**Dental Tribune**  
The World’s Dental Newspaper • United Kingdom Edition

### News in Brief

**Number of patients seen by NHS dentists increases**  
According to a new quarterly report looking into NHS dental activity, almost one million dentists in England have had check-ups compared to the same period five years ago. A total of 29.1 million patients were seen and given a dental examination in the last two years—967,000 more than the baseline figure in March 2006. The figures show that 56.2 per cent of the population is being seen by a NHS dentist, exceeding the standard level of 55.8 per cent for the very first time. The report also revealed a 100,000 decrease on the previous year in Courses of Treatment (CoTs) with an estimated 9.4 million in the last quarter; the largest decrease was seen in North East, which saw a provisional drop of over five per cent.

**Dentsply buys Astra Tech**  
According to a report from Reuters, U.S. company Dentsply International has brought AstraZeneca’s dental implants and medical devices unit Astra Tech for £1.1 billion, securing themselves another section of the dental market. Dentsply’s revenue will now increase by approximately a quarter after it bought off bids from rival private equity firms and medical technology groups, strengthening its position in the dental market. Last year the Swedish-based company Astra Tech had a revenue of $555 million, ranking itself as the world’s third-largest dental implants maker after Straumann and Nobel Biocare. As one report stated, for AstraZeneca, this change reinforces its role as a “pure play” pharmaceuticals company at a time when many rivals are diversifying.

**Otzi the Iceman**  
20 years ago Otzi the Iceman, the 5,300-year-old mummy, was discovered encased in ice in the Italian Alps; but even though he had a full set of teeth reports said that they were in bad shape. Recently at the World Congress on Mummy Studies in San Diego new findings from CT scans were presented revealing that the man suffered from advanced dental problems, specifically caries and other forms of decay. The figure show that 56.2 per cent of the population is being seen by a NHS dentist, exceeding the standard level of 55.8 per cent for the very first time. The report also revealed a 100,000 decrease on the previous year in Courses of Treatment (CoTs) with an estimated 9.4 million in the last quarter; the largest decrease was seen in North East, which saw a provisional drop of over five per cent.

**Contamination threat Dental mills create risk for patients**  
A recent study published in the Journal of Dental Research has revealed that some dental milling machines are contaminated with bacteria. The study found that 20% of the machines tested had detectable levels of bacteria, including Staphylococcus aureus and Escherichia coli. The study also found that the contamination was highest in the first batch of samples, which had been used for the longest time. These results suggest that dental mills may be a source of infection for patients who receive implants made on these machines.

**Myth busting Alum Bees discusses the wheel of life**  
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**The brace debate Deborah Lyle discusses the threat of infection**  
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**The scope goat Dave Martin looks at direct access**  
At European level, plans are in motion to put proposals forward to amend the regulations surrounding tooth whitening in the European Parliament. According to Chief Dental Officer for England Dr Barry Cockcroft, there has been a meeting between the Department of Health, the Department of Business, Innovation and Skills (BIS) and the Medicines and Healthcare products Regulatory Agency (MHRA) to look at the situation. This has initiated ‘internal procedures’ to write a proposal to amend the regulations at EU level. According to Dr Cockcroft, this is ‘an opportunity to sort this situation out properly in Europe.’

The timelines for this are short; the proposal is due to be published in a few weeks before going to the European Commission for progression to the European Parliament. Unlike previous unsuccessful attempts to change the law by going through the Cosmetics Directive, this approach is seen to be more favourable as there is support in the Commission for amendments to the regulations.

### White at the end of the tunnel

Trading Standards Essex ‘support’ in-surgery tooth whitening: CDO announces regulation amendment proposals to be sent to EU Parliament

The confusion surrounding the issue of tooth whitening could be nearing an end as situations both at home and in Europe see major developments.

In a meeting of the British Dental Bleaching Society, Dental Director’s Sales and Marketing Director Mike Volk read out part of a letter received from Essex Trading Standards by the company over the issue of supplying teeth bleaching products (Dental Tribune Vol 5, No. 15 pg 10):

"As outlined during our conversation on Friday, this Service has no issue with peroxide-based whiteners > 0.1% supplied to GDC-registered dentists for use in the course of a professional whitening service conducted by a registrant. It is the view of this Service that such treatments should be regulated by the GDC. Provided your business takes reasonable steps to restrict supplies of such whiteners to registrants, making it clear that the product is only for use in surgery (ie not for supply as an over-the-counter take-home cosmetic product for consumers), then the view of this Service is that there is no need for any trading standards action.

This Service is in agreement with the view of dental professionals and organisations such as the BDA that the safest place for cosmetic teeth whitening to take place is in the care of registered dental professionals, and that it is not in the public interest for action to be taken to restrict the supply to dentists of the necessary raw materials and whitening kits to make this possible."

In view of this statement, Dental Directory has announced that it has reinstated the sale of chairside whitening kits with immediate effect. Mr Volk stated: “I would like to think that as a result of our campaign, at last common sense has prevailed and Trading Standards now recognise and have put into writing that, in their opinion, registered dental professionals are the only professional group who should offer Tooth Whitening procedures.”

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The process to appoint a new Council member to the General Dental Council is underway. The GDC is looking for a dental professional to join the Council which is made up of 12 lay and 12 registrant members. Candidates from all registrant groups can apply.

The recruitment will be carried out by the Appointments Commission which is independent of the GDC. The campaign opens the week commencing Monday 27 June and finishes at midday on Thursday 28 July. During this time, further information can be found on www.appointments.org.uk.

To be successful in this role, you will be committed to protecting patients and the public, able to demonstrate sound judgement, grasp complex information and be an effective communicator. You will also enjoy working as part of a team with the GDC executive in the achievement of high performance standards.

The GDC aims to confirm an appointment by September.

Could the deadline be extended for GPs?

After the CQC revealed that it was struggling due to a lack of resources, a consultation document has been published to set out plans to defer GP registration. Currently, the deadline for GP registration with the CQC is April 2012; however, the document proposes that the deadline be extended to April 2013. If the extension goes ahead, it will mean that GP leaders will be able to raise the funding for the proposed £1,000 fee that practices will face.

However, for out-of-hours providers or providers of NHS walk-in centres, the 2012 deadline will remain the same.

CQC chief executive Cynthia Bower was also quoted as saying: “The aim of the delay is to try to improve the process for GPs, to give the Commission more opportunity to embed compliance monitoring in the sectors we already regulate, and to ensure registration is more closely aligned with accreditation schemes.”

GPC negotiator Dr Richard Vautrey welcomed the delay. “It will give practices breathing space,” he was quoted as saying.

Dr John Canning, chairman of the GPC contracts and performance subcommittee, was quoted as saying that he believed the consultation could signal changes to the scope of registration.

However, as far as has been reported, the CQC have not revealed any plans to alter the scope of registration.
Editorial comment

Dentistry seems to be a profession that loves challenges. Nothing ever seems to be easy, in fact it seems that often the profession goes out of its way to make life difficult for itself!

Take tooth whitening as an example. For a procedure that is so straightforward and so beneficial, ‘Bad Nashers’ goes viral

A new viral video campaign has been developed by leading change agency ICE alongside NHS Coventry to help students look good on the dance floor by using their local NHS dentist.

