GDC bans ‘unqualified’ implants

The General Dental Council is telling all dentists they must only undertake procedures they are properly trained in, after a number of dentists were found carrying out dental implants without proper training.

Dentists currently doing implant dentistry, and those considering branching into that area, are being told by the General Dental Council (GDC) to read guidelines published by the Faculty of General Dental Practice (UK), ‘Training Standards in Implant Dentistry’.

These guidelines stipulate the minimum training the GDC would expect dentists to have successfully completed before undertaking implants.

New glasses

Having a vision is all well and good apparently and that’s great, but not if the vision never materialises as Andy McDougall explains.

New horizons

Dr Derek Mahony tells us how new expansion techniques offer patients and doctors less invasive and more comfortable therapies.

NHS dentistry fails pensioners

Elderly people are finding it hard to see a dentist because of the poor access to dentistry services, according to Help the Aged.

In the past, many older people had dentures but this is happening less now because of the improvements in dental care since the creation of the NHS.

Charlotte Potter, a senior health policy officer at Help the Aged, said it’s a particularly acute problem for people in care homes or for those that are housebound.

She added: ‘Services are just not flexible enough and it means that elderly people often go without treatment.’

The problem has been exacerbated with more and more elderly people keeping their own teeth for longer.

More than a third of over 75s fail to have regular check ups - the highest for any age group, according to Help the Aged.

It would like to see mobile dental units visiting care homes to give older people more of an opportunity to see a dentist.

Nigel Carter, chief executive of British Dental Health Foundation, said that teeth decay quicker, as people get older as they are not producing so much saliva.

A Department of Health spokesman said guidance had already been issued to NHS managers about the importance of providing dental services for the elderly.

He said: ‘We recognise how important it is to have accessible NHS dentistry services for everyone.’

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Communication combats stress

Good communication between the patient and the dental team leads to reduced stress and fewer complaints, according to Smile-on, which has just launched its communication in dentistry programme.

Smile-on, which provides educational resources for the dental industry, has joined forces with Dental Protection Limited (DPL) to run the three-module programme Communication in Dentistry: Stories from the Practice.

A spokeswoman for Smile-on said: ‘With this groundbreaking programme, the entire dental team can enjoy the benefits of a happy working environment by implementing practical communication techniques.

Better lines of communication with patients and between members of the dental team leads to reduced stress and fewer complaints. This means less legal claims and greater financial success for your business.’

Other educational courses for dental professionals on offer from Smile-on include D'LAST, a method to deliver crucial knowledge to dental nurses, a Clinical Photography course and Clinical and Governance Progress Management.

It also recently announced its new series of Webinars with Dr Julian Webber, former British Endodontic Society president, Christine Plesance, former British Dental Hygienists' Association president (now the British Society of Dental Hygiene & Therapy) and Patrick Holmes, a leading lecturer in Contemporary Aesthetic Dentistry.

For more information on any of these courses please call 020 7400 8989 or email info@smile-on.com.

Thieving dentist is up for fraud

A dentist in Carmarthen-shire has been struck off after fraudulently claiming nearly £38,000 from the Dental Protection Limited (DPL).

Newton Daniel Johnson, who is currently serving 24 months in prison for the thefts which took place over a period of five years, has had his name erased from the list over a period of five years.

He dishonestly claimed and received a large sum of money from the Dental Protection Board, for National Health Service Treatment, which he had not provided, according to the report by the GDC’s Professional Conduct Committee.

The report said ‘in the circumstances the Committee is satisfied that Mr Johnson’s fitness to practice is impaired’.

Mr Johnson was convicted of 20 counts of theft on 31 March this year at the Crown Court in Swansea. The thefts took place between 1999 and 2004.

The Committee considered that this was a case of very serious dishonesty and breach of trust in Mr Johnson’s capacity as a dentist.

The report added that the Committee is concerned that, to date, Mr Johnson has shown little or no insight or remorse into his conduct and that he took two years to acknowledge his guilt.

The Committee said that it did consider written testimonials produced by Mr Johnson’s professional colleagues and patients and noted there were no criticisms of his clinical abilities.

Vending machine clearout

Fizzy drinks, sweets, chocolates and crisps have been banned from vending machines in hospitals in South Wales from the beginning of November.

The new guidelines issued by the Welsh Assembly Government ban junk food from being sold in vending machines in Wales, said: ‘We are determined to promote healthy eating and living.

The ban includes all chocolate and chocolate biscuits, sweets, including mints, crisps, but baked snack products will be allowed. All fizzy drinks and those with added sugar are banned.

However yoghurt, milk drinks and smoothies are allowed if they meet strict nutritional rules.

The British Dental Health Foundation said the move would help to prevent tooth decay. Dr Nigel Carter, chief executive of the Dental Health Foundation, said: ‘Sugar products taken between meals are the main cause of tooth decay, which can lead to fillings and extractions. Your teeth are under acid attack and risk of decay for up to an hour each time you eat sugary products.’

As part of the changes, the vending machines will not be allowed to promote foods or drinks high in fat, sugar or salt or brands associated with such products.

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Halitosis reaches 2.5m

One in five Britons think their partner has had breath and nearly half the population think that a friend or colleague has it, according to a study by the British Dental Health Foundation.

Breath affects over 2.5m people in the UK. All of us get it from time-to-time but for others it can be a big problem.

It is important that dental professionals give the right advice to patients in order to combat the problem.

A spokesman for the British Dental Health Foundation said: ‘It’s a very common problem and there are many different causes. Persistent bad breath is usually caused by the smelly gases released by the bacteria that coat your teeth and gums. Bits of food that get caught between the teeth and on the tongue will rot and can sometimes cause an unpleasant smell. So correct and regular brushing is very important to keep your breath smelling fresh.’

He added: ‘However, strong foods like garlic, coffee and onions can add to the problem. The bacteria on your teeth and gums (plaque) also cause gum disease and dental decay. One of the warning signs of gum disease is that you always have bad breath or a bad taste in your mouth. Again, your dentist or hygienist will be able to see and treat the problem during your regular check-ups. The earlier the problems are found, the more effective the treatment will be.’

The BDHF also stresses the importance of regular check-ups as it allows the dentist to watch for any areas where plaque is caught between the patient’s teeth.

‘Your dentist or hygienist will be able to clean all those areas that are difficult to reach. They will also be able to show you the best way to clean your teeth and gums, and show you areas you may be missing, including your tongue,’ advised the BDHF spokesman.
Editorial comment
A double-edged sword?

According to the World Health Organisation (WHO) global database, adults with no teeth have fallen by 50 per cent from 1968 to 1998. Always the optimistic, this is great news. Or is it? Like the elixir of youth, keeping our teeth until the grave should be the ultimate goal, and let’s face it we are getting there – on both counts. Only there appears to be a problem. Whilst we are delighted to have better teeth for longer, we could really do with a bit of help along the way. So hello access problems—again. Now speaking to Dr Cockcroft the other day, we asked him about that niggling, irritating access rumour that everyone’s talking about, and this is what he said. ‘Access is completely unrelated to dental disease; it’s education, smoking, cessation, obesity and diet that affect it—it’s also the availability of fluoride toothpaste and water fluoridation coupled with sugar consumption.’ And yes of course lack of access doesn’t cause dental disease, but without checkups any minor problems will quickly develop into much bigger snowballs. Does a categorical denial come to the fore? Or are the UK’s pensioners sitting around smoking, eating too many sweets and piling on the pounds again? Tut, tut, tut, but I don’t think so. The charity, Help the Aged has no reason to tell lies. It says that ‘elderly people are finding it hard to see a dentist because of poor access to dental services.’ Enough said? No, because it’s not just difficult it’s an acute problem for the house-bound as well as people in care homes. In her own words, the senior health policy officer for the charity, Charlotte Potter said: ‘Services are just not flexible enough and it means that elderly people often go without treatment.’ And ironically, this problem is exacerbated as increasing numbers of elderly people keep their teeth for longer. Now I repeat, it is fantastic that we have our own teeth as we draw out our dwindling pensions—yes, it really is, but is this turning into a double-edged sword? If old people can’t get check-ups the knock on effects could turn into pain, discomfort and extra hassle they are too tired or frail to deal with. The charity said that more than a third of over 75s fail to have regular check-ups, and this is the highest for any age group. By limiting access and having inflexible NHS dental care nobody wins, and pensioners continue to suffer in silence. Thank god for charities in this instance.

Will you be hearing the patter of tiny feet next year?

Walking out of your door.

In April 2009 there is a very real chance your PCT will remove your child only contract.* Imagine what that would mean to your practice, and your patients. Shouldn’t you make a decision now, so you can treat your younger patients in the way you feel is best for their future and your practice?

We provide a flexible framework for you to build a tailor-made plan for your younger patients. Almost 1,000 dentists have already made the choice to offer Plans for Children in their practice.

