher standards in CAD/DAM technology with Cerec AC and the Cerec Bluecam camera. Never before have intra-oral scans been made as fast, sharp, or accurately in 5-D. Whole-jaw images broaden the indication spectrum and, with virtual models, allow the dental office and the dental laboratory to work together impression-free.

The acquisition unit of the Cerec 5D system – called Cerec AC (acquisition center) – has been equipped with a new camera (Bluecam). Cerec AC replaces the previous Cerec 5 acquisition unit; however, the new system is still completely compatible with Cerec 5 camera. Cerec AC is compatible with both milling units – Cerec 3 milling unit and Cerec MC XL (extra large). The advantages of an improved intra-oral image-capturing system do not stop at producing larger restorations chairside. The simplified inclusion of the adjacent teeth and the opposing jaw makes it possible to improve the occlusal and functional design, and the more exact measurement of the preparation enables an increase in the information content of the image. Furthermore, intra-oral recorded 3-D data sets of gnathic situations offer new diagnostic possibilities.

The heart of Cerec AC is the Bluecam camera. Instead of infrared light, Bluecam emits shortwave blue light produced by diodes. In addition, the less confusing is new: aspherical lenses bundle the light beam and orient it parallel to the image sensor (CCD). The light sensitivity has been increased, the image capture time shortened by 50 percent, and the image sequence accelerated. The projection matrix still employs the tried-and-tested light-stripe grid.

Faster, sharper, blur-free
As a result, the new Bluecam offers higher image accuracy in the occlusal region. The image depth has been increased by 20 percent and the focus depth decreased by 14 percent. The sharpness of individual images has been heightened, and marginal blurring eliminated. Blur control (automatic capture), the sensitivity of which can be pre-selected, checks the intended image, and the camera automatically takes the image only when it is certain there is no blurring. In quadrants and across the dental arch, any number of pictures can be taken as an overlapping sequence.

The 5-D image catalogue manages the individual images on the screen. The software assesses its usefulness, marks and rejects useless scans, and joins the images to form a complete row of teeth (matching) and a virtual cast modelled on the natural example. Images acquired at the beginning of the sequence, the quality of which may have been lessened owing to the presence of rubber dam or cotton rolls, are automatically excluded for a suitable image pair as soon as this is found. In this way, inadequate images are quickly replaced. In vitro studies in the laboratory at the University of Zurich in Switzerland have shown that the image accuracy deviates from the reference measurement of a master laboratory scanner by only 19–20 μm — this is equivalent to one-third of the diameter of a human hair. This means Bluecam’s accuracy is similar to that of stationary laser scanners. Such precision increases the marginal fitting accuracy of the restoration; thus, less excess occurs during adhesive luting, which in turn takes less time to remove.

Because of the image depth and focus depth, it is not necessary to keep an exactly determined distance from the preparation; the camera’s prism window can be placed directly on the tooth, which makes the acquisition easier, particularly in the distal region. The Autocapture function, responsible for actually taking the image, engages automatically upon ensuring that the image is in focus. Hence, there is no need to operate a footswitch, which requires eye-foot coordination. This means that an entire quadrant can be scanned in 30 seconds. The blue control makes the image sequence and menu operation accurate and simple; thus, this phase can be delegated to the dental assistant. The acquisition unit has a wireless or WLAN connection to the milling unit, the system can operate without power with no data loss for up to six minutes, thanks to its own optional, uninterrupted power supply – ideal for changing location during the milling/grinding phase.

Up to four-unit bridges chairside
Bluecam takes about 30 seconds to scan a complete quadrant and is suitable for scanning stone casts. In addition, bite records with static and dynamic occlusion are digitised and prepared for functional articulation of the restoration. After selecting bridge tooth databank, the preparation for a four-unit bridge can be scanned with Bluecam. This enables the construction and chairside manufacture of long-term, provisional composite-resin restorations employing the Cerec milling unit, which broadens Cerec’s indication spectrum considerably.

As when constructing crowns with Cerec 3D, fissure axes and cusps of the adjacent teeth are analysed – if desired, the antagonists’ morphology is also analysed – and incorporated into the occlusal surface calculation. The software adjusts the occlusal contact points and slicing planes of the crown construction to the occlusal surface of the antagonist. The wall thickness of the projected ceramic framework is checked beforehand, as are the insertion paths of the abutment crowns. After designing the restoration, the data set can be transmitted to the milling unit or the practice’s laboratory, or sent via LAN or wireless LAN to the dental laboratory. In the rapid milling mode of the Cerec MC XL milling unit, a four-unit bridge can be produced in about 20 minutes. Composite resin blocks by Vita (CAD-Temp) and Merz (Artline Temp) can be used to fabricate the provisional restoration. The milling preview shows the size of the block required and the positioning of the restoration in the material – ideal when using ceramic blocks with integrated, density-determined enamel/dentine colour progression (VITA TriLuxe, Ivoclar Multishade).

The virtual cast, online
Using the Cerec Connect system, the digital data of the optical impression, even of the whole jaw, can be sent from Cerec AC to the dental laboratory. This enables the cast-free manufacture of the restoration. In the future, it will be possible to manufacture a physical cast using these data from a portal, for dental laboratory use. In this manner, all single-tooth restorations could be manufactured, such as inlays, onlays, partial crowns, veneers, crowns and temporary crowns and bridges using CAD/CAM technology.

With the milling unit Cerec MC XL, the new Cerec 3D software and Cerec Connect, Cerec AC sets a new standard in restorative dental treatment. The system’s ease of operation allows a constant and time-saving workflow in the dental office. The progressive technology also offers new opportunities for highly efficient cooperation with the dental laboratory. In addition, the modularity of the Cerec system, its consistent development, and its total compatibility with all system components, including the lab-side system inLab, ensure complete treatment flexibility and sustainable investment security.
Oral health link to premature births

Poor oral health during pregnancy can contribute to the risk of giving birth prematurely, of having a low birth weight baby or the newborn child getting an infection, according to new research.

A team of researchers from Queen Mary University of London, found bacteria from a mother’s mouth can be transmitted to her unborn child via the blood and amniotic fluid in her womb.

This may contribute to the risk of a premature delivery, a low birth weight baby or infection of the newborn child.

The researchers tested the gastric aspirates (stomach contents containing swallowed amniotic fluid) of 57 newborn babies and found 46 different species of bacteria in the samples.

Two of the species of bacteria were recognised as coming from the mouth and are not normally found elsewhere in the body.

These particular bacteria, Granulicatella elegans and Streptococcus sinensis, are known to be able to enter the bloodstream and have previously been associated with infections such as infective endocarditis, an inflammation of the lining of the heart cavity.

Researcher, Cecilia Gonzalez-Marin, said: ‘Our studies show that sampling the stomach contents of newborn babies by using gastric aspirates can provide a reliable method of microbial identification.

Our research group is using DNA techniques to confirm if bacteria from the newborn matches the bacteria in the respective mother’s mouth.’

Details of the findings were presented at a meeting of the Society for General Microbiology in Harrogate.

No more Assault charges

A dentist, who refused to treat a Muslim patient unless she wore a headscarf, has been cleared of assaulting a policewoman.

Omer Butt, 32, was alleged to have hit the officer twice on her right knee with his Audi, following an argument over parking.

However Bury magistrates ruled that the Crown Prosecution Service had not proved beyond all reasonable doubt that an offence was committed.

Dr Butt, of Unsworth Smile Clinic dental surgery in Bolton, denied assaulting Pc April Stevenson in Parr Lane, Unsworth, on October 21 last year.

The magistrates heard that police were called to a car park behind Dr Butt’s Unsworth Smile Clinic dental surgery following reports an Audi was blocking other cars.

Pc Stevenson told the court she raised her right arm to make a clear ‘stop’ signal but was still hit.

Alan Rogers, chair of the magistrates’ bench, said a video recording of the incident did not show the car moving towards the officer.

‘The video shows after the alleged first instance that she [the officer] is relaxed and in no obvious discomfort,’ said Mr Rogers.

‘There is no medical evidence of the injuries. We find that the allegation of assault has not been proved.’

Dr Butt said he was undergoing counselling over ‘trusting people in authority’ after several incidents with the police in which he had been subjected to spot checks while driving.

Dr Butt said he did not see any stop signal and made no contact with the officer.

Dr Butt was reprimanded for serious professional misconduct by the General Dental Council in 2007 when he refused to treat a Muslim patient unless she wore a headscarf.

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Representatives criticise pay rise

Representatives of England's salaried dentists have joined with industry bodies in criticising the NHS dental pay rise.

Representatives of dentists working in salaried primary care dental services, hospitals and academia have all criticised the award, arguing it will not help staff and morale problems in their respective fields.

Dentists look to get a 0.21 per cent increase in earnings followed Dental Association's Review Body on Doctors' and Dentists' Pay.

The 0.21 per cent rise is based on a formula that, taking estimated decreased expenses into account, suggests GDPs will actually see a 1.5 per cent increase in net incomes.

However the Dental Practitioners' Association, claims that as the Retail Prices Index is currently 3.2 per cent—anything less than this is effectively a pay cut.

Peter Bateman, chair of the British Dental Association's (BDA's) Salaried Dentists Committee, has now added his voice to the criticism.

He said: 'While we appreciate the current economic situation in Britain and the need for restraint in determining pay uplifts, it is also important that the effect of these uplifts is properly considered.

'We know that almost two thirds of ICT-run salaried dental services across the UK are already struggling to recruit dentists. This uplift will do nothing to solve the problem of recruitment, and could even exacerbate the problems we and the vulnerable patients we treat face.'

Keith Altman, chair of the BDA's Central Committee for Hospital Dental Services, is also critical of the award.

He said: 'Dental staff working in hospitals are very disappointed by this award which will do little for the morale of dedicated professionals working with very limited resources. Those in training grades in particular need reassurance that a career in hospital dentistry is valued in order to encourage entrants to this branch of dentistry.'

The percentage of children who visited NHS dentists fell from 70.7 per cent in March 2006 to 69 per cent in June 2008. Less than half of the adult population is accessing NHS dentistry, and the numbers are continuing to decline, said the report.

The Green Party claims that access to an NHS dentist all depends on 'geographical accident'.

In the report, a Green New Deal for the NHS, it claimed that between 55 and 60 per cent of NHS practices are not taking on new NHS patients.

The information based on Freedom of Information Acts revealed that access to NHS dentists can range from one dentist per 1,000 people—to as little as one-quarter of that, depending on where people live.

The new policy report claims that little more than two-thirds of children visit NHS dentists and the situation is getting worse.

It also found that some Primary Care Trusts have no NHS dentists taking on new patients.

The Party wants £1.8bn funding for NHS dentistry, and the numbers are continuing to decline, said the report.

The Green Party is calling for the government to increase funding by £1.8bn to 'restore NHS dentistry to what it should be'.

Green Party health spokesperson Stuart Jeffery said: 'The dental service received £2.1bn of direct funding in 2007/08. If the current NHS dental service was provided free at the point of use, the total cost to the NHS would increase by £551m to a total of £2.6bn.

If the NHS wanted to provide free dentistry to 75 per cent of the population (from the current 50 per cent, assuming that some people will want to remain private), the total level of funding would need to increase from £2.6bn to £5.9bn.

As the NHS currently provides £2.1bn, an increase in funding of £1.8bn would be required for patients to have dentistry free at the point of access.

He added: 'It seems little to ask to restore NHS dentistry to what it should be - a service that Britain can be proud of.'

Volunteers tackle Tanzanian tooth decay

Twelve volunteer dentists from the UK have just returned from Tanzania, where they have been extracting teeth from more than 180 people a day.

Martin Anderson, from the Wessington Way Dental Practice in Sunderland, was among the volunteer dentists who have just returned from a fortnight in the East African country. The 54-year-old went out from more than 100 people a day.

Children were given Easter Eggs filled with toothbrushes and toothpaste

A dentist in London turned into an Easter Bunny when dentistry practice Aqua Dental Spa gave out Easter eggs containing a toothbrush, some toothpaste and a guide to healthy brushing.

London-based dentist Anoop Maini, founder of Aqua Dental Spa in central London, faced a personal dilemma deciding what to give his member's of his family for Easter.

