Is Improved Access Really Necessary?

The NHS Constitution: a Consultation on New Patients’ Rights, was published on November 10, with a Government pledge that everyone wanting NHS dental access should have it by Spring 2011.

The document states: “There have been problems with NHS dentistry access since the early 1990s. Our 2006 dental reforms have given PCBs the power to contract dental services to meet local needs. In order to expand services wherever they are needed, we have set up a national dental access programme, headed by Dr Mike Warburton, to support the NHS in further improving access.”

Recommendations also include linking some of dentists’ income to registered NHS patients and encouraging preventative care advice. The right to private treatment is proposed, if a patient cannot access an NHS specialist within 18 weeks, after referral.

But Eddie Crouch, Birmingham LDC secretary, has hit out at what he regards as the Department of Health’s (DH) ‘blanket policy’ to improve country-wide NHS dental access. He says registration in the early 90s was never cross referenced, hence figures are likely to be inaccurate and inflated. He thinks Government money would be better spent towards an area’s particular needs, as access isn’t a nationwide problem. He adds: “I have sympathy with the pressure PCTs are under, they are unlikely to want to object to pressure from central Government, even if they agree with local dentists.”

Mr Crouch also thinks the time-span for PCBs to make comprehensive needs’ assessments is too short. But he adds: “I have sympathy with the pressure PCBs are under, under they are unlikely to want to object to pressure from central Government, even if they agree with local dentists.”

He is awaiting a response from a letter, drafted to Ann Keen, minister responsible for dentists and LibDem MP, John Hemming, has commented that orthodontic, periodontal and endodontic treatments are hard to access and home visits for housebound patients and nursing home residents are inadequately funded. Surely money would be better spent on real problems.

Ros Hamburger, HOBTPCT dental public health consultant, said: “We are committed to providing the right kind of dental care and want to ensure everyone has a say in how that service functions in the future.”

DH figures released in August showed that 720,000 more NHS dental patients accessed services in the four quarters ending June 09. Courses of treatment in 2008/09 increased by four per cent (1.4 million) from the previous year and UDAs were up 5.7 per cent.

Chief Dental Officer for England, Dr Barry Cockroft says access is not only about procurements, but also covers improved contracting and better communication. He says: “How needs are tackled is also about social and cultural education, not just more services. It is important to get the right message through.”
Leicester in NHS dentist drive

NHS Leicester City is on a drive to encourage people to visit NHS dentists in the area. Dentists in Leicester are aiming to brush away myths about the lack of NHS dental provision, in a bid to inspire thousands of local people to access dental services.

A campaign was recently launched to raise awareness as to which dental surgeries in Leicester are offering NHS treatment, as well as to challenge the notion that it is hard to find an NHS dentist in Leicester. There are currently 60 NHS general dental providers in the city, of which more than half - 33 in total - are accepting new patients.

Staff from NHS Leicester City’s patient advice and liaison service (PALS) are signposting people to those dentists accepting new patients via a new dedicated dental helpline.

The campaign is also aiming to make dental charges clearer, so that patients who pay for NHS treatment can easily understand charge bandings.

Toby Sanders, NHS Leicester City’s director of primary and community care, said: “There is a belief that it is difficult to find an NHS dentist, but in Leicester this is no longer true.

“We have invested in dental services to make it easier than ever before for people to get an appointment. There are dozens of dentists across the city waiting to see NHS patients and we want people to take full advantage of this.

Dentist Philip Martin, who is chairman of Leicestershire and Rutland local dental committee and has a dental practice in Leicester, said: “There are many high quality NHS dentists available to people in Leicester and as local dentists we are all keen to support good oral health. We are sure that this campaign will encourage people to make an appointment now and to continue to see a dentist regularly in the future.

“We particularly want to see people back in our practices, who have not been to see an NHS dentist for some time. Visiting the dentist before problems develop is the best way to avoid costly bills and potentially painful problems in the future.”

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National Dental Nursing Conference Success

This year’s National Dental Nursing Conference, held at the Cheltenham Chase Hotel was the biggest and most successful to date. A record number of delegates attended the conference in October, which was sponsored by the BDTA, NHS Direct and Philips Sonicare.

Participants saw outgoing president, Angie McIlhain hand over the chain of office to Sue Bruckel who became BADN’s 2009-2011 president at the opening ceremony, where the keynote speaker was GDC president, Hew Mathewson.

The conference’s extensive lecture programme offered up to seven hours of verifiable CPD. Lectures covered cross infection control, introducing preventive practice, law and ethics, back care for dental nurses, risk assessment, prosthetics, oral and maxillofacial surgery, implants, medical emergencies and resuscitation, the new Bs for dental care professionals, forensic dentistry and accessibility for people with learning disabilities. Delegates could choose in advance which presentations they wanted to attend, through BADN’s new CVENT on line registration facility. A wide variety of speakers attended the event, from organisations including Schuëlle, Colgate, the British Chiropractic Association, Nobel Biocare, Philips Sonicare, the University of Kent, Gloucestershire PCT and the 2gether NHS Foundation Trust.

Outside the lecture theatre, delegates talked to representatives of NHS Direct, the GDC and Parliament Hill, providers of the BADN benefits’ scheme. At lunch, they were treated to a selection of British cheeses, courtesy of the British Cheese Board.

Peterborough general dental practitioner, Martin Fallowfield, was master of ceremonies at the black tie presidential dinner. Entertainment was provided by swing tribute act Swing Thru a Lens, whose repertoire of rat pack classics and modern swing favourites proved to be a big hit with delegates.

At the closing ceremony, the new president presented four new BADN fellows with their certificates, introduced new members and first-time delegates, congratulated delegates on recent qualifications and achievements and presented a wedding present from the BADN to newly-married chairman of the BADN’s student education group, Samantha Ball.

Next year’s national dental nursing conference is at the Blackpool Hilton in November.
Editorial comment

Access v need – a utopia

The top story this week looks at the necessity of improving access over addressing need. Some areas of the UK are seeing ‘access saturation’, where there are no more people wishing to access an NHS dentist, and plenty of spaces left.

So, is access the best target? If there are areas where money is being spent on surgeries which aren’t, where do we look? Local need is a vital area to look at. The needs of the population can vary from county to county, town to town, postcode to postcode. Dental professionals working in the NHS system know their patient base and know the needs that they have. Why not pass this information to the PCT or SHA? If every dentist in the same area did this, the strategic planners would be able to see the vital areas of need existing in their region.

I understand that in a perfect world this would be the case and I have no doubt that some readers are shouting ‘I do that already!’, maybe with little success. Those in the profession know that the levels of engagement are variable across the country, and if your views are not being heard, with the new wave of commitment by the NHS to the dental profession, perhaps now is a time to try again and let your PCT know what your patients’ needs are.

Champagne reception

Patients and staff at EndoCare Richmond celebrated its recent opening with a champagne reception.

EndoCare Richmond combines the latest endodontic specialist treatment techniques with the best quality patient care. The new branch, which is based in south west London is an opportunity for dental professionals to make use of this service, which is provided by clinical director, Michael Sultan and his team of specialists.

Mr Sultan said that dentists referring patients to the Richmond centre could be assured of the same outstanding care and high calibre endodontic solutions for their patients, which have already given EndoCare its outstanding reputation.

He said: “It is a very exciting time for EndoCare and now we can continue to take great care of your patients and treat them at either Harley Street or our new Richmond practice. We understand the trust that is placed on us by referring dentists and we want to work as an extension of your team, so you can continue to proceed with the next part of the treatment. We will make ourselves available to you and are always happy to give advice and support, aiming to see your urgent referrals as quickly as possible.”

For more information, log onto: www.endocare.co.uk

DIO implants have an effective cutting edge for ease of insertion, with double threading for better primary stability and excellent torque values. The tapered shape improves bone healing and density, whilst the internal torx design helps to reduce stress during insertion by up to 50% compared to hex-type fixtures. The availability of eight platform options makes for the best abutment performance.

However, given the current economic climate Dr Nandra is finding that quality is not the only critical factor. Instead, the balance between product performance and cost, as well as the subsequent impact on the end user, are becoming increasingly important considerations.

Alongside usability, price is of key importance. All implant surgeons will appreciate the handling and ease of use of all the DIO range, but we have found that the competitive price means everyone - from patient to surgeon - benefits.”

Historically, high prices of implants here in the UK have meant that many people are choosing to travel abroad where costs are much lower. Many practices are discovering that the pricing of DIO products means they can offer a high quality and financially attractive service, growing their customer base as people realise they do not have to go through the hassle of traveling abroad to afford the treatment they want. Dr Nandra continues:

“The credit crunch has meant more and more people are carefully considering the financial implications of dental treatment. I am able to offer my patients an excellent product at a significant saving to them. This does not harm my business as I can maintain the same level of profitability and pass the cost saving on to my patients. It is a win-win situation!”

The Edgbaston Dental Centre is representative of many practices across the UK that are finding the comprehensive range, cost effective pricing and high quality of DIO products appealing for their own technical demands and customer satisfaction. All fixtures are approved to relevant CE, ISO and FDA standards across Europe, the USA and Asia.

