Call me Dr, Dentist Dr

British Dental Association survey results show overwhelming clinician support for use of the courtesy title Dr

Four-fifths of dentists think it is appropriate to continue to use the courtesy title of ‘Dr’ according to a poll carried out by the British Dental Association (BDA). The survey, which was carried out as part of a discussion hosted on the communities section of the BDA website between late July and early September, attracted high levels of interest, being viewed more than 2,800 times.

The results of the poll will be used to emphasise the profession’s concerns in the BDA’s formal response to the General Dental Council’s consultation on the issue.

“This issue has generated unprecedented levels of interest from contributors to the BDA’s online communities. Participants have sent a very strong signal about their wish to continue using the title Dr. We have listened to them and will convey the strength of that feeling to the GDC in our response to its consultation on this issue,” Dr Susie Sanderson, Chair of the BDA’s Executive Board, said.

“It is clear from the contributions to this forum that, as long as it is made clear that the individual in question is a dentist, patients do not seem to be confused by the use of the title.’

A spokesman for the Department of Health said: “The title of “Doctor” is not a protected title, so you don’t have to be a medical practitioner to use it.”

He added, however, that there was a provision in the Dentists Act 1984, which prevented dentists from using any title or description to suggest a qualification that they did not have. A dentist was ordered by the Advertising Standards Authority (ASA) to remove the title of ‘Dr’ from their name as they failed to have a medical qualification or a PhD.

While dentists are not prohibited entirely from calling themselves Dr, the ASA says that to do so without also making it obvious that they are not doctors is a clear breach of advertising laws.

AOG

Business Management

Tribune

Clinical

Lose weight with milk

The American Journal of Clinical Nutrition has found that milk drinkers lose more weight than people who do not drink milk. Regardless of an individual’s diet, the study showed that people who had the highest intake of calcium from dairy products had a greater chance at losing weight. However, milk is not just beneficial for those who wish to lose weight. Dental health experts have emphasised for many years that milk is a source of calcium, which is necessary for maintaining good oral health.

IDA ignore EPA’s mercury warning

Today environmental groups applauded EPA’s announcement to propose a new rule requiring dentists to reduce mercury pollution. “Dentists are the largest polluters of mercury to wastewater,” said Michael Bender, director of the Mercury Policy Project and a steering committee member of the Mercury Policy Project said Michael Bender, director of the Mercury Policy Project and a steering committee member of the Mercury Policy Project Campaign. Twelve states have mandated best management practices and amalgam separators at dental clinics, which can eliminate 95 per cent -99 per cent of dental mercury released to wastewater. The EPA’s website states that: ‘When amalgam enters the water, microorganisms can change it into methylmercury, a highly toxic form that builds up in fish. Methylmercury is a well-documented neurotoxin, which can cause adverse effects on the developing brain.”

Fortunately, the American Dental Association continues to ignore the latest science on mercury from EPA’s website and say that: “Dental amalgam has little effect on the environment...[and] this amount is not in the form [of mercury] found in fish, which is the greatest concern.”

www.dental-tribune.co.uk

Dentists are now performing far less veneer procedures than they were two years ago according to the BDA. Less invasive techniques, such as quick-result braces, are on the rise as patients try to preserve their natural teeth. The survey found that half of all cosmetic dentists named the Inman Aligner, a removable brace, as the first choice in quick-result braces. Other high scorers were the Invisalign brace, which 22 per cent of dentists placed top, and the Clearstep or Six-Month Smiles, which one in seven said was the top performer.

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Local orthodontists trek their way to £3000

In the midst of some of the most beautiful views of the south, 50 employees from Total Orthodontics pulled on their walking boots and got on their shades as they headed out into the sunshine to take part in a 10 mile trek across the South Downs to raise £5000 for Hospice in the Weald.

The group of specialist orthodontists, who have been straightening the smiles of Sussex and Kent for more than 10 years, took part in the walk in memory of a much loved member of their team, Jenny Branner, who sadly lost her battle against cancer earlier this year.

Jenny was cared for by Hospice in the Weald, which provides specialist palliative care, advice and clinical support for people with life limiting illness, their families and the bereaved. With the cost for the average length of stay for a patient being £5000, the money the orthodontics raised was most definitely going to help.

Setting off from Arundel, the team made their way along the river to Amberley, where a much deserved pub lunch was waiting for them. However, the food and drink wasn’t the only thing that kept up the groups’ moral – much to the teams’ amusement, Director John Costello emerged from the pub dressed as a reindeer, a costume he had previously donned for the group’s Christmas party! Having laughed their way through lunch, the team trekked their way back to Arundel, albeit at a much slower pace, where everyone finished off the day with a well-deserved drink at the Black Rabbit.

Amanda Wyatt, Corporate and Community Fundraiser for Hospice in the Weald, said: “We very much appreciate Total Orthodontics raising £3000, the money the group raised was most definitely going to help.

As most events go though, the day wasn’t without injury! Assistant Operations Manager Dionne Ward slipped from a rope swing, breaking two bones in her leg. However, the money the group raised was sure to bring a smile to her face.

Alice Clarke, Marketing Executive, said: “It was far harder than a lot of us had envisaged and there were some very achy legs the next day! It was more than worth it though, everyone was in great spirits and nearly the entire company were there to show their support, with only a few members of the team staying behind to hold the fort.”

Kirsten Heasman, Accounts Assistant, said: “Not only were we raising money for a brilliant cause but the day provided a great opportunity for staff from our different practices to get to know each other. The walk was tough but very rewarding and the South Downs provided a stunning backdrop.”

At the end of the day, the trek was a great success; Exceeding their fundraising target the group of orthodontists is hoping to plan something even bigger and better next year.

Oral & maxillofacial surgeon awarded first joint research fellowship

The first joint training research fellowship has been awarded to Mr Andrew Schache, an oral & maxillofacial surgical trainee in Liverpool, by the Faculty of Dental Surgery at the Royal College of Surgeons and the Wellcome Trust for their support so that I can continue my research into the role of the Human Papilloma Virus (HPV) in mouth and throat cancer.

Mr Schache, a Specialist Registrar at University Hospital Aintree and the University of Liverpool, has been given joint research fellowship of £179,707 to conduct a two-year joint research fellowship of Human Dental Institute and the University of Liverpool, by the Faculty of Dental Surgery at the Royal College of Surgeons to support research into the role of HPV in oral and oropharyngeal cancer.

Several Smaller Grants Scheme prizes have also been awarded this year to the development of HPV positive cancers and to other smaller HPV research projects investigating the best test materials are among the research topics.

For further information about the Grants, Awards and Fellowships awarded by the Faculty of Dental Surgery, send a query to: http://www.rcseng.ac.uk/fds/grants-awards-and-fellowships.
Editorial comment

I am just back from Cardiff where Smileon has celebrated another milestone in its 10-year history with the official opening of a second office, located in the Welsh capital. The event was attended by both the CMO and CDO of Wales, Dr Tony Jewell and Dr Paul Langmaid respectively.

In true journalistic fashion I ‘collared’ Dr Langmaid and asked him about the state of dentistry in Wales and projects going forward to help improve the oral health of the Welsh population. The interview will be in Dental Tribune in an upcoming issue – keep an eye out!

As the beginning of registration with the CQC comes bearing down on the profession, there is still much confusion and anger amongst dental professionals.

The BDA has written a letter to the CQC requesting a meeting to help get clarity from the new regime that it says ‘lacks proportionality and fails to accord with the general principle of simpler regulation, that is, the avoidance of duplicated effort and multiple jeopardy’.

This may be over-sensationalising the situation, but it is clear that practices are not getting the new regulations. I hope that the CQC and the profession can deal with the confusion and make it easy for practices to adhere with the latest regulations.

B2A Unity Programme

Bridge2Aid, the dental and community development charity working in the Mwanza region of North West Tanzania, have announced the launch of their new ‘Unity Partnership’ for dental practices and businesses at BDTA Showcase.