Dentist, Oxfordshire
“The conversion was very successful—we retained a lot of children by giving the option of Denplan or pay-as-you-go. Denplan is good value for money, as children get lots of benefits at a reasonable cost. Sign up is easy, as no assessment is required.”

Dentist, Pembrokeshire
“Parents immediately understood why we had to change our registration system. It was the best decision I could have made—absolutely no regrets.”

To find out more, call Denplan on 0800 169 9934. Or for an opportunity to talk with like-minded colleagues over an informal buffet, attend one of our free seminars. Details can be found at www.denplan.net

*53.3% of PCTs anticipated withdrawing general dentists in their NHS contracts after April 2009. Source: The Patients Association, The New Dental Contract – A Survey of Primary Care Trusts in England. 06/03/08.
Dental patient suffers neglect

A dentist has been suspended for nine months after neglecting a patient and failing to treat her extensive tooth decay.

Brian Ford treated the woman, at his practice in Walton-on-Thames in Surrey, from when she was five-years-old.

She only found out the true extent of her tooth decay in January last year when she saw another dentist after Mr Ford had stopped practising, and was told 18 of her teeth needed treatment.

The General Dental Council (GDC) heard that Ford completed just two dental charts for the patient during 34 visits to the practice between September 1987 and July 2006.

A GDC panel found Ford guilty of a string of charges relating to ‘unprofessional and inappropriate care’. The panel chair said: ‘On numerous occasions and over many years, Mr Ford repeatedly failed to provide the standard of care that the patient was entitled to expect. Mr Ford did not record any radiographic findings and, instead of repeating radiographs as required, based his treatment on inadequate evidence. The consequence of these deficiencies was that Mr Ford failed to detect multiple carious lesions and give appropriate treatment.’

The dentist did not attend the hearing and made no response to the charges.

Thousands to switch surgeries

Thousands of dental patients in Bury St Edmunds are being forced to change to new NHS practices after NHS Suffolk decided to offer more specialist services at one of the town’s practices.

NHS Suffolk, the primary care trust, is making changes to Blomfield Dental Practice, in Looms Lane, so it can specialise in treating ‘vulnerable people and priority groups’, some of whom have learning, sensory or physical disabilities.

An NHS Suffolk spokes-woman said: ‘These patients often need more specialist care and time. To make sure these patients are given the best possible care and attention, we have asked some of the practice’s other patients, who were being treated at Blomfield under a special arrangement set up some years ago, to meet the gap in NHS dentistry, to transfer to another of the town’s NHS dentists.’

Debt-ridden company ends contract

Primary Care Trust in Yorkshire has had to step in and provide interim NHS dental care after the company Primecare terminated its NHS contracts after running up huge debts.

NHS dental care has been withdrawn from surgeries in Northallerton, Bedale, Leyburn and Hawes.

North Yorkshire and York Primary Care Trust (PCT) is providing the interim services until the tendering process is completed for a new NHS dental provider in the area.

The PCT hopes that normal NHS services will resume from April 1 next year.

Interim cover is being provided by two surgeries in Catterick, one surgery in Richmond and one surgery in Northallerton.

Jane Marshall, director of commissioning and service development for the PCT, said: ‘We remain fully committed to providing a continuity of service to minimise disruption for patients in accessing dental services in these areas.’

Learning Objectives:

- Explains research in the clinical field of analgesia
- Outlines equipment available to the practitioners
- Explains techniques available to the dental team
- How to ensure safe and effective local anaesthesia
- How to enhance the experience of your patients

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Wednesday 19th November 2008
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For better dentistry
Howard Stean’s
dentistry classes

When you walk into Howard Stean’s Edwardian house in west London, it is like walking into a tardis.

Inside is his home, his surgery and right on the top floor is a classroom for teaching dentistry.

The classroom, which has just been built, seats about 20 students who come from all over the UK to attend the courses he runs on aesthetic and restorative dentistry.

Mr Stean, who calls himself a pioneer in the UK for aesthetic dentistry and professional testing which evaluates new and improved materials and techniques, said: ‘I am always revising the course, he says.

The people on the course come once a month for six months. It is a full day, which runs from 9.30am through till 8pm, and they even get a ‘home-made supper’.

Students attending on Bonfire Night this year were even treated to a special fireworks display in Mr Stean’s back garden.

Mr Stean has been involved in restorative dentistry for over 25 years and has a private referral practice in Kew, West London.

Mr Stean decided to build the classroom as he had been teaching his courses on aesthetic dentistry in his lounge and felt he needed somewhere a bit more formal.

‘I was limited by space so now I can take more students. I can also have proper teaching resources in the classroom and they can sit in comfort and learn. Having a dedicated teaching room means the students are not so distracted and can concentrate much better. Aesthetic and restorative dentistry is changing all the time and is constantly being updated so I am always revising the course,’ he says.

The students are ‘of varying levels however they are all qualified. Some are newly qualified and some have been qualified for many years,’ he says.

Primary Care Trust chiefs in Bolton have asked NHS Northwest to look at the costs and practicalities of adding fluoride to water in the town.

Bolton was one of the three towns in Greater Manchester which had not asked NHS North-west to come up with a fluoridation plan, but the Primary Care Trust board has now decided to officially submit its request.

Alison Merry, consultant in dental public health for Bolton PCT, said: ‘Areas with high levels of caries are consid- ering it. We only need to fluoridate 40 per cent of the country.

The main part of our policy is preventing disease and so we are looking at fluoridation. We are making progress for the first time in 20 years.’

Southampton is the first area to hold a consultation on the issue and this is already underway. Fluoridation was first introduced into the UK in the 1960s when areas in and around Birmingham and Newcastle were fluoridated, along with the Republic of Ireland.

The government has set aside £42m over three years to strate- gic health authorities who decide after consultation to introduce fluoridation schemes.

Critics such as the National Pure Water Foundation and the Green Party are opposed to the plan and link it with diseases such as cancer and Alzheimer’s disease.

However Dr Cockcroft dismissed the ‘scare mongering that says it causes cancer’ and said: ‘All the water in this country contains some fluoride. So we have had it for generations and there is no evidence linking fluoride with systemic disease. The only thing that is connected with fluoridation is dental fluorosis and that only occurs in a tiny minority of children.’

Berries beat oral cancer

The British Dental Health Foundation has welcomed a study that has found blueberries, papaya, and blackberries potentially reduce the risk of developing oral cancer.

Researchers from Hong Kong University published the article concerning the properties of these fruit in the Journal of Cancer Research. They found that lupeol is a terpenene compound abundantly found in these fruits and exhibits anti-cancer properties by blocking NF-kB, a naturally occurring protein, which assists cell growth.

The study concluded that lupeol suppresses the spread of cancer and reduces tumor size three times faster than cisplatin (a platinum-based chemother- apy drug).

Dr. Nigel Carter, chief executive of the British Dental Health Foundation, said: ‘We already knew that a healthy diet, including at least five portions of fruit and vegetables each day, could reduce a person’s risk of developing mouth cancer. However, the news that certain fruits might actually help to combat mouth cancer in people who have already developed the condition is a real revelation.’

He added: ‘It is true that this research is still in its very early stages. However, the suggestion is that the lupeol compound could be more effective than traditional drugs in preventing the growth of mouth cancer.

In the UK, oral cancer has a mortality rate of one person every five hours.
GDPUK round-up

Discussions on the financial crisis hit GDPUK this week, as well as the legalities surrounding tooth whitening techniques used in a beauty salon. Tony Jacobs reveals the latest topics.

At the end of a busy weekend, GDPUK members began to discuss issues concerning the theoretical risk of a bird flu pandemic. Dentists will be drafted in to help medical teams, and UDA requirements will be dropped which will hopefully be the least of the country’s worries.

The developing financial crisis continues to dominate the forums of GDPUK following the breakdown of the banks in Iceland. Correspondents discussed the effect on the dental corporate chain ADP, but the news was unclear. No doubt when this piece is published, the situation regarding Icelandic assets in the UK will be clarified. Perhaps the ADP group will be sold as a going concern?

The imminent publication of the new cross-infection guidance by the Department of Health (DH) has led to pre-emptive discussions and no doubt when published, this issue will provide a great deal of food for proponents to dissect.

But this wasn’t all being aired on the forum. Many other issues discussed include:

• Clinical waste contractors
• A beauty salon carrying out bleaching – the client takes their own impressions, and also has to build the bleaching light. Is this legal?
• A photograph of a fractured maxillary tuberosity
• The position with regard to Global Crossing providing communications to the ADA.
• Stainless-steel worktops – shiny or textured for decontamination?
• Importantly, the response of the DH to the Health Select Committee report.

