Vetting and barring scheme under review

Home Secretary withdraws scheme pending a ‘fundamental remodelling’; dental groups ‘wait with interest’

A vetting scheme for all dental professionals changing jobs or starting work for the first time has been put under review by the new government.

The Vetting and Barring scheme, aimed at protecting children and vulnerable adults, has been criticised by many as disproportionate, overly burdensome and unduly infringing on civil liberties.

It was announced last year that from July 2010, any dental professionals who were changing jobs or starting work for the first time would need to register with the Independent Safeguarding Authority (ISA) and that by 2015 all dental professionals would need to be registered with the Vetting and Barring scheme. However, registration with the scheme has been postponed.

Home Secretary, Theresa May said: “The safety of children and vulnerable adults is of paramount importance to the new government.

“However it is also vital that we take a measured approach in these matters. We’ve listened to the criticisms and will respond with a scheme that has been fundamentally remodellled. Vulnerable groups must be properly protected in a way that is proportionate and sensible. This redrawing of the vetting and barring scheme will ensure this happens.”

Children’s Minister, Tim Loughton said: “Protecting vulnerable children is a top priority. Any vetting system should not be a substitute for proper vigilance by individuals and society. At the moment we think the pendulum has swung too far.”

The scheme was devised in response to an enquiry into the 2002 Soham murders which called for better information sharing. It was designed to protect children and vulnerable adults by preventing those who pose a known risk from gaining access to them through their work.

Within the meaning of the Safeguarding Vulnerable Groups Act 2006, the delivery of dental care is a ‘regulated activity’; therefore it was proposed that all those delivering that care must be registered with the ISA in the long term.

Head of standards at the General Dental Council (GDC), Janet Collins said: “We will watch with interest the review into this scheme by the government. We will make sure registrants are up to date with any changes which affect their obligations under the scheme, as well as what information the GDC is obliged to share with the ISA.

“We’d also like to remind dental professionals the GDC expects all registrants to be aware of the procedures involved in raising concerns about the possible abuse or neglect of children and vulnerable adults.”

British Association of Dental Nurses’ President Sue Bruckel said: “Whilst we at BADN acknowledge the need to safeguard children and vulnerable adults, we welcome the Government’s decision to review the proposed scheme; and await with interest further developments.”

Susi Sanderson, chair of the British Dental Association’s Executive Board, said: “We hope that the announcement of the halting of the proposed vetting and barring regulations signal a fresh approach to regulation that puts patient care before bureaucracy.”

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Government to review its dental ‘inheritance’

The new dentistry minister has confirmed that the government will review the details of the NHS dental system that we have inherited.

Earl Howe, the Parliamentary Under-Secretary of State for Health with responsibility for dentistry, also confirmed that the government’s proposed reforms will be announced once they have talked to the profession and patient groups.

Earl Howe’s comments were said during the Queen’s Speech Debate in the House of Lords, in response to a speech by Lord Colwyn, a dental surgeon and Conservative Peer.

Lord Colwyn spoke of dentistry as being at ‘another crossroads’.

He said that the decisions made in this Parliament to transform the delivery of NHS dentistry will be ‘extremely important. We have been left with an unfinished reform following the 2009 spending review. We must grasp this opportunity if we are to improve the oral health of the nation’.

The Government is to review NHS Dentistry in this document is very positive and much needed,” he said.

He also alluded to the extra regulation that dentists will have to adhere to as both NHS and private practices will have to be registered with the Care Quality Commission by the end of March next year.

Lord Colwyn, who is also an officer of the All-Party Parliamentary Group for Dentistry (to which the BDA is elected secretary), said that the challenge of reforming dentistry—to deliver a better system both for patients and dentists—comes at a time when tough financial decisions are to be made across all Whitehall departments.

He also welcomed the coalition government’s commitment in their programme for government.

“Secondly, we must pursue consistently high-quality commissioning of primary dental care. Some PCDs perform well, but service and recorded messages with instructions on how to deal with specific health emergencies.

Deborah Evans, NHS Bristol chief executive, said: “This application is a way for us to open services up to the public and provide genuine information and choice for patients. I’m excited at the way we can use new technologies to improve patients’ choice and I’m sure that the people of Bristol will feel the same way.”

The application has been developed in partnership with Bristol-based company MyOxygenMobile, and is the first application of its kind. It is in the process of being developed for the new ‘AnDruid’ platform of mobile phones.

Andrew Farmer, MyOxygenMobile manager, said: “We focused on making the application clear and accessible using familiar icons and images to help the user. We feel the application is great for the people of Bristol, a perfect way of using new technology and we are keen to see how successful it will be.”

The application can be downloaded for free through iTunes.
The last few weeks have seen a wave of cutbacks by the coalition Government akin to an over-enthusiastic gardener and a new set of hedge trimmers. First to go was the controversial Vetting and Barring scheme, which admittedly was much more political than fiscal. Then there was a cull of project funding which had been agreed by the previous government since January. Projects such as the Stonehenge Visitor Centre, the roll out of the Future Jobs Fund and the building of a new North Tees and Hartlepool hospital have all been cut, while the Health Research Support Initiative and Search and Rescue Helicopters are some of the projects which have been suspended.

Then there was the budget. Deputy PM Nick Clegg paved the way for doom and gloom in an email newsletter sent out the day before entitled *Why we have to do this*. Flashbacks of Dad with a paddle saying ‘it’s for your own good’ aside, the country braced itself for cuts in public spending, rises in tax and duty on all the good things in life and a rough ride as the country tries to stop the slide into a Greece-style financial crisis.

We will be looking into the budget in much more depth with regards to healthcare in the next issue of Dental Tribune, so watch this space.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA Or email: lisa@dentaltribuneuk.com

Editorial comment

Cut to the quick

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If oral hygiene isn’t getting their undivided attention, why not recommend adding Listerine? It kills bacteria deep in the plaque-biofilm.1 And, added to brushing and flossing, provides up to 52% extra plaque reduction.2

References:
New GDC panel website launched

A new website has been set up to recruit 50 new Fitness to Practice panel members to the General Dental Council (GDC).

The GDC wants dental professionals to get involved and play a key role in their work in protecting patients. The panel members will sit in public hearings and consider cases where a registrant’s fitness to practise may be impaired due to their health, conduct or performance, as well as applications for restoration to the registers and appeals against registration decisions.

Chair of the GDC, Alison Lockyer called it an ‘opportunity to make a real difference’. She said: “We welcome applicants from all walks of life. We’ll provide induction and regular training for successful candidates.”

“So please take a moment to consider whether you – or someone you know – could be the sort of person we’re looking for.”

“We know that dental care professionals traditionally haven’t put themselves forward for these roles and we’re trying to reverse that trend in particular. The competencies required may look daunting, but including simple examples from your daily life at home, at work or any voluntary or community groups in your application is often enough to demonstrate that you meet them.”

“I also hope that people will be encouraged by reading about the experiences of our current FtP panel members.”

Applicants must be able to demonstrate the following competencies: working within a legislative framework, analytical and decision-making skills, collaborative and professional communication skills, integrity and valuing diversity and team work.

The Fitness to Practise Committee is currently made up of 75 panel members. There are 56 dentists, 22 lay people and 15 dental care professionals on the Committee.

They are paid £353 a day and are reimbursed their expenses.

It is a part-time role, with members sitting for around 20 days a year and members are allocated to a particular hearing well in advance.

Computer imaging shows patient new smile

Patients can now see through computer imaging how cosmetic dentistry can transform their teeth, before they undergo the procedure.

Many people are self-conscious about their teeth and their smile, but are hesitant to agree to cosmetic dentistry because they’re unsure of the results. A new computer system called SmileVision allows the dentist to use a digital video camera to capture an image of the patient’s teeth. That image is then sent electronically to the SmileVision Laboratories.

The inventor, Dr Lawrence Brooks, and his team of experts can show them definitively what their teeth could look like after cosmetic procedures.

Smilevision is different from other kinds of computer imaging in that it uses the patient’s own teeth in the after images.

In about a week, the patient receives before and after photographs at home showing what his or her teeth could look like.

The patients are able to really know how they’ll look, and they get excited.”

He said: “For years we spent hours explaining what the options were and how a patient’s teeth could look, but it was hard for them to visualise. Now, we can show them definitively what the results will be.

“The patients are able to really know how they’ll look, and they get excited.”

Practice to take 8,000 patients

A new NHS dental practice opening in Fareham is among the first general dental practitioners to receive before and after photographs at home showing what his or her teeth could look like after cosmetic procedures.

New practice to take on more than 8,000 new patients.

The new practice is opening in the Fareham area at the end of July.

Julia Bagshaw, associate director for primary care commissioning for NHS Hampshire, said: “We are committed to increasing the number of NHS dental places for Hampshire residents and are really pleased that this practice is opening in Fareham. The new practice means we now have 189 contracts for NHS dental services in place across Hampshire and currently 44 of these are taking on new NHS patients.”

Appointments will be available in batches over the next few months. People are being told not to turn up at the dental practice without an appointment.

“People may look daunting, but including simple examples from your daily life at home, at work or any voluntary or community groups in your application is often enough to demonstrate that you meet them.”

“We know that dental care professionals traditionally haven’t put themselves forward for these roles and we’re trying to reverse that trend in particular. The competencies required may look daunting, but including simple examples from your daily life at home, at work or any voluntary or community groups in your application is often enough to demonstrate that you meet them.”

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Short-term Ortho lecture

One of the first general dental practitioners to become a six-month smile provider will be giving a presentation on Short Term Orthodontics in Birmingham.

Dr Anoop Maini will be giving the lecture in September to British Academy of Cosmetic Dentistry Study Club members in Birmingham.