The concept of the Unity Partnership is based upon the realisation that significant benefits, in terms of public profile and perception, will accrue to those dentists and dental practices involved in the Dental Volunteer Programme, where UK dentists work on a one-to-one basis with a Tanzanian Clinical Officer delivering an effective proven programme of training in emergency dentistry. The Clinical Officers are then equipped with instrumentation and sterilisation equipment by Bridge2Aid and supervised by a government District Dental Officer.

In order to be recognised as a Unity Partner, dental practices commit to the financial support of the training of a Clinical Officer to serve a community of around 10,000 people and the ongoing supervision of their work.

Bridge2Aid’s CEO Mark Tupley said: “We are very excited about the potential benefits the Unity Partnership can bring to all concerned. Many of our dental supporters have already testified to the rewards they have gained from working with us.

“The partnership will enable us to secure training for communities and extend B2A’s work throughout Tanzania.”

More details and the founder members will be announced at a launch press conference at Bridge2Aid/A-dec’s stand Q04, 11am on Friday 15th October at London Dental Showcase Excel.
Spending cuts see 1,700 job losses

According to reports, 1,700 members of NHS staff will be axed as part of government spending cuts. The Department of Health has not officially announced the job losses; however, they did regard any changes as “temporary”.

A spokesman for the DH said: “We are reshaping and improving public health strategies. There will be plenty of opportunities and jobs to be done in both national and locally-led public health service.

“The Government is committed to increasing the health budget in each year of this Parliament. We will spend that budget in a way that makes it a more effective and efficient service. As a result of the changes, the staff involved in the programmes will probably lose their jobs; this news was confirmed by a document published on the department’s intranet system, which revealed that funding for programme budgets would be stopped.

It is believed that the members of staff affected were employed to work at the Department of Health offices in London and other parts of the country; they were working to reduce the amount of money spent by the NHS by improving general health and reducing the burden caused by obesity, poor diet, alcoholism and smoking.

The human resources department of the DoH claims that around two thousand members of staff will be affected by the cuts. Only 500 of these are protected because they are civil servants employed on specific programmes.

The Department of Health said the budget for public health programmes is being reduced quite substantially to make it a more effective and efficient service for front-line services and direct patient care; however, critics have slammed the move, claiming that investment should be focused on cutting costs in the future by tackling serious health problems including obesity, regular drinking and smoking.

Dentistry firms unite for charity

Although Christmas may still be only just on the horizon, a number of the dental companies have come together to create a unique set of Christmas cards for the dental charity, Bridge2Aid.

The tailor-made cards are designed by plan provider Practice Plan Ltd. After being created through a brainstorming session in 2009 by the Bridge2Aid Corporate Friends, the Christmas cards most definitely have a unique look, and with all the proceeds going to helping the people of Tanzania, the Christmas cards are a refreshing change from traditional scenes, these cards have a worthwhile purpose!

The Bridge2Aid Corporate Friends, which includes A-dec (UK), Dentsply, Henry Schein Minerva, Practice Plan and Schulke, discussed how, as a group, they could work collectively to raise funds and awareness for the worthwhile charity.

They met to discuss a number of initiatives, including how to raise funds over the festive period, and as a result the unique card idea was formed. Styles, packaging and marketing were all discussed and now Practice Plan can excitedly reveal the unique African Christmas cards.

The cards cost £3.49 for a pack of 10, and all proceeds go directly to Bridge2Aid, which in turn goes straight towards helping the people of Tanzania.


AHA reveals smokeless tobacco danger

The American Heart Association (AHA) has revealed some shocking results with regards to smokeless tobacco products.

Their statement notes that smokeless tobacco products are not safe alternatives to smoking because they are associated with heart attacks, strokes and certain cancers. They have also suggested that due to the marketing of these products, smokeless tobacco products may initiate further tobacco use and perpetuate smoking.

GlaxoSmithKline (GSK) Consumer Healthcare, a leader in helping smokers quit and the marketer of nicotine replacement therapy (NRT) products, supports the findings of the American Heart Association (AHA).

Tobacco use, including smokeless tobacco, is the largest cause of preventable death and disease in the world. The proven way to reduce these health consequences is to stop using tobacco completely.

Even though NRT products have helped millions of people around the world quit smoking and, as a result, reduced their exposure to the risks of cancer and other smoking-related diseases, there are still concerns with regards to further health risks.

While the FDA is the final authority on the labelling of NRT products sold in the US, GSK Consumer Healthcare is committed to continuing to work with medical and clinical experts and the FDA to ensure that consumers have the best possible chance to quit smoking.

With quitting smoking being the single most important step smokers can take to improve their health, the development of innovative new products and support systems to improve the quit experience, with available for further health risks, is vital.
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Whiten with the speed of light.
With more than 9,000 different colleagues visiting the site during the month, GDPUK is busier than ever in the autumn and colleagues reading the forum are looking forward to the upcoming GDPUK Conference in Manchester (see http://www.gdpuk.com/Conference2010). Concerns about the CQC and HTM 01-05 continue to dominate discussions; these are clearly the topics at the top of the agenda for all dentists.

For many reasons, the enhanced Criminal Record Bureau check for dentists demanded by the CQC has raised ire amongst forum members. CQC spokesmen have always stressed that the role of the registration was to protect the public with regard to the premises – are they safe for the public and are processes and procedures correct? In other words, regulating the provider. The GDC remains responsible for making sure the public is treated and cared for by suitably qualified professionals, the performers. With the CQC needing to make all dentists have a further CRB check is questioned. All the forms necessary for this must be taken personally, by every single dentist, together with passport, photos and further proof of identity to a Crown Post Office. There are only 27 of these Post Offices in England, and many dentists will have to spend time traveling and queuing at that office, possibly a full day. For example, for the whole of Yorkshire, about two thousand dentists, there is one such Crown Office, in Leeds. Imagine the queues if all 2,000 visited on one day! As one senior notable colleague wrote in the forum “what sort of moron sits in their glass palace in Westminster and thinks up ideas like this?”

Back to the HTM 01-05 document that continues to dog the profession: One concern has been that washer disinfectors, in their final heat cycle, bake proteins (onto) only stainless steel instruments. In letters to colleagues in response to specific enquiries, the DH are now rebutting this, having commissioned research at the University of London. This research will be published in due course. Some GDPUK respondents still believe that it is best not to buy or use one of those machines, not needed to reach “essential requirements” but required to reach “best practice”.

In the same vein, a dentist wrote (in a dental discussion in another dental publication) that after 35 years in practice the latest wave of regulations, paperwork and interference were too much, and retirement beckoned – even though the dentist insisted he enjoys his daily work, and finds helping patients daily to be rewarding. I found it uncomfortable to read that so many agreed with his sentiments.

Creating new documents for consent to various procedures have been discussed, and will be shared in the files section of GDPUK. Apparently, when questions about this are put to lawyers, these days, they insist that risk of death is placed as the number one risk at the start of all these documents. Patients could have a reaction to local anaesthetic, and this reaction could ultimately be fatal, so perhaps this wording should be to all dental consent documents? Would you be comfortable warning every patient of this?

That is a sobering thought for us all.
Patient protection and value for money focus for GDC

The General Dental Council has spell out its priorities in its new corporate strategy, highlighting patient protection and value for money as its key aims.

The strategy 2010-2014 commits the GDC to delivering its regulatory functions as efficiently and effectively as possible within the next five years, screened 132 people and lead by members of the Oral Health Team. The strategy was launched online on the 23rd September 2010.

Recognising the importance of strong relationships with a wide range of people and organisations, the strategy sets out clear aims, putting patients at the heart of the GDC’s thinking.

Chair Alison Lockyer said: “This is an important step forward for the GDC in explaining its purpose, values, aims and objectives clearly and concisely to registrants and the public. Council members have shown their dedication and determination to drive forward change in order to further improve the GDC. We have re-affirmed our commitment to protecting patients and regulating the dental team - As the strategy says: This is why we exist.”

