Another Brown(e) causes potential money woes

Proposed university fee increase in independent review could have serious implications for dental students

Lord Browne of Madingley in his Review of Higher Education Funding and Student Finance has recommended an increase in university tuition fees. If the proposed plans go ahead there could be serious implications for students all over the country.

It is currently unclear whether the government will consider going ahead with Lord Browne’s review; however, whatever decision the government decides to make is likely to involve increasing university fees. Along with the proposed changes to the system with regards to budget cuts, universities across Britain will lose a proportion of state-funding in an effort to try and reduce the country’s ever-increasing deficit.

The problem that arises with the proposed changes will have far greater implications for dental and medical students, as their courses tend to be significantly longer than the usual three years. Recently, figures of £7,000 per year are being discussed; however there is also talk of an unlimited annual fee to be determined by individual universities. If these changes are brought into action then students are going to potentially leave university with a staggering debt of £100,000.

As it stands, many students are struggling to find a job after graduation due to the economic climate, resulting in interest piling on top of their student loans at an uncontrollable rate; this undoubtedly will put off future students.

The implications that this could have on society has a recipe for disaster. A decrease in the number of future dental and medical university students could result in a sudden shortage of trained professionals in the future and could ultimately affect economic growth. As Lord Browne stated in his review: “Analysis submitted to the Review suggests that, in the UK between 2000 and 2007, the increase in employed university graduates accounted for six per cent of growth in the private sector (measured by the extra wages they earned as a result of being graduates) or £4.2bn of extra output.”

According to the Independent Review of Higher Education Funding and Student Finance, the current system puts a “limit on the level of investment for higher education” and it has been suggested that the country’s education standard is at risk of “falling behind rival countries.” The proposals will introduce a greater investment: students are going to be persuaded that by paying more in they will get more out.

Reported cuts throughout the economic sector have further made the proposed fee increase an ever more pressing subject; university budgets will be cut by £1bn, affecting research funds and student support, and it is feared that worse may follow. Reports in the media suggest that the coalition government aim to cut £82m from university budgets next year and that the number of student places available is to be halved.

It is believed that if the proposed changes are adhered to, selected universities, where students compete to get a place, would end up charging higher fees for the privilege.

However, through all the speculation, those who are closest to the students have generally said that ‘dental and medical students are guaranteed a job that is well paid and because of this they leave university in a better position to pay back their fees.”

Dental Tribune contacted various dental schools who were reluctant to comment before the announcement of the Comprehensive Spending Review (CSR).
The General Dental Council (GDC) has opened its new 12 week consultation into revalidation. The aim of the revalidation is to provide a way of checking that dentists continue to meet GDC.

The issue that the GDC’s Fitness to Practise proceedings has had in the past is that it is assumed dental professionals are continuing to meet its standards, unless the regulator receives information which suggests otherwise. The GDC have admitted that this is not good enough.

The GDC plans to introduce revalidation for dentists in 2014; they have stated that the revalidation will simply build on the current requirements for continuing professional development and will provide an opportunity for those in difficulty to identify and tackle any problems before they become serious.

A standards and evidence framework will set out the standards dentists must meet under the four domains of clinical, management and leadership, communication and professionalism. The framework will also set out the evidence which will be acceptable to demonstrate compliance with each standard.

Dentists will gather this evidence over five years, and revalidate at the end of each cycle.

The GDC are proposing a three-stage process at the end of each cycle:
• Stage 1 – compliance check, which will apply to all dentists;
• Stage 2 – remediation phase, which will provide an opportunity to dentists who do not pass Stage 1 to remedy deficiencies;
• Stage 3 – in-depth assessment, which will apply to dentists who fail to demonstrate compliance at the end of the remediation phase.

The consultation can be found on the GDC’s website www.gdc-uk.org. The proposals aim to avoid over-regulation by making as much use of existing and developing quality systems.

The consultation takes into account the findings of an earlier consultation, research and pilots carried out in 2009.

Chair of the GDC’s Revalidation Working Group and Council Member, Denis Toppin said: “We are keen to get feedback from a range of stakeholders including registrants, patients, organisations representing the interests of patients and providers of quality initiatives. We want to make sure we get it right for the dentists we regulate. As a practising GDP I want the GDC to keep the extra regulatory burden to a minimum whilst maximising patient protection. We need you to get involved and have your say on our proposals so that you can help us to get them right and have the confidence of the public and professionals alike.”

Dental Tribune UK Ltd
4th Floor, Treasure House, 19–21 Hatton Garden, London, EC1N 8BA
Tel: 020 7400 8979
Lisa@dentaltribuneuk.com

Managing Director
Mash Seriki
Mash@dentaltribuneuk.com

Director
Noam Tamir
Noam@dentaltribuneuk.com

Editorial Assistant
Laura Hatton
Laura.hatton@dentaltabulous.com

Advertising Director
Joe Aspis
Tel: 020 7400 8969
Joe@dentaltribuneuk.com

Design & Production
Ellen Sawle
Ellen@dentaltribuneuk.com

For further information on this and any other product, please contact:
Purity Laboratories Ltd, 1st Floor, Broadway Studios, 20 Broadway, Hammersmith Broadway, London, W6 7AF
Tel: +44 20 8563 8887 or e-mail: info@beverlyhillsformula.com
www.beverlyhillsformula.com
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
Fresh after another successful BDTA Showcase, I hope readers are not counting the cost of gadgets and gizmos on their credit cards (although, one dentist said to me, “I don’t need the cards; they all know me”). There was a lot to see and hear at the event, so look out for a comprehensive review of the exhibition.

Of course, the majority of the talk in the coffee shops was CQC registration. One of the main bugbears was the lack of information about fees; even those who have been on the advisory boards had to admit exasperatedly that they didn’t have a clue what the potential fees might be! Conspiracy theorists amongst you are convinced that the CQC were waiting for the GDC’s fee announcement (for your thoughts on that, see page six…) to see what they could get away with. Not something I’d necessarily agree with, but it is easy to understand the frustrations of knowing you have to sort this CQC thing out but not being able to properly budget for all of the fees being piled up on practices. We all need clear guidance from the CQC about fees, regulation, expectation… a lot of things really, and with the start of registration date looming, this guidance should be here.

Colgate DCP Research Awards
The Colgate DCP Research Awards are in partnership with the Oral Dental Research Trust (ODRT) and support research of clinical relevance, which has been carried out by Dental Care Professionals. There is a special emphasis on preventive care and up to four awards, each to a value of £2,500, are presented annually.

The 2010 awardees were presented with their certificates by Professor Angus Walls, Chair of the Oral Dental Research Trust, at a reception and luncheon held at the British Dental Conference in Liverpool earlier this year.

Professor Walls commented that: “The Colgate DCP Research Awards is recognised as an important forward thinking initiative encouraging DCPs to embark on novel research of immediate clinical relevance and help build and strengthen the academic base of the entire dental team.”

The Colgate DCP Research Awards is an important introduction to research methodology for those who have never been involved in research previously and it offers all DCPs the opportunity to carry out research. A research team can be made up of all members of a general dental practice, including dental nurses, hygienists, technicians and therapists, and may also include a dentist as a mentor or supervisor.

Look out for the call for 2011 applications which will be announced in the dental press before the end of this year.

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L. R. Kerry Stone (School of Dental Sciences, Newcastle), Prof Angus Walls (Chair, ODRT), Susan Bissett (School of Dental Sciences, Newcastle), Lisa Pope (Hafren House Dental Practice, Alfreton), Hayley Lawrence (The Dental Practice, St John’s Woods), Dr Amanda Mac (Scientific Affairs, Colgate)
Dunmurry Dental Practice gets a makeover

After an extension and refurbishment Dunmurry Dental Practice has been officially reopened and is now one of Northern Ireland’s largest dental practices.

The practice was opened by Donna O’Carolan, Chief Dental Officer for Northern Ireland. Over the years, Dunmurry Dental Practice has won numerous industry awards including Best Practice, Best Young Dentist in Northern Ireland (at the UK Dentistry Awards) for 2008 and 2009.

Over £400,000 was funded by Ulster Bank to finance the investment and the development is enabling the local business to provide increased dental services to the local community, where it is already providing both NHS and private dental care to over 6,000 patients.

The 100 year old property, in which the Practice is situated, has been sympathetically restored, all of which are fully equipped with state-of-the-art equipment.

Speaking at the official opening, Chief Dental Officer Donna O’Carolan said: “Around 90 per cent of health service dentistry is delivered through high street dental practices such as this one. I acknowledge the significant personal and financial investment that Philip has made into Dunmurry Dental Practice. This investment enables patients in and around the Dunmurry area to access health service dentistry, prised to a high standard and in well-equipped modern facilities. You provide an essential and valued service and your commitment is greatly appreciated”.

Speaking at the opening of light and Principal Dentist Philip McLornan said “We are delighted with the results of the design and building works which has developed the Practice to incorporate six surgeons. I am very proud of our team who have worked very hard through what has been an exciting but very busy year and we look forward to providing dental care to more people within the local community.”

Claudette Christie, Director BDA Northern Ireland said “The dental practice as a workplace and clinical environment has to meet the demands of today’s requirements for patient care and best practice. It is a pleasure to see Dunmurry Dental Practice developing to meet the needs of patients both now and for the future.”

Since the development the team has been newly expanded and the practice now incorporates five dentists, a dental hygienist, seven nurses, three receptionists and a business manager.

For further information visit www.dunmurry-dental-practice.co.uk or follow us on Facebook.

