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 effect whatsoever on younger people; some even believe it will encourage them to start smoking.

However, there are some that believe that the 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.
Health and Social Care Bill gains royal assent

The Health and Social Care Bill recently gained Royal Assent to become the Health and Social Care Act (2012).

The core principles of the Act mean that doctors and nurses will be able to tailor services for their patients, more choice will be given to patients over how they are treated, and bureaucracy in the NHS will be reduced.

The Act aims to:
• Devolve power to front-line doctors and nurses. Health professionals will be free to design and tailor local health services for their patients
• Drive up quality: Patients will benefit from a renewed focus on improving quality and outcomes
• Ensure a focus on integration: There will be strong duties on the health service to promote integration of services
• Strengthen public health: Giving responsibility for local public health services to local authorities will ensure that they are able to pull together the work done by the NHS, social care, housing, environmental health, leisure and transport services
• Give patients more information and choice: Patients will have greater information on how the NHS is performing and the range of providers they can choose for their healthcare. And they will have a stronger voice through Healthwatch England and local Healthwatch
• Strengthen local democratic involvement: Power will shift from Whitehall to town hall – there will be at least one locally elected councillor and a representative of Healthwatch on every Health and Wellbeing Board, to influence and challenge commissioning decisions and promote integrated health and care
• Reduce bureaucracy: Two layers of management – Primary Care Trusts and Strategic Health Authorities - will be removed through the Act, saving £4.5 billion over the lifetime of this Parliament, with every penny being reinvested in patient care

Andrew Lansley, the Health Secretary, said: "The Health and Social Care Act will deliver more power to clinicians, it will put patients at the heart of the NHS, and it will reduce the costs of bureaucracy.

“We now have an opportunity to secure clinical leadership to deliver improving quality and outcomes; better results for patients is our objective.”

Professor Steve Field, chair of the NHS Future Forum, said: “It was a tremendous privilege to be able to chair the Independent NHS Future Forum. All the comments and debate that we heard helped improve the Bill.”

The implementation of the Act will now enable clinical leaders, patients’ representatives and local government to take new and leading roles in shaping more effective services.

World Health Day

World Health Day was celebrated on the 7th April, marking the anniversary of the founding of the World Health Organisation in 1948. World Health Day is a global campaign, inviting everyone – from global leaders to the public in all countries – to focus on a single health challenge with global impact – the focus this year being Ageing and Health.

World Health Day 2012 focused on how good health can add life to years, enabling older men and women to not only live longer, but also to extend their active involvement in society. Ageing concerns each and every one of us – whether young or old, male or female, rich or poor – no matter where we live.

Before the end of this century, the world will have more older people than children. People are living longer and life expectancy continues to improve around the globe, but living longer is just one of the key to ensuring that older people remain healthy, energetic and involved in their communities and society as a whole.

As the world’s population continues to age, social and economic implications of an ageing population will need to be addressed. Evidence suggests that moderate physical activity can help to improve and prolong mobility in the elderly, yet as age increases, physical activity often decreases. This sort of decline in activity levels is more pronounced in women, low-income groups and in persons with low education levels.

Education and awareness are therefore key as well as adequate provision of age-friendly, community-based exercise and recreation facilities as well as improved access to basic primary health care. But perhaps the most important role for government and community leadership bodies lies in acknowledging the value of older people and the contributions they make to family and community life.

Although it is never too late to adopt a healthy lifestyle, starting early will make sure that your later years are not only long, but also healthy. Studies show that children’s arteries start showing atherosclerosis from as early as two years of age, which means the effects begin in utero. Whatever age your regular exercise is crucial, so don’t delay.
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.

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.”

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 Evelyn 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.

DT

Denplan with-

draws from

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Surgeons perform full-face transplant

S urgeons at the University of Maryland in Baltimore have reported the transplantation of an entire face ont o a 57-year-old man.

According to a report, the surgeons successfully transplanted facial bones, a tongue, teeth, and upper and lower jaw.

The procedure is considered to be the world’s most extensive full-face transplant. The patient Richard Lee Norris from Hillsville, Virginia, had the face transplant after a gun incident 15 years ago left him severely disfigured. Richard lost his lips and his nose, and his jaw-line was almost completely destroyed. As a result, he was left with limited movement of the mouth.

It wasn’t until 2005 when Richard first approached doctors at the university to discuss surgical options. After a face was donated by the family of a deceased anonymous donor, the extensive and difficult surgery could commence, and was 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 reconstructive surgeons experienced in both trauma and dental and facial reconstruction.

The project was financially supported by the US Navy, which hopes to gain better insights into the reconstruction of the wounded faces of returning soldiers.

Clarification on licensing for dental surgeries

I f you’re a dentist performing copyright music in your surgery, it has been announced that you need aPRS for Music licence.

According to PRS, clarification on the requirement for aPRS for Music licence when playing music in a dental surgery following the decision of European Court of Justice (“the Court”) on 15 March 2012 in the case of Società Consortile Fonografici (SCF) v Marco Del Corso (“the Decision”).