'Kids all over Britain will be eating chocolate this Easter, and why not? At Aqua Dental Spa we believe in general dentistry with a difference. Good oral hygiene does not mean you have to completely avoid chocolate and sugary foods, but it's important that you have balanced diet and take care of your teeth.'

With our egg, kids get their sweet treat but are then encouraged to think about their teeth and take care of them,' he said.

Maini's 'Good Egg' was made from chocolate also packed full of dental goodness, including a tube of toothpaste, a good quality brush and information on better brushing.

The eggs were given out free to patients at Aqua Dental Spa as a healthy and tasty alternative Easter gift for friends and family.

Mr Maini said: 'This is about educating adults and children alike.

People might think it's crazy for a dentist to give kids chocolate but this is better than other eggs they will get this Easter. They are still delicious but contain a healthy message that I hope children will remember for the rest of their lives. It’s an Easter gift that keeps on giving.'

Oasis Healthcare expands

Graham Cox, the firm's marketing director, said: 'Oasis is committed to expanding its network to give as many people as possible in the UK access to high quality dental care and customer service.

Our team has been working round the clock to finalise all the details and this is an indication of the level of commitment and support the dentists and their patients will get from being part of Oasis going forward.'

Oasis was acquired by Duke Street Capital for £15bn in 2007.

JHA stake up for sale

The largest private dental chain in Britain, James Hull Associates, is currently in talks to sell a 50 per cent stake to a private equity firm in a deal which values the business at about £250m.

The business was founded by dentist, James Hull, 48, with just a single practice in Newport in South Wales, in 1987.

JHA wants to use the cash raised to expand into the Continent and the Middle East.

It has received first round offers from four bidders, one of whom is known to be Axa Private Equity, which lent JHA £15m in August last year.

Hull, still a practising dentist, holds a 57 per cent stake in the firm and finance house Hutton Collins owns the remaining 45 per cent.
Blended learning:

An ideal combination for general dental practice

King’s College London Dental Institute is one of the largest Dental Institutes in the world and offers a wide range of postgraduate programmes. Most popular of these are the blended learning degrees. Blended learning is described as ‘a learning solution that incorporates a mix of online and face-to-face elements’. Busy practitioners can therefore choose their time and place to study the academic components of the modular courses online and focus on the face-to-face intensive courses for the hands-on learning experience. These residential components are available annually in the UK and some as also available in India.

The MSc Advanced General Dental Practice is aimed at dental practitioners who wish to develop their clinical skills and expand on BDS level knowledge. It covers a range of topics from clinical skills to practice management to enable dentists to run a successful and rewarding dental practice.

Our new MSc in Aesthetic Dentistry is very popular and offers advanced training in invasive and non-invasive techniques for hard and soft tissue aesthetic treatments.

The MClinDent in Fixed and Removable Prosthodontics (FRP) is currently our most popular programme and covers more advanced skills. This programme includes most of the components listed in above degrees but goes on to train dentists in managing advanced clinical problems such as severe tooth wear, TMJ dysfunction, aesthetic challenges, replacement of missing teeth and occlusal treatments. It is ideal for those aspiring to be competent to run a high quality private practice tackling the more demanding clinical problems. This programme is also available at MSc level for those undertaking parts of the MClinDent degree pathway.

Similar MSc programmes are currently available in Dental Public Health and Dental and Maxillofacial Radiology. We are about to launch an MSc in Maxillofacial Prostheses.

The mode of delivery for all our blended programmes, has been designed to enable dentists to remain in dental practice while training, allowing them to maintain clinical contact and establish a dental practice using skills learnt on the programme. The residential courses of approximately 9 days duration, held at one of our training centres, will provide the supporting face-to-face tuition in clinical skills. The training centres are in London and India, both providing the same programme taught by King’s staff and lead to the same King’s Masters Degree. Examinations are held in the student’s home country with one written paper per module.

The success of the programmes comes from the balance between interactive online content, which includes ready access to the King’s College London e-library, and the intensive annual 9 day block face-to-face teaching courses which provide the hands-on elements essential to a dental programme. The courses also include one-to-one tutoring for the final year of study and advice for the clinical work carried out in practice.

The MSc programmes run over 3 years (4 years for MClinDent FRP and MSc Dental and Maxillofacial Radiology) through part-time training. For any dentist not wishing to sign up for the full MSc (180 European credits) or MClinDent (360 European credits) then it is usually possible to complete a shorter course leading to a Certificate (60 credits) or Diploma (120 credits).

All courses are quality assured, independently verified and are taught by experts from the King’s College London Dental Institute and other centres of excellence around the UK.

For further information or an application form please see:

www.kcl.ac.uk/distancedentistry
or email: distancedentistry@kcl.ac.uk

Dr Brian Millar BDS, FDSRCS, PhD
Director of Distance Learning, Consultant in Restorative Dentistry, Specialist in Prosthodontics
A study has found there is no evidence to prove that the practice of extracting baby canine teeth, to make way for adult canines that are breaking through the gum in the wrong place, has any benefits.

The study Extraction of primary (baby) teeth for unerupted palatally displaced permanent canine teeth in children which was published in Issue Two of the Cochrane Database of Systematic Reviews 2008, found there is no evidential basis for the practice.

Lead author of the study, Nicola Parkin of the Department of Oral Health and Development at the University of Sheffield, said: ‘The recommendation of extracting the baby canine is in fact based on one uncontrolled study that was carried out over 20 years ago.’

It is common for adult upper canines to grow in the wrong place.

Near three-quarters of managers and directors believes that companies are responsible for looking after the oral health of their employees, according to a survey.

The Simplyhealth's Annual Dental Survey, surveyed 255 human resources (HR) managers/directors via independent research agency Opinion Matters, and found 71 per cent of employees think that companies should offer dental benefits.

While 40 per cent of companies who do offer dental benefits believe they help to 'increase employee engagement', according to the research.

James Glover, corporate director at Simplyhealth, said: 'Despite companies seeing their value, only 56 per cent of respondents actually offer dental benefits.

However, of these employers offering dental benefits, nearly half believe they help to reduce absence for dental health problems, and 48 per cent believe it makes it easier to monitor time off for dental appointments.

These results are crucial since they demonstrate the value dental benefits bring to the employer.

When looking at the barriers to implementing dental benefits, it may be unsurprising to learn that the main one is cost, with complexity coming a close second. However, with the perception that access to good dental care has become difficult, employers who are serious about the well-being of their staff should be looking seriously at making provision for dental treatment.'

With the UK now in a recession, the results were very different to the survey held which looked at the same issues last year.

The survey found that 84 per cent of HR Managers are concerned that their employees cannot afford to look after their oral health, compared to 75 per cent last year.

Managers call for dental benefits

Managers think that introducing dental benefits would improve staff morale, compared to 51 per cent last year.

Sixty-four per cent of HR Managers think that introducing dental benefits would improve staff morale, compared to 51 per cent last year.

The final presentation from Ken Eaton, one of the faculty’s two national research facilitators, will give ideas on how the Faculty of General Dental Practice (FGDP) UK can help DCPs in their research, including examples of DCP research projects from around the world.

To find out more and sign up for the research day for DCPs, email Marina Harris, president of the British Society of Dental Hygiene and Therapy: marina.hyg@virgin.net.

Research day for DCPs

The Faculty of General Dental Practice (UK) has organised a research day dedicated to dental care professionals.

The event will be held on 15 June, 10am-4pm, at The Royal College of Surgeons in London.

The one-day event will be held in partnership with the British Society of Dental Hygiene and Therapy (BSDHT).

It will include presentations from dental care professionals (DCPs) who have carried out or contributed to research projects.

There will be morning and afternoon plenary sessions to review the presentations and guide DCPs on their best route into research projects, with a focus on new evidence to prove that the practice of extracting baby canine teeth, to make way for adult canines that are breaking through the gum in the wrong place, has any benefits.

The new study found there is no evidential basis for the practice of extracting baby canine teeth, to make way for adult canines that are breaking through the gum in the wrong place.

Normally adult canine teeth erupt in the mouth around the age of 12 years and, in approximately 2-5 per cent of the population, the eruption of the adult canine is in fact based on one uncontrolled study that was carried out over 20 years ago.”

It is common for adult upper canines to grow in the wrong place.
Consider your team for a moment. Does the thought cause you to roll your eyes and sigh in despair? Some days they’re good, other days they’re so-so, and on the worst days they are just plain bad. But they are your team.

Most of the time they show up when they’re supposed to and together you take care of the patients. So you simply accept what you consider to be the trials and tribulations of people working together day-after-day. But what if you could take the good days and double, if not triple, those? What if you could build on the strengths of each individual? What if each person could think outside the box and work and contribute fully? What if you could make all this team stuff actually work for your practice? Maybe it’s time to turn those ‘what ifs’ into realities. Read on.

We spend a lot of time talking about dental teams — their effectiveness, their cohesiveness, their efficiency, their productivity, etc. Google the word ‘teamwork’ and you’ll get 25.5 million hits. Search for books on teamwork on Amazon, com and you’ll find nearly 59 thousand to choose from. For all of our interest in teams — dynamics, operations, possibilities, advantages, challenges, the team is largely in the Neanderthal stage in it’s evolution, still lurking along. As Ken Lencioni, leadership guru and author of the best-selling book ‘The Five Dysfunctions of a Team,’ describes it, ‘Teamwork remains the one sustainable competitive advantage that has been largely untapped.’

What’s more ‘teams’ are frequently composed of individuals whose skills are vastly under-utilised. According to J. Richard Hackman, author of ‘Leading Teams: Setting the Stage for Great Performance,’ most teams generally leave unused enormous pools of member talent.

Many dental teams struggle to truly maximise their effectiveness. They face the daily challenge of merely getting everyone on the same page let alone working in the same direction. Often they simply avoid taking action necessary to create high performance teams. Dentists become frustrated with team members because they don’t like the way employees handle certain procedures, tasks, or patient interactions, yet they routinely make excuses for those individuals rather than give constructive direction. ‘Patty is new, so there’s a learning curve we have to consider,’ ‘Ellen is great at what she does, but she has difficulty dealing with people.’ ‘Joe is a really nice guy, but he’s afraid to mention a problem until we have a crisis.’

Conversely, team members complain that dentists don’t give enough direction, feedback, or refuse to hold others accountable. They’ll assert that certain team members get preferential treatment or that the office politics interfere with any real efforts to improve systems. Some team members will become immensely frustrated with their inability to fix what they see as a problem or ineffectiveness because the practice has ‘always done it this way.’ Others shun discussion of those issues that make fellow team members or the doctor uncomfortable for fear of making waves.

Workgroup or teamwork

Take a look at your practice environment. Your office probably foster a culture of teamwork that is built on trust and respect or does it operate more like a workgroup? Many dental ‘teams’ function more like workgroups. In workgroups, people are primary concerned with their own job and output. They have little or no interest in what their coworkers are doing. In fact, they see their coworkers as their competition. This ineffective attitude leads to a loss of efficiency and production. The office feels disorganised; there is a general acceptance of poor or mediocre performance fueling a ‘that’s just the way things operate here,’ attitude, and high turnover is common. Worse yet, conflict, turf wars, and pettiness are all too frequent.

In this type of environment, it is not uncommon for the doctor to discuss the value of taking steps to strengthen the dental team. ‘They’ll dismiss or belittle the concept of ‘team’ with comments such as ,’ ‘My staff and I work pretty well together, and I don’t want to spend time on intangibles.’ Intangibles? An ineffective team costs time, money, patients, staff, and stress — five tangible things, wouldn’t you say.

Answer the following questions about your team:

• How many times during the past year did you wish a member of your team would handle a patient, a procedure, or a situation differently? How much do you think it cost your practice?
• How many times during the year were you managing conflicts between team members? How much do you think it cost your practice?
• How many times did you feel like one or more members of your team were heading in the opposite direction of the rest of the group? How much do you think it cost your practice?
• How often were you frustrated by team members’ inability to solve problems or take necessary action? How much do you think it cost your practice?
• How often were staff meetings either dead with silence or dominated by one or two people? How much do you think it cost your practice?
• How many good ideas surfaced but were never implemented? How much do you think it cost your practice?
• How many times did you hear the expression ‘It’s not my job?’ Or I thought that was Jane’s responsibility? How much do you think it cost your practice?
• How often were you faced with a two-weeks notice? How much do you think it cost your practice?
• How many patients did you lose in the last 12 months? How much do you think it cost your practice?
• How many times did you feel like the practice should be doing better financially, that work should be less stressful and more rewarding? How much do you think it cost your practice?