Smiles all round for Denplan Golf Champions

The Denplan Golf Challenge final went off to a free once again this September, as 26 golfers took part on the Ailsa Championship course at the Westin Turnberry Golf Resort in Scotland.

Each player qualified from regional heats around the country, which took place throughout the summer.

The ultimate 2010 Denplan Golf Challenge champions were Glenn Robb and Roger Armstrong, whilst Nick Dobbs and Robert Bond took second place and Paul White and Mark Turner came in third. Whether they won or not, everyone thoroughly enjoyed the day.

Gemma Mills, Events Executive at Denplan commented; “The Denplan Golf Challenge is one of the most long-running and popular events on the Denplan calendar and this year’s event certainly went with a swing!”

“All the golfers enjoyed some great weather while they completed a nine-hole warm up round and a full day’s play on this most prestigious course. This was all followed by a complimentary dinner, awards presentation and overnight accommodation - all courtesy of Denplan! It was another hugely successful day and we’re already planning the Denplan Golf Challenge 2011, so watch this space!”

For more information about the Denplan Golf Challenge or any of the other Denplan events, Please contact the Events team on 0800 169 5697.

For more photos from the event please visit Denplan’s Flickr page.

Light therapy research at UCL

The UCL multidisciplinary research team of the UCL Eastman Dental Institute has been awarded a grant to support their work into the use of light-activated antimicrobial agents.

The grant, which was awarded by the Medical Research Council, builds on the auspices of the UCL Dental Institute’s Dental Research Funding Scheme (DFFS), which was set up to support the development of novel health therapies and interventions, includes a contribution from commercial collaborator, Ondine Biopharma Inc. and totals £1.1m.

The UCL research team, which includes Professor Michael Wilson and Dr Jonathan Pratten, have successfully applied the technology, known as photodynamic therapy, to develop a new system named the Periowave™ system. The system is used in the painless treatment of periodontitis, and is planned to be extended into potential applications in the medical field, particularly in the development of catheters.

The research is entitled “The use of light-activated antimicrobials to prevent catheter-associated infections” and builds on the group’s knowledge and expertise in the use of light-activated antimicrobials, which is a result of development undertaken by a multidisciplinary project team that includes Professor Ivan Parkin (UCL Chemistry), Dr Chris Kay (UCL Chemistry), Dr Sandy Mosse (UCL Medical Physics and Bioengineering) and Dr Sandy MacRobert (UCL National Medical Laser Centre).

Colgate Partners with European Dental School Deans

At the recent Association for Dental Education in Europe (ADEE) Congress held in Amsterdam, Colgate once again partnered with the Forum of European Heads and Deans of Dental Schools (FEHDD). Established in 2007, FEHDD facilitates the sharing of expertise across the continent and together with the ADEE aims to form a powerful combined ‘lobby’ for dental education.

The daylong event included a dynamic and interactive session on “The future of dental care: the role of the deans” by Claudette Jacques, whose motto is “what will be the benefit for the audience, and what are they going to change in their organisations?” brought a wealth of experience in increasing awareness about this topic.

Professor Nairn Wilson, Secretary of FEHDD and Dean and Head of School, Kings College London, Dental Institute said “This symposium was very well received and provided very useful information to support European Deans and Heads of Dental Schools”.

Dr Anousheh Alavi, Scientific Affairs, Colgate UK and Ireland, said “Colgate are delighted to once again partner with the FEHDD. This year’s theme highlighted the importance of the key role of the deans in the current climate as agents of change”.

For more photos from the event please visit Denplan’s Flickr page.
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We asked for your comments, and we got them...

Dr Martin & Edwards, Dental Surgeon

I think it is absolutely disgraceful that the GDC have put the ARF up for DCNs. As we are all aware, DCNs are made up of dental hygienists, therapists, technicians and dental nurses; all of whom earn differing amounts of money. Why should dental nurses, most of whom earn nothing compared to the likes of dental hygienists and therapists, have to pay the same ARF? The GDC will not even consider, it seems, a pay monthly scheme for the ARF, even though this would greatly reduce the burden of paying the now £420 out of our meagre pay packets. Surely the GDC should come to some sort of an arrangement where the ARF is based on the registrant’s earnings or at least lowered for dental nurses? The rising cost of the ARF as well as indemnity insurance, the cost of CPD and the lack of decent wages for dental nurses could very well drive more dental nurses away from the profession.

Flustered Practice Manager

This is nothing but extortion and we are paying for the failings/incompetence within the GDC as well as those DCNs who did not re-register this year. The GDC need to get their act together and manage their finances, as we have to do in our businesses. Shame we cannot put up our prices by 55 per cent! My anger cannot be put into words.

Name and address supplied

We are paying for the mismanagement of the GDC over the past few years. Every project they have undertaken has become unnecessarily complex and expensive. Revaluation should be dumped before it gets completely out of hand. Jenny Pinder

On my wages I can barely afford the current fee. As this is coming into force 2011 I think it would be a good idea if GDC introduced the option paying this in monthly instalments via direct debit. You can pay pretty much everything else (car insurance, house insurance etc) via instalments so I think this option would be welcomed. I know there are a lot of DCNs on a lower wage than me who would struggle and the new fees could possibly make people think twice about choosing dentistry as their chosen career. Kate Powell

Why has the CQC not yet decided what the registration should be for their enforced membership? They are waiting to see what the GDC can get away with. Today I have to take time out to go to a compulsory talk about our registration. No fee for this, but no compensation for loss of UDA time either. Retirement? Foreign climes? Anything! I am a clinician, get me out of here! Peter F-Jones

Somebody please outline the justification for this 51 per cent increase for the ARF when there are fees payable for another regulatory body on the way. Is the wine cellar looking empty at the GDC? Is name and address supplied

It is reasonable? The industry is in a recession and we are being asked to pay more. I do think that as the GDC is a monopoly the case for increase of its ARF should be referred to the trade’s commissioner, I know that I personally have not received any increase in revenue this year and it will be financially difficult for the average dental technician to pay these fees.

Name and address supplied

It’s a disgrace! The GDC are helping themselves to a 51 per cent pay increase at a time when every one else is tightening their belts.

The GDC already charge more than the General Medical Council, who charges £420 per annum (www.gmc-uk.org/docs/fees.asp). It should be noted that the GMC also give a 50 per cent discount for registrants who have a low income - such as those on further studies.

Some minutes from a GDC finance committee meeting give a few clues as to where the money goes: (www.gdc-uk.org/ NB/don/lyres/F466199-4064- 4D74-8453-9E6C70674450/0/1 51200MinutesConfirmedwebsi te.doc). The highlights point to lax procedures for approving expenses, lack of budget planning and not having the time to review their current Final Salary Pension Scheme which had a deficit from last year. It also mentions planning permission issues for developing Wimpole - the lavish central London offices.

Are they really on the same planet as us? 51 per cent fees hike, final salary pension schemes? Have they been somewhere else for the last few years? It amazed me to find out that they still have a final salary pension scheme - even open to new recruits. I’m not sure how pleased most dentists would be to realise this is how the ARF is spent.

This isn’t professional self-regulation - it’s difficult to describe their behaviour using civilised language! Maybe it’s time to abandon “self-regulation” and allow the profession to be regulated more sensibly by the HPC. I for one can find better ways to spend £500 per annum than someone else’s pension scheme, expenses, and flashy offices.

Name and address supplied

A rise of 25 per cent in the ARF is appalling for dental nurses. Unlike hygienists and technicians the salary scale of qualified dental nurses is still dreadful and an insult after working for two years - attending a course and working in their spare time so that they can qualify. As a hygienist with FETC, I have in the past tutored dental nurse students and qualified dental nurses studying for their Oral Health Education Certificate, and I was surprised at the syllabus content for both of the qualifications. Perhaps the dental nurses’ professional body should try and educate dentists and fight strongly for better salaries.

Barbara Jones, RDH

I find it despicable that we pay for the running of this inept organisation and have no say as to how they are run or how they spend my money. And in addition they have no real teeth, or are about to become enclu- lous, when the new CQC thing takes over, which an issue that is beyond imagination.

Brian Rubin, East Sussex

When the rise in ARF hap- pened a few years ago, I was in- censed and wrote to the GDC. I explained that I work part-time in Community Dental Services - why should I pay the same retention fee as a GDP work -ing full-time in private practice probably earning five or six times my salary! I received a standard letter from the GDC saying that they had no facilities to pro rata the fee for part-time staff. As many women are part-time because of having families etc, I feel this is discrimination against women. I still feel very angry about this stupid ruling.

Dr Cate Jarrold, Aledshor

What are we paying for? It seems that bureaucracy has gone mad. How can they warrant a rise of 25 per cent in times of recession when dentists are finding a lower footfall into their practices with addition of CQC inspection at a cost to the practice of around £1,500 (what registered laser practices have been paying)? For many practices this will have an effect on the ability to cover other NHS contracts as these rises were never in the contract costs when they were introduced. Surely this is the time to get every dentist into action against these excessive increases. This on top of the intention to remove the use of the title “Doctor” makes one wonder what the real role of the GDC is.

Name and address supplied

I find the trend across the entire public sector of increas- ing fees with the rate of inflation to be disgraceful and unsustainable. If a dentist wishes to practice, he or she must register with this body, the GDC, which represents a monopoly in that regard. Monopolies are insensitive and, uncompetitive, with a relaxed attitude to their captive audi- ence’s plights.

