Name change
A dental assistant is auctioning her name on eBay to raise money for Children in Need. The auction winner can change her name to one in a list of 90 names listed – including Margot, Simpson and Pat Butcher from EastEnders. Edeline de Bont has already attracted 12 bids, the highest being £6,000 from the UK Deed Service to change her name to Padsey Bear. Ms de Bont has agreed to change her name by deed poll for one year. Half of the proceeds will go to Children in Need with the rest going to her children.

UDA increase
Figures from the Department of Health have revealed that 82.5m Units of Dental Activity (UDAs) were commissioned for the three months running up to the end of September. This shows an increase of 1.5m, compared to the last quarter running up to the end of June, when 81.8m UDAs were commissioned. It is also 5.9m higher than the same period last year, when 75.7m were commissioned.

Complaints increase
The Dental Complaints Service received 790 complaints in September. This was nine more than the equivalent period in 2007. It also revealed that 42,191 dental nurses, 7,344 dentists and 5,355 dental hygienists have registered.

Great expectations
The Health Select Committee’s report revealed a few damning truths to the profession, so what now? Read our analysis here.

Feeling grumpy?
Everybody always wants to know how much money the other person is earning – especially in dentistry. Mr Penfold shares his views.

Different strokes
Summarising endodontic files – somany techniques...somewhere you start and who do you listen to? Never fear, Julian McSpadden is here.

Mouth Cancer calls ‘you’ for action
A crème de la crème of the dental profession gathered together last week at the Houses of Parliament to back Mouth Cancer Action Week 2008.

Kicking off the launch, president of the British Dental Health Foundation (BDHF), Dr Chris Potts thanked the sponsors and said: ‘We are announcing a name change today from Mouth Cancer Awareness Week to Mouth Cancer Action week because it is time to take action, and it is absolutely fundamental that this event is supported from the top down.’

Supporting Dr Potts, British Dental Health Foundation’s chief executive, Dr Nigel Carter said: ‘With 25 per cent of people not recognising mouth cancer as a serious condition that will kill them, it is very important to promote awareness of the condition amongst the public.

‘The campaign over the next week is about media awareness and we are encouraging you to support the blue badge kit as it raises awareness and we want to encourage that.’

Denplan’s Sarah Bradbury said: ‘We feel it is extremely important that dentists spend the time with patients to check for mouth cancer but we feel confident that we are getting the awareness out there.

Britain’s leading oral cancer specialist called on the government for backing to beat the disease. Explaining the mouth was among the top-three organs most susceptible to cancer-causing carcinogens, Dr Saman Warnakulasuriya said: ‘A lot needs to be done – and I am pleased we are here with politicians who have the will and the power to take this forward.

‘We have achieved a ban on public smoking, but we need to protect children from smoking, in terms of the way sales are restricted.’

Guest speaker and award-shortlisted novelist Lia Mills moved guests to tears with her real life account of diagnosis, treatment and recovery from oral cancer. Backing the Foundation’s campaign motto ‘if in doubt, get checked out’, She said: ‘After my sister died of breast cancer I sailed in and out of breast cancer clinics getting checked out, oblivious of the fact that my mouth was eating me.’

GDC conference
The General Dental Council recently held its first one day public conference Dental check-up – your views on protecting dental patients. Over 100 members of the public attended the event in Birmingham which sought to gather a range of views on dentistry, dental professions and professional regulation. The topics covered included what are dental professionals good at and what could they do better. It discussed the issue of dental professionals being registered for many years and looked at what they should have to do to remain registered.

New generations
Young dentists have the world at their feet, or do they? Will they flourish in NHS dentistry or will they be forced into private practice?

Tradition with a modern twist...
Mouth Cancer calls ‘you’ for action

No training spells danger warns experts

Implant experts are calling for a gold standard qualification for dentists offering implants, and for implantology to be a specialism in its own right.

The General Dental Council (GDC) recently reminded all dentists they are only under- 

The GDC pointed to guidelines published by the Faculty of General Dental Practice (UK), Training Standards in Implant Dentistry. These say: ‘It is essential that the dentist carrying out this work has received suitable training, and has been assessed as compe-

It adds: ‘This will normally in-

He said: ‘It’s fairly easy to do implants but very difficult to do them to the standard the Royal College demands. And, bluntly, these should be the standards that, if not mandatory, are those to which the profession aspires.’ He is concerned that there are ‘real dangers lying in wait for the dentist who has had insufficient training and/or does not invest in first class diagnostic equipment’.

Dr Dandapat, who is principal at the Dental Implant Centre in Twyford, Berkshire, believes that at the moment implantology stan-

He added: ‘When you look at the medical sector, it is highly regulated. Even pharmaceutical representatives have to hold a li-

In an increasingly litigious society, there is a real need for caution, he warned.

The risk of getting facial can-

Bupak Dey, marketing coordi-

He said: ‘It is not very regu-

Mr Dey warns that if this does’n’t happen, we are soon going to see a huge court case hitting the headlines’.

‘We are going to see a situa-

Mash Seriki, commercial di-

He would also like to see it be-

However the British Dental Association (BDA) is content to stand by the training standards published this year by the Faculty of General Dental Practice (UK), claiming it provides an ‘authori-

A BDA spokesman said: The BDA supports the General Den-

He added: ‘Dentists should also ensure that they have appropriate indemnity arrangements in place.’
Editorial comment
It’s time to save lives

It is a telling confession when a mouth cancer sufferer diagnosed her own condition from surfing the web. Speaking at the Houses of Parliament last week, guest speaker Lia Mills recalled her shocking journey. Her sister died from breast cancer three weeks after the diagnosis — that was had enough. Vigilant to the letter ‘T’, Lia had regular check-ups, but during each mammogram she had no idea that her own mouth was, as she put it, ‘eating me alive’. It all began with a ‘sore’ in her mouth that would not heal. Her first dentist told her she was unconsciously chewing her cheek and prescribed Bonjela. Her second dentist recommended replacing her old fillings. But still the sore continued. Extensive Internet research steered Lia towards the real problem — mouth cancer. After divulging her suspicions to her dentist (and this is the really shocking bit) he laughed, and said ‘no way’. Why did he laugh? Because her ‘profile’ did not match the ‘typical’ mouth cancer sufferer. By the time the mouth cancer was confirmed, it had spread to Lia’s lymph nodes and surgery began in haste. She had bone, skin and fat taken from her leg to rebuild her face, and surgery began in haste. She had no idea that her own mouth body has to suffer to make other people listen and this woman is to be applauded."

to her dentist (and this is the really shocking bit) he laughed, and said ‘no way’. Why did he laugh? Because her ‘profile’ did not match the ‘typical’ mouth cancer sufferer. By the time the mouth cancer was confirmed, it had spread to Lia’s lymph nodes and surgery began in haste. She had bone, skin and fat taken from her leg to rebuild her face, but after aggressive radiotherapy she can now eat, chew and swallow — things we all take for granted. Nevertheless, mouth cancer or no mouth cancer, Lia has a way with words and a powerful voice so strong you are compelled to sit up and listen.

This woman is a survivor and standing up in front of powerful people from the dentistry profession is part of her destiny. Somebody has to suffer to make other people listen and this woman is to be applauded."

Dental Tribune reported just a month ago that mouth cancer causes more deaths per number of cases than breast cancer, cervical cancer or melanomas. The mortality rate of these cancers is just over 50 per cent because it is always detected too late. In 2005, there was approximately one death every three hours. Enough is enough — we need to raise awareness and we need to take action in whatever way we can.

Mouth Cancer Action Week ran from November 16th-November 22nd. Dental Tribune urges all of you from the profession to do what you can to get the word out there. Lia Mills was lucky — she lived to tell the tale. There are many other people who will die, because of lack of awareness of this condition. Whose life will you save this week?"

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1N 8BA.
Or email: penny@dentaltribuneuk.com

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A £2m investment into NHS dental care in Moray in Scotland is at last starting to make a difference, according to NHS Grampian.

Moray has the lowest number of people registered with an NHS dentist in the whole of Scotland. Just over three-quarters of adults and nearly 50 per cent of children in Moray are not registered with an NHS dentist. Around 7,500 people are currently on the NHS waiting list.

The Scottish Government and NHS Grampian have invested in a number of purpose-built dental practices in a bid to get people off the waiting list and registered with a dental practice.