In line with the current trend for conservative cosmetic dentistry, Dr Maini will be explaining how GDPs can realistically utilise STO within their practice, outlining its strengths and limitations, as well as how it differs from the objectives of Comprehensive Orthodontics.

Dr Maini will also advise GDPs on how to identify patients within their practice who might benefit from STO treatment, as well as how to inform candidate patients about the different components of the six-month smile system.

The presentation, entitled Re-allocating Fixed, Fixed Cosmetic Orthodontics for GDPs, will take place on 16 September at James Hull & Associates in Birmingham at 7pm and will be followed by a question and answer session. Tickets for members cost £25. Non-members are also welcome.

Text continued on next page.
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Awareness of oral cancer ‘too low’ in the UK

A wareness of the risk factors and symptoms of oral cancer is ‘too low’ in the UK, according to the British Dental Health Foundation.

A new study published in the British Dental Journal revealed that the majority of mouth cancer sufferers ignore the first symptoms of the disease and do not seek the advice of a healthcare professional during the early stages.

The Scottish research, entitled The experiences of young oral cancer patients in Scotland: symptom recognition and delays in seeking professional help, was conducted by lead author Liz Grant, a public health pharmacist from NHS Greater Glasgow & Clyde.

The research team interviewed relatively young mouth cancer patients in Scotland and found that most had heard of oral cancer but didn’t think their symptoms were indicative of the life-threatening illness.

Furthermore, 40 per cent of the participants decided to self-manage their symptoms and sought over-the-counter treatments which were suggested by a pharmacist.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter said the study further confirms gaps in understanding and awareness of oral cancer.

He said: “Public awareness of oral cancer and the associated risk factors appears to be too low here in the UK. An awareness of the risk factors and symptom recognition by the public is a critical issue in determining survival rates, as early detection greatly improves the chances of survival.”

“Almost 90 per cent of patients who were interviewed had a prior knowledge of oral cancer and the causes such as tobacco and alcohol. However, this prior knowledge was neither instrumental for them to suspect they may have mouth cancer nor did it prompt them to visit a healthcare professional in the first place.”

None of the interviewees thought it would happen to them.

A third of interviewees mentioned their first sign as some kind of ‘lump’, a few described a ‘white spot’ ‘mark’ or ‘patch’ and two described an abscess.

It was also found that wasting time of a healthcare professional or appearing to be a hypochondriac was a delaying factor in patients seeking help.

For those attempting self-treatment there was an inevitably some delay in visiting their GP or dentist.

This period of delay in these cases ranged from a few days to two months. The period of time which elapsed between the interviewees noticing their symptoms and them making contact with a health care professional varied from a few days to a year, although two thirds saw someone within eight weeks.

Participants who had taken part were all in their thirties and forties and from Scotland.

Mouth cancer has previously been found to be more common in men than women and people over the age of 40, though an increasing number of women and young people are developing the condition.

Tobacco and alcohol are thought to contribute to at least three-quarters of mouth cancer cases.

Poor diet is linked to a third of all cancer cases. Evidence shows an increase in fruit and vegetables lowers the risk, as can fish and eggs.

Around 5,000 people in the United Kingdom are diagnosed with mouth cancer each year, claiming the lives of almost 2,000, making it the UK’s fastest growing cancer.
Healthy teeth rise in Scots kids

A record number of children in Scotland have healthy teeth, according to a new report.

The report, by the National Dental Inspection Programme, found that 64 per cent of pupils in primary year seven (last year of primary school) had no sign of tooth decay in 2009. In 2007, the figure was 59.1 per cent.

The figure exceeds the Scottish Government's target for 60 per cent of 11-year-olds to have no obvious signs of tooth decay. However, the target was not reached in some parts of Scotland, such as Glasgow and Lanarkshire.

Children in Shetland recorded the best average last year while children in Greater Glasgow and Clyde, Dumfries and Galloway, Lanarkshire and Western Isles health board areas are still below the 2010 target.

The report found that dental disease is still being found much more in children from deprived backgrounds than those from affluent homes.

Minister for Public Health Shona Robison announced the report's findings at an NHS Scotland event for National Health Service staff. She said: “There are now more kids in Scotland with healthy teeth than ever before.

“We wanted 60 per cent of primary seven to have no sign of tooth decay by 2010 and I am pleased to say that this target has been met.

“Dental health in Scotland is improving, particularly in deprived communities, and this is a trend that we want to continue.”

“Thanks to work to ensure that children know the importance of dental care at the earliest age, Scotland's primary seven are now better placed to have a lifetime of good oral health.”

Ms Robison added: “Across all areas of the NHS, not just in oral health, we are committed to improving the wellbeing of our nation. That means supporting measures that prevent ill health. We don’t just want to treat people who are ill; we want to make sure people stay healthy.

“In today’s tough economic times we need to be as efficient as possible and that means maximising our investment in the health of the Scottish people.”

The 2009 National Dental Inspection Programme (NDIP) is a development of the Scottish Health Boards’ Epidemiological Programme. It is a joint venture between all NHS Boards in Scotland, the Scottish Health Department, Glasgow Dental School (University of Glasgow) and the Dental Health Services Research Unit, Dundee.

Dentistry is child’s play in expanded scheme

A scheme where children dress up as dentists and dental nurses so they can learn about oral healthcare and visiting the dentist has now been launched in the north-west of England.

The programme Dental Play Box is run by Action for Sick Children and has been operating for a number of years in Scotland. It is now expanding into the north-west of England.

The play facilitator travels around nurseries and pre-schools running play sessions with a box of resources, which includes role play uniforms such as a dentist and dental nurse, hand puppets, toothbrushes, games, stories and a teacher’s pack. The settings are able to borrow the resources so the children can explore the contents in their own time.

A spokeswoman for Action for Sick Children said: “These boxes help children to learn through play how to understand dental treatment and encourage them to co-operate with the dentist, which in turn makes a visit to the dentist a much less scary experience. Some of the items inside the Play Box are dressing up outfits, a wide selection of toys and jigsaws, videos, books, dental tools and leaflets.”

The Dental Play Box, sponsored by Boots, is focusing on the north-west as it has bad statistics regarding oral health care. The charity’s long-term plan is to expand into different areas of the country.

Treatment pilot in care homes

Dentists are going to be offering NHS treatment to residents in care homes in Northamptonshire after a study found some older people are missing out on regular dental care.

Nine dental practices will offer oral health assessments to residents at £1 of the country’s care homes.

Any follow up care can then be done at the dental surgery or at the care home itself.

The scheme will run as a six month pilot and if it is successful, it will be rolled out across all the care homes in Northamptonshire.

An improvement in oral health has led to people retaining their teeth into old age, and so maintaining good oral health is important for daily comfort and living.

Di Fenton, head of dentistry for NHS Northamptonshire, said: “A sample of care home residents showed that all had some degree of oral health which they could improve and people’s general quality of life, and more seriously can lead to problems with eating.

“We’ve committed that every patient in Northamptonshire should have the opportunity to access an NHS dentist, including those who would struggle to visit the dentist at their surgery.

“We’ll be carefully monitoring the outcomes of this pilot, and should it prove successful we hope to make it available to every care home resident in Northamptonshire in the autumn.”

[Image 50x494 to 338x633]
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United Kingdom Edition  · June 28–July 4, 2010

A website is a dynamic low cost marketing tool for your practice

Says Seema Sharma of Smile Impressions and Dentabyte

Do you tend to treat everyone who wanders through your door, or do you have a dynamic growth strategy which moves your practice in the direction that you want to take it? When I decided to take time out to work on my business instead of in my business I found it had profound effects on my practice and my work/life balance.

There have always been two ways to achieve a pleasing bottom line - increase revenues or reduce costs. With the rising costs of rents in Docklands, my insistence on highly trained staff to implement my vision, and the costs of compliance brought about by the growing raft of regulations in dentistry, I have always found cost control quite a challenge, and have tended therefore to concentrate on revenue growth.

I have three mantras which have worked wonders for my practices over the years - market something different; market differently; market to different people.

Marketing something different
Routine dentistry has a routine hourly rate, so for ‘in-hours’ growth, the challenge became to balance this with higher value services to make a difference to the average hourly rate. Over the years we have introduced orthodontics, Invisalign, Clearstep, specialist oral surgery, implants, endodontics and of course aesthetic dentistry, and pushed our average hourly rate up by 50 per cent.

Marketing differently
Having spent years producing paper leaflets, I am now completely indebted to my web designer for the fantastic marketing tools my websites have become, and the direct and indirect costs we have saved. We built a layered website - simple visual information for those who just glance, depth for those who wanted more and comprehensive patient information leaflets which encourage treatment plan acceptance. All the text we used followed the FAB (Feature, Advantage, Benefit) approach - less about the features (treatments), more about the advantages and benefits of our services. We then trained our team to use the website as a treatment planning tool in the surgeries and show patients the benefits of our services and how to download information leaflets. As a result, my treatment coordinator’s job has become easier and our treatment plan acceptance flew up, accompanied by a huge reduction in the amount of time, paper and ink that we had to expend on advertising and production of printed patient information.

Marketing to different people
A stream of new patients is the lifeblood of any practice and should be the cornerstone of marketing strategy for all practices, whether it is online or offline.

Conversion rates!
You could be found a thousand times a day but if you don’t give the patient compelling reasons to come to you, optimisation is all lost. Building our low cost marketing strategy is one of referrals and recommendations - delivering the patient care and service that drives someone to talk about us at a dinner table is one of our key drivers. These days social networking is incredibly powerful – so getting patients to shout online for us is another growth strategy.