The strategy defines the GDC’s values when it comes to delivering regulation and governing the organisation:

• Regulation is proportionate, targeted, consistent, transparent and accountable
• Policy is developed on the basis of consultation and evidence
• Resources are managed effectively, efficiently and sustainably
• Decision-making is collective, robust and accountable
• Leadership of the organisation is strategic and ethical
• Equality and diversity is embedded in our policies, systems and processes
• Management of people is open, fair and constructive

Alison adds: “It is important to highlight our ongoing drive to deliver value for money. We recognise that the money we spend comes from the dental professionals who register with us. We will work hard to ensure that the burden we place on registrants is proportionate and fair, both financially and administratively. We will be successful if we ensure that the annual retention fee for mouth cancer patients can be set at a level that enables us to fulfil our statutory purpose.”

Each regulatory function – Standards, Registration, Fitness to Practise and Education/Quality Assurance/Revalidation – has a set of objectives. Alongside these objectives, are success indicators, to which the Council will be held accountable. A common theme throughout all the functions is driving up performance on dealing with fitness to practice, processes and outcomes.

The full strategy can be found at www.gdc-uk.org

Denplan host CQC seminars at BDTA

As one of the most talked about topics within the dental industry draws closer, Denplan is inviting members to attend a short seminar addressing the application process for registration with the Care Quality Commission.

These hour-long seminars take place at this year’s BDTA Dental Showcase at ExCel London and will be hosted by Denplan’s Chief Dental Officer, Roger Matthews and Deputy Chief Dental Officer, Henry Clover. They offer one hour’s CPD and are to be held in the North ern Gallery Room 8 (situated above the main exhibition hall) at the following times:

– Thursday 14 October - 11.00am or 2.00pm
– Friday 15 October - 11.00am or 2.00pm
– Saturday 16 October - 11.00am

Roger Matthews commented: “Applications for CQC registration will commence on 16th November 2010 and by 31st December 2010 all practices will have to be registered. Numerous opportunities will have to be available to support them, including a ‘plain English’ guide to the application, which is available through Denplan Online Services.

“We’ll also address how Denplan Excel and the Denplan Quality Programmes support the CQC Essential Standards.”

To attend, please register with the Denplan Events team on 0800 168 9514 or email Lynn.godfrey@denplan.co.uk.

Mouth cancer awareness takes a walk

With nearly 8,000 people being diagnosed with Mouth Cancer every year, it is vital to generate a high level of public awareness. The Mouth Cancer Foundation has therefore once again provided free mouth cancer screening to the public at the annual Mouth Cancer 10km Awareness Walk.

The specialist screening team was provided by the Department of Community Special Care Dentistry, King’s College London and lead by members of the Oral Medicine Department of the Eastman Dental Institute.

The ‘Awareness Walk’, which had its biggest level of success in five years, screened 152 people and 6 were advised to see a dentist or a doctor for referral to a specialist for further investigation, as participants visited the screening unit during the walk.

The founder of the Mouth Cancer Foundation Dr Joshu said: “A common story many mouth cancer patients can relate to is that they were diagnosed late. Early diagnosis dramatically increases survival rates. There are many particularly obvious signs and symptoms mouth cancer patients have which are often over-looked by GPs and GDPs because of their lack of awareness of the disease.

“The public needs to be aware of mouth cancer. The screening process goes smoothly for Denplan members, we have produced a range of support materials to assist them, including a ‘plain English’ guide to the application, which is available through Denplan Online Services.

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Back on Tour!
Where now? But to Indiaaaah

The AOG is well known for its fun family days, packed dinner dances, worldwide charitable projects and stunningly different international trips.

Every trip is a unique experience. There is an international conference and dinner, a major themed occasion, a significant charitable act, tours and dances and lots of fun time or time to devote entirely to yourself, just to chill out. The AOG actively encourages families as it is based on the traditional values of work and play.

On the 18th of February 2011, the AOG will travel to Delhi for a conference. Following this, the party will fly to Khajuraho – the temples of the Khama Sutra which it uses as its base to go to Chitrakoot. Chitrakoot is where the epic Ramayana has its turning point: It is also where the AOG supports a cleft palate and palate treatment centre and provides facilities for 500 villages with respect to dental care.

The trip will include an invitation to a magnificent Indian wedding (bring your best dress and dancing shoes), tours to evocative temples and the chance to participate in ancient mystic rituals, as well as a visit to the exotic Raneh falls and an adventure in the Tiger reserve. There will be a festival of colour and dance, an audience with astrologers (bring your date, time and place of birth) and soothsayers, henna painting, and the chance to relax in a luxurious spa - an endless myriad of stuff to do!

The Hotels are the Hilton, Radisson and the Taj. Accommodation includes bed and breakfast in Delhi, half board in Khajuraho, and full board (for the intrepid travellers who choose to make that part of the journey) in Chitrakoot where the AOG will launch its important new project.

Following this, you have a choice of a beach holiday in exquisite Mahabalipuram, or the chance to continue your temple tour through the gateway to Hindu heaven in Varanasi. A third option would be to take the famed trip to the golden triangle. The cost for the main tour of 7 days, including airfares is just £999 per person (based on two people sharing). Business class upgrades on international flights are available at £975 per person with the option of booking an all suite hotel option to pamper yourself!

So far this year, AOG Events have included attending the packed Clinical Innovations Conference at the Royal College of Physicians followed by a dinner - a family fun day in July which attracted over 400 people. Still to come is the AOG’s annual dinner and dance event on the 4th of December (sorry, this year’s event is already sold out, but bookings are being taken for 2011).

The AOG’s name means ‘Welcome’ in Hindi, Urdu & Punjabi, and AOG membership is open to all dental professionals, irrespective of their background. The AOG is an understated society whose slogan is ‘towards the greater good’. In its long 50 year history, the AOG has undertaken many significant acts of charity, including the building of several dental centres, libraries, and orphanages. Amongst its membership, the AOG boasts many prominent dentists and the AOG plaque can be seen on the walls of many buildings.

Be part of the ‘greater good’ and join the AOG today. Subscription is only £50. A small price to pay for a great act!

For more information, or to join, visit www.aoguk.org

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Safeguarding the oral health of children

Maria Anuita looks at children’s oral health

There are fears that the oral health of children in deprived areas is being put at risk as a result of budget cuts affecting schemes such as Sure Start. Despite reassurances from the Department of Health that the DH is not concerned about any domino effect: “The Department will continue to work closely with the Department for Education on services for children to ensure that the changes in the NHS White Paper and the subsequent public health White Paper support local health, education and social care services to work together for children and families.”

Declining child oral health

A report from the Audit Commission has found that despite £1bn being spent since 1998 on initiatives that aim to improve the health of children, dental health among the under-fives continues to decline and the overall health gap between the richest and poorest children has become wider.

In the last 10 years there has been a dramatic increase in the number of children with decayed, missing and filled teeth.

Research published in the August issue of the British Dental Journal reports that a quarter of three year olds surveyed in Greater Glasgow have tooth decay, and that in deprived areas this figure rises to 1 in 5 (out of 4000 children examined). Andrew Lamb, BDA director for Scotland, said that as adult, oral health can be predicted by childhood dental health and targeted interventions are vital to closing the gap in oral health inequalities.

The Sure Start scheme, an initiative aimed at providing health and social services for the under-fives, involves health initiatives typically focusing on oral health promotion and fluoride toothpaste. Programmes, such as Fluoridation schemes, delivered by health visitors, provides toothbrushes, toothpaste and dental health education material at children’s eight, 18, and 56 months developmental checks.

However, these schemes are potentially facing the axe at worst and severe funding cuts at best.

In June 2009, the BDA’s Oral Health Inequalities policy paper called for adequate resources and remuneration to enable the dental team to spend time with patients and carry out their role effectively. It called for an evidence-based, integrated approach between all healthcare and social services. However, in light of recent budget announcements, Peter Bateman, Chair of the BDA’s Salaried Dentists Committee commented that: "Social deprivation remains a sadly accurate predictor of poor oral health. Closing the gap between those with the best and worst oral health must be a priority.”

The White Paper proposes the introduction of a new dental contract with a particular emphasis on improving children’s oral health and increasing access to NHS dentistry. It also says that the NHS will need to release £20bn in efficiency savings by 2014 through cutting administration and management costs, implementing best practice, and increasing productivity.