Dr. Anoup Nandra BDS (Lbirm) MF GDP RCS

A Fixture of Success

Dr. Anoup Nandra explains why DIO Implants are perfect for the UK

DIO has been manufacturing implants for over twenty five years, which means users are assured of a highly developed and reliable product that meets all key requirements. Their most popular implant range is based around the SM Submerged Fixture, which boasts a range of important features to improve durability, surgeon usability and patient comfort.

It has an effective cutting edge for ease of insertion, with double threading for better primary stability and excellent torque values. The tapered shape improves bone healing and density, whilst the internal torx design helps to reduce stress during insertion by up to 50% compared to hex-type fixtures. The availability of eight platform options makes for the best abutment performance.

Dr. Anoup Nandra BDS (Lbirm) MF GDP RCS
BDA attacks Widening Gap in Oral Health Inequalities

There is an “unacceptable and growing chasm” between those with good and poor oral health, according to the British Dental Association.

The Association’s recently published oral health inequalities policy document highlights the growing gap between satisfactory and unacceptable oral health in the UK. The document stresses the close association between low socio-economic status and poor oral health, calling for more focus on preventive care. It also emphasises that there should be a more integrated approach to oral health from health and social care providers. In addition, the paper argues that greater priority should be given to specific patient groups, such as those with disabilities, older people and the prison population.

The effect of alcohol and tobacco on oral health inequalities is stressed in the paper, especially with regard to their role as risk factors for oral cancer. Professor Damien Walmsley, scientific adviser to the BDA, said: “There has been a significant improvement in the nation’s overall oral health over the last 50 years, but in spite of that, we still see a huge disparity which is all too often related to social deprivation. It is completely unacceptable that in Britain, in 2009, such a wide gap should exist.

“Much good work to address this problem has begun and this report commends a number of schemes such as Brushing for Life and Sure Start which are starting to make a difference. However, a great deal of work still remains to be done and it is vital that dentists are supported in carrying it out.”

The BDA’s Oral Health Inequalities policy sets out measures designed to tackle the unacceptable and growing inequalities in the nation’s oral health. It shows that those living in the most deprived areas of the UK suffer the highest levels of oral disease.

It identifies the dental team as ideally placed to inform and advise patients about matters affecting their oral and general health, including nutrition, tobacco and alcohol. Strategies are set out to address the special requirements of vulnerable sections of society, including children, older people, prisoners and those with disabilities.

The paper also highlights the need for resources and remuneration to enable the dental team to spend time with patients and carry out their central role effectively. It is calling for an evidence-based, integrated approach between all healthcare and social services, because many causes of poor oral health are also risk factors for systemic diseases. Oral health prevention and education programmes should be part of overall Government health programmes.

Fellows in honour ceremony

Four new fellows of the British Association for Dental Nurses (BADN) were honoured at the closing ceremony of the 2009 National Dental Nursing Conference.

BADN president, Sue Bruckel presented new fellows Val Davis, Jackie Gazzard, Anne Hewitt and Wendy McCormack with their certificates at the recent conference in Cheltenham.

In order to become a fellow, dental nurses must have been a BADN member for 10 or more years, be registered with the General Dental Council and hold the City & Guilds Licenti- ate in Dental Nursing. In order to be awarded the Licenti- ate, a dental nurse must hold a preliminary qualification in dental nursing, such as the National Certificate or the S/NVQ 3, have further qualifications or evidence of five years in a supervisory position, and have evidence of further CPD.

It is vital that dentists are supported
Time to talk about dry mouth?

Approximately 20% of people suffer symptoms of dry mouth, primarily related to disease and medication use. More than 400 medicines including tricyclic antidepressants and antihistamines can cause dry mouth and the prevalence is directly related to the total number of drugs taken.

Ask your patients
Some patients develop advanced coping strategies for dealing with dry mouth, unaware that there are products available that can help to provide protection against dry mouth, like the Biotène system.

Diagnosis may also be complicated by the fact physical symptoms of dry mouth may not occur until salivary flow has been reduced by 50%.

Diagnosing dry mouth
Four key questions have been validated to help determine the subjective evaluation of a patient’s dry mouth:

1. Do you have any difficulty swallowing?
2. Does your mouth feel dry when eating a meal?
3. Do you sip liquids to aid in swallowing dry food?
4. Does the amount of saliva in your mouth seem to be too little, too much or do you not notice?

Clinical evaluations can also help to pick up on the condition, in particular:

- Use of the mirror ‘stick’ test - place the mirror against the buccal mucosa and tongue. If it adheres to the tissues, then salivary secretion may be reduced
- Checking for saliva pooling - is there saliva pooling in the floor of the mouth? If no, salivary rates may be abnormal
- Determining changes in caries rates and presentation, looking for unusual sites, e.g. incisal, cuspal and cervical caries.

Consequences of unmanaged dry mouth include caries, halitosis and oral infections.

The Biotène patented salivary LP3 enzyme system
The Biotène formulation supplements natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths.

The Biotène system allows patients to choose appropriate products to fit in with their lifestyles:

- Biotène Oral Balance Saliva Replacement Gel
- Biotène Oral Balance Liquid.

Hygiene Products:
- Biotène Dry Mouth Toothpaste
- Biotène Dry Mouth Mouthwash.

The range is appropriately formulated for the sensitive mucosa of the dry mouth patient:
- Alcohol free
- Mild flavour
- Sodium Lauryl Sulfate (SLS) free.

The Biotène formulation:
- Helps maintain the oral environment and provide protection against dry mouth
- Helps supplement saliva’s natural defences
- Helps supplement saliva’s natural antibacterial system - weakened in a dry mouth.

Samples available from www.gsk-dentalprofessionals.co.uk
New Oral Cancer Test

A new non-invasive technique of oral cancer diagnosis is in the process of development, which could mean screening is more accessible for those at risk.

A recent discussion on oral cancer in the House of Lords revealed increasing evidence suggesting that the condition is becoming more common in females and young adults than previously recorded.

Although this type of cancer has a relatively low profile in the public consciousness, and is less widespread than some other forms of the disease, it is still responsible for more deaths than testicular and cervical cancer combined.

Prof Stephen Porter, director of the UCL Eastman Dental Institute, said there remained a need for effective methods of early diagnosis once a clinician's suspicions had been aroused. He pointed out that there was a growing case for the screening of those sections of the population with the highest potential risk of developing this form of cancer.

He said: “The analysis of a biopsy of the suspect lesion is in the process of being done in children. However, researchers from the UCL Eastman Dental Institute and the University of Surrey are pursuing a study, funded by the National Institute for Health Research (NIHR), on the potential benefits and efficacy of a new, non-invasive method of diagnosing oral cancer and other potentially malignant diseases involving abnormal cellular development.”

The new technique, known as dielectrophoresis, detects electrophysiological changes within the cell structure. Although only in the early stages of development, it is hoped that this new analytical method will prove to be an effective diagnostic tool in the early identification of oral cancer prior to the creation of a tumour, or before the cancer itself actually develops.

Prof Porter said: “The sampling method is non-invasive and merely requires brushing the surface of the lesion; if the accuracy of dielectrophoresis is proven to deliver an accurate diagnosis, then the screening of large at risk populations will become both practical and cost effective, potentially saving many lives.”

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Dental Prevention Study Funded

The University of Manchester’s oral health unit (OHU) has been awarded funding to lead a study focusing on prevention rather than treatment.

The £1.7 million research project will investigate as to whether a prevention package - delivered by dentists in their practices - can actually prevent the development of tooth decay in children.

The OHU, which was selected to run the trial following a call for applicants, has a good track record of delivering high-profile dental research. Its outcomes could be useful in informing the development of NHS dental services and interventions in the UK.

Although the three-year collaborative trial involves a team of dental experts led by Professor Martin Tickle of the OHU at Manchester University, it actually takes place in Northern Ireland. The region has a particularly significant oral health problem, in that approximately 45 per cent of five-year-olds have tooth decay.

Professor Tickle said: “This trial is hugely significant for dentistry, because we were competing with all other areas of dental, health and health care research. It demonstrates our research reputation, in being selected to deliver a study with such important potential outcomes.”

Recent studies have shown that prevention of decay in children’s primary teeth in NHS general dental practice is not as effective as it could be. Studies have shown that over a three-year period, approximately 55 per cent of two-to-three-year-olds registered with a dentist developed tooth decay.

Although all NHS general dental practitioners in England have been sent Delivering Better Oral Health; an evidence-based toolkit for prevention, which identifies the best evidence for preventive care, research has yet to demonstrate as to whether these interventions are cost-effective when used in everyday NHS practice.

Therefore the trial will test the cost-effectiveness of fluoride varnish and family-strength fluoride toothpaste, which are provided in general practice two times a year to help prevent tooth decay.

Professor Tickle added: “The aim of the trial is to see if we can keep a larger proportion of children free of decay by using a fluoride varnish and toothpaste. Hopefully, the findings will help to inform future policy on children’s dental health and focus on proactively preventing tooth decay, rather than treating the disease once it has started.”

The trial, which is backed by the Department of Health, will be managed by a partnership of general dental practitioners and community dental service dentists, as well as academics from the University of Manchester and Queen’s University.
Eight ways to significantly increase your impact on those you treat

The experiences that your patients/clients/customers have can vary between forgettable and memorable. The ideas which follow will ensure that what they take away from you will be positive, says Adrienne Morris...