One proposed dental practice on the site of Spynie Hospital in Elgin will create a 10 dental chair surgery, four of them allocated for student dentists and the remainder for special needs patients and general practice.

Dental lead for Moray, Malcolm Stewart, hopes to get 100 people each month off the waiting list and registered with a dental practice.

Children under 12 will be given priority and the aim is to have them registered with an NHS dentist by the 12 weeks of their name being placed on the waiting list.

Latest figures show that just 26.5 per cent of people—adults and children—in Moray were registered as of June, which was an increase on last year’s figure of 24.8 per cent.

This compares to the Scottish average of nearly 60 per cent.

Highlands and Islands MSP MaryScanlon, the Tories shadow health secretary, called it a ‘shocking state of affairs’.

The British Dental Association (BDA) is launching a new masterclass seminar to help dental professionals ‘enhance the patient experience, perfect their communications skills and develop more effective business plans’.

The event, ‘Advanced business and communication skills for dental practices’, will be led by speakers from Henley Business School.

It will also feature an interactive session analysing dental professionals’ communication styles and techniques.

Peter Ward, chief executive of the British Dental Association (BDA), said: ‘Communication and business skills are vital to the success of dental practices.

This seminar brings dentists the very best advice from leaders in the field and provides clear ideas of how their knowledge can be translated to improve the everyday performance of the practice.’

Sessions on the one-day course will tackle subjects including improving the patient experience, enhancing the profitability of the business and developing a convincing business plan.

The interactive afternoon session will look at determining personal communication styles, the advantages and disadvantages of different styles. It will also use an actor to demonstrate different communications techniques that can be applied in business situations.

Details of the seminar, which was developed with the support of the British Dental Trade Association (BDTA), are available at: www.bda.org/events.

The first session will be held at London’s Café Royal on 28 November 2008.

Seminars will also take place at The Novotel Birmingham Centre on 6 March 2009 and the Radisson Edwardian Manchester on 10 July 2009.

Delegates can book online or by calling the BDA on 020 7563 4590.

The £2m investment ‘makes a difference’

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The course will tackle subjects such as improving the patient experience.

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Me & Henry Schein

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Mike & Helen - Briercliffe Road Dental Practice, Burnley

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Yemi Opaleye explains how he took one of the biggest gambles of his life - relocating his NHS practice.

When you first meet Yemi Opaleye he does not strike you as much of a risk taker, he is a very calm man, with a gentle manner that you can imagine makes his patients feel very much at ease. Yet two years ago, Yemi took what was probably one of the biggest gambles of his life when, in partnership with his colleague - Bob Middlefell, relocated their NHS dental practice into what was then, the local cottage hospital that had recently been earmarked for closure. The arrival of dental services gave a much-needed boost to the hospital and after constant local campaigning it appears that the hospital (dental services and all) have been saved.

Nestling in beautiful Gloucestershire countryside, Tetcbury is a small “chocolate-box” town where it seems surprising to find NHS dentistry alive and well. Yet here, Yemi, Bob, and their Associates have established a real commitment to the provision of NHS treatment and are working extremely hard to service the needs of the 15,000 patients on their list.

Tetcbury Dental Practice was originally set up in 1969 and the move to the hospital was in truth, a necessity.

“Our existing building was very old and would have required a complete refurbishment to bring it up to standard, so although there was some doubt about how long the hospital would be open, we figured it was the best option under the circumstances.”

Once installed on the hospital’s first floor, in what was originally an open ward, Yemi and Bob with the help of a team of external consultants commenced on a programme of re-designing the facilities. Now, two years later they have six surgeries, a dedicated hygienist suite, two large sterilisation units - one situated at each end of the building, efficiently servicing the surgeries and a large, welcoming waiting room.

Helping in whatever way she could on this large, sometimes overwhelming project was Sally Dawson, Yemi’s local Henry Schein Minerva representative. Yemi contacted Henry Schein Minerva when he first moved to the hospital premises and Sally visited him one lunchtime, a meeting which he admits was the point at which he began to have real confidence in the future, and the potential success of the practice.

“Sally was fantastic. She didn’t just turn up to take an order, she had a real interest in the whole project, the refurbishment, design alterations, and all that we were trying to achieve. She just talked to us such a lot of sense and what was surprising for me was that a huge company like Henry Schein Minerva could offer extra support and help with things like training - no strings attached!”

In conjunction with Henry Schein Minerva this has become even easier to do. Sally arranged a whole programme of staff training, including a session on cross-infection techniques to bring staff up to date with the latest protocols and help the practice’s sterilisation units run effectively.

“Henry Schein Minerva are providing us with everything we need; great service, excellent delivery, additional support in the form of staff training, we don’t need to waste time looking for other deals - we are more than happy with the deal we get from Henry Schein Minerva.”

They are delighted with the training their staff have received which they acknowledge is playing an important role in building the patient base and helping the practice run smoothly and efficiently.

“Everyone is aware of the sheer numbers of patients seen by NHS practices. We must run an efficient model to make sure we can cope. It only takes one small problem for appointments to back up very quickly.”

With a total of 6 dentists (full and part time) and a part time hygienist to keep up with, ensuring a constant and consistent supply of consumables and equipment is essential. For this, Tetcbury Dental Practice relies completely on Henry Schein Minerva’s expertise in service and delivery and Yemi sees no reason to consider any other suppliers.

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Two years after making the move to Tetcbury Hospital, they are very pleased with the progress they have made. They have a busy, successful NHS practice, providing quality care in pleasant surroundings. Naturally, the demand for these services is high and their goal is now to build the practice to a level where all the surgeries are in full-time use, efficiently providing quality care for all their patients.

To do this they recognise the role that dental companies have to play.

“To be successful you need help from many different sources. Henry Schein Minerva and Sally my local representative have been true to their word from the beginning. They have delivered on all their promises and are a fantastic partner for our practice.”

For more information email: me@henryschein.co.uk
“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
A close inspection

The Government’s response to the Health Select Committee raised a few hackles in the profession, but what does it all really mean? *Dental Tribune* takes a good hard look at the report and analyses the good, the bad and the ugly parts.

When the Health Select Committee produced its damning report on NHS dentistry in July, many commentators hoped that the Government would rewrite the dentists’ contract. Even before the report was published, Conservative spokesman, Mike Penning MP, had called on the Secretary of State to “scrap this ludicrous contract” which had left nearly a million members of the public with no access to NHS dentistry.

The British Dental Association (BDA)’s chair, Susie Sander son described the report as ‘damning’, which had highlighted the ‘failure of a farcical contract’. She called on the Department of Health (DH) to ‘listen to this condemnatory report and act swiftly’. Three months later they produced their ‘interim’ response.

Far from promising radical reform, the Government said it was confident that the new dental contract provided a ‘better basis for Primary Care Trusts (PCTs) to commission services’. Although it accepted the Committee’s view that progress on improving access was disappointing to date, the DH would work to see how the NHS could achieve ‘the maximum benefits for patients from these reforms’.

It had already started to work with Strategic Health Authorities (SHAs) to improve access to NHS dentistry. This project will be completed later this autumn and the Government will then make a fuller response setting out further actions. Media speculation suggests the DH is planning a crackdown on dentists who have been exploiting the system to maximise their incomes, denying thousands of patients access to treatment.

‘Media speculation suggests the DH is planning a crackdown on dentists who are exploiting the system to maximise their incomes’

Accessing services

The Committee was most scathing about patients’ access to services reporting that the DH’s goal of improving this had been ‘unrealistic’. It admitted that progress was ‘unconvincing’ and that improvements would soon be seen. It pointed out that ‘the various measures of access available all indicate that the situation is deteriorating’.

In reply, the Government admitted that progress was ‘uneven’. It did acknowledge that the first two years had been ‘a difficult transitional period’, both for PCTs and dentists. Many were yet to see the true impact of the new system on commission services. Although it acknowledged that PCTs had set unrealistic targets and the Government pointed to evidence that this was already happening. There were also more dentists in the system to do the work and the ‘there was no shortage of applicants when PCTs tendered for new practices’.

The Government accepted that there was more to do, such as addressing the problem that some PCTs are better than others at commissioning in a bid to improve access. Similarly, the public are not using the services in some areas where PCTs have opened new practices.

Those UDAs

Many dentists wanted to see the death of units of dental activity (UDAs). The Committee said that the system had proved extremely unpopular with dentists and that it was ‘extraordinarily likely that the Department did not pilot the new payment system before it was introduced.’ Too many PCTs had set unrealistic UDA targets and the Committee recommended that the short-term number of payment bands should be increased from three to five or more.

