BACD: research foreign dentists

People thinking of travelling overseas for dental treatment are being urged to shop around in Britain before going abroad.

The British Academy of Cosmetic Dentistry (BACD) has warned potential patients that they need to carefully research the dentist who may be carrying out the work.

This is because they will be away for a limited amount of time and so such any procedures may be done ‘a bit more quickly’ than they would be in the UK, said the BACD.

Tiff Qureshi, board member of the BACD recommends that people check out the foreign dentist’s portfolio.

Ex-dental chief tells lies

The former chairman of the British Dental Association (BDA) has been struck off by the General Dental Council for fraudulently claiming £51,000 in expenses from the BDA.

Trevor Mann, of Sutton in Surrey, claimed expenses for meetings at the BDA from October 2005 to July last year.

He said that he worked at a surgery in Byfleet, Surrey, but an investigation found there was no trace of the practice.

The professional conduct committee report said: ‘Mr Mann clearly lied to Mr Ward about the scope and status of his practice.

It added: ‘From 6 October 2005 to 27 July 2007, Mr Mann inappropriately and dishonestly claimed from the BDA sessional allowances stating that he had read the BDA expenses policy and was entitled to claim sessions for Monday to Friday. This too was misleading and dishonest.

Mr Mann’s dishonesty was compounded by the fact that the claims were made over a sustained period of time and were not isolated incidents.’

The report concluded: ‘The Committee hereby directs the Registrar to erase the name of Trevor Irvin John Mann from the Dentist Register’.

A spokesman for the BDA said: ‘The British Dental Association notes the conclusion of the case it referred to the General Dental Council. All of the money inappropriately claimed from the BDA has been repaid. The BDA now considers that the case is closed.’

Mr Mann did not attend the hearing at the GDC.

Anxious talk

Dealing with anxious patients is a bit like waiting for a time bomb to go off, but if you handle it gently you can defuse the worry.

Oral links

So is there really a link between oral and systemic health? Dental Tribune reports back from a scrutinising conference on the subject.
G

raduate dentists at a new dental school in the north east of Scotland are being offered incentives to remain in the area and practise as NHS dentists.

The new Aberdeen Dental School will produce 15 graduates this year and 20 fully-qualified dentists every year after.

Graduates will be offered incentives to remain in the region as NHS dentists.

The dental school, which has received £2m of funding from the Scottish Government and NHS Grampian, will have facilities for radiography and restorative dentistry as well as dental laboratories.

Public Health Minister Shona Robison said: ‘The Aberdeen Dental School will be a centre of excellence for the north of Scot- land and an important asset for the whole country.

‘Young dentists who train at the school will provide a significant boost to the numbers of trained practitioners in our country, helping to bring NHS dentistry within reach of more and more people.

‘The new school is a fantastic opportunity for dental students to come and develop their skills.

North east Lib Dem MSP Mike Rumbles called it a step in the right direction’ but added ‘it’s not the solution to the problem, which is what the government seem to think it is. It is not a fully- fledged school, it is a post-graduate facility.

‘What the government has done is not good enough because the school should be producing at least 60 dental students a year, not 15.’

The government wants to make sure the directive does not adversely affect the NHS’ ability to plan and manage services – and ensure patients can only access services to which they are entitled to on the NHS.

Public health minister Dawn Primarolo said: ‘We want to en- sure that, where UK patients choose to travel abroad for care, the NHS retains the ability to de- cide what care it will fund.

Equally, anyone from other member states travelling to the UK specifically for healthcare will have to pay the full NHS cost of treatment upfront.’

She emphasised that the go- vernment is ‘committed to pro- viding high quality healthcare close to patients’ homes.

The consultation will help formulate the UK’s negotiating position when discussions on the directive are held by Council of EU health ministers on 15-16 De- cember.

The consultation closes on 3 December.

Stripping for charity

Dental patients in Sunder- land have agreed to be photographed wearing nothing but a smile for a saucy charity calendar.

Riveredge Cosmetic Den- tistry practice in Sunderland decided it wanted to do a char- ity calendar after losing its manager, Amanda Fisher, to bowel cancer three years ago.

The calendar features the Riveredge team, Rugby League player Paul Sculthorpe and nine Riveredge patients.

Lesley Collard, practice manager, said: ‘We were keen to do something a bit different to sup- port St Oswald’s, the hospice that looked after Amanda so well. We were all pretty nervous about do- ing the calendar, but it was great fun and for a great cause.’

Three cancer charities are set to benefit from the venture including St Oswald’s Hospice, where the Ms Fisher, was treated before she died.

The 2009 Wearing Nothing But A ‘Smile’ calendar costs £10. It can be bought by calling the Sunderland- land clinic on 0191 567 1020.

CDO opens new dental school

The government’s Chief Dental Officer has officially opened a new dental training school in East Lancashire.

Before unveiling the official plaque, Barry Crockett met dental students who are training at the centre.

The £2.2m Oak House NHS Dental Centre will act as a train- ing facility for new dentists and for dental therapy students and is one of the first new dental schools to be opened in nearly 100 years.

The aim is to train ‘home- grown’ dentists for the future, with the hope that they will stay and work in the area where they have trained.

Quality teachers compete

Some of the best practition- ers in dental education will be battling it out for the title of teacher of the year in the 2009 DDU Educational awards.

Rupert Hoppenbrouwers, head of the Dental Defence Union said: ‘The finest teachers are able to communicate their enthusiasm for dentistry, as well as their knowledge of the subject, to stu- dents and newly qualified dentists.

These qualities are always evi- dent in our finalists, so we look for- ward to some interesting and in- spiring presentations and, as ever, I’m sure it will be tremendously difficult to choose a winner.’

Two finalists have been se- lected from a shortlist of nomi- nees in three categories:

New links for CIC

Smile- on-ising joins forces with the International dental as- sociation, Alpha Omega, to hold next year’s Clinical Innova- tions Conference.

The conference in 2009 will bring together the Clinical Innova- tions Conference and the An- nenberg Lecture.

Dr Nitzan Bichacho and Dr Dahi Schwartz-Arad will present the Annenberg Lecture ‘Success in Dental Practice’.

Overall winners in each cate- gory will receive £1,000 towards the cost of educational materials for their schools or Vocation Training (VT) schemes.

All the finalists will receive £250, and an award.

The DDU Educational Awards are sponsored by Dentistry and supported by the British Dental Association (BDA).

This year’s awards are being held at London House, Goode- nough College, London on Wednesday 19 November.

The theme for the event is Edu- cation, Ethics and Aesthetics and in the afternoon there will be a series of presentations on cos- metic dentistry, from the ethics of cosmetic treatment, to the chal- lenges of defending dental pro- fessionals against allegations about their aesthetic practice.

The two finalists in each cat- egory are:

• Dentist teacher of the Year: D Samarawickrama of Barts and the London School of Medicine and Dentistry and Sheila Oliver of Cardiff University Dental School.

• VT Teacher of the Year: Stephen Brooks from the Oxford Dean- ery and Dai Jones from South West Dental Postgraduate Deanship.

• DCP Teacher of the Year: Alison Grant of Bristol Dental School and Judy Fraser of University of Portsmouth, School of Profes- sionals Complementary to Dentistry.

Noam Tamir

International Imprint

International Imprint
Editorial comment

UDAs in translation?

It’s a sad state of affairs that the British public is resigned to booking dentistry appointments away from an otherwise civilised country. Flying abroad to get the basics done is a sham – period, but then being urged to investigate the dentist they are seeing as well makes a mockery of the UK dentistry system. So now patients are combining their holidays around implants and fillings. Some people might think that if they can fork out for a holiday as well as their dental treatment – albeit abroad – then they must be able to afford it. But if the treatment they need is going to take a week or two then they have to find somewhere to stay. Plus who wants to stay away from their family for that long anyway?