1. Promise less, deliver more - experience is shown that it really pays to undersell what you are giving and then overdeliver: the end result, a client who is thrilled to have gained a truly valuable product/result which vastly exceeded their expectations. At the same time you will have more than fulfilled your brief and hopefully have an extremely satisfied client who will be happy to recommend you and use your services again and again. Whatever you have gained profit-wise, you will have vastly exceeded as far as your reputation for performance, delivery and reliability is concerned.

2. Play full out - you know this isn't a dress rehearsal! Treat each and every opportunity as if it's the most important in your life and give it everything you've got. You never know who is watching you from the sidelines to see how you're performing and even if they don't sign up this time, it may take just one more occasion for them to see you or the results of your work in action to convince them that you've got what they want. Don't be disappointed if they don't give you an order or booking at the first meeting or the next - you have to build up trust and confidence and hopefully if you're always giving of your best, that will be enhanced each time they meet you or hear about you.

3. Pay attention to detail - don't be sloppy - attend to every small detail because experience is often a significant difference to you in the long run. Facing a seemingly daunting task but breaking it down into manageable chunks and dealing with each of these, one step at a time, will make it seem much more approachable. The learning you will get from your setbacks will be invaluable and make you stronger. Focusing on the solutions rather than the problems is a much more positive approach.

4. Know your subjects - If you're trying to reach someone, get names of the 'gatekeepers' i.e. secretaries, personal assistants, receptionists - establish a rapport with them - they're the ones who might just get you through the door when they're rejecting everyone else (Peter Thomson, the renowned business consultant, refers to receptionists as 'rejectionists' with good reason!).

5. Follow up good contacts - Always follow-up when you meet someone new with whom you feel you have really connected - drop them an email and remind them of what it was you had in common or had chatted about, remind them what it is you do, and for whom you have done it. If you have to write a thank you, a handwritten note will always leave a good lasting impression, as long as it's legible! Mention that if you meet someone who could be a potential client for them in whatever they are doing, you will definitely put them in touch - and do so! Hopefully in time they will reciprocate.

6. Be positive and put on a happy face - sure it's hard but it's the result of experience. The Tony Robbins mantra "attitude of gratitude" really does have power. Whenever you're facing a setback, do a mental checklist of what IS working in your life right now, what you DO have going for you, who IS in your corner cheering you on, and give thanks for your good health, for a roof over your head, for your friends and family, the strength and courage you have to be striving to do better. Lift up your head, put your shoulders back and smile - you should feel better straight away!

7. Focus on solutions, not problems - you have to switch your focus to solving the issues preventing you from getting to where you want to be. During the process every step will be a learning exercise and it is this learning that is going to help you grow and in itself be life-changing. This, as well as the end result, is going to make a significant difference to you in the long run. Focusing on the solutions rather than the problems is a much more positive approach.

Adrienne Morris is a success coach helping professionals and small businesses reach new heights of success in all areas but in particular confidence, self-worth, communications and relationship issues. She can be reached on 07966 344744 or coachad@alphalifecoach.co.uk Read more at http://alphalifecoach.com

"Success is the result of good judgement. Good judgement is the result of experience. Experience is often the result of bad judgement" - Tony Robbins
GDPUK round-up

Tony Jacobs shares the most recent snippets of conversation from his ever-growing GDPUK online community

One of the things colleagues on GDPUK like to discuss is their input to other forums. Often, when there are articles in the mainstream media, the public is encouraged to comment on the story, which is often done so in ignorance, when of course, we are better informed. When this type of article is highlighted on GDPUK, it can often be seen that our members are wading in and righting the wrong impressions and negative PR put about by the doomsters.

One of the GDPUK stalwarts has spent years patrolling the forums of moneysavingsexpert.com and correcting errors and misconceptions about dentists, dentistry and how the system works. Recently there was a call for colleagues to help out in the same way on another more obscure forum, to repel those ill-conceived ideas and spread positive PR on dentistry. A worthwhile occupation.

Will a pay freeze in dentistry help dentists find further efficiency savings? Or has the owner operator system in UK dentistry made dental practices lean and efficient already, and indeed increasingly so for the last 50 years? The Department of Health evidence to the Review Body calls for a freeze in dentists’ pay. It will be some time before any freeze or change in pay will be announced, which usually happens in the new year. Dentists also have to factor in that VAT will rise in January, and thus expenses next year will rise, as well as inflationary pressures. Something has to give – where do you think the fracture lines will appear?

What would you do in this situation? A patient, two years ago had a crown prep. They paid in full, and you make an excellent temporary crown. The patient is phobic however, and before the crown can be fitted, he gets in touch with the practice and decides to live with the interim situation, meaning the crown and models remain in the cupboard. Now, 27 months down the line, the patient calls and asks for the crown to be sent, and for another dentist to fit it – she has paid for this service, but has decided to ask for this elsewhere. Do you send it without question, or refuse? Contact the other dentist? Warn the patient of the risks? Contact your defence society?

Here is another thread, which has not been fully discussed at the time of writing. Suppose Key Performance Indicators are contracted, and dental income is partly based on patient responses following treatment. What do patients really know about their treatment? In other countries, it is illegal to publish a website where patients can compare services from medical and dental providers, including hospitals. It is considered that patient’s opinions are not appropriate to judge professional services. Does this hold in the UK? Should dentists be revolting against this? Or will there be some colleagues who will accept and sign the new access contracts with these clauses and provisions?

These short summaries of topics are just a small sample of the complex and interesting ideas and concepts discussed – there are hundreds more online at GDPUK.com.

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GDP friendly, with our with our Diagnostic Faculty providing full specialist diagnostic input and treatment planning, no orthodontic experience is necessary. As your complete orthodontic toolbox, Clearstep empowers the General Practitioner to step into the world of orthodontics and benefit not only their patients, but their practice too.

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This accreditation seminar is aimed at General Practitioners, providing you with all the knowledge and skills required to begin using The Clearstep System right away.

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Receive a visit from a Clearstep Account Manager, providing a personal accreditation in your practice at a time convenient to you.

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www.clearstep.co.uk

About the author

Tony Jacobs, 52, is a GDP in the suburbs of Manchester, in practice with partner Steve Lazarus at 406Dental (www.406dental.com). He has had roles on his LDC, local BDA and with the annual conference of LDCs, and is a local dental adviser for Dental Protection. Nowadays, he concentrates on GDPUK, the web group for UK dentists to discuss their profession online, www.gdpuk.com. Tony founded this group in 2004, which now has around 7,000 unique visitors per month, who make 55,000 visits and generate more than a million pages on the site per month. Tony is sure GDPUK.com is the liveliest and most topical UK dental website.
The 10th Dimension... the power of 10

In part one of this two-part series, Ed Bonner and Adrianne Morris discuss the important art of effective problem solving.

What's the problem?

When we started writing this article, we encountered a problem – we could not agree on what the word ‘problem’ actually meant. Is a problem, as one dictionary suggests, “a source of perplexity”? Well, indeed it is, if you are talking about say Sudoku or a crossword, but there is nothing in that definition to suggest the emotional component that very often accompanies a problem.

If you can’t work out a correct sequence of letters or numbers, that’s one kind of problem - there’s always a solution: a dictionary, going online, checking your newspaper the next day. But if you have that problem and also torment yourself that you are stupid, cannot do anything properly, or are getting Alzheimer’s, that’s another problem altogether. A much bigger problem occurs when there doesn’t appear to be a solution: for example, you are getting bad headaches or your overdraft is getting bigger and bigger despite increasing effort to prevent either of these occurrences.

Whatever kind of problem you might be having, there are some things that you can contemplate that will make dealing with it a great deal easier, so here is a list of things to consider:

1. Origins: To deal with a problem appropriately, you need to think about when you first became aware of the problem. What happened? When did it happen? How did it make you feel?

2. Background history: Are the issues that have arisen consequences of events that happened in your infancy, childhood or youth? Is the work problem a consequence of something happening at home, or vice versa?

3. Attempt at resolution: What did you do about it? How effective was what you did in terms of offering a solution? If not effective, what was blocking its resolution?

4. Secondary problems: What has happened since you first encountered the problem? Has the problem got worse? Why? Has the initial problem created one or more secondary problems? For example, not earning enough can cause relationship stress and loss of respect. Is there a relationship between the first event and the way you feel about it at present?

5. Effects: What is this problem causing you to do? Perhaps...
What’s in a name? Quite a bit actually...

ASPD member Amanda Maskery talks about the importance of choosing a name for your brand and making sure you protect it once it’s yours.

When launching a new dental practice, one of the first things you will need to deal with is your name. Your name is your “brand”. It is the most powerful marketing tool you have. For this reason, it is imperative to check that the name is free to use and once you have, to protect your brand as much as possible.

Checking your name
Before you settle on a name, you must check to see if anyone else is using it. You must check the registers at Companies House and the Intellectual Property Office (IPO) and you should also check other directories such as Yellow Pages to ensure that no other practice is trading under that name.

