Could cigarette packaging go up in smoke?

A UK-wide consultation on whether tobacco should be sold in standardised, or plain packaging, has been launched

The recent consultation concerning the future branding of cigarette packaging has come about in an effort to impact on people’s health and reduce the uptake of smoking.

The consultation suggests for the first time what requirements for standardised packaging could consist of, including no branding, a uniform colour and a standard font and text for any writing on the pack.

The consultation will seek views on whether tobacco packaging should remain unchanged, plain packaging should be adopted, a different option should be considered.

Respondents will also be asked to consider what the specific impact of standardised packaging could be, including whether it could reduce the appeal of tobacco products, increase the effectiveness of health warnings, impact on the tobacco industry and retailers or encourage consumers to buy tobacco products abroad for their own consumption.

There has however already been mixed opinions on health forums and news sites regarding the consultation.

Non-smokers and smokers alike are exclaiming that policies such as this are “incredibly patronising” and some non-smokers are even suggesting that it shows a complete lack of understanding about addictions.

Whilst some people believe that it could have an effect on steering people away from starting the habit, many people believe that the plain packaging policy will have little to no affect whatsoever on younger people; some even believe it will encourage them to start smoking because cigarettes will have that “forbidden factor”.

However, there are some that hope that if the policy does come into effect it will reduce the attraction of cigarettes; but many people remain sceptical. One concern that non-smokers, ex-smokers and smokers alike are raising is how the “plain packet policy” will be “an open invitation” for smugglers and counterfeiters to produce fake cigarettes with harmful substances. Further worries, such as a substantial loss in Tax from cigarette purchases are also concerning members of the public, whilst others believe that the consultation is a waste of Taxpayers’ money. People are even asking why plain packaging would be needed if the cigarettes are hidden from view.

The consultation will be open for responses from 16 April to 10 July. Any person, business or organisation with an interest is encouraged to respond.

To take part in the consultation visit http://consultations.dh.gov.uk.
King’s dental alumni awards announced

Health and Social Care Bill gains royal assent

World Health Day
Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so, don’t hesitate to write to:
The Editor,
Dental Tribune UK Ltd,
4th Floor, Treasure House,
19-21 Hatton Garden,
London, EC1 8BA
Or email: lisa@dentaltribuneuk.com

**Editorial comment**

Today I spent most of the day at the GDC CPD Review Conference. It was a very interesting day, looking at the delivery of CPD and the barriers to accessing quality courses.

The delegate list was filled with practitioners, under- and post-graduate dental Deans, educators, academics, GDC members and commercial providers. Chaired by GDC Chief Executive and Registrar Evlynne Gilvarry, the day took in many aspects of CPD and its relevance to revalidation; both allowing course providers to gain an insight into the potential direction for CPD in the future, and for the GDC to get feedback from stakeholders.

One of the buzzwords from the day was ‘blended learning’ – the use of different teaching modalities to allow for a rounded learning experience. This can use both online and face-to-face methods, with interactivity at the heart of it.

If CPD and revalidation are here to stay, then so is blended learning.

**Denplan withdraws from ROI**

Following its launch in the Republic of Ireland in August 2010, Denplan’s Executive Board has taken the difficult decision to withdraw its presence from this region.

Denplan has been working with a range of member dentists over the last 19 months in order to increase the level of support it can offer to both the dental professionals and their patients - following the Government’s decision to remove state-funded dental provision and reduce the Medical Card provision to children and exempt patients.

However, ongoing interest by the insurance regulators in this region has necessitated a growing investment in legal services to explain Denplan’s product design and cover, which has, in turn, made this market financially unviable. This has been compounded by Denplan’s recent sale to Simplyhealth, which is not yet registered to trade in the Irish Republic.

Denplan’s Managing Director, Steve Gates, commented: “We’re disappointed to be withdrawing from the Republic of Ireland, but I would personally like to thank all of our contacts in the area for the support and business they placed with Denplan and wish them every success in the future.”

“This decision in no way affects our substantial presence in Northern Ireland, which still offers strong opportunities for growth over the coming years, I would also like to reiterate that there will be no job losses as a result of this decision.”

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A round 1,500 cancer pa-
tients a year will benefit
from a cutting-edge can-
cer treatment – Proton Beam Therapy – that will be avail-
able in London and Manches-
ter, Health Secretary Andrew
Lansley announced today.

Up to £250 million will be
invested by the NHS in build-
ing Proton Beam Therapy fa-
cilities at The Christie NHS
Foundation Trust hospital in
Manchester and University
College London Hospitals NHS
Foundation Trust. The Depart-
ment of Health have set aside
public capital for this scheme.

Proton Beam Therapy is a
type of radiotherapy, which
uses a precision high-energy
beam of particles to destroy
cancer cells. The treatment
is particularly suitable for
complex childhood cancers,
increasing success rates and
reducing side-effects, such as
deadness, loss of IQ and sec-
ondary cancers.

Given the complex nature
of the treatment and facilities,
Proton Beam Therapy won’t be
fully available in England until
2017. Until then, the NHS will
continue to fund patients in
need of Proton Beam Therapy
to go abroad – either to Swit-
zerland or the USA. By 2014/15
the NHS will be spending £50
million per year sending up to
400 patients overseas.

Health Secretary, Andrew
Lansley, said: “Developing a
national proton beam thera-
py service is vital to ensuring
our cancer facilities are world
class. We have always said that
it is patient outcomes which
matter, and to get the best for
patients we must always be
looking to push the bounda-
ries.

“In addition to improved
success rates, Proton beam
therapy reduces the side-e-
fects which patients, particu-
larly children, can suffer as a
result of traditional forms of
cancer treatment.

“One this service is in
place, The Christie and UCLH
will begin unparalled cancer
facilities. It will mean more
patients will be able to get this
treatment, including those for
whom travelling abroad for
long periods is not possible.”

Andrew Lansley made a
commitment to the programme
in 2010 when he pledged over
£50 million across the Spend-
ning Review period to allow up
to 400 high priority patients
to be treated abroad while we
developed the business case
to establish a national service
here.

The Department of Health
plans to introduce PBT servic-
s at The Christie and UCLH.
The Department’s assessment
shows this to be affordable
and deliverable in the short
term. The development of the
service will be closely moni-
tored and should further ca-
pacity be needed in the future,
the preferred third site is Uni-
versity Hospitals Birmingham,
subject to normal business
cases processes and the views
of the NHS Commissioning
Board.

Centres selected to host cutting-edge cancer services

Surgeons perform full-
face transplant

S urgeons at the University
of Maryland in Baltimore
have reported the trans-
plantation of an entire face onto
a 57-year-old man.

According to a report, the
surgeons successfully trans-
planted facial tissue to a top-
ner teeth, and upper and lower jaw.
The procedure is considered to
be one of the most extensive
full-face transplant. The pa-
tient Richard Lee Norris from
Hillsville, Virginia, had the face
transplant after gun incident
15 years ago left him severely
disfigured. Richard lost his
lips and his nose, and his jaw-
line was almost completely de-
stroyed. As a result, he was left
with limited movement of the mouth.

It wasn’t until 2005 when
Richard first approached doc-
tors at the university to discuss
surgical options. After a face
was donated by the family of a
deceased anonymous donor,
the extensive and difficult sur-
gery could commence, and was
done conducted in late March by
a multidisciplinary team of more
than 150 medical professionals
and lasted 56 hours. According
to the university, this is the first
time in history that a full-face
transplant has been completed
by a team of plastic and recon-
structive surgeons experienced
in both trauma and dental and
facial reconstruction.

The project was financial-
ly supported by the US Navy,
which hopes to gain better in-
sights into the reconstruction of
wounded faces of returning sold-
iers.

Clarification on licensing for dental surgeries

Surgeons performing copyright music in their surgery do need a PRS for Music licence

According to PRS, clarification
on the requirement for a PRS for Music licence when
playing music in a dental sur-
gery following the decision of European Court of Justice
(“the Court”) on 15 March
2012 in the case of Società
Consoritale Fonografici (SCF) v Marco Del Corso (“the Deci-
sion”).