The Government defended the system. It said that there had to be some measure of activity, and that it was reasonable to use a weight of treatment to do this. But it accepted that UDAs should not be the only measure of activity and that PCTs should work with dentists to develop other measures for monitoring work. It was working with the University of Manchester to develop a research proposal to assess the impact of the new system on oral health.

Child-only contracts

The Committee argued that child-only contracts should be removed from NHS dental services as soon as possible. The Government agreed that they were undesirable and had the effect of ‘pressurising adults to accept private dentistry, so that their children can receive NHS care’. The DH had issued guidance so that they should move away from child-only contracts, but in a managed way that did not threaten children’s access to NHS dental services.

Complex treatment

The laboratory industry has certainly suffered with the number of treatments involving laboratory work falling by half. The Committee was working with the University of Manchester to develop a registration system to carry out a review of how services are responsive to the needs of individual patients, ‘ensuring a strong focus on quality of care’.

Registration abolition

The Committee believed that it had been a mistake to abolish registration and recommended the DH should ‘reinstate the requirement for patients to be registered with an NHS dentist’. The Government agreed on the importance of continuity of care, and recognised the significance still attached to the term ‘registration’. It would examine the possibility of some form of registration in the future.

For the future

The Government promised to carry out a review of how dental services should develop over the next five years and the Committee welcomed this pledge. It will look at all aspects of the arrangements for commissioning, including UDAs and other matters of concern. Its aim will be to ensure that services are responsive to the needs of individual patients, ‘ensuring a strong focus on prevention as well as treatment’, with improvements in the quality of care.
“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
New deputy CDO joins the DH

The Department of Health has appointed a new Deputy Chief Dental Officer.

Sue Gregory is currently the dental public health consultant for Bedfordshire, Luton and Hertfordshire Primary Care Trusts. She will replace the current Deputy Chief Dental Officer, Tony Jenner, who is leaving the Department of Health after six years.

Ms Gregory chairs the UK Consultants in Dental Public Health Group and was president of the British Association for the Study of Community Dentistry in 2006-07.

Sue was also previously honorary secretary, and then president, of the British Society of Disability and Oral Health.

Barry Cocksroll, Chief Dental Officer for England said: ‘I am delighted that Sue is joining the dental team at the Department of Health. Her experience in active local commissioning and her particular expertise in helping Primary Care Trusts to ensure that their resources reach the best and most appropriate local dental services.

He added: ‘It has been a real pleasure to work with Tony Jenner over the last six years. He has been closely involved with changes to legislation that have enabled consultation on water fluoridation, and has made a significant contribution to the development of Choosing Better Oral Health and publication of the prevention toolkit - achievements of which he should be truly proud.’

NHS Bedfordshire chief executive, Andrew Morgan, also congratulated Ms Gregory on her new appointment and said: ‘Sue has made a huge contribution to dental services in Bedfordshire and will be a hard act to follow.’

Her appointment will take effect in January 2009.

Queuing up for ortho

Hundreds of children in West Wales are facing a two-year wait for orthodontic treatment due to lack of funding, according to an orthodontist.

Dr David Howells, who works in Llanelli and Carmarthen, claims he has been forced to put more than 600 children on a waiting list because he has not been given enough funding by the local health boards (LHBs).

In an open letter to Bernardine Rees, chief executive of Carmarthenshire, Pembrokeshire and Ceredigion LHBs, he said: ‘It is no exaggeration to state that recent events have had a catastrophic impact upon an already dire situation.’

Dr Howells claims he has only received enough funding to treat 480 patients a year – even though more than 1,000 children are being referred for orthodontic treatment at his practices every year.

In a letter to Ms Rees, he said that orthodontics is ‘a time-consuming and expensive service to provide. The old funding system remains in Scotland and Northern Ireland but, regretfully, Wales chose to copy England instead. As a result of imposition of the personal dental services contracts, much of the previous growth has been reversed’.

An LHB spokeswoman said: ‘While the LHBs request waiting list information from orthodontic practices on a regular basis, the numbers supplied include those currently awaiting an assessment and it is unclear at this point how many of these would go on to receive NHS orthodontic treatment within primary care.’
A matter for debate

Graham Penfold and Dental Tribune discuss dentists’ earnings

Dental Tribune: Money matters have dominated the media for some months now. The stories have been mainly ones of doom and gloom for the economy both here and globally. But recent figures for dentists’ earnings tell a different story. Average net earnings, from both private and NHS sources, for all dentists were £96,135, before tax. Average gross earnings (including expenses) were £206,255, with average expenses of £110,120. Sounds pretty good, so why are dentists so grumpy these days?

Graham Penfold: The figures relate to the financial year 2006/07 which is almost certainly a ‘freak’ year because it will not include any adjustments for clawback monies and will also include monies paid out under the old contract. In any event, I do not think that this level of pay is unreasonable for a dentist because it is a difficult and demanding profession involving a long period of training. What NHS dentists are grumpy about, and understandably so, is the rigid and unreasonable way that they are forced to earn their fees under the new contract.

Dental Tribune: The figures were based on income-tax returns which should have allowed for clawback and pre-contract earnings. However to move on one of the things that was interesting was that whether dentists were private or NHS, it made little difference to their net earnings which were around £103,000 in both instances. Every time you read a story in the media about the contract, it says that dentists have left the NHS for private practice ‘where the fees are higher’. The fees may be higher, but not the profit; how can the profession get this message across?

Graham Penfold: I think the message is a simple one. Yes, in private practice the fees may be higher, but this is to allow more time to be spent with patients. This provides a more relaxed and less stressful environment which is beneficial for all parties including the patients. It also enables the practice team to go on more courses and invest in new equipment, materials and techniques advancing the level of care and choices to patients. After more than 20 years of helping practices both convert to and promote private practice, it is very, very rare that increased personal profit is the sole driver.

Dental Tribune: The Department of Health (DH) is going to jump on these figures. It may say that dentists are not taking on new patients, extracting teeth that could be root filled and ‘not having time for prevention’. Yet they are guaranteed net earnings far in excess most other professional people. The BDA’s evidence to the Review Body, however, is claiming an extra 5.3 per cent on net income, because general dental practitioners ‘are ex-

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posed to prevailing economic conditions more than other healthcare professionals. They haven’t a hope of getting that, have they?

Graham Penfold: Yes, I think you are right that the DH will jump on these figures and if they do not then, given the parlous state of the public finances, the Treasury certainly will. I do not think that there is any chance whatsoever of an award of anything like 3.3 per cent in normal economic times let alone now. And yes, some dentists are not taking on new patients with high treatment needs, nor providing root canal treatment nor focussing on prevention because the new contract has a major flaw. It puts the need for commercial survival harshly against the need to provide the best possible care for patients.

Graham Penfold: With the introduction of the new contract, it is little wonder that expenses in NHS practices have fallen. Given that in an NHS practice it is now completely impossible to influence the income line, unless you want to bid for more UDAs, the only way that net profit can be improved is to reduce the cost base. This has happened in a large number of practices as evidenced by the very large fall in expenses in NHS practices; the number of advanced treatments that are being performed.

Dental Tribune: The figures for associates, however, paint a very different picture though. Practice owners (mainly NHS) had net earnings of £146,599, but their associates, who do the bulk of the NHS work, only made £72,360. We of course do not have the figures for the corporates, but is it no wonder that contractors are falling over each other to bid for new contracts?

Graham Penfold: I think this section needs more analysis because there have been a number of important changes. First, because of the fear of clawback and also because most contracts are practice based rather than specific to each dentist, many practice owners have decided to pay their associates for completed UDAs rather a simple one-twelfth of the annual contract sum. In the short term, especially where there is ‘underperformance’ this will inflate the practice owners’ income and deflate that of the associates. What we need to complete this confused picture is the amount of monies to be clawed back and to know who is responsible for writing the cheque; this adjustment will be very significant. Also, however, the New Contract and overseas recruitment have resulted in a dramatic change in the dental manpower market. There is no longer the chronic shortage of associates there once was, so an automatic 50 per cent is no longer guaranteed. As for contractors falling over themselves for more UDAs, the phrase ‘fools gold’ comes to mind!

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No one is immune to the effects of a slow economy, including dentists. Levin Group data indicate that dental practice production began to slow late last year and has remained sluggish compared with previous years.