The music-video ‘Bad Nashers’ is aimed at young people and students in an effort to encourage them to visit NHS dentists. It features the talents of ‘Lady Godiva’ – a cross between Coventry’s local heroine, Lady Godiva, and Lady Gaga and has been described as a tongue-in-cheek campaign.

The video for Bad Nashers follows Lady Godiva in her pursuit of perfect pearly whites across the social minefield of a night out in a student union bar. It’s being distributed via Facebook, Twitter, and email direct to 10,000 students – as part of the mission for the black-toothed pop diva to achieve web stardom.

Aaron Garside, Director of Social Change at ICE said: “It’s for the black-toothed pop diva to help students look good on the dance floor by using their local NHS dentist. The ‘Bad Nashers’ campaign aims to break down some of the myths around NHS dentists, and helping more young people to realise that achieving that perfect smile doesn’t have to be expensive or painful!”

“This tongue in cheek approach aims to break down some of the myths around NHS dentists,” adds Kerrie Woods, Senior commissioning manager at NHS Coventry.

The video can be seen on Lady Godiva’s website www.covnhs.nhs.uk/badnashers.

You can also find out more about Lady Go’ Diva at facebook.com/LadieGoDiva and twitter.com/LadieGoDiva.

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With Pro-Argin™ Technology, you can finally provide instant and lasting relief from dentine hypersensitivity using the Colgate® Sensitive Pro-Relief™ Treatment Programme:

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Instant relief achieved with direct application of toothpaste massaged on sensitive tooth for 1 minute and continued relief with subsequent twice-daily brushing

Visit www.colgateprofessional.co.uk to learn more about how instant relief from dentine hypersensitivity can benefit your patients.
Bill revisions tread sensible line, says BDA

The government’s response to the future forum report on the health and social care Bill appears to tread a sensible line but requires more detailed analysis, the BDA has said. The response does not deviate from BDA-supported plans for dental commissioning, while appearing to address some of the areas of the Bill about which the BDA has expressed concerns.

The government’s response restates its intention for the NHS Commissioning Board, the body that will take charge of commissioning dental care, to take on its full responsibilities from April 2015, as originally envisaged.

The BDA supports this transfer of responsibility.

Amendments are, though, proposed in a number of areas in which the BDA has expressed anxieties or sought further detail. The importance of professional input, something which the BDA’s lobbying activities have emphasised, is reflected in a proposed strengthening of the duty of commissioners to secure professional advice. The BDA’s call for effective local input into the planning of care is also reflected in the amendments.

The role of Monitor, and the lack of clarity about whether the organisation will licence dental providers, has not been resolved by the amendments, although it has now been made clear that Monitor’s role is being reformed. A specific commitment has also been given that Monitor will not open up competition by requiring providers to access its facilities to another provider, a measure the BDA has campaigned against because of its possible implications for practice ownership.

BDA calls for clarity about the place and role of dental public health are also addressed by the amendments, which stress the importance of public health input and promise that Public Health England will be established as an executive agency of the Department of Health rather than within it. The BDA believes the body should be given NHS agency status.

Another key area of concern for the BDA, arrangements for dental education, is also addressed by today’s announcement, which guarantees a safe transition for the system during which deanships will continue to oversee training of junior doctors and dentists.

Dr Susie Sanderson, Chair of the BDA’s Executive Board, said: “While there’s more analysis to be done in order to understand properly the implications of today’s announcement, we are pleased to see that the central thrust of these reforms for dentistry, the move to national commissioning, has not been abandoned. The BDA supports this transition. We are also pleased to see that some of the areas about which we have expressed concern, for example, professional input, the place of dental public health, dental education and the role of Monitor, have been reconsidered. We will look carefully at these amendments, seek clarity on their implications and continue to lobby to ensure that the revised Bill delivers new arrangements for dentistry that work for dentists and patients alike.”

JHA International awards honour Middle East launch of a London dental academy

Dr Abdul-Hamid was named International Dentist of the Year 2011 in recognition of his tireless work forging relationships with international universities and Saudi Department of Health to launch the Arab Academy for Oral health, which is planned to open in September.

The centre will be based at Eastman ICED in London, which is home to a host of well-renowned UK specialists. And also for setting up the Saudi British Medical Forum with the blessing of his excellency the Saudi minister of health to promote the ties between healthcare organisations between the United Kingdom and the Kingdom of Saudi Arabia. Dr Abdul-hamid was honoured to spend 15 months with her majesty the Queen at the Buckingham palace garden party on 17th of July 2007 for his role in promoting British Dentistry in the Arab world.

Saudi Bin Majed Al-Duwaish, Chairman of Saudi Telecom Company was presented with a plaque in tribute to his personal and company’s support for the project and in fostering relations between the partners for this important Anglo-Arab initiative.

The awards were presented at the JHA Gala Dinner, held at The Royal Garden Hotel, Kensington on the eve of the 2011 Clinical Conference. For more information about James Hull practices contact 02920 772 950 or visit www.jameshull.co.uk

Examining dental access

A symposium organised by the Faculty of General Dental Practice (UK) held on 31 May 2011 at The Royal College of Surgeons of England, an international panel of speakers addressed the issue of access to dental services.

A range of definitions of ‘access’ were presented to more than 60 key figures in dentistry, along with the challenges that arise from each. Benedict Rumbold of the Nuffield Trust argued that “equal access is about equal opportunity, not equal utilisation”, while Maria Goddard, Director of the Centre for Health Economics at York University contended that “utilisation is usually the proxy for access, but does it capture quality?” More access does not necessarily result in better access.” Paul Batchelor, Honorary Senior Lecturer in Dental Public Health and Course Director of the FGDP(UK)’s Diploma in Dental Health Services Leadership and Management, defined access as “the opportunity to use a service if the individual feels it appropriate”.

Evidence was presented of the progress made towards improving access to dentistry. Mike Warburton, formerly the National Director for GP Access at the Department of Health (DH), argued that work by the DH had greatly improved access. However, he stated concerns around the effective management of dental contracts by Primary Care Trusts (PCTs) in the past and described a number of DH initiatives to support PCTs in delivering dental access more effectively. He heralded achievements in improving access over the last six months and quoted results from a recent GP survey showing that 96 per cent of patients who tried to get an NHS dental appointment in the last six months were able to do so.

Paul Batchelor asserted that not securing a dental appointment is a barrier and that the biggest barrier is cost, stating that “if you want to increase attendance, offer access as a free entitlement through lifelong registration”. 

Shortening healing times for patients

Researchers at the University of Gothenburg, Sweden, have studied the surface structure of dental implants, at micro level and at nano level, and have come up with a method that could shorten the healing time for patients.

“Increasing the active surface at nano level and changing the conductivity of the implant allows us to affect the body’s own biomechanics and speed up the healing of the implant,” said Johanna Loberg at the University of Gothenburg’s Department of Chemistry in one report. “This would reduce the discomfort for patients and makes for a better quality of life during the healing process.”

Dental implants have been used to replace lost teeth for more than 40 years now and it was Per-Ingvar Bränemark who was the first person to recognise the qualities of titanium, realising that it could be implanted into bone without being rejected. Bränemark has recently been awarded the prestigious Euro-inventor Award.

Today’s implants are often characterised by their levels of roughness, which is notably better than a smooth surface. As the report stated, the topography (roughness) of the surface is important for the formation of new bone, and therefore it is essential to be able to measure and describe the surface appearance in detail. However, roughness is not the only property that affects healing.