Dental Showcase at Excel was given some thought. Many list members attended the event, either to work, or simply to visit. Although there were more than 500 stands, and colleagues spent money, the general feedback this year was not of great innovation or groundbreaking new must-have products. The GDPUK one-to-one feedback also suggested that many traveled far and wide to get to the conference.

The issue of outbreaks of ANUG entered the forum at some stage. One list member said that he receives clusters of cases, even though the patients do not seem to have links. Another feels the outbreaks are more common in autumn and spring. Others observed the link between young people with full-time jobs, and busy sleep-deprived weekends. Smoking was not always a common factor, even though the dentists discussing this thought it would be.

A few tongue-in-cheek topics were aired, with one colleague claiming he had toothache following a small composite repair, and asked for root treatment from another colleague. Many jumped in to offer extraction of the L68 and some even offered to use local.

UCL EASTMAN DENTAL INSTITUTE

COMMENCING IN MAY 2009, THE UCL EASTMAN DENTAL INSTITUTE AND THE UNIVERSITY OF THE WESTERN CAPE ARE DELIGHTED TO OFFER A POSTGRADUATE CERTIFICATE IN DENTAL SEDATION AND PAIN MANAGEMENT (CONSCIOUS SEDATION). THE COURSE IS PARTICULARLY SUITABLE FOR DENTAL AND MEDICAL PRACTITIONERS WITH LITTLE OR NO PREVIOUS EXPERIENCE OF SEDATION, AS WELL AS THOSE WANTING TO UPDATE THEIR KNOWLEDGE AND SKILLS.

The course is delivered over six months and will include four days of lectures and problem based learning (6, 7, 9 and 10 May 2009) followed by practical training over the following six months in which practitioners deliver conscious sedation to patients under the close supervision of an experienced sedationist. Course participants will be encouraged to return to their practices and administer sedation for their own patients, with ongoing advice from the course mentors as required.

The final day will take place six months later and is aimed at providing students with the facility to ask further questions and discuss cases they have seen as well as an examination. Course work will include a dissertation and formal assessments are an integral part of the programme.

The emphasis of the course is to equip clinicians with the knowledge, skills, practical training and confidence to provide effective and safe sedation for their patients. The course is suitable for both dental and medical practitioners as well as hospital based clinicians from all specialties.

Note: Participants already involved in the practice of sedation may attend for the initial four lecture days by way of theoretical update and to gain dedicated and essential CPD in this area.

Victoria Banks, Course Administrator
Eastman Continuing Professional Development
123 Grey’s Inn Road London WC1X 8WD
Tel: 020 7905 1251 Fax: 020 7905 1267
E-mail: v.banks@eastman.ucl.ac.uk Web: www.eastman.ucl.ac.uk/cpd

Topics to be covered include:
• Medical conditions and sedation provision
• Patient assessment: including clinical examination
• Treatment planning
• Intravenous and oral sedation: standard techniques
• Inhalation sedation
• Prevention and management of sedation complications
• Pain management
• Practical aspects of setting up a sedation service
• Medical-legal aspects of sedation
• Introduction to paediatric sedation
• Behaviour management techniques
• Biomedical techniques
• Life support – resuscitation techniques and dealing with medical emergencies

The sedation course is directed by Professor James Roelofse, Professor of Anaesthesia, and co-ordinated by Dr Yusof (Joe) Omar and Dr Andre du Plessis. Our speakers are all leaders in their fields with a wealth of practical experience in their subject.

The course will equip clinicians to provide sedation services in keeping with current best practice and in line with contemporary UK guidelines. This limited attendance course is offered in May of each year and is open to both dental and medical practitioners. Overseas applications are also welcome.

The course fees are £3,950 (subject to confirmation by UCL fees committee), which includes all materials, lunch and refreshments but does not include travel to the sedation clinics for the clinical sessions.
Men drive cosmetic trends

More and more men are opting for cosmetic dental treatment, according to the British Academy of Cosmetic Dentistry.

Men who used to account for 28 per cent of all veneers, now account for nearly a third of all procedures, according to an audit of cosmetic dental work done in 2007 by the British Academy of Cosmetic Dentistry (BACD).

Similarly men used to account for less than 10 per cent of orthodontics. They now represent almost a quarter with 400 cases this year.

Bridges are another procedure which has become more popular with men, who used to account for 42 per cent and now edging ever closer to women at 46 per cent.

Overall orthodontics (which include both visible ‘train track’ braces as well as invisible and removable) has boomed in popularity, more than tripling since 2006.

Women are still the big spenders on cosmetic dentistry, accounting for 61 per cent of all procedures.

Women also still account for the majority of whitening procedures.

Dr. James Goolnik, dentist and BACD board member, said: ‘These results show that men have become more accepting of cosmetic treatments in general - reflecting the importance we now place on a healthy smile.'

The advent of new procedures such as the removable adult braces and more realistic-looking veneers which require much less drilling also means people are less likely to choose invasive and irreversible treatments.'

Dr. David Bloom, dentist and president of the BACD added: ‘This audit has highlighted some very exciting trends, such as an impressive increase in the number of orthodontic cases. This could well be a backlash against the dramatic smile ‘overhauls’ popularised in makeover shows but may also herald a more subtle, and indeed cost-effective, approach to cosmetic dentistry by the industry as a whole.

It’s also interesting to note the overwhelming preference for less invasive treatments such as general procedures, general fillings to cover part of the tooth, over crowns - which involve drilling to achieve full coverage.'

The top 5 dentistry procedures for men in 2007 were:

• White fillings (back teeth, usually replacing silver amalgams, 22,069 procedures)
• Crowns-Inlays-Onlays (16,884)
• Veneers (9,488)
• White fillings (front teeth, 6,944 procedures)
• Teeth whitening (5,800)

The top 5 procedures for women in 2007 were:

• White fillings (back teeth, 17,252 procedures carried out)
• Crowns-Inlays-Onlays (11,088)
• Veneers (4,568)
• White fillings (front teeth, 3,856 procedures)
• Whitening (1,764)

GDC forms new links

The General Dental Council has entered into a new specialist training partnership with the Joint Committee for Specialist Training in Dentistry.

The partnership between the two organisations is vital in ensuring that specialist training continues to meet the GDC’s standards for specialist listing and clarifies the respective roles and responsibilities of the General Dental Council (GDC) and the members of the Joint Committee for Specialist Training in Dentistry (JCSTD), according to a spokeswoman for the GDC.

She added: ‘The figures are a further demonstration of our determination to bring NHS dentistry within reach of as many people as possible.

However the figures also revealed that in some areas registrations were considerably lower.'

In NHS Grampian, just 58.3 per cent of residents were registered with a health service practising compared to 70.7 per cent in NHS Greater Glasgow and Clyde.

Ms Robison added: ‘There are still parts of Scotland where registrations are unacceptably low and I will expect all NHS boards to continue putting plans in place to further improve access for their populations.'

More than 2.2m examinations were carried out by NHS Scotland dentists in 2007-08 - an increase of just under 6,000 on the previous year.

Goodbye Mr Rose

A dentist who specialises in treating children and patients with disabilities is at last hanging up his drill and retiring.

Dr David Rose, 64, has worked at the Violet Hill House health centre at Stowmarket in Suffolk since 1974.

He has cared for thousands of patients through the decades and concentrates on treating patients with disabilities, who often struggle to find a dentist, because of their physical disabilities or the strong medicines they take.

Dr Rose said he ‘will miss' being a dentist and added: ‘My emotions are very mixed and part of me wants to stay, part wants to go.'

Dr Simon Rudland, a GP at the health centre, said: ‘He will be hugely missed.'
Creating a selling culture

Providing dentistry is all about selling your product, giving patients correct and honest information and providing them with options that help them find ways to best suit their financial circumstances. Lina Craven explains

There is little resemblance between the healthcare industry today and the industry we worked in 10 years ago. Technology, industrial relations, economic circumstances, legislation, patient care and expectations have all influenced the dental sector and facilitated the changes we see within practices today. Practices continuing to offer the same services, in the same environment, with the same expectations of team contribution today, as they did in the 20th century, would cease to exist. Customer satisfaction is fundamental to business success and that’s why the best results are achieved by those practices that create a passion for continual improvement.

Continual improvement

Culture is the shared beliefs and values of a group of people, and in this case that group is your team. Creating any sort of culture within your practice requires the constant reinforcement of a specific message. In the case of continual improvement that message must be that it is OK for team members to regularly review the way things are done, to question why they are done that way, and to ask if there is a better way of doing it. Such an approach doesn’t encourage anarchy as some of you might believe; in fact it does quite the opposite. By giving team members responsibility for moulding the practice they develop a sense of ownership that is visible in every aspect of their performance. All the things you had been striving to achieve and implement through a hierarchical, perhaps more dictatorial approach, suddenly begin to happen.