The GDC gets a large number of frivolous complaints, but almost everything goes to first stage of litigation. I recently endured a frivolous com- plaint, which was eventually thrown out. Although the GDC came to the correct conclusion; the process was cumbersome and resulted in hours of work for my defence lawyers. I was stressed for months. I would have appreciated a call from someone at the GDC to explain the process, which was unfa- miliar and disturbing to me. Instead I received a threatening letter accusing me of six major breaches of my duty of care to patients, based on the say so of one individual.

The GDC is out of touch. In my opinion, the increase in GDC retention fees is a reflec- tion of their lack of innova- tion in dealing with increased complaints, and a failure to budget correctly. The GDC should be pursuing costs against those people who make frivolous complaints, and using the monies acquired to balance the budget. They’ve already grabbed millions from dental nurses and other DCNs, and yet still claim it’s not enough. Something is very wrong with that. It feels to most dentists that we are being forced to pay for a body which likes to punish us whenever it can. The voice of the public drowns out the voice of the profession, the majority of who are caring and conscientious and doesn’t need a big stick to put patients’ interest first.

I suppose the extra money gets completely out of hand. This isn’t professional self-regulation - it’s difficult to describe their behaviour using civilised language! Maybe it’s time to abandon “self-regulation” and allow the profession to be regulated more sensibly by the HPC. I for one can find better ways to spend £500 per annum than someone else’s pension scheme, expenses, and flashy offices.

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I suppose the extra money will come in useful for their misguided and malign campaign to prevent dentists using the courtesy title Dr!
Putting things into perspective

Neel Kothari talks to Leo Cheng about the work of Christian dental charity Mercy Ships and how it’s providing many West African communities with much-needed dental care.

O
der the past couple of years, we have read numerous articles outlining some of the day-to-day failures seen within the NHS (some even by myself, perhaps). While the difficulties have been much publicised, many of the things we get right are often forgotten and, dare I say it, taken for granted.

The advantages of the NHS are even more noticeable when looking at developing countries, where a lack of basic provisions often results in the spread of disease considered eradicated in the west.

Reaching out

Let me turn your attention to the work of Christian dental charity Mercy Ships, who provide free medical and dental care for countries who are not fortunate enough to have a system like the NHS.

Mercy Ships comprises of a fleet of hospital ships, which have been visiting developing nations since 1976 and are crewed by volunteers offering healthcare and other professional services free of charge.

Many people in developing countries have never had the opportunity to see a dentist. Dental care is almost non-existent in much of West Africa, as well as many of the other areas Mercy Ships visits. In common with many industrialised countries worldwide, the most frequently seen oral diseases are dental caries and periodontal disease. However, unlike many countries, thousands of people suffer from dental pain for weeks, months, sometimes even years, because of the lack of available dental care.

Although difficulties accessing NHS services can lead to difficulties for some patients in some areas, in the UK we rarely hear of death as a result of untreated dental infections. Consultant oral and maxillofacial surgeon Mr Lee Cheng, who regularly volunteers onboard Mercy Ships, informs us that in third-world countries dental infection and does kill.

For example, because of a direct lack of healthcare, one patient required life-saving emergency treatment as a result of a spreading dental infection. Drains were inserted in all facial spaces in his neck and floor of mouth and regular irrigation through the drains with antiseptics (for example, betadine, hydrogen peroxide, etc) was necessary to wash out abscess cavities within his chest. Thereafter, this patient was intubated in ITU and was kept in ITU for three days before extubation. He continued to receive irrigation of his mediastinal abscesses for another two weeks before his infection was under control.

First-class dentistry for the third world

Onboard, the volunteer dentists, nurses and hygienists play an important role in the prevention of dental diseases and help educate patients by showing simple oral hygiene tips, as well as by introducing fluoride to the oral cavity. While many patients have to undergo procedures such as the extraction of teeth and roots, dentists are also able to restore teeth with composite fillings. Mr Cheng also informs us that when at one point dental students had come on board to observe Mercy Ships in action, in the short time they were extremely difficult, due to their remote location, lack of medical facilities and financial constraints. Conditions that would be treated in the early stages in developed nations grow to the point of being life threatening in underdeveloped nations; the consequence for many is a lifetime of disability and rejection.

Cleft lip and/or palate is a condition easily repaired in the developed world; however, cleft lip babies born in developing countries are often malmourished because they cannot feed properly. Children who do survive are often rejected because of their deformity. The statistics tell us that cleft lip and palate is the number one facial birth defect and the fourth most common birth defect overall, affecting 1 in 700-1,000 live births (WHO).

In the UK, cleft lip and/or palate is routinely treated at a young age, however, in West Africa it can be left untreated. In West Africa, superstition also plays an important role in how children with facial deformities are treated. I am informed that many children with this condition are kept hidden from view, rejected by friends and family, stoned if they appear in public and in some cases have been buried alive.

Superstitious practices

The lack of healthcare provision and education has meant that in many cases, witch doctors or village chiefs are often the first port of call for many local villagers. Unfortunately, the advice given is based on local superstition and a real lack of healthcare access means that, for many, there is no option other than to take this advice.

In a recent report by the BBC, Humphrey Hawksley reported that, while billions of dollars of aid have been invested in programmes to modernise Africa
and end poverty, traditions such as secret societies and witchcraft are still deeply entrenched and often pitted against what the West is trying to achieve there.

If you are interested in learning more about the work provided by Mercy Ships, please visit www.mercyships.org.uk, where you will be able to find a plethora of information and some truly heartwarming stories about some third world citizens not lucky enough to have access to proper health care, let alone a national health service.

**About Mercy Ships**

Mercy Ships is an international Christian charity that provides free medical care and humanitarian aid to the poorest countries in Africa through its ship — the Africa Mercy. The Africa Mercy is the world’s largest charity hospital ship. It has a 78-bed ward with six operating theatres, x-ray facilities, a CT scanner and laboratory facilities. The surgeons on board perform operations on children and adults such as cleft lip and palate, cataract and crossed eye corrections, facial reconstructions, club feet and dental treatments. Entire communities have been changed through the provision of medical equipment and medicines, as well as water sanitation projects, and agriculture and construction training.

Over the last 30 years, Mercy Ships has worked in more than 70 countries providing services valued at £530 million and impacting about 2.5 million people.

The charity has treated more than 485,000 people in village medical and dental clinics, performed more than 47,000 surgeries and completed more than 1,000 community development projects focusing on water and sanitation, education, development and agriculture.

**Who works on them?**

The Africa Mercy is crewed by more than 450 volunteers ranging from surgeons and nurses, to engineers, cooks and agriculture. Each paying crew fee helps engineers, cooks and agriculture. The surgeons on board perform more than 700 operations on patients such as cleft lip and palate, cataract and crossed eye corrections, facial reconstructions and treatments. Entire communities have been changed through the provision of medical equipment and medicines, as well as water sanitation projects, and agriculture and construction training.

**Decontamination**

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**About the author**

Neel Kothari qualified as a dentist from Retallack University Dental School in 2000, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice.
World of Webinars

Dental Tribune looks at the upcoming Dentsply academy series webinar starring Trevor Bigg

The 2010 Dentsply Academy webinar series, in association with Smile-on, is in full swing with broadcasts from Baldeesh Chana and Sarah Murray discussing root surface debridement; and Carol Tait enlightening attendees with techniques for cleaning and shaping the root canal system.

Next to take to the virtual stage is Trevor Bigg looking at Smart Dentine Replacement™ (SDR™), the recently-released composite base from Dentsply designed for posterior restorations offering bulk filling (up to four mm) combined with excellent flow-like cavity adaptation.

Trevor will be looking at the various indications where SDR might make a cost- and time-effective alternative to more traditional methods, as well as giving hints and tips on how to use the material to best effect, from the restoration of deep cavities to children’s dentistry. Patients are requesting ‘white’ fillings and the latest research suggests that we dentists should be supplying them if we want to reduce tooth fracture in later life. The only problem with this is that a good composite filling takes so long to insert. SDR™ simplifies this process and reduces the risk of sensitivity from composite contraction, in the process saving time.

Trevor’s easy presentation style and large knowledge base has proven very popular with past webinar attendees and this event is looking like no exception. For those new to the webinar concept, webinars are a type of web conference with a difference, as it is live and interactive. The direction of the presentation is primarily led by the presenter/speaker however, audience participation is integral and indeed necessary for a more useful and interesting experience. A webinar is ‘live’ and interactive – with the ability to give, receive and discuss information. There is a ‘chat’ facility available for attendees to post questions and comments, which can then be answered live by the presenter.

Trevor’s presentation, Smart Dentine Replacement – No more time-consuming layering!, will be broadcast on October 26th starting at 7.30pm. For more information go to www.dental-webinars.co.uk or call 020 7400 8989.
My name is Michael Oliver, from Oliver’s Dental Studio, Sunderland. I had heard about the Moroccan people’s struggles through a friend who went there for three days and was stunned by the sheer beauty of the unspoilt landscape and the friendly people. But on further inspection, he noticed their teeth were in a state of had decay and they desperately needed help. So with this insight I was duty-bound to finance my own charitable journey and treat the Berber people with a newly formed charitable group; Dental Mavericks.

On route we would meet the following adventurers; Abdul high up in the Rif mountains who served up real bee’s honey combs for breakfast, a Belgian counsel who spoke like Rene from Alo Alo, a female Moroccan Professor of dentistry, and a handsome maverick Moroccan missionary doctor… all of them had one purpose - to make a dental difference for 50 Berber children.

Never had this been undertaken by a UK dentist and so I set off with seven dynamic dental colleagues on a charity expedition I will never forget.

It was a hot sunny afternoon in El Jebah, Morocco and I was treating 50 Berber kids in a remote fishing village nestled in the hard to reach Rif Mountains. Make no mistake this was the most overwhelming experience of my dental career!