Although dental practices have not been hurt nearly as much as retail stores or estate agents, an increasing number of dentists are wondering what they should do to protect their practices. Should they simply sit tight until the economy improves? The answer is, certainly not. This is no time for passivity. You have the power to grow your practice even in a down economy.

Why this economy is different

Not all economic downturns are equal. In the late 1960s, the United States witnessed a stock market devaluation that resulted in a troubled economy a few years later. That downturn was precipitated by the burst of the ‘dot-com’ bubble. However, everyone knew what had happened and what could be done to fix things. When corrections were made, the economy rebounded.

Many people were not affected by the 1990s downturn because the consequences only hit certain segments of the economy. Also, consumer spending slowed very little. The current economic situation is different. It is what I refer to as a consumer downturn. Although it was precipitated by the housing crisis and issues with major lending institutions, there were many factors behind it, and almost every consumer in the United States and throughout the world feels the effects. An economic ‘perfect storm’ has occurred, with rising energy and food prices coming on top of the housing and banking emergencies.

In a consumer downturn, most dental patients are affected. Difficulties are not restricted to those with housing problems or those having trouble paying their gas and electric bills. Rather, all the country will be making tough choices about the way they spend their earnings, and dental practices will not be immune to cutbacks in consumer spending.

Protecting the practice in the current economy

There are a series of steps dentists can take to strengthen and protect their practices. Levin Group clients have been able to maintain a growth rate of 2% to 2.5% per cent, despite the economic downturn, by making five important changes in their practices:

1) Have 98 per cent of all active patients scheduled at all times.

In today’s economy, it is imperative that practices bring in 98 per cent of their patients on a regular basis for hygiene procedures and diagnosis. Most practices come nowhere near this Levin Group imperative, with many scheduling less than 80 per cent. This results in a great deal of missed production each year. All overdue patients should be contacted to remind them how important regular dental appointments are for their oral health. Patient appointments should be confirmed using all the techniques available, including email and mobile phone text messages.

2) Increase the amount of cosmetic and implant dentistry offered to patients.

Elective procedures are an excellent way for dental practices to increase production. In a good economy, it isn’t nearly as necessary to offer a full range of services as when the economy stalls. Set a goal of increasing elective production to 22 per cent to offset downturns in the economy. To boost elective production, the practice will need to strengthen its communication with patients through case presentations and marketing. To increase case acceptance, the practice should offer a number of payment options, including patient financing. Many who cannot afford cosmetic and implant dentistry out-of-pocket will elect to undergo these procedures if they can pay for them through an outside financing company.

3) Collect 99 per cent of all money owed to the practice.

In tougher economic times, patients will pay their bills more slowly. This means that a practice may have money on the books without actually seeing it for six months or more. To counter overdue accounts, Levin Group recommends collecting every non-payment for larger cases and outside financing. Patients should understand their options and obligations so that the practice is paid when services are performed.

Many dentists do not remember the 1990s, when collections were a serious problem for practices. This problem could recur if practices are not current in adhering to their collection policies.

4) Watch your overhead.

Practices need to more carefully evaluate the importance of major purchases during slower economic times. While you may think the addition of a certain service or technology will stimulate practice growth, it may have the opposite effect in a sluggish economy. In no way would I suggest that dentists should stop investing in their practices.

However, investments should be well thought out and the outcome of purchases carefully monitored. Every potential purchase should be evaluated based on return on investment (ROI). Levin Group has seen a number of clients in the last six months who enrolled in our programs because investments in new practice areas far outpaced ROI. This resulted in the practices experiencing a cash crunch.

5) Check your line of credit.

Most practices will never have to use credit to pay bills or staff. However, it is a good idea to establish a line of credit in preparation for possible temporary slowdowns. The ability to access credit over a short period of time is a good safeguard for any business. Otherwise, doctors might have to provide funding personally, which can be difficult if sufficient money is not available.

Money Matters

Dental practices can successfully compete for patients’ discretionary funds, but offi ces must do so in a more sophisticated manner than in the past. The recommendations given above will allow dental practices to grow, whatever the shape of the economy. Success is possible, in good times and bad.

About the author

Dr. Roger P. Levin is founder and chief executive offi cer of Levin Group Inc., a leading dental practice management consulting fi rm that provides a comprehensive suite of patient services to its clients and partners. Since 1985, Levin Group has embraced one single mission — to improve the lives of dentists. For more than 20 years, Levin Group has helped thousands of general dentists and specialists increase their satisfaction with practicing dentistry. Levin Group may be reached at customerservice@levingroup.com.
Riding the bear market

With recession imminent, Peter Dunn asks whether it's better to hold off saving for the long-term until the good times return

Stock market turmoil; bankrupt financial institutions; property prices collapsing; imminent recession – it's not exactly good news week as the financial soap opera continues to unfold.

You may be asking if there is really any point saving for the long-term in the present climate. Would it be better to hold back and wait until the news is more positive and the good times return once again?

Let's wind the clock back to 2002 when stock markets were well into their third year of a downturn, or bear market. We would periodically pick up the phone to clients who were worried about their pension funds and wondered if they should consider bailing out of equities. The FTSE 100 index had dropped by around 50 per cent and was showing little sign of recovery.

Our advice to our clients at that time was 'keep the faith' and not to sell in a depressed market. In fact, we were actually suggesting a contra-cyclical approach: that they should be actively investing into equities; not enormous lump sums but lesser amounts and on a regular basis.

Keeping the faith

Fast forward six years and markets once again appear to be in crisis. The FTSE 100 index has dropped 25 per cent over the last year and the global impact of the 'credit crunch' is potentially much more damaging than the dot.com boom-bust cycle of the late 1990s. Yet the difference we are noting this time is the reaction of our clients, or rather the lack of it. We are receiving far fewer distress calls; in fact most clients that we talk to seem quite happy to keep investing in equities.

I've a couple of theories for this. The first is that back in 2002, property was still booming and offered an attractive alternative asset class to invest into. In 2008, the property market is depressed and the short-term outlook remains poor. Very few dentists are investing in residential property, especially buy-to-let properties.

The second theory is that the events at the beginning of this decade are still relatively fresh in our minds and those clients who heeded our advice and remained actively investing in equities actually did rather well, as the UK FTSE 100 index doubled in value over the ensuing three years.

According to Jim Wood-Smith, the head of research at the investment managers Williams de Broë, the recent events surrounding Lehman Brothers and HBOS have taken us significantly closer to the end of the credit crisis and as the sub-prime issues are resolved, one at a time, the closer to the bottom we get.

Regardless of whether markets are already trawling along the bottom or have further to fall, the rationale behind our advice to clients back in 2002 remains just as relevant today. If you believe that markets are cyclical and will eventually bounce back, it is not a good time to heavily sell equities when they have already taken a substantial knock, especially if the fundamentals look good. Currently price/earnings ratios, which measure how expensive stocks are, are at a much lower level than when the FTSE 100 bottomed out in March 2003 which indicates there is good value to be had out there in the stock markets.

Active management, reduced risk

Of course, we are not suggesting that 100 per cent of a portfolio should be exposed to equities in the current climate, even for a client with a high tolerance to investment risk, as there may still be further fall-out. A good strategy for many investors is to maintain exposure to equities but diversify into investments that can still benefit even when markets go down.

A well-structured portfolio for a medium-risk investor is likely to be diversified between the following asset classes:

Fixed interest

At the base of a well-structured portfolio would be a selection of fixed-interest securities
such as government securities (both conventional and index-linked) and corporate bonds.

**UK equities**
A weighting in equity-based securities, commencing with UK equity funds, would be included to achieve long-term capital growth and income.

**International equities**
Overseas investments are important for a growth portfolio as they give access to parts of the global economy that are unavailable in the UK. For example, exposure to areas such as Asia can provide attractive growth opportunities.

**Commercial property**
Commercial property is a key element in a balanced investment portfolio as it is not directly influenced by market conditions in the same way as stock market investments. Even when share prices are in the doldrums, property can still deliver healthy capital growth and a decent income yield, and can potentially deliver more stable returns than shares.

**Hedge funds/structured products**
These are an asset class that do not correlate directly with fixed interest and equity markets and, perhaps surprisingly, given their current reputation, can be a very useful tool in lowering the overall risk and volatility of the portfolio.