So shows like the Health Tourism Show 2008 has its place, and if Portuguese clinics can offer cheaper implants with a comfortable hotel to boot who wouldn’t be tempted? Nevertheless let’s not be too damning. With the government carrying out a consultation on an EU directive that will allow patients to ask the NHS to pay for their dental treatment abroad, things could be looking up. It is asking for the views of healthcare professionals, patient groups, health organisations and the public on the new Patient Mobility EU Directive. As public health minister Dawn Primarolo said last week: ‘We want to ensure that, where UK patients choose to travel abroad for care, the NHS retains the ability to decide what care it will fund.’ And this is great is it not? Perhaps. But how will they work out what UDA band fits what treatment if the treatment they have done is above and beyond any of the UK bands? Moreover, why waste time faffing around on a new consultation anyway when really their efforts could be used elsewhere, i.e. finding new ways to attract the UK’s profession back into NHS dentistry, and increasing more dental students a year.

Handing out incentives to new graduates is one way of encouraging some dentists to stay put and work in the NHS. It’s all ready happening in the north east of Scotland at the Aberdeen Dental School. But are the incentives big enough to keep the graduates away from the much greener grass?

Opening new training schools is of course another step in the right direction – our CDO opened another one in East Lancashire, and is one of the first dental schools to be opened in 100 years. David Peat, chief executive of East Lancashire PCT, is understandably thrilled with the new school. As he says: ‘We see this as a major opportunity to train our own NHS dentists of the future, while helping local people as the trainee dentists do their supervised practical.’ Whatever happens with dental tourism and the UK’s profession, it’s always worth remembering our glass is never half empty – but always half full.

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Orthodontist changes a boy’s life

A specialist orthodontist has won first prize in a national competition for changing a boy’s life through orthodontic treatment.

Orthodontist, John Costello at Total Orthodontics in Tunbridge, Kent, was awarded the trophy for ‘Against the Odds’ at the British Orthodontic Society’s annual conference.

Mr Costello was given first prize for his orthodontic work on 14-year-old James McAuliffe.

James first visited Mr Costello a few days before his 11th birthday in early 2004 when it was discovered he would not develop four adult teeth - the two either side of his contrastingly large front teeth.

X-rays revealed that four upper front teeth were missing and when his milk teeth fell out he would be left ‘Bugs Bunny-like’ when his milk teeth fell out he would be left 'Bugs Bunny-like' with two front teeth in isolation.

The first thing, Mr McAuliffe did was make James a temporary removable retainer brace which had four false adult-sized teeth fixed to it.

The false teeth were shaped in such a way that they slotted over James’ milk teeth and gave him the appearance of a complete dentition and to anyone else he looked like any normal 11-year-old boy with a retainer brace.

James wore the retainer for about a year during the day and had a head brace at night which was designed to make more space conditions but everyone did so he would be created to replace his own baby incisors.

The brace was attached to the molars at the back of his mouth and helped to draw these backwards upwards space for the front teeth to be moved using braces and bands.

Mr McAuliffe created an orthodontic appliance with a fixed plate that was moulded to the top of James’ mouth, which again had false teeth affixed to it.

With his natural teeth now in the right position and firmly settled, James finally had a bridge fitted to allow permanent replacement teeth to be fitted, and these were fixed to his natural teeth which had been moved to allow space for the four new teeth. This completed the stream-lined appearance of his upper teeth allowing him to smile for the first time in years.

James said: ‘My teeth now look absolutely amazing. It’s so hard to put into words what a difference my treatment has made. My first permanent teeth are now in and always love to flash people a smile - all thanks to John. All the hard times have been finally worth it and thankfully the bad memories are already fading.’

London dentist treats Cambodians

London dentist has just spent two weeks in Cambodia treating orphan children who have never been to a dentist.

A London dentist has just spent two weeks in Cambodia treating orphan children who have never been to a dentist.

Lydia Pink, a dentist at Amnill dental practice in Tower Bridge Road was accompanied on the trip by two dental therapists. On arrival they worked alongside the Sultan of Brunei’s former dentist who set up the project in Cambodia.

He is working full-time with nurses to help the children, many of whom are orphans or are disabled. Most of the children have HIV and are working in rubbish tips to survive.

Much of Ms Pink’s work included preventative treatment and the team was able to present a year’s supply of fluoride treatment to 10 schools in the country.

One-stop health complexes

This is expected to open in April 2010.

The second phase, which is due to open in March 2011, will provide residential care, nursing care and specialist care for the elderly and young people with disabilities. When fully completed, the scheme will provide more than 70,000sq ft of healthcare, residential and public service facilities.

Mr Lunnon has revealed there are plans for similar developments in the pipeline.

Cycle ride raises £5k

Cyclists raised over £5,000 for the oral health charity Denbody by completing the 2C2 cycle across the north of the UK.

The ride was organised as part of the Denplan partnership, with the majority of the riders from Denplan practices.

It followed the famous 140 mile route, starting in Whitehaven travelling through the northern Lake District and finishing in Tynemouth.

Jenni Phillips, part of the support team for the cyclists said: ‘The nine cyclists not only battled some huge hills, but also the harsh elements, as they continuously faced heavy rain, gales and flooding. I would like to say a big thank you to everyone who supported Denbod and took part in the bike ride, it was great to see everyone’s enthusiasm and commitment to the ride and Denbod’s work. There were some tough conditions but everyone did amazingly well.’

YouTube dental advice

More and more Britons are watching their pennies because of the credit crunch and are trying to do their own teeth whitening after taking advice from YouTube.

Dr Prav Solanki, founder of the Cosmetic Dentistry Guide – a website that offers guidance and information for anyone considering cosmetic dental treatment, claims people are putting their health at risk by getting advice from YouTube rather than a qualified dentist.

“Our dentists have reported more cases of people turning up with damaged teeth and gums after trying to do their own teeth whitening,” said Dr Solanki.

He called YouTube home videos ‘irresponsible and dangerous’ for showing people how they brush hydrogen peroxide straight onto the teeth.

Dr Solanki added that some over-the-counter products are ‘fine in principle’ but without the expert guidance of a dentist, he warned that patients could be causing themselves damage that will cost more in the long run.
“When we opened our new practice, cashflow was a key priority for us. We operate a “just in time” ordering system so that we don’t have too much money tied up in stock and Henry Schein Minerva’s stock audit makes this much easier. We regularly order on-line and because we know we can rely on Henry Schein Minerva’s excellent service and delivery, we can maximise our cashflow and credit terms.”

Alex & Abby – Michael Dental Care, Cheltenham
Taking the plunge!

Briercliffe Road Dental Practice in Burnley could be considered by some as an unlikely place to find a thriving, dynamic private dental practice. Helen Powell – Practice Manager and wife of Dentist Mike Powell, explains their journey into Private Practice and how help came from an unexpected source.

The practice stopped taking adult NHS patients in March 2003, now 5 years later they are really experiencing the benefits of what, at the time, seemed to be a momentous decision. Mike’s commitment to providing high quality treatment and the booming NHS contract changes were the real driving forces behind their decision and although they knew that similar decisions were being taken by many practitioners, their location, in a less than prosperous area of North West England, made the decision to become a private practice more difficult. Up until 2003, their patient base had grown steadily, as they had picked up patients from practices around them who had taken the private road years before and they were worried that their decision would result in a loss of patients. In fact, they had one of the most successful single handed Denplan conversions ever, with over 1,000 of their patients becoming enrolled in one way or another. Mike and Helen had a visit from Steve Gates, Denplan’s MD and were asked to talk on several occasions to groups of dentists considering a Denplan conversion.

Since converting to private practice they have received a great deal of help in establishing and driving their business forward and at the forefront of much of their endeavours was help which came from what some may see as an unexpected source.

Alistair Newsham – who Mike and Helen had known for many years, came to see them in the middle of 2005. He had recently been taken on by Henry Schein Minerva in the role of Business Consultant and came to tell them about his new role and how it might be of interest to them. Naturally, having known and trusted Alistair for a number of years Mike and Helen were keen to explore any ways in which they could add to their now steadily growing private practice. Alistair explained to them that Henry Schein Minerva’s philosophy was to help practitioners maximise profitability by helping them to run successful businesses. A philosophy that encourages those running the practice to look at the “bigger picture” and not get too obsessed with comparing the relative costs of a box of gloves!

From the outset, Alistair encouraged them to think about where they wanted their practice to be in the future and helped them to pinpoint where they could improve productivity and efficiency. Most of the ideas Alistair put forward would be straightforward for most large, established businesses, but for a small business like Mike and Helen’s it was nothing short of a revelation.