**Duty Calling Day 1**
Flying to Malaga we spent a night in Alora, Spain, where we visited Spain’s second oldest church. It was locked, but our flamboyant expedition guide Domien asked a few local gypsies who held the key and voila, we gained entry to a magnificent church!

**Duty Calling Day 2**
We got up eager and early next morning and headed onto Algeciras to jump aboard the fastest ferry in the world to Tangier. According to history, the Moorish people were kicked out of Spain in 1609 as part of the Spanish Inquisition. Little did we know that many settled in a town in North East Morocco called Chechaouen (pronounced Chef Chowan): It’s nick named the ‘Blue City’ in the hills.

En route we stopped at a very traditional Moroccan restaurant where we were treated to meat balls; it was there that I avoided the first hole in the ground toilet. On arriving in Chechaouen we were treated to a guided tour around the ancient city’s small Medina; I was most surprised to see that in this day and age Berber women still washed clothes in the river. To finish off our second day we scoffed a traditional Moroccan tagine of meat and vegetables.

**Duty Calling Day 3**
Five times a day the Muslim lo-
cals are enticed to the Mosque by a loud speaker. The first call goes at five am (ish) and I eventually got use to it. We started our day early and after six hours of walking through the magnificent Rif Mountains we arrived at Alberge De Aziliane. It was the home of Abdul Carear, one of the most fascinating and happy characters I had ever met. We had home-made bread, sweet mint tea and cheese on arrival and Fruit of the Land – a traditional Moroccan Tagine consisting of a tiny piece of gristly meat and fresh steved vegetables for dinner.

Berber Tribe Day 4

After a, traditional breakfast consisting of four different breads and bees honeycomb, our charity expedition continued towards God’s Bridge; a natural arch built upon the Farda River through the dorsal limestone grounds. We were laden with honey and bread (well, actually it was stored in our rucksacks on the hardy Donkey we named Josephine). We continued trekking through the Rif Mountains and various Berber settlements along easy shaded paths, which wound their way between smallholdings, tiny farmhouses, and numerous ancient mills that were still working amongst green crops and fields.

As we got higher in the mountains, we glimpsed monkeys and found ourselves walking along a mountain path, which was one foot wide and sometimes narrow to less than a centimetres, where it cascaded vertically hundreds of feet down to the village of Akchour! Scary!

Dental Difference Day 5

Bah Ieret is a small town that trades in one of Morocco’s biggest exports, Hashish. We didn’t stop here, we drove through a cowboy town high up into the mountains, where some of us cycled 50km downhill into El Jebah, a little fishing village on the Mediterranean coast not yet ruined by tourism.

A fish dinner bought from the fishing boats was served by Fred, the guest house owner, on the spectacular roof terrace overlooking the smelly fishing port. At 9pm we were exhausted and eager to start the next day: we were ever closer to making a dental difference for the Berber kids.

Dental Difference Day 6

At 9am sharp we were taken to a school nestled in the Rif Mountains by the Belgian Counsel to Morocco, who had been our go-between. He was a real gentle caring man who re-enacted Rene from Ali-Baba. We were next introduced to an extreme humanitarian Dr Banani, the founder of a group of international medics ‘Ranks of Honour’, who travel to hard to reach villages in Africa to set up camp to treat all kinds of illnesses and disease.

We were introduced to Dental Professor Tress from Morocco and her team of young dentists, as supplies were unloaded courtesy of Henry Schein dentists, as supplies were unloaded courtesy of Henry Schein. We were excited but scared children were still working amongst green crops and fields.

It was here where they were educated on brushing and caring for their teeth, which were mostly rotten. After a diagnosis with urgent dental treatment they were sent to get fillings or to have teeth pulled to prevent further dental damage. On further investigation we discovered about 20 per cent had a toothbrush at home; but how many of them actually used it was another question. The decay in some of the children was so bad there were just roots left which had to be extracted.

I wanted to speak English to reassure the scared and in pain kids and put them at ease, but I found it difficult and often distressing with the language barrier even though we had translators. It was very upsetting for all of us, including the children, but we served our purpose.

At the end of the most humbling of days, I presented a Sunderland football shirt to Dr Banani and to Luc a signed book.

Dental Difference Day 7

We finally ended up in Marbella in a nice hotel; we had a hot bath and some serious memories to linger on forever.

This delightful dental difference trip was the tip of the iceberg. Overall, fifty Moroccan kids, some of them Berber, were treated out of a school of six hundred; we had made just under a ten per cent difference.

Our next objective was to fund a nurse who would visit the school weekly, educating the children on tooth decay prevention; for serious cases where children were in pain, we aimed to bring in a dentist from Chechaouen every month.

I plan to go back next year to make a further difference.

I got an awful lot from being able to help some beautiful, beautiful children with their dental problems. To come to a country that doesn’t have any dental care at all and to do just a little bit, which to these people, probably felt a lot, means a lot to me. Hopefully for those children who’ve had the treatment, they will feel better from our efforts.

This privilege does carry a responsibility, because once the Moroccan air had been absorbed into my lungs, there was no cure. Like me, I hope you have become fascinated by the people more commonly known as the Rifians, who have been displaced for more than 700 years from as far away as Egypt and the River Nile - the possible meaning “free people” or “free and noble men.”

Please note that Dental Mavericks is a non-profit organisation and all time, money and resources spent organising the Morocco Expedition, has been done so, free, at our own expense. If you would like to help us make a dental difference for 600 Rif Mountain children, you can do so here www.castleparkdental.co.uk.

If you have any further questions please email me at mjolivar75@sky.com.

‘It was very upsetting for all of us, including the children, but we served our purpose.’

‘We served our purpose.’

End
Phil Wander details the launch of Seminars@38 in London’s West End

I attended the launch of Seminars@38 which is located at 58 Devonshire Street, just off Harley Street in the heart of London’s West End Medical District. It is an elegant Edwardian building steeped in medical and dental history, which has just been brought bang up to date with the launch of a dedicated conference suite on the whole of the lower ground floor.

58 Devonshire Street is home to a successful, private dental practice run by Gaynor Barrett, which has a number of large and beautifully appointed and equipped dental consulting rooms, which can also be used for hands on courses, photography (of special interest to me!) and filming.

The seminar suite and practice facilities offer an impressive and flexible venue to entertain and educate dental professionals with first rate continuing professional development (CPD).

More than 70 guests visited during the open event and we were told that a roster of elite lecturers drawn from Gaynor’s worldwide contacts had been drawn up and that the dedicated suite would allow guests direct access to both speakers and sponsors in a way not possible with hotel or conference venues, allowing them to interact in an intimate and less intimidating setting. In fact I was told it was the only seminar facility in the area which provides the delegates or the company hiring it with a whole dedicated suite to configure in the way best suited to their needs.

According to the new website, a Diplomate of the American Board of Endodontics, Pirooz Zia, was the first to lecture in the new seminar suite before its official launch and he will be followed by high profile lecturers, including Jason Smithson who is running a hands on course on direct resin artistry and is supported by Nuview and Optident in October and November and Professor Giovanni Zanaboni in 2011. Seminars@thirtyeight plans to offer courses at various times during the working week and at weekends with the aim of making high quality CPD more accessible to both dentists and team members alike.

I intend to run a hands-on Dental Photography course at the venue in 2011.

I am told that after I left the atmosphere shifted and a pianist sat at a baby grand piano in the wood paneled reception room and entertained the guests to a jazz concert. At one point, one of Gaynor’s Associates, Emiliazzo Zanaboni, sang some operatic Italian arias to the delight of the crème de la crème of the medical district who sipped Champagne and toasted the success of the new venture.

Further details from www.seminars@thirtyeight.co.uk

Details to follow.

Dr Marc Cooper DDS
Mystery Programme, Details to follow.

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Ed Bonner and Adrianne Morris consider the considerable power of persuasion

By mere dint of the fact that we have a professional qualification, it can (for the most part) be assumed that we are competent in our sphere of endeavour. Why then are some of us successful and others less so? James Borg, an eminent work psychologist, business consultant and development coach believes that the crucial factor may be an individual’s power of persuasion.

We all know people who, regardless of the issue under consideration, seem able to get us to see, accept and even vote for their point of view. We also know others whom we like and respect, but do not have the power to persuade us that we should accept and buy into their ideas. Compare Tony Blair and Gordon Brown, or Margaret Thatcher and John Major, for example.

Now, you may not think this is all that important, but if you think about the number of treatment plans that you have suggested to patients and consider how many of those have not been taken up, you might come to the conclusion that your inability to get others to accept that it is to their overwhelming advantage to ride with you is actually costing you a huge amount of lost revenue.

If you cannot move others, you may remain unmoved yourself. As Borg says: ‘Every day at work – and in your personal life – you come into contact with people who need to understand your point of view, either for you to help them, or for them to help you. Equally, you need to understand their point of view.’ We need to find that magic formula, that ‘message that attempts to influence people’s opinions, attitudes or actions’.

So, what 10 factors increase our powers of persuasion?

1. Treating people as individuals
   The first big key; unlike socks, there is no “one size fits all” approach that will work for all patients. Some need to be given dollops of TLC, while others want only efficiency, by the same token. Some staff need an authoritarian approach; others thrive under the “I trust you, get on with it” tactic. Successful dentists find the key and then use it to persuade both patients and staff that the surgery is the best place to have their dreams fulfilled.