A prime example of this phenomenon is selling. Often just expressing the word within a practice is like committing blasphemy. The notion that selling and professionalism can co-exist is not readily accepted within our industry along with the belief that patients do not welcome being sold to. I would like to dispel that assumption.

Selling is what patients want and demand

Modern dentistry requires a whole new approach. It isn’t just about looking and finding problems, it’s about asking the right questions, explaining the options, educating and supporting, and offering the most appropriate services – in any other language that is selling!

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Practice Management

We might not feel comfortable talking about money but it is expected and necessary.

As selling. Not only does this represent a lost revenue opportunity for the practice, it also results in the patients’ disappointment and mismanagement of their expectations.

If you thought these patients belonged to your practice, wouldn’t you want to change your approach to satisfy their needs better? A culture for continual improvement would insist that you consider whether your approach is as good as it could be; it would demand that you find ways to make it better. It would naturally result in someone from your practice recommending dental products to his/her patients; them assessing the very positive response patients would elicit, and them openly suggesting more formal processes be introduced to take advantage of the opportunity to boost revenue while improving patient satisfaction.

This selling example is just one small drop in a huge ocean of opportunity and in the interests of satisfying patients across the UK, and to help you launch such a change in mindset that may lead to a cultural revolution in your practice, here are the Dynamic Perceptions’ top six tips to selling.

Adapt your communication
Selling skills are only effective when we learn to communicate properly. By recognising that people possess different personality traits we learn to change our approach to achieve the right result. What we say, how we say it – our tone of voice - and our body language are all ingredients of communication that we have to master. We do it naturally in everyday life; watch how an adult speaks to a baby, a teenager and a pensioner for instance: the tone of voice, speed and words used differ considerably.

Align your services
The patients visiting your practice do so because they feel some affinity for what you are offering. Your target customers are drawn to you because your services, your premises and your team all satisfy their requirements. So for instance if your practice is targeting the business client then the provision of early morning or late evening appointments would be a valued service and one that recognises the specific needs of that target group. What do you provide for your target patients and how do you let them know that you offer this particular service just for them?

Know your products
We often find that practice staff do not understand many of the products and services provided. They are confused with different levels of private treatment and can’t explain differences between treatments or financial packages. It is imperative that everyone interacting with patients fully understands the products and services they are selling. It doesn’t have to be technical, but an awareness of the key features and benefits is paramount.

Talk money
We must be able to present the customer with details of how much the treatment will cost. We might not feel comfortable talking about money but it is expected and necessary. The treatment required to meet the patient’s needs is the latter. It is much more receptive to the patient than the former. You should aim to meet the patient’s needs in the best way possible – obviously always legitimately and honourably.

Close the deal
How many ways do you know to ask for the order? When would you like to start? May I go ahead and book the appointment for you? Are you ready to proceed? As long as you have fully explained the benefits of treatment, it’s not unreasonable to ask for commitment from the patient. As the saying goes, what you don’t ask for, you don’t get.

Breaking down barriers
What’s in it for me? (WIIFM). The goal, a win-win outcome, is only achieved by overcoming barriers and concerns. We must learn to understand patients’ needs and wants, and to be able to express ourselves without sounding pushy or forceful. I learning to ask the right questions is of the utmost importance. Not all patients will be ready to proceed after the initial appointment but never assume that they never will.

It’s all about giving patients correct and honest information and providing them with options that help them find ways to best suit their financial circumstances. And regardless of what you want to call it, in any other industry that’s called selling. By engendering an environment where the needs of the patients come first and where the team is encouraged to constantly think of better ways of fulfilling those needs, you create a culture of confidence, support and success where selling is part of meeting the customers’ expectations. You are a business that provides a service and therefore everyone in the team must understand that it is OK to ask for money – and that it is OK to charge for services. After all, the customers understand it.

About the author
Lina Craven is the founder and director of Dynamic Perceptions. Over the past 25 years, she has assisted dental practices to realise their vision of success through the achievement of a customer-driven culture that focuses on delivering an exceptional patient journey. Lina’s qualifications and experience as an orthodontic therapist, treatment co-ordinator and practice manager in the US have given her a unique insight into the day-to-day practical problems faced by dental practices. Visit www.orthodontic-management.com or call 0844 275 5277.
The 10th Dimension – the power of 10

In this series of articles, Dr Ed Bonner BDS MDent, Sloan Fellow London Business School, looks at the similarities between selling and coaching skills

Sales skills? What sales skills?

Through the practical experience I have accumulated in many years of working with practices, I have come to realise that the area in which dentists are most lacking is in sales skills. Having to sell our skills was never the reason we chose to practice dentistry, yet unless we are able to enrol patients to use our skills. So, how do we acquire the ability to be able to sell without embarrassment, something we were never taught at dental school? One possible way is to be coached by someone with the ability to sell to us the idea that knowledge, skills and techniques (their ‘product’) are valuable and worth paying for.

Need and acquisition

Consider the patient who has a missing upper premolar. What they want is a pleasing smile. What they need is an implant or bridge. Their want and our perception of their need match perfectly, but unless we can convince the patient that the far from in-substantial cost of the treatment in terms of time, discomfort and money represent fantastic value to them, we will not get the opportunity to use our skills. So, how do we acquire the ability to be able to sell without embarrassment, necessarily linear, but moving from a vision to a conclusion that is satisfactory for the coach and the ‘coachee’. An effective model for that structure is one described by Graham Alexander and Ben Renshaw in their book Super-coaching – the missing ingredient for high performance. The acronym they use for this structure is GROW: Goal, Reality, Options and Wrap-up. As I read this, it struck me that this was not only an excellent model for coaching, but also a brilliant way of describing what selling was about.

The elements of GROW capture the key aspect of what coaching is and does, and what selling skills are about; enabling people to grow, to develop their capabilities, achieve high performance and gain fulfillment.

So, let’s look at the GROW model.

The GROW model

In coaching terms it is defining the topic for conversation or investigation and then agreeing measurable outcomes or output (define the GOAL). This is followed by describing the current situation, uncovering the salient issues and barriers, and finding out how the client (patient) really feels about them, free of pre-existing assumptions, prejudices, fears, generalisations and judgments (the REALITY). This is followed by OPTIONS: drawing out all possible solutions and selecting the preferred one. WRAP-UP is the action phase where we discuss all possible implications, obstacles and costs, commit to action and identify support.

All grown up

Following the GROW model is ‘grown’, and NAILDOWN is the fifth and quite possibly the most important dimension that requires you to get the patient to commit. This creates not only commitment but also accountability. You become committed to accountable to your coach, your patient becomes committed and accountable to you. Your job is to follow up immediately on the commitment, and once the job has been done, check that the goal has been achieved.

Application

Now apply this to the desire of your patient to have a lovely smile and their need for an implant or bridge, and you have an excellent low-pressure sales technique that works every time without you even realising that you are selling. Not surprising, because what you are actually doing is enrolling the patient to buy into your knowledge, skill and enthusiasm which somehow seems different to selling them a product but in reality isn’t.

As Abraham Lincoln once said, ‘A goal properly set is halfway reached’.

Ed Bonner runs a personal consultancy for dentists, with coaching for the entire dental team. He can be contacted on 07766 601338 or by emailing bonner.edwin@gmail.com.

A patient with a missing upper premolar just wants a nice smile

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Counting the pennies

It is becoming more difficult to raise finance, says Andy Acton, but with a little help a good broker can get you what you need

There are many reasons why the modern dentist may need a loan. For example, in order to retain a competitive edge in the 21st century, a dental practice needs to be kitted out with the latest, most effective equipment. With ergonomic designs improving conditions for patients and clinicians alike, and new technology enabling faster and more accurate diagnosis, it is becoming less possible to fulfill the expectations of patients without investment.

Another reason might be to refurbish the practice, to make it more welcoming, or the dentist might be initiating a new build project, developing a dream practice from scratch. Whatever the reasons, finding the right deal is crucial.

A tricky situation?

It is getting more and more difficult to raise finance. A global credit crunch is looming, and some expect Britain to follow the US into recession. Couple this with the present issue of mortgages being at their lowest approval rate since 1999 and it becomes evident why dentists seeking finance should be a little concerned.

The banks are tightening their belts in preparation for whatever worst-case scenario they have drawn up, but this does not mean that your needs will be dismissed out of hand. What has changed is that if banks are not approached in a wholly professional manner, they are unlikely to feel confident about authorising the loan. The best way to ensure the request is presented as effectively as possible, to secure the best possible loan package, is to enlist the assistance of a broker.

Take your pick

Choosing a broker can be something of a minefield. There are so many options that dentists might be tempted to save time by just selecting the first one they come across. This can be dangerous; considering that the success of the dentist’s business itself hangs in the balance, since being unable to secure finance can mean falling behind the competition, losing patients and ultimately even closure, it is imperative that the right broker is selected.