They have incorporated a number of marketing ideas, mostly based on the advice given by Alistair and their marketing now extends to almost every area of the practice. Some activities are naturally more costly than others, but they all contribute to the growth of new patients and the delivery of excellent service and treatments to their existing ones.

“..."As Practice Manager I can now see the value of spending time working on aspects of the practice that will build our patient base, rather than searching through catalogues saving pennies on a couple of products. Ironically, by putting the bulk of our orders through Henry Schein Minerva we were able to negotiate extra discount anyway. Of course, we still take advantage of good value savings, but it has become much less of a driving factor for me."

Since 2005, and as they gained more confidence, Mike and Helen have followed a series of business programmes that they are certain have contributed to their success. In 2005, they achieved Investors in People, BDA Good Practice Award and completed their hat trick with the Denplan Excel accreditation, awarded in May 2005. As a team, Mike and Helen feel it is important to measure themselves regularly against these external standards, ensuring they are the best they can possibly be. Of course time does not stand still and Mike and Helen continue to be pushed and prodded by Alistair, with the backing of Henry Schein Minerva, to set objectives and achieve more for the benefit of their patients. “Our immediate goals for the practice are to make sure we make much better use of our intra-oral camera; equipment we have had for over 5 years! Alistair has given us the idea of doing “mouth tours”, to encourage patients to take more responsibility for their oral health and to ask patients what improvements they would like to see. We are also exploring the sale of Oral Hygiene products in practice and how we can maximise the potential of this part of our service.”

The decision to go private is not an easy one, it is very hard work, but it was definitely the right one for Mike and Helen and although times are changing and they know they will lose a percentage of their patients as some new NHS practices spring up around them, they are quietly confident that discerning patients will see the benefits they have to offer. “Our practice is busy and Mike has no desire to be more than a single handed practitioner, so for us, success is built around having a great team and being able to provide high quality dental treatment to motivated, enthusiastic patients in a pleasant and comfortable environment.

For more information email: me@henryschein.co.uk
Me & Henry Schein

“Henry Schein Minerva’s philosophy is to help practitioners maximise profitability by helping them run successful businesses. From the outset, they encouraged us to think about where we could improve productivity and efficiency, providing practical advice and marketing ideas based on our individual circumstances. Working with Henry Schein Minerva in this way has been nothing short of a revelation.”

Mike & Helen - Briercliffe Road Dental Practice, Burnley

Partnership in Practice

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Log all complaints says DDU

The Dental Defence Union is advising dental professionals to log all complaints and ensure a system is set up to carry out proper investigations.

The Dental Defence Union (DDU) has issued its advice in the wake of the National Audit Office (NAO) report on complaints handling, which highlighted a ‘lack of learning’ from complaints in the health and social care sector.

Rupert Hoppenbrouwers, head of the DDU, said: ‘In 2007, the DDU was asked to help with over 700 complaints by dental members. Some complaints were unjustified, others were the result of human error which led to an adverse outcome, and many were a consequence of a system failure such as not keeping a record of a treatment plan given to the patient. We entirely agree with the NAO’s recommendation, and usually advise our dental members to use complaints as an opportunity to identify underlying system problems and seek to resolve them.’

He added: ‘Patients and their representatives often say that their motivation in making a complaint is to find out what went wrong and that they would like an apology. Equally important, they seek assurances that steps have been put in place to stop the same thing happening again.’

This guidance includes:
• Recording a complaint in writing and having it acknowledged by the designated complaints manager within three working days in primary care (two days in NHS bodies outside primary care).
• It can also be useful to offer the complainant a meeting to discuss the concerns raised.
• Investigations should look beyond human error in order to identify and eliminate risks that could lead to a recurrence.
• For more serious incidents, you may decide to hold a meeting to discuss the issues in greater detail where all staff can contribute. Ensure a record is kept of the meeting and agree a date to follow up any action points.
• Provide a full, detailed and positive response to a complaint within 10 working days of receipt in primary care (25 days outside primary care). This should ideally include an account of what happened, an apology where appropriate, and an explanation of any steps which have been put in place to prevent a repeat of the problem. If appropriate, you may also choose to waive or refund the fee, or offer remedial treatment free of charge, as a goodwill gesture.

Mouth Cancer Action Week

Campaign organisers of Mouth Cancer Action Week are urging dental practices to claim their free Blue Ribbon Badge Appeal kits to raise awareness of the disease.

The British Dental Health Foundation (BDHF) is holding its Mouth Cancer Action Week poster campaign in November. Dr Nigel Carter, chief executive of the BDHF said: ‘Action can act on the front line against this killer, and ordering a kit can be an opportunity to identify underlying system problems and seek to resolve them.’

He added: ‘Patients and their representatives often say that their motivation in making a complaint is to find out what went wrong and that they would like an apology. Equally important, they seek assurances that steps have been put in place to stop the same thing happening again.’

The BDHF claims that by sharing knowledge and awareness—which can be helped by giving all dental staff a blue ribbon badge to wear during Action Week—their motivation in making a complaint is to find out what went wrong and that they would like an apology. Equally important, they seek assurances that steps have been put in place to stop the same thing happening again.

Support is greater for people already diagnosed with mouth cancer. Yet one in five people remain unaware of the disease.

Dr Carter added: ‘It is up to all of us as health professionals to act on the front line against this killer, and ordering a kit can be just the start.’

Early detection of mouth cancer can improve survival chances to more than 90 per cent – currently around 1,700 people die from the disease each year.

Easy-to-spot warning signs include mouth ulcers that do not heal within three weeks, red or white patches in the mouth and unusual swellings or lumps within the mouth or neck.

The BDHF claims that by sharing knowledge and awareness—which can be helped by giving all dental staff a blue ribbon badge to wear during Action Week—their motivation in making a complaint is to find out what went wrong and that they would like an apology. Equally important, they seek assurances that steps have been put in place to stop the same thing happening again.

Recruitment website launch

The Dental Schools Council has launched a recruitment website for people looking for clinical academic jobs in dental schools.

www.clinicalacademicjobs.org is a non-profit website which enables job seekers to search free of charge for current clinical academic, teaching and research jobs in undergraduate and postgraduate dental schools in the UK.

The aim of the website is to help schools recruit dental clinical academics, whilst acting as a career resource for the current and future academic workforce.

In addition, job seekers will have access to relevant organisations offering funding and training for clinical academic careers.

The website is managed in partnership by the Dental Schools Council and the Medical Schools Council.
“Sometimes people think that big companies aren’t interested in NHS dental practices, my experience of Henry Schein Minerva is just the opposite. They have encouraged and supported us in many ways, providing an excellent staff training programme which has really helped develop our personnel. We now have an established facility that provides outstanding care for our patients, all made possible by the first class service we receive from Henry Schein Minerva.”

Yemi Opaleye – Tetbury Dental Practice, Tetbury

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The Sceptic presents
The case for... and against
Virtue

More than five centuries ago, Socrates sat around ancient Athens engaging in philosophic dialogue with the local citizens. One question that was debated at length was "What is virtue?" Let us fast-forward to today and try to answer that question.

Is virtue that which brings everything into harmony? Yet one might inquire whether beauty and harmony and order are all virtues themselves or whether they are constituents of qualities that make up virtue. One view of virtue might be that it is a combination of several human characteristics such as honesty, piety, being charitable and telling the truth - in short, being good. These are traditional religious values, applicable even if one does not believe in religion.

Qualities vs function
Socrates might better have tried to define virtue more in terms of its function or the ends it serves, rather than on dwelling upon the qualities of which it is made. It seems to me that no two people, no two societies take the same road to becoming more virtuous. But I think they all have the same starting place. They start by asking, "What is virtue?", because only by answering that question can you then answer, "How can we become more virtuous?"

Virtuous lies
But if this is so, are there any circumstances where, for example, not telling the truth might be considered virtuous? Yes, you might say, not telling a frail old woman that her son had been killed in a car crash, was a virtuous deed. Telling her the truth might very well kill her too, and it might just be kinder to tell her that he had gone away for an extended period on business. It might be kinder not to tell a young child that he had cancer until the last possible moment. A German gentle hiding a Jew during World War II might have lied to save him from the Gestapo. Plato thought that these could be considered 'noble' lies.