The Decision concerns the
liability of dentists to pay eq-
suitable remuneration for what
under Italian law is a statu-
tory right to use sound record-
ings by communicating them
to the public. In its Decision,
the Court held that such use
by dentists to patients in public
waiting rooms did not amount
to a “communication to the
public” with regard to this li-
sibility.

The Decision does not af-
fect the requirement for a busi-
ness to hold the correct PRS for
Music licence where they play
or perform PRS for Music rep-
ertoire in public.

The Decision specifically
dealt with the right of produc-
ers and performers to re-
novation for certain uses of
sound recordings, as provided
for under Italian law. PRS for
Music does not administer this
right.

PRS for Music administers,
amongst other rights, the ex-
clusive right conferred on the
copyright owners by UK law, to
perform and to authorise the
performance in public of their
copyright musical works.

Therefore if you intend to
continue playing music in your
medical works in your premises
regardless of the means of
performance, for example by
radio, TV, CD, MP3 or live per-
formance, then you will need a
PRS for Music licence. Under
UK law a performance is re-
garded as taking place ‘in pub-
lic’ if the audience comprises
individuals outside of the com-
poser’s domestic or home cir-
cle.

By not having, or cancel-
ling an existing PRS for Music
licence, you may be liable for
infringement of copyright in
PRS for Music’s repertoire.

In the UK, the owners of
the copyright in commercial sound
recordings enjoy an exclusive
right to play sound recordings
in public. If you intend to con-
tinue playing such recordings
in public in your workplace,
we suggest that you contact
PPI to discuss your require-
ments. www.ppluk.com

*PRS for Music is the trad-
ing name for the Performing
Right Society (PRS). This in-
formation relates to the rights
represented by PRS.
Switch on to new ideas

Speakers:
- Prof Nasser Barghi
- Dr Richard Kahan
- Prof Gianluca Gambarini
- Dr Wyman Chan
- Dr John Moore
- Dr Ajay Kakar
- Ms Jackie Coventry
- Dr Mona Kakar
- Basil Mizrahi
- Fraser McCord
- Mhari Coxon
- Amit Patel
- Anthony Roberts
Campaign for CASPER

Glenny Bridges and Jane Armitage launch the Campaign for Administrative Standards and Professional Education for Receptionists and Practice Managers (CASPER)

In the modern dental profession there is no shortage of Standards and Regulations, or authoritative bodies to assess and comply. The origins of the current legislation date back as far as the Dentist Act 1921, which restricted the practice of dentistry to qualified, registered practitioners, working within ethical standards set by a regulatory body; The Dental Board for the UK, the initial forerunner of the General Dental Council (GDC) establishing how many procedures were required and Clinical Governance was introduced to the Healthcare Sector.

Over the 90 years since the Dentist Act 1921 the health care professions have changed considerably, so too has their relationship with the public. When dentistry was restricted in 1921 the purpose of this legislation was to protect the public. In 2001 following some high profile medical cases, including the Harold Shipman, Alderhay and The Bristol Babies it was clear that to maintain public confidence higher profile measures were required and Clinical Governance was introduced to the Healthcare Sector.

Over the past 10 years the dental profession has introduced a curricular framework to enable members of the dental team to gain registerable qualifications and this has enabled a range of dental professionals to increase the scope of their contribution to patient care. As a result careers in the dental profession have become more prestigious and attractive to a wider range of people with a vocation to work in a caring profession.

Clinically dentistry can claim almost 100 years of ongoing development with excellence as its primary objective. However, when it comes to the non-clinical aspects of dental care there is a massive black hole in terms of training and ongoing development requirements.

The Health and Social Care Act 2005 sets out clear regulations which in turn have been translated by each constituent country of the United Kingdom to local essential standards of quality and safety. Each has appointed inspectors to visit registered practices to assess compliance. If you look really hard you will find training recommendations for Registrants and Managers. But not only do you need to look hard, to find any meaningful education requirements, you also need to use a broad span of interpretation because qualification requirements for Registered Managers are not definitive. Worse still the standard for administrators and receptionists are non-existent; or at least I have not been able to find them.

It is indisputable that the quality of UK dental dentistry is world class. However, nowadays patients demand more at the point of contact. Good quality dentistry, they will not settle for less than an excellent dental experience from the moment they decide to make an appointment on until they complete their treatment.

This is recognised in care quality outcomes. To consistently achieve these outcomes requires a range of quality management skills, such as planning services, auditing performance, creating, implementing and evaluating SMART objectives and gathering feedback on clinical and non-clinical aspects of care. Without formal education these skills will be absent from dental teams’ skills sets, therefore patients’ experiences of quality if their dental experience will suffer.

Jane Armitage is a high profile multi-award winning practice manager. Over recent months she has helped numerous practice managers who are completely out of their depth with the new quality management regulations.

Jane says: “I believe academic training requirements must be introduced on a tiered level in-line with individual managers’ responsibilities. How can a manager’s be expected to run practices without academic training? It is bizarre, how can you lead a team of committed dental professionals without demonstrating the same level of commitment to your own training and ongoing development? We must begin by establishing educational and professional standards and then establishing how many practices are educated to that level. From a quality standard should this be an issue that needs addressing.”

The Campaign for Administrative Standards and Professional Education for Receptionists and Practice Managers (CASPER) has gathered high profile dental professionals who believe that qualifications for practice managers and receptionists are the next logical step in the progression of the dental profession and are urging the GDC and CQC to formalise a non-clinical curricular framework.

Jill Taylor, President of the Association of Dental Administrators and Managers (Formerly the BDPMAs) has added her support to this campaign with the following Statement “I agree that the dental profession needs definitive non-clinical educational CPA standards for dental managers and administrators.”

If you would like to add your voice to ours, simply email us your name and: casper.campaign@gmail.com

“We agree that the dental profession needs definitive non-clinical educational CPA standards for dental managers and administrators”

e-mail us your name and:

casper.campaign@gmail.com

Registration for Showcase 2012 now live!

Delegates are now able to register online for their No.1 dental exhibition, with over 10,000 members of the dental team expected to visit the three-day event, and more than 550 companies exhibiting, presenting the latest products and services that the dental industry has to offer.

Each year the BDTA holds an outstanding show, which is why Dental Showcase continues to be the biggest and best exhibition in the dental calendar. Book your ticket now to ensure that you don’t miss out!

For more information, or to register for your free ticket to BDTA Dental Showcase please visit www.dentalshowcase.com.
Research to target threat caused by sepsis

Twelve new research and development projects that aim to improve the future diagnosis, detection and management of sepsis, a life-threatening illness caused by the body over-reacting to an infection, are to receive government funding totaling £8 million.

The grant funding – from the Technology Strategy Board, the Department of Health, Ministry of Defence, Home Office, Engineering and Physical Sciences Research Council and Medical Research Council – will be matched by funding from the UK companies involved in the projects, bringing the total value of the R&D to more than £15 million.

Iain Gray, Chief Executive of the Technology Strategy Board, said: “There is universal recognition of the need for new and improved diagnostic tools to help in the management of sepsis. The products that will emerge from this important research and development will help to reduce the economic burden, death and illness from sepsis and infectious diseases and create opportunities for UK companies in the huge global market for diagnostic devices.”

The 12 business-led R&D projects will see more than 20 UK companies working collaboratively with more than a dozen universities, research organisations and NHS Foundation Trusts. The funding awards follow successful applications by the consortia to two competitions managed by the Technology Strategy Board.

The Multi-pathogen detection and/or simple discrimination competition sought proposals for projects to develop point-of-care diagnostic tools to assist clinicians and health workers in the management of sepsis, while the Advancing biomarker use in sepsis management competition looked for R&D projects that would advance the effective use of biomarkers in the management of the condition.

The projects will be led by BD Biosciences (Oxford) (2 projects), BioGene (Kimbolton, Cambs), HPA Microbiological Services Porton (Salisbury), Innovate UK Ltd (Birmingham), Magna Parva (Leicester), MAST Group Ltd (Bootle), MicroLab Devices Ltd (Leeds), Mologic Ltd (Sharnbrook, Beds), Randox Laboratories Ltd (Crumlin, Co Antrim), Sepsis Ltd (Liverpool) and Smiths Detection Watford Ltd (Watford). Taking into account the other organisations that make up the twelve consortia, companies and experts from every part of the UK will take part in the research and development activity.