The method in which Johanna Loberg describes the implant’s topography from micrometre to nanometre scale and allows theoretical estimations of anchoring in the bone by different surface topographies. The method can be used in the development of new dental implants to optimise the properties for increased bone formation and healing. She has also studied the oxide’s conductivity, and the results show that a slightly higher conductivity results in a better cell response and earlier deposition of minerals that are important for bone formation.

The results are in line with animal research, which describes the commercial implant Osseospeed (Astra Tech AB), which show a slightly higher conductivity for the oxide and also an exchange between hydroxide and fluoride on the surface of the oxide. Surfaces with a well-defined nanostructure have a larger active area and respond quickly to the deposition of bone-forming minerals.

The project is a collaboration between the University of Gothenburg and Astra Tech AB in Mölndal, and will be further evaluated in follow-up studies.

The thesis Integrated Biomechanical, Electronic and Topographic Characterization of Titanium Dental Implants was successfully defended at the University of Gothenburg.
Good communication is integral to good care and a good working environment for the whole dental team.

For further information on this interactive learning programme please call 020 7400 8989 or email on info@smile-on.com
Dental bibs pose cross contamination threat

In a recent report it has been highlighted that unsterilised bib chains that are used in dental practices can create a risk for cross contamination for patients.

A survey has been conducted on the various types of dental chains and clips by Noel Kelsch, a national infection control columnist, Registered Dental Hygienist and former President of the California Dental Hygienists’ Association. She directed the study after seeing debris falling from a chain she had planned to use to protect her uniform at lunch. What she found led her to write an article titled “Don’t Clip That Crud on Me” for RDIH Magazine, a trade publication for dental hygienists.

When a bib chain comes into contact with hair or accumulates patients’ sweat, makeup and various oral substances from the mouth cross contamination can occur. For example, during a dental cleaning, saliva, plaque and even blood can come in contact with the bib and bib chain. For cross contamination to occur all it takes is for one of the dental team or a patient to come in contact with it.

“Studies have shown the more cracks, crevices and indentations on a bib chain, the higher the bacterial count. The problem with this is we use the same bib chain with patient, after patient, after patient, the accumulation creates a risk for cross-contamination.” Noel Kelsch said in one report. According to a report, one specific study Kelsch conducted involved taking samples of bacteria found in a major U.S. airport bathroom and comparing them to the bacteria found on a used bib clip.

“What we were trying to do was put across to the public how bacteria-laden a bib clip can be, and what we discovered was, by looking at a bathroom floor at a busy airport, and looking at this bib chain, we got about the same level of bacteria in both of them. This is a risk that everyone needs to be aware of.”

What was also found was that disposable clips and holders that were freshly opened for each patient were free from contaminants and posed no cross-contamination threats.

“As an advocate for patient safety within the dental profession, one of the most important things I can do is keep patients out of harm’s way. By simply educating the public about this possible cross-contamination, we can make an impact and keep our patients out of harm’s way.” Noel Kelsch said.

Her findings echoed a study that had previously been conducted by the University of North Carolina at Chapel Hill’s School of Dentistry Oral Microbiology Lab; researchers found that bib chains and clips are potential sources of contamination after sampling 50 bib clips from various hygiene and dental operations. The results concluded that one in five bib clips were contaminated.

APPG stops the rot

The All-Party Parliamentary Group for Dentistry held its Summer reception at Parliament, lending ministerial support to the issues surrounding oral health inequalities.

Under the banner of Can we improve access to dental health services to ensure those who do not attend ‘drop off’ and ‘pick up’ times to give children a brief examination and apply fluoride varnish. Parents get advice on how to protect their child’s teeth at home and children are given a toothbrush and toothpaste, to encourage a good brushing routine. Children are then followed up after two months with a second session in the school for those who have not attended a full check-up at the dental surgery after the first session.

Dr Bridgman concluded: “The outcomes of the scheme speak for themselves. A large number of children are captured and those who are in pain get treatment. This has a knock-on effect to improve school performance. Dentists have been very enthusiastic about the scheme and welcome the opportunity to get out of the surgery and gain a better understanding of who does what in the system. There is great potential to roll-out this scheme in other parts of the country which have an identified need.”

The Manchester Smiles scheme identifies the ‘missing thousands’ – the children who fall through the net as they do not attend a dentist regularly, and are therefore more likely to suffer from dental decay that is preventable. The scheme links up dental practices, schools, sallyed dental services, school nurses and safeguarding children teams to provide timely preventative intervention, dental care and advice. Part of the scheme is the ‘Buddy Practice’, an initiative that sees dental teams visit schools at ‘drop off’ and ‘pick up’ times to give children a brief examination and apply fluoride varnish.
Last week the British Association of Dental Therapists held their Annual Scientific Meeting and AGM in Manchester. The main talking point of the event was direct access.

Dental therapists who attended the event focused their discussions on the issue of direct access by patients to the services therapists provide.

The theme for the event Embracing and Changing the Face of Dental Therapy provided a backdrop to the intensive pressure the BADT and other organisations are putting on the GDC to look at direct access in the Scope of Practice revisited.

We asked you what your thoughts were on the issue of direct access for dental hygienists and therapists. Here is a selection of the comments we received:

“The lectures were all very interesting and it was great to have Barry Crockcroft there too. I feel fired up about the role of therapists but then came home for an interview today, where they are very keen but the principal is worried about how to pay, she says if it is her COT and she is claiming the UDA’s how can I do some of it and what are the legal repercussions in terms of indemnity?”

“It is a constant problem that we will come up against until we can get our own performance numbers. I hope that with the work that Baldevs Chana is doing we are moving forward to direct access, but how speedily is anyone’s guess.”

“We are a highly trained motivated adaptable workforce who would like to be able to examine treatment plan, provide treatments AND refer onwards as is the case now, this point was made by our outgoing conference coordinator Dave Martin in our most recent journal!”

“As a dentist I feel this is ridiculous. Why did we spend five holy free years at dental school? The main skill a dentist has is as a diagnostician. I seriously don’t feel dep’s have the right skills to take on this role. But I feel this is all backed by a government strategy to reduce the cost of dentistry. It is so obvious from the change of name of pdf’s to dep’s to the current proposal. Ultimately patients will suffer. I am sure the corporates will find this opportunity of hierarchical leverage to be an easy business model to take advantage of.”

“As an Australian dental therapist – direct access is a must. The OHTs and DTs in the UK should be trained in diagnosis and treatment planning – to be similar to those of us who trained in Australia and New Zealand. With this training, there should be no barrier to direct access as we have in Australia and New Zealand.”

According to the NASDA goodwill survey for the quarter ending April 50th, the average goodwill value of a dental practice increased by roughly 10 per cent in the first few months of 2011. The deals struck between January and April of this year show that the average sale value has gone up from 84 per cent to 97 per cent of turnover.

This good news is not spread equally across the board, however, as NHS and mixed practices are faring better. The average NHS practice reached more than 105 per cent of turnover while private practices fetched just over 90 per cent. (NASDA define a private practice as one with an income of 80 per cent or more from private fees). Meanwhile, the sale values are still generally above valuations for goodwill.