Conversion! Say it, ensure your marketing activity for all practices is online or offline.

a) Giving us visibility on the web – With more practices moving onto the web, when we were not online we did not stand a chance of being heard so we had to embrace the net. Rome wasn’t built in a day so when we decided to go online we secured the capability to create a site which could evolve. This was not expensive – I was lucky to find experienced, dedicated professionals who provided real value for money.

b) Shouting as loud as we could – We did this through directory listings and link building activity - a listing is anything that brings your URL up in a search. There are thousands to choose from but picking the right ones was the trick. This was an essential for maintaining position. Keywords are shared but prevalence comes in degrees and we wanted to be at the higher end of the scale for sustained presence.

c) Encouraging our patients to shout for us – The best growth drivers are referrals and recommendations. These days social networking is incredibly powerful – so getting patients to shout online for us is another growth strategy.

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Bespoke solutions

One size does not fit all when it comes to working out which business structure is best for a particular practice, as Clive Lawrence explains

There are now several business structures under which dentists can practice. The first point to make, very clearly, is that no one solution is best for every practice. All an advisor can or should do is work with their clients and their other relevant advisors to find the solution that best delivers the requirements of that practice.

The considerations are frequently complicated and involve weighing the pros and cons. The purpose of this article is to give an outline of some of the principal considerations that arise in coming to the right decision. These are guidelines only and specific advice on the individual circumstances is necessary in each case. But what are the options?

Sole tradership - Here a dentist will simply trade on his or her own account in a familiar manner. He or she is liable for all the debts and liabilities of the practice, including any uninsured loss, without limit. There is therefore no protection for the individual dentist from commercial or liability risks. The dentist is taxed as an individual and has few filing and regulatory responsibilities.

Limited company - A dentist has the option to transfer their practice to a limited company or simply to incorporate a new practice as a limited company. This is the tried-and-tested commercial structure for doing business and has the principal benefit of limited liability. In other words, the company is a separate legal entity from the dentist, and the liabilities of the company are not those of the dentist themselves, therefore giving some protection against commercial risk and uninsured claims.

This does not mean that it will eliminate every liability arising against the individual. Exceptions to the ‘shield’ it provides may arise if, for instance, a dentist does not fulfil their statutory duties as a director. In addition, where banks or other creditors take security from the dentist for the liabilities of the company, it avoids limited liability working in relation to the debt.

The disadvantages of this can arise from the extent of disclosure, which is required by the regulations governing the filing of accounts and other information relating to the business, including earnings levels, with which some professionals are uncomfortable.

A limited company is taxed at Corporation Tax rates on its profits and the dentist’s earnings from it are taxed again, either under PAYE for salary or as dividends where applicable. Depending on both the dentist’s individual circumstances and their levels of earnings, this can be used to create tax advantages or can cause tax disadvantages. Tax advice therefore is a necessary component of any decision to incorporate as a limited company.

Dentists working together - Expense sharing - This is the ‘standard’ business structure that is put in place to organise the practice of dentists who work together in the physical sense of the relationship. There is more sharing of information, responsibility and accountability between partners.

Partnership - An orthodox ‘unlimited’ partnership operates largely as an expense-sharing arrangement in practice, but proceeds on the clear understanding that all participants are involved in the same business. In that way, it differs conceptually from an expense-sharing arrangement. There is more sharing of information, responsibility and accountability between partners.

In a partnership which is not a Limited Liability Partnership, the partners have unlimited liability of the same nature as that which exists in an expense-sharing arrangement.

A formal partnership format allows less flexibility and outright self-determination to the practitioners in it than an expense-sharing arrangement; however, procedures on exit can be greatly simplified as a
departing or deceased partner is selling that partner’s ‘share’ in the overall business to the remaining partners, rather than looking to sell an individual business belonging to that partner. Provisions such as the use of life insurance to create funds for use in paying for partnership ‘shares’ released on involuntary departures (such as on death) can be more easily accommodated into a partnership structure. The differential between the earnings of individual partners from their ‘own’ practices can be more difficult to accommodate. However, careful drafting can be used to place the partners largely in the same position (and the same relative positions amongst themselves) as would be arrived at in an expense sharing arrangement.

A partnership will complete a Partnership Tax Return, but each partner is individually liable for his or her own tax on the basis of his or her earnings as an individual from the partnership.

**Limited Liability Partnership (LLP)** - An LLP operates day to day largely in the same way as an ‘ordinary’ or ‘unlimited’ partnership, but with some differences. The main difference is limited liability. The LLP is a separate legal person from the partners participating in it and the liabilities of the LLP are not therefore the liabilities of the constituent partners. Exceptions to this position can arise in the same way as with limited companies.

The members of the LLP (who are equivalent to partners in a partnership or directors of a company) have statutory duties similar to those of company directors, and also the LLP must file statutory information and accounts. This therefore can lead to a limited extent of publication of the earnings and profits of the LLP and of its constituent members. There are different levels of limitation on the reporting required depending on the turnover of the LLP and until the turnover of the LLP is in several million pounds, the disclosure required is not extensive.

An LLP has the same benefits in relation to ongoing management and entry and exit as those benefits afforded by a partnership. In the LLP context, those benefits are also increased by the fact that the party which pays the departing partner is no longer the other partners but the LLP itself. The partners are therefore in less of a situation of risk amongst themselves as well as to the outside world. The downside may be for the departing partner if the LLP does not have the funds required to pay him or her out.

**Limited company** - Dentists can choose to practice together in a limited company. The benefits, and downsides, are similar to those discussed above in the context of the sole practitioner. When more than one dentist is involved in a company, they would usually enter into a Shareholders Agreement taking effect between all the dentists involved, each of whom would usually be both a shareholder and a director of the company.

This would deal with largely the same issues and concerns as those which would be covered in a Partnership or LLP Agreement and avoid the simple majority rule which otherwise obtains within a company from compromising the interests of individuals. That also permits the limited company to provide comparatively straightforward routes to entrance and exit for participants through the sale and purchase of shares.

A limited company can also be the best business structure where there is any mixture in ownership or business participation terms between dental professionals and people who are not dental professionals. A body corporate can conduct a dental practice so long as the majority of its directors are dental professionals, and a limited company therefore can provide a medium for diverse forms of dental business.

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**About the author**

Clive Lawrence joined Cohen Cramer in 2009 as a Consultant and is a key member of the firm’s dental team. He advises dentists on a broad range of options in relation to business structures, dealing with partnership arrangements, limited liability partnership (LLP) arrangements, corporate structures and the numerous connected issues that can arise. To contact Cohen Cramer Solicitors, call 0113 2440907, email dental.team@cohencramer.co.uk or visit www.cohencramer.co.uk.
Reducing tax bill, part II

Dentists can ensure their tax burden is efficiently managed, says Thomas Dickson in the second of this two-part feature

As a number of dentists earn more than £150,000 a year, or aspire to, they need as much information as possible to reduce their tax bills.

Offshore investing

An offshore portfolio bond is an investment wrapper used to help with tax planning. Investing overseas can bring advantages to UK residents and offshore portfolio bonds are usually based in a number of different jurisdictions.

When bonds are held in the UK, income is paid net of tax. The benefit of an offshore portfolio bond is that it defers investment tax until you cash it in; the income can be rolled up gross over a number of years. The fund only becomes tax liable when the holder brings money back to the UK.

Offshore savings

Most of the big high street banks, as well as private banks, have subsidiaries that offer offshore accounts. Usually the minimum deposit is between £5,000 and £10,000, with anyone being eligible to open such an account. It is important to remember that the UK Financial Services Compensation Scheme does not cover offshore institutions. Some banks and building societies have pledged to cover any liabilities that their offshore subsidiaries cannot meet, but not all of them have made such a commitment.

Offshore trusts offer a good way of reducing inheritance tax liability. Money put in trust will enjoy the benefit of compound interest to help the fund grow. When tax is payable, it will be at the basic rate, so long as the beneficiary is not a higher-rate taxpayer. As long as the donor has lived for seven years after setting up the trust, the money is free from inheritance tax.

ISAs

From April 2010, the rules governing ISAs has changed. For cash ISAs, the maximum that can be saved will be £5,100 per year. With an investment ISA account, the ceiling will be raised to £10,200 per annum can be saved, of which 50 per cent can be in cash. Since the personal allowance for capital gains tax is £10,200, an individual can make a healthy profit up to this amount without paying any tax.

The trick is to pick funds and/or individual shares and bonds that will deliver high returns for the lowest risk, with low charges. Seek the advice of an Independent Financial Adviser to ensure you make the right choice.

Employing a spouse

Transferring part of your income to your spouse is worth considering as a way of reducing the tax burden. There are important steps to take.

A commercially justifiable wage needs to be paid, and minimum wage regulations are likely to apply. Keep clear records of not only the work the spouse does for the practice, but also the payments, ideally into a separate bank account in the spouse’s name. An employment contract is also a legal requirement. A salary between £110 and £884 per week is subject to employees’ national insurance at 11 per cent and employers’ national insurance at 12.8 per cent.

About the author

Thomas Dickson, director of Essential Money Limited, formerly a partner of Money4Dentists. For more information, and to receive a free copy of The Little Book of Money, packed full of practical hints and tips, contact Essential Money on 0221 885 3098 or email thomas@essentialmoney.co.uk.
How to achieve better interdental healthcare routines

Clare Southard looks at the use of the interdental brushes in patients’ oral healthcare regimes

We all know what’s good for us; eat well, exercise more, but there always seems to be a reason why we’re unable to make the changes we’d like to see in our lives.

This is no different for our patients when it comes to maintaining a good oral healthcare habit. When it comes to interdental care, although many know the importance of removing the plaque that builds up unseen between teeth and below the gum line, there is still a lack of motivation to adopt a regular interdental routine.

According to a survey conducted in 1998, over half the adult population is suffering from periodontalitis. As most dental practitioners know, the emphasis of the recent Steele Report was the need to improve oral health as a preventative method for the more serious complaints seen everyday in practices across the country.