The Decision concerns the liability of dentists to pay suitable remuneration for what under Italian law is a statutory right to use sound recordings 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 liability.

The Decision does not affect the requirement for a business to hold the correct PRS for Music licence where they play or performPRS for Music repertoire in public.

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

PRS for Music administrators, amongst other rights, the exclusive 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 your music in your premises regardless of the means of performance, for example by radio, TV, CD, MP3 or live performance, then you will need aPRS for Music licence. Under UK law a performance is regarded as taking place ‘in public’ if the audience comprises individuals outside of the composer’s domestic or home circle.

By not having, or canceling 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 continue playing such recordings in public in your workplace, we suggest that you contact PPL to discuss your requirements. www.ppluk.com

*PRS for Music is the trading name for the Performing Right Society (PRS). This information relates to the rights represented by PRS.
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Dr John Moore
Dr Ajay Kakar
Ms Jackie Coventry
Dr Mona Kakar
Basil Mizrahi
Fraser McCord
Mhari Coxon
Amit Patel
Anthony Roberts

EARLY BOOKING DISCOUNT
Glenys 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 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 Registered 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 Clinical dentistry is world class. However, nowadays patients demand more than what dentistry, they will not settle for less than an excellent dental experience from the moment they decide to make an appointment 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.

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 professional education requirements.

The Dental Showcases are the UK’s 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 BDTRA 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 BDTRA Dental Showcase please visit www.dentalshowcase.com.

Campaign for CASPER

Jane says: “I believe academic training requirements must be introduced on a tiered level in-line with individual managers’ responsibilities. How can 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 standards and then establishing 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.

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 BDTRA) has added her support to this campaign with the following Statement “I agree that the dental profession needs definitive non-clinical educational and CPD standards for dental managers and administrators.”

If you would like to add your voice to ours, simply email us your name and:

“I agree that the dental profession needs definitive non-clinical educational and CPD standards for dental managers and administrators.”

to: casper.campaign@gmail.com

Registration for Showcase 2012 now live!

Delegates are now able to register online for their ticket to BDTRA Dental Showcase, which takes place at Excel London from 4-6 October 2012. Registration is free and can be completed easily online at www.dentalshowcase.com and you will instantly receive your e-ticket.

Dental Showcase is the UK’s 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.

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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 grant funding totalling £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 12 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 (Sharpham, Beds), Random 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 (DIA) 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 Herts. 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 £15 an adult and £5 for children under 16, while the special members’ rates are £5 per adult and £1 for under-16s.

The AOG began as a source of 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.
The British Dental Conference and Exhibition preview

Dental Tribune previews this year’s Manchester event

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?

14:45 - 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 is a session not to be missed, as The Earl Howe addresses developments in dentistry for the UK.

13:00 - 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 ofdeveloping 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.

15:00 - Fast smiles for the GDP - exploring ‘quick fix’ orthodontic treatments

Russ 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 huf- fet 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 re-lax 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 06535
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/
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.

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 are as cheap, long lasting, durable and malleable, and most importantly, usable in circumstances that are less than ideal.

In the meantime the United Nations Environment Programme also decided it needed to look at mercury globally 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 to 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 like 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.

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 a message 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 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.

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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

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

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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.

‘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’
“ 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-welcomed, change is the fact you can no longer 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.
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...
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 anyway. 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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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, undercuts 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 periodontal ligament between the crestal bone and the root. Once in the periodontal ligament the Luxator is worked down the length of the root with a side to side rocking motion and steady axial pressure (Fig 2). This motion firstly severs the periodontal fibres, then as the blade is introduced further, the socket is dilated to allow an easier path of removal. Finally, as the periodontal ligament is severed and the socket dilated, bleeding and air ingress overcome the vacuum that resists tooth removal.

The Luxator should be inserted 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 disinfection 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."

**Fig 3 Correct handling of Luxator Periotome**

**Fig 4 Luxator Periotome vs. Luxator Forte**

**Fig 5 An atraumatic extraction is performed**

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**‘The careful and considered use of a Luxator helps the dentists to divide and conquer the forces retaining a tooth’**

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**About the author**

Dr. Simon P. Jones is a leading UK dentist with a practice in Middlesbrough, north east of England. He qualified in 1985 and has worked mainly in the British NHS since then. For the past six years he also served as a Vocational Trainer for the Northern deanery of Newcastle University Dental School.

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The Luxator Extraction Instruments were invented by a Swedish dentist to make extractions as trauma free as possible. He developed subtleties in the design only a practising dentist would appreciate with an acclaimed and ergonomic handle design. For this reason our Luxator instruments are discernably different.
The Inman Aligner...fact or fiction?

Dr Dominique Kanaan, certified Inman Aligner dentist, shares her experience of the Inman Aligner and gives some handy hints to facilitate success

How many patients have you had step into your clinic and say that they would like to improve their smile as they are going for a new job or are getting married soon... probably quite a few. It's also likely that you've had just as many who want to improve their smile for no specific reason at all, other than they've always wanted to. Nothing wrong with that you might say... but at what cost?