The projects include work that will lead to the development of:

- Point-of-care devices to detect multiple pathogens and antibiotic resistance profiles
- A rapid test (less than three minutes) to detect the presence of bacteria in blood
- Devices capable of detecting pathogens and the host response in a single system in less than 15 minutes
- Biomarker based cellular assays to predict stages of infection and sepsis
- Tests incorporating physical and biological measurements that can be used in multiple settings to detect the early signs of infection and sepsis

The Technology Strategy Board used the Multi-pathogen detection and/or simple discrimination competition to pilot a planned initiative called Design Option, which aims to help businesses think more about design at the start of their research and development project. Through the Design Option initiative, applicants to this competition were offered free access to design mentors while they were in the early stages of developing their project proposals. Five requests for Design Option assistance were received and approved. Three of these were invited to submit full applications and two were ultimately successful in securing offers of grant funding.

The funding programme is part of the Technology Strategy Board-managed Detection and Identification of Infectious Agents (DIIA) Innovation Platform, which is managing a range of government investment in innovative research and development into diagnostic tests and devices that will help to cut the number of deaths and cases of illness caused by infectious agents in humans and animals, while reducing the economic burden.

Celebrate with the AOG

Come and celebrate the AOG’s 30th anniversary this summer, at the Haberdasher’s Aske’s Girls School in Hertford. Enjoy the sun with superb Indian cuisine, wine, beer, soft drinks and plenty of entertainment for the kids including a bouncy castle and an interactive animal zoo.

The event will take place on 8th July 2012 and tickets are available online. Non-AOG members can purchase tickets from the website for £5 per adult and £3 for under-16s, while the special members’ rates are £5 per adult and £1 for under-16s.

The AOG began as a source of social networking for dental professionals, and over the years has become a place for people of all ages to come together and give back to those within dentistry. Open to everyone, the AOG organises events, educational support and charitable trips with the aim of working ‘towards the greater good’.

Help us celebrate our 30 years of success, and enjoy great company and fun for all the family at our BBQ this summer.

For further details on forthcoming trips and events, or to join, visit www.aoguk.org

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The British Dental Conference and Exhibition preview

Dental Tribune previews this year’s Manchester event

The British Dental Conference and Exhibition, to be held in Manchester at the MCCC, is the UK’s largest three-day dental conference and exhibition and is certainly a must-attend event in the dental calendar.

The conference, run by the British Dental Association, hosts a world-class clinical programme of lectures and seminars covering all aspects of dentistry, with leading experts from both the UK and overseas.

The exhibition itself hosts a fantastic array of companies from the dental industry and this year includes an educational exhibition with free seminars featuring a demonstration theatre and training essentials theatre (all of which offers verifiable CPD).

As well as an all-encompassing variety of seminars, lectures and social events, there will also be a number of new features on offer. These include a live Demonstration theatre offering a full three-day programme and the Innovation Zone!

Innovation, innovation, innovation

New for the 2012 Conference is the live Demonstration theatre, which offers a full three-day programme, including the chance to see experts from the UCL Eastman Dental Institute demonstrate on phantom head simulators. Delegates will also be able to learn more about managing dental anxiety and medical emergencies through role-play enactments.

There is also the exhibition’s Innovation zone, where delegates will be able to discover cutting-edge dental technology and the latest innovations in practice improvement. What’s more, the zone will allow delegates to see demonstrations of innovations that are contributing to the future of dentistry (and all whilst gaining 50 minutes of FREE verifiable CPD).

This year delegates will also be encouraged to plan their visit to the exhibition element of the event using an innovative new online bookings system that allows attendees to reserve time with exhibitors.

Conference highlights

The conference is providing a fantastic range of topics, encompassing aesthetics, core CPD, endodontics, general dentistry, oral health, periodontics, career development and practice management.

Thursday’s highlights

11.45 - 12.30 - Capability of the 21st century mind

Susan Greenfield CBE discusses the human brain, at the Motivational keynote session: Capability of the 21st century mind.

Here Susan will discuss how the human brain is exquisitely evolved to adapt to the environment and question that as the screen culture of the 21st century is changing in unprecedented ways, will the next generation therefore think and feel in a totally new way?

1.45 - Infection control: Fighting the tide of communicable disease and avoiding infection – experiences from the cruise industry

This session, by Kate Bunyan, Medical Director, Carnival UK (Cunard and P&O), will take a look at where, how and why the cruise industry manages decontamination, cross-contamination, water safety and environmental pathogens.

Friday’s highlights

10.00 - Developments in dentistry for the UK | Session for young dentists: What is the future of clinical dentistry?

This session will discuss the future of clinical dentistry, and enable the audience to consider whether clinical dentistry is viable.

1.30 - Volunteering - you only get what you give!

This session will be looking at the ways in which responsible volunteering and partnership with Bridge2Aid can add value to your practice, your team, your reputation, and your personal development whilst making a sustainable difference to the oral health needs of developing nations.

Saturday’s highlights

09.00 - 10.00 - Session 1: How to achieve aesthetic results with conservative treatments (direct and indirect) and 10.45 - 12.00 - Session 2: How to achieve aesthetic results with prosthetic treatments on both natural teeth and on implants

Professor of Restorative Dentistry Lorenzo Vanini will be providing lectures on how to blend function and aesthetics in every clinical situation.

1.50 - Fast smiles for the GDP – exploring ‘quick fix’ orthodontic treatments

Ross Hobson, Specialist Orthodontist, discusses orthodontics and how many GDPs have been enticed by the apparent simplifying of the mysteries associated with braces. His presentation will examine the various brace options and how to understand what is good and bad orthodontics.

Social events

Along with its fantastic conference programme, The British Dental Conference and Exhibition is also famous for its social events!

On Thursday the entertainment begins at 1800 at the Central Hall with the exhibition hall drinks reception as the BDA hosts a get together to celebrate the opening day of the event!

On Friday there is the Friday Night Party, held at the Palace Hotel, Manchester, where you will be able to enjoy a free drink and sample a spiced infused hufret which will be cooked in front of you by the Palace’s experienced chefs. With this year’s entertainment provided by Killer Queen, Europe’s number one Queen Tribute band it’s an event not to be missed!

The Golden Age of Hollywood will also be making an appearance on Friday at the now SOLD OUT FD Ball.

Finally, on Saturday evening, the BDA will be hosting a black-tie Gala dinner. Held at the Hilton Deansgate Hotel, Manchester, the event is the perfect way to end the conference in style, with drinks at the pre-dinner reception and a chance to relax with friends and colleagues over a three-course meal.

For more information about the British Dental Conference and Exhibition, got to http://conference.bda.org or call the BDA on 0870 166 6652.
The Queen’s Diamond Jubilee...do you know the drill?

A four day weekend lies ahead to mark the Queen’s Diamond Jubilee – or does it? NASDAL, the National Association for Specialist Dental Accountants and Lawyers, is advising dental team members not to be too jubilant until they are sure that they really are entitled to the additional holiday.

The Spring Bank Holiday has been moved to Monday 4th June and there is an additional Bank Holiday on Tuesday 5th June to mark the 60th year of Queen Elizabeth II’s reign. But 5th June could be just another day in the practice.

In the same debate that surrounded last year’s Royal wedding, the tabloids have already stepped up the campaign for employers to grant their staff the day off to celebrate, but in many cases, employers are being advised that they are not obliged to do so.

Amanda Maskery, a Lawyer and a member of NASDAL, has shed some light on the matter. It is a common misconception, she said, that employees are entitled to time off work for bank holidays. Usually, employees are simply entitled to the statutory minimum number of holidays, currently 5.6 weeks (or 28 days) a year.

She suggests that the starting point is to look at the contract of employment for guidance. Where the contract states that an employee is entitled to public holidays in addition to their annual leave, but neither the number nor the specific dates are referred to, they will be entitled to an additional day’s holiday. That said, if the employer has the contractual right to grant a day off in lieu of a bank holiday, an employee may still be required to work on 5th June, and their extra day’s holiday can be postponed.