Peter Bateman has a clear vision of what the role of the dentist should be during this time of financial adversity: “It will be more important that the new contractual arrangement, with less emphasis in dentistry support a preventive approach to care for both children and adult patients. It is also essential that the profession is engaged in the development of these new arrangements.”

Central to the proposals of the White Paper is collaboration between the NHS and other departments. However, the Department of Education, which administers the funding of Sure Start and ancillary health and social services for children, has been ordered to slash £1bn from its budget, and it is inevitable that this will filter through to the detriment of children’s health services. However, the DH is not concerned about any

Increasing cost

New figures published by the NHS Information Centre highlight the increasing expense of dental care. The report Dental Earnings and Expenses in England and Wales 2009/2010 shows that expenses borne by dental practices are escalating at a faster rate than incomes, which does not bode well with the government’s ambition of increasing the number of people accessing services. According to the Local Commissioning Survey from the British Dental Association, nearly 17 per cent of PCTs had spent less than 95 per cent of the ring fenced dental budget during 2009/2010.

It is not clear whether remaining funds were completely unspent or diverted to non-dental spending. The BDA warns that in order to be effective, dental services must be fully integrated within primary care to help develop local solutions, and that dentistry should be more integrated in health services to improve holistic patient care.

Figures from the NHS Information Centre, NHS Dental Statistics, shows that in the 2-year period ending June 2010 a total of £28.5m patients were seen by an NHS dentist, an increase of 578,000 on the March 2008 baseline. However, the percentage of the population seen by an NHS dentist, at 55.4 per cent, remains below the March 2008 level of 55.8 per cent. The report also shows that areas with the highest percentage of NHS patients (up to 78 per cent) are in poorer boroughs, compared with richer boroughs such as Kensington and Chelsea where only 25.8 per cent of people see an NHS dentist.

Peter Bateman said that: “Dentists work hard to improve the oral health of the whole population and the new arrangements must support that work. A focus on the oral health of young people makes sense because instilling good habits encourages good oral health.”

The question yet remains: who is going to pay for this?
The luxurious Pennyhill Park Hotel and Spa in Surrey was the setting for a daylong symposium to mark the UK launch of Septodont’s new product, Biodentine, last month.

More than 80 key opinion leaders and leading dentists from across the country came to hear how this cutting edge technology, which, for the first time, offers a bioactive substitute to dentine, could revolutionise their practice.

The symposium began with general manager of Septodont Holding Olivier Schillier introducing Biodentine as the product of a love story and a 12-year development into a dentine replacement set to change the face of restorative dentistry. Prof Trevor Burke was next to the podium. Acting as chair for the day’s proceedings, Trevor set the scene by discussing the change in thinking in caries management towards a more minimally invasive procedure where only a percentage of the caries is removed then a suitable material is used to seal in the remaining caries. He posed a question for delegates to ponder as they listened to the day’s speakers: Can one solution be a substitute for all restorative materials, ie MTA and amalgam?

Next to speak was Prof Gilles Richard, who is R&D manager for Septodont France and the developer of Biodentine. Prof Richard’s presentation, From Scientific Concept to Clinical Use, detailed the origins of Biodentine and the journey it took from conception to launch as a commercial product.

He explained that the goal to developing the product was to be able to treat many pathologies with a single solution. Biodentine began as an idea in 1998 when a dentist and a material developer contacted Septodont

"Biodentine began as an idea in 1998 when a dentist and a material developer contacted Septodont"
water as similar to that of concrete and many comparisons in the studies he described were made to other materials (for example, ProRoot MTA).

After a fantastic lunch (with the amount of food available, I can see why the venue is the base for the England Rugby team for matches!) it was time to hear more about the use of Biodentine in practice. Prof Tim Watson, director of research at King’s College London Dental Institute and Head of Biomaterials Science and the Biomaterials, Biomimetics & Biophotonics Research Group, discussed Biodentine; the new dynamic, bioactive, interface with the dental tissues. He explained that he had been working with the product for about 10 months, and was interested how biomimetic it was especially in the field of restorative dentistry and caries management.

He looked at how Biodentine interfaced with the natural tooth surface as it settled into the mouth after placement. He explained that there was some form of remineralisation that can be seen. In addition, the product lays down good reactionary dentine when reacting with the pulp. His main message said; ‘it will work with caries – so get using it!’

Next up was Prof Gilles Koubi from the University of Marseilles. His presentation, Biodentine: the new dynamic, mimetic it was especially in the field of restorative dentistry and caries management.

He gave many practical hints and tips on using it in endo.

The last clinical speaker, Dr Julian Webber, looked at the use of Biodentine in a specific discipline - endodontics. He began Biodentine, an Endodontic Perspective by detailing his six-month experience in using the product. He gave a very honest appraisal of Biodentine, discussing the advantages of a longer setting time of 10 minutes being beneficial to endodontists, but also that the fact that it is very dependent on how it is mixed was a potential problem. He showed some cases which he had used the product on and gave many practical hints and tips on using it in endo.
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Call us for your FREE DentalSky Catalogue
Michael Lansdell outlines the advantages of incorporation for an independent practice owned and operated by a dentist or partnership

Most dentists are not primarily business people, so it’s not surprising that since the General Dental Council (GDC) altered the regulations to allow dental practices to operate as limited companies from 2006, there has been much speculation and misinformation circulating within the profession about whether to take his step.

Limited Liability
The use of the word ‘limited’ in the title ‘limited company’ refers to limited liability. While even in these parlous times, few dental practices are in danger of closing, the shareholders in a limited company have the security of knowing that their exposure to liabilities to creditors will never exceed their original share capital, usually between £100 and £1,000.

Another advantage of trading as a limited company is the higher level of credibility in many commercial negotiations or inter-business relations accorded to a company compared with a sole trader.

Selling to a third party
It is often easier to transfer the ownership of a practice trading as a limited company. This is because the company remains in existence unless it is dissolved or liquidated.

The existing business arrangements, bank accounts and supply contracts, for example, all stay the same under the new ownership, while the new owner of a sole-trader practice would need to re-establish these relationships under his/her own name. This is especially important with PCT contracts, which should be unaffected, provided the PCT has been properly approached at the time of incorporation and the PCT contract has been transferred into the limited company without restriction. Experience shows that incorporated practices with PCT contracts are realising higher selling values than unincorporated practices, partly for this reason.

The process of incorporation and the resulting altered tax regime enables converting sole traders to use tax savings arising from incorporation to substantially increase their pension contributions without affecting their current quality of life, subject to the new rules on pension contributions for high earners.

Tax benefits
Other taxation benefits related to the differences between how individuals and companies pay tax and National Insurance depend on the individual’s income, which is effectively the practice’s profit in any given year.

For example, a sole trader making a profit of around £100,000pa, and drawing out of the practice all of the profit, would expect to be about £4,000pa better off after incorporation, just based on the rate differences alone (09/10 tax tables), before any other planning is done to significantly increase the amount of the total tax savings.

Cash-flow benefits
Converting to a limited company also has cash-flow benefits. Sole traders normally pay tax on their profits (income) in two instalments, with about half becoming due two months before the end of the tax year and the other about half payable four months after the end of the tax year. Limited companies of this size do not make payments on account, and their Corporation Tax, as opposed to Income Tax, is not payable until nine months after the end of the tax year.

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When the practice is transferred to the newly formed company, it can often borrow to pay for the goodwill, which can amount to 100 per cent of the annual turnover of the practice. The interest on this loan qualifies for tax relief, and the capital sum borrowed by the limited company can be used by the dentist to reduce non-tax deductible payments, for example on his/her home mortgage. In some cases, the home mortgage can be paid off in its entirety, depending on the goodwill value.

Even if the company does not need to borrow to complete the purchase of the practice, it is possible for the dentist as both shareholder and company director (employee) to draw from the company a combination of salary, dividends, and loan repayment, to reduce his/her personal tax liability to zero, for a number of years after incorporation. Corporation Tax on the practice’s (now the company), profits is of course still paid, currently at a rate of 21 per cent on profits up to £500,000.