You must do these checks before you decide on a name. If you do not, you may find that you spend large amounts of money on designing your logo and producing new brochures/signs/letterheads, only to find that someone else is already using that name and you have to re-brand.

If you do use someone else’s name or logo (or something that looks or sounds similar to that name/logo), they may take action against you for infringement. If successful, the claimant can ask the court for an injunction, damages, delivery up of the infringing materials and even an account of the profits you have made by trading under that name.

Protecting your brand
Once you have done your checks, the next step is to protect your brand. One of the strongest forms of protection is to register your brand as a trademark.

A trademark is a sign capable of being represented graphically and which distinguishes the goods and/or services of one trader from those of another. It may consist of words, designs, shapes, colours and sounds.

In order to register your trademark, you must apply to the IPO. In order for you to register it, a trademark must be distinctive for the goods and services you will be providing. It must not describe your goods and services or any characteristics of them, for example, a dental practice would not be able register its name as “The Dentist”, as this just describes the service offered by the practice.

The Trademarks examiner will check your mark to make sure that it is registrable. He will then check the Trademarks Register to see if there are any earlier trademark registrations that look or sound the same or similar to the one that you wish to apply for. The examiner will write to the owners of those marks, notifying them of your application. You mark is then published in the Trademarks Journal and there is a period of two months during which third parties may object to the registration of your mark. If no objections are made, the mark will be registered and it will be protected for 10 years from the filing date. It can then be renewed for further periods of 10 years on payment of renewal fees.

It is a common myth that registering a company or limited liability partnership at Companies House automatically means that you have a registered trademark. This is not true. In order to register a trademark you must separately apply to the IPO.

Do I need to register?
No, but if you do not register your trademark, you will only be covered by the law of “passing off”. To succeed in a passing off action you would have to show that your business has substantial goodwill attached to it. You would also need to prove that you have suffered damage. In practice, this is difficult to show, particularly if you are a new or small business. Pursuing a passing off action can be time consuming and expensive.

Registering your trademark is an easier (and often cheaper) way of protecting your mark. If your trademark application is successful, you will have a monopoly right in the UK to use your trade mark on the goods and/services for which it is registered. You can put the ® symbol next to your mark; this warns others that your mark has been registered.

Some examples of dental practices that have registered trademarks include James Hull & Associates and ADP Dental Company Limited.

Having a website
These days, most businesses have a website which has been put together by a web developer. The web developer will often register your domain name for you.

You must ensure that the web developer registers the domain name in your name. If the developer registers the site in his name, he will be the registered legal owner of the domain name and will be able to deal with it as he wishes. This may lead to problems in the future when you come to sell or transfer the domain name.

As clients, we don’t tend to think about the importance of branding. However, in business, an effective brand strategy will give you the edge over competitors. Your brand may be the single most important asset that your practice owns. It is well worth protecting.

About the author
Amanda Maskery is an associate at ASPD member Simons. LLP. ASPD members offer professional, objective and practical advice and services, based on experience within the industry, to dental practices and other businesses within the dental sector. ASPD members include solicitors, accountants, banks, financial advisers, valuers and sales agencies, insurance brokers and leasing and finance companies. For further information on the ASPD, its members and services, call 0800 458 6773 or visit www.aspd.co.uk.

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you have become depressed or angry or despondent or are losing confidence. You may spend a lot of time seeking sympathy. But when push comes to shove, it is all about “I.” As Elinor Roosevelt once said, ‘No-one can make you feel inferior without your permission.’

**Responsibility:** To what extent are you taking personal responsibility for what has happened? Perhaps you are blaming another or others. To what extent are you blaming someone else?

**What it is preventing:** What is the problem preventing you from doing? An increasing overdraft might cause you to work harder or not to take a vacation. ‘Poor us!’

**What it is allowing:** What is the problem allowing you to do, which would have to stop once the problem disappeared? For example, having an illness might allow you to seek greater emotional support from a partner, or blame them if they weren’t sympathetic. ‘Poor me!’

**Sub-conscious purpose:** Is the real rather than the apparent problem something going on in your subconscious or unconscious mind? Is there a subconscious purpose in creating a problem or holding onto it even if you did not create it? Even though there is a primary cost, there might be secondary gain: you get sympathy. Would you actually feel better off if the problem disappeared? You might prefer to live with the problem because it brings you unexpected benefits, such as love and care and sympathy – ‘poor you!’

**Possible resolution:** Think about how you might be able to resolve the problem. For example, you might be in a difficult marital relationship – one way of dealing with it would be to go for counselling; another could be to live apart for a while; having an affair is the most usual attempt at dealing with it, but divorce is one more option. If you had a work issue, you could hire someone, fire someone, change your job, or speak to your employer. How would each of these actions make you feel? What are the benefits of each of these courses of action? What are the costs (emotional and physical)? What emotional or physical things might you have to let go of to find a real solution? Are you prepared to let go of them?

There is an old piece of received wisdom which states that for every problem there is a solution. However, the solution will come only if you want to seek it. The bottom line is: the problem is not the problem, it is how you deal with it.


As Elinor Roosevelt once said, ‘No-one can make you feel inferior without your permission.’

**About the authors**

Adrianne Morris is a highly trained success coach whose aim is to get 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. If you would like to book a consultation, or to subscribe to The Power of 10 e-zine, feel free to contact Ed at bonner.edwin@gmail.com, call 07776 660 1338 or email Adrianne at alplifecoach@yahoo.com.

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About the authors

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As managers or business owners I'm sure we all think we communicate really well. But how many times have you come across a breakdown in communication, albeit minor, and stopped to think about how your message was conveyed?

The art of effective communication is getting the right message across in the right way. Effective communication is a vital part of practice management, in terms of both managing our team and patients; good communicators make much better managers and leaders.

However, many of us fail to deliver our messages as effectively as we could – why? We are usually 'in a rush' or 'busy' and want to get the message across as quickly as possible. This is almost certainly the case when communicating with our team.

So where do we start?

Communication with your team needs to be positive, clear and confident. Understanding your team and how each individual learns is key; one team member may interpret a message differently from another. Asking your team to complete learning styles questionnaires will be an eye opener and will certainly help you to understand how to adapt your methods of communication to suit each team member. It will also ensure that each team member is given every opportunity to receive and understand your message clearly.

Communication with the team and patients, at all times, should be:

- **Confident.** Be confident in your communication; don’t shy away from saying what you really need to say, no matter how difficult or awkward the situation may be. Be aware of your body language and your tone of voice so that confidence is not confused with arrogance or aggressiveness. It can sometimes be difficult to show confidence when communicating in a difficult situation but remember, being confident does not stop you from also being kind, approachable or empathetic.

- **Genuine.** Be honest in your communication – again, in a difficult situation this does not mean that you can’t also be tactful.

- **Natural.** Be yourself. The way in which you communicate may sometimes need to be adapted to suit certain individuals, but you are you, insincerity or ‘falseness’ when communicating will generate a lack of respect.

- **Open.** Sharing information with team members is vital. Be open with your communication, share and ask for ideas, thoughts, views and opinions about your practice.

Communication at work does not have to be about work. It is extremely important for managers and leaders to be in touch with their teams on a personal or social level. Show an interest in what they do outside of work; what are their hobbies? What do they do at weekends? Who are their families? Communication will become easier with individuals as you get to know them better, as you may share common beliefs or goals.
Think about it – it is much more difficult to communicate effectively with a stranger than with someone you know fairly well isn’t it? Take time to talk to your team on a regular basis, it will build trust and respect, as well as improving communication within the team as a whole.

**Know your patients**

Getting to know your patients is also extremely important, certainly if they are embarking on a lengthy course of treatment. How often have you considered a patient to be ‘grumpy’ or ‘bad mannered’? Have you considered...

- **They may be nervous or anxious about their treatment** – we all take our surroundings for granted but would you be nervous when visiting a hospital or your GP? I would be a little. Talk to the patient, communicate with them, spend some time with them, try and alleviate their fears.

- **A patient may have difficulty taking time off work for lengthy appointments** – offer early or late appointments, talk to the patient about their work commitments, show an interest, try and help to schedule convenient appointments wherever possible.

- **Childcare** – a single parent may find it difficult to arrange childcare for treatment sessions, or may need to bring a child along; be helpful and thoughtful.

- **Finance** – a patient may desperately want or need treatment but may be concerned or embarrassed about money/affordability – discuss alternatives, do you offer zero per cent finance? Can the treatment be spread over a few months?

  Take time to think about a situation from the other person’s point of view; don’t make assumptions about how other people may respond to your communication.

  Effective communication is also about:

  - **Listening**
  - **Understanding**
  - **Empathy**

  We automatically think of communication as verbal, but there are many other methods of communication that we can use in dental practice.

  **Handouts** – questionnaires, memos, notices, reports, photos, information leaflets.

  A handout, usually in the form of a memo, is an ideal form of communication as they are usually prepared and performed by people who do this for a living and the quality of information is usually excellent.

  Meetings – team meetings, individual feedback sessions, inductions and appraisal.