Where the contract specifies a total number of days’ holiday that includes bank holidays, or where it states either the number or the specific bank holidays that may be taken, then the employee will not be entitled to an additional day’s holiday.

Amanda has warned that employers should also consider their custom and practice when taking a decision on whether to grant an extra day off. She adds: “Employers should be aware that their employees may have an implied right to the extra holiday by virtue of the employer previously granting time off in similar circumstances. Given that the situation does not arise very often, the likelihood is small, but in the shadow of the Royal Wedding, there is clearly the potential for a custom and practice argument.”

Amanda suggests that employers would be wise to consider any potential staffing issues now and consult their employees’ contracts of employment, together with holiday policies, so their staff know whether or not they will have a four day weekend.

- Amanda Maskery of Simpsons LLP can be contacted on 0191 226 7838 or to find a member of NASDAL in your area, go to http://www.nasdal.org.uk/

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About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Sawston, Cambridge as a principal dentist at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at UCL’s Eastman Dental Institute.
Looking towards the future

In the fourth and final part of this interview, Neel Kothari talks to Susie Sanderson about the amalgam issue and her thoughts on the future of dentistry.

NK: A recent WHO report recommended the phase down of the use of amalgam in dentistry. What impact will this have on the profession?

SS: I know quite a lot about this, because I chair the working group of Council of European Dentists. This issue has been going on for a very, very long time, but started for the Council of European Dentists with the European mercury strategy, back in 2006.

The mercury strategy doesn’t just cover dentistry, it covers the whole use of mercury in Europe and the aims were to reduce environmental impact, reduce use where it could be substituted with something else, replaced with alternative materials, right across the board. So for example the chlor-alkali industry and batteries, gold mining, etc.

We did a huge amount of work to review the literature and evidence on the health issues of dental amalgam. At that point the health risks were not seen to be significant and, as things currently stand, as a result the Commission has virtually parked health anxieties about dental amalgam. But it did find, through the work of its Scientific Committee, there was very little evidence about the environmental impact and how it would be mitigated if there was a difficulty. So that was around 2006 and they said they would review the mercury strategy about now, and that’s exactly what they are doing.

Bio Intelligence Services is carrying out a big piece of work on behalf of the Commission at the moment looking at the life cycle of dental amalgam. All the way through the interim five years we’ve discussed with the Commission that really the only way you can look at dental amalgam is through the life cycle of how you track where it is, who’s using it, what they’re doing with it, how they’re disposing of it.

At the same time we’ve monitored European dentists’ approach to dealing with the environmental load, and we’ve watched the improvement monitored. Dentists are largely seen in Europe as being hugely responsible about their use of dental amalgam. They also understand the Council of European Dentists’ stance that dental amalgam should remain as part of a dentist’s ‘armoury’ in combatting oral disease and that the choice of materials to be used should be a clinical decision in discussion with the patient and consented by the patient after a proper evaluation of the risks and advantages. So the ideal is that it remains as an available material for as long as it’s needed, because there is no equivalent substitute.

Dental amalgam has qualities which none of the other materials that we currently have at our disposal satisfy in the same way. None of them (and it is mercury globally, not just dentistry again). Dentistry is high profile once more because, like compliance in any other area, we’re really easy to circumscribe and pick off in terms of enforcement of change.

For a regulatory authority, it’s really easy to control mercury in dentistry – you just say, don’t use it any more. Now if you say to the chlor-alkali industry or the Chinese power station industry, stop using anything that’s got mercury in it, they’ll go ‘we can’t, the whole industry would fall apart – we can’t do it’. So then dentistry is a very easy target.

However the World Health Organisation document has been published. It is a report of a consensus seminar with all the world’s experts present and it proposes that a “phase down” would be the best way forward. We acknowledge that actually it would be useful if we could get to a situation where we weren’t contributing to the global mercury environmental load, but until there is something that we can use as effectively, in the circumstances I have just described, it has to be a phase down. A phase down is over, say 20-25 years might give an opportunity for research to produce a substitute material. Until we have that, we can’t lose amalgam.

NK: That’s the difficulty, isn’t it?

SS: Absolutely. So we’re talking about the destabilising of health services. What we’re fighting for is a new contract which will give dentists the time to do what’s right.

So, ‘phase down’. The terminology is really important. A ‘phase out’ we could probably entertain if it was 50 or 50 years, because by that time we might have a proper substitute material. A ‘phase down’ over the next 20-25 years is probably acceptable. The Department of Health will say that the use of dental amalgam is dropping significantly and that in 20 years we probably won’t be using that much of it anyway. But during that ‘phase down’ time, the investment governments have to invest properly in implementing genuine prevention.

So all in all there’s a massive piece of diplomatic and scientific work going on. It’s unlike a swan paddling like anything underneath while we’re trying not to create panic. Apart from anything else, the minute you start talking about amalgam in public all the anti-amalgamists emerge and create smoke screens about the real issues. So we keep it low key in public, but it takes huge resources here, in this building, to be dealing with it.

NK: Now that you’re in your final six months as chair of the BDA, what do you consider are your proudest achievements and what do you see as priorities for dentistry in the future?
SS: I came into the job at the time of the new contract. I started in the February before the new contract was imposed on the 1st of April, so almost simultaneously. I think that my biggest achievement has been to make sure that at every stage we challenged the fact that it wasn’t fit for purpose and that successfully that challenge was understood, listened to and that we’ve achieved, in political terms, a turn-around of intention, to reform really quite swiftly.

So I think I’m extraordinarily proud of that. I gave evidence to the Health Select Committee and I’m proud of having done that successfully and been treated with respect and had an influence there, as well as the huge amount of teamwork that went behind it.

I’m very keen that in the future we’re never divided and ruled and I suppose that if I have a message, it’s to keep on trying to make sure that the profession works as one.

And I also consider that, as far as we possibly can, getting the profession to work together has also been something that I’m proud of.

I’m very keen that in the future we’re never divided and ruled and I suppose that if I have any messages for my successor, it’s to keep on trying to make sure that the profession works as one and it doesn’t expose itself through fighting and internal bickering. It’s hugely counter-productive and we need to make sure we present a unified front.

I hope that in the way we continue to affect health, that we continue to improve it and that we’re seen as significant players in the improvement of health of the nation as well.

So, whilst I don’t think dentistry will ever be properly integrated into the NHS perse, because we’re a primary care sector of what is primarily a secondary care business, I think that I’ve been treated as a profession with respect and credibility is hugely important and I hope that what I’ve done over the six years is to facilitate that and to move that on.

At all times I think what I’ve tried to do is to promote the integrity of the profession and I hope that I’ve been an ambassador for that.

NK: I think you have.

SS: Thank you very much.

The disposal of amalgam is one of the issues that has come up in recent discussions.
Important Facebook changes impact your business page

Rita Zamora outlines the most important changes and how they can affect your practice

As of March 30, 2012 drastic changes were seen on all Facebook business pages. In addition to the visible changes Facebook’s new timeline design brought to page walls, there are also many unseen modifications that are important to note.

One of the most important changes to note is the removal of the prominent “recommend this place” option. I’ve touted this as one of the most powerful ways to actively promote your practice on Facebook. If you never saw this option, it used to be located in the upper right hand corner of your page. It was a place where recommendations (testimonials) lived. If you had lots of recommendations, take comfort in knowing that each of those recommendations likely resulted in dozens or hundreds of pieces of word of mouth being shared on Facebook about your practice.

From here forward Facebook has yet to decide if they will continue to feature recommendations in a separate box or not. Regardless, you will get the same ability to automatically feature testimonials or comments from patients in a box labeled “recent posts by others”, which is essentially similar to the recommendation box, except it’s labeled and positioned differently... It will still provide benefit in messaging that will be published to the poster’s Facebook friends when they post a testimonial or comment on your page wall. Again, the benefits are the same; it’s simply an adjustment on the layout and wording.

Remember inviting patients to share their likes, comments, recommendations or thoughts on your business page is still the most powerful way to actively market your practice on Facebook.