A family business
Legislation to curb “income splitting” has been deferred for now. However, other family members, often a spouse employed to manage appointments or other aspects of administration, assist many dentists acting as sole traders in the running of their businesses.

For higher earners not domiciled in the UK for tax purposes, there are more sophisticated tax-planning techniques that make use of offshore structures. If you fall into this category, (and your domicile in this context is not necessarily the country in which you live or hold a passport from!), you need to take specialist advice to optimise your tax position.

It’s evident that all dentist sole traders and dental partnerships, whether or not they are currently considering incorporation, would benefit from a review of their status which compares their present position with that after the formation of a limited company. There is, quite literally, nothing to lose.

At the same time, incorporation is not necessarily appropriate for every practice. The ultimate decision, after considering specialist, professional advice, must take into account the individual dentist’s present business circumstances, personal position and preferences and also, where relevant, his or her future plans.
Society in general is becoming more litigious. A recent study from one of the UK’s dento-legal indemnity providers suggests that dentists and nurses are among some of the most at risk in the world when it comes to legal action from patients. It is believed that the figures in the UK are even higher than those of the US.

It is possible that a practitioner may find themselves on the unpleasant receiving end of a complaint at some stage in their career, be it an irate phone call to a practice manager, or in the worst possible case, legal action. While an upset phone call or visit from a dissatisfied patient, whether aimed at yourself or a member of your team, is unpleasant enough, receiving legal action from a patient is every practitioner’s worse nightmare.

Essential cover

With this in mind, ensuring that you are protected with professional indemnity insurance cover, which offers comprehensive cover to perform procedures using products such as Botulism Toxin, dermal fillers and other rejuvenation treatments is a must.

On some occasions, patients come into the clinic with unrealistic expectations as to what can be achieved. While it is the professional’s responsibility to inform the patients what they can realistically expect, it is sometimes the case that the patient simply doesn’t understand, and then is disappointed with the final result.

This may not be down to the professional’s actions. It can simply be a case of the patient either misunderstanding, or choosing not to listen to the professional’s honest advice about treatment, instead preferring to see it as a ‘miracle-cure’.

Warning of risk

Of course, like any medical procedure, the delivery of facial aesthetic treatments does carry a risk, and it is up to the practitioner to ensure that the patient is aware of this. It is common practice for patients to sign an agreement declaring that they do understand that they are undertaking a medical procedure, and are fully aware of the risks involved; however, when faced with a bad reaction, it is not uncommon for the patient to forget all the advice and panic.

Another common issue is patients are not aware that in order to maintain the effects regular treatment must be carried out. Although, again, it is the responsibility of the professional to impart this information, it is only possible to give patients estimates of their treatment’s duration. Everybody is different, and the products used can react differently.

The primary concern should be patient protection, and as such, all practitioners should aim to ensure the highest level of care. However, in the event of a patient being dissatisfied, it is important to ensure that you and your team are protected, and that the indemnity cover that you have is appropriate for all of the treatments you offer in your practice.

About the author

Dr Bob Khanna is President and founder of non-profit organisation The International Academy for Advanced Facial Aesthetics (IAAFA). He is the appointed clinical tutor in facial aesthetics at the Royal College of Surgeons and has trained thousands of dentists and doctors through the Dr Bob Khanna Training Institute. For more information about Dr Bob Khanna, call 0118 9606 930 or visit www.drbk.co.uk.
Keeping them keen
Making sure new patients know everything they need to know about future treatment will add value to your practice, says Simon Hocken

Recently, on a trusted recommendation, I attended a small private hospital in the South East of England (a 500 mile round trip from my home), to have a consultation with a specialist and to participate in some tests.

The fee for the time I spent in the hospital was around £1,700, and the outcome (apart from a chat and a couple of short emails), mainly consisted of an estimate for the treatment that they had offered to me.

Although I was grateful to be given a solution, albeit an expensive one, the process I went through to get it irritated me. Most of us are too impatient for the consultation process, although we accept that a consultation is a necessary step toward finding a solution or providing an outcome to our situation. That's why carpet fitters, for example, write 'Free Estimates' on the side of their vans – they know that their clients don't really want to pay for them. However, the carpet fitter needs to size up the job, decide the way forward, offer an estimate and close the sale, much like a dentist.

Boosting patient experience

Now, I'm not an advocate the offering of free consultations – I've always believed people don't value what they don't pay for. Look at the number of missed appointments in NHS GP surgeries and hospital out-patient clinics. However, paying for a consultation can leave the patient feeling grumpy too, unless you can turn the experience into one which genuinely adds value to the patient.

So, how can you do that during a new patient consultation in a dental practice?

Let me tell you a little bit more about my private hospital experience and I think you will see the parallels with a dental practice. During my visit, they ran late and I wasn't told how long I might have to wait or how long the consultation would take, so I couldn't easily arrange to do anything else with my time.

At no point did anyone explain to me how they conducted their consultations, what might happen, how long it might take and what I could expect at the end. I felt that my presence in their clinic was mostly to allow them to reach whatever conclusions they could. Part of this deal was that I would behave like a good patient and do whatever was asked of me as I was poked and bled! I felt my experience was a win for them, but a loss for me, particularly financially. They hadn't made it clear what the value of a consultation would be, and I left the clinic with the very same symptoms that I arrived with.

Communication is key

So, in order for your patients to leave your new patient consultations feeling satisfied with their appointment, I suggest that you consider some of the following ways to make a patient's initial consultation feel like a valuable experience. Make sure patients understand:

1. How your new patient consultations are structured, both in advance of the visit and on the day
2. How long the whole visit will take
3. How you will communicate the outcomes, treatment plan/solutions that you will be offering
4. To inform the practice staff if they are experiencing any pain or discomfort, you will then have time to offer any first aid or temporary solutions to relieve their symptoms
5. That they will receive a thorough verbal and written explanation

Communication is key, and informing patients about new treatments can help to boost the patient experience.
When you offer patients a treatment plan:
1. Provide any information sheets that you might have on their diagnosis or the treatment that you are offering them and include other useful sources, such as website address etc.
2. Show them any visual aids you have, including videos, ‘before and after’ testimonials, for example, to help them increase their understanding and give them confidence that they can deal with their problem
3. Tell them how long the procedures will take (in terms of car parking/time away from the office, out of mobile contact purposes)
4. Tell them what to expect, during the treatment, and how they might feel afterwards including: whether they can/should drive, whether they should be accompanied, whether they can expect to go back to work and function properly
5. Tell them what will be expected of them before, during and after the treatment in terms of managing their eating/work/social life
6. Tell them what to expect, during the treatment, and how they might feel afterwards including: whether they can/should drive, whether they should be accompanied, whether they can expect to go back to work and function properly
7. Tell them what will be expected of them before, during and after the treatment in terms of managing their eating/work/social life
8. Give them a chance to ask questions in private and not at your front desk
9. Dedicate one of your team to them as a point of contact so that once they've had a chance to discuss their visit with family and friends, they can ask more questions or voice their fears.

Accurately explain what the costs are likely to be in order to reach the solution/outcome they are seeking.

Tell them when payments are due and how you accept payment. If you offer credit facilities, this is a good time to tell the patient.

Tell them how long the procedures will take (in terms of car parking/time away from the office, out of mobile contact purposes).

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Options for young dentists
Geoff Long looks at the professional outlook for those starting out

Over the past four years, we have seen the pool of independently owned practices in the UK dwindle. This has been brought about by aggressive purchasing by the corporates and strict funding control from the PCTs for new start-ups.

It is not surprising that options for young dentists are somewhat limited working as an associate for 55 per cent or £9 a UDA. I can see the day coming when associates will be working for corporates for as little as £5,000pm as they do in South Africa.

Dentists become used to crises, moan a little and absorb their problems into the great British characteristic of “putting up with it”. However, given the popularity of dentistry, there is no great wave of public sympathy about to solve the problems for young dentists.

Disparity between the wages of nurses and dental nurses is a telling example of the unpopularity of dentistry and public support for nurses.