But just how do you build the team that not only works together, but truly excels together? It starts with a clear vision and a solid plan to implement the vision. The team has to know where they’re going, before they can be expected to actually travel in the same direction. Success will be the outward evidence of a common purpose and hold themselves and each other accountable for the team’s effectiveness and efficiency.

Effective team fundamentals

Effective teams produce concrete and measurable results. But it doesn’t just happen. Often times, practices have employees that together could become an outstanding, highly effective team. Individually, most of the members are dedicated, hard working, and knowledgeable, but they simply don’t know how to function effectively as a group.

They don’t know how to establish team goals and to identify the strategies to achieve those goals. But show them the possibilities of working as a team and give them the tools to function together, and you’ll be able to build the high performance group.

Start with the fundamentals of the highly functioning team. No. 1: Individuals need direction and a basic understanding of how their day-to-day work fits into the practice’s overall goals. That begins with the practice vision and goals coupled with individual objectives. Help each employee understand their specific part in realizing the established objectives. Staff members are able to see the relationship between their roles and practice goals are much more effective and far more motivated to succeed than those who feel they are just another cog in the wheel.

And, most importantly, use job descriptions to give employees the direction they need to carry out their duties effectively. Employee job descriptions are essential to clearly articulate exactly what is expected and why carrying out specific duties is essential both to the individual’s success and that of the practice.

In addition to clearly explaining duties and expectations, talk to your employees. Give them feedback regularly. Catch your employees doing something right and tell them every day. Ongoing feedback is absolutely essential in any business environment, but in a small business, particularly a dental practice, in which the success for failure of each system hinges on the performance of a small collection of employees, it is critical. Feedback from the doctor and other members of the team is the only means individuals have to better understand what they can do to improve their own performance. And it’s one of the most essential resources for continuously assessing what is working and what isn’t in your practice.

Create a culture of teamwork

Team members need to know they can trust each other. They need a process for managing conflict, which is inevitable and occurs on every functioning team. They need to understand what their individual strengths and weaknesses are as well as those of their teammates. Team members need to feel included in the process. They need to feel valued for their contributions, and they need to feel empowered to make decisions and take action when it is in the best interest of the practice.

Team members need to know how to communicate with each other. A true team environment encourages individuals to risk speaking up, to ask for help, and it gives them a safety net to make mistakes. It also creates a strong environment for solid constructive feedback. Effective team members turn team priorities into individual priorities. They understand that their roles don’t just benefit them, but everyone else as well. Take steps to turn your staff into a highly effective team and enjoy the benefits of significantly greater practice efficiency and effectiveness and far less daily stress and anxiety.

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Renewing your lease

Mark Waterfield highlights the traps and pitfalls of lease renewals

If you are a dentist looking to purchase either a practice with an existing lease, or set up a squat with a new lease, you need to be aware of your statutory rights when it comes to renewing the lease at the end of the contractual term. Unless you are fortunate enough to be offered the freehold you will typically need either a new lease of between 10 and 20 years in length, or an existing lease having that number of years unexpired.

Can you renew?

Firstly, it is important to realise that you will not be able to automatically renew your lease unless it is a protected lease. The Landlord & Tenant Act 1954 offers protection to tenants of business premises in that he has the right to renew the lease, subject to fulfilment of certain conditions. This is typically referred to as a “renewable lease”. However, not all leases are renewable leases. It is therefore important for you, as purchaser, to obtain proper legal advice to ascertain whether your lease is renewable or whether it will come to an end on the expiry date stated in the lease, in which case you could be faced with the spectre of eviction at the end of your contractual term and the resulting loss of your business. A solicitor will be able to advise you whether this situation is likely to arise by a quick and simple check of the lease.

In the unfortunate event that you are faced with taking on a lease which does not have a right to renew, all is not necessarily lost. In the case of a new lease, the draconian effect of “an excluded lease”, as it is referred to in the profession, can be compensated for, for example, by possible negotiation of either an option to purchase the landlord’s freehold interest or at least a right of first refusal on any proposed sale of the freehold by the landlord.

Mechanism for renewal

Assuming your lease is renewable, you will need clear advice as to what you must do in order to safeguard your right to renew. Either landlord or tenant can commence the renewal procedure at the end of the lease term by serving a notice on the other, the effect of which is to terminate the existing lease and initiate renewal negotiations. There are complex and detailed rules governing the form, content, timing and period of notice which must be given and legal advice on all of these aspects is absolutely essential.

You need to be aware that, even where the lease is renewable, the landlord can still prevent a renewal and regain possession. If he can show that one of a limited number of statutory exceptions applies. An example is the landlord requiring the premises back for his own use. If the landlord objects to a renewal on any of these grounds, your solicitor will be able to advise on the course of action you should take.

If no statutory notice is served by either party, your lease will continue by law automatically and indefinitely after the expiry date unless and until terminated by service of a notice. There are tactical reasons dictating whether one or other party should serve a notice in certain circumstances and again good legal advice is of the utmost importance.

Negotiate and agree

Where the landlord has no objection to renewing the lease it will be up to both parties to negotiate and agree terms for the new lease within a reasonable time. The tenant has the right to a new lease on similar terms to the existing one, subject to a possible change in the amount of the new rent to be charged. At this point it would be wise to engage the services of a reputable surveyor in order to establish what the new level of rent should be and whether any of the other lease terms reasonably ought to be changed or at least modernised.

In the majority of cases it is usual for the landlord and the tenant to agree renewal terms between them. However, should agreement not prove possible, then it is open to either party to apply to the court for a decision on what the terms should be. Time limits apply with regard to when a court application can be made. These and all other statutory provisions applying to the renewal procedure generally are very strict and, unless adhered to in every respect, can result in the right to renew being lost. Caution is therefore the watchword during this whole process.

If you do have to apply to court, you should be warned that court proceedings can take a long time and it might be many months or even years before a final hearing is held to determine the issues. Therefore, it is recommended that you should try to agree the new lease terms with your landlord wherever possible.

Interim rent

Whilst the renewal procedure is going on, either landlord or tenant can apply to court for a determination as to what the rent should be for the interim period between the end of the contractual lease and commencement of the new one. Such an application is not warranted in every case, however, and again, you need advice as to whether you should make one.

Compensation

In some of the cases where the landlord is entitled to prevent a renewal, the tenant is entitled to receive compensation for having to vacate the premises. Compensation is calculated by reference to rateable values and the amount of compensation will also depend upon how long in total the premises have been used as a dental practice (including any time your predecessor(s) in title carried on the practice).

Costs

You will inevitably incur legal and surveyors’ fees and, understandably, you will want to know what these are likely to amount to. Costs will very much depend upon how the renewal negotiations develop, for example, how long it takes for the parties to reach agreement on the renewal terms or, alternatively, if agreement cannot be reached, to what extent issues are contested in court proceedings. Solicitors have a professional duty to provide clients with an estimate of costs, both at the outset, and also with updates as a case progresses. Thus, you should have a reasonable idea of the likely total costs at any given time in the process.

About the author

Mark Waterfield

The author, Mark Waterfield joined Howell-Jones solicitors’ (ASPD members) dental team in March 2007 and works closely with Martin Whiteman and Chris Pomfret on the commercial property aspects of acquisitions and disposals for dental practitioners. Mark can be contacted either by email mark.waterfield@howell-jones.com or 01485 540547. ASPD members offer professional, objective and practical advice and services, based on experience within the industry, dental practices and other businesses within the dental sector. For more information on the ASPD call 0800 458 6773 or visit www.aspd.co.uk.
More pension or more cash?
With new NHS pension scheme rules in place, there are now different options available when it comes to how you receive your money when you retire. Ray Prince explains

In the past, when it came to how the NHS paid your pension, it was very simple. You had a pension based on the number of years' service in the scheme, your income, and whether you had purchased added years. You also received a tax-free lump sum of three times that pension (although GDPs have their pension entitlement calculated on a slightly different basis).

No thought was required when you reached retirement age. You simply signed the form to say you were retiring and waited for the pension payments to reach your bank account. However, since April 2008, the NHS has given you new options:

1. Just take pension only
2. Take more in tax-free cash and less pension
3. Take the maximum in tax-free cash and even less pension

To calculate how much pension you would receive if you choose option two, you need to apply a ratio. The ratio is 12 to 1, and does not change whether you retire at age 60 or 65. For every £1 of pension you give up, you receive £12 in tax-free cash. The limit in the amount of tax-free cash is 25% of the capital value of your pension fund. The remaining 75% provides your pension.

Having had two recent cases of clients coming up to retirement, these new rules give some interesting options. Let's look at an example, and in the interests of keeping things simple, the figures are approximate.

What's the best option?
A principal dentist with an NHS practice is retiring aged 60 in April. With all debt paid off, the children in their 30s and working, he is really looking forward to spending more time in his boat and brushing up on his golf.

He has amassed the equivalent of 36 years' NHS service and his latest pensionable income is a little over £111,000 pa. His entitlement is actually based on the notional pension pot that he has accrued with the NHS Pension Scheme.

The next step was to visit the NHS Pensions website calculator and look at the most obvious options re points 1 and 2 above.

These are the figures:
1. £50,000 pa pension plus tax-free lump sum of £150,000
2. £40,000 pa pension plus tax-free lump sum of £270,000

Making a choice
The first thing to take into account is that he needs £2,600 after tax income per month to pay the bills and run a car etc. This is equivalent to about £37,500 gross pa. Any extra spending would be on holidays (and he and his wife certainly intend to have quite a few over the next 10 years). So they would need an extra £10,000 pa for this.

Next, it is important to note that any income received above around £41,000 pa is taxed at the higher rate of 40 per cent. So, in

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effect, the real difference between options 1 and 2 is £500 per month inflation-proofed income on the one hand, and £120,000 cash on the other.

Looking at it like this, it would appear that it would take approximately 20 years for the pension option to catch up. Of course, we do not know what effect inflation will have over the next 20 to 50 years, nor what return he will get on his cash, depending on the risks he is prepared to take.

Important factors
As you will know, we live in interesting times at the moment and interest rates are low on deposit accounts. It is reasonable to assume that he could get two to three per cent pa (gross) in a deposit account over the next 20 years, and pay less tax by putting the money in his wife's name as she is a lower rate tax payer. But what would happen if he died soon after retiring?

With the cash option, it is 'in the bank'. But with the higher pension option you would assume that his wife would be slightly better off, as the benefits are based on 50 per cent of the pension. The good news is that this is waived by the NHS in the event of his death, and the 50 per cent is always based on the higher pension regardless of whether he took the maximum tax free cash or not.

Another factor here is that he will receive a state pension of circa £5,000 pa at age 65 in 2014, and his wife will also benefit with her state pension for a similar amount starting in 2015 at age 62. Even if he takes the maximum NHS tax-free cash, the income he is receiving from his pensions (by age 65) will mean he will be paying Higher-rate tax.

All this information was entered into his retirement cash-flow forecast, and he could then make an informed choice confident that all factors had been covered. So, bearing all this in mind, he is choosing to go for the maximum tax-free cash, and lower pension. Visit http://tinyurl.com/bqwkqy, to see a calculator.

The key point
Deciding whether to opt for more cash or more pension is a one-off decision. Therefore, make sure you do your homework before you decide!

Take action
If you are approaching retirement, write down all your assets on the one hand, and your anticipated expenditure on the other. Have your adviser build you your own cash-flow forecast to show the overall picture and the effects of inflation etc. This 'Sat Nav' will give you the context to make one of the most important financial decisions you will ever make – more pension or more cash?

More information
To learn more about your retirement planning options, you can request a free copy of one of Rutherford Wilkinson’s audio CDs: ‘How To Avoid The Three Most Common Retirement Planning Mistakes’. Just call Catherine Lowes on 0191 217 5340 and a copy will be posted to you (please quote ref: DT).