Virtue and excellence
Another possible view is that 'What is virtue?' could be the same as asking, 'How can we become more excellent?' and 'Is becoming successful a virtue?' In certain cultures, for example the Navajo Indians of North America, 'personal excellence' is a key value, while 'personal success' is not, although it is in the general European/North American culture, which is all about personal success. For the ancient Greeks, every deed and act was committed for the greater rather than the individual good. There was no private self then as there is today, only a self that was part of a whole. In this respect it is akin to the 'dharma' of Hinduism. Virtue encompasses not only an individual's duty to himself, but also to his religion, society and nation.

Japanese virtues
Compare our Western values to those of the Japanese where tatame, the public side, is kept separate from honne, the private side. Honne means 'genuine feelings', whereas tatame means 'masking yourself, hiding your feelings'. This is why Japanese go to great lengths to avoid confrontation. In Japan, each individual must have a co-operative spirit, and must care for the excellence of the group more than for, and before, individual excellence. To the Japanese, virtue creates social harmony. Unfortunately, all is not social harmony, not in Japan nor in Great Britain.

Present-time virtue
Virtue at present is defined in different terms: not the good that you do, but what you can get away with. A few years ago, a cricketer who snicked the ball would walk before the umpire raised his fin-
The 10th Dimension – the power of 10

In this series of articles, Dr Ed Bonner BDS MDent, Sloan Fellow London Business School, looks at how to deal with difficult colleagues

Although it’s the preference of many dentists to be self-employed, and to work in a single-handed practice, many others feel the need to interface with colleagues on a daily basis. This may come within the community service, in a hospital or clinic environment or in general/specialist practice as a partner or an owner employing associates. High levels of skill are necessary to navigate through the choppy seas of human inter-relationships, but the teaching of these skills at a formal level is conspicuous by its absence. So it is left for individuals to work out their own sailing methods and map-reading techniques and it is no surprise that they often founder on the rocks of human conflict.

Loads of baggage
There is not one among us who does not arrive at work unencumbered by personal baggage: parental attitudes, lack of recognition for past work well


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Surely the ship will sink with all this baggage?
1. Empathy; the ability to un-
derstand someone else’s feel-
ings as if they were your own;
placing yourself in the other
person’s shoes.
2. Sympathy: compassion for
some-one else’s discomfort,
pain or distress.
3. Non-judgmental attitudes:
accepting that people are as
they are and not as you think
they should be.
4. Doing for others and allow-
ning them to do for you; many
individuals are far more com-
fortable doing part of an-
other’s work, perhaps in the
hope that the other’s percep-
tion will be raised.
5. Being able to give and re-
ceive praise: the One-Minute
Manager says, “Catch some-
one doing something right!” Don’t just catch them – tell
them, even if it’s something very small, such as using
a pleasant perfume. When someone praises you, don’t
look for their motivation or downplay the praise: smile
and say thank you!
6. Thinking about and un-
derstanding another per-
son’s motivation: team
members work best when they
feel motivated, and be-
come difficult when they do
not. Try to find out what
makes your colleague per-
form better and add your en-
ergy to assist in developing
the upside.
7. Understanding the dynam-
rics of relationships: this
means understanding that
how you communicate is at
least as important as what
you communicate. Always
be positive and constructive
in everything you do with an-
other person.
8. Offering constructive sug-
gestions rather than criti-
cism: you are much more
likely to achieve your objec-
tives if you do not make
someone else feel wrong, but
merely suggest that there
might be other ways of
doing a job that might also
work.
9. Being able to accept con-
structive or even uncon-
structive criticism: this is
possibly the most frequent
cause of relationship melt-
down: people just don’t like
to be told they are wrong,
even if they are. Humility, on
the other hand, often allows
acceptance of criticism and
earns the respect of the
critic.
10. Learning that you don’t
have to be right, and that
it’s ok not to be: I was on a
flight the other night. A
young mother with three ir-
ritable kids was trying to
keep her family together
so that she could control
them; the air steward was
adamant that as they were
the last on board, they just
had to sit separately. The
woman was getting angry,
the steward more and more
determined to apply the
rules. The flight was de-
layed by 50 minutes, and the
woman complained about
the steward. He was within
his rights, but shouldn’t have
tried to prove it.

The key to success is to bring
collaboration and ultimately
co-ownership to everything
that occurs in the practice. That
way, everyone is responsible for
the successes and no one in par-
cular is responsible for the
failures.

Since selling his prizewinning
dentistry100 practice, Ed Bon-
er acts as a consultant (guru) and
practical coach to the den-
tal profession, working with in-
dividuals as well as groups of
dentists. He can be reached at
bonner.edwin@gmail.com
All above board?

David Seals gives an essential run-down of employment law so that you can ensure that the day-to-day running of your practice is legal

Permission to work in the UK

Employers must refuse to hire applicants who cannot demonstrate that they have a right to work in the UK under our immigration laws. Under the Immigration and Asylum Act 1999, employers can be fined £5,000 for each employee found to be illegally employed. In the event of the employer being a company, any director, manager, secretary or similar officer of a company who consented to, or knowingly allowed the offence to take place can be guilty of the offence as well as the company itself. Liability can be avoided by checking a candidate’s documents – usually their passport – to ensure they have the requisite permission to work in the UK.

Pre-employment checks

Prior to offering employment, a sensible employer will usually request to see identification documents and references. In addition, an employer may wish to carry out background checks such as health checks or a check to ensure a candidate has the specific qualifications required by the employer.

Offers of employment

An employer can either offer a candidate a conditional or unconditional offer of employment. The latter will be where an employer imposes conditions such as the provision of a satisfactory reference. If an offer is withdrawn on the basis that a condition is not met, an applicant cannot make a complaint unless it can be shown that the employment was withdrawn because of unlawful discrimination. If a candidate’s unconditional offer of employment was withdrawn then the employer would be liable to terminate on notice. This would be a week’s pay or more depending on any longer contractually agreed notice period. Employers should generally therefore ensure they make offers conditional on receipt of satisfactory references.

Data protection

An employer should only obtain such information which is necessary and relevant to the employment. Employers have a duty to make sure that any use of personal information about an employee complies with the principles of the Data Protection Act 1998. The DPA is complex and requires, among other things, that holders of personal data keep it secure and up-to-date and delete it after an employee leaves.

Young workers

There are special laws to protect the employment rights of young workers. These concern health and safety, hours of work and the type of work that can be done. Employers can refuse to employ applicants under the minimum school-leaving age, as it is generally illegal to employ them except for part-time or holiday work.

National minimum wage

The National Minimum Wage is the minimum amount of pay that workers are entitled to. There are three different rates. These are (currently):

• 18 to 21 inclusive – £4.60 per hour
• 16 to 17 year olds – £3.40 per hour
• 22 and over – £5.52 per hour

Deductions from wages

An employer is not allowed to make a deduction from an employee’s pay unless it is either authorised by the contract of employment or the employee has agreed to it first in writing. A deduction may also be made if it is required or authorised by law, such as income tax, national insurance or student loan repayments. Usually, the employer will also be able to recover any over-payment of salary without any written agreement from the employee.

Sick pay

If an employee needs to take time off work due to illness, their pay during this period will depend on their terms of employment. An employer may elect to run a company sick-pay scheme and can offer any scheme providing it does not fall below the legal minimum of statutory sick-pay (currently £72.55 per week for most employees). An employer must provide an employee with a written statement of employment particulars within eight weeks of employment commencing, which must state what sick-pay provisions apply.

Performance-related pay

An employer may offer performance related pay to encourage staff to work harder and/or achieve set targets or objectives. In order to avoid disputes the conditions for such payments should be clear and agreed between the employee and employer in advance.

Equal pay

Generally speaking men and women are entitled to receive the same level of pay for doing the same work. Equal pay means that you provide the same pay and benefits for men and women doing work that is:

• the same or broadly similar;
• has been rated as equivalent under a job evaluation scheme;
• is of equal value in terms of the effort, skills, knowledge and responsibility required.