The challenge for dental professionals is how to achieve and maintain better rates of compliance with oral healthcare routines by patients. Although 22 per cent of adults claim to floss regularly, is there good reason to be suspicious of this claim, and what might be the reasons for the low take-up?

Flossing is by no means a recent invention. Since the 1800s the notion of passing a silk thread through the teeth to loosen collected matter has been advocated as being an effective way of preventing tooth decay, but there’s evidence of people carrying out this practice back to prehistoric times of such methods being employed. Since the 1970s flossing has become an integral part of oral healthcare, and yet it’s still undertaken by a relatively small fraction of the population.

Interdental brushing vs Flossing

One reason may be that many dental practitioners find effective flossing difficult to teach, and patients often find it a tricky technique to master.

For those with poor manual dexterity, limited mouth opening or a strong gag reflex, alternatives to flossing (such as interdental brushing) should be sought. Only requiring one hand to perform the task of plaque removal is certainly an advantage for many patients, regardless of their manual dexterity, especially when the handles are ergonomically designed for greater manoeuvrability.

There is evidence supporting the view that interdental brushing is a better option for patients. A three-month trial found that not only did the people become proficient in using the brushes more quickly than floss, but also plaque and gingival inflammation was reduced more.

It’s been recognised that flossing may not always be the most effective tool for removing interproximal biofilm, and that flossing becomes progressively less effective in interdental areas that have slight to moderate recession or complete loss of the interdental papillae. In contrast, interdental brushes offer the flexibility of a range of filament thicknesses and lengths, meaning that regardless of the gap, there is a brush suited to best reach the recesses, making the process more effective:

As evidenced, because the filaments are soft there is less risk of damaging the delicate gum membrane, causing the pain and bleeding which will often de-motivate the patient from persevering with the oral healthcare routine.

Maintaining motivation

Dental professionals, particularly dental hygienists, are at the forefront of oral healthcare education. With the shift in focus on NHS dentistry set to change, and a recommended restructuring of the payment structure to reflect the practice’s efforts to improve oral health, motivating the patient to adopt and then maintain an oral healthcare routine should be in the minds of practice managers. The question is how.

Explain the risks: the connection between gum disease and heart disease has long been anecdotally suspected, but recent research has confirmed the link. It’s now understood that people with periodontal disease are almost twice as likely to suffer from coronary artery disease as those without periodontal disease.

Patients who are pregnant ought to be made aware that there is a relationship between periodontal infections and low birth rate.

Setting goals is a useful tool. Often a patient will claim a lack of time as being the reason for not maintaining a healthcare routine that involves flossing. One suggestion is to negotiate with the patient to produce a written healthcare plan.

One advantage of interdental brushes is their ease of use. The ergonomic grip makes reaching the trickiest of interdental spaces easy to reach with one hand, making it feasible to clean the gaps between teeth at times convenient to the patient; whilst watching television at home or on the move. The handy-sized brushes can be kept in a bag or purse to be used any time or anywhere.

By creating a written plan the patient is far more likely to maintain an oral health routine, especially when another person (such as a dental hygienist) monitors their progress.

With more than 50 years of experience in designing interdental brushes, Curaprox have created the most durable and effective brushes now on the market. With ergonomic grips providing excellent manoeuvrability and control, patients will soon see an improvement in their oral health.
Periodontology is innovative

Prof. Dr. Liviu Steier looks at some of the new ideas in Periodontology as discussed by Robert J Genco

Genco summarised in his paper published the Journal of Periodontology the, ‘clinical implications of the workshop on inflammation and periodontal diseases’. In this paper, he managed to compile a list of innovations currently still in the pipeline. These can be categorised as follows; Short-term: ready for clinical application over the next one to two years; Mid-term: ready for clinical application over the next five to 10 years; Long-term: ready for clinical application more than 10 years from today.

New risk profiles under development for periodontal disease and diabetes to be self-reported used in practice.

Risk assessment of risk for potential atherothrombotic vascular events in dental patients, with special consideration for those having periodontal disease using traditional markers of risk or C-reactive protein (CRP) in the Reynolds Risk Score.


Indication for use of nutraceutical and drug combinations (omega-5 fatty acid and aspirin) to control inflammation associated with periodontal infections.

Indication and application for use of inhibitors of matrix metalloproteinase for adjunctive management of periodontal disease as an adjuvant in surgical and non-surgical therapy.

Mid-term innovations
1) New diagnosis technology for measuring active bone loss
2) Application of diet rich in omega-5 fatty acids to reduce genetic predisposition to metabolic syndrome and the application of nutragenomics
3) Therapeutic approach to use of anti-inflammatory agents, the endogenous resolvins and protectins
4) New tests to control MMP-8 in saliva, and fragments of bone collagen in tissue fluids for monitoring periodontal disease
5) The application of bone sparing agents to inhibit osteoclast recruitment and limit bone loss
6) Application of statins and targeted anti-inflammatory therapies in periodontal disease for modulation of inflammation

Long-term innovations
1) New approaches to regulate and prevent bone loss
2) Apoptosis regulation to reduce bone loss
3) Dietary modulation with genetic influence on phenotype in pathogenic pathways, for example, cholesterol levels and obesity – leading to prevention and treatment of cardiovascular diseases and other complex inflammatory disease such as periodontal disease
4) Identification of genetic risk profiles for periodontal disease
5) Genetic test to identify correlation between CRP, inflammatory mediators, periodontal disease, diabetes, and premature atherothrombosis
6) New data and information regarding pathogenesis of periodontal disease which may be modeled by incorporating gene, protein, and metabolite into dynamic biologic networks
7) Vaccines using periodontal pathogens to protect against periodontal infection
8) New prevention approaches to avoid uncoupling of bone deposition and bone resorption.

References

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Where did all the periodontists go?
Dr Louis Malcmacher finds out what’s changed the face of periodontology

Through my weekly travels to different cities across America, I speak to many dental specialists and their groups on the hottest topics in dentistry, practice management and total facial esthetics.

There are definite trends that are changing in all specialties across the board, whether it is short-term orthodontics versus long-term orthodontics, adhesive resin endodontics versus traditional gutta-percha endodontics or the conversation as to whether or not general dentists should be providing some of these specialty services.

I would have to say that the biggest change of any single dental specialty that I have seen has been in the periodontal field. There has been a real mind-set change that deeply affects the profession. I am not commenting here on whether this change is good or bad – I will leave that up to the reader to decide.

It is certainly something to consider as general dentists who refer patients to periodontists on what your treatment will be for the long run.

I have always believed that general dentists are the quarter-backs of any patient treatment case and we certainly rely on the skills and input of dental specialists, but the ultimate responsibility should be on the general dentist.

Removing teeth

Here is what I am being told by many periodontists whom I have spoken to over the last couple of years: they would rather remove teeth and place implants than actually treat patients through traditional periodontal surgery and try having them maintain their dentition.

The reason for this is really quite simple and every dentist knows this inherently. Patients refuse to take good care of their teeth even after they have gone through the time, cost, commitment and pain of traditional periodontal surgery. This is certainly not earth-shattering news to any of you.

For years in our own practice, we have had patients who did not want periodontal surgery and would rather maintain the state of their oral health with three to four-month recall prophylaxis visits. We would often predict that their teeth would fail out within two to three years.

Surprisingly, many of these patients have done reason-ably well 20 years later, with the occasional loss of a tooth here or there.

This thought was blasphemy to periodontists for years and years, but certainly it seems that conservative non-surgical periodontal recall visits and treatment has helped many patients maintain their dentition in a reasonable state so that they can function and smile with their original teeth for years.

Old habits

As general dentists we have known that even with the best periodontal surgery treatment, patients would often fall into their old habits and eventually their dentition would fail anyway. Not all patients, but many of them.

We have learned that we have to treat people as people and sometimes you just cannot change them no matter what you do.

It seems to me that periodontists have now caught up with this concept and that is where...
With a 94 percent implant success rate, it is hard to argue when that success rate is so high compared to the poor long-term success rate of traditional periodontal surgery.

This is primarily because we have to depend upon the patient to keep up their regimen for the long-term success of their natural dentition.

New procedures — such as the wavelength optimised periodontal therapy (WPT) procedure with the Powerlase AT Laser by Larex Research, and LANAP procedures done with the Periolase laser by Milenium Dental — have brought periodontal services into the minimally invasive realm as a solution for patients who do want to keep their teeth without heavily invasive periodontal surgery.

**Technology advances**

New procedures — such as the wavelength optimised periodontal therapy (WPT) procedure with the Powerlase AT Laser by Larex Research, and LANAP procedures done with the Periolase laser by Milenium Dental — have brought periodontics today. Laser periodontal treatment will continue to develop and become even more effective in the future.

Laser periodontal treatment will continue to develop and become more effective in the future.

Procedures such as implants and minimally invasive laser periodontal therapy will continue to improve and change the way we practice in this new decade.

*Is this good or bad? You are the decision-maker; this is for you, the periodontist and the patient to decide.*

**This article was first published in Dental Tribune US edition Vol. 5, No. 12.**
A challenging task

Prof Dr Liviu Steier discusses how to restore the aesthetic zone with implant-supported restorations

Restoring the anterior aesthetic zone using implant-supported restorations is one of the most challenging tasks. Knowledge of related literature, impeccable skills, a lot of experience and a well-trained team compliment a successful treatment. Different implant systems claim to offer the only technology leading to success. The author describes a case where an “outdated” system, external hex implant system offers a similar success rate, by only following a correct protocol.

Aesthetic 3-dimensional requirements

For optimal aesthetics, some literature suggests some key factors to be respected as they play an important role for long-term success:

• Availability of two mm buccal bone plate
• Implant-tooth distance should be 1.5 mm
• Implant-to-implant distance three mm
• Biologic width is indicated with two-three mm

Clinical case

A 45-year-old male has been referred to the practice for rehabilitation of the anterior aesthetic zone. His medical and dental history, as well as his treatment desires, were recorded.