  Meetings are an essential part of team communication; they ensure good teamwork, motivate and allow all team members to communicate with each other. Meetings also allow the practice manager to assess team communication. Every practice, without exception, should have the following in place:

  - Induction policy/meeting
  - End of first month review
  - Six-monthly ‘one to one’ reviews
  - Annual appraisals
  - 15-minute morning ‘team huddles’ to assess and plan the day ahead
  - Monthly team meetings
  - Quarterly strategic planning meetings
  - A team ‘day out’

  **Seminars** – presentations, workshops. Seminars and presentations by professionals/training companies are an excellent form of communication as they are usually prepared and performed by people who do it for a living and the quality of information is usually excellent.

**Communication pitfalls to avoid**

- **Inappropriate tone of voice** – inappropriately pitched.

- **Facial expressions** – smile (when communicating (unless conveying bad news) – do not roll your eyes or frown. Ensure you make eye contact.

- **Body language** – hand gestures, crossing of arms and legs and any kind of rapid movement can be interpreted as aggressive, disinterested or apathetic.

- **Facial expressions** – smile when communicating (unless conveying bad news) – do not roll your eyes or frown. Ensure you make eye contact.

  Inappropriate tone of voice, body language and facial expressions can have a very negative effect on communication and will almost certainly provide a barrier with regards to further communication with that individual as it can break down trust and respect.

  Remember that how you communicate is just as important as what you communicate.

Effective communication is not difficult but it takes time, consideration and practice; the huge benefits to your team will far outweigh the small efforts you will need to make.

The BDPMA is the essential forum for dental practice managers and organises seminars on all aspects of practice management. For more information telephone the BDPMA at 01452 886564 or visit www.bdpma.org.uk.

**About the author**

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How often have you heard people say they live for the weekend, holidays or time away from work? We learn from an early age that work is bad, negative, a chore; time off work, on the other hand, is good, life affirming and pleasurable. But why is this? What if work and play seamlessly interacted so that you enjoyed all of the week equally instead of just the two days at the end of it?

The work thing
On average we spend some 40 hours a week working – until we are around 60 years old. We often spend more time with our work colleagues than we do our families. But instead of considering it the daily grind we should concentrate on what it is about our career that makes us happy. Think back to what made you choose this path in the first place. What aspects of your profession do you enjoy the most? And how much time do you actually spend doing them?

Some time ago, during a regular business meeting, my colleague Suzanne and I were discussing those aspects of our roles that gave us the most and the least pleasure. We independently concluded that we most enjoyed the interaction with clients, the creative planning process and the satisfaction that resulted from our clients’ financial security. From this realisation, we began to remodel our business to focus on what we were best at and derived the most pleasure from.

It is all too easy to become bogged down with aspects of the business that are emotionally draining, not financially rewarding and that make us miserable. As dentists it is your clinical work that brings financial rewards and it is practicing dentistry that made you want to go into the profession in the first place. Yet many dental professionals spend a considerable amount of time involved in non-clinical activities such as running the day-to-day business, despite the fact that a manager is employed to do so.

Time to de-compartmentalise
From earliest childhood we are taught boundaries, rules and limitations. We enter adulthood believing that our life is made up of three separate parts: work, rest and play. We talk about the work/life balance, prioritising our careers and ambitions with our families and personal lives. At the end of the week, you lock the practice doors and go home, leaving work behind. You take holidays to give yourself a break from work and return invigorated – for a day, if you’re lucky. You are that hamster perpetually running in the wheel.

By compartmentalising our lives, we are drawing down the shutters between different aspects of our existence. Yet how
We have to teach ourselves that work does not always equal drudgery. Financial planning is vital in ensuring you get the most from your newly united life. Instead of only considering what you will do once you cease working, you can seize the day and start living for the moment. Life is flexible and we all learn to adapt to our changing circumstances. But at our core we are the same person, we have the same hopes and dreams, it’s just that they sometimes get buried and forgotten. Financial planning should marry seamlessly with life planning – and by that we mean considering what it is we want to achieve, the aspirations we have, what makes us happy.

The realisation that we actually enjoy our profession may lead to questions about retiring. Does a painter stop creating works of art just because they have reached 60, or a writer put down his pen, never to pick it up again? The idea that someone who loves their work should give it up because they have reached a certain age sounds ludicrous in these circumstances but it can be applied to anyone who is passionate about what they do. In this case holding off doing all the things you dream of until you retire – and planning your finances around this notion – needs readjusting.

Instead of developing a clear image of what you want to do when you retire, consider what can be done to make your life more enjoyable right now – and plan your finances accordingly.

Planning decisions must not be based on work, rest and play as separate entities but on your life as a whole. It’s only work

Since our meeting, Suzanne and I have implemented changes to our business that have set a new set of wheels in motion. It won’t happen immediately but our business strategy clearly sets out a methodology that means we can do more of the activities we enjoy and hand over the rest to carefully chosen colleagues equipped to undertake them. With our chosen business plan in place, I can honestly say that since I’ve stopped thinking of work as a separate part of my life, it has ceased to become such a chore. Life is more fun; my work more enjoyable.

Financial planning can also be a much more enjoyable experience if we don’t just think of it in terms of our life once work ceases. Armed with this liberating information learning to juggle life, work and the bigger picture becomes more like playing catch with a single ball – simple.
Many dentists who have lived abroad will have an offshore bank account. That is quite legal and understandable. Many overseas dentists will have originated from areas where nationalisation exchange control and even persecution were order of the day (Iran, Uganda, the Middle East and even RSA etc). So it is not surprising that they seek to have money invested in safe havens such as Jersey or Gibraltar. However, a small percentage may have made bad decisions with their practice income, diverting money to an offshore bank account and not declaring it to the Inland Revenu.

HMRC’s New Disclosure Opportunity (NDO) is an opportunity to come clean, pay the tax, clean up your act and pay a very modest 10 per cent penalty and probably avoid a potentially horrendous tax investigation.

Some dentists have recently received letters from their bank saying they have disclosed their offshore account to the tax authorities. If the amount has not been declared on your tax return, the taxman is going to start asking why. Next they will want to know where the money came from, and if you cannot provide an answer, it could trigger a tax investigation.

So, what is the answer? You need to get a tax specialist to check your affairs, and if there is a problem, make a disclosure to HMRC. You must register your intention to disclose by 30 November 2009, or the chance is gone.

The prospect in store for those who are subsequently found out by HMRC is not good; penalties of up to 100 per cent of the tax, a long drawn out investigation possibly lasting years and costing a fortune in accountants’ fees, a tax inspector who is likely to disbelieve everything you say, possible naming and shaming under the new proposals in the last Budget, and even criminal prosecution. So, from the tax point of view, it is a no-brainer – take the opportunity and move on.

Where funds are held in Liechtenstein, there is a special alternative facility called the Liechtenstein Disclosure Facility (LDF), which has even more advantages.

Save yourself from indecent disclosure!

In light of the upcoming deadline, accountant Geoff Long and tax specialist Tony Borman explain why HMRC’s Disclosure Opportunity should be taken by dentists.

Points to bear in mind:
- The net is closing – 308 banks are now starting to send information to HMRC.
- The deadline is looming – 30 November 2009.
- Funds in Liechtenstein get special treatment.
- People who get caught later will face a full-scale investigation of all aspects, plus far higher penalties.
- Lots of scope for innocent mistakes on offshore arrangements.
- Lots of scope for savings with proper advice.

About the authors
Geoffery Long FCA is a specialist dental accountant based in Hertfordshire. Geoff advises on a range of dental tax issues and regularly writes for the dental press. Geoff has more than 15 years’ experience managing dentists’ accounts and is recognised for his proactive approach. Call him on 01438 722224 or email office@dentax.biz.

Tony Borman is co-owner of Covertax Chartered Tax Advisors. Tony specialises in helping clients to resolve tax problems, complex or serious tax investigations and appeals to the Tax Tribunal. Tony has over 25 years’ experience gained both as a tax inspector and as a senior adviser in the accounts profession. Call him on 0845 643 5450 or email Tony.Borman@covertax.co.uk.
A super-personal service

A great receptionist will thrive on a busy front desk, always remembering names and faces, and be in their element interacting with new people, says Glenys Bridges.

Along with the ability to complete routine reception duties, there are a further range of innate traits, which make a good receptionist, a great receptionist. Most of the people who enjoy the busy hustle of a reception role are “people-people”, who thrive on the rich mixture of people they interact with day to day. However, most of the best receptionists have one notable aptitude in common; the ability to remember the names and faces of the huge numbers of people they meet.

Never forget a face
Psychologists at Harvard University in Boston have looked into this further to find out why some people more than others will remember faces. The research I’m talking about is published in *Psychonomic Bulletin and Review*, and was led by Richard Russell, a postdoctoral researcher in the Department of Psychology at Harvard, with co-authors Ken Nakayama, Edgar Pierce Professor of Psychology at Harvard, and Brad Duchene of the University College London. The research that produced these findings involved conducting standardised face recognition tests. The research results show that rather than people being “good” or “bad” at remembering faces; the range of skills are much greater and span from “super recognition” to “face blindness”.