Alan Suggett, a partner in unw LLP in Newcastle who carries out the NASDA goodwill survey, commented: “NHS practice values appear to be holding up in value, and so do mixed practices, but private practices are having a tougher time.”

Alan added: “I am still concerned that the market value of private practices is clouded by those practices which are “sticking”. If practitioners are holding out for an unrealistically high sale price then the proportion of low value deals will be less, and the “average” could therefore be misleadingly high.”

Russell Abrahams, a lawyer member of NASDA, said a private practice valued at more than £500,000 was, unless it was exceptional, virtually unsaleable. Although the economy generally appears to be recovering, private practices are seeing bigger gaps in their appointment books and this is reflected in goodwill values.

Meanwhile, Russell said, banks were becoming ever more reluctant to lend to dentists. One senior bank manager recently employed a traffic light analogy to illustrate the dramatic change in policy at his bank, saying that while property generally had gone from amber to green, dental lending had gone the other way, from green to amber.

A new study that will attempt to use DNA to detect and predict the risk of gum disease has been commissioned in the USA.

The University of Michigan, School of Dentistry has partnered up with Interleukin Genetics Inc. in order to conduct the breakthrough study, and will take place over the course of one year, collecting genetic information from around 4,000 people.

Should positive results arise from the test, they could prove very important for the preventative care in fighting serious oral health complications.

In the past, several research points out that genetics is closely linked to gum disease; it has also been proven that factors such as low birth weight or heart disease complications are an indicator of developing periodontal gum disease later in life.

The issue of DNA testing has proved controversial in the UK in recent years. Tests now exist that can detect common disorders such as diabetes and heart disease, but many people fear discrimination by insurance companies. People in the USA are already protected by The Genetic Information Nondiscrimination Act of 2008, which prohibits discrimination on the basis of genetic information with respect to health insurance and employment.

The results of the initial genetic test will be then combined with the two leading factors of diabetes and smoking. Researchers will also examine rates of tooth survival against what kind of dental treatment plans people have. All these results will give the researchers enough precious data in order to see how they correlate.

To view the source of the article visit http://worlddental.org/dental-news/genetic-testing-prevent-gum-disease-complications/4652

A £200K funding available for primary care research

Applications for funding for research projects in two areas are being sought by the Shirley Glaistone Hughes Trust Fund this year. Bids for the 2011 competition are invited for research projects that explore one of two questions:

1. Does dentists’ fear have an adverse effect on clinical decision making?

2. Which dental liners under amalgam restorations have greater patient benefit?

The questions have been selected after a review of 12 topics suggested by users of the Primary Care Dentistry Research Forum, an online community that helps general dental practitioners to shape the research agenda. A maximum of £200,000 of funding is available to the successful applicant(s).

The successful projects are expected to begin in January 2012 and should be of no more than three years’ duration. Bids are welcomed from UK-based candidates only and will be judged on criteria including originality, relevance to quality enhancement in primary dental care and the involvement of dental practitioners in the research.

Full details of the award and how to apply are available at: www.bda.org/dentists/policy-research/research-overview/shirley-glaistone.aspx.

The deadline for applications is 19 September. The trustees of the fund are expected to announce which bids have been successful by the end of November.

Dental practitioners are also encouraged to submit topics for consideration for the 2012 shortlist. They can do so by logging on to the Primary Care Dentistry Research Forum at: www.dentistryresearch.org.
Don’t lose your smile factor

The British Dental Health Foundation (BDHF) is urging people to change their attitudes towards their teeth and dentists, or risk losing their ‘Smile Factor’ forever.

The British Dental Health Foundation has been promoting good oral health as part of its National Smile Month campaign. The Foundation believes the nation is not making oral health a priority and people need to adopt a different attitude to their teeth and oral care if they are to keep their ‘Smile Factor’ – the theme of this year’s campaign.

The Foundation has developed a checklist, challenging the public to change their views towards their oral health. This includes advice to develop knowledge in order to become a healthier patient, be proud of their natural teeth – you don’t have to be perfect to have the ‘Smile Factor’ – and keep a good diet, staying away from sugary foods and drink to help maintain good oral health.

Other steps encourage to give up smoking, to prevent staining teeth and to pamper our teeth as much as we do our skin and hair, both of which will boost our ‘Smile Factor’. There is also advice to visit dentists regularly in order to prevent oral health from deteriorating.

The BDHF has found that nearly half of the population admitted to regularly skipping brushing their teeth. They discourage this completely, recommending a routine of brushing for two minutes, twice a day, using a fluoride toothpaste.

The tips also encourage to “count our smiles”; smiling, they say, is infectious, and makes a huge difference to our mood and relationships. The Foundation states that receiving and sharing 25 smiles a day will boost your confidence and ‘Smile Factor’.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “Following these tips will not only give you good all-round oral health, they will give you a renewed energy and the confidence to portray your smile on a daily basis.”

Information is available from the British Dental Health Foundation’s website at www.dentalhealth.org. Confidential advice is also available by phoning the Foundation’s Dental Helpline on 0845 065 1188.

Dentist faces jail for parking Ferrari

A millionaire dentist who used a deceased gentleman’s disabled badge to park his Ferrari for free faces being struck off the dental register.

Dr Chirag Patel, 33, admitted two charges of misusing the permit on December 8 and 9, 2009 and a judge has ruled that he must now stand trial for fraud.

However, Patel denies the more serious count of fraud, which carries a sentence of up to five years imprisonment. If he is convicted it could mean that he will be taken off the GDC register.

According to one report, Dr Patel, who lives in a £2m house in Coombe Lane West, Kingston, tried to get the charge thrown out at South Western Magistrates’ Court; according to his lawyers the charge was “irrational and oppressive”.

However, district Judge Barbara Barnes ruled Wandsworth Council acted properly by pursuing the case and the case will return to trial on September 9.

Chocolate makes us smile the most

The British Dental Health Foundation has asked hundreds of people what makes them smile the most. In a close fought competition a simple bar of chocolate has topped the poll, followed by ‘seeing a loved one’.

Food and ‘relationships’ were common inclusions in a bewildering array of things mentioned in the poll, which spontaneously gave people the ‘Smile Factor’ – the theme of this year’s National Smile Month campaign run by the BDHF.

Around half of respondents featured chocolate on their list of items, with 60 per cent of women making it their favourite choice. Men preferred a Sunday roast to chocolate, but both scored highly.

The contagious nature of smiling was also highlighted by around a third of people saying they smiled when they ‘saw someone else smile’.

Chocolate came up tops in making us smile
The phrase work-life balance is frequently used by lifestyle gurus, weekend newspapers and advertisers. A Google search brings up nearly 20 million references in less than a quarter of a second so I suppose there might be something to it; but as a great many of those websites are seeking to sell a cure for the very thing they describe, they would seek to maintain the myth. My view is that the very phrase suggests that work and life are different and mutually exclusive, which is of course plainly nonsense.

Life is everything and work is merely a part of the whole, (a very important part I acknowledge and for many people it is the driving force of their very existence but it is still only one aspect,) So my suggestion is that what is needed is balance in all things in one's life whether that be career, money, family and friends, health, spouse and romance, personal growth, fun and recreation or physical environment.

During my coach training I was introduced to the “Wheel of Life” which comes in many forms, a simple one of which accompanies this article.