10 years ago, I worked full time at Dentics' flagship Cosmetic Dental Clinic (formerly Ora) at the world famous Selfridges department store in London. Although it was thought that all we did was tooth whitening, we actually carried out many smile makeovers as well as general dentistry. At the time, we were inundated with requests for various forms of smile enhancements. Is it any surprise when the public are faced with celebrities on the big screen, small screen and in various glossy (and not so glossy) magazines with perfectly white teeth and that infamous ‘Hollywood Smile’? In those days, there was no recession and smile makeovers were the order of the day... every day! Of course I didn't carry this out on everyone that asked for it, but the WANT was there and the requests flooded in.

Although I believe that tooth whitening can be considered as a scalpel-free face-lift, porcelain veneers are definitely not - and that includes the thin or prepless variety.

Back then, adult orthodontics was not what it is today. Lingual braces were in their infancy and in the realm of the very few specialist orthodontists that had the skill and the will to carry out this innovative but tricky treatment.

There were various reasons why porcelain veneers were requested, but one of the most common in my experience 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.

Having heard a lot about the ‘three-month wonder brace’ Inman Aligner, I thought to myself, could this really be as simple as it sounds and could this also be the answer to what I had always wanted in my Dentics days... a fairly quick fix to the same old problem of...
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It may be tempting to carry out IPR in the region of most crowding, in this case LL1. However, if IPR had been carried out mesial and distal to the LL1, this would have created ledges, poor contact areas, a far from ideal contour and final result. It is important to remember the ‘Domino Effect’ with these cases. IPR in this case is done remote to the site of most imbrications or crowding.

IPR is best carried out using Brasseler VisionFlex metal preformed polishing strips in the following sequence (depending on space required and if needed): Yellow (Extra fine, 15µ), Red (Fine, 50µ) and Blue (Medium, 45µ). 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 Easix 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 stand-alone 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.

About the author

Dr Dominic Kanaan achieved a Diploma in Hypnosis and most recently she has become a Licentiate of the Faculty of Homeopathy. She enjoys all aspects of dentistry but, after working in a leading为广大客户提供了优质的口腔服务。她对正畸学、美学学、牙科治疗学等所有领域都有涉猎。她对牙齿美白、牙齿矫正、冠桥修复等都有深入的研究。她还与牙科及美学牙科领域的专家合作，不断提升自己的专业技能，致力于提供最优质的口腔服务。
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 exam-

Blame someone else and prepare the patient for the change

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

Delegate 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 their own phone. Then they can play it back at home to reinforce the new routine.

There is an app for that

I find one of the best people 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.

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About the author

Mhari has 20 years experience in dentistry, working as a nurse, receptionist, oral health adviser 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 5 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 CPDoDental, 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, Dietetic, International Symposium of Dental Hygiene, the dentistry show and many others. In 2000 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 Odysseus 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 duties2 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 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 need of the individual. The contemporary mode of mentoring does not require the mentor to be older, wiser and more experienced, but rather 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 coined within the three key concepts of mentoring as: Unconditional positive regard, Congruence and Empathetic understanding.2 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
- Trustworthy
- 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 and Coaching Council have produced a document, which outlines the code of ethics for those in the mentoring field3. In line with Pockora and Connor6, they 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.

Applications are invited for a hospital based “certificate” year course (one day a month) starting on 7th November 2012.

This unbiased multi system clinical course in its 20th year is designed to teach practitioners how to incorporate implant treatment to their practices safely with the back up of three most documented implant systems according to the FGDP/GDC Training Guidelines: Astra, Nobel Biocare and ITI/Stromann, the market leaders in implantology for their unique indications, predictability, research and documentation, are taught step-by-step during the year course. Each participant will have the opportunity to place implants in their patients under supervision. The course has been granted approval by the FGDP (UK) for accreditation towards its Career Pathway.4

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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 loop9 instrumental learning, whereby they learn something new, to double loop10 self-efficacy in changing societal learning schemes, but we must not overlook the need to master these skills in order to do least harm and most good.

References

Who said private practices weren’t selling?

I have a lot of practices and also do a lot of seminars with dentists and commonly I come across a number of what I can only define as myths about the buying and selling of dental practices so I thought I’d restore some confidence in the private principal that ultimately their business does hold a good value 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 30% between the valuations. E.g., 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 EBITDA? (DTUK 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 the 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 per cent Private
T/Over – c£1.35m, Agreed Price £1.15m

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 per cent Private
T/Over – c£260k, Agreed Price £200k

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 per cent Private
T/Over – c£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
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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 on how this could be improved.
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The courses will be taught by Dr. Armin Nedjat, an experienced Dental Implantology specialist. He has placed and restored more than 20,000 implants.

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Contact Ross Hobsbawn on 01772 241600 or email r.hobsbawn@elga.com for further information.

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