**Exchange Traded Funds (ETFs)**
These provide exposure to a particular index such as the FTSE 100 or S&P 500 and track the performance of this index. They are also low cost and provide passive exposure to the index.

As ETFs are actually listed on an exchange they trade in ‘real time’ so can be bought and sold at any time during market hours, rather than only being traded once a day like unit trusts.

**Commodities**
Then at the top level there may also be exposure to commodities as they provide long-term diversification and a hedge against global inflation.

**Cash**
Lastly, some cash should be maintained in the portfolio to provide some liquidity and immediate access to other assets when the fund manager feels the timing is right.

**Managing your investments**
How do you readily access this style of portfolio for your pensions and other investments? It is possible that your financial planner actively manages the investments on your behalf, using research made available by independent institutions. However, a fully diversified portfolio as described above may consist of some investments that are only available to institutional investors.

Increasingly, financial planners see their role more as strategic planners, helping their clients create and maintain wealth. The trend is to outsource the management of investments to specialist firms with extensive in-house research departments.

Lastly, it is good to recall Sir John Templeton’s Investment Maxim Number 7: The time of maximum pessimism is the best time to buy, and the time of maximum optimism is the best time to sell.

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**About the author**

Peter Dunn is director and senior consultant for Heritage Financial Advisers; a team of independent, fee-based financial planning specialists dedicated to the dental sector. Peter has over 28 years experience working within the dental industry in financial services companies allied to Dental Business Solutions and Practice Plan. In 2001, he relocated to Newbury with what is now Heritage Financial Advisers and assumed joint control of the company in 2006. To contact him, call 01635 48727 or email info@hfadvisers.co.uk.

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Example of a typical medium-risk diversified portfolio

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NEW-LOOK BDPMA

The BDPMA is preparing to offer even greater support to its body of dental practice managers, as the demand for commercial skills grows. The Association’s marketing co-ordinator Vikki Harper, gives us a taste of what’s new for 2009.

The BDPMA has long been considered the leading body for support of dental practice managers (DPMs). What began many years ago as a forum for managers to meet and share common issues and solutions has now become a forward-thinking association that seeks to advise, encourage and champion managers to up-skill and have a louder voice in the industry.

LOOKING TO THE FUTURE

Having gone through a strategic review itself, the BDPMA has made preparations for a new journey in 2009. Its vision is to be the first port of call for DPMs with a desire to improve their commercial skills and to be more effective business managers. Having analysed the role of the dental practice manager in its many guises, and taken into account the rapidly emerging need for higher levels of commercial ability, the BDPMA seeks to be the greatest supporting body for managers.

Over the last six months the BDPMA has gone through considerable soul searching and fact finding: what are the skills needed by modern practice managers and how can the Association position itself to be the first choice organisation for equipping and advising managers to be the best that they can be and to grow them for tomorrow’s challenge? In order to achieve its vision, the BDPMA has not only thrashed out its strategy for the next three years, it has restructured its executive to ensure it has the capability to deliver its goals.

DPMS ARE SKILLING UP

In essence the role of the practice manager can be divided into eight core competences (which can be downloaded from the BDPMA website at www.bdpma.org.uk) and while the general management and clinical aspects of the role have seen less drastic changes, the demand for commercial skills has never been so vital and is not going away.

The problem has been that there is no one definitive route to practice management. DPMs herald from many walks of life and bring with them different levels of skills across each of the required competences. Add to this the numerous flavours of the role as a consequence of different structures practices ranging from single chairs to large corporates, and you definitely don’t have a one size fits all situation.

Some managers have sought further education via the diploma route and while all learning is beneficial; some

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managers have discovered that achieving great results in exams and assignments doesn’t necessarily translate into the ability to apply theoretical knowledge in a practical sense back at the practice. It's the same with attending many of the CPD courses available in our market: the speakers may be fabulous and give some great generic advice but putting what they say into action on a day-to-day basis isn’t easy.

A PRACTICAL SOLUTION

All education is great for development; the problem lies in being able to apply that knowledge in a practical way. For this reason the BDPMA has structured its agenda to deliver the prescribed competences to its members in a unique way. To start with, the Association has launched a series of training forums that deliver an integrated approach to learning by building up the necessary business skills in a co-ordinated way. These events focus on giving the managers ‘hands-on skills’. Delegates will return to work with a practical understanding of how to apply their new-found knowledge, and armed with hundreds of tips and tools from each training event.

The events were launched under the generic heading of, ‘Running a Business’ and they began in Taunton on September 26 2008, with the first of five UK regionally-based, finance seminars. The Taunton event was sold out with over 60 delegates in attendance and numbers for York, Midlands, Cheadle and London filling up fast. The demand has been so great that the BDPMA is considering the need to repeat the courses for managers who were unable to attend.

Finance is the basis for every business decision and is the language of business, so no development of commercial skills could occur without a sound understanding of numbers. Delegates attending the finance events will be in a stronger position to advise and to shape the future of their business skills and knowledge in subsequent events commencing in spring 2009.

APPROACH TO MANAGEMENT

The plan for 2009 is to work through the main commercial competences of a DPM with training events on Business Planning and Performance Management, followed closely by Marketing, Change Management, and IT. Those delegates attending all events will definitely be more commercially astute, aware and capable of managing a business by Christmas 2009 and they will have literally hundreds of tips, useful models and notes to support their continual development. In addition delegates will have the opportunity to benchmark their skills against the various levels of competence. It is imperative that we understand what it is we don’t know so that we are in a position to honestly appraise our skills and determine our skills gap.

BUILDING ON A SOLID FOUNDATION

For members of the dental community with an excellent grasp of commercial knowledge, the BDPMA is launching a series of business classes aimed at practice managers and principals who would like an understanding of the tools and skills widely used in the wider commercial world. Looking outside our industry helps us to acquire broader skills and knowledge that support us in our quest to continually outmanoeuvre the competition and to successfully take our business to the next level. Details will be announced towards the end of 2008.

DPM pay scale

The new strategy encompasses those vehicles that members value and that means once more, in January, the BDPMA will release its recommended pay scale for 2009. As a highly valued member benefit, this document presents a clear and consistent basis for principals and managers to discuss and negotiate remuneration in line with experience and performance. It provides a consistent platform of pay and benefits for the industry allowing principals and managers to negotiate from a common footing.

So with a clear vision, and a strategy and structure to deliver it, the new-look, BDPMA has never been more strongly positioned to deliver what its members need most of all – practical, business skills.

For details of the BDPMA’s training events and to find out more about membership visit www.bdpma.org.uk, email Denise at d.simpson@bdpma.org.uk or phone 01452 886364.
Elements for success

Dr Salt outlines the essential twin facets – experience and education – for a successful career providing implant treatment

Although implant studies go back 40 years, they are a relatively recent development in dentistry and have only really been commercially available for the past 10 to 15 years. Many dentists practising today completed their initial training before implants began to feature in general practice. Nevertheless, it’s important in the context of overall public oral health as well as for the individual patient that this treatment option is available when it represents the optimum response for tooth replacement.

Choosing a training path

There are a number of training routes open to dentists seeking to expand their knowledge and skills in implant dentistry. A formal, university-based training course is the ideal, but spaces are limited and working practitioners may be deterred by financial and time constraints. I personally found formal training suited my purpose better than the other courses available. After taking a Masters in prosthodontics which focused on the restorative aspects of implants, I completed a year at the Eastman Institute to gain more surgical-implant experience.

For those whose responsibilities preclude full-time study, part-time courses offer a viable alternative and include mentoring programmes, where a fellow professional with the appropriate experience offers guidance throughout the training process and during the novice’s first cases. Dentists can also approach implant suppliers such as BioHorizons, whose representatives will attend their practice and deliver training in the safe and effective clinical application of their products and protocols.

Experience is key

As with most practical skills, experience is vital and intending implant practitioners should expose themselves to as much implant dentistry as possible; starting with simple cases before progressing to more complex surgery. Doing this quickly improves both techniques and confidence.

The science of implants has advanced rapidly over the last 20 years and research is ongoing. Structures, surfaces and interface technology change to reflect the latest findings, and implant dentists need to keep abreast of current developments in order to offer their patients the best treatment. Practitioners should also keep a portfolio of their cases; both for their own reference and to introduce potential new patients to the benefits implants can deliver. Post-treatment monitoring is also vital for the success of the implant.