About the author
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Money Matters

What’s on your mind?

Invest wisely and allay your concerns about financial independence during the credit crunch. Thomas Dickson

Not only do dentists face the constant pressure of keeping up-to-date with new techniques and equipment, meeting the ever-increasing expectations of patients and for (NHS dentists in particular) negotiating with Primary Care Trusts, but there is also the challenge of choosing how to invest any disposable income.

Many dentists have seen their investments drop considerably over the last 12 months, leading in some cases to a reluctance to invest. However, the belief that dental professionals do not invest in property, stocks and shares, long-term or short-term, may find themselves with very little money at a time of life when they should be financially independent.

Save for the future

Because every dentist’s situation is unique, there is no one solution. Those dentists expecting a sizeable windfall from the sale of a quality practice, or an inheritance sum, need to realise that neither of these can be guaranteed, and that they, along with their peers, should think about allocating a quarter of their net monthly income to ensure that their future is provided for.

As a rule of thumb, dentists without an effective investment strategy need to consider their short-term, medium-term or long-term options. For a short-term saving, there are high-interest bank accounts. For medium-term investments, dentists should make the most of their £7,200 maximum annual allowance for Individual Savings Accounts (ISAs). Long-term investment opportunities can include contributing to either the NHS or a personal pension.

Contrary to what some dentists believe, now is potentially a good time to make an investment in the stock markets. There is always an element of risk, due to the market’s volatility, but the old investment tenet of ‘be greedy when everyone else is fearful’ might well be valuable advice. The ability to earn money can simply be taken out of the bank and put into the property market any time, and there can be significant profits to be made for the canny investor as the stock market is likely to rebound several months before the economy does.

Plan for the future

Financial planning should always be a priority for dental professionals, but in the current climate it is vital. The obvious benefit of having a plan in place is that it provides security and comfort in uncertain and challenging times. Dentists who have done everything that could be done to be able to face the future with more certainty, and are better placed to roll with the punches should a financial crisis develop.

The ability to earn money is of course a key factor in determining whether or not the dentist will achieve financial independence, and the ability to earn money depends on how well you spend and work in the necessary day-to-day tasks. For instance, a dentist who cannot sit for long periods due to back injury has a severely curtailed ability to perform certain procedures important to diagnosis and treatment. A hand injury can effectively end a dentist’s active involvement in clinical duties, throwing his or her future into uncertainty. For these reasons, a comprehensive income protection strategy is important, as it will ensure that the dentist can still achieve financial independence even if he or she is unable to work due to health reasons.

Think of it like this: dentists in their home and contents and motor car, but what if they had a machine in the practice that printed several thousand pounds a month? Should they insure it? Of course they should, and they would, too.

Dentists without income protection who suffer an injury that prevents them from working are liable to see their whole plan for financial independence fall apart. Whether in practice or hospital-based, dentists without income protection should contact an independent financial adviser specialising in advising dental professionals, in order to discuss their needs.

Planning for retirement

Planning for retirement is not just about investing in a pension. It includes putting together a financial plan for the majority of cases as they are an extremely tax-efficient form of long-term investment, especially for higher-rate taxpayers.

However, it does not suit everyone to invest in pensions as soon as the opportunity arises. Dentists recently set up in practice, or who have student debts to pay, might be better advised to make a success of their new business first, or even step onto the property ladder, before thinking about putting money aside for retirement.

This is not to suggest that making pension savings is reserved only for dentists settled into a successful career. Younger dentists, or dentists yet to pay off student debts, can always make short to medium-term investments, which carry the benefit of allowing the dentist to access the funds invested should they be needed. An ISA can be an advisable investment option, because if the dentist finds that he or she has overcommitted, the money can simply be taken out again.

Once a dentist is in a secure financial position and can afford to make regular pension payments to save for retirement, there are many reasons why he or she should start as soon as possible.

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About the author

Thomas Dickson, director of Essential Money Limited, formerly a partner of Money4Dentists, has a wealth of experience in advising the dental industry. Beginning as a financial adviser, Thomas has recently launched Essential Money to provide expert independent financial advice that dentists throughout the UK can rely on. For more information, and to receive a free copy of ‘The Little Book of Money’, full of useful hints and tips, contact Essential Money on 0121 685 5060 or email thomas@essentialmoney.co.uk.
Playing it safe
With the credit crunch taking a big bite out of your bank account, you need to grab any opportunity to safeguard your money, says Frank Pons

This includes protecting yourself against any sudden expenditure against which you have no defence. For instance, HM Revenue and Customs has made it a part of its modus operandi to select cases at random, which means that your business could fall under the microscope even if you haven’t done anything dishonest, or made any mistakes on your self-assessment tax return – and with the average cost of an enquiry reaching £5,000, crossing one’s fingers and hoping for the best is not a good idea.

You’re not immune
This flies in the face of conventional wisdom. Plenty of dentists consider themselves somehow immune to investigation, or at least invisible to the tax authorities, because as far as they are concerned, their tax returns are perfect and they have nothing to fear. Unfortunately, this is not the case. Because the tax authorities are randomly selecting cases, this means that it is absolutely vital that dentists have a safety net in place.

Prepare for the worst
Then there is the bombshell that will inevitably land on your doormat. Even in a best-case scenario, with your adviser successfully fighting your corner against the tax authorities, you are certain to pay the price – quite literally. Usually, the bill will run to thousands upon thousands of pounds. At this time, with all of your patients feeling the pinch, do you really want to take the risk of having a sizeable bill come through your letterbox?

Fortunately, you can provide a safety net for your hard-earned money. With insurance against tax investigations you can ensure that you are covered for up to £75,000 towards accountant’s fees in case of:

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About the author
Frank Pons
A qualified chartered accountant and tax expert, Frank Pons founded PFP in 1984, the first company to recognise the need for and provide dentists with tax investigation insurance. For more information contact PFP on 0845 507 1177, email info@pfp.uk.com or visit www.pfponline.com.
Quality dentistry? Part 2

In the second part of this interview, Neel Kothari continues his talk with Chief Dental Officer Dr Barry Cockcroft to find out more about how well he thinks the NHS system of dentistry is working and what standards it should be aiming for.

NK: How have the new arrangements affected the workforce balance between performers and providers?

CDO: In our evidence to the review body, we suggested that they look at the relationship between those who hold contracts and their performers, obviously the providers have done very well out of this financially and the workforce situation has fundamentally changed. We asked the review body to comment on the transparency of the relationship between providers and performers. We would like to see CPTs including that in the governance arrangements between providers and CPTs.

NK: Do you think there needs to be more transparency between principals and performers?

CDO: Yes, I think there should be more honesty and transparency in the relationship between providers and performers. I was in practice for 25 years and there was a time when you couldn’t get associates to come to your practice. If you had advertised for an associate on many occasions they would actually interview you to see if they wanted to come to your practice. The workforce problem now isn’t the same as it was previously, there is no shortage of people wanting to work in practices, and this is just market forces starting to have an impact.

NK: What about the Health Select Committee’s (HSC) concern about the large number of overseas dentists being recruited?

CDO: I think overseas recruitment is an emotive topic and we also recognised that we needed to grow our own graduate numbers and we’ve done that. We increased the number of dental graduates by 25 per cent and we will see the first impact of that with 100 extra graduates coming out this year, and beyond that we will have more UK graduates from this year.

NK: Is it fair to charge patients the same amount of money for simple treatment such as a single filling compared with another patient who may need 10 fillings?

NK: Is there then a risk that some patients may wish to shop around for their needs, as they will be better off financially?

CDO: We have no evidence that this is happening. People keep saying that, but quite frankly, I think we have got no evidence to support that.

NK: Many patients on low incomes do not qualify for NHS welfare packages, so what can the Government do to help these people with the NHS charges?

CDO: The new system for patients’ charges was designed to be fiscally neutral. In actual fact, if you look at patients’ charge revenue, the proportion has gone down a bit. As I say, 50 per cent of adult treatments are free of charge, all children are free of charge and if you’re on what is judged to be a genuinely low income then you are exempt, and that’s a judgment the Government has to make.

NK: Why did registration need to be removed from this current contract?

CDO: What is important is not registration; what is important is continuity of care, and if you read the BDA’s evidence, they recognise that as well. I worked in general practice from 1975 until 2002; most patients I saw over that period had considered themselves to be registered with me for that whole period, but in actual fact registration was only introduced in 1990 and for the period between 1975 and 1990 patients thought they were my patients and I considered them my responsibility. Registration didn’t give patients any other rights, other than to be able to identify a dentist who would provide them with out-of-hours’ service. That’s the only right the patients got, and as the CPTs now have the duty to provide out-of-hours care, then it seemed a reasonable thing to do. Allregistration was, a payment to dentists. We expect continuity of care; we’ve got no evidence to
say that people are not getting continuity of care.

NK: In a recession, does the Government expect a higher demand for NHS dentists if people move away from their private dental schemes? Is there any evidence that this may happen?

CDO: I think it’s a little bit early to say how significant the effect of the recession would be, but I think if you go back to the Mori poll the Citizens Advice Bureau (CAB) did, they say that 4.7 million people who have wanted to use NHS dentistry were going private, compared with the 27 million on the NHS. The CAB said about 50 per cent of those people would like to access NHS care if they could. Now, the commitment the NHS has just been made to say anybody who wants it should be able to get it by April 2011 at the latest, and I think, putting aside the recession, will impact on the private sector. I think that’s highly likely. Obviously none of us have had any experience of something like this. I’m not an economist and I wouldn’t like to predict, but common sense suggests that people will start to look around for economy al alternatives and of course private capitalisation plans are around 10 times more expensive than the NHS, so I think people are doing their research. There is a big issue also at the moment about a perception of lack of care. We have many examples now of Primary Care Trusts (PCTs) providing access to patients relatively quickly, and dentists are actually saying their doors are open, yet people are not coming in. And it’s because there’s still that perception cut out there that you can’t get NHS treatment, and in some areas it’s more difficult than others, but I think when that perception changes, you will see people starting to move a little bit in that direction. The important thing for me is that not everybody goes from the private sector to NHS, because a lot of patients would choose to stay with their existing dentist, since it’s a personal decision. However, I think we’ve put enough money in and the commissioning capacity we’ve got means that if people wish to choose to go private, they can. Now, if they wish to choose to stay NHS care if they could. Now, going private, compared with the NHS, is much less than the cost of not doing it.

NK: The Government has recently announced another review into NHS dentistry. Is this a good use of tax payers’ money? Why do we need another review when we already have an in-depth review from the HSC?

CDO: First of all, we announced the review in March last year. We told the HSC we were going to create a vision for the future of dentistry, and also the HSC wasn’t a review, it just took evidence and its report was very much based on projecting the evidence it heard. Many of the things it actually said have of course not come to pass, but I think it did talk about the difficulties and issues and I think it was right that we commissioned an independent review, engaging with all stakeholders, because we need instructions for the way forward across a range of areas. The review is reporting in the short-term with medium and long-term significance. It is an attempt to report in the spring. I think the fact that we will get major stakeholder involvement with Jimmy Steel is doing it as we speak, and he’s independent and knows a lot about health services – the cost of that is much less than the cost of not doing it.

NK: As dentistry advances, treatment options such as dental implants are becoming more commonplace. Is NHS dentistry ever going to fund complex treatments such as implants?

CDO: NHS dentistry already funds implants in the secondary sector for people who’ve had facial cancer, facial trauma, cleft lip and palate as well as a range of other conditions. Within this widely criticised system, it’s reasonable to justify that at all. But it’s important to realise that there is no evidence to support that at all, and changing that culture is important. Where a practice is recalling 40 per cent of its patients every six months, it may be that six months or three months is the appropriate period. NICE guidance says you should use your clinical judgement and money should play no part in that.

NK: Do you feel by and large that dentists are adhering to the NICE guidelines?

CDO: I think it’s taking a long time to change a culture, and that’s not always the dentist’s fault, as I found out myself in 1998. Patients are wedged to regular six-month check-ups, even though there is no evidence to support that at all, and changing that culture is important. Where a practice is recalling 40 per cent of its patients every six months, it may be that six months or three months is the appropriate period. NICE guidance says you should use your clinical judgement and money should play no part in that.