Dental history

The patient lost tooth 11 due to trauma about 17 years ago. He was advised to restore the gap with a PFM bridge. He also reported multiple recementation sessions. Later, insufficient root canal treatments (X-rays) seemed to have weakened the remaining tooth structure. The clinical picture below demonstrates also fractured adhesive posts.

X-ray diagnosis proved vertical root fracture of both teeth. Poor prognosis led to immediate extraction recommendation, to avoid further infection (leakage) and optional bone loss.

Treatment plan

The following treatment options were identified and discussed with the patient:

• Extraction and no treatment
• Extraction and restoration with a removable device
• Extraction and immediate implant placement.

Benefits and disadvantages of different treatment options

Extraction and no treatment

Benefits

• Fast
• No cost implication

Disadvantages

• Aesthetic breakdown of the anterior area
• Function and speech alteration

Extraction and restoration with a removable device

Benefits

• Fast
• Minor cost implication

Disadvantages

• Aesthetic breakdown of the anterior area
• Function and speech alteration.
• Removable device acts as an impediment

Extraction and immediate implant placement

Benefits

• Preservation of bone
• Optimal functional and aesthetic rehabilitation

Disadvantages

• Cost implication
• Extended treatment need

Patient decided to go for the extraction and have im-

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Immediate implants placed. Impressions were taken so the patient could be offered a removable temporary device once extraction and implants performed for the healing time.

**Treatment procedure**

Retained roots were extracted in local anesthesia (four percent Articain) using minimal invasive procedure.

The alveolae were thoroughly scooped and cleaned. Available bone was sounded and found adequate for immediate implant placement. Two Biohorizons Ø4.0mm x 12mm external implants were inserted in the alveolae. The remaining buccal gap to the buccal bone wall was less than 1.5 mm so that no further attention (fill) was requested.

Implant in position 11 was performed ad modum flapless surgery. Once drill protocol as recommended by the manufacturer has been performed a Biohorizons Ø4.0mm x 12mm external implant could be seated.

Successful three-dimensional implant placement was performed following the criterias mentioned in the introduction. Bone and soft tissue healing went extremely well also due to available thick gingiva phenotype.

**After treatment**

Allocated healing time was five months. Second stage surgery was performed under local anesthesia. Temporary abutments were screwed in place and temporary crowns performed. The emergence profile could be nicely shaped during the next visits.

Impression was taken once optimal conditions were achieved. The technician manufactured three zirconia abutments. The final impression was taken and the final restoration were delivered after a try-in session with bisque bake.

The final crowns were cemented while a retraction cord in place to enhance cement excess removal. Occlusion was checked and patient received hygiene instructions. Recall sessions were scheduled.

**Conclusion**

It is of course only of anecdotal value to use a case presentation to exemplify the achievement of predictable aesthetics with conventional implant systems, but doubts might raised today about statements and claims made by modern implantology.

The author recommends the following criteria as mandatory:

- Good treatment planning
- Adequate protocols
- An excellent team (surgeon, restorative and laboratory technician) for predictable long-term success

**About the author**

Dr Liviu Steier (FDS) is Specialist fir Prosthesis (www.dgzmk.de) and specialist in Endodontics (GDC-UK). He is an honorary clinical associate professor at Warwick Medical School and course director of the MSc in Endodontics (www.warwick.ac.uk/go/dentistry). He is a member of the Scientific Advisory Board for the Journal of Endodontics (AAE) and maintains a private referral practice for endodontics, implantology, etc at 20 Wimpole Street, W1G 8GF London (www.msdentistry.co.uk).
Using resorbable barriers to make root recession coverage predictable
By Drs David L Hoexter, Nikisha Jodhan and Jon B Suzuki

Gingival recession is defined as the location or displacement of the marginal gingiva apical to the cementoenamel junction (CEJ). Recession is the exposure of root surface, resulting in a tooth that appears to be of longer length. From a patient’s perspective, recession means an unaesthetic appearance and is associated with aging. The gingiva consists of free and attached gingival tissue, as seen macroscopically.

The free marginal gingiva, located coronal to the attached gingiva (AG), surrounds the tooth and is not attached to the tooth surface. The AG is the keratinised portion of gingival tissue (KG) that is dense, stippled and firmly bound to the underlying periodontium, tooth and bone. In ideal health, the most coronal portion of the AG is located at the CEJ, where the most apical portion is adjacent to the muco-gingival junction (MGJ). The MGJ represents the junction between the AG (keratinised) and alveolar mucosa (non-keratinised).

Reasons for recession
There are numerous etiological factors that may result in recession. Generally, the etiology can be categorised as either mechanical or as a function of periodontal disease progression. Recession usually occurs due to tooth malposition\(^1\),\(^2\), alveolar bone recession\(^3\),\(^4\), high muscle attachments and frenal pull\(^5\), and iatrogenic factors related to restorative and periodontal treatment procedures.\(^6\)

The detrimental effects of recession include compromised esthetics, an increase in root sensitivity to temperature and tactile stimuli, and an increase in root carries susceptibility due to cementum exposure. Thus, the main therapeutic goal of recession elimination is gingival root coverage in order to fulfill esthetic demands and prevent root sensitivity.

Miller classifies recession defects into four categories:
- Class I: marginal tissue recession does not extend to the MGJ
- Class II: marginal tissue recession extends to the MGJ, with no loss of interdental bone
- Class III: marginal tissue recession extends to or beyond the MGJ; loss of interdental bone is apical to the CEJ but coronal to the apical extent of the marginal tissue recession
- Class IV: marginal tissue recession extends beyond the MGJ; interdental bone extends apical to the marginal tissue recession.\(^7\)

A possible treatment modality for recession includes restorative/mechanical coverage, such as cer-cival composite restorations. This kind of treatment may effectively manage root sensitivity and root carries. However, such treatment entails a long-term compromise from an esthetic perspective. Composite restorations stain over time, and any marginal leakage may lead to secondary caries, recurrence of sensitivity and/or local inflammatory changes.

Additionally, colour matching can be difficult and such restorations may involve the undesirable removal of vital tooth structure in order to create adequate retention form. Thus, clinicians must determine whether the restorative benefit outweighs the esthetic shortcomings and whether it is possible to employ a treatment modality with few, if any, functional and esthetic disadvantages.

Muco-gingival surgery
Another treatment modality for recession is muco-gingival surgery. Muco-gingival surgery refers to periodontal surgical procedures designed to correct defects in the morphology, position and/or amount and type of gingiva surrounding the teeth.\(^8\)

In the early development of muco-gingival surgery, clinicians believed that there was a specific minimum apical-coronal dimension of AG that was necessary to maintain periodontal health. However, subsequent clinical\(^9\)\(^-\)\(^13\) and experimental studies\(^14\)\(^-\)\(^17\) have demonstrated that there is no minimum numerical value necessary.

However, for esthetics, a uniform colour and value of AG is desirable among adjacent teeth.\(^18\) Some of the earliest techniques for correcting recession involved extension of the vestibule.\(^19\) The subsequent healing usually resulted in an increase of AG. However, within six months, as much as a 50 per cent relapse involves.

**Fig. 1:** Preop labial view of anterior teeth. The GTR membrane was shaped and placed over the root surfaces of teeth #6 and #7.

**Fig. 2:** Flaps reflected preserve the interproximal tissue, which preserves the blood supply and prevents black triangles (unesthetic interproximal spaces).

**Fig. 3:** The GTR membrane was shaped and placed over the root surfaces of teeth #6 and #7.

**Fig. 4:** Gingival tissue was normally repositioned, covering the membranes and the roots of teeth #6 and #7, and sutured in place.

**Fig. 5:** Post-op labial view: the previously recessed roots of teeth #6 and #7 are covered with attached pink, keratinized gingival tissue, with no pocket depth upon probing.

**Fig. 6:** Pre-op labial view of anterior teeth.

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of the soft tissue position was reported. Thus, these techniques did not adequately address recession.

In order to improve esthetics and increase KG for root coverage procedures, current periodontal surgery largely involves the use of gingival grafts. There are a multitude of surgical techniques, which can be distinguished based on the relationship between the donor and recipient sites.

Gingival graft procedures involve either (a) pedicle soft-tissue grafts, which maintain the pedicle blood supply or (b) free autogenous soft tissue grafts. Techniques involving the latter type require the clinician to prepare two surgical sites: one to harvest the tissue and another to prepare the recipient site.

In this case, the autogenous soft tissue graft has a separate blood supply to the recipient site. Combinations of (a) and (b) have also been reported.[26][27]

Soft-tissue grafts

The pedicle soft-tissue graft was first described by Grupe and Warren in 1956.[6] This involved raising a full thickness flap and laterally positioning and then raising a full thickness flap and also been reported.

Combinations of (a) and (b) have also been described more recently. In 1992, Pino Prato et al. described a combination technique of subepithelial placement of a membrane with coronal advancement of the flap, such as e-PTFE.[28]

The function of the membrane is to maintain space during the healing period for tissue regeneration to occur. From a patient’s perspective, biodegradable membranes with GTR technique have also been used. For instance, when a connective tissue graft is employed, the graft is placed sub-epithelially with a coronal advancement of the overlying keratinised tissue. GTR techniques have also been developed more recently. In 1992, Pino Prato et al. described a combination technique of subepithelial placement of a membrane with coronal advancement of the flap, such as e-PTFE.[28]

Procedures combining both free grafts and pedicle techniques have also been detailed. For instance, when a connective tissue graft is employed, the graft is placed sub-epithelially with a coronal advancement of the overlying keratinised tissue. GTR techniques have also been developed more recently. In 1992, Pino Prato et al. described a combination technique of subepithelial placement of a membrane with coronal advancement of the flap, such as e-PTFE.[28]

Later modifications of the technique included the double papilla flap[29]—introduced by Cohen and Ross in 1968—and the oblique rotational flap[30] and the rotational flap.[31] Another type of gingival movement flap was described later as the coronally repositioned flap.[32] This technique involves mobilising a full thickness flap and repositioning the tissue to the CEJ, thereby covering the exposed recession.