2. Being a good listener
   The second big key; really hear what your patients and staff tell you about their problems, rather than simply imposing your solutions on them. Listening to them tells them that you really care, but having heard, it is necessary to act as well. Pay attention to detail – this tells the person with whom you are communicating that you have heard, remembered and valued everything they have said. Paraphrase what they have said, so that they can hear that you have heard them.

3. Avoiding too many options
   We are obliged to discuss all treatment options explaining their benefits and downsides, and we should note that we have done so. This said and done, when you actually come down to give them a choice between the two or three best options and emphasise the one you favour most.

4. Positive body language
   Two people in discussion send messages to each other, not only verbally but by their dress, demeanor and posture. You are more likely to trust someone when the words they are speaking are in harmony with their body language as expressed by eye contact, position of arms, activity of fingers etc.

5. Having a good memory
   Ever noticed how impressed someone is when, at a party, having only met them once and that 50 minutes before, you remember their name? Magic! Not as difficult as you think, but it requires concentration and focus – or writing it down. Remembering people’s names, birthdays, where they went on holiday, family details, but most of all what you discussed last time is an essential key to being able to get them to buy into your ideas.

6. Avoiding ‘attention breakdown’
   An example of this might be the scenario where you are discussing something with a patient, the phone rings, you take the call, and on completion you say ‘Right, where were we?’ Remember, it’s difficult to control attention when there isn’t any in the first place!

7. Understand why ‘difficult’ individuals behave the way they do
   Difficult people use stratagems to achieve certain objectives for themselves, for example very autocratic or authoritarian people try to persuade you that they are stonger than you and bully you into submission: I understand that you can only come to the conclusion that they are stronger than you and bully you into submission: I understand that you can only come at night/weekends, but I cannot get staff of the quality I have done so. This said and done, when you actually come down to give them a choice between the two or three best options and emphasise the one you favour most.

8. Using ‘open’ communication
   Instead of saying, ‘You have to floss twice a day’, you could say: ‘I think that it would really be of benefit to you if you could floss twice a day.’ Other useful ‘open’ phrases include: ‘In my opinion…’, ‘I feel that…’. Make the words you use work for you rather than antagonising the patient or employer.

9. Selling the benefits, not the problems
   The message that people take away from a meeting is the one that makes the biggest impact on their minds. By having the treatment now, you will save yourself a lot of money and pain in the future and help keep all your teeth and your lovely smile, is a better message than, ‘Because you have such serious problems, your treatment will be painful and it’s going to cost you a lot of money, and I can’t guarantee success’ Creating fear will send them elsewhere.

10. Creating mutually beneficial outcomes
    Stephen Covey was clear that in order to be successful, we need to create win/win results where both parties benefit. It will benefit you not all at when the cost (to you and/or that person) of working with someone exceeds the benefit you or they experience.

The 10th dimension... the power of ten

About the author

Adrianne Morris is a highly trained success coach whose aim is to help people from where they are now to where they want to be, in clear measured steps.

Ed Bonner has owned many practices, and now consults with and coaches dentists and their staff to achieve their potential. For a free consultation, or a complimentary copy of The Power of Ten e-zine, email Adrianne at alphido.search@yahoo.com or Ed on bonner. edb11@gmail.com, or visit www.thepoweroften.co.uk.
CQC registration - an introduction

Vinai Patel and Amar Flora discuss Care Quality Commission registration

April 1st 2011 should be an important date in the diaries of any dental practice manager or clinical director. After this day, it will be illegal to provide dental care without being registered with Care Quality Commission (CQC).

CQC has introduced a new system of registration for all providers of Health and Social Care. This one-off process gives the Health and Social Care Commission (CQC) the opportunity to make sure that all registered dental care without being managed by the CQC will be legal. After this day, it will be illegal to provide dental care without being registered with CQC.

The deadline for completing the application forms is 31st December 2010. Whether you run an NHS or a private practice, you will need to complete these application forms and private practices have until the 31st December 2010.

The forms will be assessed by the CQC in early 2011 when they will judge each application and make a decision about registration.

CQC will then produce a live feedback report, which will be the current depot price. All prices are subject to the statutory rate of value added tax and delivery charges. The current price charged may be higher or lower.

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Making your pension work

Thomas Dickson explains just what’s involved in buying a freehold dental practice through your Self-Invested Pension Plan (SIPP)

Pensions are the future. There is no doubt that a wise saver will have considered their future financial security and plan. This will also involve making sure they have sufficient assets in place to maintain their lifestyle throughout retirement.

For those dentists with a secure, guaranteed NHS pension scheme, the assets cannot be accessed until you reach the age of 55. However, for those with private pensions, although the age to access the money stays the same, there is a great deal that you can do in the meantime.

Control your future

Pensions do not have to work hard for you just when you’ve retired. A well-implemented pension scheme can also provide the opportunity for a dentist to control their future now, managing a portfolio of investments or even buying property.

Pensions are not the first thought in many investor’s minds when they think of purchasing property. When it comes to taking the plunge and securing your own practice, practitioners either buy the freehold or simply lease the premises.

Buyers’ market?

Arguably, there has never been a better time for practitioners to enter into the acquisition of commercial property. The financial sector is looking favourably on the dental market, while the new NHS contract is helping practitioners secure a more regular monthly income stream.

Buying the freehold directly is only one of the options. Many practitioners are choosing to explore another option: purchasing the property through a Self-Invested Pension Plan.

What are the advantages?

While not for everyone, there are some definite advantages to buying commercial property through a Self-Invested Pension Plan (SIPP):

• The pension fund can borrow into line with the highest rate of CGT has been lowered to 18 per cent, this is still a tax worth saving and there’s every possibility this will be raised at some point in the future, to bring it into line with the highest rate of tax at 50 per cent.

• The pension fund can borrow against the security of the property – is considered to be a reliable ‘safe lend’. However, it’s stress-free – and at your fingertips.

• VAT can be reclaimed if the property is VAT registered.

Potential downsides

As well as the obvious benefits of this opportunity, it is also wise to point out the potential downsides. Most pension funds are implemented for good reason, and the assets are usually invested with a fair degree of diversification often combining a range of financial options, including stocks and shares, bonds as well as cash. Therefore, investing wholly in just one asset class – commercial property – is considered to be a relatively high-risk strategy.

Another disadvantage is that a SIPP containing a property is usually considerably more expensive to run. It’s also worth pointing out that technically the investor does not own the property, it is owned by the pension fund/trustees and any rental income or capital receipts from the sale of the property cannot be removed from the fund until retirement age is reached – the minimum retirement age is now 55.

Before making a decision on the most appropriate way to purchase a property, it is advisable to seek professional advice. There are many pitfalls that can befall a practitioner when taking this big step, and professional assistance from the start can save thousands of pounds, as well as hours of time.

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 its Guide to Buying a Dental Practice, packed full of practical hints and tips, contact Essential Money on 0212 885 5069, email thomas@essentialmoney.co.uk, or visit www.essentialmoney.co.uk.
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How attractive are the following concepts? Providing financial security for your family and future generations? Securing pension arrangements? Investing funds? Leaving assets for worthy causes? Protecting your assets from third parties? These are just some of the situations where a modern-day trust is applied. All very appealing, no doubt, but what on earth is a ‘trust’ and how can this apparently mysterious device be of practical benefit?

So, what is a ‘trust’? A trust best describes the situation where one person (known as the ‘Trustee’) is given an asset by someone else (the ‘Settlor’) for that person to hold ‘on trust’, that is for the benefit of a third person (the ‘Beneficiary’), usually subject to various terms. The relationship between the Trustee and the Beneficiary is said to be a ‘Trust’ and is governed by numerous rules and obligations.

Trusts in the modern world

Trusts have a very broad range of application in domestic life, and in the world of commerce. Some typical illustrations follow.

Wealth Preservation Tax, we can be comforted, will remain a constant in ever changing times. The Trust can be used to plan to reduce or even avoid taxes charged on benefits received and on formal ownership of property. All of us would prefer to avoid unnecessary income tax, capital gains tax and inheritance tax both now and in the future. Higher-rate taxpayers can save subsequent tax by transferring assets into a trust. Income tax earned by the capital assets will disappear because the asset will have been given away. Capital taxes will be avoided if the asset's capital value increases as the asset will belong to the trust. Inheritance tax payable on death will be avoided as the asset will not form part of the taxpayer's estate. Some examples:

Pay into a Trust an amount up to the prevailing nil rate band (currently £325,000) every seven years without any lifetime inheritance tax becoming due on that transfer. For married couples or civil partners the limit is £650,000.

Create growth in asset value outside your estate. For example, create a Trust with a modest amount of cash or take out a large loan to acquire capital assets. Over time the loan is repaid and the growth in value of the assets remains in the Trust, not in the Settlor's estate. Transfer into a Trust assets having a low value but potential for large growth. The value transferred from the Settlor's estate is small and all future growth occurs outside the estate.

Leaving business property on death to a spouse wastes tax relief. A gift to a spouse or civil partner is exempt. Business property qualifying for 100 per cent relief should be given to the lower generations or to appropriate Trusts. This overcomes the problem that such property, if left to the surviving spouse, may become an investment rather than a trading asset, losing entitlement to business property relief on the spouse's death. If the spouse may need the business assets, place them into a ‘wait-and-see’ discretionary Trust and, if needed, distribute to the surviving spouse after the first spouse's death. Leave a legacy to one or more pilot Trusts creating a nil rate band for inher-
Estate Planning Trusts can provide security for the family and future generations, for example, by giving away assets into a Trust set up in your lifetime or by making a gift into a Trust upon your death. This has the effect of ring-fencing the assets for specified and/or prospective beneficiaries. Protective Trusts protect family funds or property from a financially vulnerable or spendthrift child. The child would receive some benefit but core funds would not be at risk.