For those considering a career as an implant specialist, all dentists today have a responsibility to acquire sufficient knowledge of implants to offer informed advice to their patients, and to be able to refer them to the appropriate specialist if they lack the training to perform the treatment themselves.

About the author

Dr Stephen Salt, BDS MDent (Rand) specialises in prosthodontics and has 16 years of dental implantology experience. He is the principal of Century Dental Clinic, a state-of-the-art private dental practice situated in Putney. Dr Salt also teaches restorative dentistry at Guy’s Hospital and St Thomas’s School of Dentistry.

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With the continuous introductions of endodontic rotary files, recommended techniques for their use seem to proliferate even more rapidly. Although a desired canal shape can be prepared with virtually any series of instruments, voices of advocates confuse the choices with differing and sometimes conflicting approaches for accomplishing that shape. One is inclined to ask, ‘Can they all be right?’

Coupled with the fact that some endodontic files might become obsolete before the techniques for their use can be thoroughly evaluated, the important question becomes apparent: ‘Are there not common principles by which all present and future files can be used most effectively, efficiently and safely to conform to the operator’s treatment ideals?’

The quest for the answer to that question culminated in one of the most ambitious NiTi rotary file research projects ever undertaken that spanned over five years and encompassed over 2,400 evaluations. Understanding the dynamics of the results of those evaluations has the potential to save thousands of hours of chair time, significantly increase production income, and provide satisfaction that one is mastering excellence.

Many who have incorporated rotary instrumentation into their practice understandably looked for a simple system of files and an easy technique that could be used in a routine manner. Many were attracted by claims that techniques, having the fewest instruments, facilitated canal preparation. That notion needs to be replaced with the realisation that understanding the scientific principles of instrumentation needs to be the foundation of expertise rather than cookbook type instructions or recommendations that seem to suggest that one routine fits every canal anatomy. With understanding, there is no need to rely on the ability to decipher conflicting explanations of noted authorities. Neither is there a need to rely on time-consuming and costly trial and error experience. It is easy to forget that it requires ten years to have ten years of experience.

Rudimentary to understanding the principles of rotary instrumentation are the interrelationships of file dimensions that are important for considering the threat of file failure due to the stresses of fatigue and/or torsion. (Fatigue results from the excessive stresses of repetitive compression and tension that occurs during rotation of a file around a curvature. Torsion is the axial force of being twisted when one part of a file rotates at a different rate than another part.) Some important interrelationships can be expressed as irrefutable statements of physics and are as follows:

1. Fatigue of a file increases with the square of the file’s diameter.
2. Fatigue of a file increases with the degree of curvature of the canal and the number of file rotations.

3. In a straight canal the ability of a file to withstand torsion increases with the square of the file’s diameter.

4. The torque required to rotate a file varies directly with the surface area of the file’s engagement in the canal.

5. A file with a more efficient cutting design requires less torque, pressure or time to accomplish canal enlargement.

In addition to using the above file dimension relationships in establishing our parameters for enhancing instrumentation techniques, we can now draw on trends that became apparent during our 2,400 evaluations. Although research evaluating endodontic instruments and techniques cannot result in absolutes, extensive research does provide the most significant evidence based predictability to be used for formulating instrumentation techniques. To test the validity of claims for file designs and techniques, a computerised clinical simulator was constructed to simultaneously measure torque, pressure and time, during various prescribed uses of types, sizes and tapers of instruments, to determine efficiency and the threat of file failure (Fig. 1). The simulator computer provides the means for precisely duplicating motions (U.S. Robotics) designed to simulate clinical applications for comparing different instruments and techniques. In eliminating operator variability and subjectivity while conforming to operation procedures, computer programming can control the preparation parameters for the depth and the speed of file insertion and withdrawal, as well as the speed of file rotation. Not only can the stresses of the force of insertion and torsion of each individual file type, size and taper be measured under different circumstances, but also the stresses, using different file sequences, can be recorded in order to determine the least stressful and most expeditious technique design. All measurements are plotted overtime to illustrate when and how stress occurs. The simulations can be applied to different canal dimensions and curvatures to determine if technique modifications are necessary. The logged data determine the methods for which each instrument may be used most effectively while minimising the threat of failure. Technique solutions quickly become apparent. The results may be surprisingly different from what has been recommended. In fact, no published file technique conformed to all of the parameters for technique design suggested by the research.

As noted above, research cannot result in absolutes, but some observations became particularly evident in achieving efficiency while minimising threats of failure. Some of the more important observations are as follows:

1. Advance a file into the canal with no more than 1 mm increments with insert-withdraw motions.

2. To advance a particular file the first 1 mm into a canal after it becomes engaged, a minimal specific pressure needs to be applied. If that pressure needs to be increased in order for additional advancement to occur or if a negative pressure (screwing-in force) is encountered, change to a different tapered file or circumferentially file coronal to this position.

3. File advancement into the canal should be able to occur at a rate of at least 1/2 mm per second without having to increase the pressure for insertions.

4. If a file has more than a 0.02 taper do not advance more than 2 mm beyond the preparation of the previous file if any part of the file is engaged in a curvature.

5. Apply no greater than 1 pound of pressure on any file while advancing into the canal.

6. Except for 0.02 tapered files having a size diameter of 0.20 mm or smaller, do not engage more than 6 mm of the file’s working surface if any part of the file is engaged in a curvature.

7. Beyond the point of canal curvature, the file diameter should be no greater than: 0.60 mm for a 0.02 taper, 0.55 mm for 0.04 taper, 0.50 mm for 0.06 taper, 0.35 mm for a 0.08 taper.

(This consideration is the result of testing for 45-degree curvatures having 8 mm radii and applies only to these dimensions for rotary NiTi files. File diameters should be smaller for more severe curvatures and can be adjusted larger for less severe ones.)
Although developing expertise in using rotary instrumentation depends upon a thorough understanding of the file dimension relationships and research observations presented, the first attempts at putting them all together can seem at first confusing and a cause for returning to a technique with fewer efficient results but one with a definite standard sequence. However, basic techniques procedures of expertise instrumentation contribute to the development of expertise of instrumentation more than any other.

Fig. 1. The canal portion short of the resistance defines the apical zone, and the portion beyond the resistance defines the apical zone.

In a survey of the frequency of curvatures, the results of Schafer et al., (JOE, Roentgenographic Investigation of Frequency and Degree of Canal Curvatures in Human Permanent Teeth) indicated that of the 102 canals in maxillary first molars examined, the median degree of curvature was 42 degrees with a 6.6 mm radius when viewed from the buccal and 14 degrees with a 9.2 mm radius when viewed from the mesial. This curvature is substantially greater than the standard selected in our research for testing. With these findings in mind, a thorough understanding of the concept stated in 7° probably contributes to the development of expertise of instrumentation more than any other.

The ability of a file to resist fatigue has an inverse relationship with the square of its diameter. Therefore, a severe apical curvature can be less threatening than a more moderate, more coronal curvature. Since the diameter of a file increases along its taper, determining the location of a canal curvature beyond which a file can advance is of paramount importance for the prevention of excessive stresses on the file. The first step is to determine if there is a curvature of any significance and how far the curvature is from the apex. Withdrawing the file used to establish the working length, and passively re-inserting it will indicate a curvature if it meets any resistance short of the working length since the canal is now larger than the file. The length of the canal to the curvature, the coronal zone, is measured and recorded with the same importance as determining the working length. The canal can now be divided into two zones, the canal portion short of the resistance defines the coronal zone and the portion beyond the resistance defines the apical zone (Fig. 3).

The second step is to determine the distance each of the files having different sizes and tapers can safely be advanced around and beyond the curvature and which size file will need to be used in the coronal zone to prevent any subsequent file from binding in that zone when used in the apical zone. In other words, as a means to minimise total file engagement, any file used in the apical zone should not bind in the coronal zone. The coronal zone offers no particular problem for enlargement because this is the straight part of the canal. By using the parameters suggested above for diameter limitations* (0.60 mm for a 0.02 taper, 0.55 mm for 0.04 taper, 0.50 mm for 0.06 taper, and 0.55 mm for a 0.08 taper), we can calculate if the diameter of a selected file would exceed our limitations. That determination can be calculated by using the following formula for the file we intend to use (Fig. 4).