With bank managers shifting uneasily in their seats, dentists need the expert help of brokers who know the needs of the industry, so that the relevant information can be gathered, studied and presented to secure the best possible loan. Dentists who require finance to boost their business, win new patients or just retain current ones, should not be put off by the current situation – however, it is advisable that, if you are looking to raise finance in the near future, you contact a leading broker today, and discuss your concerns, plans and requirements.


Andy Acton, an ASPD member, is director of Frank Taylor & Associates, leading independent valuers and consultants to the dental profession. To contact him, call 08456 125454 or email andy.acton@ft-associates.com. For more information on Loan Hunter, call 08456 125424 or email info@loan-hunter.co.uk.
Vision or delusion?

An unfulfilled vision is no better than mere delusion, so it’s important to know what you want for your business, so you can reach your goals. Business guru Andy McDougall offers some advice.

The Vision: overused, often misunderstood and with numerous flavours; in reality a vision is simply a clear picture of the future of your business. There is no doubt that every business needs a vision: if you don’t know where you are going, any route will do. The problem isn’t that businesses lack vision; even if not articulated most business owners would have an ideal picture of their future. The problem is that most visions are never implemented because there is a widespread lack of know-how to turn vision into reality. Like most things in life that consist of five per cent idea and 95 per cent implementation, left simply as blue-sky thinking, an unfulfilled vision is no better than mere delusion.

Creating the vision is easy

I like the way Jim Collins and Jerry Porras in their book, Built to Last explain a vision. The authors selected the paradoxical phrase ‘envisioned future’ to encompass their definition. They suggest that on the one hand a vision conveys a sense of concreteness – something vivid and real; you can see it, touch it, feel it. Yet on the other hand, it portrays a time yet unrealised – a dream, a hope, an aspiration. In other words, your vision is the image you have for your business at some point in the future. All you have to do now is make it happen.

So this is how it normally goes: you have a day of coaching and you are all revved up from your ‘blue-sky’ session. Everyone leaves feeling highly motivated and will undoubtedly go to sleep dreaming of the golden future their newly developed vision will deliver. Everyone enjoys these touchy-feely sessions where teams can bond behind a common purpose but just a few days back in the usual routine, reality kicks back in. Without the means to convert the vision into reality, the vision very often gets left in the too hard to-do pile.

A vision without action is just fantasy

The only real way for your vision to become reality is to go through a structured process, which maps out the journey and offers tangible milestones that must be hit in order to make the vision a reality.

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be achieved in order to succeed. The name given to this process is business planning. From this document everything else sprouts: the budget, the necessary resources (human or otherwise), the sales target, the marketing plan, the training needs, and specific objectives for members of the team. It doesn’t sound as much fun as the ‘blue-sky’ motivational team day, but generating a business plan is the only means by which you can bring your vision to life.

The likelihood is that your current momentum will not allow you to turn your vision into a reality unless specific plans and actions are taken. Even if your recent results have been impressive, this does not guarantee your future will be. No business is immune to changing market conditions which are often driven by external factors outside our control like customers, competitors, government, and the economy: these and other influences will create an uncertain future and most likely drive the need for change.

Bridging the gap
Having established a true position of where you are today, we must look at tomorrow. What will it take to realise your vision? Is your goal to exit the business in five years? Is it to double in size, or to make an acquisition? or maybe your business is in trouble and you want to turn it around and take it to the next level? The key is to build a model at the macro level, which will tell you what must happen to make the dream come true. You need to be honest in the process. The model will tell you how realistic your achievement is. For example, if the only way to achieve your dream is to triple the size of your business every year for the next five years, you might want to rethink your vision.

Once you have ascertained that your vision is achievable the question is, will your current momentum over future years deliver it or will there be a gap? The business planning process enables you to assess the gap and to find strategies for closing it. The plan will break down the overall journey into deliverable milestones and will not only identify where the business must be in any given month and year ahead, but translate the key drivers that will underpin success. Your plan has mapped out what has to take place in each of the crucial areas of your business and the exact deliverables team members must achieve – so congruence of business and people objectives is realised.

Managing performance
The essential bit is to keep the performance of the business on track through regular review of the numbers and lots of other key metrics. Through the production and analysis of monthly management accounts you can track real performance against targeted performance ensuring corrective action is taken whenever the results move off track.

Performance management is not just a numbers game. There is a saying that what gets measured gets done. But as the key behind any successful business is its people, without the right team not much can be done about the rest. The key drivers in the plan will only be achieved if someone is responsible for making them happen. So our performance management system will include the performance of our people. Regular reviews to identify the things that have been done well and those that require improvement, along with the associated training and development, ensure everyone in the business aims for the same target.

A business plan is the only means of translating what is essentially pie in the sky into the kind of business you dreamed of owning. By breaking things down into detailed bite-size chunks in this way, and ensuring you stay on track month by month, we have in effect created the blueprint for translating the vision into a reality.

The only way to create your future is to plan it.

About the author

Andy McDougall has over 25 years experience of business planning and brings techniques and expertise from a wide range of commercial and competitive business sectors. He delivers business-planning services, email info@ spoton-businessplanning.co.uk or call 07710 382559.

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Stop thief! Give me back my retirement savings!

Introduction

You have a thief in your practice. Every day, this interloper siphons money right out of your pocket. Over the course of your career, this kleptomaniac will rob you blind. At stake are millions of dollars. That's right, millions!

Who is this cunning culprit? Its name is inefficiency. Left unattended or ignored for years, inefficiency can wreak havoc on the practice's long-term profitability, resulting in the dentists losing hundreds of thousands—perhaps even millions of dollars over the course of a career.

To combat this vexing problem, dental practices must be designed with step-by-step systems that facilitate maximum production without a high level of stress.

Stress is proportional to efficiency. Higher stress clearly indicates lower levels of efficiency, which ultimately translates into lower profitability.

Levin Group has found that these four action steps can help dentists build a high-performance practice:

1. Remove Bottlenecks
2. Document Systems
3. Build and Train the Team
4. Provide Superior Customer Service

1. Remove bottlenecks

Bottlenecks are built-in inefficiencies that slow down a particular system. The goal for practices is to eliminate bottlenecks by redesigning systems. Review all major practice systems, streamline processes, and eliminate bottlenecks. Without careful monitoring, bottlenecks can creep back into redesigned systems, especially when new procedures are introduced.

2. Document systems

Document all systems in a step-by-step manner. This allows the team to be trained quickly, excel in their jobs and increase practice production. Documenting systems provides consistent and necessary information to the entire dental team. When systems are not documented, knowledge gaps occur which lead to inefficiency and confusion on the part of team members. Practice stress levels and staff turnover are both reduced when systems are documented.

3. Build and train the team

Once the systems are in place, the next step is training. If the systems have been written out in a step-by-step manner with accompanying scripts, then team members will be able to follow these systems on their own. This is especially advantageous to new team members and team members without an extensive dental background. Scripting is a critical training tool that keeps team members “on the same page.”

4. Provide superior customer service

Customer service affects every aspect of practice operations. Superior customer service combines documented protocols and scripting to achieve increased patient satisfaction, case acceptance and referrals. As an example of a documented customer service system, Levin Group advises clients that there are more than 50 steps to follow when a new patient calls the practice, including:

- Answering the phone using specific scripts
- Requesting who referred the patient
- Educating the patient about the practice
- Helping the patient to be comfortable with the doctor and team
- Providing information about advanced technology and services

Conclusion

Inefficiency can rob dentists of the opportunity to grow their practices and save for retirement. Don’t let outdated systems drain your practice of hard-earned revenue, production and profitability. You can reduce inefficiency by updating your systems and removing bottlenecks. Train your team on the updated systems, and you’re on your way to achieving a high-performance practice.
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Praise where it’s due

The GDC’s new initiative is set to help stamp out the problem of unregulated, imported dental appliances. Richard Daniels explains

Public bodies, especially those involved in the administration of healthcare, are more often targets for criticism than congratulations, and the General Dental Council is no exception. Here at the Dental Laboratories Association (DLA), we have certainly had our own disagreements with that August institution, but on this occasion we happily applaud, and welcome, its new initiative.

The problem of unregulated, imported dental appliances has been with us for some time, and in the US, a number of patients have suffered unfortunate consequences from their use, which have attracted the attention of the mainstream media. Following intensive lobbying by the DLA and pressure from other professional dental bodies, the GDC has at last responded by opening a consultation process to consider standards on commissioning and manufacturing of dental appliances.

The consultation seeks to identify the responsibilities of all registered practitioners, or their agents, who commission, source or receive custom-made dental appliances, whether manufactured within Europe or in other regions beyond the jurisdiction of the EU’s Medical Devices Directive.