In the group named as “super-recognisers”, people could easily remember the face of someone they met in passing, even many years later. Their research findings acknowledge a vast range in people’s ability to recognise others by their face. At the extremities, they confirmed previous research which found that around two per cent fall into possessing what they called “face blindness”, because they have great difficulty in recognising faces. For the first time, this new research shows at the other end of the scale that others excel in face recognition, indicating that the trait could be on a spectrum, with face blindness on the low end and super-recognition at the high end, opening new and different ways to think about face-recognition ability, and possibly even other aspects of perception, in terms of a spectrum of abilities, rather than there being normal and disordered ability.

Hiding their talent
Super-recognisers report that they recognise other people far more often than they are recognised. For this reason, some of these people told researchers that they often compensate by pretending not to recognise someone they met in passing, so as to avoid appearing to attribute undue importance to a fleeting encounter. At times, they were able to recognise a person who was shopping in the same shop with them two months ago, even if they didn’t speak to the person. It doesn’t have to be a significant interaction; they really stand out in terms of their ability to remember the people who were actually less significant.

Irrespective of whether you have been fortunate enough to be born with super people-recognition skills, taking an active interest in people and making them feel important is something every receptionist should aim to do. As practice makes perfect with all types of skills, maybe it is possible with some effort to elevate yourself to super-recogniser status. Who knows? It’s worth a try.

For more information on receptionist skills, visit www.dental-resource.com.
10 Top tips on achieving great aesthetics

Drs David Bloom and Jay Padayachy discuss some practical advice on getting great aesthetic results for your restorative cases

1 Photography. When it comes to any form of restorative treatment, digital photography is an essential tool and will aid in treatment planning, discussion of the proposed treatment with the patient as well as a medicolegal record. In addition to pre-ops, take pictures of your provisional (if an aesthetic case) and don’t forget the post-op pictures as well. Intra-oral cameras are excellent for showing the tooth preparation especially if doing any posterior work as it will show up recurrent caries and any fracture lines present so that you can show the patient and warn them about any possible root treatment in the future being required for the tooth. This is especially valid if the tooth does become non-vital a few years later and they try and blame you for it. In this increasingly litigious age, meticulous record keeping is a must.

2 Wax ups for provisional restorations and visual diagnostic try-ins. Before embarking on any form of aesthetic work it is important to know where your end point is. Diagnostic wax-ups will help considerably with this in helping to visualise what you are trying to achieve and also gain acceptance from the patient before you actually start by enabling a visual diagnostic try-in. Wax-ups can range from full arches to single teeth to enable correct contouring for a fractured incisel edge, and for ideal implant placement via stents.

3 Lab communication. Any form of laboratory based restoration must be accurately communicated. Thus the appropriate lab slip needs to be fully completed and signed off by the dentist. This ensures that the prescription is carried out correctly by the technician. This includes information for both the wax-up and the final restorations. For aesthetic work, photography, as already discussed, is a given; the technician needs to see all the pre-op pictures, the pictures of the provisional restorations and it is also nice to send them a copy of the post-ops so they can see how beautiful their work looks in the mouth, a luxury they don’t usually experience. (fig 1)

4 Whitening. As part of your treatment planning for any restorative work, always ask the patient if they would like to have their teeth whitened first, particularly if doing anything anteriorly. Once the restorations are placed it will be too late unless you want to replace the work you have just fitted. We prefer not to whiten teeth we will be preparing for veneers so that their true foundation shade can be assessed. If they have been whitened first they will darken with time which may compromise the aesthetic outcome. Don’t forget to make new whitening home trays once the new restorations are fitted and build this into your treatment fees.

5 Bonding. In this porcelain veneer dominated world remember that conventional bonding with composite resin can give a great result. It is non-invasive of tooth tissue ensuring that the enamel is not violated. This works very well when building out buccal corridors in an otherwise intact dentition. (figs 2-7)

6 Smile design. An understanding of the principles of smile design is crucial in your treatment planning. Even if the case is not an aesthetic one, you need to be able to communicate what can be achieved by looking at the bigger picture rather than just necessarily the one tooth they are concerned about. They may not be interested but at least you will have covered it (and make a note of this in their records). Fortunately now we are going away from the mass produced standard American-style smile (unless you are using an American lab for some reason) to a more natural European beautiful form whereby the teeth do not all look the same but have a hint of individuality.

7 Ovate pontic site. This enables the pontic to look as though it is emerging from the gingiva similar to a natural tooth rather than just sitting on the ridge. Upon extraction of a tooth and the making of the provisional bridge ensure that the pontic is actually sitting down in the socket by at least three mm. If it is not doing this then it is easy to add flowable composite onto the temporary restoration to achieve this. If the ridge has healed and no site has been created then it is very easy to create it with a laser, electrosurgically, or large round bur; your impression can then be taken but ensure that your provisional restoration is
filling the newly created site. Communicate with your techni-
cian the depth of the ovated site, and ask them to scrape away a 
further mm on the master model so when the final bridge is seat-
ed there is some blanching of the soft tissue which will help 
remodel the tissue further. (Figs 8-10)

8 Multi-disciplinary approach.
A dentist should no longer 
regard himself as an island but 
should utilise their specialist col-
leagues to aid in the restorative 
treatment plan. This can range 
from orthodontic pre-alignment 
with Inman aligners to minimise 
the degree of tooth preparation 
required by getting the teeth in 
the ball park, to surgical crown 
lengthening based on the diag-
nostic wax up and appropriate 
stents or re root treating teeth to 
be restored if there are signs of 
apical pathology.

9 Tissue training for implants.
Historically implants were 
regarded as successful if they 
integrated fully. Patients were 
happy to have their space filled 
with something fixed and were 
less concerned by the aesthetics. 
Nowadays if the implant crown 
doesn’t look beautiful and the 
emergence profile and tissue 
height and contour doesn’t look 
natural, it would be regarded as 
a failure albeit aesthetically. The 
use of temporary crowns to train 
the tissue to correct contour can-
not be underestimated. Time 
and care spent at this phase of 
treatment which can take any-
thing from three to 12 months 
is of paramount importance in 
creating this effect. These tem-
porary crowns should be under 
contoured as this can allow ‘gin-
gival growth’. (Figs 11-15)

10 Occlusion. An under-
standing of the basics of 
occlusion is essential to ensure 
the longevity of your restorations. 
Ideally the occlusal form should 
include equal intensity contacts 
on all posterior teeth in a cusp 
top to fossa relationship with a 
canine protected occlusion in lat-
Treating children in practice

Complaints of litigation involving dental treatment provided for children occur less frequently than in many other areas of dentistry, say Dental Protection

When complaints involving dentistry for children do arise, their management is complicated by a number of factors, over which the clinician has little or no control. Dentists, hygienists and therapists can all be involved in the provision of dentistry for children, and many of the problems they face are the same. It is easy to overlook the fact that the treatment of children – particularly, of young and/or nervous children – can be clinically very challenging and highly demanding in terms of time, concentration, and personal skills. Juggling the clinical and personal needs of the child with the sometimes irrational and disproportionate demands of the parent(s) can also be very stressful. Another factor which can arise in private practice, or any clinical setting where fees are charged for the treatment of children, is the imbalance which can arise between the expectations and demands associated with the treatment of children, and the reality of the fees that tend to be charged and/or that the parents find acceptable.

Undercurrents

Cases involving children tend to be affected, to a greater or lesser extent, by factors that can easily be overlooked. Firstly, patients in this group are vulnerable and sometimes apprehensive, and emotional pressures can often influence the progress and outcome of a case, as well as the perception of those involved in it. Secondly, treatment is generally being provided in an ever-changing environment as the child continues to grow and develop; as a result, clinical decisions tend to have immediate short-term consequences and also some broader and longer-term implications. Sometimes, this impacts upon a case in the sense that it is asked how things might have developed if a specific event had not happened, or if a certain treatment which was not provided, had been provided. Thirdly, these cases can often be fraught with conflicts and hidden agendas. Parents are invariably involved in the situation and not uncommonly, responses are clouded by feelings of guilt, or natural parental protectiveness (or over-protectiveness on occasions) of anger and sometimes a single-minded determination to see a dentist “punished” for some actual or perceived act or omission towards the child. One of the classic situations arises when attempting to treat widespread caries in a very young child who is only brought to a dental surgery when the child is in pain (perhaps from an abscess) and acutely distressed. If problems arise during or following the treatment, some parents will be unable (or unwilling) to consider, let alone accept, that the child’s problems might have been avoided altogether, if they had acted differently, or more quickly in the child’s best interests. This can sometimes produce a reaction...
whereby the parent’s wrath is directed at the clinician, perhaps as a means of deflecting any suggestion of blame or responsibility on their own part.

Key issues
Eight recurring factors tend to arise in cases involving children, often with a single case embracing two or more of them.

Consent
While this is generally obtained from a parent, the legal situation varies from one country to another. A useful general principle to bear in mind is that while the needs and best interests of the child should always be the paramount consideration, the child’s wishes must also be taken into account. This can lead to difficult judgements on the part of a clinician, who must assess the child’s capacity to understand the nature and purpose of the treatment being proposed for them. In older children who may not yet have reached the legal age of adulthood/majority, but who are perfectly capable of understanding the issues surrounding a proposed dental procedure, this can create some very difficult situations. This is particularly likely when the child and the parents do not agree as to what treatment should be provided. If in doubt, it is always wiser to postpone treatment than to proceed against the wishes of either the child, or the parent(s).