The use of free gingival flaps was described in the 1960s by Sullivan and Atkins.[6] The free autogenous graft can be made up of either gingival or gingival plus connective tissue. Initially, the therapeutic goal was to increase the zone of KG. The clinical objective was to evolve to covering the recessed root with a zone of attached KG.

This can be achieved in one or two stages. Initially, Sullivan and Atkins described a one-stage procedure in 1968. Its purpose was to increase the zone of KG without concentrating on coverage of a recessed root. In the 1980s, a two-stage modification was suggested for an increase in root coverage, which proved to be more successful with increased predictability. This involves first placing the free gingival graft or the free connective tissue graft apical to the area of recession and using the coronally repositioned technique after healing.

Autogenous grafts

Freeautogenous grafts are predominantly harvested from the palate. Recently, materials other than gingival grafts have been explored. Using a guided tissue regeneration (GTR) technique, an acellular dermal matrix has been reported to yield favorable outcomes in root coverage.[33] This material may provide the patient with a less invasive alternative than a palatal donor site in order to achieve root coverage.

The coronally repositioned flap was sutured in place with the flap covering the zone of KG. Upon examination, the desired flap movement was achieved. Upon periodontal probing, no pockets were present (Fig. 5). The final view presents a visual symmetry of health and colour that is maintainable.

Recession was also present at the maxillary left side (teeth #11 and #12; Fig. 6). After local anesthesia of the areas involved, a full thickness mucoperiosteal flap was completed. This exposed the extent of the recession defect (a). Tooth #11 was treated, as was the other side of the mouth, by utilising the GTR technique using an acellular connective tissue membrane to preserve the space for regeneration.

Fig. 2: Cervical groove on tooth roots solid, hard and non-carious.

Fig. 3: Gingival tissue coronally repositioned over the GTR membrane on tooth #9 and tooth #10.

Fig. 4: Post-op view: tooth #9 only; no membrane was placed on the surface of the recession of tooth #10.
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Know your patients

It’s important that you get all of the information you need when you meet a patient for the very first time, says Dr Michael Sultan

In dentistry, as in any medical field, it is advantageous to be as well informed about the patient as possible before proceeding with treatment.

The initial communication a practitioner has with their patient is often the most important, as this is the stage that the patient will form their first thoughts about the professional, and decide whether or not they feel comfortable with them. With this in mind, communication should be non-intrusive, open and sensitive, and accommodate active listening and acknowledgement of the patient’s concerns.

Dig deep

It is important to gain as much information about the patient as possible before they even get into the chair. This ensures the professional is armed with information on the patient’s medical and dental history, any fears or phobias, and the patient’s needs and desires for treatment from the very start. This allows the practitioner to offer a more tailored treatment plan, and any additional support, such as sedation or distraction techniques, should be required.

The whole dental team should be involved in the initial communication with a patient. After all, it’s not just the practising dentist who is seen! Many patients will be very nervous of a visit to the surgery, so a casual chat with a friendly receptionist, or a conversation with the dental nurse about the upcoming procedure before arriving at the surgery can often help put their minds at ease.

All patients want to deal with people who are empathetic to their situation, so an initial meeting with a team that is warm and friendly is one of the best ways to help relax a nervous patient. One of the key members of staff in this situation is the dental nurse. Ensuring that you have a strong nursing team is very important, as the nurse is the person who will be there to hold the patient’s hand and offer reassurance. Nobody can be taught how to offer this kind of support, so ensuring you have a compassionate and personal nursing team definitely makes the dentist’s job much simpler!

Address patients’ concerns

Good communication before an appointment can help patients to air any concerns or fears they have about a procedure. Concerns should never be ignored – acknowledging a patient’s anxieties and reassuring them that they are understood, and that you are prepared to tailor a treatment plan to ensure that they feel as comfortable as possible shows compassion.

While the personal approach is vital when a patient is in the surgery, the advent of modern technology has simplified the process of gathering initial information from patients. I have included a section on my website where referring practitioners can provide detailed information about referrals, so by the time a patient enters my surgery, I already have a comprehensive document detailing the patient’s previous dental care. This is incredibly useful when putting together treatment plans, however must be followed by a face-to-face conversation during the initial consultation!

A good relationship

If receiving a referral patient, working closely with the referring practitioner is vital – after all, the patient’s own dentist knows the most about the patient. Maintaining a good relationship also helps relax the patient, and they feel that the team they are visiting is an extension of their own practice. I often tell patients to imagine that they are visiting is an extension of their own practice. I often tell patients to imagine that they are visiting my team and I are just another room in their own surgery – everything they know and trust is the same, and I we are simply an extension of their own practitioner’s team.

Occasionally you will experience a patient who is reluctant to offer any personal information. I would advise to proceed very carefully in this situation. Personally, I refuse to treat any patient who refuses to provide medical details, as a lack of information in this area can put everyone involved at risk. It is more difficult when discussing less clinical details, as many patients feel that their personal information is not needed to carry out dental treatment.

In many ways, this is the case, however I believe that the more I know about a patient the better the procedure. The relationship between practitioner and patient needs to be one of trust and respect, and I believe that it is very difficult to feel this way about a patient when all you have in your chair is the equivalent of a sheet of medical facts. Of course, knowing your patient’s favourite colour is slightly too much detail, but a certain amount of personal information is useful!

For example, if a patient doesn’t like the taste of mint, you can accommodate by using an orange-flavoured toothpaste instead – thus making the experience a more pleasurable one! Details like this help ensure that a patient leaves the surgery feeling that they have experienced a good service, and are not likely to be as apprehensive should they have to return.

Communicate clearly

I firmly believe that the relationship between patient and practitioner is one that should be nurtured, and good communication from both is vitally important.

I firmly believe that the relationship between patient and practitioner is one that should be nurtured, and good communication from both is vitally important. The patient is likely to receive better treatment, and by humanising the practitioner, the patient is likely to feel more relaxed and comfortable in the chair.

About the author

Dr Michael Sultan BDS MSc DFO is a specialist in Endodontics and the clinical director of EndoCare. Michael qualified at Barts, University in 1986. He worked as a general dental practitioner for five years before commencing specialist training at Guy’s hospital, London. He completed his MSc and in Endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPO, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 1999, he became clinical director of EndoCare, a group of specialist practitioners. To talk to a member of the Endocare team call 020 7224 0999 or email reception@endo- care.co.uk or for more information please visit www.endoscare.co.uk.
A helping hand
A difficult situation, a chance meeting and a world of difference made possible by KaVo

It is not an easy thing to admit that a helping hand would be nice, but sometimes it’s just what you need.

And that’s exactly what happened for Peter Soin, dental surgeon, practice principal and student on the MSc in Restorative and Aesthetic Dentistry.

Peter, who qualified from the University of Liverpool in 1995, owns two practices - one NHS and one soon to be developed private cosmetic practice. He says: “I’ve been committed to the NHS for the last 15 years but as time has gone and so many things have changed I’ve been beginning to feel a little bit lost and I have been searching for a way to bring myself closer to dentistry.”

To achieve this, Peter chose the new offering from Smile-on and The University of Manchester, a two-year MSc in Restorative and Aesthetic Dentistry that is provided through online webinars, to allow students the flexibility to study wherever they are. “The MSc was something I would be able to manage because of my experience and my familiarity of many of the key components of the course and I felt that a degree course of this kind would give my career the focus it needed. “The MSc has allowed me to not only to develop the cosmetic side of my career and be a fantastic refresher on other subjects to bring me up to current standards of dentistry, but also has enabled me to pick a new part of dentistry and focus on it.”

Though, like many students, Peter’s plan hasn’t quite followed the script! “I’m loving it. I thought I’d picked a course that would be easy for me, but that hasn’t been the case! I have had to work a little harder than I’d expected, which has been a challenge in itself managing my time around my work and my life, especially with three children and a newborn!”

Despite the love for the course, there was more than just the time issues making life difficult for Peter. An increased commitment to his study meant a decrease in his clinical working time, as well as being the sole earner while his wife is on maternity leave. This has meant extra purchases such as a clinical digital camera for recording of his case studies an extra burden. This is where a chance meeting at the recent Clinical Innovations Conference gave him the helping hand Peter needed. “There was a discussion at this year’s Clinical Innovations Conference about the availability of bursaries for students in the 2011 MSc uptake. I had a discussion with Noam Tamir, Director at Smile-on, about how a bursary would be very useful to a student such as me on this year’s course.

“I was later contacted and offered a bursary of £1,000 from KaVo. This bursary is exactly what I need right now and has been absolutely invaluable.”

Peter is very honest about what the KaVo bursary has meant to him. “It has meant that I have been able to buy a camera I need for the MSc without having to hold that money - it’s just taken some of the pressure off. At the start off the course I had to get the camera and I’ve been putting it off for as long as possible and now it means I don’t have to worry.

“This is a very generous gesture by KaVo - as a practitioner for 15 years I have been a user of KaVo products and have always been very happy with them. But to give me this bursary with no direct contact is very kind and shows their strength to be able to support practitioners in this way. It’s funny, a bursary is something you think of giving to a 25-year-old dentist just starting out, but everyone is struggling and this has made a world of difference to me.”