A second change, and perhaps the most welcome of enhancements, will be the addition of what Facebook calls ‘Inviting patients to share their likes, comments, recommendations or thoughts on your business page is still the most powerful way to market your practice on Facebook’.

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“Tiers of administrator” controls. Facebook claims this new option should become available soon. The new option should allow you to designate “ownership” of your page, as well as allow for limited access, or controls, for other administrators. This option is one of the most valuable upgrades as it will finally allow practice owners to protect their pages. This means you will no longer have to worry that a disgruntled employee could steal or delete your page.

Facebook has also introduced a new message option for pages. This means that your patients or followers may now contact you in a private manner, using this message feature. Notifications about any new messages will appear in the right-hand section of your admin panel. The admin panel will appear automatically when administrators land on their Facebook pages... As long as you actively manage and monitor your Facebook page, I recommend you allow this new messaging.

Only time will tell if potential new patients or existing patients will find this a preferred method of communication. We are all aware of the growing popularity of society’s desire to type rather than talk these days. However, if the thought of allowing messages via Facebook is unappealing to you, you have the option to hide this feature from visitors.

To hide the “message” button from your page wall, click on edit page, and then click on “manager permissions” and you will find a box to uncheck the option under “messages”.

A fourth, and not-so-welcome, change is the fact you can no longer generally set custom applications as landing pages. However, if you place an advert on Facebook, you will still be able to choose exactly where people will land and what they can expect to see when they get there. In the months to come I’m sure many people will begin exploring new solutions to try and regain their beloved landing page opportunities.

Whether you like the new Facebook changes or not, the one thing we can count on is that there will continue to be more change. Facebook claims this recent set of “enhancements” are in effort to further align with their mission, which is: “To give people the power to share and make the world more open and connected”. It is best to keep this mission in mind when setting goals for your practice Facebook marketing.

The world of business, and dental practices, is becoming more and more transparent and connected. One way you and your practice can win in this new world is to commit to being open and connected with your patients and community. Be sincere and authentic in your patient care and in your Facebook communication. In turn your Facebook marketing efforts and the relationships you build via your Facebook community will continue to benefit you.

Facebook has introduced a new message option for pages. This means that your patients or followers may now contact you in a private manner.

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About the author

Rita Zamora is an international social media marketing consultant and speaker. She and her team actively co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email rita@ritazamora.com.

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Recently, I received a letter from my former mobile phone service provider—a large international company. The letter was in response to my terminating my contract (just beyond the 24-month contract period). I did so because I moved house and found the signal strength in the area I moved to inadequate.

There was a small amount owing on my account (£14.77). The letter explained, in what can best be described as terse language, that if I didn’t pay this within 14 days they might register my account as a bad debt with a credit reference agency and instruct a ‘Debt Collection Agency’ (this being more important than a debt collection agency, you understand) to collect the payment on their behalf, with 15 per cent added to the amount outstanding. Rather sweetly(!) the letter ended by thanking me for my custom.

Until I received the letter, I’d had nothing to complain about with this service provider. I’d even visited their local store to see if there was an alternative to my switching providers—the assistant was unhelpful, to say the least.

So, what’s the point of this little story? It’s that while first impressions are important, final impressions are the ones we retain. And you can guess what my final impression of this company is!

There’s a learning point here for dealing with complaints from patients. How each patient’s complaint is dealt with and resolved will determine the lasting impression. You may be the best practice on the planet with the world’s loveliest staff but if the resolution of a complaint leaves a patient dissatisfied, their lasting impression (and the one they’ll convey to family and friends) will be negative.

Before we consider how to avoid this, I should point out that I’m discussing non-clinical complaints. Clinical complaints, as we all know, should be dealt with in accordance with GDC guidelines.

Now, I can imagine some of you reading this are smugly thinking: “But we never get complaints”. Well, here’s some statistics I learned at last year’s BDA Conference. Only four per cent of dissatisfied patients actually complain—the other 96 per cent just go elsewhere. If a complaint is resolved, seven out of 10 patients will stay and if it’s resolved quickly that figure rises to nine out of 10.

Most complaints are received by your front of house

Jacqui Goss suggests productive ways to handle complaints

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Not because they’re poor performers necessarily but because they’re the ones who answer telephone calls and meet patients in the reception area. They should, of course, listen politely and try to gather (and note down) as much information as possible about a patient’s complaint. Should they then, as a matter of procedure, refer the complaint to the practice manager? I say not. If you give your FoH team the scope to resolve complaints and, most importantly, to offer compensation when they deem it appropriate, you’ll stand the best chance of retaining the patient.

There can be no generic rules as to which complaints FoH staff in dental practices should deal with. I suggest you discuss the matter with your team and devise some ground rules particular to your practice that suits the confidence and experience of your FoH staff. You may decide that FoH staff should deal with complaints arising from mistakes they have made (such as mix ups with appointments) and with clerical errors (getting a patient’s name or address wrong, for example). They should surely not, however, deal with complaints about them – such as alleged rudeness – since these ought to be referred to the practice manager. Resolving a complaint or dispute at the reception point doesn’t mean it gets forgotten about – they should all be reported to the practice manager. From the point of view of running a patient-centred practice, the manager needs to know if mistakes are being made repeatedly and causing complaints or, indeed, if particular patients are ‘always’ disputing things.

The question of compensation is a tricky one. While you don’t want to be giving products or services away willy-nilly, there’s little doubt in my mind that the lasting impression will be positive if the complainer takes away something tangible. And it’s this positive impression that they’re most likely to convey to friends and family.

Hopefully, you will have picked up some oral hygiene products cheaply at dental shows or you will have purchased some end-of-line stock from your supplier. These are the sorts of items FoH staff can offer as recompense in face-to-face situations. The person complaining receives, say, an electric toothbrush worth £25 yet your financial loss is considerably less and will be more than made up for by retaining the patient.

For complaints made by telephone, I’ve found that the offer of a free appointment with a hygienist (“Which usually costs £xx”) is often regarded as acceptable recompense.

If the complaint is of such a nature that it needs to be handled by the practice manager, the FoH team still has a vital role to play. Often in this situation, the practice manager will need to do some investigation and maybe confer with the principal dentist or practice owner. They may need to interview other members of the team. This invariably means the patient will be told that someone will telephone them. Do ask the patient what time would be convenient and make sure the call takes place at that time. If the matter is still unresolved by the agreed time, make the call any way. It gives a much more positive impression to telephone at the arranged time and explain that further investigation is required than to leave the patient in the dark.

My final tip when dealing with complaints is to never say “No”. Someone making a complaint is sure to resent having what they consider a reasonable request flatly denied.

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**About the author**

A proven manager of change and driver of dramatic business growth, Jacqui Goss is the managing partner of Yes!RESULTS. By using Yes!RESULTS dental practices see an increase in treatment plan take-up, improved patient satisfaction and more appointments resulting from general enquiries. Yes!RESULTS turns good practices into great practices.

Jacqui’s complaints policy is: No complaints, no complaints.

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Atraumatic extractions with Luxator Periotome
Dr Simon Jones discusses why he prefers using Luxators for extractions

The extraction of a tooth is probably the most traumatic event a patient can experience in the dental surgery, and if the extraction doesn’t go smoothly, things can become quite stressful for the dentist too! When the use of a simple surgical instrument can make the extraction process infinitely easier for both patient and dentist, I find it surprising that not all dentists reach for a Directa Dental Luxator as their first instrument of choice.

To understand how best to remove a tooth, it helps to appreciate the structures and forces that are holding the tooth in position. It is only by overcoming these forces that the tooth can be removed.

First to consider is the bone structure surrounding the roots. As the bone sits intimately against the root surface, any irregularities, undercutts or curvatures of the root will provide mechanical retention. To overcome this retention the socket must be dilated until the path of removal of the root is unimpeded by bone.

The second factor resisting the removal of the tooth is the periodontal ligament, composed of collagen fibres.