Investigating quality

Historically, the UK agencies responsible for the regulation of imported, customised or bespoke dental appliances have relied on the individual importers exercising their own judgement and standards of quality control over the suitability of the appliances. In effect, the end-user, the dentist, has been responsible for enforcing the EU Directive and little attention has been paid by the authorities as to whether the individuals concerned actually carried out the relevant checks, had the knowledge or experience to do so, or were even aware of this responsibility. In any event, even those who conscientiously fulfilled their obligations could not be expected to investigate the quality of the actual materials, which comprised the appliance.

For example, how many dentists have actually registered with the MHRA as on-site manufacturers of their own custom-made appliances, or as the recipients of custom-made appliances directly imported from overseas? The dental laboratories both within and outside the UK, as well as dispensing practices, will not in itself ascertain the source or quality of either the materials or the manufacturing processes involved in producing the appliances. To achieve transparency a verifiable audit trail needs to be established.

The dental professional’s responsibility, as well as that of the industry’s governing authorities, to the individual patient is absolute, and this dictum is as relevant to the lab technician as it is to the clinical practitioner. The universal application of the Medical Devices Directive, ensuring that all manufacturers conform to the regulations, will not only establish a fully transparent system, it will relieve the pressure on the hard pressed individual practitioners registered with the GDC.

For further information, please visit the DLA website at www.dla.org.uk, or call 0115 925 4888.

The GDC’s new initiative is set to help stamp out the problem of unregulated, imported dental appliances. Richard Daniels explains

Ensure the patients benefit from a uniform and improving standard of care, complementary action is required from the Medicines Healthcare and Regulatory Authority and the Department of Health. A simple inspection programme, which should include dental laboratories both within and outside the UK as well as dispensing practices, will not in itself ascertain the source or quality of either the materials or the manufacturing processes involved in producing the appliances. To achieve transparency a verifiable audit trail needs to be established.

The dental professional’s responsibility, as well as that of the industry’s governing authorities, to the individual patient is absolute, and this dictum is as relevant to the lab technician as it is to the clinical practitioner. The universal application of the Medical Devices Directive, ensuring that all manufacturers conform to the regulations, will not only establish a fully transparent system, it will relieve the pressure on the hard pressed individual practitioners registered with the GDC.

Dental Laboratories Association (DLA)
Registration for dental nurses became mandatory on July 31 2008. As a result, thousands of dental nurses countrywide have paid their registration fees, purchased professional indemnity insurance and will complete their obligatory CPD. However they have not seen any financial gains to offset the costs incurred.

Question: Will there be a direct financial pay-off for dental nurses who increase their skills through CPD?

Answer: Not in the immediate future.

Question: Why should dental nurses make an investment in their professional development when there’s unlikely to be a return on that investment?

Answer: Dentists and their nurses’ employers will need to play a ‘long game’ here. The way is open for dental nurses to work in roles that directly affect practice profitability. Care co-ordination being just one of many examples this. From a business point of view, any investment is only worth the return it realises, so where a financial investment from the practice is matched by the nurses investment of time and effort to develop relevant skills, together they enable the business to provide more and higher quality healthcare, more profitably.

Implementing change

The first step for individual dental nurses will be to produce their Professional Development Plan (PDP). This should begin with long-term, mid-term and short-term objectives. Once these have been specified, the pathway to achieve them can be determined.

Before individuals can define their development needs, it is essential for the dental business they work in to set long-term objectives. This is the role and responsibility of the practice management. Working in a well-focused and ambitious environment keeps team members engaged, while they work toward a mutually desirable destination.

Over recent years, dental businesses have become more aware of the importance of making an investment in their people. In some regions of the UK, government-backed funding for training and development initiatives promote business skills. To find out what’s available in your region, contact your Business Link or Learning Skills Council.

There can be no doubt that highly trained and motivated dental teams are equally beneficial to patients, dental businesses, and dental professionals. The costs of achieving these high levels of care and competence should be borne in the same even-handed way.
Edward H Angle dominated orthodontic armamentarium, diagnosis and treatment planning for almost 50 years until Charles Tweed successfully challenged his mentor’s non-extraction mantra. The ensuing diagnostic regimen used by Tweed, however, proved to have serious limitations and clearly resulted in the extraction of too many teeth. This caused a subsequent deterioration of soft-tissue appearances of patients that neither they, nor their doctors liked. This article will describe and illustrate how new expansion techniques differ qualitatively from those of Angle, and how these techniques offer patients and doctors less invasive and more comfortable therapies which do not jeopardise facial appearances.

How it began
For the first third of this past century, orthodontists found themselves dominated by one man, Edward H Angle, with the resultant intellectual stagnation that arises from such monomaniacal control. This recognition in no way detracts from Angle’s contributions – notably his clear and simple classification system along with the edgewise bracket. Both of these inventions have endured for a century, and that is no mean achievement in any scientific discipline. Nevertheless, orthodontists’ unquestioning acceptance of his limited diagnostic and treatment planning regimens hindered the advancement of this discipline more than it helped, and the last half of this past century was spent trying to overcome the stupor of the first half.

Angle’s influence continued until an apostate student of his, Charles H Tweed, had enough courage and objectivity to challenge Angle’s non-extraction scheme. It wasn’t a tremendous leap of intellectual power. Tweed simply and honestly recognised that when 100 per cent of your patients relapsed, there might be something wrong with the diagnosis and/or treatment planning.

Courage to object
Dr Tweed acted appropriately in the face of this challenge – quite unlike the ancient dentist who chided a young colleague who was describing his meticulous technique of endodontic filling to the monthly assembly of dentists. The old man explained his own technique that used a simple matchstick sharpened with a pocketknife and then jammed into the canal. When the young dentist asked if a lot of these root canal fillings didn’t subsequently fail, the older man replied, “Every damn time!”

Dr Tweed tired of those orthodontic abscesses and, unlike his peers, sought to correct the deficiencies he saw in Angle’s philosophy. Some would say that he overcorrected, but that said, we must pay homage to anyone who has the skill and temerity to successfully challenge a mentor and his minions.

Nevertheless, I don’t think that Tweed would have ever been able to deliver his paper describing his extraction technique had Dr Angle still been alive. Angle’s influence over the society that bore his name was too immense to permit such
hubris from a young upstart. But as Samuelson, the MIT econo-
mist, once noted: ‘Science pro-
gresses slowly – funeral by fu-
neral.’ And so it was and is in orthodontics.

Non-extraction philosophy

Aside from the edgewise bracket and the classification
system, Angle’s most enduring
legacy has been his belief in
non-extraction therapy. Angle
had unsuccessfully experi-
enced with premolar extrac-
tions while using his ribbon-
arch appliance, but he never
solved the problem of parallel-
ing the roots to prevent the ex-
traction spaces from opening. If
he couldn’t do it, then, ergo, no
one else could, and this resulted
in a virulent opposition to any
extractions and an insistence
upon enlarging the arches to ac-
commodate all of the teeth.

This dogma stayed domi-
nant for several decades until
Tweed advocated the extraction
of premolars based on his diag-
nostic triangle, which was the
first systematic treatment plan-
ning stratagem orthodontists
had. Tweed received corrobora-
tion simultaneously from an-
other former Angle protégé in
Australia, Raymond Begg,2 who
had studied aborigines and con-
cluded that nature intended for
enamel to wear. He decided that
orthodontists could mimic na-
ture by extracting teeth prior to
orthodontic therapy. The Tweed
and Begg Extraction Philoso-
phies eventually prevailed and
remained uncontested for some
time.

Several years past before
Holdaway3,4 published his arti-
cles that suggested the soft tissue
as the determining feature of di-
agnosis. This disputed Tweed’s
narrow diagnostic regimen that
focused on the mandibular inci-
sor and totally neglected the soft
tissue. Tweed’s triangle set in
motion a trend that emphasised
more prudence in the extraction
of teeth. Soon others added their
discoveries regarding soft tissue
and the maxillary incisors as
main determinants of diagnosis
and treatment planning.5-7

Keeping a record

From the inception of this spe-
cialty, with Dr Angle, diagnosis
never had too much importance
because everyone received the
same non-extraction treatment
with the same expansive appli-
cance. The marvel of it all is that
the collection of orthodontic
records never became important.
A few months ago, an orthodon-
tist boasted that since invoking a
different treatment regimen, he
was treating 98 per cent of his pa-
tient’s non-extraction. One was
tempted to ask if he still took
records because with diagnostic
certainty such as that, records are
clearly redundant. Orthodontists
shouldn’t waste patients’ time
and money taking impressions,
cephalometric X-rays or doing
treatment simulations if all treat-
ment plans are essentially the same. One doesn’t need orthodontic records to come to such a preconceived conclusion.