It is worth looking at the wealth accumulation ability of dentistry. We took a sample of 1,000 dentists, split roughly 400 principals to 600 associates. Why that split is probably down to the effect of corporate dentistry swallowing up the larger three or four chair practices. The results were remarkable:

- Millionaires in dentistry
  - Percentage of Millionaires – principals 54 per cent, associates one per cent
  - Percentage of Multi-Millionaires – principals 6 per cent, associates 0 per cent

Of the 54 per cent of principals who were millionaires all but two made their money from dentistry. The usual story was one of hard work and not spending the money! The average age for hitting the elusive million was 58. Incidentally, the two associates made their million out of property and shares.

Looking to the future, the ambitious young dentist will find it more and more difficult to make a million pounds out of dentistry. It is not surprising that one of the most common questions I am asked as a dental accountant is, “How do I earn a living outside of dentistry?”

The answer is: ‘Not easily!’ Nevertheless, I have compiled a list of businesses/occupations of some of the self-made millionaires to help young dentists with career planning.

Businesses/occupations of self-made millionaires:
- Agriculture
- Antique Sales
- Artist-Commercial
- Attorney
- Audio/Video Reproduction
- Author-Fiction
- Author-Text Books/Training Manuals
- Automotive Leasing
- Baked Goods Producer
- Beauty Salon(s) Owner-Manager
- Beer Wholesaler
- Builder/Real Estate Developer
- Commercial Laundry
- Cafeteria Owner
- Clinical Psychologist
- Coin and Stamp Dealer
- Business/Real Estate Broker/Investor
- Computer Consultant
- Developer/Construction
- Engineer/Architect
- Farmer
- Fast Food Restaurants
- Florist
- Investment Management
- Jewellery Retailer/Wholesaler
- Engineering
- Lecturer
- Marina Owner/Repair Service
- Medical Research
- Micro-Electronics
- Motor Sports Promoter
- Nursing Home
- Patent Owner/Inventor
- Physician
- Plastic Surgeon
- Publisher of Newsletters
- Printing
- Publishing
- Scrap Metal Dealer.

About the author
Geoffrey Long FCA is a specialist dental accountant based in Hertfordshire. Geoff has over 15 years experience managing dentists' accounts and is recognised for his proactive approach to dental taxation and business problems. Call him on 01438 722224 or email office@dentax.biz.
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It seems that in recent years, social media sites, such as Facebook and Twitter, have been coming on leaps and bounds, and it is easy to understand their popularity when it comes to networking with friends and relatives. But for many people the business benefits of such forums is often less clear. So what do you need to know?

The following tips are designed to give you all the information you need to choose the best social media outlets for your business, and to show you how they can help you market your practice, create brand awareness, network with colleagues and increase communication with your patients.

Is it for you?

With social media becoming so popular, and the economy forcing everyone to be on their toes, dental practices should try and explore every option to help them increase patient numbers and maintain the patients they have. Not only can social media allow you to share all your latest news and information with colleagues and patients, but the real-time nature of online updates can cause a real buzz and interest in what you have to say. Furthermore, users can interact and comment on your messages, giving you a sense of what the people that matter to you and your business really think. It is important however, not to be too sales oriented when using any form of social media - if your followers feel they are being sold to they will often switch off.

Social media is also a great way of increasing traffic to your website, as the more networking you do, and links you have going to your website, the higher your ranking will become on search engines such as Google. This means that when a potential patient searches for a dentist in their area, your practice is far more likely to be at the top of that list. It also means that there are more opportunities for people to visit your website, as you can put a link to it on any social media sites, as well as any key messages you want to get across.

Denplan has recently undertaken a number of social media ventures to enhance its offering even further and I think the following sites are a great place to start for any dental practice interested in joining the social

Join the Social Media Revolution!

Jodie Tisson looks at why dental practices should be making the most of social media and how it can be used to promote your practice and increase communication with both colleagues and patients.
All dental health practitioners deserve optimal protection

As a dental professional you’re committed to giving your patients the most attentive care, while protecting them and yourself from infection. Recent guidelines* highlight the serious risks of infection during dental procedures and the need for better hand hygiene, including the correct use of gloves. Ansell’s Micro-Touch® range of versatile and innovative products covers all dentistry examination applications. With high levels of comfort, dexterity and breathability, Micro-Touch® gloves are manufactured to strict specifications to meet EN 455 norms for exam gloves.

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Blogging

Probably the most established social media outlet is blogging. A blog is a type of website which features regular entries and commentary from you and your practice team—and it's completely free! You can set up a blog in minutes by using certain web services and it is the ideal way of getting into social media. You can regularly post your latest practice news, events and update people on your services and products, or you could even try and write a series of short articles about the sort of treatments you offer and who they would be appropriate for.

Blogs are picked up really well on search engines such as Google, and keen bloggers can subscribe to your blog and receive alerts when a new post is uploaded. However, it is vital that if you decide to undertake a blog, or any other form of social media, that you tell all your visitors and colleagues about it. Whether this is though postcards or information cards in your waiting room, information on your TV screen, or a friendly word from your practice team, continuing to market the service you provide will ensure the best results.

Facebook

Easily one of the most popular social networking websites, Facebook users can add friends and followers and keep them updated with regular messages. You can also update your personal and business profile for free to notify patients about your latest news and join networks of other people with similar interests. This will not only help you communicate regularly with your patients, but also keep you “in the loop” with real-time news from your peers and colleagues.

Twitter

Twitter is a free social networking service that enables its users to send and read messages known as ‘tweets’. Tweets are like online text messages of up to 140 characters, and can be great for sending individual patients appointment reminders, instead of calling or writing. Just ensure that the people you are contacting are regular followers to ensure the message is received. Senders can restrict delivery to those in their circle of friends or, by default, allow open access. Users can send and receive tweets via the Twitter website, Short Message Service (SMS) or external applications.

Twitter is ideal for posting your blog and Facebook updates on or, if you have updated your website, it is a great vehicle for escalating your messages to more people. You can also search for mentions of your practice and follow in the footsteps of some larger companies and use the site to deal with customer enquiries and questions.

Other options

If you would rather ease yourself into the art of social media a great place to start is by adding a company profile of your practice to websites such as Wikipedia or LinkedIn. These are free sites and you can simply add your company details and a short description of your products and services. These sites can be subject to editing by anyone, so you need to make sure you check your page regularly.

How do you know if it’s working?

All this advice and information is all very well and good, however, it is important to know that all the effort you are putting into social media is paying off. Perhaps the most valuable aspect of social media is the fact that it is not a great way of getting feedback from people who have visited the practice. Even if someone leaves negative feedback, it is important to see this as constructive criticism and an opportunity to improve. You can also respond to these comments and any other questions or queries in order to help put people’s minds at rest.

If you are more interested in actual facts and figures to show the value of the social media you have undertaken, there are a few websites out there which will monitor your brand name for free. However, because these sites are free, they can often be unreliable and work best if you have an unusual or distinctive practice name. There are companies which will monitor your online profile more effectively, but this can be expensive and is really designed for bigger organisations. I think the best way of monitoring the success of your social media are the most straightforward, as simply noting the number of interactions and comments on your social media sites each month can give you a really good idea of what messages were well received and the kind of thing your followers are interested in.

A word to the wise however…

undertaking an effective social media strategy requires a lot of work and regular updates, so it is not something to take on lightly. Some payment plan providers, can give you a range of help and advice to assist you in choosing the best social media outlets for your business, but it is clear that with the world of social media ever expanding, it is vital that dental practices take advantage of this tool and utilise the benefits it can bring.

About the author

Jodie Tisson is digital marketing channel executive at Denplan

The use of social media brings you close to patients at the click of a mouse.
The heart of dentistry

Andrew McCance offers some advice on how to motivate patients to develop better oral health.

The state of the nation’s oral health is a concern for all those involved in the dental profession. Finding ways to improve the standard of oral hygiene regimes through new techniques, cleaning aids and initiatives, has played a role in raising awareness about the importance of brushing twice a day and cleaning interdentally, as well as regular visits to the dentist.

Encouraging patients to maintain a regular cycle of examinations is certainly a challenge for clinicians, especially in troubled economic times such as these. With the prospect of another shake-up in the contractual arrangements between PCTs and practice owners, developing new ways of getting fee-paying patients through the door might well make all the difference.