Caries
A failure to treat caries (and particularly, rampant caries in the very young) and/or to institute appropriate preventative treatment or advice (oral hygiene, diet etc) sometimes, is taken to keep caries under review, or temporary restorations are used where young and nervous children find it difficult to accept treatment. Such approaches can later be misinterpreted as supervised neglect. Meticulous record keeping is important in these cases, and careful communication with parents is essential. In primary teeth, it can be a short step from caries to an acute alveolar abscess, with all the associated pain, suffering and distress. It is sometimes forgotten on these occasions that the dentist did not actually cause the caries which led to the abscess.

Trauma
Cases tend to relate either to the actual management of an acute traumatic episode where anterior teeth have been damaged, or to the absence of emergency arrangements outside surgery hours, or to the delay in accomplishing a child presenting with an acute traumatic problem. Dentists have been accused of negligence on the grounds that they should have suggested/provided a sports mouthguard for a child who was known to be involved in contact sports carrying a high risk of injury to the front teeth.

Growth and development
Practitioners have a duty to monitor the child’s dental and oral development, and the need for orthodontic intervention should be considered either personally, or by referral to a specialist. Many cases relate to the delay, or failure, in recognising and acting upon incipient orthodontic problems.

Behaviour
Not all children are as cooperative as one might wish, and parents tend to have their own views on how their child is best managed. Treatment should never be imposed forcibly upon a child, and the child’s best interests must always be paramount.

Local anaesthetic
All the well-recognised problems associated with local anaesthetic administration and with extractions are exaggerated in the case of children, who may not always follow postoperative instructions. Lips and tongues bitten while anaesthetised are not uncommon and warnings given to prevent this occurrence should be recorded in the notes. A further problem is a breakdown in communication somewhere between an orthodontist, a referring dentist, and an oral surgeon, resulting in the extraction of incorrect teeth. Referrals for extractions should always be made in writing, and the details checked both by the referring, and accepting dentist. A failure to check for permanent successors before removing deciduous teeth is another common cause of litigation.

Orthodontics
The main problems arise in diagnosis and planning, which includes deciding whether the presence of supernumerary or congenitally absent teeth, in root resorption or the loss of vitality of teeth during orthodontic movement, and in dissatisfaction with the final outcome – usually, but by no means always, from an aesthetic viewpoint. Very often, problems arise when treatment does not proceed as quickly, or a successfully as originally hoped. It is important to act upon any lack of compliance or co-operation on the part of the patient, and to keep parents fully informed and involved. This helps to avoid a situation where the clinician is blamed for the lack of progress.

Dento-legal complications
When negligence claims do arise, the first problem is the extended limitation period in which legal proceedings can be brought. In many countries, legal proceedings in child cases can be brought at any time up to (and for a short period after) the time when the child reaches the age of adulthood. Through this extended period, legal costs can continue to accrue. Because of this, lawyers acting for the child patient are under no pressure to act quickly; this, coupled with the natural wish to make a measured assessment of the eventual consequences in the context of the child’s subsequent development, means that progression can be painfully slow. This can be an added burden for clinicians who may have a case hanging over their head for many years. In it, with long-term consequences (brain damage, for example, or cases involving rotative dentistry which would need successive replacement over a lifetime) the long life expectancy of children can have a huge impact upon quantum in the amount of damages payable. Finally, once again, emotions can get in the way of a reasoned and balanced approach to cases involving children. On the one hand is the ever-present parents’ perspective, and on the other, the emotions of those to whom reference has already been made, and which can pervade particularly unfortunate or tragic cases.

Summary
Treatment of children carries all the dento-legal risk of treating adults, but is further complicated by a number of other factors. An awareness of these factors should prompt a suitably prudent approach to the treatment of child patients.
One visit is all it takes

There’s a new system for taking impressions, which means patients need not come back for a second visit, saving both time and money. Justin Stewart explains

Traditionally, at dental school we are taught to take basic primary impressions and then have special trays made on a patient’s first visit, and a secondary impression on a second visit. However, with patients having to come back a second time for more impressions, this method can be time consuming for both dentist and patient. And if the bite registration is taken on the second visit, the bite rims will be made on the primary impressions and will tend to be less stable.

To generalise, dentists tend not to take as much care and attention over primary impressions which can result in sub-optimal special trays leading to a less than perfect secondary impression.

No more problems

A new technique has come to my attention, which is achieving excellent results and is overcoming the above disadvantages. This system involves choosing a tray that can be heat moulded. There are a number of sizes of trays, for example, five for full uppers, and five for full lowers, which can then be easily adapted so the extensions of the trays end in the mid-vestibule of the sulci. Once the tray has been selected, and heat modified where necessary, impressions are taken using several viscosities of polyvinylsiloxane materials. In essence, the impression is taken several times, building it up in layers.

To give an example of the benefit of this technique, we can examine the common example of an upper ridge, where the gingivae of the pre-maxilla is loose and flabby but the posterior ridge is fibrous and firmly attached. While doing the impression, the anterior portion of the tray can have a very light/light body viscosity wash placed whereas the posterior section of the tray may have a medium body wash.

More flexibility

For the above scenario, I remember being told at dental school to leave a window in the upper tray and take a plaster impression of the pre maxilla. In reality, it was a very rare dentist who would use that technique, partly because it was so time consuming. This new technique does not require a lot of time, but gives the dentist much more flexibility, as one simply loads the tray with a viscosity to match the underlying gingivae character and mobility and ridge height.

You can also change the viscosity in relation to a patient’s muscular function. During final impressions, we need to activate all of the facial musculature to capture an accurate peripheral border thereby obtaining the optimal retention of the final prosthesis. For patients with a strong muscular action, we can choose a heavier body material. This overcomes a disadvantage with using alginate, where strong muscular action can create an overly thin impression flange.

I would strongly recommend that dentists try using the Massad tray system with different viscosity polyvinylsiloxanes, and compare the results of this system to the one you are using now.
Implementation, implementation, implementation

With no new reports, reviews or quango bodies planned, Neel Kothari thinks about where NHS dentistry can and will go from here.

We have now arrived at a point where we have numerous reports from patient groups, widespread media criticism, the Health Select Committee (HSC) report, the Steele review and of course around 10 per cent of dentists leaving the NHS, but the UDA system still grows older. When the Steele review was announced, this initially kicked the debate over NHS dentistry out of the political spotlight and into the long grass, but now (at the time of writing) with no new government reports, reviews or quango bodies planned, the question ‘where does NHS dentistry go from here?’ must be asked.

Cash boost needed

The Steele review has received both favourable press and acceptance since its release. Now, without entering into a debate regarding its content and recommendations, it seems to me that any change that may arise out of this needs money; money which the DH has already spent. The Steele review recommends a shift in the way dentists are paid from a fee-per-item system, towards a part-capitation and part-fee per item system. While this would probably help resolve issues regarding access and funding to dentists by encouraging dentists to take on new patients, what it does not do is address issues regarding quality within the NHS.

It is clear that among many GDPs working within the NHS, there is a genuine feeling they don’t feel able to provide good-quality treatment under this contract. Irrespective of where you may sit on this particular fence, the statistics are clear: the number of teeth being saved is down, while the number of dentures being made is up. Whether this phenomenon is down to the need for complex treatment decreasing as the often seems to suggest, or a genuine failure of the new contract, one thing is clear – the current contract is certainly not based around quality.

Finding a balance

The sensible debate that needs to take place is exactly what level of care NHS dentistry is willing to fund. To clarify, I accept that under this current contract dentists are now paid more for many items of treatment compared with before, however at the same time, it only takes a few patients with high dental needs to take up much of a dentist’s time, leaving a great deal of uncertainty within this system. The funding which is derived from the UDA system is also relatively static and does not take into account the ever-growing costs of cross infection, laboratory and staff costs, as well as material costs such as single-use endodontic files. All things being equal, some things were poorly funded in the old system and some things are still poorly funded in this new system, but because of the unpoliced ‘swings and roundabouts’ approach to funding dentistry, it’s hard to tell exactly which procedures are affected and how this may affect the quality of treatment provided by individual dentists.

About the author

Neel Kothari qualified as a dentist from Bristol 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 Eastman Dental Institute, and regularly attends postgraduate courses to keep up to date with current best practice.

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2009 DENTAL TRIBUNE United Kingdom Edition · November 23-29, 2009

Feature 23
More of the world’s accomplished oral surgeons and implant dentists will have the opportunity to be inspired by the clinical and presentational prowess of a dentist from a quiet corner of Cheshire during 2010. Dr Nigel Saynor’s level of expertise has gained him a worldwide reputation as one of the leaders in the field of implantology. Based at Bramcote Dental Implant Centre in Bramhall near Stockport, Dr Saynor is due to address colleagues at prestigious dental meetings in Europe and the US during the next twelve months.