Obviously, this one-size-fits-all planning planning to benefit patients a hundred years ago, and it doesn’t in our own age. But such simplicity continues to plague many orthodontists. Orthodontists pride themselves in being scientific, and without doubt they receive good training in the scientific method; but it takes very little anecdotal information to eclipse the scientific judgment of many in the profession. As Angle likely believed, probably more right than he knew when he said, ‘The brain is not an organ of thinking but an organ of survival like a claw and fang. It is made in such a way as to make it accept as truth that which is only advantage.’

No matter how spectacularly orthodontic therapy changes, it will benefit our patients minimally if we do not have a comprehensive approach to our diagnostic and prognostic knowledge. This remains the number one imperative for those who practice orthodontics. Orthodontists should view any new therapy unaccompanied by equally sophisticated diagnostic knowledge suspiciously. Patients have already received far too much orthodontic treatment and far too little diagnosis.

Instrumentation

The first attempts to correct malocclusions used simple large arch wires ligated to the malposed teeth. Pierre Fauchard of France developed the precursor of the modern appliance – expansion arch (Figure 1).

This arrangement gave only tipping control, in one dimension and was inadequate for controlling rotations. In 1887, Angle introduced the E-a-Draws that was to develop an appliance that would apply first, closely followed by the Frankel appliance on a regular basis.

Metallurgical developments by the early 20th century allowed clinicians to encase all of the teeth with bands and solder attach- ments that could control the horizontal rotations. Angle developed a popular attachment known as the pin and tube attachment in 1911 (Figure 5), and it satisfied many of the requirements of clinicians; but this demanded unusual dexterity, patience and skill, so dental clinicians continued to use the pin and tube attachment for the next several decades. The ribbon arch attachment also was introduced in 1928. It received early and enthusiastic endorsement from dental clinicians throughout the United States and eventually eclipsed other useful orthodontic appliances such as the McCoy open-to-Greyson appliance, the Atkinson universal appliance and the Johnson twin-wire attachment.

The universal application and durability of the edgewise bracket confirmed Angle’s modest claim that it offered the latest and best in orthodontic mechanisms. Innovators have added minor but practical trimmings such as rotating wings, twin brackets, different dimensions, preadjusted appliances, lingual applications, etc., but the essence has remained for those who practice orthodontics.

Simplified orthodontic appliances have dominated the profession for the past 50 years, and the belief in them shows little sign of abating even though many have questioned the one-size-fits-all idea.2-16

And back again

The publication of Frankenfeld’s9 work with functional appliances illustrated significant enlargement of dental arches and reawakened an interest in non-extraction therapy. Nevertheless, Frankenfeld mechanisms required the use of removable appliances, and that didn’t resonate well with many orthodontists or their patients. After a brief flurry of interest in the United States, few clinicians continued to use the Frankenfeld appliance on a regular basis.

Nevertheless, the successful use of orthopedic appliances alerted orthodontists to the possibility of increasing arch widths and arch perimeters with minimum forces. Although mandibular canines offer significant resistance to expansion, mandibular premolars and first molars often demonstrate substantial and stable expansion. Brader26 hinted at this with his work on the tri-focal ellipse arch form, but he didn’t follow through about how this might give wider and more accommodating arch forms.

Low-force titanium coil expanders have shown their ability to develop arches laterally,21 and recently Damon22 has suggested that low arch wire forces, coupled with a passive tube and a small wire-to-lumen ratio, enable teeth and their accompanying dental tissues to expand in all planes of space. Damon feels that using small, low-force wires such as those of Copper Ni-Ti (Ormco Corporation, Orange, CA) achieve ideal biological forces proposed long ago by several investigators.20-24

Self-ligating brackets that essentially form a tube developed several decades ago with the Ormco Edgelok26 being the first, closely followed by the Speed brace.25 Both of these early self-ligating systems suffered from the fact that the Straight-Wire appliance phenomenon debuted at the approximate the same time, plus a lack of appreciation for what the newer titanium wires could achieve.

Trial and error

Damon has persisted since 1995 with his version of a self-ligating bracket (Figure 8) and has fundamentally changed the types of arch wires and the sequence in which clinicians use them. His experience has shown that with many patients he can often eliminate distalisation of molars, extractions (excluding those needed to reduce bimaxillary protrusions) and rapid palatal expansion. He offers compelling clinical evidence of doing this with consistency.22

The Damon bracket is essentially a tube designed with the right dimensions to foster sliding mechanics where needed and enough play in the system for torque and rotational control using the larger cross section wires. Damon starts cases with a large lumen arch wire slot and .014 or smaller diameter high-strength titanium wires such as those of Copper Ni-Ti. The low force wires such as those of Copper Ni-Ti (Ormco Corporation, Orange, CA) achieve ideal biological forces proposed long ago by several investigators.20-24

CT Scans

The most logical questions readers could propose would be why has Damon shown successful expansion whereas Angle did not? The quantity of expansion probably differs little,
but the quality of expansion offers a quantum change. Moltenhauer\(^2\) has suggested as much with his appeal for light forces. Even though Angle used a ribbon arch, (which suggests a thin, delicate wire) the actual size of the wire had the dimension of .050 x .022 inches. Ligating to this wire would overwhelm the periodontium and prevent the development of a supporting dentoalveolus. Rather than forming new bone, the supporting dentoalveolus would simply bend and upon completion of treatment quickly return. Astute clinicians often see this with molar distalization from headgear use and often see this with molar distalization from headgear use and often see this with molar distalization from headgear use and often see this with molar distalization from headgear use. The most important caveat Damon offers clinicians is not to use their ordinary mechanics with his system, and I could not agree more. When I first began to use the Damon system, I continued to use the regular sequence of arch wires and saw little advantage to these new, more expensive brackets. Nevertheless, as I began to use the brackets according to Dr. Damon’s advice, I started seeing phenomenal changes. The following patient illustrates typical responses to the biomechanics offered by the Damon System (see patient case). I am witnessing shorter treatment in most of my Damon cases with less discomfort to my patients. The playing field seems to be leveled between adults and children. These changes I am seeing are more than enough reasons for me to question my previous force systems.

What it all means

The paradigm shift in our current thought processes is the belief that alveolar bone can be altered and re-shaped with low clinical forces. Using low force, low friction orthodontics, the alveolar bone allows the bodily movement of teeth in all directions.

The architecture of alveolar bone appears to improve over time following low force orthodontics so clinicians should be very creative on how to maintain the appropriate biologic forces during all phases of treatment.

Orthodontists are currently witnessing an interest in qualitatively different expansive biomechanics that offer patients the possibility of obviating the use of distalizers, rapid palatal expanders and many needless extractions. The bracket system that makes this possible should command the utmost respect and clinicians should use them as recommended with light forces.

I am witnessing shorter treatment in most of my Damon cases with less discomfort to my patients. The playing field seems to be leveled between adults and children. These changes I am seeing are more than enough reasons for me to question my previous force systems.

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About the author

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Sink or swim

In a new series, recent graduate Sarah Armstrong offers final year students essential tips for survival, coping with the workload, getting ahead and most importantly, staying sane.

This autumn, hundreds of dental students across the country have returned to university, their electives a mere distant memory, ready (or not) to commence their final year. It’s a daunting time, and a huge amount of pressure rests on the shoulders of those taking their final steps through dental school. Although the format of teaching/examinations ranges widely across dental schools, there is one thing the same – to make sure every graduate is a safe, professional, competent dentist by the time summer arrives.

Inevitably, as term begins there will be plentiful pep talks (some more terrifying than others) from senior members of the dental school, designed to motivate you into getting organised early. Occasionally these cause the reverse response, evoking panic and dread to the private into getting organised early. Occasionally these can cause the reverse response, evoking panic and dread to the listeners, but try to look past the shock tactics and listen to what senior members say – they have to say, after all the staff have to say, after all the staff members from senior members of the dental school, designed to motivate you into getting organised early. Occasionally these can cause the reverse response, evoking panic and dread to the listeners, but try to look past the shock tactics and listen to what senior members say – they have to say, after all the staff have to say, after all the staff members (some more terrifying than others) from senior members of the dental school, designed to motivate you into getting organised early. Occasionally these can cause the reverse response, evoking panic and dread to the listeners, but try to look past the shock tactics and listen to what senior members say – they have to say, after all the staff have to say, after all the staff members.
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 Philips Oral Healthcare has launched three seasonal promotions to encourage patients to give a gift wrapped smile this Christmas.

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 As a second present idea, Philips is offering a Stand Alone Sanitiser with any Sonicare Flex Care or HealthyWhite brush and patients will receive a £25 cash back bonus.

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 Oral Health and the Renal Patient

 54,000 people in the UK are being treated for end stage renal failure (ESRF) with 19,000 of these receiving dialysis and since 2001 there has been a 4.5% increase in the number of patients with ESRF.