NK: You have mentioned a higher amount of preventative work being done under these new arrangements. What changes in particular have taken place?

CDO: All around the country now I’m being asked to go to these open new schemes where dentists and PCTs are working on fluoride varnish schemes in Sloughersdale, Knowesley, Tower Hamlets, for example. The use of high-concentration fluoride toothpaste has gone up by 15 per cent in a year that actually predated Delivering Better Oral Health guidance, so we are changing the culture to a more preventative way of working. To change culture takes more time than anything else, but I’m very encouraged now by what I see happening locally.

NK: Do you think the local councils should be put under more pressure to consider water fluoridation?

CDO: We’ve already said in the Choosing Better Oral Health document in 2005 that in an area where we’ve got high levels of decay, the NHS should look at using fluoridation and all of its tools in the medium and long term. We’ve finished one consultation and we’re awaiting the outcome, but there’s lots of interest in other places as well.

NK: How should the NICE recommendations be interpreted, as a fixed regime or a flexible guideline based on dentists’ judgments?

CDO: It’s about clinical judgement. The patient should be told according to what the dentist judges to be clinically appropriate for that patient. Some body like myself, who is definitely wrong of side, and relatively decay-free, relatively disease-free, with no history of smoking or drinking to excise, wouldn’t want a recall every six months. For somebody who’s smoked heavily, drunk heavily, got a very difficult mouth and perhaps white lesions, it may be that six months or three months is the appropriate period. NICE guidance says you should use your clinical judgement and money should play no part in that.

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 holds a graduate 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 for the NHS, and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.
Building stronger bonds

Dr Julian Caplan discusses how to achieve the best adhesion to enamel and dentine for maximum bond strength

If you believe the success rates of the leading cosmetic dentists for their indirect adhesive restorations you may go along with this. If you have had adhesive failures, you most probably do not. Is it down to luck, better technique or good case selection?

At dental school, we all learned about MG Buoncore in the 1950s discovering he could bond acrylic to enamel if he treated the enamel surface with 37 per cent phosphoric acid. By etching the enamel, he removed the biofilm, increased the surface energy, produced a microretentive surface and managed to achieve bond strength in the region of 30MPa. It was a small step to extrapolate this to bonding BisGMA resins to enamel. But what actually happens. What is required to bond two materials together?

Here’s the problem

The two key issues in dental bonding are:

- Can a mechanical lock be produced?
- Can we get the intermolecular forces to produce true adhesion?

Under an SEM image, it is apparent that contact between two surfaces is not as intimate as it first appears with the naked eye. In fact, they only touch in sporadic places along their surfaces when viewed on an SEM image.

This means in order to get mechanical interlocking or to allow the intermolecular forces to work to achieve adhesion we have to use something to fill in the many gaps to give us the necessary intimacy. A fluid material is needed that will easily coat the two surfaces. For good wet ability, the contact angle of the intermediary material needs to be very shallow.

The intermediary material must ‘like’ the surface we want it to get close too. In dentistry, the surfaces to be bonded to can be divided into:

- Surfaces that can be dried (as with enamel)
- Surfaces that can not be dried (as with dentine)

The intermediary material can also be divided into whether it is:

- Hydrophobic
- Hydrophilic

As would seem obvious a hydrophilic material works best on enamel and a hydrophobic material is required for bonding to dentine.

Dentine bonding systems for bonding a BisGMA material have three elements present – an etchant, a primer and a bond.

The etchant is used to remove the smear layer, to demineralise the dentine to expose a network of collagen fibres and to remove some hydroxyapatite from the intertubular dentine. The dentine is kept moist to maintain the for-

Dentine bonding

Enamel bonding is very predictable. The bond resin that is hydrophobic will readily bond to acid etched enamel. However dentine is another matter because:

- There is always water present in vital teeth
- There is pulpal pressure
- There is a collagen matrix
- A smear layer is formed when dentine is cut.

Dentine bonding systems for bonding a BisGMA material have three elements present – an etchant, a primer and a bond.
1. Etching.
   - Over-etching can lead to a deep layer of exposed collagen fibres that are too deep to be penetrated completely by the primer. This leads to an area bereft of primer and causes nanoleakage, unprimed collagen. Nanoleakage is much less extensive than micro-leakage and has probably no short-term clinical relevance. However, the long-term stability of the adhesive bond between dentin and the restorative material might be adversely affected.

2. Prime
   - The primer must penetrate to full depth of the exposed collagen. Over-etching may produce nanoleakage as discussed above.
   - The primer is a hydrophilic monomer (for example, Hydroxyl methacrylate-HEMA). This may attract water after bond-
     ing causing ‘water trees’ to de-
     velop at the dentine adhesive in-
     terface. There is a possibility that
     this may cause long-term degra-
     dation of the dental adhesive.13

3. Bond resin
   - The primer and adhesive bond separate from the hydrophilic primer if left to stand. In systems that have primer and adhesive components in the same bottle, as in fifth-generation bonding sys-
     tems, they must be vigorously shaken to recombine the solu-
     tions prior to use.
   - Over-thinned primers can result in the bond strength being reduced.

Possible problems with each stage:

- Over-etching
- Nanoleakage
- Over-prime
- Over-set

5. Bond resin
- This is a hydrophobic material that will separate from the hy-
  drophilic primer if left to stand. In systems that have primer and adhesives in the same bottle, as in fifth-generation bonding sys-
  tems, they must be vigorously shaken to recombine the solu-
  tions prior to use.
- Over-thinned primers can result in the bond strength being reduced.
- Some bonds contain filler parti-
  cles at a level that makes them relatively thick. It is paramount that
  the hybridised layer is set prior to seating of the restoration to
  prevent the collagen matrix from collapsing with the pres-
  sure from the luting cement. This is where most of the bond
  strength is developed from. However this thick layer can
  prevent the correct seating of in-
  direct restorations. To try and
  overcome this, the idea of imme-
  diate dentine bonding has been
  proposed. In this technique the
dentine is etched, primed and
  bond applied and set immedi-
ately after the preparation has
  been completed. The enamel
  is cleaned with a finishing bur
  to expose fresh, unbound enamel. The impression is now taken after the oxygen inhibition layer has been removed with al-
 cohol from the bonded dentine. This prevents this unset bond on the bond surface from reacting with the impression material and affecting its correct setting. The working model produced from this impression has the thickness of the bond on the den-
  tine recorded on the working die.
  At the seating appointment the enamel is etched and bond applied. The bond on the den-
  tine is roughened with air abra-
  sion using 50 micro aluminium
  oxide particles, the enamel etched in the usual way and
  bond applied. The restoration is
  silanated, dried and bond ap-
  plied to the fitting surface. Lut-
  ing cement is placed and the
  restoration seated. Following
  excess cement removal the lut-
  ing cement and the bond are set
  with a suitable light-curing unit. As the bond is set after the
  restoration is seated an intimate
  fit is achieved. Some research
  shows that the bond strengths
  produced are as good as or bet-
  ter than conventional delayed
dentine bonding techniques.

Classification of bonding systems
- There are two main ways to
  classify the present bonding sys-
  tems. They can be classified
  chronologically or sometimes by the number
  of generations. The fourth to eighth genera-
  tion systems are:

  • Fourth generation. These are
    three bottle systems compris-
    ing of separate etch, prime and
and fifth-generation bonding systems are not included.14

Looking at a number of recent studies it would appear that fourth-generation bonding systems are still the gold standard but, following close behind, sixth-generation bonding systems are giving clinically acceptable good long-term bond strengths.15,16,17,18,19

References are available on request. [2]

DR JULIAN CAPLAN qualified from Sheffield University in 1988. He is a Director on the board of the RACD, a senior lecturer for the Larry Rosenthal Aesthetic Continuum course and lectures internationally on CAD/CAM dentistry, specifically Cerec. He has completed all levels of occlusion courses run by Peter Dawson in Florida, USA. He owns Aviva Cosmetic Dentistry, a dental practice aimed at providing high-end cosmetic and functional dentistry in Hertfordshire. For further information about becoming a member of the RACD or to register for the 2009 RACD Conference ‘The Future of Dentistry’ please call Suzy Rowlands on 020 8241 8526 or visit www.bacd.com.

Dr Julian Caplan
Flexible partials – why they work

Using flexible partial dentures gives patients a new and improved confidence in their smiles. Derren Neve explains.

The goal of metal framework design is to (a) retain the partial and (b) support the partial. The challenge of conventional removable partial dentures is to balance those goals with minimal detriment to natural dentition and the supporting ridge.

"Conventional metal and acrylic partial dentures are usually anchored to abutment teeth by metal clasps that are designed to work with vertical stops to create a balanced retentive and supported removable appliance," says Dr Maurice N Stern DDS in his article published in the New York State Dental Journal. He went on to say that such metal clasps can be especially destructive when there are no distal abutment teeth to maintain full support of the partial. In addition, the resulting torque on the abutment teeth may contribute to movement of the abutment teeth, while the imbalance of pressures on the residual ridge may lead to loss or modelling of the supportive bone and the disproportion of pressure on the mucous membrane may traumatisé soft tissue.

There are limitations to rigid partial dentures requiring routine patient maintenance and modification to remain stable. The forces exerted on rigid partials are shown in Figures 1, 2 and 3 that demand sophisticated architecture to mitigate them.

The Valplast® approach is to provide a simple solution to problem Figures 4 and 5 show how a flexible denture base acts as a functional solution in the real world.

A stress breaker

As can be seen from Figure 5, the flexible denture base acts as a stress breaker to disengage the forces on individual saddles and balances the distribution of forces over the edentulous areas. This has the effect of eliminating unnecessary stresses on the remaining natural teeth shown in Figure 4. The elimination of occlusal rests means that no tooth preparation is necessary and the nature there is less likelihood of causing tooth mobility – provided the flexible denture base is constructed to the correct thickness it has, by virtue of the nature of its material, a built-in stress breaker.

No visible metal clasps are required to retain the flexible dentures. Clasping is achieved by use of the same tissue coloured material on the soft tissue surfaces and only encroach on the natural dentition by 1mm. The difference can be seen in Figures 6 and 7 where the improved aesthetics is much appreciated by patients.

Because of the high tensile strength, abrasion resistance and near perfect elastic memory of the material, a super-polyamide (an improved relative of the "nylon" family of plastics), dentures can be made with a much thinner, translucent, cross section. The tooth clasps, or fingers, when properly placed by a skilled dental technician, do not encroach on the natural dentition by 1mm. The difference can be seen in Figures 6 and 7 where the improved aesthetics is much appreciated by patients.

From a patient’s point of view, the thin palatal or lingual connector presents a minimal disruption in proprioception. The flexible partial is lightweight and delicate, temperature sensation is natural and patients report a quick adaptation to the feeling of wearing a properly designed and constructed flexible partial.
Solving problems

Do flexible dentures solve all the problems of partial restoration? No product can solve all the problems of partial restoration, the key is to solve as many as possible in a simple way that is affordable to the patient. An increasing number of products are being marketed for use as flexible removable partial denture-base materials with little data to support this application. A study was carried out at the Indiana University School of Dentistry which compared the mechanical properties of four flexible denture bases; Valplast, Proflex, Ultraflex and Flexite Supreme. In high cycle fatigue Proflex exhibited fracture, Ultraflex significant deformation and Valplast and Flexite lesser amount of deformation. The study concluded that upon the properties examined only Valplast would appear suitable for an all plastic partial denture.

A properly designed and well-made flexible denture acts as a stress breaker to disengage forces on individual saddles, gives a balanced distribution of forces over edentulous areas and eliminates unnecessary stresses on remaining natural teeth. Aesthetically, flexible partial dentures give patients a new and improved confidence in their smiles – no visible metal clasps.

3. The following trademarks are the property of the companies shown. Valplast – Valplast International, NY; Proflex – Dental Resources, MN; Ultraflex – Astron Dental, IL – Flexite Supreme – Rapid Injection Systems, NY.
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Society constantly tells us to improve; lose weight, banish wrinkles and get that perfect Hollywood smile. Continual pressure to conform has people doubting their appearances. Everyday there are dental patients who are self-conscious about their teeth and smile; they let their mouths dictate their level of confidence and are unable to live a full, rounded life.