For instance, one dentist in Manchester took the unorthodox step of providing a taxi service to get patients to their appointments. As a result, they claimed to have generated a 30 per cent fall in missed appointments, representing a significant saving for the practice, as well as ensuring patients got the check-ups vital for preventive dentistry.

Patients appreciate a good deal, and so offering a package of both general and more specialised dental care at a discounted price can be maintained, with the positioner removed from the contractual arrangement between PCTs and practice owners, developing ways of getting fee-paying patients through the door might well make all the difference.

An invisible solution

Developed by experts in orthodontics, the Clearstep system offers a complete, ‘invisible’ orthodontic treatment methodology for patients from the age of seven upwards. By adopting a hybrid approach, combining clear positioners with traditional mechanics, the once perceived limitations of such removable positioners has been overcome.

As a result, clinicians can offer the best results at an attractive price while keeping treatment times to a minimum.

The benefits are not just subjective and abstract. According to a recent study, both general dental practitioners and orthodontists rate the positive effect of orthodontic treatment on periodontal health as quite high. So clinicians have a way of helping to improve not only a patient’s smile, but also their dental health.

It would seem that the overriding influence in preventing gum disease would appear to be patient motivation and so the argument returns to the initial question: how to encourage patients to visit their dentist regularly, and to maintain an effective oral healthcare regime?

Regular assessment appointment forms an integral part of the system. These not only give the opportunity for clinicians to assess the progress of the treatment, they also provide the chance to monitor more closely the overall oral health of the patient: an important aspect of preventive dentistry.

One of the advantages of a removable appliance is that a normal cleaning routine can be maintained, with the positioner removed to allow access for brushing and interdental cleaning.

Looking after the oral health of our patients is at the heart of dentistry. With the Clearstep System, clinicians have access to an innovative system that tackles a range of malocclusions in a way that allows patients to keep up their usual daily oral health care routines with ease.

About the author
Dr Andrew McCance has gained a wealth of experience in multi-disciplinary practice. In the mid 1990s, Dr McCance began to develop the Clearstep brace, based on the demands of the 4,000 patients treated annually in his specialist practices. For more information, call the OPT Laboratory & Diagnostic Facility on 01342 337910, email info@clearstep.co.uk or visit www.clearstep.co.uk.

The patients feel encouraged when the patient has a smile of which they can be proud.

Offering a way to correct a patient’s malocclusion that doesn’t involve fixed appliances is certainly appealing for many patients. This market does not have over a.

The state of the nation’s oral health is a concern for all those involved in the profession.

patients to take better care of their teeth is a challenge, but one which is made easier when the patient has a smile of which they can be proud.

Maintaining good results

It stands to reason that a patient will be more inclined to keep their teeth in a better condition if they looked good in the first place. Moreover, if they have invested both time and financial resources into achieving their new and improved smile, they will be far more likely to want to maintain the positive results that have been achieved.

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Under pressure?

Neel Kothari asks: Will the pressure to meet academic requirements repel potential hard-working dental nurses from entering the profession?

As every dentist knows, finding a good nurse is like finding gold dust. In the last few years, dental nursing has undergone a mini metamorphosis, where nurses learnt their trade through in-practice training, many choosing to undergo further training. Today, however, qualification through a structured course is mandatory. General Dental Council (GDC) requirements for trainee nurses. Along with this, a new annual registration fee to the GDC, as well as having to undertake verifiable CPD hours.

I applaud the professional status now endowed upon nurses through registration with the GDC. Many dentists, myself included, have always felt that the hard work and care provided by nurses far outweighs the credit they are given (and in many cases the pay too). However, this does come at a cost, whether it is to nurses or to the practice; ultimately in the business of dentistry, an eventual trickle down to patients is likely to be seen. So, are nurses, practices and patients actually better off?

Justifying fees

While dental care professionals have their annual retention fees (ARF) set to a lower level than dentists, £96 is still a lot of money, especially to many of the dentists. For me, the jury is still out. Along with now having to fund the business of dentistry? What benefits and the cost be justified to the trade off between the benefits and the cost?

Splint opinion

When asking various nurses what they thought of the rapid transformations seen in the last few years, I have to admit that to my surprise opinions have been split. Sure, plenty felt that the ARF fees were disproportionate and a far greater financial burden than they need to be, but many nurses also felt a great sense of achievement in having completed their qualification and are looking forward to undertaking further CPD in the future. Almost all of the nurses I have discussed this with are glad to have a recognised qualification on their CV, but many are worried about just exactly how they are going to achieve all of their CPD.

Restricted access

As the majority of nurses are female, another key issue that arises is how these new reforms fit in with those nurses that raise families and need flexible working patterns. It seems that for those choosing to work on a part-time basis (which is a high proportion), the burden of reform is disproportionately high. Not only do they have the same ARF and indemnity, but often access to CPD is very restricted, especially if practice CPD days fall outside of their work days. I have been told that for many the prospect of carrying on with nursing is no longer worth the pay or the hassle.

So are nurses, practices and patients actually better off? Certainly some nurses have benefited from their elevated status, however, by requiring registration were in place when they first entered dental nursing. So are nurses, practices and patients actually better off? Can some nurses benefit from their elevated status, however, by requiring registration were in place when they first entered dental nursing?

Shouldering the burden

So, the question that must be raised is: are we actually likely to see many complaints that result in GDC inquiries into nurses? Or fitness to practice inquiries arising in error from the GDC? The BADV reports from those nurses surveyed, 52 per cent of registered dental nurses do not have their own indemnity cover, with 18 per cent of registered dental nurses having no indemnity cover at all.

So in the event of a patient complaint, what level of burden is fair for nurses to shoulder? Given the constraints that nurses work within (often set by the dentists), in my opinion the answer should be very little.

Many of the nurses who have assisted me in the past have struggled with exams during their school years. This does not mean that their ability to do the job is necessarily impaired, nor does it mean that they lack the intelligence or the skill to take on further responsibilities. However, in reality, some of the best nurses currently working in general dental practices today may have been put off in the past if mandatory requirements of registration were in place when they first entered dental nursing.

Study fears

I fully endorse pathways that enable nurses to further develop their skills within their profession; however, by insisting on qualification, we must as a profession be fully aware that we are potentially alienating good, hard working candidates for dental nursing who are more than able to cope with the stresses and strains of the job, but are put off by the academic requirements required.

In my opinion, all members of the dental team should be encouraged to improve their skills and knowledge base, but this should not be to the detriment of those who have all of the practical ability to do the job, but struggle with the academic rigmaroles.

Along with new having to pay for registration and indemnity (if chosen), nurses now also have to undertake regular CPD. The BADV reports that around 45 per cent of employers make no contribution to nurses’ CPD with only 15 per cent covering all costs associated with CPD.

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With the esthetic zone being absolutely critical to a patient's external appearance and inner emotions, orchestrating a bioesthetic result is mandatory. Too often, this is complicated when esthetic desires infringe on the health of the periodontal complex. This is often true when biologic width violations have occurred iatrogenically.

Many factors may contribute to these failures; the two main culprits being intracrevicular margin location and overcontoured restorations. Not only is plaque accumulation problematic, but the supracrestal fibres also become interrupted, causing the tissues to become further inflamed and esthetically unmanageable. Kois’ landmark study defined the total dentogingival complex (DGC) as clinically predictable at 3mm on the direct facial aspect, and at 3mm-5mm interproximally when measured from the free gingival margin to the osseous crest.

It is critical anteriorly that the gingival margin mimics the osseous scallop while maintaining the DGC. Further complicating these complex situations is the degree of inflammation in the soft tissue, affecting the clinical development of health and esthetic symmetry.

Dental lasers have evolved considerably as an adjunctive and alternative treatment to safely, conservatively, and reliably decrease bacterial levels and improve the hard and soft tissue contours.

An ideal result

Often the patient is frustrated with his or her previous poor cosmetic results. However, to improve the periodontal framework in order to create an ideal result, they must be referred to yet another doctor. Even more challenging is the extended healing time created by reflexive mucoperiosteal surgery. This not only affects the chronology of final restorative care, but also delays the patient's ultimate satisfaction and happiness for a minimum of two to three months.