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Dealing with difficult patients

How do we care for our more awkward patients without giving in to their demands and having to care for them too much? Mhari Coxon finds out how to strike the balance

I have a patient who I am very fond of, but our appointment always starts the same way. He will walk in to the room and immediately announce that I am going to be annoyed with him and disappointed at the state of his mouth. Hackles raised, I calmly reply that no, I won’t be annoyed or disappointed with him, as it is his health not mine.

He sometimes even says: “I know what you are going to say, that you are not cross with me, but it must be disappointing to have a patient like me.” After unclenching my jaw, I reply that if there is any disappointment, it is because you feel so guilty at letting me down.

After a few minutes of this, he usually says: “Yes, I know it is my health, and I am only letting myself down, but how can you not care? You are such a hard woman.” I explain that I have more than 1,000 patients whom I treat and I cannot be responsible for each individual’s health, as it would be too heavy a burden for my shoulders. This does not mean I do not have empathy for patients. I do care; just not on the level he would like me to.

Same old score

We then do our usual bleeding score and BPE, followed by plaque score, all of which are in the ‘just getting away with it’ section and have been there for over a year now. Once he sees he is not getting worse he is more relaxed and we go over all his hygiene routine, usually deciding that all is manageable and it is just a case of implementing it regularly.

To register contact:
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ITI Education International
Peter Merian Weg 10
CH-4052 Basel, Switzerland
education@itcenter.ch
www.it.org/educationweek
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The UCL Eastman Dental Institute is a major centre of excellence at the forefront of evidence-based clinical service, research and education in the oral health care sciences.

Course details

This six-day ITI Education Week has been designed for clinicians who wish to acquire further knowledge in basic and advanced treatment techniques in implant dentistry through an evidence-based approach. The course will be delivered through lectures, surgical and prosthetic simulated hands-on workshops, exposure to live procedures and interactive treatment planning sessions.

Topics

- Current principles of bone and soft tissue integration around dental implants
- Patient risk assessment (surgical and prosthetic aspects)
- Smile design and treatment planning considerations for patients with demanding aesthetic needs
- Advanced treatment planning using radiographs and 3D imaging (lecture and workshops on radiographs and 3D images)
- Prosthetic principles and loading protocols in implant dentistry
- Basic surgical and prosthetic workshop (tissue level & bone level implants)
- Guided bone regeneration
- Alveolar ridge preservation vs. immediate implants
- Piezoelectric bone surgery for intra-oral bone grafting and implant site preparation
- Advanced soft tissue management by means of periodontal plastic surgery
- Provisional restoration and final prosthesis in the aesthetic zone
- Implants in periodontal and systemically compromised patients
- Management of peri-implantitis and supportive/maintenance therapy
- Case presentations with interactive treatment planning exercises and case discussions

We have to guide them to a state of awareness of a need to change before we can begin to introduce choices for them.

As a highly intelligent lawyer, he is used to fighting his corner and I have not found a way of breaking this cycle: we have fallen into. We discussed it after our last appointment and he said it was his own need to succeed at everything that led him to be hard on himself about his own hygiene. So, after our last maintenance session a few weeks ago I have been looking into ways of dealing with this cycle so we can both progress and I can keep my blood pressure where it belongs.

How to deal with difficult patients

I am loathe to use this as a heading, because I am so fond of this patient and his family. But, it is a tiring start to the day (he is always an 8am patient) and if I can make it easier for both of us, it would be good. I also believe the only way we can make progress is to stop this cycle. So here are a few tricks we should avoid:

- Don’t take difficult patients’ behaviour personally. It is often habitual and affects most people with whom they come in contact. This does not mean they
are not worth having as a patient.
• Don’t try to cater to them. Appeasing difficult people can feed their insatiable appetite for more. It can lead to what we call a “black-hole client” who will suck all your energy during their visits for very little return. (I bet you are thinking of one now!)
• Don’t fight back or try to beat them at their own games. They have been practicing their skills for a lifetime, and you’re an amateur. Sometimes not responding at all and changing the subject can work very well with this.

Finally and most importantly I think:
• Don’t try to change them. You can only change your responses to their behaviour. While a patient is going through the motions, they will not be responsive to any attempts to change their behaviour. We have to guide them to a state of awareness of a need to change before we can begin to introduce choices for them.

Dealing with overly aggressive people
Thankfully this is not a daily occurrence in most practices, but it is very unpleasant for those facing it. Abuse of staff should not be tolerated and the principal should always side with their staff in this situation. The best solution, however, is to avoid the confrontation completely.

Stand up to them, but don’t fight. Overly aggressive people expect others to either run away from them or react with rage. Your goal is simply to assertively express your own views, not try to win a battle of right and wrong.

First, wait for the person to run out of some steam. Sometimes writing down their complaint is a good way of defusing them. Then call the person by name and assert your own opinions with confidence.

There are many other types of negative behaviour that we can stop with good patient-management skills.

It is helpful to go on courses from time to time to enable us to deal effectively with this type of issue and it improves our complaints-handling skills if we are all aware of how we deal with certain situations. Ursula Markham’s book How to Deal with Difficult People is great. You could read it and discuss it as a group, with clear outcomes and a chance to feedback. What’s more, you will have completed verifiable CPD, as well as making your working environment easier.

So, next time you look at your day list and see a name that makes you groan, think of how you can break the cycle, so they do not get the result they desire, which stops the behaviour that can be so draining. Go on; give it a go – it just might make your day.

About the author
Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSCDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@cpdfordcp.co.uk.

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Dietary analysis consists of two elements. *Enquiry into lifestyle.* *Enquiry into dietary components themselves.*

Information about the diet itself is of little value unless it is taken in context with the patient's lifestyle. Only dietary recommendations tailored to the patient's life are likely to be adopted. The diet record should include all the foods and drinks consumed the amount and the time of eating or drinking. Every morsel eaten and every drop that has been drunk. The diet record should include all the foods and drinks consumed, the amount in readily estimated units and the time of eating or drinking.

Analysis of the diet itself may be performed in a variety of ways. The patient can be asked to recall all foods consumed over the previous 24 hours. This is not very effective, relying on a good memory and honesty, and is unlikely to give a representative account. Relying on memory for more than 24 hours is too inaccurate.

The most effective method is to keep a written record of their diet for four-five consecutive days, including two working days and two leisure days. The need for the patient to comply fully and assess their diet honestly must be stressed and, of course, the diet should not be changed because of it being recorded. Ideally the analysis should be performed before any dietary advice is given. Even the patient who does not keep an honest account has been made more aware of their diet. If they know what foods to omit from the sheet to make their dentist/ oral health educator/dental nurse happy, at least the first step in an educative process has been made.

How to analyse a diet sheet

Highlight sugar rich foods and drinks

Note whether they are confined to meal times or whether they are eaten frequently and spaced through out the day as snacks.

The number of sugar attacks should be counted and discussed with the patient. Also the consistency of the food because dry and sticky foods take longer to be cleared from the mouth. Sugared drinks taken immediately before bed are highly significant because salivary flow is reduced during sleep and clearance time is greater. Identify foods with a high hidden sugar content because patients often do not realise that such foods are insignificant: ex. Baked beans

• Breakfast cereals
• Tomato ketchup
• And plain biscuits

If the diet sheet shows the main problem for the patient is too much sugar contains drinks and frequent drinks and carbonated drinks. Most meals or snacks contain high sugar item and some more than one. The patient needs to be educated in safer diet. The patient should be educated in the relationship between caries and high frequency in consumption of sugar.

The dental profession has been aware for over half a century that the frequency of sugar intake is far more significant in the development of caries than the amount consumed at any given time.

Advice based on Diet Diary

• Particularly those containing sugar. It is important to give the same advice as other health professionals such as dieticians and health visitors, who are concerned with other aspects of health, such as obesity. But it is rare that patient opt to have a healthy diet having concerns about their teeth rather than size.
• Dental profession has suggested that plain crisps, peanuts and cheese are tooth-friendly alternatives to sweet, biscuits and confectionery. When reading labels, it can be seen that some nut snacks contain hidden sugars, and this should be pointed out to the patients.
• Should always check and liase with the patients medical condition. Some must have been a told by their health professionals to avoid such foods for other health reasons. Advice always must be balanced and accurate.
• Particularly school children and adolescent require frequent intake of carbohydrates to sustain energy. In such cases it is essential to mention frequent snacks such as pasta, bread and toast, bread sticks fruit and raw vegetables.
• Public has raised awareness of hidden sugar and salt with the current trend towards healthy eating. It is important to be able identify hidden sugars (eg. Glucose, Fructose, dextrose, maltose, lactose and molasses) to look for these on food labels.
• The relationship with such food can contribute to obesity and heart disease as well as caries and behavioural disorders.
• The use of artificial sweeteners is increasing as the public becomes more diet conscious, since their low caloric value means that they are virtually non-cariogenic and non-fattening. Sweeteners can be of synthetic or natural origin.(eg. xylitol, a plant extract)

Facts: The advice below can elaborate on it more.

*Reduce the amount of sugar.

Check manufacturers labels and avoid foods with sugar such as sucrose, glucose and fructose listed. Natural sugars (eg honey, brown sugar) are as cariogenic as purified or added sugars. When sweet foods are required, choose those containing sweetening agents such as saccharin, ace- sulfame-K and aspartame. Diet formulations contain less sugar than their standard counterparts. Reduce the sweetness of drinks and foods. Become accustomed to a less sweet diet overall.

*Restrict frequency of sugar intakes to meal times as far as possible.

Try to reduce snacking. When snacks are required select safe snacks such as cheese, crisps, fruit or sugar free sweets, such as mints or chewing gum(which not only no sugar but also stimulates salivary flow and increases pH). Use artificial sweeteners in drinks taken between meals.

*Speed clearance of sugar from the mouth.