When the word ‘denture’ is mentioned, the psychology of patients varies considerably across a broad spectrum. Some are completely comfortable with their dentures, for example, playing tricks with their dentures to amuse their grand children. Others are ashamed, and wish to keep their dentures secret, so those close to them, even their partners in some cases, are unaware that they have dentures.

Reading your patients

As the principal of a denture referral practice, I see the whole spectrum of issues and fears. It’s helpful to divide patients into groups, starting with those who would be happy with dentures if they were to fit well and look natural. The second group will never be happy, regardless of the look and fit, because they don’t like the idea of teeth going in and out of their mouths. These patients are prime candidates for fixed implant solutions.

For those who are unhappy with the function of their dentures, they worry the dentures will drop and become loose. Restaurants can be an issue as patients feel they must check their teeth between courses or take extra precautions in what they order for fear of not being able to chew properly. There are some who refuse to go to restaurants due to denture difficulties.

Lack of confidence

Dentures can affect private lives, for example, those who feel awkward and nervous when kissing assume the other person can tell they are wearing dentures, especially if they move. There is also a common fear about dental fixative, as patients are worried too much will ooze between their teeth, as they have to apply so much, or their dentures will fall out when speaking if fixative is not used.

Cosmetically, patients sometimes refrain from having their photo taken, as they despise the appearance of their teeth. Many put their hands over their mouths when talking, and don’t smile, as they feel incredibly uncomfortable. One of the biggest fears is the thought of anyone seeing them without dentures. For some, there is a fear of friends observing them closely, but being too polite to ask, ‘Are you wearing dentures?’

Sensitive patients generally feel embarrassment, shame and guilt about dentures. Many get angry with themselves for not taking better care of their teeth when they were younger. The thought of having dentures fitted can be extremely daunting making the whole procedure difficult for both the patient and dentist. Observing particular signs when dealing with weary patients will help assess the situation. It is important to isolate the area of concern with a sensitive approach.

The final group of patients are fixated with their dentures, and know denture terminology very well. They may be very critical of the dentist at each stage of the treatment. It is important to be realistic about expectations, and dentists must be prepared not to take on patients if significant improvement in the denture is unlikely.

Developing trust

It is imperative for dental professionals to talk to their patients and develop a trusting relationship. The dentist should ask questions so they can judge the patient’s reaction and decide on an appropriate course of treatment. It is not uncommon to have patients in tears over the possibility of losing their last remaining teeth. It is difficult for dentists to estimate the life changing effects on a patient when taking them from a poorly fitting denture to an excellent, functional and cosmetic one.

Thoroughly explaining the procedure and allowing an opportunity to ask questions will reassure the patient, proving they are treated as an individual. In my view, dentists need to add in extra time and cost in order to have these conversations and not rush treatment. This is more important with dentures than other dental treatments because of the huge psychological impact dentures have on many patients. Gaining the patient’s confidence will ease the process, and they will be much happier to co-operate and go ahead with recommendations.

About the author

Dr Justin Stewart considers the psychological impact of wearing dentures

Mind over matter

Dr Justin Stewart

was the first qualified Biofunctional Prosthetic System (BPS) dentist in the UK. He is a member of the American Prosthodontic Society and the British Society for the Study of Prosthetic Dentistry. Dr Stewart has recently been appointed to Dr Joe Massad’s International Advisory Board. An experienced lecturer, Dr Stewart is dedicated to resolving denture related problems through teaching and training. For further information please email Justin Stewart at enquiries@thedentureclinic.co.uk

Education

Dr Justin Stewart considers the psychological impact of wearing dentures

‘One of the biggest fears is the thought of anyone seeing them without dentures.’
Maintaining momentum for training

Whether you’re a dentist, technician, hygienist or nurse, everyone must legally complete CPD. Sharon Holmes outlines the situation

By now we all know that CPD is an essential element in the dental industry. Not only is it required – it is also a legal necessity. At the end of a five-year period, the GDC will request from you a signed statement swearing that you have completed all your CPD as stipulated according to your qualifications, whether you are a dentist, technician, hygienist or dental nurse. You do not have to submit evidence, but there is a possibility they may ask you to present your certificates. There is no getting away from continual development.

Facilitating change

I have been with Dental Arts Studio for almost six years and my bosses, Dr Malhan and Dr Solanki, have always keen on carrying out in-house training. I was given the task of preparing this out, which at first I found stressful. After all, I had never taught anyone anything in my life. Despite the stress, I learned to create training material and teach and as a result, I became more confident in my role.

In stating the obvious, as discussed, this should make us all comfortable with the effect of CPD and what it will bring to the industry on a whole. The face of dentistry changes all the time. Not just with technology as far as equipment and dental materials, but also with legislation and health and safety. The only hour of CPD. Then more recently, we have implemented training sessions to take place once every three months. We close the practice down for three hours of the day and I host the training.

The subjects that are chosen are based on the problems that these individual reports and create an across-the-board score sheet and take note of what the weaknesses are. I then research and read some good training material and from this I create my material to suit the needs of the practice. This is very time consuming and needs to be managed well to enable me to create effective material. I also inject some fun in there to keep the staff interested and motivated.

However, in saying this I cannot always leave the problems I find for a three-monthly period, so a short-list is made and they are addressed either one-on-one with the particular staff member, or the problems are raised in weekly staff meetings. If it is in relation to reception in particular, the issues are raised in the 8.30am morning huddle meetings that take place every day with all of the receptionists.

‘Change will not come if we wait for some other person or some other time.’

This training has got to maintain momentum and be revised regularly, seeing as practice staff can be busy and can forget what has been taught to them. The more persistent you are with your mission to create a sound and stable work environment, the more the staff will absorb what is being taught.

As Barack Obama says: ‘Change will not come if we wait for some other person or some other time. We are the ones we’ve been waiting for. We are the change that we seek.’

‘Despite the stress, I learned to create training material and teach and as a result, I became more confident in my role.’

Sharon Holmes

Originally from South Africa, Sharon Holmes moved to the UK in 2002. She thoroughly enjoys her position as business development manager at the Dental Arts Studio and her role in the dental industry, which has moulded her into a winner in her field. She believes that her position is based on common sense.

About the author
ADI Biennial Implant Team Congress 2009
Congress for the whole dental team at the ICC Birmingham

Following the success of the 2007, 20th Anniversary Congress at the Birmingham National Convention Centre (ICC), the Association of Dental Implantology (ADI) is returning for this year’s Implant Team Congress between May 7 and 9, 2009. The focus at this year’s congress is very much on the whole dental team, with programmes tailor-made for clinicians, technicians, hygienists and nurses alike. Key international implant professionals take to the stage offering two days of lectures covering both the surgical and restorative elements of implantology. Running concurrently is a trade exhibition with key suppliers from the implant industry, while on the Saturday the industry are offering their own workshops.

A choice of programmes
Anthony Benckendorff, President of the ADI, will open the congress on Thursday 7 May 7 followed by Professor Fouad Khoury’s talk entitled ‘Predictable long-term long-term hard- and biological concept for bone grafting’. At this point, delegates have a choice of programmes that are dedicated to their chosen profession. A combined programme for hygienists, nurses, practice managers and receptionist will run parallel to the plenary session for clinician and technicians. Other autonomy for day one include, Matteo Chiapasco, Jürgen Meschoul and Jan Kielhorn for the plenary while the combined programme will be presented by Tracey Lemmann and Carole Brennan.

Day two has targeted programmes for each of the professions. A plenary session will run for clinicians, while technicians have a programme entitled ‘A journey through CAD-CAM Technology’, the nurses have ‘The Essentials of Dental Implant Nursing’ and the hygienists have ‘A Journey through Biofilm Pathology: Moving towards the whole Body Therapy’.

There are tailor-made programmes for clinicians, technicians, hygienists and nurses alike.

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NobelProcera™ can offer your practice. Discuss the advantages with a NobelBiocare expert at ADI 2009!

A chance to network
Along with the educational opportunities, the ADI is hosting two social functions giving attendees the chance to network with like-minded professionals.

A welcome recep- tion will be taking place on Thursday May 7 at the Birmingham Museum and Art Gallery. While Friday May 8 will see the cul- mination of the congress with an American Pie Party, taking place at an exciting new venue in Birmingham. The New Bingley Hall. Entertain- ment will be provided by a world class piece of blues band (Rubber Biscuit), A Grease tribute act plus dodgems and much more.

CPD verified certificates will be provided at the conclusion of the congress on completion of appropriate evaluation forms. Full Congress attendance offers up to 16 verifiable hours CPD. Additional CPD hours are avail- able for those who attend the whole congress industry day, on Saturday May 9.

Book your ticket
Why not join hundreds of your colleagues at this year’s congress, which is an education opportunity not to missed. Book now to avoid disappointment, either by visiting the ADI web- site at www.a-di.org.uk or call the office on 020 8467 555.

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Contact Details Carolyn Wilkinson Swallow Dental Supplies Ltd Unit 8 Ryefield Court Ryefield Way Silsden West Yorkshire BD20 0DL Tel: 01535 666632 Email: carolyn@swallowdental.co.uk www.swallowdental.co.uk

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The Osteology Foundation is internationally recognised for clinical research, education and coordination between universities and industry in the field of tissue regeneration. Subjects such as these will be the basis of discussion at Osteology UK in May 2010 when National and International Osteology Leaders will present high quality science supported by practical skills workshops.

Osteology UK, May 22nd – The Royal College of Physicians, London. Tel: 01244 427654 or visit www.osteology-uk.org

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Visit Geistlich on booth 6/13 at ADI congress or contact the Regeneration Support Team: call +44 1244 453744, email education@geistlich.co.uk or visit www.geistlich.com/ukevents

The Otology Foundation
The Otology Foundation is internationally recognised for clinical research, education and coordination between universities and industry in the field of tissue regeneration. Subjects such as these will be the basis of discussion at Osteology UK in May 2010 when National and Inter- national Osteology Leaders will present high quality science supported by practical skills workshops.

Osteology UK, May 22nd – The Royal College of Physicians, London. Tel: 01244 427654 or visit www.osteology-uk.org
Sident Dental Systems

Get over £22,000 worth of FREE Extras with Sident’s New Teneo Treatment Centre Offer

To celebrate the launch of Sirona’s New Teneo Treatment Centre, Sident Dental Systems are offering a吸引了 the exciting and competitive offer of FREE Extras. The Extras include a FREE Comfort Package, Innovations Package, Clinical Package and Sivision Package. For further information contact Sident today!

In addition to all the above, the NEW Teneo Treatment Centre offers many exceptional innovations and is designed to reduce the operator’s workload, leaving them free to concentrate on the patient instead.

It offers clinicians simple and intuitive operation via its EasyTouch user interface, wire-free foot control for optimum flexibility without cable clutter, intuitive and dynamic seating via the HUGO stool, and an array of patient communication and entertainment tools.

Teneo is available in three attractive and interchangeable colour schemes, which enable clinicians to create their own individualised interior design. For further information contact Sident Dental Systems on 01952 582800, email j.colville@sident.co.uk or visit www.sident.co.uk.

Whose been sitting on my chair?

Bambach’s revolutionary stool could become a hot seat – and not just for you! We all know about healthy eating and taking regular exercise but what about healthy seating? As dental professionals we tend to sit a lot of the time and with increasingly complex treatment cases it looks like longer sessions in the chair are not just in store for our patients but us too.

Sitting with the correct posture is very important as it reduces the strain on your lower back. Bambach’s unique saddle seat design allows the spine and pelvis to work together to create balance and mobility in the upright position. As a result good posture happens naturally as you sit on this cleverly designed stool which encourages ‘dynamic’ seating where body weight is additionally taken on the feet further promoting health.

So for natural relief and to prevent occupational back pain for all members of the dental team call Bambach today on freephone 0800 581108 or visit www.bambach.co.uk There’s even a free 50 day trial period!

Heka Dental

Get a FREE trip to Copenhagen. With Heka Dental you’re in safe hands!