Like millions of little guy ropes, the cumulative strength of these fibres resist the strongest of biting forces. Imagine how much force would be required to overcome their combined strength in an attempt to simply pull out a tooth.
The third force to be overcome is that of atmospheric pressure. Withdrawing a tooth from its socket will create a void or vacuum at the apex of the socket, and until this void is filled with blood or the ingress of air, then atmospheric pressure will effectively push on the tooth to keep it in position. Anyone who can remember back to the Magdeburg Hemisphere experiment in school physics will know that simple atmospheric pressure resisted the force of two teams of horses pulling in opposite directions.

Little wonder then that simply using a combination of forceps and brute force can lead to unnecessary loss of alveolar bone, root fracture, and a subsequently more stressful and stress-free process.

The Luxator should be introduced around as much of the circumference of the root as possible to evenly dilate the socket. Once this has been achieved, then the final delivery of the tooth using a Luxator, if it is felt that greater dilating and elevation forces are required then the stronger Luxator Forte should be used. The Forte is easily recognizable by its black handle (Fig 4). This sequence of luxation followed by elevation generally means that forceps are only ever used for the final easy delivery of the tooth.

The Swedish dental company Directa not only invented the name ‘Luxator’, but have developed this range of instruments to perfection. The use of high-grade surgical steel blades and a two-part moulding technique for the uniquely ergonomic polymer handle combine to provide a high-quality instrument that will give years of reliable service, and endure countless cycles of dishwasher disinfecting and autoclaving.

Having used Luxators for more than 20 years, I cannot imagine undertaking the extraction of any tooth without first severing the periodontal fibres with my trusty friend. It would be the equivalent of struggling to remove my boots without first undoing the laces.

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There were various reasons why porcelain veneers were requested, but one of the most common was crowding in the anterior segment. Frequently this involved people who had worn fixed orthodontics as teenagers, but relapse had set in and a quick fix was requested and, a lot of the time, guess what was carried out... yes, veneers. Even in a recession, there still remains the substantial demand for cosmetic dentistry.

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IPR is best carried out using Brasseler VisionFlex metal perforated polishing strips in the following sequence (depending on space required and if needed): Yellow (Extra fine, 15µ), Red (Fine, 50µ) and Blue (Medium, 15µ). You must always go back the other way and finish off with the extra fine yellow strip to ensure a smooth enamel surface. A fluoride mouthwash is also recommended.

The patient was reviewed every two-three weeks, depending on progress, and 15 weeks later he was delighted with the result. The patient was given the option of bonding to level the incisal edges off but he was happy to accept the final result as it was. The composite attachments were polished off and a wire retainer fitted. A 0.5mm Emax style clear retainer was made to fit over the wire retainer. This acts as a good back up in case the wire comes away, however the patient is instructed to wear this every night for the initial three months, reducing this to every other night and then once a week after the first year.

There has been much debate about whether ‘simple’ orthodontics can or should be carried out by GDPs. In my view, the key word here is ‘simple’. We are not reorganising the occlusal scheme, we are not moving molars and we are not extracting teeth. In fact, I see no downside to providing this treatment. Whether the Inman Aligner is used as a standalone treatment, before whitening, bonding or even veneers, one thing is for sure, it simplifies treatment and allows minimal preparation or no preparation at all. Not offering tooth alignment, in my opinion, verges on negligence. It is not a question of ‘should we be providing this treatment option?’ We must provide it.

So is the Inman Aligner the Real Deal? It sure is.

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**About the author**

Steve J Robson, BA (Hons) Dental Hygiene, Clinical Services Director, has been involved in the field of cosmetic dentistry for many years. He has attended many courses and keeps up to date with the very latest techniques, attends courses both national and internationally and is a Fellow of the British Academy of Cosmetic Dentistry. He has written for many of the dental journals and has presented at many conferences. He is a member of the London Dental Education Centre and has presented courses at the London Dental Show and Dental Update.

Steve is a member of the Dental Development Group and the Inman Aligner Advisory Board. He is a member of the British Academy of Cosmetic Dentistry and has written and lectured extensively on all aspects of cosmetic dentistry.
Back to basics – keep it simple works....but technology is nice too

Mhari Coxon discusses technology and innovation

It is so easy to get caught up in new innovation and technology. I love shiny things and am drawn to them. And, innovation makes ours and our patients lives much easier. But the mistake we often make is to start to drop the basic staple fundamentals of prevention. This can lead to our patients becoming un-healthy again and, in worst case scenario, have active dental disease.

When we have been working in the same practice for a long time, it can be hard to change or add to your clinical work, as patients have become familiar with how it works just now. Once we have established the rhythm of our appointments it can be difficult to add to or change our clinical behaviour.

Bringing it back to basics

I lectured recently at Dentistry Show 2012 and talked about implementing change in your clinical day. One of the examples I used was re-introducing disclosing patients to better assess their oral hygiene. Periodontists hardly ever use it as a tool and so can often forget to reinforce its importance in general practice.

Many of us found this boring and messy and if enough patients complained, and we forgot the benefit of it; we tended to drop it as a tool pretty quickly after qualifying. The trouble is if it has been a few years without this basic, how do you explain to patients that you are reintroducing it and that their oral hygiene needs to be better? What do you say when they ask why you haven’t ever done this before?

‘Once we have established the rhythm of our appointments it can be difficult to add to or change our clinical behaviour’

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toolkit and how we have to be evidence based. Neither of these bodies will be bothered and you have your excuse for change.

Prepare the patient for the change. If you write or call to confirm their appointment, explain that this time we will be using a special dye that will show us how we can help you to clean better at home and act as a road map so we can clean your mouth really well. Impress them that it will all come off before they leave the surgery. Giving the patient notice of the change will reduce the negative response you can get with no prior warning.

Delegating to an enthusiastic team member for best results

I love to disclose my patients. It makes me happy that they care about what the outcome will be. I like that entire families compete with each other to do the disclosing and digital photographs of this is one of the dental nursing team. They can even provide the oral hygiene advice to the patient in a non clinical environment. This can make it much easier for the patient to listen, relax and respond to advice. The digital photographs act as a record of oral hygiene advice being given and can be sent to the patient be email to help them remember where to brush. My friend Fiona, who has recently re-established her love of disclosing, goes one step further and films the patient using the correct product and technique on the areas they need to concentrate on their own phone. Then they can play it back at home to reinforce the new routine.

There is an app for that

There is a fantastic app to complement this that really is simple, back to basics combined with technology. It is called brush DJ and was the brainchild of dentist Ben Underwood. It selects tunes from your phone or iPad and plays them with a circular timer on screen to help you brush for two minutes. It also helps you to remember to floss, not spit out and use a fluoride mouthwash. You can set your appointments with your dentist and hygienist in it and it will even remind you when it is time to get a new toothbrush head. For more information and to download the free app visit www.brushdj.com/

So go back to basics, mixed with a bit of technology and see your patient’s enthusiasm grow and see their health improve.

About the author

Mhari has 20 years experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London. From Chairing the London BSDHT for 3 years, and working as an MD, Mhari excels at motivating and co-ordinating a team and utilising skills, decentralising leadership and developing self efficacy in members. Throughout her career Mhari has developed hygiene protocols and plans in practices which have continued to be used with great success. Mhari is Clinical Director for CPDforDCP Ltd, a training company offering motivational and interactive development courses to the dental team. A keen writer, Mhari is on the Publications Committee of Dental Health, the British Society of Hygienists and Therapists (BSDHT) Journal, has a conversational column in Dental Tribune and writes articles for many other publications and online sites. As a speaker Mhari has presented regionally, nationally and internationally for many groups including Talking Points for Doctors, British Orthodontic Society Specialist group, the BSDHT, Dental Show, the International Symposium of Dental Hygiene, the dentistry show and many others. In 2006 she was the Probe Awards hygienist of the year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the UK.
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Mentoring in learning
Fiona Ellwood explores the role of the mentor

You may have thought that mentoring was predominately there to offer support, advice and guidance when things go wrong. Of course current thoughts are a far cry from this. As part of the BADN team, it has become increasingly evident that the more contemporary approach towards mentoring is key to our agents of change and supporting others in their learning journey.