Never finish meals with a sugary food or drink. Follow sugary foods with a sugar free drink, chewing gum or a protective food such as cheese.

The dietary advice is almost always provided using the health belief model of health education. How ever it is well known that education about the risks and consequences of lifestyle, habits and diet is often ineffective. It is important to judge the patients likely compliance and provide dietary advice which can be used to make small but significant changes rather than attempting to eradicate all the sugar from diet. As the diet improves, the advice can be adopted and extended. Advice must be acceptable, practical and affordable. In this case the patient has already suffered consequences from his poor diet and this may help change behaviour.

The patient must be made aware that damage to teeth continues up to 20mins to 2hrs of sugar intake. The statement should comprehend with Stephan curve without difficulty.

The Stephan Curve describes the change in dental plaque pH in response to a challenge. The type of challenge does not matter but it is usually some element of the diet.

Characteristically the Stephan Curve reveals a rapid drop in plaque pH, followed by a slower rise until the resting pH is attained. The time course varies between individuals and the nature of the challenge.

The initial drop is usually rapid with recovery being sustained within a very few minutes. However, plaque recovery can take anything between 15 and 40 minutes depending to a large extent on the acid-neutralising properties of the individual's saliva.

The patient should be advised to use fluoride containing toothpaste. During the period of dietary change it would also be beneficial to use a weekly fluoride rinse as well. This could be continued for as long as the diet is felt to be unsafe.

Oral hygiene instruction is also important in view with elaborating importance of diet.

The Committee on Medical Aspects of Food Nutrition Policy established in 1986 in the UK. It is the panel on Dietary sugars to look at the role of the sugars in the diet. Make sure all the patients are very welcome to do their own research. Amongst the panel recommendations:

• The frequency of sugary snacks and drink consumption should be minimised.

• Food and drinks that predispose caries should be limited to main meal times. This is specially important for older dentate people, children and adolescents.

Conclusion

According to the UK Department of Health 'Eating a healthy, balanced diet which contains plenty of fruit and vegetables and is low in fat, salt and sugar and based on whole grain products, is important for promoting good health.'

Food is the fuel which provides energy for the cells of living organisms to grow, reproduce and eliminate waste: and if the cells of the body are to function efficiently, all the nutritional substances must be consumed in the correct proportions.
New Owandy Vistex Intra-Dental X-Ray System

Vistex is pleased to announce a new Digital Intra-Dental System featuring unique USB connectivity and both size 1 and size 2 CMOS sensors. Both sensors have either a hard wearing cable connection for the removability of the cable to the back of the sensor for easy ergonomic handling in the mouth or the sensor connected to the computer via a simple and efficient cable. The Vistex features a simple and efficient cable that will allow for the cable to be woven through the patient's mouth easily.

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Dentists must come across this frequently; patients whose own reluctance to seek out treatment then leads to them experiencing long lasting and often irrevocable damage to their oral health. If only the patient had faced their fears and broken the vicious cycles of fear and anxiety, a great deal of stress and pain could have been avoided.

A very common scenario is that the contributing factors that led to the undesirable situation, had been culminating over a long period of time. Often the person will be unaware of the slow evolution that leads into a situation that becomes as uncomfortable as a familiar old pair of slippers. This is seen a great deal in work places, particularly where practices have evolved as a reaction to developments in techniques, materials and equipment, as opposed to focusing on and planning for the future.

If you are a dentist, please take a moment to consider and review your current surround ings. Would you say that it has been specifically designed for the task? Or has it instead evolved over time as a reaction to circumstances? If your response falls into the latter category, then its being fit for purpose could certainly be called into question. The reiteration to make change can be identified by several characteristics...

Complacency – the idea that something ‘will do’ (but rarely does)

Unfortunately, this attitude is in every way counter-productive. Countless people take it to work with them each day, because it serves a useful purpose as a denier and complacency go. Aside from the fact that this philosophy acts as a damper to feelings of discontent and discontent, it also has, without a doubt, an unseen negative impact on the fruits of your labour. Consider the reaction of a client to the quality of a piece of surgery if the dentist had taken a ‘that’ll do’ attitude to the procedure. It is always worth seeking a company dedicated to excellence and who take pride in the work being carried out. It’s fair to say that most people have an expectation, particularly within the work place due to the knock-on effects with regards staff and clients. It goes without saying of course that any company worth its weight is going to strive to ensure that the minimum disruption to daily business is avoided.

Arguably the most likely reason that people avoid a much needed refurbishment is the cost. This is totally understandable but not a good enough excuse! What is important is that the right company is chosen to do the job and warrant your hard earned money being spent. Additionally, thinking about the refurbishment from the perspective of investment rather than ‘cost’ is vital as it really will pay off.

Something worth considering is how great the impact of an uncomfortable workspace is on production and quality of the products being produced. No one is able to work to the best of their abilities in outdated and unsuit able environments. It is naïve to expect someone to work effectively with substandard work areas and unsuitable equipment and it not have a detrimental effect. The most prevalent effect will be to lower morale and heighten complacency, neither of which is conducive to productivity. With the ever-increasing array of guidelines and regulations holding sway over the dental profession, ensuring the current workspace is up to standard may well become even more expensive in the long run, particularly if ‘it’ll do, let’s just mend it’ attitude is employed.

This can be avoided. By providing staff with up-to-date, modern equipment, productivity will blossom and the state of morale will soar. The new environment will undoubtedly improve working conditions, and will inspire all who work in it, therefore increasing productivity.

In order to take the most stress-free route to refurbishment, there are several key points to consider when looking for a company to carry out your refurbishments. Firstly, has the company got experience in hais ting with sub-contractors? This is something that will make a huge difference in ensuring that all aspects of construction are carried out smoothly. Next, think about recommendations. Does this company boast an experienced team of fitters who will do a fantastic job? This seems obvious, but hiring a team that can’t work effectively together is the most counter-productive move you can make. Thirdly, does the company have enough experience to form an excellent relationship with the client and to provide a service that is both professional and carried out with enthusiasm?

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About the author

Peter Higson Tavom UK. Coming from a Facilities Management background within the Hotel & Restaurant industry, Peter Higson has been in the dental industry for 55 years. Age 40 and married with two Children and Lives on Farm in Cheshire. Having previously worked in Capital Equipment Sales and Surgery Design, Peter has been the Sales Director for Tavom UK for the last 4 years.
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From the Banana Dash to Human Demolition games, it’s a Knockout is described as ‘a sports day for grown ups’ and will feature many of the games from the classic 1970s TV show. It’s a perfect event to get your team or practice involved in. Teams can vary in size from between six and 10 people at £500 (minimum) sponsorship per team.

The funds raised will be vital for Bridge2Aid’s training programme in emergency dentistry, as CEO Mark Topley explains: “Our training programmes this year will give access to simple, pain relieving dental treatment to almost half a million people in East Africa. But this only possible with funds donated by our ‘Friends of Bridge2Aid’ and raised by events like ‘It’s a Knockout’. I hope that many practices and teams will join us for what promises to be a great day out having fun and making a big difference to the poor rural communities where Bridge2Aid works.”

Let the fun begin!
The games will start from 11am to 5pm at Aston University’s sports ground. There’ll be a cash bar and barbecue to enjoy, as well as plenty of shower and changing facilities. Spectators are more than welcome to help cheer on their favourite team and looking silly and having fun is definitely compulsory – in fact, extra points will be rewarded to the best-dressed team!

If you’d like to take part, contact us soon to register. There are limited spaces available, and you don’t want to miss out on what will be a fantastic day!

For more information and to register a team, please call the Bridge2Aid office on 01245 780102 or email Naomi at fund-raising@bridge2aid.org.

About the charity
Bridge2Aid (BZA) is a dental and community development charity working in the Mwanza region of North West Tanzania. We started full-scale operations in 2004 and work closely with the Tanzanian Government to deliver aspects of their dental strategy. We operate a not-for-profit dental clinic in the city of Mwanza (Hope Dental Centre), and have a community development programme for the disabled community based at Bukumbi Care Centre.

Our focus is sustainability – empowering local people to improve their own lives over the long term. We have Trustees and administration in the UK and we are a UK registered charity no. 1092481. Bridge2Aid is a registered Non-Governmental Organisation (NGO) in Tanzania with additional Tanzania-based Advisors.

The four key aspects of Bridge2Aid’s vision are:

• To provide primary dental care and oral health education to communities in Tanzania
• To equip and further train local health personnel to provide emergency dentistry to rural communities
• To care for and empower the poor and marginalised in Tanzanian society
• To provide opportunities for UK dental professionals and others to use their skills to serve Tanzania, as locals or participants on the Dental Volunteer Programme (DVP).
“Give me something that works fast and I might be interested”

Patient, UK

Sensodyne Rapid Relief – rapid* and long-lasting** relief from the pain of dentine hypersensitivity¹,²

The strontium acetate formulation of Sensodyne Rapid Relief forms a deep occlusive plug within the dentinal tubules³,⁴ providing:

• Clinically proven relief¹,²
  Works in 60 seconds*¹
• Proven long-lasting relief with twice daily brushing²
• A deep, acid-resistant occlusion³,⁴
• Fluoride to strengthen tooth enamel

The robust occlusion formed by Sensodyne Rapid Relief is still maintained after an acid challenge⁴

Unoccluded dentine  After treatment and a 30 second acid challenge  After treatment and a 10 minute acid challenge

In vitro study of dentinal tubule patency following an acid challenge (immersion in grapefruit juice, pH 3.3) applied after dabbing and massaging for one minute with Sensodyne Rapid Relief. Adapted from⁴.

Recommend Sensodyne Rapid Relief for rapid relief from the pain of dentine hypersensitivity

* when directly applied with finger tip for one minute  ** when used twice daily