Heka Dental invite Dentists to visit Copenhagen to see their design and production facilities, as well as their beautiful city. There will be several trips a year, normally running from Thursday morning to Saturday afternoon. During which guests will have an opportunity to visit their factory as well as Wonderful Copenhagen. For Dentists ordering a Heka Dental pack-age here or during the trip the entire visit will be free. Otherwise, Dentists will only need to pay for the flight and hotel.

Incorporating the latest Treatment Centre Technology, Heka Dental’s UNIC is the ultimate embodiment of feedback from patients, dentists and service engineers etc. Combining aesthetics with functionality, its inviting appearance and carefully thought through functionality creating the perfect environment for a pleasant dental visit.

Heka Dental equipment is available in the UK from Dental Services Direct, telephone 0156 267 2778 or visit www.heka-dental.co.uk for further information.

ABAC compressors

Many dental practices face unexpected interruptions and high repair costs, caused by failing and overheating compressors. An old compressor can be also providing poor quality air, which reduces lifetime of dental units and handpieces, and can seriously compromise the effects of your work, if contaminated with oil.

ABAC compressors are characterised by the four most important features for a dental practice: very low noise level, medical grade clean air, reliability and best price to value ratio. A wide range of products is available to suit all needs: Basic, when sound level is not crucial; Sky and Silent, when quiet operation is required; Plus, with an adsorption dryer, when the compressor is fitted outside the practice or in a basement.

Contact Profi on 01791 075157, for a free survey and quotation. ABAC compressors are offered with free delivery and installation, starting from £599 for a single surgery and £899 for 5 surgeries.

Ceramic Systems (CEREC®)

NEW CEREC® AC makes impression free dental practice a reality

The NEW CEREC® AC from Ceramic Systems (CEREC®) enables Clinicians to capture whole jaw arches – quickly and conveniently – without the need for impressions; generating virtual 3D models enabling Dentists to offer an even wider range of restorations. It combines the NEW CEREC® Bluecam with updated CEREC® 3D software which makes it even easier to operate.

Instead of conventional laser or infra-red light sources, Bluecam features high-performance LEDs which deliver optical impressions of unprecedented precision; this ensures the final restoration’s excellent accuracy of fit, speeds up the bonding process and reduces any excess luting cement to be removed.

Bluecam delivers razor-sharp images, its built-in shake detection system enhancing overall precision. Its automatic exposure function and extensive depth of field means the entire impression-taking process can now be delegated.

For further information, contact Ceramic Systems Limited on 01952 582956, email j.colville@ceramic-systems.co.uk, or visit www.ceramic-systems.co.uk.

Are You Sitting Comfortably?

Introduce leading cutting-edge technology into your practice with KaVo and see fantastic results.

The KaVo ESTETICA E80i is a suspended chair that gives the patient and dentist exceptional freedom of movement. The area under the unit is completely open for the dentist and assistant; there is plenty of room for comfortable leg positioning. Procedures run much smoother and more efficiently leaving the professional free to focus on quality dental care.

The ESTETICA E80 takes your health into consideration as the individual working position and habits ensures that your posture is constantly healthy, stress-free and relaxed.

The Primus 1058 is designed to offer all the quality and technology advantages of a KaVo unit, with the added benefit of working flexibility. This unit allows for permanent installation in either the right or left-handed position, whilst offering ideal patient positioning including an offset backrest artic-
NEW CEREC AC Bluecam ~ Seen in a new light

Sirona has helped to successfully integrate CEREC into dental practices for over 22 years, with more than 24,000 systems now in place worldwide. It offers convincing long-term aesthetic restorations in a single visit.

With product simplicity key to the success of any dental practice, Sirona are now proud to launch their new CEREC AC Bluecam imagining unit making the CEREC even easier to use for the dentist.

Sirona UK is a specialist division of Sirona Dental Systems, the manufacturer of the CEREC System, and has now for the last 5 years supplied and supported CEREC 3 CAD/CAM all-ceramic restoration system here in the UK.

DentalEZ also offering lighti, stools and suction to give you a fully integrated look to your surgery.

To find out how the Sirona team can directly support your practice and for a no obligation demonstration please telephone 0845 071 5040 or email: info@sironadental.co.uk or visit www.sironacadcamsolutions.co.uk

DentalEZ Chairs & Units

DentalEZ pioneered sit down dentistry in the 1950’s with the J Chair and have continued developing their range of equipment throughout the decades.

Whether you want a good all round starter package, such as the Simplicity (shown), through to the J/V Generation with its standard eight programmes and unique seat tilt movement for sheer luxury.

DentalEZ have been making equipment for over 50 years and offer ambitiously styled, over patient, cabinet mounted and cart style units which can be mounted to a range of chairs and with upholstery choices from basic through to Ultra-leather and colour range to suit all tastes.

DentalEZ also offer lighting, stools and suction to give you a fully integrated look to your surgery.

Contact Tel 01442 269501 email info@dentalez.co.uk www.dentalez.co.uk

Industry News

NEW 2009 Catalogue – Out Now!

The new Henry Schein Minerva catalogue contains a range of products, it is also fully bar-coded to make purchasing both quicker and easier.

Since no two practices are ever the same, the new catalogue also features a unique reference guide, with details of ‘ Platinum,’ ‘Gold’ and ‘Silver’ groups for your large capital equipment purchases.

 Request your FREE copy of the NEW 2009 Henry Schein Minerva catalogue today, call 08700 10 20 43.

Tri-Sok now available in a cost effective 7gr tube!

Tri-Sok is used for the treatment, after development, of inflammation in an extraction socket. Tri-Sok also prevents infection in the extraction socket where there is a history of Dry Socket and where the extraction has been traumatic. It contains Chlorotetracycline, a broad-spectrum antibiotic that acts against infective organisms.

Aspirin exerts analgesic and anti-inflammatory actions. The topical application reduces swelling and post-operative pain.

Tri-Sok is available from Panadent 0168 88 1788 £24.99 plus VAT or from your usual supplier.

TMS Link Plus from Coltène Whaledent

The TMS Link Plus pins embody detailed features developed from research and clinical applications. The safety shoulder stop and depth-limiting drill eliminates the danger of pulpal and periodontal penetration and gives consistent shear.

A ball-joint link to shank provides self-alignment and the tapered end provides easier penetration. The buttress...
For the 1st time in UK Dentistry, one lucky Dentist, Hygienist, Practice Manager, Nurse or Therapist could walk off with One Million Pounds!

DENTSPLY has teamed up with a major company to indemnify this massive sum to help you invest in the practice you’ve always wanted.

No purchase is necessary; simply fill out a 5 minute questionaire at www.dentsply.co.uk and DENTSPLY will automatically enter you into the draw.

10 finalists will then be selected at the end of October and the final winner will be drawn at the BDTA on Saturday 14th November at 12pm.

The finalist will have the chance to win one of the following prizes; One Million Pounds, one hundred thousand pounds, ten thousand pounds or at the very least five thousand pounds!

To find out more about the DENTSPLY One Million Pound giveaway and to enter the draw go to www.dentsply.co.uk.

Quality Options, Ongoing support!

Wright Cottrell are the national company with the local touch. Working with UK dentists and lab technicians, the team at Wright Cottrell can provide outstanding options for all your dental materials, your practice and your budget.

The excellent ranges of teeth from Wright Cottrell include options like the Acrrotone range. This line reflects the most significant advances in materials and production technology. With a natural lustre, translucency and outstanding hardness and solvent resistance, you can be assured that you’re working with the best quality available with an unparalleled choice in shade and moulds.

With 25 individual upper anterior moulds and 15 lower anterior moulds, the Acrrotone range offers 14 internationally accepted shades and ISO 9001 quality assurance. The posterior moulds in this range offer professional’s enormous flexibility with:

• 5 x functional
• 2 x zero
• 4 x 20°
• 5 x 55°

For outstanding solutions without compromising on quality, contact the experienced team at Wright Cottrell to tailor made solution to meet the needs of your practice.

Free phone 0800 66 88 99 or go online to www.wrighthealthgroup.com.

BACD Study Clubs: 4 New Dates For 2009

May 7th, Belfast – ‘Simple And Predictable Aesthetic Gingival Surgery For The General Dentist’
Dr Ken Harris, at the Deans at Queens. A leading authority on cosmetic dentistry, Dr Ken covers Biologic Width and provides methods for predictable, confident and aesthetic results.

May 12th, London – ‘The World Of Cerec CAD/CAM’
Dr Julian Caplan, at the British Dental Association. Discover how to provide porcelain veneers, crowns and inlays in one visit, achieving outstanding restorations.

June 24th, Nottingham – ‘The Kois Deprogrammer’
Dr Ken Harris, at the Park Inn, Nottingham. Confidently record Centric Relation and master the use of Dr John Kois’ device, which can benefit every dental practitioner.

September 11th, Nottingham – ‘Smile Design Dentistry: The Essential Fundamentals’
Dr James Russell, at the Park Inn, Nottingham. Facilitate aesthetic and predictable treatment with strategies that can be implemented immediately.

Spaces are limited and interested parties are invited to book early to avoid disappointment.

For more information contact Mrs Suzy Bowlands on 0207 612 4160 or email info@bacd.com www.bacd.com.

For more information, phone Prestige Dental on 01274 721667 or email Steve@prestige-dental.co.uk.

Flexible, Quality, Training!

Nobel Biocare is renowned for offering the finest education and support outside of dental school and dental nurses will benefit from the excellent training courses with verifiable CPD points.

Nobel Biocare understands the great importance and responsibility placed on the shoulders of nurses and has constructed informative, flexible training to help you grow in your chosen field.

With a busy schedule, time away from home and work is difficult, so Nobel Biocare is bringing the courses to you. You will find a range of dates across the UK and Ireland that will not only suit your timetable, but also your abilities.

Delegates will also benefit from the hands-on Replace™ Tapered system and patient folio, tips and management advice.

**COURSE DATES – Level 1**

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For more information contact Mrs Suzy Bowlands on 0207 612 4160 or email info@bacd.com www.bacd.com.

Cutting Edge Training Resources From PracticeWorks

PracticeWorks is providing innovative, cost-effective and convenient access to training using the latest technology. The excellent training facilities offer:

• Recorded Online Classes and Training Videos: delivered using MasterWorks Learning Centres and accessible through http://practiceworks.centra.com*, these content-rich and excellently produced courses are always available for repeat viewing.

• Live Online Training: thanks to the Centra system, which enables real-time information sharing in a virtual meeting room environment, dental professionals can access http://practiceworks.centra.com*, this comprehensive source of support includes software update information, advertising and training solutions.

PracticeWorks Online Training simply represents great value for money. There is no need to take time away from the practice, and the cost is lower than that of on-site training. The software is easy to use, and PracticeWorks provides all the necessary tools for a successful training session. The site also includes news streams, consulting support, forums and a support call log.

All you need is a PC connected to the Internet. No technical knowledge is required, making this the perfect way to master the latest technology, including the new version of R4 Practice Management Software.

For more information call PracticeWorks on 0800 169 9682 or visit www.practiceworks.co.uk.

Triotray

The smart new Triotray by Triodont is a rigid and accurate posterior impression tray, producing consistently successful impressions. It removes that dreadful moment of doubt when you fit a new crown and saves time and money spent on ad-
Pulpal and periapical pathology

Low cost Endodontic diagnosis No pain, no sensation and no Detects and monitors decay Success and failure Single patient disposable Improve patient experience Encourage the involvement of Reduce the scope for error Non-vital bleaching

Happy Birthday KaVo!

Dental Innovation and Inspiration for 100 years!

From its humble beginnings in 1909, KaVo Dental Ltd quickly grew into one of the market leaders in the dental sector. The company was built and founded on quality, precision and longevity, and KaVo has remained true to its 100-year old motto and outstanding principles.

Crafting equipment from the finest materials, each design has been carefully created in conjunction with the thoughts and desires of dental professionals from around the world. The team at KaVo prides itself on listening to the voice of the industry front line, where professionals who are exposed daily to the dental working environment can offer excellent insights into what really makes a difference in the equipment they use.

The vast KaVo range offers every practice the opportunity to have the very best instruments, a beautiful, harmonious interior and state-of-the-art technology available to staff and patients.