Asset Protection Trusts can be particularly helpful if you anticipate that your assets may be exposed to risks including: Claims (whether actual or prospective) from your own creditors ‘Forced heirship’ laws, where you may be subject to the laws of a country which dictate that on your death your property must be dealt with in a certain way. However, simply placing assets into a Trust to defeat creditors could be unlawful and liable to be set aside. Again, careful advice needs to be taken when considering any such steps. Trusts themselves incur tax!

Bear in mind that the trust is not a magic wand and tax may not vanish completely. Certain types of Trusts attract tax charges. The basic rate of tax applicable to trusts for income tax is 50 per cent on rental and savings income and 42.5 per cent on dividends. Advice is essential to see whether there can be any reduction in the amount of tax suffered by trusts.

Beware of the distinction, which is not always clear, between tax avoidance and tax evasion. The former is legitimate estate planning carried out to prevent a tax from falling due in the first place. The latter is a criminal scheme disposing of tax that has already fallen due. It is wise to be aware of this when considering any attractive suggestions that promise to make your current tax liability disappear!

HMRC are razor sharp in identifying any sham or artificial arrangements entered into, ostensibly giving away property into Trust but in fact reserving the Settlor a benefit and/or a degree of control over that property; in such an event tax will be charged according to the transaction’s true nature. The threat of this will deter such arrangements. It is essential that you take proper legal advice before committing to any such arrangement.

Who would you trust? As someone creating the Trust by giving away assets, you will need to ensure that you make the right appointment of Trustees. Trustees are in a fiduciary position to the Beneficiaries. They must act in good faith and with the utmost integrity, putting the interests of the Beneficiaries first at all times. As the Trust may exist for many years, you need to be assured that what was once your own capital is administered properly. You need not only to make the right choice of Trustee but also to ensure that the Trust deed is drafted with the utmost care and in anticipation of all reasonably foreseeable developments.

Why dispose of your assets? There are many advantages to be obtained from setting up a Trust. Why would you be interested in so doing? You have available funds from the sale of your practice.

Your practice may be about to undergo restructuring, from the introduction of new partners to the acquisition of land; cross-option agreements need to be set up; you wish to protect your assets; you wish to make provision for your family and future generations. There are, however, many pitfalls in this complex area of the law. Legal advice should be taken only from those with sufficient expertise and experience.

This is not intended to be a detailed consideration of the law and advice should always be sought as to the options that might be suitable for your situation.
A revealing measure of a dentist’s level of care and commitment to patients’ needs can be found in the way they deal with emergencies. Many complaints and allegations of negligence involve a patient’s feelings of having been abandoned or ignored, when finding it was impossible to access dental care in an emergency situation. Pain. If there is one particular treatment outcome, which has a particular propensity to inflame a patient’s sense of dissatisfaction, and to make a complaint or claim more likely, it is the onset of pain. Whenever a patient experiences pain or severe discomfort following treatment, it may well be attributed to some kind of failure on the part of the clinician. The patient’s displeasure on these occasions is exacerbated if the dentist is unavailable (or inaccessible) at the time when they are in pain.

The situation can sometimes occur where a patient attends for routine dental treatment having experienced no symptoms to date whatsoever, but subsequently find themselves in acute pain shortly after the treatment has been completed. Certain procedures carry a particular risk of creating postoperative pain or sensitivity, and in these cases it is sensible to prepare patients for any adverse outcome by giving them both preoperative warnings and postoperative instructions.

Pulp Proximity. Commonly this situation arises when a deep filling is provided in close proximity to the pulp. This can often precipitate a transient acute pulpitis, which, if the patient has been warned about what to expect and how to manage the symptoms, is generally overcome without too much difficulty. But if such a procedure is carried out just before a weekend or public holiday, or a special event in the patient’s life, and the patient has not been forewarned, they may well assume that something has gone wrong. The patient may subsequently hold the dentist responsible for the pain they have suffered.

Practical arrangements. Emergency patients without appointments can be difficult to accommodate within normal surgery hours unless time has previously been set aside for this purpose. Alternatively, time can sometimes be found for them, but only at the expense of time which had originally been reserved for other patients.

Good practice management is an integral part of good risk management, and the effective
Patients in pain need to be handled with compassion

Care of a patient in pain challenges many aspects of practice management. Having an effective telephone system and appropriate staff available to answer the telephone promptly and effectively during surgery hours, with a caring and compassionate telephone voice is certainly a good start. An appointment system that can accommodate emergency patients at short notice is the next requirement, and will make it easier for a receptionist to respond promptly and effectively to the patient’s needs.

In this connection, it is important to recognise the crucial role played by reception staff not only in making an emergency appointment, or offering appropriate advice, but also in the way in which the patient is listened to and spoken to. Patients requesting emergency treatment are, at best, being inconvenienced and, at worst, may be in severe pain or distress. Not uncommonly, the patient may not have slept because of their dental problem, and any response needs to take these factors into account.

What is an emergency?

There is a wide spectrum of opinion as to what constitutes an ‘emergency’. The obvious examples are a patient in acute pain, or with an abscess, or swelling, or excessive postoperative bleeding. It must also include the shocked and distressed child who has parted company not only with a skateboard or bicycle, but also with one or more teeth. All of these are situations where few would disagree that a dentist’s duty of care extends to seeing these patients without delay.

Views differ, however, on the sore spot beneath the denture, or these patients without delay. Duty of care extends to seeing these are situations where few would disagree that a dentist’s duty of care extends to seeing these patients without delay.

Cover Arrangements

Dentists will normally put in place some kind of emergency cover arrangements for periods of holiday, sickness or other absence. This may take the form of a colleague within the same practice, or perhaps someone in another local practice where cover is provided on a reciprocal basis. Emergency rotas are common, whereby a number of dentists in one area join forces to provide out of hours cover on a rota basis.

Other dentists – particularly those in isolated or rural areas – will sometimes prefer to make their own arrangements wherever possible. In some areas, a local hospital or other clinic can provide a readily available additional level of cover for patients, while in other areas there is no such backup, within a reasonable distance of the surgery.

A sympathetic team

It may not always be possible (or even necessary) for the patient to speak to the dentist immediately, and here the experience and knowledge of the person answering the telephone should allow him/her to assess the severity and possible causes of the patient’s pain. If it is necessary for the dentist to ring the patient back, make realistic and achievable promises of when this will be possible – and ensure that those promises are kept. Time passes very slowly for patients in pain, while perceptions of abandonment and feelings of anger develop surprisingly quickly.

Every effort should be made to convey a supportive, caring, compassionate and sympathetic response; transmitting the feeling that the team has understood the problem and are doing their very best to resolve it as quickly as possible for the patient.

Refusals cause complaints

A patient’s request for emergency treatment is a situation that has a significant potential to create dento-legal problems. In most cases it is a perceived lack of care or concern, perhaps compounded by a refusal (by the dentist, or by a member of staff) to see the patient, or the lack of emergency cover arrangements, that causes the complaint. Sometimes the problem arises from the treatment actually provided; perhaps as a direct result of the fact that time has to be created at short notice, when in reality no time is available, and any treatment is done within tight time constraints.

A refusal to see a patient and consideration. In such cases expressions of genuine anger and resentment are not unusual. Sometimes, the patient’s request for emergency treatment is not related to pain or swelling at all; their emergency request is based on some imminent personal deadline. Having a crown re-cemented before going on holiday the next day, or a filling replaced before getting married, or before an important business meeting, may not be an ‘emergency’ in the eyes of the dentist or members of staff, but it is an emergency as far as the patient is concerned. Refusing such a patient will provoke similar levels of resentment, anger and frustration.

Systems

The best approach to the problem is to establish a clearly defined system for dealing with emergency patients. Like any system, you and other front-line members of the dental team will need some ‘house rules’ about what exactly constitutes an emergency, leaving some flexibility to assess other situations on their merits.

The next stage is to design a structured system for accommodating emergency patients both during surgery hours and (where necessary) out of hours, and then to communicate information about this system and how it works to all patients. In some practices, there is a pattern whereby more requests for emergency attention tend to be received at certain times of day, or on certain days of the week.

Professional Commitment

Most dentists show an admirable professional commitment to patients who have a reserved (pre-booked) appointment on a given day. But there will be occasions when, in order to accommodate a genuine emergency, these plans may need to be altered. Explaining this to a patient who will thereby be inconvenienced, will, if handled correctly and with sensitivity, be less problematic than trying to explain to a patient in severe pain why they must wait several hours before they can be seen.

Any request for emergency treatment needs to be recorded in the patient’s notes (preferably indicating the time) together with a note of the response, advice/treatment given, etc. If a receptionist at times finds it difficult to explain to the patient to attend, later that day, but the patient declines because they are too busy that afternoon and would prefer to come in the following morning, then all of this should be recorded in the patient’s notes. If the patient’s condition happens to worsen overnight, then at least it can be demonstrated that this need not have happened, had there been some accepted the earlier appointments that had been offered to them.

It is worthwhile keeping a ‘log’ or similar record of all calls taken away from the practice, so key details can be copied back onto the patient’s notes. Not surprisingly, many patients who are treated with care and consideration, and are accommodated promptly when their need is greatest, will often be enduringly grateful; some will demonstrate their appreciation by becoming the most vocal and enthusiastic ambassadors for the dentist concerned.

Predictably enough, the reverse is also true, and a failure to offer or provide emergency care can create a damaged reputation for being uncaring, unprofessional or even arrogant and dismissive of patients’ needs.