The first ever UK speaker to present on the main podium at the American Academy of Osseointegration was Dr Nigel Saynor. In Seattle in 2006 his session was voted the best lecture, with the highest rating by delegates of any speaker that year. Dr Saynor’s presentation to the 2009 gathering in San Diego was described by one delegate as ‘The best speaker at the conference in the last ten years’. At the AO’s 25th anniversary meeting in Orlando, Florida in March 2010, Dr Saynor’s address will examine ‘the limits and set parameters which influence where implants can be placed side-by-side with successful aesthetic outcomes’. During a counterpoint discussion, he will argue that, ‘utilising an implant which can demonstrate a tissue care concept, platform offset, rigid connections, and etching to the top of the implant, can have a positive impact on the outcome’.

The 2010 AO meeting is preceded by a speaking tour of the US during which Dr Saynor will address study clubs in Chicago, St Louis and Minneapolis. Later that month he will be in Barcelona with colleagues from Britain and around the globe for the 14th DENTSPLY Friadent World Symposium (www.dentsply-friadent.com). During the two-day biennial event more than 2,000 delegates will participate in hands-on workshops and a packed scientific programme featuring expert speakers from Europe and beyond. Dr Saynor’s session describes intelligent ways for successful decision-making when treatment planning implant cases. Dr Saynor explains: “The presentation will provide a comprehensive overview of the key indicators of treatment planning. These include timing, patient-specific or indication-specific factors and orosurgical and restorative concepts”.

‘Most enlightening and entertaining speaker’

In June 2009, more than 500 dedicated dentists, specialists and presenters from around the world converged on the Ritz-Carlton Key Biscayne, Florida. Hosted by DENTSPLY Tulsa Dental Specialties, the North American ‘Summit by the Sea’ focused on tissue wellness in implant dentistry. Dr Saynor’s presentation covered the aesthetics of dental implants and biological harmony of the ANKYLOS implant system. Dr Saynor presented a series of cases together with analysis of systematic reviews of the Cochrane Library of Implant Cases and scientific evidence to compare various treatment modalities. The exceptional
feedback from attendees included: ‘Literally the best, most enlightening and entertaining speaker’, ‘Awesome’ and ‘An amazing lecture’.

Somehow, speaking engagements in London, Birmingham and Copenhagen were also squeezed into Dr Saynor’s busy international programme this year. In September he addressed the International Academy of Advanced Facial Aesthetics IAAFA Conference at the Royal Society of Medicine, Wimpole Street, London. Dr Saynor’s presentation highlighted the role of the patient’s teeth in determining soft tissue contours of the lower facial third. He explained to delegates that ‘Tooth position within the prosthetic envelope can have a significant impact on lip support. It can also unduly affect the patient’s phonetic capabilities. Optimum tooth position can be achieved, restoratively or with surgical intervention through hard and soft tissue grafting’.

Complex case referrals and advanced implantology training
It is clear that Dr Saynor is passionate about the aesthetic aspects of dental implantology and how to optimise the outcomes of treatment modalities and protocols. He is also actively involved with the development of implant product and the promotion of implantology in the UK and internationally. He has placed and/or restored over 4,000 dental implants, frequently for other dentists and their families. Dr Saynor is an honorary clinical tutor on the MSc programme in Implantology at Manchester Dental Hospital and with the support of DENTSPLY Friadent he presents a high level course for experienced implantologists who aspire to achieve superior aesthetic results and long-term predictability in implant treatments.

After attending Dr Saynor’s advanced implantology course, Dr Rob Burgess of Rocky Lane Dental Practice, Wirral, said that it increased his knowledge of the range of options for patient rehabilitation with implants and gave him the stimulus to undertake more education and training. He added: ‘Nigel’s presentations are excellent. His style is very open, honest and highly entertaining. There was plenty of time for discussion during the day and I appreciated the way he showed us problems as well as successes’. The postgraduate implantology education website www.courses4implants.com includes details of the clinical course content which covers sinus elevation, bone grafting and treatment planning for complex cases. If you can’t make it to Orlando or Barcelona next year, the Advanced Course for Experienced Implantologists takes place at Dr Saynor’s Bramcote practice (www.smiledoc.co.uk). Bramcote is a premier provider of cosmetic, aesthetic and implant dentistry in Manchester and the North West. At the practice Dr Saynor treats implant case referrals from colleagues around the UK, particularly complex and/or problematic cases. The practice offers state-of-the-art technology and the very latest equipment, to assure consistency and quality of care. The course is very popular, so early booking is advised. Further information and bookings: www.courses4implants.com Freephone: 0800 077 8650 Email: courses@friadent.net

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The new G2 is an outstanding ultrasonic scaler which offers maximum control and flexibility. Combining the NSK’s unique graphics display with an ergonomic design, the Eclipse G2 is proven to be a real time-saver for your practice.
Endodontics: a field of its own

Untreated infections can lead to the loss of teeth. This has psychological, as well as physiological, consequences with many patients reporting low self esteem and feeling embarrassed to be seen in public.

Demanding patients
Today there are two options for diseased teeth: endodontic therapy and extraction/implant placement. The rapid growth of the internet over the past decade has resulted in patients being better informed about these options and often expecting their teeth to be saved rather than extracted or replaced.

With this surge of demand from patients and advances in endodontic methods and technology, endodontics has become a recognised field of dentistry in its own right. Endodontic instruments are now so accurate that the length of a root canal can be determined to 0.5mm. This is all thanks to fibre optic illumination, minute video cameras attached to microscopes, sophisticated apex locators and ultrasonic technology.

A rapidly growing industry
The field of dentistry is continually growing and evolving; statistics show that the amount of knowledge required by a General Dental Practitioner (GDP) doubles every five years. Consequently, current undergraduate dentistry education is unable provide the level of detail required for GDPs to feel suitably qualified to perform intricate procedures. In terms of endodontics, it is often when teeth with a more complex anatomy are involved, such as back molars, that further training is needed. For this reason, many dentists choose to follow a postgraduate route of study to specialise in the field of endodontics.

The European Society of Endodontics, a highly prestigious academy of scientists, teachers and clinicians, published guidelines for undergraduate education in endodontics. However, a recently published study in the BDJ critically commented on the coverage of the subject in dental schools throughout Europe. The same European Society of Endodontics is currently developing guidelines for postgraduate endodontic education.

The USA has progressed much further in this field. The American Association of Endodontics published strict guidelines years ago, which are followed rigorously by the majority of postgraduate dental institutions.

A new MSc in Endodontics
The University of Warwick will launch a new MSc in Endodontics in January 2010. The programme follows the American Association of Endodontics’ guidelines. It will be delivered by leading professionals, academics and researchers in the field of endodontic dentistry, and supported by respected academics from the field of continuing professional development.

As a part-time course, it has been designed to offer a flexible training pathway tailored to individual requirements and circumstances. The programme will allow students to improve and increase the scope of endodontic treatment in their practices through the study of a wide range of topics, such as tooth morphology, mechanical shaping, chemical disinfection and pain management in endodontics.

Learning will take place through traditional seminars and practical work, performed in labs and at regional training centres. Students will gain a thorough understanding of modern technologies, using materials and instruments such as surgical microscopes and cone beam CT.

Applications are being accept ed new and further information about the course can be found at www.warwick.ac.uk/go/dentistry.
Volunteer programme success

One million ordinary Tanzanians can now access safe emergency dental treatment, thanks to the sustainable training carried out by volunteers on Bridge2Aid’s Dental Volunteer Programme.

For 75 per cent of the world’s population – those living in the rural areas of developing nations – relief from unbearable dental pain is several hours’ or even days’ walk away. Worse still, many will walk for hours or days for help, only to find that there is no-one qualified to treat them.

For so many Tanzanians, this has been a daily reality. Driven by overwhelming pain and despair, many people will resort to self-treatment or unqualified help. DIY extractions often aggravate the problem, resulting in sepsis, fractures and other life-threatening situations. Every year, many Tanzanians suffer horrific injuries and complications that could easily have been prevented with the right primary care.

Addressing the problem

Bridge2Aid has been actively addressing this problem since 2004. The Bridge2Aid Dental Volunteer Programme (DVP) is now helping to make this scenario a thing of the past. Over one million of the world’s poorest people are now able to access qualified local health personnel, who have been trained and equipped to deliver emergency oral healthcare under the ongoing supervision of their own regional dentists. This is a proud moment for the charity and for all the volunteers that have helped make this a reality.

On a Bridge2Aid DVP, qualified UK dentists and dental nurses volunteer their time and spend two weeks in Tanzania, delivering specialised one-to-one training to local clinical officers. Since 2004, over 120 dentists and 80 dental nurses have taken part in the programme, devised by Bridge2Aid in collaboration with the Tanzanian government. One hundred and five clinical officers have now been successfully trained. And not only that, in 2010, a further 500,000 Tanzanians will gain access to the same standard of dental treatment, thanks to the continuing growth of the capacity of the programme.

A lasting legacy

Volunteers with Bridge2Aid leave behind a lasting legacy – by passing on their dental skills to Tanzanian healthcare workers, all patients that access the service receive high-quality treatment using safe equipment in an environment with a high level of cross-infection control. Training clinicians in this way ensures that a volunteer’s time in Tanzania has a maximum impact over the long term.

To take part in the next Bridge2Aid Dental Volunteer Programmes in January and February 2010, or to find out more, visit www.bridge2aid.org or call Ruth Bowyer on 07748 845006.
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