For more information on 100 years of KaVo or how you can celebrate with us for an entire year contact KaVo on 0141 475 0000, email sales@kavo.com or visit www.kavo.com

Vizilite Plus™ Screening Test for Oral cancer

Vizilite Plus™ is a simple technology to assist in the early detection of oral abnormalities including premalignant lesions and oral cancer.

Vizilite Plus™ comprises of a chemiluminescent light source (Vizilite) to improve the identification of lesions and a blue photostimulable phosphor (Vizilite Plus) is a simple, low cost, pain free and 100% sensitive test that can help save lives or give Patients peace of mind.

For more information please call 01276 469 600 or email info@implantsuccess.com www.implantsuccess.com

Cariescan

The unique Cariescan PRO™ offers dentists the earliest possible detection of caries, reducing fillings and the use of X-rays. The first dental diagnostic tool to use AC Impedance Spectroscopy Technology (ACIST), Cariescan PRO™ has been engineered to quantify dental caries in teeth early enough to enable effective preventive treatment.

The proven technological advantages of Cariescan PRO™ over traditional methods including X-ray, laser fluorescence and clinical visual examination. Cariescan PRO™ is 92.5% accurate at detecting both sound and carious teeth – minimising false positive or false negative results.

Once again, Smile-on has answered the call for a flexible and involving learning solution. The combination of an introductory seminar, comprehensive workbook and 90-minute CD-ROM and/or online course, enables dental practices to comply fully with the clinical governance agenda.

Using the proven Plan-Do-Study-Act strategy, the programme helps dental teams to:

• Improve patient experience and satisfaction
• Reduce the scope for error
• Promote evidence-based care
• Encourage the involvement of the whole team
• Facilitate compliance with industry requirements

With the Clinical Governance Performance Management tool, practices can upload their own indicators to help them quickly and easily identify what has been achieved, and what remains to be done.

Smile-on is dedicated to delivering learning solutions that are flexible, convenient and make your entire team confident in their knowledge of cutting edge dentistry.

For more information please call Smile-on on 0845 888 6890 or email info@smile-on.com www.smile-on.com

Be An Inspiration To The Industry With Genus

The possibilities of modern dentistry are defined by its leaders. With the Genius Design and Build service, you can distinguish yourself as one of the best, and gain inspiration to the industry.

Harness your individual vision with the aid of cutting edge computer aided design software, which allows you to see fully realistic 3D views of your practice before construction has even commenced. Working with an experienced team that understands the demanding guidelines of the dental industry, you will reach a design that is fully compliant whilst remaining true to your personal vision.

Dedicated experts make sure that the process runs smoothly to budget and timescale, as your vision takes shape. While you continue to treat your patients, Genius over-sees everything, and when the construction phase is complete, help you to ensure that you get precisely the equipment, furniture, fixtures and fittings you want.

With a unique non-adversarial and cost-effective approach, Genius is known for its quality of service and guides clients through the entire Design and Build process, always striving to raise the standard of excellence.

For more information please call Genius on 01582 840 484 or email info@genusgroup.co.uk www.genusinteriors.co.uk

Meet The Challenge Of Clinical Governance With Smile-on

Smile-on has the tools you need to comply with the Health Care Commission’s standards. The Clinical Governance programme has been designed to correspond with the standards identified in Standards for Better Health (Department of Health, 2004).

For more information please call Smile-on on 0845 888 6890 or email info@smile-on.com www.smile-on.com

Cariescan PLUS™™

In The General Practice by world-renowned specialist Dr Roger P. Levin (Friday 26th June, London).

Recommended for dentists and their teams, the seminar will explore how to successfully embrace the opportunities offered by implantologists. Dr Levin will explain how to realise practice potential by following strategies for patients, presenting cases effectively, developing superb customer service and more.

Dr Levin is a well-known lecturer and consultant, with over 50 books to his name. The Levin Group offers an invaluable practice management consultancy service to dentists, including financial planning, wealth management, recruitment and transition services. Dentists seeking to provide outstanding implant treatment should reserve their place today, as this is set to be another popular seminar from a leading expert with an international reputation.

For more information, please contact Panadent 01869 881788 or visit www.panadent.net

UCL Certificate in Endodontics

The UCL Eastman Certificate in Endodontics is a 24 day course commencing in October and running over 12 months. Participants will have the choice whether to attend four day blocks of theory and four day modules spread over the year.

Delivered partly through seminars and lectures, practical sessions will take place in state-of-the-art endodontic skills laboratory using microscopes and the latest instruments.

Some of the topics to be covered will include:

• Pulpal and periapical pathology
• Endodontic diagnosis
• Success and failure
• Innovations in endodontics
• Non-vital bleaching

The course will be directed by Richard Kahan and co-ordinated by Tony Druttman. Lecturers will include Nigel Foot, Maria Lessa and Christine Premdas amongst others.

This innovative technique course will enable participants to experience current endodontic armamentarium with interactive discussions on clinical cases.

The course will lead to a UCL Eastman Certificate in Endodontics through examination.

For more information please call Tania Vera-Burgos, on 020 7905 1244, email t.burgos@eastman.ucl.ac.uk or visit www.eastman.ucl.ac.uk/cpd

Nobel Biocare continues its commitment to UK dentistry by working with and supporting dental nurses.

For more information contact Tanya Wade 01895 452912 or Kyle Anderson 01895 452958 or visit www.nobelbiocare.com

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Dedicated experts make sure that the process runs smoothly to budget and timescale, as your vision takes shape. While you continue to treat your patients, Genius over-sees everything, and when the construction phase is complete, help you to ensure that you get precisely the equipment, furniture, fixtures and fittings you want.

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For more information please call Genius on 01582 840 484 or email info@genusgroup.co.uk www.genusinteriors.co.uk
Bleaching success

In the lead-up to the forthcoming Clinical Innovations conference – which brings together the world’s top Aesthetic and Restorative dentistry experts – Dental Tribune talks to Dr Wyman Chan in a sneak preview of the much-anticipated two-day event in central London.

Teeth-bleaching expert, Dr Wyman Chan, is lecturing with Professor Edward Lynch, where the pair are giving a hands-on demonstration of the latest teeth-bleaching techniques. Dr Chan has spoken at the conference for the past five years and is looking forward to sharing the fruits of his latest innovative research on chair-side bleaching with colleagues.

He says: ‘There are many new developments in teeth-bleaching technology, especially in chair-side bleaching. There is a recent report on the efficacy of using a bleaching light in this technique, which subject I am covering in detail. We are performing a live chair-side bleaching case, so delegates get a clear step-by-step guide to carrying out various chair-side bleaching methods.’

Dr Chan started his first practice 18 months after qualifying from Guy’s Hospital Dental School which led to ownership of seven practices within the M25 area, of which he still owns two. He has been a dedicated teeth-whitening dentist since 2002, when he founded London’s first dedicated teeth-whitening centre – the Smilestudio Teeth Whitening Academy in, Piccadilly Circus.

A consultant for several teeth-whitening companies globally, he is currently writing his PhD at the University of Bolton, where he is a researcher at the Centre for Materials Research and Innovation, working with a team of chemists to develop safe and effective teeth whitening products and techniques.

He says: ‘I was a cosmetic dentist for many years, but now consider myself an aesthetic dentist. I am currently working towards solving those unanswered mysteries of teeth bleaching. Hopefully our work will benefit the dental profession in providing safe and effective bleaching techniques.’

He believes the lecture, entitled Profitable Clinical Practical Dentistry to include the latest clinical practical tips for successful posterior composites and bleaching, will help delegates unravel the facts and fictions about chair-side bleaching, as well as getting practical tips about using the latest composites and adhesives.

He says: ‘There are lots of controversies about chair-side bleaching, as well as many claims from various bleaching companies that their products produce good results in an hour. Conference delegates will learn the evidence-based science of chair-side bleaching, which will give them confidence in dealing both with the side-effects of increased tooth sensitivity and the inconsistent results of most chair-side tooth-bleaching systems currently on the market.’

Dr Chan runs a monthly teeth-whitening workshop in London and has trained over 1,000 dentists and their teams in the art of teeth-whitening techniques. He says: ‘I hold five granted British patents and many more are pending in teeth-whitening technologies.’
Successful whitening

Learn how to develop a successful whitening centre with Sia Mirfendereski at the Clinical Innovations Conference

To achieve excellence in the fields of aesthetic and restorative dentistry takes dedication and skill. With a strong foundation for providing unprecedented access to the world’s best authorities in state-of-the-art dental treatment, the Clinical Innovations Conference is set to continue to impress with its 2009 programme. This year sees the world’s finest come to the splendid Royal College of Physicians, a venue with a long and proud history. Set in the delightful Regent’s Park, in the middle of London, this provides the ideal backdrop for this unmissable event.

Establish your practice

Patients are keen to enjoy the benefits of a bright and healthy smile, and with the help of Dr Sia Mirfendereski, delegates can begin to establish their practices as leading providers of this popular service.

Principal dentist in three London practices, Dr Mirfendereski is a true dentist of renown and a gifted specialist in prosthodontics. His lectures on dental bleaching have inspired and informed dental teams around the world. Recognised as one of Europe’s very best, he was commissioned as consultant to the prominent British artist Damien Hirst’s remarkable project ‘For The Love Of God’, in which he provided vital guidance in the dental restoration of a platinum skull from the 19th century.

He is currently the University of Warwick’s associate clinical professor, visiting honorary lecturer at the University of Florence in Italy, and has served in the past as honorary senior lecturer in restorative dentistry and oral and maxillofacial surgery at the Royal London Hospital. The Clinical Innovations Conference sees him take time out from his busy schedule to impart his unparalleled knowledge and experience to delegates.

Must-see session

Dr Mirfendereski’s practical session entitled ‘Key steps to a successful whitening centre’ is a must for any dental professional interested in providing a tooth-whitening service on the treatment list.

The session will incorporate a comprehensive overview of whitening, examining in great detail every stage in treatment to help dentists achieve excellence. The most suitable bleaching method is crucial to great results, and delegates will be shown how to choose the right method for their needs – of great benefit, with so many alternatives on the market. Dr Mirfendereski will also deal with issues of concentration and chemical activation. Providers of restorative dentistry will also benefit from an examination of restorative implications pertaining to whitening treatment.

Smile-on is delighted with the line-up for this year’s event and is inviting interested dental professionals from across the dental team to ensure their places as quickly as possible. It is a rare thing indeed to have such an impressive list of speakers, and the Clinical Innovations Conference 2009 is sure to set a high standard for future events.
Face the Future with the FGDP(UK)

FGDP(UK) Facial Aesthetics masterclass

The ONLY hands-on facial aesthetics course for GDPs in the UK that combines instruction with dissection on fresh (unembalmed) cadaver heads.

“As embalming invariably distorts the finer details of facial anatomy, it is important that we use fresh cadaveric material in surgical training in order to provide an experience as close to real surgery as possible.”

Professor Vishy Mahadevan, Barbers’ Company Reader in Anatomy at The Royal College of Surgeons of England.

The course spans five days*: 2–4 July and 11 July 2009
Final day session 7 November 2009
*Case study element included

Application deadline: Friday, 1 May 2009

Cost of course: £2,995

On completion, delegates will qualify for 35 hours of verifiable CPD.

Email fgdp-education@rcseng.ac.uk or call 020 7869 6772 to find out more, quoting reference FA09DT1.
Dual care for gums and teeth

Corsodyl Daily Gum & Tooth Paste is different from regular dentifrices

✓ The only formulation to contain sodium bicarbonate, 1400 ppm fluoride and six natural plant extracts
✓ Backed with 30 years of dedicated gum health expertise
✓ Over 67% of the ingredients are for the care of gingiva and teeth – compared to 25% in many other regular dentifrices
✓ Free from sodium lauryl sulfate – suitable for patients using 0.2% chlorhexidine digluconate mouthwash

Corsodyl Daily Gum & Tooth Paste is a clinically proven dentifrice, which can kill bacteria that can cause gum disease¹. With regular brushing, it helps maintain firm and tight gums and a low gingival index².

Recommend Corsodyl Daily Gum & Tooth Paste – because teeth need gum care too


CORSODYL is a registered trade mark of the GlaxoSmithKline group of companies.