To those of my clients who are struggling to find balance in their lives (whatever that means to them) I recommend that they read M Scott Peck’s book The Road Less Travelled which is based on his personal life and professional experiences as a psychiatrist.

There’s no need to read the whole book and, if your time is short just go to the first page and read and accept the first line - Life is Difficult.

So why is it that so many dentists insist on making it even more so?

One of the answers is that the very nature of the job contributes hugely. Dentistry is an exacting, precise task. It is performed in an environment that is restricted, poorly lit and technically challenging with materials that need sympathetic and correct handling. Added to that of course is that the recipients are awake and bring with them a lifetime’s baggage of dental experiences. For success the surgeon must be in total control of every aspect of all procedures in which they are involved. That is how things should be; it is what I expect in a professional dealing with me.

The downside of this however is that dentists try to bring the successful disciplines of the surgery to every other aspect of their business; the result is frequently a micro-managing, all controlling individual who frequently has problems seeing the wood for the trees. In many cases they will not let anybody else have any more than notion-al responsibility for the management of the business, they have to have sight of and check every last procedure. Software systems that produce increasingly detailed reports give them ways to know (and therefore add to the delusion that they control) more and more about things that matter less and less.

With an in-built mantra of “fill the book, we’re only successful when we’re going flat out” they arrive at the end of the day, week, month or year exhausted but with all the running of the business to do. The result is an individual who spends his or her evenings and weekends “catching up”. Why? Because nobody else knows how to write referral and patient letters correctly. No matter how many courses the practice manager has attended they’re not permitted to make any kind of “strategic decisions” (that’s a phrase they read about in Forbes magazine just after
they were told that they had to be an entrepreneur these days to be successful) and it wouldn’t be appropriate for them to know the details of the finances of the practice would it? Why on earth not?

Behaviour like this is fine in a start-up or a new purchase when you’re living and breathing every element of the business, when you’re feeling your way and building a business from the bottom up, imbuing it with your personality, your outlook and vision. However the time must come when both you and it start to grow up or else those two enemies of the successful self-employed, burnout and frustration, will rear their ugly heads. The result is an unhappy principal, staff who just come to work because it’s what they do to earn a crust and a business that will fail in one or more ways as it progresses on its downwards spiral.

Perhaps you are that principal, or an associate who is considering stepping up to the plate to become a practice owner. How do you prevent yourself being drawn down the route I have described above? Be under no illusion many dentists live, as Thoreau described, “Lives of quiet desperation” and sadly many do nothing about it until the pain of not taking action outweighs the pain of change.

Many dentists have been on the conveyor belt of GCSE, A-level, degree, VT, associate-ship and ownership. As they have made their way they have picked up student debt, marriage, family, professional & personal debt and other people’s expectations. Then one day there’s a “is that all there is?” moment.

Frequently the catalyst to change is a marital breakdown, a financial or other crisis within the business, a physical illness or any of several other symptoms, which may contribute to what the marathon runners refer to as “hitting the wall”. The result is often a dramatic fall from the treadmill that is of their own design and invention, a call for help and a remodelling of their life - all of their life.

A brief way to start regaining control of your life is by becoming absolutely clear about what it is that you want from life. I will be covering this in greater detail in the next article but for now I would ask you to take some time and think about what you really want. The ideal way to do this is to take some time away from the day-to-day routine; but I respect how hard that can be, so to start with why not stop for a few minutes on your way home from work and start to visualise the life that you want. Try using the wheel of life that accompanies this piece or make up your own and ensure that you explore every element of your life.

Your future starts here.
FDA use shock tactics for tobacco

According to an American newspaper, the federal government has unveiled a new plan designed to shock customers with images of tobacco’s impact: images will include sick smokers exhaling through a tracheotomy hole, smokers struggling for breath in an oxygen mask and even smokers lying dead on a table with a long chest scar. The report stated that in the most significant change to U.S. cigarette packs in 25 years, the Food and Drug Administration released nine new warning labels that depict in graphic detail the negative health effects of tobacco use.

Beginning from next year, cigarette cartons, packs and advertising will feature these and six other graphic warnings.

The tobacco companies, several of which are challenging the new rule in court, refused to comment on the starting images that will now have to dominate half of the front and back of each carton and pack and 20 per cent of each large ad.

Innovative probe unveiled

A leading dental implant provider has launched a pioneering new instrument that can significantly improve the consistency and quality of periodontal measurement.

Implantium has partnered with Professor Iain Chapple, Head of Periodontology at the University of Birmingham, to design and deliver a new double-ended force measuring probe. Inconsistent probing pressure is a major source of measurement variation and discomfort for patients. However, the new UB-WHO-CF15 Probe creates a standardisation of probing pressure, which not only improves the consistency and quality of periodontal measurement, but also reduces patient discomfort.

The double-ended instrument combines a World Health Organisation (WHO) C-type end for screening periodontal disease, with a 15mm graduated end to enable detailed measures of probing pocket depth, recession, and attachment levels. Its design also enables effective washer-disinfection and autoclaving.

Jason Buglass, Director of Implantium, explained: “It is a real challenge to achieve consistent measurements with perio probes. Professor Chapple’s new probe is a big step forward from previous instruments. By producing consistent measurement forces, more relevant comparisons can be made over time, in both the fields of research and standard monitoring. The design is ergonomic to reduce the risk of repetitive strain and the calibrated forces make it more comfortable for the patient.”

“To work alongside someone as experienced and highly respected as Professor Chapple has been a real pleasure. We believe the final product will be of genuine interest to the industry, and at a cost of just £85 + VAT, is an extremely cost-effective solution too.”

Professor Thomas Dietrich, Head of Oral Surgery at the University of Birmingham, commented: “I generally think that this is a major advancement in periodontal measurement forces, more relevant comparisons can be made over time, in both the fields of research and standard monitoring. The design is ergonomic to reduce the risk of repetitive strain and the calibrated forces make it more comfortable for the patient.”

Hospital stays cause oral deterioration

A study titled ‘The impact of hospitalisation on oral health: a systematic review’ has uncovered how oral health deteriorates during hospital stays.

The study suggests that oral health deteriorates during hospitalisation and is associated with an increased risk of hospital-acquired infections and reduced quality of life. The background of the study was to research how poor oral health of hospitalised patients is connected with an increased risk of hospital-acquired infections and reduced quality of life.

The researchers reviewed the evidence on oral health changes during hospitalisation using five before and after studies recorded between 1998 and 2009 in the UK, USA, France and Netherlands; the data suggested deterioration in patients’ oral health following hospitalisation, and that there was an increase in dental plaque accumulation and gingival and mucosal inflammation; the findings were worst amongst patients who required help with their breathing.

The research points to several potential reasons for the decline in oral health during hospitalisation including: the low priority given to oral care provision; the implementation of improper oral care regimes; and as a direct consequence of hospitalisation.

The study concluded that ‘hospitalisation is associated with a deterioration in oral health, particularly in intubated patients’.
David Bridges provides advice on how to make progress with difficult patients

Like many colleagues, I am an avid user of the internet. I spend a lot of time browsing a wide range of dental and associated sites researching the latest news, trends, politics and general "stuff". I'm also a frequent visitor to dental and associated sites, literally, from around the world. Sometimes, a post appears that, at first sight, seems quite innocuous yet can make you stop, think and re-evaluate your approach and beliefs.