“Mentoring can be defined as a relationship between two people with learning and development as its’ purpose.” Brockbank 63

Historical dimension
Mentoring is far from a new phenomenon, indirect links to mentoring have been associated with Plato and Socrates as far back as 347BC. However, the word mentor first appears in literature in the Homeric narrative “The Odyssey” some 5,000 years ago. The narrative asserts that Odyssey left son in the capable hands of his entrusted friend Mentor asking him to teach him everything he knew, whilst he went to the Trojan Wars. This however, provides a misconception that the mentor is older, wiser and by virtue more experienced. Evidence shows that over the last 50 years mentoring has grown in popularity, in Government, industry, education, the medical profession and more recently the dental arena.

With the rapidly changing landscape for dental care professionals (DCPs), there has never been a better time to explore this role and look at how it can be contextualised not only within a given career trajectory, but in a learning setting. DCPs now have the opportunity to undertake additional duties and make full use of professional development plans, when planning career pathways. This has come about as an indirect result of statutory registration and a greater public awareness of the sector.

What is mentoring?
Mentoring is a dyadic professional learning relationship which, enables and facilitates individuals to take charge of their development and realise their potential.1 The mentoring relationship helps individuals to review the here and now, to explore short term goals, shaping and influencing their future.

There are two approaches to mentoring, the Gestalt approach and the Humanistic approach, which are portrayed through either the traditional mode of mentoring or the contemporary mode of mentoring. The traditional mode of mentoring can often be a mode that has a power imbalance and is based on the mentors’ experience, rather than the needs of the individual. The contemporary mode of mentoring does not require the mentor to be older, wiser and more experienced, but can indeed be a fellow work colleague or friend; a peer mentor. This is because the contemporary mode of mentoring is accepting of the humanistic approach, whereby the individual is placed at the centre of the mentoring relationship; this is known as the person-centred approach.2 This approach asserts that the individual is the resourceful one, not the mentor; the mentor merely enables and facilitates in the professional relationship.

What attributes and traits do you need to become a mentor?
Becoming a mentor requires you to have an ownership and understanding of certain aspects of human behaviour and the reasoning behind it, in order to fulfil your role. The attributes that a mentor should ideally have are outlined within the three key concepts of mentoring as: Unconditional positive regard, Congruence and Empathetic understanding.3 If we unpick these concepts the attributes and traits that would be unveiled are:
• Empathy
• Good communicator
• Good listener
• Congruence
• Good facilitator
• Encourages creativity/flexibility
• Trustworthiness
• Honest
• Social/emotional intelligence

Quite often these skills are a natural occurrence and merely need to be developed or enhanced and by working on these skills and embedding them within the relationship, you are able to create the right environment for that agent of change, which is so often missing. What often happens over a period of time is that the dynamics of the relationship shift from the mentor working with the individual, to the individual taking the lead and the mentor playing a much lesser part as the individual grows.

Being an effective mentor
It is imperative that a mentor recognises their own strengths and weaknesses and knows their limitations, not only of self, but from an ethical stance. The European Mentoring Code of Practice states, Councils have produced a document, which outlines the code of ethics for those in the mentoring field.2 In line with Pokora and Conner2 have outlined nine key principles that underpin the effective practice of being a mentor at work:

1. The learning relationship is at the heart of change
2. The context is work
3. The individual sets the agenda and is resourceful
4. The _mentor facilitates learning and development
5. The outcome is change
6. The framework for change provides movement and direction
7. The skills develop insight, release potential and deliver results
8. The qualities of the _mentor affirm, enable and sustain the individual
9. Ethical Practice safeguards and enhances mentoring

Of course not all mentors work from an ethical stance and can be disabling or toxic either intentionally or unintentionally. They have a tendency to be destructive and limiting to the individuals learning and developmental processes. Toxic mentors are those who are often unavailable or inaccessible, undermine and criticise those whom they are helping and on occasion lead individuals into new situations and then withdraw their support.

Models of mentoring
There are many models of mentoring that can be applied to given situations, individuals and organisations and can be adapted to other approaches:
• Egan Skilled Helper Mode®
• G.R.O.W Model®
• Cyclical Mentoring Model®
• Double Matrix Model®

This list is far from exhaustive and models can also be used interchangeably to suit the situation, after all, the model is merely a framework, an underlying structure and not something that is central to the mentoring relationship. Indeed Egan 2010 reminds us that we should beware of the man of one book.4 This concept is evident in the mentoring course that has been developed at FGDP(UK), which is primarily associated with the person-centred approach, and champions both the Skilled Helper Mode® and the G.R.O.W Model®, which have been integrated and further developed to form the Y.U.G.R.O.W D® Model®. Through personal expe-
The benefits of mentoring

The benefits of mentoring are far reaching not only for the individual, but for the mentor alike. From experience the benefits for the individual are namely motivational and a greater sense of self-awareness and self-efficacy, the development and enhancement of skill sets and underpinning knowledge. In addition to this individuals have shown an ability to recognise and assist with problem solving situations. As a mentor the benefits to me have been: greater job satisfaction, an opportunity to develop professional relationships and interpersonal skills, I have been able to give greater consideration to my reflective practice and felt a sense of personal satisfaction through supporting the development of others.

How can mentoring be applied to learning?

As DCps embark on post registration qualifications and additional duty programs, it is crucial we understand how the notion of mentoring can facilitate their learning, whether they are enrolled on external courses or undertaking in-house training most learners will need a mentor, if they are to reach their full potential and reap the rewards of success.

Mentoring and learning are closely aligned and together considered to be a learning process. Often our previous experience influences our future behaviour in learning. Bandura (1977) asserts that “...individuals often avoid situations they believe exceed their capabilities.” By helping to develop self-efficacy in the learner, the learner is more likely to be motivated and want to succeed. If we apply the person-centred approach of mentoring to the learning environment, it may be possible to support learners in moving them from single loop learning to instrumental learning, whereby they learn something new, in order to enable and facilitate others in their professional learning journey. This is an exciting and fluid arena for DCps, which will benefit greatly from mentoring schemes, but we must not overlook the need to master these skills in order to do least harm and most good.

There is a need for those engaging in professional mentoring to have an understanding of some of the mentoring concepts, in order to enable and facilitate others in their professional learning journey. This is an exciting and fluid arena for DCps, which will benefit greatly from mentoring schemes, but we must not overlook the need to master these skills in order to do least harm and most good.

References


About the author

Fiona Ellwood BSc (Univ. of Greenwich), FRADN, LGSD, Cert OBE, FETC 1 & 2, NVD IV & Assessor. Member of IGD, NIDPG, IVA, Associate member FGDG (AI). BADM. She has been involved in helping dental nurses reach their full potential for many years. During this time she has developed successful training courses in the Midlands for the National Diploma, an Oral Health Education Certificate Programme and more recently a distance learning programme. She is a former examiner for both the National Certificate, the Diploma and Oral Health Education Certificate. She is presently undertaking a BA (Hons) in Education Studies and more recently became the director of education for The Dental Business Academy and works along side Integrated Dental Holdings. Her opportunities to undertake mentoring are immense; becoming a member of the Mentoring Development Team at FGDP (UK) has armed her with some very powerful tools and changed the way in which she practices her mentoring skills.
Who said private practices weren’t selling?

I

exist a lot of practices and also do a lot of seminars with den-

ists and commonly I come across a number of what I can only define as myths about the buying and selling of dental prac-
tices so I thought I’d restore some confidence in the private principal that ultimately their business does hold a good value and in my opinion will do for some time!

There is no secret that when it comes to buying and selling NHS dental practices they are proverbial hotcakes but I believe this has led many to believe that private practices aren’t selling which simply isn’t the case. So, let’s get the facts straight:

1. Proportionally, they don’t sell for the same prices – This is true depending what measure you use for valuation. If you are valuing in EBITDA terms there is a difference of 28% between the valuations. Eg, an NHS Practice in Cambridge with a £400k turnover would likely collect 5.4xEBITDA. As similarly sized and located private practice would probably be nearer to 4.3xEBITDA. Although if you are using turnover as a measure of practice value this is often misleading as if the private practice is managed efficiently could actually be more profitable, see my article What the EBIT? (DT UK Vol.5 No.11)

2. There is a direct relationship between risk and price – If the practice is an implant referral practice where there is a reliance on external referrals and the average spend per patient head is higher then this will value for a lower multiple than a practice with a large maintenance plan contingent where a lot of income is paid to the practice on a monthly basis by direct debit and the cash flow is more predictable.