‘Pay’ includes salary and all other contractual benefits such as bonuses and pension contributions. Individuals may complain to an employment tribunal under the Equal Pay Act 1970 up to six months after leaving the employment to which their claim relates. Normally, they may claim arrears of remuneration (which includes sick pay, holiday pay, bonuses, overtime etc as well as normal salary) for a period of up to six years before the date of their tribunal application.
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root) in adults and children over 10 years. Dosage and administration: Adults and children over 10 years old: Use daily instead of normal toothpaste. Apply a 1 cm line of paste across the individuals with known sensitivities should consult their dentist before using. Not to be used in children under 10 years old. Special warnings and precautions for use: Not to be Colgate-Palmolive (UK) Ltd, Guildford Business Park, Midleton Road, Guildford, Surrey, GU2 8JZ. Recommended retail price: £4.99 (75ml tube), £8.99 (dual pack containing 2x75ml

years of age, particularly amongst patients at risk from multiple caries (coronal and/or root caries). Dosage and administration: Brush carefully on a daily basis applying a 2 cm ribbon onto the excipients. Special warnings and precautions for use: An increased number of potential fluoride sources may lead to fluorosis. In order to prevent the accumulation of fluoride, of Duraphat Toothpaste. When carrying out oral cavity calculations of the recommended fluoride ion intake, which is 0.09 mg/kg per day from all sources, not exceeding 1 mg per day. Sodium Benzoate is a mild irritant to the skin, eyes and mucous membranes. Undesirable effects: In patients with immune system disorders rare (6.110,000 <11,000): hypersensitivity GIU) 8JZ. Recommended retail price: £6.99 (51g tube), £13.99 (triple pack containing 3x50g tubes). Date of revision of text: September 2003.

Prevention of caries, desensitisation of hypersensitive teeth. Dosage and administration: Recommended dosage for single application: for milk teeth up to 0.25ml (5.65mg but more frequent applications (every 3 months) may be made. For hypersensitivity, 2 or 3 applications should be made within a few days. Contraindications: Hypersensitivity to colophony should not be carried out on an empty stomach. On the day of application other high fluoride preparations such a fluoride gel should be avoided. Fluoride supplements should be suspended swelling has been observed in subjects with tendency to allergic reactions. The dental suspension layer can easily be removed from the mouth by brushing and rinsing. In rare cases, asthma Guildford Business Park, Midleton Road, Guildford, Surrey GU2 8JZ. Price: £19.31 Inc VAT (10ml tube). Date of revision of text: October 2003.
Cost-effective recruitment

Are you struggling to find a new team member? If so, it’s worth considering the benefits of working with an agency. Jeremy Reuben explains why.

When it comes to solving recruitment issues, many principals will advertise in the local and dental press, and on the internet. In the age of information technology, this seems like a convenient and straightforward solution – simply send an email to the publication or website in question, and wait for the bill. The problem is, sometimes the bill is all you receive.

When you advertise a job in the press, you are not guaranteed a response. When you consider the high cost of advertising in the most prestigious publications – for example, those that will reach the highest calibre of candidate – this approach is shown to be far from cost-effective.

Finding a replacement

There are many reasons why you might need a new team member. It might be due to long-term sickness, or the team member might have left for a new challenge elsewhere. Whatever the reason, you need to recruit a replacement, and you need to do so quickly.

Great care needs to be taken when doing this. No principal is going to put patient loyalty to the test by taking on a candidate who is not suited to the task. In the current competitive climate, the dental team needs to be as skilled and experienced as possible to retain patients and to lure patients away from competitors.

Finding the right professional for your practice involves a great deal of hard work, and a large amount of that most precious resource: time.

Lowering the cost

In order to avoid the financial and temporal cost of advertising, you can enlist the help of a recruitment agency. The leading agencies will dedicate themselves to understanding your business and your unique needs, and provide you with excellent candidates whenever you need new team members (be it on an emergency, temporary or permanent basis). With the agency handling the screening and interview process, you can focus on the business of treating patients.

Working through a recruitment agency is simply the most cost-effective method, not only of recruiting urgently-needed expertise, but also to provide you with a safety net should you need to recruit in the future. What’s more, you are much more likely to get the candidates you want from an agency as opposed to those who respond to an advertisement. This is because recruitment agencies are able to scour their extensive databases for candidates who have the experience, education and character to fit straight into your practice with a minimum of time needed to settle in and get acclimatised.

So the next time you need a new team member, think about the benefits of working with an agency. With none of the risks associated with costly press advertising, it really is the best method.

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About the author

Jeremy Reuben is director of Browns Dental Employment Agency (BDEA) which trades as Browns Locumlink. He’s a qualified pharmacist and a member of the Royal Pharmaceutical Society since 1983. For more information, contact Browns Locumlink on 020 8927 0972, email webdental@brownslocumlink.com or visit www.brownslocumlink.com.
Building trust and loyalty

Dealing with dental-phobic patients can be tricky, but with some lavender oil and an iPod to hand, Mhari Coxon shows there are ways to help patients overcome their anxiety

I recently treated a patient who had not been for a hygiene session for over three years. Looking at her history, I could see she was extremely sensitive during her last cleaning and had found the whole experience quite traumatic. Added to this, she had just finished her second series of chemotherapy for ovarian cancer, and you have a patient who needs a lot of care as well as therapy.

First contact
When she arrived, I met her in one of our waiting rooms and sat down beside her. She had not met me before, which didn’t help her anxiety. I explained I would need to find out some information, so I could give her the best care. She was a little abrupt and felt this was a waste of her appointment, however I reassured her that everyone has to give this information, so I can care for them in the best way, too.

I asked about her general health, giving her the opportunity to discuss what had been a tough time. We then moved on to her dental health and routine, and her diet. She was repeatedly apologetic for ‘the state my teeth will be’, I reassured her she needn’t apologise. She was adamant that she wouldn’t floss because it was ‘too much hassle’, which she had had enough of recently.

Discussing fears
I could see she had relaxed a little and asked her if she did not like the dental experience. As I put it, ‘Let’s face it, no one likes a visit to the dentist, not even dentists; but are there some things in particular that makes you uncomfortable?’

She explained she had an unpleasant experience as a child where she had felt pain and was not allowed to stop the treatment. She still feels that lack of trust and control now, even as a grown woman. I found out that the smells and sounds of the surgery make her feel anxious and she panics at the thought that she won’t be able to stop treatment if she feels pain. I also learned that the slow-speed drill and the noise it generates, makes her feel anxious.

Add to this that she had had chemotherapy through a Hickman line in her chest, which left her very tender around her neck, so her fears were justifiable.

Reducing anxiety
Once I checked she wasn’t sensitive to essential oils, I put some lavender oil on an electric stone heater to eliminate any dental smells. I also offered her the use of my iPod for the noisier bits (I have Eva Cassidy for this very situation, while The Future Heads are not such a relaxing choice). I then offered her a covered beanbag neck support.

Some of you will be thinking I am a bit namby pamby, others will think that it must have taken me an hour to do all this. It took me 15 minutes in total to find out her history and get her comfortable in the chair. I was empathetic but not condescending when offering solutions to ease her anxiety.

Carrying out treatment
Before starting treatment, I used a desensitising solution on her teeth (another two minutes) and made sure the rinse was lukewarm. I talked her through each stage and stopped regularly to check she was comfortable. I told the patient to give me a wave if there was any reason she needed me to stop.

Using disclosing solution, I showed her the plaque deposits and modified her brushing technique (this took another five minutes). I did not add an interdental aid at this stage as I thought it better to move slowly. I gently removed the more obvious supra gingival deposits with hand scalers and did a little prophylactic cleaning with a slow speed (and iPod). Although she was booked in for an hour, I called it a day at 40 minutes and said I would need to see her at least twice more to get her feeling better about her mouth.

Completing the work
Five shorter sessions on, we have just completed all the cleaning and her bleeding and plaque scores are good. We both decided to add an interdental brush to her routine. She still feels anxious about coming, but trusts me a lot more. She brings her own MP3 player and ‘zones out’ while I work. We both understand it will be hard for her to book in for her three-month maintenance session, as anxiety has a way of making you forget how well it went last time.