Fortunately, dental lasers have evolved considerably as an adjunctive and alternative treatment to safely, conservatively, and reliably decrease bacterial levels and improve the hard and soft tissue contours.

Studies of Er: YSGG lasers by Rizoiu and others have shown that thermal coagulative results, as well as bony ablation characteristics are similar to a dental bur. From a patient-friendly standpoint, less need for suturing and shorter healing times improves case acceptance for doing ideal dentistry. In selected cases, such as the one presented in this article, minimally invasive laser procedures, with precise restorative planning and technique, can satisfy esthetic and functional parameters. Furthermore, patients can enjoy optimal results more comfortably and efficiently.

A conservative strategy was devised that would allow us to correct the problems and causes in a “multi-tasking” manner.

Case Presentation

A 58-year-old female patient presented for correction of what she termed her “tilted smile” (Fig 1). Given that she was starting a new sales career, she also wanted to make her teeth brighter and her smile much broader. The patient shared her frustration about previous dental consultations that had focused solely on orthodontic or surgical solutions without considering a more practical approach that would fit her busy life.

Her smile analysis estab-
lished a collapse of the buccal pips in the buccal corridor. Furthermore, the axial inclinations, irregular gingival margins, and incisal edges created a down-ward tilt to the patient’s right due to tooth positioning. Close-up imaging showed healthy gingival tissues as well as a weakened right central incisor from a large composite (Fig 2).

Findings
A full clinical examination with radiographs and mounted models revealed the following:

• Biomechanically, the majority of her teeth remained strong despite previous dental care.
• Periodontally, soft and hard tissues were healthy.
• Occlusally, load testing was normal (after muscle relaxation) and there was obvious CR-CO anterior-vertical slide due to a premature contact at tooth #50.
• Esthetically, the width-to-length ratio of the upper centrals was 1:2, far from the ideal range of 0.75:1.0. Tooth shade was a Vita A2.

Treatment Plan
Given the patient’s previous history and her desire for minimally invasive dental care, a conser-vative strategy was devised that would allow us to correct the problems and causes in a “multi-tasking” manner.

A conservative strategy was devised that would allow us to correct the problems and causes in a “multi-tasking” manner:

• Muscle and bite therapy with a Tanner appliance, followed by careful equilibration aided by the T-scan (Tekscan System; South Boston, MA).
• Three-dimensional wax-up on a Stratos articulator (Ivoclar Vivadent; Amberst, NY) (Fig 5)
• Home bleaching of the lower teeth with Opalvance 15 per cent (Ultradent; South Jordan, UT)
• “Closed flap” periodontal modification with the Waterlase ErCr: YSGG (Biolase Technologies; San Clemente, CA) while the first three items were being accomplished (the combination of these four steps was a tremendous time-saver; it allowed us to carefully monitor progress on a weekly basis)
• Definitive restorative care with porcelain veneers and a crown on tooth #8.

No tissue necrosis or significant bleeding occurred as a result of using the laser’s rela-tively lower settings.

Treatment
At the initial closed periodontal lift, the ErCr: YSGG laser was used in three modes (gingival sculpting, osseous recontouring, and bio-stimulation). Prior to anes-thesia, the desired framework was planned and outlined using a fine marker (Fig 4). Further-more, a stick-bite was used, not only to establish an ideal incisal plane, but also to properly align the gingival margins (Fig 5).

At the facial margins, os-seous sculpting required great precision in order to maintain a 5-mm DGC. A specially tapered T4 tip (400µ in diameter) was used at a 25 per cent higher watt-age of 2.5W. Prior to usage, the tip was measured and marked to 3 mm in order to maintain controlled adjustments within the gingival sulcus during peri-probing movement of the tip (Fig 7). The resection was smoothed with a 7/8 curette (Fig 8). Using low-level laser therapy at a setting of 0.25 W, a decrease in the release of inflammatory histamine and increased fibroblasts for junctional epithelial growth was achieved by “frosting” the outer epithelium and injection sites (Fig 9). The patient was placed on a vigorous home-care regimen (Oxygel, Oxy-fresh; Coeur d’Alene, ID) and closely monitored for a

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UCL Eastman researcher awarded prestigious Fellowship for work on cranio-facial deformity

The UCL Eastman Dental Institute is pleased to announce the award of a two-year Fellowship by the Faculty of Dental Surgery of the Royal College of Surgeons in England to researchers Nitin Shah, Lecturer in Orthodontics at the Institute. The prestigious award will support Nitin Shah's ongoing research, begun during her postgraduate studies, into the creation of in vitro craniofacial skeletal muscle tissue for use in the development of novel treatments to cranio-facial deformities such as cleft lip and palate, with the ultimate aim of providing tissues for use in future surgical treatments.

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Dr. Flax has been an Accredited Member of the AACD since 1997. He was co-chair of the Conference Advisory Committee for the 2003 Annual Scientific Session and will be for the 2008 meeting in New Orleans. He is a member of the AACD Board of Directors, is on the editorial board of The Journal of Cosmetic Dentistry, and chairs the Disaster Relief Fund. Dr. Flax also is a member of the ADA, the AGD, the ALD, the L.D. Pankey Alumni Association, and the Pierre Fauchard Society. He is a Fellow of the IADFD.

Dr. Flax practices full time in Atlanta, Georgia, focusing on functional and appearance-related conditions and advanced laser dentistry. He and his wife, Robyn, have two daughters.

‘These changes not only improve the final esthetic outcome of the case but also provide the physiologic functional parameters required for successful dentistry’

prepared for veneers and a crown with mild soft tissue re-shaping, to fine-tune our previous treatment. After taking impressions and bite registrations, prototype provisional (Luxatemp Plus, Zenith DMD, Englewood, NJ) were fabricated using the “shrink-wrap” technique. The patient was sent home with the same home-care regimen as mentioned previously, and instructed to “test-drive” her new smile for esthetics and function. She returned in a week to perfect the prototype’s occlusion, color, and morphology. Photographs and models were sent to the laboratory, providing a final blueprint for the porcelain restorations (Fig 10).

Acknowledgments
The author thanks his office team and laboratory technician, Mr. Wayne Payne (Payne Dental Lab, San Clemente, CA), for continually enhancing the lives of many patients like the one presented here. He also is thankful to his family, who allow him to contribute to the education of other dentists and their teams.

The use of a hard/soft tissue laser is a wonderful adjunctive tool for cosmetic and restorative dentistry. The case discussed here demonstrates that this type of laser technology gives dentists the ability to make significant soft and hard tissue changes while being minimally invasive. These changes not only improve the final esthetic outcome of the case but also provide the physiologic functional parameters required for successful dentistry.

References

Figure 8: A curette helps clean and smooth the sulcus of any debris.

Figure 9: A “laser bandage” is placed along the treated area to improve the healing time and decrease the patient’s discomfort. Note the immediate improvement of the geometric progression of gingival embrasures.

Figure 10: Detailed information helps the laboratory to translate clinical results to the porcelain restorations.

Figure 11: The great improvement in esthetics boosted the patient’s self-confidence and pride in her dental care.

Figure 12: Ideal proportions and emergence profiles will create long-term healthy tissues and aesthetics.
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Food for thought
The Premier Symposium 2010 will feature a range of topical lectures including the transformation of dental care through the use of implants and the risks associated with them, nerve injuries – their cause and management and the HTM 01-05 guidelines – one year on. The programme features the following speakers and lecture topics:

Prof Richard Palmer – Implants: new risks for old?
Prof Tara Renton – Nerve injuries: their cause and management

Praising original work
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The combination of Sensodyne Pronamel daily toothpaste and Sensodyne Pronamel Daily Mouthwash can provide up to 80% extra protection against future acid erosion.* Recommend daily use of Sensodyne Pronamel daily toothpaste and Sensodyne Pronamel Daily Mouthwash.

For patient samples visit www.gsk-dentalprofessionals.co.uk

References:

*compared to brushing with Sensodyne Pronamel daily toothpaste alone

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