For instance, if we want to know how far we can advance a 25/0.06 file beyond the point of curvature, the parameters state that the diameter should not exceed a 0.50 mm diameter that is reached when the file extends only 4 mm beyond the point of curvature (diameter limitation, 0.50, minus tip size, 0.25, divided by taper, 0.06, equals approxi-
mately 4). If that 4 mm distance coincides with the working length, we can safely use the 25/0.06 file to WL, provided we first prepare the coronal zone large enough that the file would not engage in this portion of the canal when advanced to the WL. That would require enlarging the coronal zone to a size larger than the equivalent of a 50/0.06 file at the terminus of the coronal zone. This procedure also conforms to parameter 6* that states do not engage more than 6 mm of the file’s working surface if any part of the file is engaged in a curvature. If the WL is more than the 4 mm distance from the point of curvature, a smaller file size or taper must be used.

Although the first impression of this process may seem complicated, little practice is required to master this approach. The benefit is maximum efficiency, expediency and the virtual elimination of file failure.

If the clinician insists on following a routine technique sequence because consistency weighs heavily in his or her practice efficiency, then the following procedure encompasses all of our considerations for file sequencing for minimising instrument stress while providing an efficient procedure for routine canals. Of course, the other parameters for the use of each file need to be followed. That technique sequence is as follows:

1. 25/0.06 to curvature.
2. 55/0.06 to curvature.
3. 25/0.02 to working length.
4. 25/0.04 to working length.
5. 25/0.01 1 mm short of working length.
6. 0.02 tapers or LightSpeed-type instruments should be used to enlarge any desired apical diameters greater than a size 25.

The exceptions to routine, of course, is any canal having an apical zone greater than 6 mm, a curvature more than 45 degrees and a radius less than 8 mm.

Although many of the accepted instrumentation techniques encompass few, if any, of the parameters listed above, working within the parameters can be done with impressive efficiency because minimum file stress is maintained. Each step of instrumentation can occur quickly without repetitive non-productive attempts. Following the parameters should provide the means to advance into the canal at least 0.5 mm per second with each file insertion. The total cumulative time can be extremely impressive when compared to other techniques. While following these procedures, one should keep in mind the purpose is to illustrate a means for providing the greatest expediency and efficiency for enlarging the canal space while virtually eliminating excessive instrument stress or failure — not to advocate a particular canal size or taper. The final canal dimensions should be adjusted to conform to the judgment of the operator and the requirements of the obturation technique used.

As one broadens the scope of understanding, skill is enhanced in a scientific manner and success becomes more predictable. The art of endodontics becomes the science of endodontics and expertise becomes the nature of the operator.

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**Fig. 4:** This formula can determine the file to use.
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Growing older gracefully?

In the second article of our new series, Neel Kothari asks whether younger dentists will be allowed the luxury to flourish in their careers and mature in the new NHS dental system or will they be forced into independent practice?

Money a priority?

When the chief dental officer (CDO) announced that all endodontic files were to become single-use, we had to ask ourselves whether this decision was supported by the evidence base or was merely an overreaction. Whatever the case, the profession has clearly been alienated by the issue of remuneration: there is no funding within the UDA system and dentists have had to swallow the extra costs. The CDO has tried to address this issue by suggesting that the financial impact of this should be relatively minimal for most dentists, and has provided examples of cheaper single-use files ranging from around £5 for hand files and £10 for NiTi rotary files. But by advocating cheaper alternatives and passing on this additional cost to dentists, the CDO has not sent a strong message to the profession that it is prepared to fund the highest level of care, when seemingly here adequate care will do. Some dentists, such as those with relatively stable lists of patients or those in private practice, have been able to accommodate this change with relative ease. However, many in the NHS feel this is just another setback for NHS endodontics, and agree with the HSC in criticising the width of range of band two treatment items.

The issue of NHS endodontics has evoked a highly emotional response from the dental profession. Rather than being the sole flaw in an otherwise workable system, this issue merely highlights the range of problems dentists face in their working lives. These problems could especially affect newly qualified dentists, since they often take over growing lists with a higher dental need, rather then stable ones. The UDA funding, based on historical data, does not accurately apply to newly qualified dentists without a reference period, and therefore causes many in the profession to question the rationale of the ‘swings and roundabouts’ approach advocated by the CDO. While the CDO claims most dentists will be better off with this new contract, the prospects for those dentists taking on new patients can be very uncertain, often having to provide an unlimited quantity of work for very little reward.

Lack of trust

The DH’s own prediction of patient-charge revenue in 2006-07 was over-estimated by a £159 million. Research from the BDA has shown that almost half of dentists in the first year of the contract failed to meet their UDA targets. It is this uncertainty which does not provide reassurance to the profession that dentistry can or will provide an unlimited quantity of work for very little reward.

So are younger dentists able to grow older gracefully in this new system or do they have to be forced into independent practice? Do we as a profession mind? And does it matter to the DH? The reduction in certain items of treatment such as root canal therapy or complex laboratory items is surely worrying, for both patients and the profession. If this trend continues, there is a real risk that NHS dentistry will be heading further towards a basic ‘core’ service, rather then promoting excellence in dental care. So if the DH is looking to rebuild burnt bridges between PCTs and dental professionals, it must look with urgency at how it might provide a platform for dentists to practice a range of simple and complex healthcare, while fairly remunerating them for this. Otherwise, our younger dentists may grow old outside of the NHS.

However, as Mark Twain once said: ‘Age is an issue of mind over matter. If you don’t mind, it doesn’t matter’.

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL Eastman Dental Institute and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

Neel Kothari

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**Be inspired!**

Nick Miedzianowski-Sinclair of Surface Imaging Solutions explains how you can draw a clear distinction between what is dental and what is non-dental facial aesthetics and thereby capitalise upon the latent opportunity within your practice.

The focus on this communication is that you can draw a clear distinction between what is dental and what is non-dental facial aesthetics. I have the good fortune to be based in Dentistry 100 (www.dentistry100.co.uk) located in the Barbican EC1 and have picked up on how well patients are informed as to what is being revealed in the x-rays that have been taken. These clearly show to both the patient and the practitioner the underlying problem and the root cause(s). The patient demonstrates their understanding of what has been said in respect to the remedies, costs and expected outcomes and at the end of the appointment both parties leave confident that they have an accord. In many cases the patient then meets with the dental hygienist to attend to oral hygiene and the aesthetic appearance of the teeth and gums resulting in that delicious desire to smile with confidence ‘my teeth look as good as they feel’!

**Example of frontal retracted image**

In facial aesthetics the same relationship and level of mutual understanding must be achieved - we must be able to show what is visible on the surface as well as what is not visible to the naked eye; the reason you have what you have is because of X-Y-Z and so forth establish the facts. In addition acquiring a set of standard facial expressions such as raised eyebrows, frown and smile underpins the causes of dynamic wrinkles as well as the changes in facial tissue volume between the relaxed and smiling face, essential in the treatment planning and outcomes management associated with muscle inhibitors (eg. Botulinum Toxin), and Dermal Fillers. Indeed we must also image the smile window and the retracted frontal, oblique left and right images to assist the hygienist in pointing out some of the issues that he or she will be working on whilst underlining to the patient what their share of the responsibility is if the desired end point is to be achieved. As with good dental care, an annual skin complexion analysis is desirable.

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For more information contact:

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When is two minutes really 56 seconds?

We all know that we should brush our teeth for two minutes a day, but how many of us do? The average is just 56.7 seconds!

Now new technology is here to help in the Oral-B Triumph power toothbrush with SMARTguide, a unique remote control device driven through a chip in the toothbrush handle and by wireless technology. This shows the time spent brushing and incorporates a quad- rant timer for each part of the mouth, provides details of the brushing mode and a visual pressure signal that lights up when too great a force is being exerted.

Recent research showed that the SmartGuide increased the brushing time to an average of 157.4 seconds per brushing compared with manual brush users’ average of just 08.3 seconds. The additional information provided by the visual guide reinforces learning and the trial also showed that the users were more often times more compliant with twice-a-day, two-minute brushing vs. a regular manual toothbrush.

Embrace Multi-disciplinary Care with The Clearstep System

The Clearstep System lets GDPs embrace multidisciplinary care by offering patients comfortable, effective and invisible orthodontic treatment.

Based around 5 key elements – Pre-Alignment, Space Closure, Alignment, Finishing & Detailing and Extras.

With complete support every step of the way from experienced specialists; this fully comprehensive and invisible system covers a wide range of orthodontics.