Just this week, I read a post from a colleague on a hygienist website that had just such an effect on me. This hygienist related a tale about the practice she was in. A patient of the practice that she had seen a number of times before that year, had returned for another three monthly visit. The patient had long-standing severe periodontal disease with a BPE of 4's. She'd previously asked this patient to book longer appointments in order for her to carry out the proper treatment that his condition dictated, but to no avail. Repeatedly, he would only book twenty-minute routine visits.

Eventually, it appears the constant reinforcement of advice from our colleague might have finally achieved the desired effect.

This time, (at yet another twenty minute appointment), he decided to engage and asked what the recommended treatment actually entailed. He wasn’t interested in a specialist referral – he didn’t want to spend the money that he said he had – could our colleague do the treatment?

Despite the fact he claimed to “use my purple tepe every day”, his plaque score was 100 per cent. Our colleague disclosed the patient, showed him in a mirror and recorded the score. She then went through her suggested treatment plan. She planned for an initial one-hour appointment first, followed by a subsequent forty-minute appointment at a later date. The slightly longer first appointment was to allow six point charting with plaque and bleeding indices, disclosure, OHI, delivery of LA and root surface debridement of one half of the mouth. The second appointment was to treat the other half of the mouth. All well and good. Perfectly reasonable.

However, our patient balked at this on cost grounds and said he would only book and pay for two thirty-minute appointments “and that’s your lot!” Despite sharing the fact he had £1000 to spend on specialist treatment, he apparently didn’t want to spend it on the proper, initial non-surgical therapy.

Our colleague instructed reception to book the patient in at the end of a session for these twenty minute appointments so that, if necessary, she could run...
over and do the proper job. On the way home, she started thinking ‘...why should I?’ but still showed signs of caring beyond the call of duty whilst asking us, her forum friends, how we would deal with this situation if faced with it ourselves. Essentially, she was asking about two options. Would we try and do the treatment in the time allotted by the patient or do we leave the rest?

Nine colleagues including myself replied. We all offered similar advice which distilled down to:

1. Offer options
2. Explain pros and cons of each option
3. Document the reply and deliver the chosen treatment

In my reply, I said that I informed my patients that in this situation they have three options.

1. Do nothing - i.e. we agree to part company
2. Carry on as we are but inform them that it is compromised treatment and the consequences of that
3. The ideal treatment plan with appropriate appointments, times and fees including the review appointments

All delivered in a non-judgemental way. Remaining friends and with all replies documented.

Hygienists are generally, as a group, a particularly caring lot and we often try to ‘go the extra mile’ for our patients even, and perhaps especially, for those who seemingly won’t help themselves. We beat ourselves up and worry about how we can squeeze every last bit of value out of inadequate treatment times and feel guilty if we haven’t done all that we think we should have during that compromised appointment. The extra pressures of HTM01-05 and CQC and the near pandemic absence of adequate chairside support help compound these feelings.

Later in the week, whilst reflecting on the theme of the story, I came to the conclusion that it was essentially one of ‘ownership’.

Firstly, as clinicians need to make sure that we do not assume ownership of our patients’ problems. This is exactly what was happening in the story above. We need to feel confident in setting out our stalls and maintaining our principles in order to help give ownership of the problem back to the patient. It is only when a patient finally accepts that they alone hold the key to the success or failure of the treatment of their problems that we can begin to make progress with these more difficult people.

Secondly, practices need to take ownership of the fact that they are responsible for providing their clinicians with the best possible environment and managerial support in order for them to perform at their peak. The ability of practices to provide great equipment together with good managerial, clinical and full-time chairside support can make a massive contribution in assisting their staff feel more confident in dealing with these more difficult patients.

Thirdly, and perhaps most importantly due to the sometimes insular nature of the dental hygienists’ job, is the realisation that we too can also take ownership. Ownership of the situation we find ourselves in. We can help ourselves deal with it by reaching out to fellow professionals for help, advice and support beyond our immediate vicinity, making use of the rich communication, education and research resources that the Internet has to offer.

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In March of this year, *Science Daily* published a story warning of the possibility of increased pathogen accumulation on orthodontic appliances. The story soon went national and the popular media were quick to warn readers about the dangers faced by the nation’s brace-wearing youth.

In fact, what the media were keen to play up as the latest ‘health hazard’ stemmed from a significant piece of research from the Eastman Institute, which highlights the importance of instilling a rigorous oral health care routine in orthodontic patients. Dr Jonathan Pratten and colleagues conducted research designed to ascertain the types and growth of microbes on removable retainers. The study confirmed the presence of potentially pathogenic microbes on over 50 per cent of the retainers studied, using a control group of patients without orthodontic appliances.

The theory behind the research was that the constant removal from, and replacement in, the mouth makes retainers susceptible to transmission of microbes. The study revealed that Staphylococcus was present on 50 per cent of retainers and Candida on 66.7 per cent. Both microbes were also found on the tongue and interior cheeks of those subjects. Although the risk to healthy individuals from these microbes is minimal, those patients with compromised immune systems could find themselves in danger of severe infection. The implications for children with underlying conditions such as Cystic Fibrosis, in whom Staphylococcus can cause debilitating and often life-threatening chest infections, are therefore serious, and this study provides further evidence for the importance of better cleaning of removable appliances and the effective removal of biofilm in orthodontic patients.

Orthodontic patients should have a rigorous oral health routine.

What the media were keen to play up as the latest ‘health hazard’ stemmed from a significant piece of research from the Eastman Institute, which highlights the importance of instilling a rigorous oral health care routine in orthodontic patients’
ies have reported different findings. Studies from 2003 and 2005 indicate that periodontopathogenic species increase significantly within 28 days of bracket placement and are notably higher in comparison to patients without orthodontics. A 2006 study by Amezquita et al further suggested that there are significantly more periodontopathic and superinfecting bacteria three months after bracket placement, which results in more inflammation and bleeding on probing. The study advised that: “Special attention should be paid to oral hygiene methods in orthodontic patients.” The evidence clearly points to the need for a solid oral hygiene routine for orthodontic patients.

Discipline

The problem that many dentists face is that orthodontic patients are primarily children and teenagers, with an estimated 66% per cent of twelve year olds requiring some form of orthodontic intervention. Compliance in adolescents is notoriously low because of a lack of discipline and self-awareness. It is therefore vital that practitioners consider every method of patient education when dealing with younger patients. For teenagers, who may resent the initial aesthetic implications of wearing braces, it can often be a case of helping them to understand the long-term effects of wearing a retainer. Appealing to a teenager’s ego can go a long way in this instance! With the vast amounts of media attention currently given to the prevalence of hospital-acquired infection, it can also be useful to use this as an illustrative parallel when explaining the importance of oral hygiene to teenagers.

Dr Pratten commented: “With the growing awareness the public has of hospital-acquired infections it is important to be aware of other potential ‘hidden reservoirs’ of harmful bacteria which could be introduced to environments where we know they can cause problems.”

Make it fun

With younger children however, the answer to inducing effective oral health care is to make it as fun as possible. As well as emphasising the importance of brushing morning, night and after every meal, it is vital that patients understand the efficacy of interdental cleaning. Many younger patients, as well as those with manual dexterity problems, can find flossing difficult however, so different methods may need to be employed.