A complaint or claim that is fuelled by a patient’s anger and resentment, and often personal animosity towards a healthcare professional who was apparently prepared to leave them in pain or otherwise suffering, is not easily resolved. Patients who make such allegations are often prepared to pursue them with a crusading zeal, demonstrating a real determination to prevent the same situation arising from other patients.

Summary

It is often overlooked what a positive impact upon practice goodwill can have by making a real effort to accommodate patients. Not surprisingly, many patients who are treated with care and consideration, and are accommodated promptly when their need is greatest, will often be enduringly grateful; some will demonstrate their appreciation by becoming the most vocal and enthusiastic ambassadors for the dentist concerned.

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We are the world’s largest specialist provider of dental professional indemnity and risk management for the whole dental team. The articles in this series are based upon Dental Protection’s 100 years of experience, currently handling more than 9,000 cases for over 48,000 members in 70 Countries. Email support@munis.org.uk or visit www.dentalprotection.org.
In this first of two articles we will discuss the technical side of the telescopic dentures before presenting the clinical side in the second part.

Telescope prosthesis or double crowns are a proven option for the prosthetic treatment of dramatically reduced dentition (fewer teeth might serve in some cases as an alternative to implants). However, the production of such a prosthesis demands high technical skills on the side of the dentist and the dental technician. Of equal importance is a good communication between dentist and technician. These are the main keys to a successful case.

The telescopic attachment consists of two parts:
1. The primary (inner) crown, or coping, which is permanently fixed to the anchor teeth, and is preferably made out of a precious metal, a high gold alloy.
2. The secondary (outer) crown implemented in to the prosthesis, made out of the same alloy.

The normal type of double crown system next to the conus type is the parallel telescopic crown. They are named due to the fact that all surfaces from the primary (inner) and the secondary (outer) telescopic are not only parallel to each other but also parallel to the axis of each incorporated tooth. However in the case of a conus telescopic system a 4 degree angle of both telescopes to the axis of the tooth is aimed for, provided by the exact preparation of the dentist.

Indications
Double crowns can be used in the following situations: where there is a strongly depleted dentition uncertain prognosis of individual teeth in a periodontally damaged jaw (existing bone depletion, increased loosening of the anchor teeth) with an insufficient distribution of the remaining teeth for the retention of removable bridges.

The almost universal applicability is characteristic for this anchoring system. Telescopic crowns can be applied as clasp-free connecting elements with purely periodontally and periodontally-gingivally supported partial prostheses.

The pros and cons of double crowns
Advantages of the telescopic system:
• a predominantly axial loading of the pillars leading to a favourable distribution of force protection of the anchor teeth from decay
• the option of primary splinting for the securing and fixing of loose teeth
• integrated tilt-avoidance
• a straightforward ability to extend the prosthesis even up to a full denture the aesthetic advantage as no clasps are used the beneficial and straightforward treatment and control of the parodontium and the internal coping can be used as a cost effective alternative to implants

Disadvantages of the telescopic system:
• requires a high technical effort
• correspondingly higher costs
• over sizing of the secondary crowns if the pile has not been efficiently reduced
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- in comparison to a PMF crown higher tooth substance loss in preparation can only be coated/veneered with composites

**How double crowns work Physical principles**

The patient expects the prosthesis to be easily inserted and removed. At the same time, the prosthesis has to be sufficiently attached so that it cannot be leveraged off by motion during speech and eating. In order for these conditions to be met, you need certain physical preconditions. These are explained below.

In order to achieve a hold between the primary and secondary telescopic, these have to fit in a particular manner. There are three different types of fit:

1. a clearance fit, in which there is still a small bit of give/play
2. the medium fit, in which there is a large tolerance or over-sizing before the joining of the components (which gives totally useless telescopic crowns)
3. the pressure fit, where the components are tight and interact such that friction is created during fitting

On the principle that both crown pieces have to join exactly and without obstruction, parallel telescopic crowns are always pressure fittings; this is why telescopic crowns are preferably made from precious alloys, because of their high elasticity.

**The importance of friction**

The inner and outer telescopes are joined together by friction. Stated simply, the friction is due to the interaction between the surface layers of the inner and outer telescope. The binding forces of the telescopic crowns are therefore a consequence of this friction.

Friction in telescopic crowns is a value that is difficult to measure. It is principally dependent on the technical construction of the crown, which is influenced by the following factors:

- the number of the planned telescopic crowns
- the length of the friction surfaces of the individual tooth and also the sum of all available telescopes
- the placement of the friction surfaces relative to one another. Only oppositely facing parallel surfaces can provide the required friction with the elasticity of the materials, which is why gold alloys are generally used
- the quality of the work

A prosthesis has to be prepared in such a way that the patient can insert it without difficulty. Additionally, it must provide the feeling of fitting firmly.

The denture should also be removable without difficulty whilst not loosening at the wrong moment or due to sticky foods. The criteria must remain valid over a longer period of wear.

Note: The force required for removal of the prosthesis:

250–500 P is regarded as acceptable to patients. The maximal force required for removal should not exceed 650 P, as with higher levels the patient can often not remove the prosthesis.

Achieving the correct friction of the individual telescopic components is only possible with considerable experience and skill by both parties technically involved; the dentist and the dental technician, and their interdisciplinary communication. The success also depends on the precision of each step.
and each detail.

**Conclusion to Part 1**

We have given you an overview of the technical aspects of telescopic prostheses or double crowns, and their almost universal applicability. The basic principles of how they work and the importance of achieving the right level of friction are described. Success is dependent on good communication and technical skill on both the dentists and the technical laboratory's part.

In the next article of "Part 2 of precision dental prosthetics with highly engineered connections" we will illustrate the clinical side to the telescopes or double crowns, i.e. the planning and preparation required.
Protocol on how to use SDR

Prof Peet van der Vyver presents a pictorial essay on the use of Dentsply’s SDR

Recent developments in composite resin materials and bonding technology have made possible the routine use of these materials in posterior teeth (Van der Vyver & Bridges, 2002). Direct posterior composite resin restorations are now predictable and durable, and in many instances their superior aesthetic and tooth-supporting properties make them the optimal treatment option when restoring the posterior dentition (Lieberberg, 1997). The main shortcomings of composite resin materials are polymerisation shrinkage (Dietzchi, Magne & Holz, 1994) and polymerisation stress. Polymerisation stress can result in contraction forces on the cusps that can result in cuspal deformation (Pearson & Hegarty, 1989), enamel cracks and ultimately decrease the fracture resistance of the cusps (Wierzczkowski et al, 1988). This article aims to provide clinicians with a protocol on how to use SDR (Dentsply) as a flowable base material for direct and indirect restorations, by means of a pictorial essay illustrating the benefits of this new innovative restorative material.

Cavity configuration and the method of insertion of composite resin into the cavities can influence the gaps at the interface between the dentine/enamel and the restoration (Walshaw & McCombs, 1998). According to Davidsson and De Gee (1984), the parallel walls of a box shaped cavity may restrict the flow of composite during polymerization, causing stresses at the resin dentine interface (Feilzer, De Gee & Davidson, 1987). The present generation of chemically or light activated flowable composites undergo free volumetric shrinkage of 4-9 per cent as compared to regular viscosity and packable composites at 2-5 per cent, with an average of 3.5 per cent. According to Jensen and Chan (1985), polymerization shrinkage stresses have the potential to initiate failure of the composite-tooth interface which could cause deformation of the tooth, which might result in post-operative sensitivity and could even open pre-existing enamel micro-cracks (Jensen & Chan, 1985).

SDR is marketed as a low stress flowable base material that can be placed in layers of up to 4mm in thickness and each bulk increment light-cured for only 20 seconds, as long as you leave at least 2mm on the occlusal surface for regular viscosity composite resin. According to the manufacturer, a polymerizable modulator was chemically embedded into the flowable resin material that allows extended polymerization without a sudden increase in cross-link density. This extended “curing-phase” maximizes the overall degree of conversion, minimizing the polymerization stress by up to 60 per cent compared to conventional flowable composite resins (Inside Dentistry, 2009). The volumetric shrinkage is 3.6 per cent but more importantly, the stress generated during the polymerization is 1.4 MPa, whereas many other flowable composites are above 4 MPa. The material is available in only one universal shade and can be used with any dentine bonding system.

Figs 1-19 outlines two clinical case reports that illustrate the benefits and clinical application of this new innovative flowable base material for direct posterior composite resin restorations.

Base materials are mainly indicated to reduce the volume of filling material (Lutz, et al., 1988).
or to create adequate geometry to the cavity preparation for inlay / onlay preparation techniques (Dietschi & Spreafico, 1997). The shape of the cavity preparation will depend on the extent of the decay or the geometry of the restoration to be replaced. The removal of decay often creates unwanted undercuts which are not compatible with the principles of cavity preparation design for inlays/onlays. In order to preserve sound enamel/dentine as much as possible, the internal tapered design should be obtained by the application of a base material (Dietschi & Spreafico, 1997). Sherrer et al., 1994 demonstrated that the resistance to fracture for full ceramic crowns is significantly influence by the elasticity of the core material and luting cement. Because of the favorable properties of the SDR material the author is of the opinion that it might be the ideal material to block out undercuts in order to preserve additional enamel for adhesion and to improve cuspal strength during ceramic inlay cavity preparations. Figures 20 - 29 depicts a clinical case report to illustrate the clinical application of the SDR flowable base material to allow ideal cavity preparation design for indirect posterior inlay/onlay restorations.