• Create space with the CODA expansion device;
• Close space with the Clearstep Closing Screw or a sectional fixed approach;
• Align in incremental stages with clear positions;
• Achieve perfect occlusion with elastic mechanics and the Buccal Segment Settling appliance;
• Offer gentle, multiple and precise occlusal refinement with the FORD appliance;
• Make use of Anchorage Reinforcement, Composite Attachments, Bite Opening appliances… and more.

The Clearstep System is convenient and easy to use, and lets you provide patients with exceptional results.

For more information call the ODT Laboratory & Diagnostic Faculty on 01542 557910 or email info@clearstep.co.uk, www.clearstep.co.uk.

iBOND® Self Etch gains best marks in six month in-vivo clinical study

iBOND® Self Etch provides the same or even better results in one-step than etchrinse adhesives, according to the latest findings of a six-month in-vivo mouth study by the Center for Dental Research at the Loma Linda University School of Dentistry in Los Angeles. The Heraeus Kulzer self-etching all-in-one adhesive earned best marks for marginal adaptation, marginal discolouration, surface stain, postoperative sensitivity, retention and secondary caries.

Clinical evaluation

In a clinical split mouth study, the Center for Dental Re-
search at the Loma Linda University School of Dentistry in Los Angeles evaluated the clinical efficacy of iBOND Self Etch in posterior direct composite restorations compared to the longer established adhesive GLIMA® Comfort Bond + Desensitiser.

Best results for iBOND Self Etch

At the six-month follow-up, the restorations bonded with iBOND Self Etch could obtain the best “Alpha” marks for all evaluation criteria, which are prerequisites for an excellent adhesivesystem. No marginal gaps or discolorations had been found nor surface stain or secondary cavities. “A” marks without exception for retention indicate excellent bond strength on enamel and dentine.

For the long term success of implants optimal oral hygiene is needed to ensure the tissues supporting them are kept in good health. Recent research has concluded that for patients with generalised severe chronic periodontitis, close monitoring is needed to prevent both development of peri-implantitis and recurrence of periodontal infection.

Brushing with the proven benefits of Oral-B’s oscillating rotating power brushes helps to ensure maximum effectiveness and efficient plaque removal. For the implant patient, their investment in oral health should encompass the best for ongoing maintenance which can be expressed simply as having the best, in the form of Oral-B’s evidence-based record, to keep the best.

The crucial importance of good oral hygiene cannot be emphasised enough for these patients. In another study significantly increased incidence of peri-implantitis and significantly increased peri-implant marginal bone loss were present in individuals with peri-odontitis-associated tooth loss, emphasising that implants are the start of a whole new oral hygiene habit.

Implants need good maintenance

With the continuing, growing number of implants being reliably placed worldwide, Oral-B power toothbrushes are the ideal adjunct to successful maintenance.

Palodent® Sectional Matrix System

The Palodent BiTine Ring is placed before and during tooth preparation, the spring steel tension gently separates the teeth; this separation provides the required space to easily place a contoured sectional matrix. In addition to the unique spring steel and excellent retention of the Palodent BiTine shape, the Palodent application takes just 50 seconds to complete. This is a huge time saver compared to conventional matrix systems that may require up to 8 minutes of burnishing.

The excellent shape of the Palodent Sectional Matrix System creates natural contours and profiles, unlike the usual flat surfaces and improper contacts achieved using other matrices. The Palodent complete kit includes 5 sizes of matrix bands and the 2 rings, along with Palodent forceps to enable you to start using this product.

For more information on the Palodent Sectional Matrix System or to arrange a free demonstration, please contact DENTSPLY on +44 (0)800 072 5515.

Velopex Colour Diode Laser

The Velopex Colour Diode Laser continues to impress with 5W cutting power at 810nm and a touch sensitive control panel. The new Velopex ‘white’ fibres provide an extremely durable way to cut, with fine detail. The 528 micron fibres are robust enough to give confidence in endodontic procedures, whilst retaining their flexibility. The new Velopex Laser Handpiece ensures ease of movement as well a rigid way of controlling the fibre. All of these advances bring even more reasons why the Velopex brand continues to strengthen.

The Velopex Colour Laser actually contains two lasers: a 10 Watt Gallium Aluminium arsenate (GaAlAs) diode laser and a small laser pointer. The GaAlAs laser is ideal for soft tissue (gum) work – as it does not interact with teeth or bone. It is particularly indicated for both periodontal work – where it can sterilise the pocket killing the bacteria – also for endodontic work where it can sterilise the root canal. 

Great offer available on Kemdent InstrumentSafe.

How does your practice grow?

If magicians, balloons, sunflowers and a garden were something you hadn’t expected to encounter at this year’s Dental Showcase, then you were in for a pleasant surprise. Following their current campaign ‘Growing Your Practice’, DPAS, a leading provider of cost-effective, practice oriented payment plans had the lot.

As more and more clinicians look to convert from NHS and mixed practices to fully private provision, Showcase was a perfect venue for DPAS to explain how their unique offering can help make the transition as smooth as possible.

With practice branding solutions at the heart of their philosophy, visitors to the stand were impressed by DPAS’s long-standing expertise and their offering of cost-effective, customised dental plans designed to suit individual needs.

DPAS are currently running a series of “Grow Your Practice” seminars, offering guidance and advice for practitioners who are considering the move to independent practice.

For more information or to receive a place call 01747 870910, or visit the events page available on www.dpas.co.uk.
Dentaid was recently approached by an organisation in Cambodia requesting the provision of 24 basic sets of dental equipment and instruments and portable chairs for graduating dental nurses from the regional training school, Kampong Cham. The aim is to help the newly qualified dental nurses set up mobile dental health clinics within regional health centres.

As you can see from the images, the need for a proper dental chair is vital to the improvement of the provision of dental care in these rural communities. The portable chair will be an essential asset to newly qualified dental nurses, enabling them to carry out vital dental work anywhere in these needy communities.

The dental nurse was introduced to meet the needs of the rural population of Cambodia in particular, those with little access to medical or dental services. The nurses provide basic medical and dental care to these people who would otherwise be unlikely to receive treatment. They can also identify conditions such as oral cancer and refer them on for further treatment.

The Cambodian Ministry of Health supports the continued training of dental nurses as they are considered a very appropriate and worthwhile asset for these rural areas where dentists are almost non-existent.

The nurses are trained to provide extractions, scaling, anaesthetic and simple Atraumatic Restorative Treatment (ART). This is basic oral healthcare that can be administered without highly technical equipment outside of a traditional dental surgery. ART is perfectly suited for taking into health centres in more rural communities who may not have electricity or running water.

Dentaid has received generous funding of £14,400 for this important project from Dr Neil Sikka of Barbican Dental Care. It is hoped that this will be the start of a long-standing relationship with the training school as there will be nurses graduating each year who require equipment to take out into the community.

To learn more about this project or the Dentaid Portable Dental Chair please contact Nicky at Dentaid on 01794 523146 or nicky@dentaid.org.

Projects like this in Cambodia are vital to realise Dentaid’s aim of reaching the needy around the World and to achieve the basic desire of everyone in dentistry – the relief of pain and improved oral health. We would like your help in carrying out this work.

Dentaid desperately needs general funding gifts to enable it to meet its aim of providing portable equipment to similar projects in the future. Part of Dentaid’s new strategy is working to provide a complete portable dental unit that can be used particularly in rural outreach clinics in needy communities similar to those in Cambodia.

Dentaid needs help with funding to assist with the production of the chair in our workshops and the completion of the portable dental kits to be used alongside the chair. To make a donation please visit the Dentaid website at www.dentaid.org or send a cheque to Dentaid, Giles Lane, Landford, Salisbury, SP5 2BG.

Dentaid in Cambodia
Vital dental equipment is helping newly qualified dental nurses set up mobile health clinics in Cambodia
Hague Dental Supplies offer sales, design and engineering services to the dental industry.

In London, Hague have one of the largest showrooms in the UK, viewings are available by appointment (inc out of hours).

Hague also offer engineering and maintenance service packages on your equipment at agreed intervals to suit your needs. At the depot, in Surrey, Hague stock a huge selection of parts and equipment – in order to get you back up and running fast in an emergency.

Trident Business Centre, 89 Bickersteth Road, Tooting Broadway, London SW17 9SH
020 7400 5003  www.haguedental.com

To place recruitment or Courses/Seminar ads please contact: Joseph Aspis on 020 7400 8969 or email joe@dental-tribuneuk.com
Acid Erosion.
A way forward.

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.

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