About the author

Deborah M. Lyle, RDH, MS, Deborah received her Bachelor of Science degree in Dental Hygiene and Psychology from the University of Bridgeport and her Master of Science degree from the University of Missouri - Kansas City. She has 18 years clinical experience in dental hygiene in the United States and Saudi Arabia with an emphasis in periodontal therapy. Along with her clinical experience, Deborah has been a full time faculty member at the University of Medicine & Dentistry of New Jersey, Forsyth School for Dental Hygiene and West Kentucka University. She has contributed to Dr Esther M. Wilkins’ 7th, 8th, 9th and 10th editions of Clinical Practice of the Dental Hygienist and the 2nd and 3rd edition of Dental Hygiene Theory and Practice by Darby & Walsh. She has written numerous evidence-based articles on the incorporation of pharmacotherapeutics into practice, risk factors, diabetes, systemic disease and therapeutic devices. Deborah has presented numerous continuing education programs to dental and dental hygiene practitioners and students and is an editorial board member for the Journal of Dental Hygiene, Modern Hygienist, RDH, and Journal of Practical Hygiene and conducted several studies that have been published in peer-reviewed journals. Currently, Deborah is the Director of Professional and Clinical Affairs for Waterpik, Inc.
Mhari Coxon discusses how to increase profit and client loyalty

**Warning** – this is not an evidence based clinical abstract. This is an article based on more than 15 years of experience in practice growing and developing, providing a preventative regime that empowers both your team and the client in a profitable manner. Those who have the perfect preventative based practice can thankfully stop reading now (that doesn’t include me you know, there is always room to improve).

**Changing attitudes in dentistry**

Dentistry has been a “see the problem - name the problem - fix the problem” profession for a very long time. We were conditioned that way while in our safe institutions and find it hard to move to a preventative approach to our health care when we transition to general practice and the time constraints and attitudes that come with it.

With growing evidence showing common sense links with our systemic health (if you had an inflamed, suppurating, bacteria covered area on your arm the size of an egg you would expect to feel ill so why would it not be the same for the same size lesion in the mouth?) and our oral health, we as a profession, need to improve our prevention led practice. This is clearly best practice.

“**But we do it already**” I hear us all cry. “You are reinventing the wheel Mhari!” If this was the case then the incidence of periodontal disease and caries in the population would be decreasing, as would the incidence of litigation against dental professionals in relation to periodontal issues and undiagnosed caries. It is not easy to look at what we are not doing and seek to improve but it is the only way we, as clinicians and as practices can develop and progress.

**Building on the right foundations – The initial consultation**

The first time your patient spends time in your practice will affect how they feel about treatment and how happy they will be at the end of treatment. How much information you glean from them can determine the level of success with each client. In my opinion, supported by its success in our practice, a short interview in a non dental environment can be very useful before the patient even sets eyes on the dentist. Our receptionist, oral health advisor, hygienist...
ist and nurse can all carry out this short interview and are trained to listen and repeat to show that the patients’ wants, needs and concerns are being understood and will be presented to the dentist. Our patient’s feedback to us is that they feel happier knowing that they have someone who knows how they feel to support them.

How many times have you been to see a consultant or specialist and forgotten all the things you wanted to ask. “White coat syndrome” can happen to the best of us so why should our patients be immune? Using staff to provide a supportive and informative role can make the patient happier and your day as a dentist more rewarding. Not to mention the happy staff you will have working for you.

Examples of questionnaire questions:

1. When was that last time you had any dental treatment?
2. What was your main reason for your visit today?
3. Do you feel you have good dental health?
4. Do your gums bleed?
5. Are you sensitive to hot/cold/sweet?
6. Do you have any worries about your mouth or treatment?

Big up your team

It is difficult to appreciate the role of preventative treatment as a patient and it is vital that you convey that importance and the skills of your team if you want to have a success with that client’s behavioral change and treatment acceptance. Do you think saying “you have some gum problems and the hygienist will see you for a scale and polish” conveys a preventative message? Does that show that the patient has to make a commitment to their treatment by supporting with their home routine? Or does it make it sound as though the patient has a “problem” that you have “named” that the hygienist will “fix” and so the cycle continues. Our principle talks about the gums and bone as the foundation to any dental work and without solid foundations he can’t work. He also explains how the biggest health benefit we can give patients is their oral health assessment and advice programme which always follows an examination and is precursor to any further treatment.

If you as “The Dentist” are telling them they need this then they will feel it has some value and are more likely to be open to advice from your team.

Communication about prevention

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For those on a budget and with time constraints, the interviewer can discuss issues with the patient and show pictures that correlate to their health and what these mean. A non expensive digital camera can be as effective as an intra oral camera.

Be positive
We all respond better to positive suggestion as a rule and so how we discuss this with the patients can affect their attitude towards their health and your team’s part in it. I do not like to be lectured or scolded by anyone - an automatic wall comes up; so why would I use this method with my patients? Yes there are “problems” in their mouths. Yes you can “name” those problems. But you and your team cannot “fix” their problems. You can help the patient to find solutions and attain and maintain health. This is ultimately more beneficial than fixing the problem than trying to modify the behaviour. That is like feeding the donkey the carrot and then asking it to carry the load.

So to summarise:
- Use your team to glean information and discuss patients needs, fears and expectations
- Question the patient gently to develop conversation about their health
- Emphasise the importance of prevention in dental health and the benefits of this
- Show your patients what is happening
- Be positive, explain that they can make a difference with their home routine
- “Sell” your team and their part in preventative care in the practice

Obviously, if the patient is immediate pain or risk then this should be dealt with. Otherwise resist carrying out treatment until the preventative routine has been introduced.

Part 2 will look at the information and direction your team need from that first appointment to support your treatment of the patient. For any questions please email me at mhari.coxon@cpdfordcp.co.uk
Periodyntitis is the most prevalent chronic inflammatory disease of humans and a major cause of adult tooth loss, impacting negatively upon oral health, function, speech, nutrition and quality of life. However, we are only now beginning to comprehend the full impact of periodontitis upon general health. Periodontitis is significantly associated with systemic inflammation, with all cause mortality, and with an increased relative risk for several other chronic inflammatory conditions, including cardiovascular disease, rheumatoid arthritis and type 2 diabetes. Successful periodontal intervention improves tooth retention, improves diabetes control, and reduces the systemic inflammatory burden. Periodontitis, and its prevention, matters.

Changing the focus: Wellness not repair
The "repair model", identifying current disease and fixing it when it breaks has pervaded dental training and practice since the beginning of the last century. This surgical mentality dates back to the days when periodontitis was considered ubiquitous and simply a bacterial infection consequent upon plaque accumulation. We now know that periodontitis requires a susceptible host and that we all vary in our susceptibility from the 10 per cent who are immune to the 10 per cent who are highly susceptible. We know that host factors are the major determinants of disease, outweighing plaque by a ratio of 80:20 in relative importance. The new medical approach, “wellness” aims to identify those patients most at risk of developing disease in the future and to engage them in individualised preventative care programs. Its validity is supported by the work of researchers such as Axelsson who demonstrated unequivocally that common dental...