Future plans
Investing this time on her first appointment has given me a patient for life. We have a good professional relationship and she feels as comfortable with me as she probably ever will with any dental professional. It can be hard in a busy day to find the time to assess patients, but it surely makes a real difference to the quality of our practice. If we can take time to make sure we meet some of the needs and expectations patients arrived with, and reduce their anxiety, they will be happier to return, and we will have a happier clinical day.

For some good, free information on how to deal with dental phobia as a professional, have a look at http://www.dental-fearcentral.org/mentalanxiety.html, which has lots of information to download.

About the author

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDoD (CPD online diploma) which provides CPD courses for all DCPS. To contact Mhari, email mhari.coxon@pdfordcp.co.uk.
Learning the easy way

There are lots of different ways to meet CPD requirements, so you need to choose a course or learning experience that suits you personally. Mike Wanless looks at the choices

Following the compulsory registration of DCPs on August 1 2008, comes the need for Continuing Professional Development (CPD). The General Dental Council (GDC) has specified that a DCP must undertake 150 hours of CPD in a five-year period. This includes the three core subjects of medical emergencies, disinfection and decontamination and radiography and radiation protection (or materials and equipment for dental technicians).

Meeting your requirements

Some learning activities need to be verifiable (have identified learning objectives, evidence of attendance, quality controls, clear outcomes). Others are described as non-verifiable. There are many ways in which these requirements can be met. CPD can be achieved through private study, reading journals, peer review, meetings and courses. A full list and further guidance is available on the GDC website: www.gdc-uk.org. Any type of learning activity has a place. As you start this process, it’s worth thinking about what type of learning suits you so that you can find a method that suits you and produces the lasting effects.

How to learn

You learn in your individual way. Some people find learning from books easy, while others hate it. You may have found that you find the format of a course helps you learn, but that others feel so uncomfortable they learn very little. There is an expression ‘horses for courses’... so how can you pick a course or other learning experience that suits you? Kolb (1974) described the learning cycle – to learn fully about a subject there are four stages. As well as experiencing something, we need to think about it (reflection), realise why it has happened and consider its application – ‘what do I need to do next time?’

This was developed into separate learning styles by Honey & Mumford (1992). They considered that pragmatists learn best where there is a clear link between the topic and their work. They like the chance to try out and practice techniques under the coaching of a credible expert. They like learning to overcome real problems. They do not like sitting, listening, watching, reading or repetition.

Who suits what?

Activists like new experiences from which to learn. They become engrossed in short ‘here and now’ tasks, such as games, competitive tasks or role play. They are happy to be in the limelight, be involved with other people and have a go. They do not like sitting, listening, watching, reading or repetition.

Reflectors like activities that let them think and/or think. They like time to think and prepare before acting, and to think about it again afterwards. They like to come to their own decision and dislike being put under time pressure. They do not like making snap decisions or responses, or having to make shortcuts.

Theorists learn best from situations where they can see the context and understand the underlying theory. They welcome the chance to question and throw assumptions and logic. They enjoy being intellectually stretched and analysing data. They learn least when thrown into doing something without knowing how or why they are to do it. They dislike having to share their emotions and feelings, or make judgements without thorough knowledge. They also dislike superficial coverage or gimmicks.

When you decide how best to approach your CPD, think about how you learn best. Decide whether self-directed learning or any other method is right for you. You may as well learn easily rather than in a way you find difficult.

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References on request
Assessing previous endodontic treatment radiographically: making clinical decisions

The clinical case pictured in Figure 1 refers to me for diagnosis and treatment. The endodontic treatment pictured was completed two years before presenting in my office. The patient described the treatment as extremely painful at the time the canals were filled, which was reported to be in the mandible. After the initial treatment, the patient’s symptoms went away and had returned approximately a week before her presentation into my office. When examined, the patient was in extreme pain. The pain was spontaneous, nocturnal and the tooth was acutely sensitive to chewing. At the time of my examination, the tooth, No. 5, was extremely sensitive to percussion, moderately sensitive to palpation, mobility was slight, and the tooth had probing depths no greater than 6. The patient attributed the pain to the sealer puffs that had resulted from the previous treatment.

The radiograph revealed the following features:

1) There were three large sealer puffs present apically as well as obvious tracks of sealer leading to two of the puffs. It was unknown which type of sealer was used in the previous obturation.

2) The master cone obturating the mesial buccal root canal filling appeared to be extended approximately to the radiographic apex with a sealer puff that leads to the largest extreme extrusion of sealer apparently in the sinus above the tooth. There is evidence of a second, unentered canal in that there is visible canal at the mesial of the existing MB root canal filling. The MB canal preparation does not have a continuous taper.

3) Radiographically, the middle third of the root has a greater taper than the coronal third. This violates one of the principles of canal preparation (i.e., to create a tapering funnel with narrowing cross-sectional diameters).

4) Reading the radiograph to interpret the palatal canal is challenging, but it appears that the core material extends to the radiographic apex or slightly beyond and that there is a slight deviation of the core material, which could be a post or canal eccentricity (which was reflected in the obturation). The obturation in the coronal third of the palatal root appears slightly serrated, giving evidence that this might be a post. The presence of the opacity to the distal of the palatal canal (in the cervical third) as well as the radiographic furcal lesion is virtually diagnostic of a furcal perforation. The canal preparation is also parallel along its length and does not have a continuous taper.

5) The DR root appears to be obturated slightly beyond the radiographic apex with two significant sealer puffs to the distal aspect of the tooth. The canal preparation is also relatively parallel (i.e., lacks continuous taper). Like the MB and palatal canals, the DB preparation also violates the principles of ideal canal preparation.

6) A cervical dentinal triangle was not removed in the access to the DB canal, nor was straight-line access obtained.

‘... is it likely that the minor constriction of the apical foramen of each of these canals was violated in the canal preparation.’

Sealer puff: mechanism of this iatrogenic event

It is noteworthy that the radiographic image was taken two years after the initial treatment and that the extrusion of sealer was in all likelihood greater than that present radiographically when examined by me.

It is unknown how the sealer puffs were created, but it is likely that one of two mechanisms were involved:

1) An excess amount of sealer was placed into the canals initially and this sealer was extruded by repeated placement of the master cones (i.e., pumping the sealer out the end of the root by repeatedly placing new sealer in the canals and refilling the master cones).

2) The clinician injected sealer with a syringe without focus or focus on the location of the needle tip. Aipal over en- largement and/or a very thin needle used incorrectly with a syringe could also explain such a gross extrusion of sealer. In- correct in this context means that the needle was beyond or locked at the apical foramen and the clinician did not realise either how much sealer had been extruded or where the needle tip was during extrusion. It is also possible that excessive sealer was extruded from a syringe and pistoned through the root end with a single cone obturation technique.

‘Length control is vital at all stages of canal preparation’

- Length control is vital at all stages of canal preparation. While this is possible, it is un- likely because of the opacity of the sealer puff and the opacity of the canal fillings are not identical.

- Discussing these findings in the context of both obturation technique and avoidance of these outcomes has value.

- There should be no delay in the placement of coronal seal. With the rubber dam on and under the SOM, the tooth can be etched and sealed with a flowable composite at the time of treatment. It is ironic in this clinical case that is even with the flaws in treatment, the tooth was sealed at the time of obturation the probabilities of a clinical success would have been much higher. Instead, having left the tooth compromised, the coronal microleakage, the clinical failure was virtually assured, especially with the perforation. Perforations should be repaired and sealed immediately to optimise the chances for clinical success. Once exposed to leakage, especially over the two-year period from the time of the perforation occurred to the patient’s visit in my office, three was no other...
Informed consent is the process by which a fully informed patient can participate in the choices regarding their health. Of course you cannot simply launch into treatment, as with all forms of medicine and dentistry, patient consent is needed. This has to be based on knowing and understanding the factors involved with treatment and their alternatives. In endodontics, the decision needs to be made as to whether to treat the tooth or to extract it. The patient needs to make an informed choice and has to understand the prognosis and any risks involved. The more thorough the discussion at this stage, the less likely there are to be problems later.