Conclusions
Providing the clinician with a flowable base material for posterior direct and indirect restorations that can be placed and cured in bulk must be one of the most exciting technological advancements in dentistry towards technique simplification for what is generally regarded as a highly technique sensitive procedures.

The fact that SDR exhibits excellent adaptation to the preparation walls due to its flowable nature, reducing the potential for void formation on the margins that could lead to post-operative sensitivity or aesthetic failure of the restoration. Another unique characteristic of the SDR material is the self-leveling feature which eliminates the need to manipulate or sculpt the material before curing. This also creates an ideal surface for the addition of any regular viscosity composite resin to complete direct restorations, providing the desired strength, aesthetics and wear resistance for occlusal surfaces.

The reduced polymerization stress of the SDR base material on normal and compromised cusps after conventional cavity preparation might provide the clinician with an improved and simplified operative technique to provide patients with more durable posterior restorations.


Fig 1: Pre-operative view of an isolated upper right maxillary sextant. Examination of the upper right first premolar revealed a defective composite restoration. Note the poor interproximal contact between the premolar and canine as well as the inadequate contour on the distal aspect of the existing composite restoration.

Fig 2: Initial cavity preparation after removal of the defective composite restoration.

Fig 3: SonicFlex air-driven scaler (KAVO) and SonicSys Prep Ceram Tips (KAVO) that were used to redefine the margins of the proximal boxes.

Fig 5: Angulated view of final cavity preparation. Note the extended depth of the distal gingival margin from the occlusal surface.
Fig. 1: Final cavity preparation after caries removal and the etched margins of the provisionals were prepared with the Sun-nytix Prep Cream Tips (K. O. G) to ensure removal of any unsupported enamel.

Fig. 2: The cavity to be treated was isolated using a thin layer of adhesive cement to ensure isolation (Dentsply).

Fig. 3: The cavity outline after removal of the defective amalgam restoration and decay on the mesial marginal ridge. Caries Infiltration (Dentsply) was used to infiltrate some caries affected tooth structure.

Fig. 4: A thin layer of the cavity margin was removed with a low-speed handpiece and diamond bur.

Fig. 5: Completed restoration after finishing and polishing with an ultra-thin 30um airbrushed finisher (Extrude) and sequential finishing with 

Fig. 6: After the bonding protocol, the SDR material was dispensed using slow, steady pressure from the deepest portions of the cavity to the light-cured proximally. (Dentsply).

Fig. 7: After the bonding protocol, the SDR material was dispensed using slow, steady pressure from the deepest portions of the cavity to the light-cured proximally. (Dentsply).

Fig. 8: Different sizes of the Wave Hedges (Dentsply) that were utilized to seal the matrix band against the mesial gingival cavity margins to gain a tight marginal seal, reducing the chance for contamination to ensure the establishment of an unconformable bond strength.

Fig. 9: Matrix assembly: Hawe Contoured Toothbender Band in a Toothbender holder activated F-Ring and small Hawe Wave Hedges (white). Note the inadequate adaptation of the matrix band on the gingival margin of the cavity preparation. The small wedge was replaced with a larger Wave Hedges (pink) (Fig. 12) to better control the adaptation of the matrix band against the gingival marginal margins.

Fig. 10: Enamel and dentine surfaces were etched for 15 seconds with 37 per cent phosphoric acid, rinsed with water and lightly air-dried. Two coats of XP Bond (Dentsply) were applied and left to dry for 20 seconds to ensure complete bond strength.

Fig. 11: SDR: Smart Dentine Replacement (Dentsply) compula tip, which incorporates a fine, non-set tip for precise dispensing of the material with the attached macro dispensing tip.

Fig. 12: After the bonding protocol, the SDR material was dispensed using slow, steady pressure from the deepest portions of the cavity to the light-cured proximally. (Dentsply).

Fig. 13: SDR: Smart Dentine Replacement (Dentsply) compula tip, which incorporates a fine, non-set tip for precise dispensing of the material with the attached macro dispensing tip.

Fig. 14: The remaining part of the cavity prep was filled with Exuv N Cement (Ivoclar), a regular viscosity composite resin, and the impression tray was removed.

Fig. 15: Another 4mm increment of SDR was dispensed on top of the previous layer up to approximately 5mm from the cavo-surface margins. The material was again left undisturbed to allow for self-harding before it was light-cured for 40 seconds.

Fig. 16: Successive increments of composite were applied in an oblique layering technique, followed by a composite increment and light-cured for 40 seconds.

Fig. 17: The cavity to be treated was isolated using a thin layer of adhesive cement to ensure isolation (Dentsply).

Fig. 18: The cavity outline after removal of the defective amalgam restoration and decay on the mesial marginal ridge. Caries Infiltration (Dentsply) was used to infiltrate some caries affected tooth structure.

Fig. 19: Final cavity preparation after removal of caries left undercuts on the axial wall preparations and an irregular papal floor plane.

Fig. 20: Final cavity preparation after removal of caries left undercuts on the axial wall preparations and an irregular papal floor plane.

Fig. 21: After etching with phosphoric acid, rinsed with water and air-dried.

Fig. 22: Cavity outline after removal of the defective amalgam restoration and decay on the mesial marginal ridge. Caries Infiltration (Dentsply) was used to infiltrate some caries affected tooth structure.

Fig. 23: Completed restoration after finishing and polishing with an ultra-thin 30um airbrushed finisher (Extrude) and sequential finishing with OptiDiscs (Kerr).

Fig. 24: After making an impression with Blue-soft utility and Extra soft light body (Dentsply) the tooth was temporized with Integrity (Dentsply). A porcelain inlay fabricated in the laboratory from pressed enamel (Exive, Ivoclar) was etched with 9.5 per cent Hydrofluoric acid (1:1) for 60sec, washed with water and air-dried. Silane Coupling agent (Dentsply) was applied and left to dry for 3min before the porcelain inlay was veneered with a thin layer of Prime & Bond NT mixed with Silvarex Activator (Dentsply).

Fig. 25: A thin layer of the cavity margin was removed with a low-speed handpiece and diamond bur.

Fig. 26: After the bonding protocol, the SDR material was dispensed using slow, steady pressure from the deepest portions of the cavity to the light-cured proximally. (Dentsply).

Fig. 27: After etching with phosphoric acid, rinsed with water and air-dried.

Fig. 28: The remaining part of the cavity prep was filled with Exuv N Cement (Ivoclar), a regular viscosity composite resin, and the impression tray was removed.

Fig. 29: Immediate post-operative view after removal of the rubber dam. The final restorative reflects optimal restoration of aesthetics, occlusal anatomy, marginal ridges and interproximal integrity.

Fig. 30: Enamel and dentine surfaces were etched for 15 seconds with 37 per cent phosphoric acid, rinsed with water and lightly air-dried. Two coats of XP Bond (Dentsply) were applied and left to dry for 20 seconds before a Fthic Light-curing unit (Ivoclar).
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Encouraging change is essential

Encouraging patients to change their behaviour and improve their oral hygiene is challenging but essential. ‘To understand how to motivate change in patients, the oral healthcare practitioner needs to be aware of the distinction between compliance and adherence,’ according to the American education experts Joyce Turcotte and Rebecca Lang.

In an article in the journal Contemporary Oral Hygiene, they explain that the word ‘compliance’ suggests patients obey the clinician’s instructions. In contrast, the term ‘adherence’ characterises patients as autonomous, independent and intelligent, taking more active and voluntary roles in their dental treatment.

‘The distinction is who is directing the change. Compliance is authority-driven and adherence is patient-driven. When a patient behaves in a compliant manner, he or she is following the hygienist’s rules. This may not be valued, understood or committed to by the patients. However, adherence is a commitment made to particular behaviours congruent with a selected lifestyle,’ say Turcotte and Lang. That lifestyle will probably include achieving the freshest possible breath.

Since most people have a bad breath problem at some time and in nine out of 10 cases the cause originates from within the mouth presenting fresh breath as a desirable, and even necessary, element of a successful oral hygiene programme can greatly influence the demand to see the hygienist.

The Facts
• The BDA estimates that approximately 50 per cent of the population suffer from chronic bad breath at any one time.
• A survey conducted by Periprod-ucts Ltd indicated that nearly 70 per cent of those questioned had experienced bad breath on someone else.
• Approximately 90 per cent of physiological malodour originating from sites within the oral cavity can be attributed to Volatile Sulphur Compounds (VSC).
• The gingival tissue is a principal location of VSC.
• 80 per cent of bad breath emanates from the back of the tongue.
• VSC present themselves as odour-causing molecules made up of small sulphur atoms.
• The aim of bad breath prevention is to eliminate the VSC as much as possible.
• A healthy mouth constantly produces VSC at very low levels therefore it is important to maintain a good standard of oral hygiene.
• Oral care products specifically designed to eliminate odour-causing Volatile Sulphur Compounds (VSC) associated with oral malodour, such as the RetarDEX™ Alcohol Free oral health care range with fluoride and the OOLITT™ excel tongue cleanser.

Co-discovering with the patient the areas in the mouth that have the potential to harbour bacteria associated with tooth decay, gum disease and bad breath will help patients to accept that they need regular visits to the dentist and hygienist. Explaining this to patients before starting their examinations places you in a position of impartial observer and allows the patient to participate in the self-discovery process that is necessary for them to become an active contributor in their own care.

An equally successful way of encouraging co-operation is to ask a simple question; ‘Are you ever concerned about the freshness of your breath?’ The answer to this question can create an excellent dialogue opener and allows for further investigation and a committed patient. Who wouldn’t want Fresh Breath?
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