3. The more confidence you can give a purchaser, the better the deal will be – a lot of this does of course rely of the abilities of your broker but I do notice a big difference between how a private practice is received to market if the vendor is nearer to 65 than 45. Equally if the vendor is happy to stay on for a period to ensure a smooth transition then this does undoubtedly give the proposed purchaser a confidence to move ahead with the acquisition if the Status Quo can be maintained beyond sale for at least enough time for the core attendees to come along to their check-up under the new management.

I also thought it may be helpful to qualify these findings with an outline of three recent practices which have both a deal and finance agreed to give you an indicator on what is actually being achieved for private practices in the market place.

Deal One – South-East – 100% private
T/Over – £1.15m, Agreed Price £1.1m

A very young business in South-East England which offered the purchaser a steady low-price private business from which profitability could easily be improved and the turnover grown over a period of time. Vendor agreed to remain in post for six months beyond completion.

Deal Two – South-Coast – 100% private
T/Over – £1.26m, Agreed Price £1.20m

A reasonably mature dental business where the Principal had begun working less and therefore the turnover had been declining. There was circa 70 patients registered to a Dental Plan but otherwise the practice was all fee per item. Marketed by two other known dental agents for six months but a deal struck by Dental Elite within three weeks. The vendor took a lower offer in order to have a guaranteed associate post for at least one year working one day a week.

Deal Three – East – 70% private
T/Over – £1.15m, Agreed Price £1.1m

A mature business with little room for growth where there was some NHS but this was largely performed by NHS associates as opposed to all dentists working on a mixed basis. Just over £10k per calendar month in income from a dental plan but otherwise the private income was fee per item. The principal has by choice agreed to remain in post for 12 months beyond completion. This practice could have got a higher price and was valued for more but the vendor chose to sell to an elite buyer on a reasonably closed market and made this decision based on the personality and ethics of the buyer.

Similarly, all of these deals are being financed by different banks so it is equally untrue that all the banks want is NHS. If a purchaser can put together a sound proposition both for maintaining and growing the proposed target then if the CV of the dentist is right they will lend just as easily on private practice as to NHS!

If you are considering buying or selling a dental practice, come and see me at Stand A32 at the BDA Conference or call me on 01788 545900.

About the author

Luke Moore
Director – Dental Elite
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Dental Elite are a Practice Sales & Recruitment Agency with a nationwide remit. We offer all Principal Dentists a complimentary on-site practice healthcheck with no strings. The healthcheck includes a valuation of the practice and a report detailing the basis for this valuation and some suggestions how this could be improved.
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For more information about Denplan, please go to www.denplan.co.uk or call us on 0800 401 402.

Dr Linda Greenwall: A Major Influence in Dentistry

The British Dental Blushing Society would like to congratulate Dr Linda Greenwall, Chair of the BDSL for achieving recognition in the annual Dentistry Top 50 poll.

Voted for by the readers of Dentistry magazine, Dr Linda Greenwall successfully reached number 12 in the publication’s top 50 most influential people in UK dentistry. Last year, she fulfilled her lifelong dream of establishing a dental charity that will empower people to take charge of their oral health. Dr Greenwall’s desire for achieving recognition in the annual Dentistry Top 50 poll.

Takera Belmont: Stand C36

Takera Belmont’s portfolio of Treatment Centres helps you to provide better dentistry. The flexibility of their range will be demonstrated at this year’s BDA Conference, highlighting the very broad range of aesthetic and ergonomics features, backed up by extended extended warranty offerings of total peace-of-mind.

Takera Belmont Treatment Centres are designed to please everyone, including your patients. Left handed practitioners might opt for the C36 (Factory Fitted Aesthetic Centres), which offers a range of different modules. Surgeons with limited space will benefit from the small footprint of the C36 II whilst treating the elderly and children can appreciate the easy access afforded by its knee break chair, not to mention the ease of communication facilitated by having your patient upright during a consultation. Various options are also available within the range, including continental red, cabinet or mobile cart options. A choice of electric versions is available on the C36 and C38.

Business of dentistry (BoD) is a fantastic new online service designed to give you all the business support you need to grow your practice.

Developed specifically for the dental market, it offers an extensive comprehensive package of products and services with exclusive discounts on services.

Of particular interest is the free guidance and support information and support, including a dedicated online service that can be accessed at any time of the day and on any device.

Go to www.businessofdentistry.com to register your details for free or become a member of BoD to access generous discounts and exclusive services. To find out more go to www.businessofdentistry.com
ELGA Process Water, a Veolia Water Solutions & Technologies company, is proud to announce the launch of its online loyalty programme for UK customers. ELGA Process Water, a Veolia Water Solutions & Technologies company, is proud to announce the launch of its online loyalty programme for UK customers.

Points can be used against all purchases including special offers. Registering for your FREE account is quick and easy. As part of the launch, all new customers who register for an account in May will receive 100 points. Points can be used against all purchases including special offer.

New training collaboration between UMD Professional Ltd and award-winning Menagerie Theatres

UMD Professional has announced the launch of an online training collaboration with Menagerie Theatres, a specialist team of performing artists. The first, ‘Exceptional leaders – outstanding teams: what’s your story?’ has been designed as a unique journey through leadership and teamwork to help dental practices to achieve more of what they set out to do. The course is facilitated by Croydon-based professional team and actor/director Paul Bourne who is also a visiting fellow at the Universities of Cambridge (Judge Business School), Moscow, and the Stockholm School of Economics. The unique and innovative approach uses theatre and the arts to challenge and explore communication and to offer new insights into how to get the best from your team. Paul Stuart-Wilson, Director of UMD Professional said: ‘Many dentists spend time and effort in developing ideas about where their teams and practices want to go and what they want to achieve, only to see those ideas disappear in the reality of day to day practice in practice. We’re delighted to be working with Paul, an exceptional trainer and actor, and to have developed this course to help dentists and their teams to achieve more. We’re very keen to help dentists to unleash the untapped potential of their teams and themselves. It’s fun, relevant and different, but above all, it’s practical. The first course is called 'Dentists in London in June. For more information about the course please contact Penny Pery at UMD Professional on 020 3235 2070 or e-mail penny@umdprofessional.co.uk.

TePe Angle® is the latest addition to the popular range of innovative interdental products, which include the TePe Interdental Brushes and the TePe Scalers. The innovation of Oral-B Pro-Expert toothpaste lies in the synergy of the active ingredients: Vitamin A, fluoride, sodium fluosilicate and two active ingredients: Vitamin A, fluoride, sodium fluosilicate and two active ingredients.

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Jubilee fever hits Grahame Gardner

To mark the auspicious occasion of the Jubilee of Queen Elizabeth II, Grahame Gardner have launched a new threeelleb – embellished with the Union Jack in antenatal and post-natal settings and is a reminder of the benefits babies bring to our health, confidence and lifestyle.

The site clearly explains the process of All-on-4 in layman’s terms and measures patients with before and after images and video testimonials. They are also reminded of the benefits that fixed teeth bring to their health, confidence and lifestyle.

Deadlines to enrol for professional enhancement at the world leading UCL Eastman Dental Institute: June 2012 deadline for outstanding educational opportunities

To find a toothpaste to complement their super-hard adult power toothbrush, the ‘Triumph with SmartGuide’. Last year, after many years of research, they launched their ‘Pro-Expert’ toothpaste. This all-in-one formulation protects against gum problems, plaque, caries, calculus formation, dental hypersensitivity, cleaning and bad breath and is supported by 12 years of clinical development and over 70 research papers.

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Diamond Carve is mainly used for Class 1 and Class 2 restorations together with metal cameo. It does not adhere to tooth, core build-up, amalgam repair and the cementing of posts in root canal treatments. It is available in seven shades. The site, together with extensive clinical testing, proves the consistency of Diamond Carve, its durability and ease of use, makes this the perfect aesthetic: alternative to amalgam.

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