Root canals are not simple straight tubes, but complicated three-dimensional structures full of nooks and crannies harbouring bacteria and therefore it is impossible (as with any other complex biological system) to offer absolute guarantees, and the patient needs to understand this.

Highlight the options

First, give them a clear and concise prognosis of each treatment option. Vital inflamed teeth with no infection have an excellent prognosis with a quoted success rate of approximately 95 per cent. If the tooth is infected with a lesion, the success rate may drop down to 80 per cent. The patient also has to be made aware that ideally the tooth may need a crown in the future to prevent fracture, and that treatment cost may not just be endodontic.

The initial decision has to be made as to whether the tooth is restorable. Most teeth can be root-filled, but if there is not enough coronal tissue it may not be worth it. If the tooth has an uncertain prognosis, then there should be a discussion regarding the merits of treatment versus extraction and replacement with a bridge/implant.

The patient's personal feelings, experience and aspirations feed into the process of informed consent as well as any cosmetic implications.

Easy does it

The following scripted conversation only takes about five minutes, but gives the patient real information that leads to valid consent and could help to prevent problems arising from any misunderstanding of the treatment plan:

‘Mrs Jones, your lower tooth has become infected and needs root canal treatment. The success rate, according to figures is about 80 per cent, unfortunately not a 100 per cent guarantee. However, to really protect the tooth, it should ideally have a crown put on it as well. Looking at the tooth, it may be difficult to get a good crown on it and the alternatives may be to have the tooth extracted.

‘If you lose the tooth, you will have a gap. Nobody has died of a gap so far but it may have an knock-on effect on the other teeth and they may change position.'
'You may want to also think about a bridge. This will involve reducing the adjacent teeth and preparing them for crowns. All the teeth are linked so it may be difficult to clean, but it is a relatively cheap and easy procedure. The half-life of a bridge is approximately 10 years so it will not last a lifetime.

'The best option is to have an implant. This is a screw placed into the bone, it involves surgery but we do not have to touch the other teeth so you can clean around it easily. The downside is that it is more expensive and you need good bone.

'Mrs Jones what would you like us to do?'

'It’s really as simple as that and your patient will certainly thank you for it in the long run.'

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Looking through the window

Yvonne Gordon reports back from a conference looking at the links between oral and systemic health

With fewer patients visiting the dentist and running increased risk of periodontal disease, top professors in dentistry and medicine are gathering more and more evidence for the link between periodontal disease and systemic health, in particular heart disease and Type 2 diabetes, both of which are increasing at alarming rates, both in the UK and globally.

At the recent Oral and Dental Research Trust’s (ODRT) symposium at the QE11 Conference Centre in central London – the Impact of Oral Health on Systemic Health: What is the Evidence and How Big is the Problem? – a series of experts addressed the audience with their research, yielding fascinating results.

Clinicians, academics, scientists and other interested parties packed the lecture theatre at the QE11 Conference Centre to hear an array of prestigious speakers from the UK and US.

Professor Nairn Wilson, CBE, dean and head of the dental institute at Guys, St Thomas’ and King’s College hospitals and ODRT chairman, introduced the one-day event, chaired by Professor Ian Chapple. The idea for the conference was born out of the review – A Strategic Review of Oral & Dental Health in the UK – a position paper published by the British Society for Dental Research.

Prof Wilson said: ‘From this paper arose the need to inform the public of the importance of oral health in relation to general health, as a result of which pilot projects were developed. ‘Oral diseases are among the most common to affect humans and systemic diseases present around the oral cavities, which has an influence on Type 2 diabetes and cardio-vascular conditions. Oral cancer is growing in families and the young, with a 50 per cent survival rate. The cost is huge.’

Periodontal disease affects the supporting structures of the teeth, when the epithelial cells are irritated and gingivitis develops. In most people, this destroys the bone and the supporting tissues of the teeth, gradually exposing the connective tissues. In five to 10 years, the exposure of the ulcerated surface to bugs causes periodontitis.

Tell-tale signs

Professor Mike Lewis from Cardiff University, who is also dean of the dental faculty at Glasgow and vice-president of the Royal College of Physicians and Surgeons, talked about the mouth as a window on the body.

He said: ‘You can tell a lot from looking at the tongue, from which the Chinese can diagnose 300 conditions. Mouth ulcers can reflect haematic or nutritional deficiency or gastro-intestinal problems. Ulcerative gingivitis is caused by immuno-suppression. Dry mouth can indicate undiagnosed diabetes. Many diseases are reflected in the mouth and early recognition may assist diagnosis and outcome.’

More studies are needed, but researchers suspect that bacteria and inflammation linked to periodontitis can also play a role in systemic diseases or conditions such as blood cell disorders, which can lower the body’s resistance to infection, making periodontal diseases more severe.

‘You can tell a lot from looking at the tongue, from which the Chinese can diagnose 300 conditions.’

Several studies link chronic inflammation from periodontitis with the development of cardio-vascular problems. Some evidence suggests that oral bacteria may be linked to heart disease, arterial blockages and stroke.

People with diabetes often have periodontal disease. In addition, there is evidence that people with diabetes are more likely to develop and have more severe periodontitis than those without diabetes. Some studies suggest that periodontitis can make it more difficult for people with diabetes to control their blood sugar.

Although periodontitis may contribute to these health conditions, it doesn’t necessarily mean that one condition causes the other. That is why researchers are examining what happens when periodontitis is treated in people with these various health problems.

Prevention better than cure

Given the potential link between periodontitis and systemic health problems, prevention may be an important step in maintaining overall health. Dentists should ensure that patients brush thoroughly twice a day and clean between the teeth once a day, as well as eat a balanced diet and limit snacks. Patients should be educated that regular dental check-ups and cleaning are essential, because professional cleanings are the only way to remove calculus, which traps plaque bacteria along the gum line.

Diabetes specialist, Professor Rhys Williams, dean of medicine and professor of dental epidemiology at the School of Medicine in Swansea, looked at the extent of the growing problem of diabetes mellitus. He said 80 to 90 per cent of sufferers have Type 2, which has increased drastically in the United Arab Emirates due to its transformation from a subsistence society to a wealthy one and the subsequent effect on nutrition and physical activity, Latin America, Africa and Asia have also seen a big increase due to urbanisation and change in diet. In the UK, there is an increase of four per cent, largely due to earlier detection, increasingly sedentary lifestyles, obesity and fast food. There are about half a million undiagnosed cases in Wales. Prof Williams said: ‘Diabetes affects many parts of the body. The vast majority of people with diabetes will have cardio-vascular disease, most of whom are women.’

Dr Phil Preshaw, from Newcastle University’s school of dental science and institute of cellular medicine, spoke about whether periodontal disease and diabetes had a bi-directional relationship. He said the mouth should not be looked at in isolation from the rest of the body. He said: ‘Type 2 diabetes is a result of poor diet and low physical activity. One in 10 children is overweight worldwide and there will be 300 million sufferers globally by 2025. One in three people born in the US in 2000 will develop diabetes.’

He explained the ‘thrifty gene hypothesis’. ‘Humans can deal with different environmental challenge in scant times. The problem now is that in times of plenty we can have too much. The same geno-type which protects us against starvation in times of crisis, causes a risk of diabetes in times of plenty.’ He said periodontal disease was often found in diabetics. For example, 60 per cent of diabetic Pima Indians had periodontal disease, compared to 36 percent in non-diabetics.

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The mechanistic links

His talk was followed by Dr Christine Ritchie from the University of Alabama, who gave a detailed presentation about the mechanistic links between Type 2 diabetes and periodontitis and then Professor Mark Caulfield, who gave an overview of atheromatous vascular disease and ischaemic stroke in the UK.

Professor Panos Papapanou from Columbia University looked at the evidence for periodontitis and macrovascular disease. He said men with periodontal disease had 4.3 times higher risk of stroke. His research includes the role of periodontal infections as independent risk factors for systemic disease, in particular, the role of periodontitis in the development of atherosclerosis, cardiovascular, and cerebrovascular disease.