 A recent study reported in the Journal of Clinical Periodontology has revealed that patients suffering from ESRF and those receiving dialysis are more prone to periodontal disease and other oral health problems. Davidovich et al found that the renal failure groups had higher gingival index and bleeding, probing depths, and attachment loss than the control. Plaque was higher in the dialysis and dialysis groups. The research concluded that dialysis duration and ESRF significantly correlated with gingivitis, probing depth, attachment loss and enamel hypoplasia.

 According to hygienist and nutritionist Juliette Reeves “The oral administration of probiotics is particularly beneficial to the renal patient. There is obviously considerable potential for the benefits of probiotics in the treatment of oral health conditions.” GUM PeriBalance
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In April 2009, ten members of the Henry Schein Minerva team will be joined by five dentists on a Bridge2Aid trip to Tanzania. They will carry out a refurbished project, renovating a roadside dormitory block at Bukumbi, which is home to a community of disabled Tanzanians.

The Henry Schein Minerva Sales Team launched the fundraising for this trip at their last sales meeting, where the Director of Sales, Patrick Allen, was treated to an unexpected beauty treatment for the cause—a chest wax! Through the laughter, screams and tears, Patrick’s extremely hairy chest managed to raise almost £4000.

Patrick, who had no idea that he was going to be the focus of the fundraiser, took the whole event in great humour: “I will certainly remember this sales conference as I’m absolutely delighted with the amount of money my pain generated.”

Any contribution to the Bridge2Aid fund is very welcome as this project will make a huge difference to the lives of the Tanzanians at Bukumbi.

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With the powerful anti-microbial LizSol as its active ingredient, Continu kills at least 99.999% of bacteria within 50 seconds.

Continu is alcohol free and has the same ‘hazard rating’ as water. This makes it kind to hands, providing you with sanitisation that does not cause dryness or inflammation when applied to skin.

Also, Continu does not evaporate as quickly as alcohol-based alternatives, making it more cost-effective, and the long-lasting residual effect inhibits microbial contamination for several days after application.

The product range is also kind to surfaces, because it is non-corrosive. Apply Continu safely to hard and soft surfaces including textiles, delicate instruments and equipment.

Because Continu has no smell, you do not need to worry about fumes either, allowing you to create a clinical environment that is both comfortable and clean, helping to make Continu the new standard in hand and surface sanitisation.

For more information on Nu-View products call 01455 759659, email continu@nuview-ltd.com or visit www.nuviewltd.com.

Upgrade to the healthier side of whitening and stop Gingivitis before it starts

Beverly Hills Formula premium brand dental whitening products have unique combinations of anti bacterial agents, low abrasion and anti-stain polishes to protect and whiten teeth. They gently remove stains from teeth, without harsh abrasives. Tests conducted by the BBC Watchdog programme revealed that Beverly Hills Formula Toothpaste removed over 90% of staining. According to another BBC research study sufferers 40-50% of adults across the world from gum disease, making this the most common dental problem. In its bid to prevent gum disease by controlling the amount of plaque that builds up on your teeth, Beverly Hills Formula has formulated Gum Strengthening toothpaste. Regular brushing with this toothpaste can help relieve symptoms of gingivitis. Beverly Hills Formula Dentist’s Choice has been formulated based on extensive research, and is comprised of all the ingredients and benefits dentists’ wanted to see in a premium toothpaste.

For further information on Beverly Hills formula call 01455 759659.

The Answer to Simple Aspiration for Dental Injections

As the mouth contains many blood vessels, it is important to aspirate to check the position of the needle tip before injection.

There are several ways of aspirating, but remember additional actions to cause aspiration.

For better dentistry

Self-Aspiration

The self-aspiration system was developed specifically to address this. This system uses a specific syringe and an adapted cartridge with a cavity open at the plunger end. The end of the syringe plunger fits into the bung, which distorts when pressure is exerted. By releasing the pressure, the bung returns to its original shape. This makes it easier for you to identify when the bung is sufficient to cause aspiration.

Both Xylocaine® 2% with Adrenaline 1:80,000 and Citanest® 3% with Octapressin (prilocaine hydrochloride with felypressin) from DENTSPLY Pharmaceuticals are available in self-aspirating cartridges.

Xylocaine® 2% with Adrenaline 1:80,000 and Citanest® 3% with Octapressin (prilocaine hydrochloride with felypressin) are available in self-aspirating cartridges.

The extensive Aseptico range includes portable patient chair as well as operators stools and lights.

If you also include the Velopex Digital system and the Nomad hand-held x-ray unit, then you can take diagnostic radiographs in situ. The Velopex Digital System, installed onto a suitable laptop, gives diagnostic images onto the screen within 5 seconds.

For more details on the range of Aseptic products supported by Velopex, in the UK, please see: www.velopex.com.

OPMI Pico: the intuitive magnification and education tool

Dr Joseph Masih practices at Dental Specialists MK in Milton Keynes, and in a specialist referral practice based in Oxford and London.

“Since using the Carl Zeiss lux® 180 xenon light.

The OPMI Pico’s applications do not end there, as Dr Masih explains. “When connected up to a monitor, the high quality images and video which I have seen on my presentations, can serve as an educational tool for patients.” This versatility makes it a great choice for dental magnification.

For more information please call +44(0)1455 759659, email info@nuview-ltd.com or visit www.nuviewltd.com.

90% Discount for VDPs

Dentists’ Provident, the leading provider of income protection to dentists in the UK and Ireland, offers VDPs and House Officers a 90% discount on premiums throughout their training year.

The company is proud to offer two income protection packages tailored for VDPs and House Officers. Both packages offer an initial cover of £500 per week.

The VDP Essential package is designed as an entry-level solution and premiums start at just £2.57 a month for a male non-smoker. The Essential package offers level benefits, so the value of the benefit payments will stay at a constant level for the duration of the claim.

The VDP Premier is a comprehensive package which includes several additional features, including ‘Escalation of Cover’ and ‘Indexation of Benefit Payments’, whereby the level of cover increases annually in line with the Consumer Price Index, as do the benefit payments throughout a long-term incapacity.

For more information, contact Duncan Harvey on 01932 837275 or write to Dentists’ Provident Society Ltd, 9 Gayfere Street, Westminster, London SW1P 3HN; www.dentists-provident.co.uk.
Mastering business skills

Don’t miss the BDA’s advanced business and communication skills course for dental practices – a MasterClass seminar with Henley Business School

If you want to raise the effectiveness, creativity and profitability of your dental practice, but want to make sure the money you spend on the training to do this is effectively spent; consider enrolling your staff on the BDA’s new series of MasterClass seminars – Advanced business and communication skills for dental practices.

These one-day seminars will feature Henley Business School speakers who will help you equip yourself with the necessary business and financial proficiency, as well as the leadership and communication skills you need to put your ideas into practice.

Boost your knowledge

You will learn about analysing the patient experience that you deliver, and ways of improving it; understanding what drives profitability in your practice and ways of increasing it. You will also find out how to develop a more effective business plan and improve your leadership style.

The day will bring together perspectives from finance, marketing, operations and people management to address four key challenges for dentists:

• Improving the patient experience
• Understanding the drivers of profitability in your practice
• Developing a convincing business plan
• Enhancing your inter-personal skills in business situations.

Dates for your diary

What’s more, the BDA’s masterclass is running on three dates giving you lots of chance to take part:

• Friday November 28 2008 – Café Royal, London
• Friday March 6 2009 – Novotel Birmingham Centre Hotel, Birmingham
• Friday July 10 2009 – Radisson Edwardian Hotel, Manchester

This isn’t just any business course, this is a BDA business course developed especially for dentists alongside the world-class Henley Business School. As well as the classic learning experience, through lectures from some of Henley’s leading minds, there will also be the chance to get hands-on and find out what it will really be like to put your learning into practice, with the business theatre group Interact.

Take the opportunity now to improve your business for the future. Book today by calling 020 7563 4590 or emailing events@bda.org. You can also find further details online at www.bda.org/events.
Howard Cohen & Co, members of the ASPD, 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 their specialist team offering advice and assistance to dental practitioners on:

- Employment Law
- NHS Contracts
- Associates
- Expense Sharing and Partnership issues
- Industrial Disputes

Howard Cohen & Co, members of the ASPD, are a Leeds based national solicitors practice providing a comprehensive range of legal services to the Dental Profession in all parts of the Country.

ASPD members offer professional, objective and practical advice and services, based on experience within the industry. In dental practice 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 more information please contact Sunil Abeyewickreme

CALLFREE 0800 542 9408

www.howardcohen.co.uk
Communication In Dentistry: Stories From The Practice

Good communication is integral to good care and a good working environment for the whole dental team.

For further information on this interactive learning programme please call or email David Bullock on:

020 7400 8989 | info@smile-on.com