Professor Thomas Van Dyke, Director of the Periodontology Research Laboratories at Boston University spoke about unravelling the links between cardiovascular disease and periodontitis. He said: ‘Both conditions have a large inflammatory component. The control of inflammatory response can prevent periodontitis as well as early vascular changes. Greater understanding of the complex pathways involved in inflammation may provide alternative therapeutic strategies to combat inflammation and chronic diseases potentially arising from it.’

In his paper, Understanding and Managing Periodontal Diseases: A Notable Past, a Promising Future, published July 2008, Prof Van Dyke wrote: ‘At the end of the 20th century, an old concept in medicine and dentistry reappeared: that the infection and inflammation of periodontal disease in the mouth could reach distant sites via the bloodstream. Apparently oral disease could, in fact, contribute to systemic diseases, such as atherosclerosis, diabetes, as well as adverse outcomes in pregnancy. This concept of oral health in relation to general health connection is now supported by sound and rational evidence-based observations. Clearly, the 21st century has arrived with a new understanding of the nature of periodontal diseases based on a notable era of discovery. There is a promising future for preventing and treating this common and troubling condition that affects not just the mouth but also the whole body.’

Jointed-up thinking

The overall consensus at the symposium was that there was a need for cross-disciplinary and collaborative research projects, because public health was suffering due to the divorce between dentistry and medicine. It was originally observed in the late 1980s that patients with acute myocardial infection (MI) had significantly more dental problems such as periodontal disease than subjects without MI. Members of a consensus group of physicians and dentists met earlier this year to review the current evidence linking periodontal disease to overall health.

The Potential Impact of Periodontal Disease on General Health; a Consensus View, published by Current Medical Research and Opinion 2008, states that: ‘The infectious and inflammatory burden of chronic periodontitis is thought to have an important systemic impact.’

The article states that periodontitis is associated with an increased likelihood of coronary heart disease and may influence the severity of diabetes, although a ‘causal relationship still needs to be demonstrated between periodontal disease, cardiovascular disease, and diabetes, through relevant prospective studies. However, it acknowledged that periodontal disease is more severe in people with diabetes mellitus, a group already at increased risk for cardiovascular events.

In the paper, the consensus group expressed an urgent need for dentists and physicians to work together in understanding and improving patient health. It concluded that good oral health is an integral component of good general health and acknowledged that research into the inflammatory pathophysiology of periodontitis, cardiovascular disease, and diabetes was revealing potential links between the conditions.

Therefore cross-discipline communication and research between dentists and physicians was essential to improve understanding of the risks.
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The **Hydrosystem** is a solution for reducing voids in A-Silicone impressions. This is achieved by reducing the surface tension on the preparation. Hydrosystem is applied with an applicator and air dried prior to applying silicone around the preparation eg a Wash (light body) or Monophase (medium body). Hydrosystem comes in a 10ml bottle with 50 flocked applicators. Priced at only £8 this is a welcome addition to enhancing impression taking.

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Choosing a new impression material is often risky, but you can be assured that RKs Tur- boxflex from Dental Sky is the perfect A-silicone that provides exceptional detail reproduction. This complete range allows you to use your existing technique, be it the wash technique or double mixing.

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So, whether you choose your existing brand of impression material or would like to try Dental Sky’s cost effective Turboxflex or Turbox, call Dental Sky on 0800 284 4700.

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Finally, in response to the needs of CAD/CAM users, Virtual CADbite has a reflective surface, which delivers excellent results when capturing images with intraoral scan- ning devices. This allows den- tists to incorporate antagonist data directly in the restoration design.

For further information con- tact your local Ivoclar Vi- vadent Representative, visit www.ivoclavivident.com or telephone 0116 284 7880.

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SIROEndo Pocket does not only indicate the approach of the apex visibly but also acoustically: The stylized rep- resentation of the root canal on the display and accompanying signals indicate that the file tip is approaching the apex. The volume of the apex signals is adjustable, as is the signal for counterclockwise rotation. The user can choose from var- ious display languages and set the display contrast in line with his or her individual prefer- ences. When using the Sirona ENDO 6:1 handpiece the den- tist can locate the apex without a file clamp. This along with the compact dimensions of the handpiece’s head ensures an optimum view on the access cavity.

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Supplied in packs of 50 OptraStick is an exciting addition to the OptraLine range which includes the anatomically shaped OptraDum for absolute isolation, OptraGate ExtraSoft for relative isolation and a clearer clinical view, and OptraLine the highly efficient diamond polishing system.

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CREATING THE RIGHT ENVIRONMENT FOR THE RIGHT IMAGE
London charity walk

Negar Monemi reports on fundraising for the Musoma Regional Hospital in Tanzania

Earlier this year, a group of London vocational training advisors (VTs) recently combined education with exercise to raise vital funds for a Tanzanian hospital. Before the group put on their walking shoes, they enjoyed a morning of presentations to learn more about their worthy cause. First, Professor Eddie Lynch gave the group a clinical talk, donating his lecture fee to Children in Need, before Manny Vasant MBE, regional VT advisor, gave a short presentation on the plight of residents of Musoma, Tanzania. Among other things, he highlighted the lack of essential items at the main regional hospital in Tanzania, such as a supply of oxygen. The Tanzanian High Commissioner and Deputy High Commissioner listened, along with Lizzie Cameron, a dedicated charity worker in Musoma. Also present was a VT who took part in last year’s event, Karen Blake, who won a digital camera for the best key skills project at the Central London Study Group and kindly chose to donate her prize to another cause in Musoma – the Lake Victoria Disabled Centre.

Made for walking

The six-mile charity walk along the River Thames started in the afternoon from St Mary’s Church in south-west London, stopping at Barnes for a well-deserved rest and refreshments at the Bull’s Head pub. From here, the walk continued to the final assembly point – All Saints Church on Putney Common – where there was a welcome barbecue (courtesy of the DPL) and gospel singing arranged by Arrif Lalani, VT for Kingston.

The six-mile walk along the Thames is part of the charity’s series of fundraising events held each year. In 2006 and 2007, the charity had raised around £24,000, which has been used to build a resuscitation unit with three additional beds with oxygen concentrators and suction units (originally the hospital only had two). It also provided a defibrillator, electricity generator and an air-conditioning unit. With the additional £8,000 raised during this walk, further essential equipment will be provided. Fundraising doesn’t stop here. Later this year, Manny Vasant will lead a delegation of volunteers to provide medical/dental, building and other community services in Musoma.

Funds are channelled through the Tanzania Development Trust, a UK registered charity, and 100 per cent of the money raised goes to fund the charity. To this date, no one has been paid any reimbursements. Any travel is paid for by the volunteer themselves. The idea for the charity came from a visit Manny made to Musoma, to oversee some school projects and to refurbish a dental unit in the same hospital (funded by Southern Counties BDA). During his visit, he was approached by a father of a nine-month-old baby who had just died due to the lack of an oxygen machine. On his return, Manny and Arrif Lalani, both Vocational Training Advisers to the London Deanery, with the encouragement of the Dean, Elizabeth Jones, planned this educational/charity where London VTs try to help these unfortunate people in Musoma.
To place recruitment or Courses/Seminar ads please contact: Joseph Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com

Howard Cohen & Co, members of the ASPD, are proud to introduce new member of their Dental Team

Howard Cohen & Co are delighted to welcome Mr Sunil Abeyewickreme who is joining their busy and expanding Dental Division.

Mr Abeyewickreme qualified as barrister in 2004. He has previously been employed by the BDA to advise their members on general legal issues but specialising in employment law. He is joining Howard Cohen & Co as part of that specialist team offering advice and assistance to dental practitioners on:

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Sensodyne Pronamel helps reharden enamel.

From Sensodyne: a toothpaste that helps protect at-risk patients from the damaging effects of erosive tooth wear, an emerging issue, as diets high in acid increase in popularity.

Sensodyne Pronamel helps remineralise and reharden acid-softened enamel, with its high fluoride availability and low abrasivity. Sensodyne Pronamel is also specially formulated for sensitive teeth, while offering effective cleaning and freshening. Use twice a day, every day.

So when you identify the signs of acid erosion, you can recommend Pronamel from Sensodyne.

Visit www.gsk-dentalprofessionals.co.uk

Reference 1.

SENSODYNE and PRONAMEL are registered trade marks of the GlaxoSmithKline group of companies.