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"Tell me I’ll forget, show me, I may remember, but involve me and I’ll understand" Liz Chapple explains how a risk based approach to periodontal management is the foundation for preventive treatment planning, patient empowerment and motivation, and medico legal protection.
subjective, qualitative judgment as to the magnitude and role these factors may be playing in the disease process. The evidence shows, however, that these subjective evaluations of pocket depth measurements, bleeding and plaque scores can be hard for patients to remember and understand. Success depends on the clinician’s ability to demystify periodontal disease.

**Risk factors and examination taking**

There are many factors contributing to the risk of periodontal disease. In 2010 the NHS incorporated the concept that risk should underpin patient care into the proposed new dentistry contract and made it the driver in the pilots for recall periods and care pathways. But predicting periodontal risk is not straightforward: how do we assess it?

**We know the risk factors**

Susceptibility and risk for disease vary greatly from one individual to another, and major factors that place individuals at risk have been identified. Factors known to influence the onset, clinical presentation, and rate of periodontal disease progression include smoking, poorly controlled diabetes, poor oral hygiene, extent and severity of existing alveolar bone loss, positive family history, proportion of probing pocket depths > 5 mm, age, gender, and gingival bleeding. The number of missing teeth is also a valuable predictive variable, while certain aetiologic microorganisms may also be indicators of risk.9

Where we assess risk factors, our assessment is subjective: Although most clinicians collect the information required for risk assessment, tools for quantification of risk previously have not been available. Consequently, as currently performed, risk assessment consists of identifying the risk factors an individual patient may manifest during the history and examination taking process, and then making a subjective, qualitative judgment as to the magnitude and role these factors may be playing in the disease process. The evidence shows, however, that these subjective evaluations of pocket depth measurements, bleeding and plaque scores can be hard for patients to remember and understand. Success depends on the clinician’s ability to demystify and explain:

**Patients are becoming increasingly interested and involved in their own care and want more and better information about their oral health status**

- help the patient to appreciate that they are different to the majority of the population due to their increased risk level
- convey the severity of their condition and its implications for their oral and general health
- emphasise the patient’s role in reducing their risk and managing the disease
- provide personalised data which the patient can monitor that your and their efforts are improving their health

**Shifting the focus to Wellness**

An alternative model of patient care is therefore proposed: the “Wellness model” which is patient rather than clinician driven. Patients are comprehensively assessed when they are well (ie prior to the development of disease) and their risk of developing oral diseases is quantified using accepted clinical measures. The patient is then provided with evidence-based and personalised information using objective risk prediction models to help them take greater responsibility for maintaining their own “wellness” and prevent disease developing in the future.

**PreViser Risk Prediction**

PreViser risk and disease assessment technology has the potential to facilitate the shift in focus from repair to wellness. PreViser is unique in that it is a clinically validated11 oral risk prediction and disease scoring technology, performed online within the dental practice and designed to provide immediate patient feedback. It adds just 3–4 minutes to a routine examination.

Routinely collected information from each patient is entered into the software whilst the patient is in the chair, and transmitted securely over the internet to the USA, where a mainframe server utilises a scientifically validated algorithm to return, within seconds, a risk score (scale 1–5) and a disease score (scale 1–100). This, together with treatment plan guidance based on the patient’s presentation, is provided in personalised reports for the patient and clinician.

The clinician report includes inputted data for future reference and storage on the patient’s clinical record. The report contains a visual display of the patient’s risk and disease scores, explanatory text about periodontitis and the patient’s role in its management.

Both risk and disease scores are objective, reproducible and sensitive to minor changes. Repeat assessments may be performed at any point in the treatment or recall cycle, and a graphical display of changes in risk and disease scores is automatically provided enabling you and your patient to track treatment effectiveness and outcomes.

**PreViser:***

- Facilitates risk factor identification and correction (both systemic and local risk factors)
- Educates patients about why they are susceptible and what their role is in managing their risk factors and their disease
- Provides personalised bio-feedback to help motivate them to take an active role in their own care and see evidence of their success in the reduction in scores
- Reduces the risk of medico-legal claims because no patient with disease is missed or uninformed about their health status and their role in its management

More information and a month’s free trial of PreViser can be accessed at www.previser.co.uk or by calling 07725125291.

**References**

8 Axelsson, J. Lindhe and B. Nyström, JCPD 2006;3:463-472
Tandex: An ‘Open Door’ approach to business for 80 years

Janni Theilvig has worked for Danish company Tandex for 15 years, and has been its Managing Director for three. With extensive experience in every single part of the company, Janni is the person to talk to if you want to know about Tandex, and she is eager to explain the company ethos:

“I like to think of Tandex, and of myself, as having an ‘open door’ policy. I encourage staff and members of the public to come to me with any ideas, praise or criticisms they feel will help improve our products. In fact we base a great deal of our research on the customer feedback we receive from dental professionals and other product users.”

It’s obviously a system that works, as this year sees Tandex celebrate its 80th anniversary, as well as receive continued acclaim both in Denmark and the UK.

Janni’s connection with Tandex was first established in 1994 when her father Ole and his partner Henrik Andersen bought the already well-established company. Janni herself first joined Tandex in 1996, initially on a three-month contract, and worked her way up through administration to the role of Managing Director. She has, over the years, done a little bit of everything for the company, from answering phones and collecting customer feedback, to working in the factory and packing deliveries.

It is this experience that makes Janni the boss she is today, and she seems to have a remarkable empathy for her staff and her clients.

By concentrating on what customers want, Tandex is able to produce reliable and effective products. The latest product from Tandex is the FLEXI Max interdental brush, as no exception. Already well known for its superb range of interdental brushes, including the popular Tandex FLEXI, the company has included the FLEXI Max in its range to meet the needs of people who find interdental cleaning difficult, including those with manual dexterity problems. The FLEXI Max’s long handle and angled head make it easy to use for people of all ages; as well as those with orthodontic appliances in place, it retains the same soft touch grip and colour coding as the Tandex FLEXI. It is an ideal addition to the range, which also includes toothbrushes, toothpicks, den-
beginnings in 1931, when business men Bay and Vissing created Tandex as the ‘dental arm’ of their brush company. Their only product at this time was the humble toothbrush, which in the early 1950s, was still made from a bone or wooden handle, fitted with bristles taken from the neck and shoulders of pigs. Little had altered since William Addis sold the first commercially marketed toothbrushes in the UK in 1885, but that was soon to change, thanks to American chemical company DuPont. In 1939, DuPont introduced nylon to the world, and toothbrush manufacturers were quick to utilise the material for their bristles, thus revolutionising the industry. With such advances in dental technology, companies like Tandex thrived, and with the advent of specialised interdental brushes in the 1980s, the company found its niche. Interdental brushes may have been initially designed for the wide interproximal gaps found in patients suffering from periodontitis, but once it was firmly established that such devices could be utilised in every patient’s oral health care regime, Tandex were quick to develop products that could be used by any patient of any age.

Since Janni’s appointment as MD, Tandex have continued to go from strength to strength and now have an excellent customer base in the UK. To ensure that things are running smoothly at this end of the line, Tandex employs a special team of dental professionals to represent the company at dental shows, help collate that all-important customer feedback, and assist in the design process. Rachel Pointer, a dental hygienist, has been instrumental in developing new products for the Tandex range, and Janni holds her and her team in the highest regard.

“It’s the work of profession- als like Rachel that really helps Tandex to continue to grow. With first-hand experience of using these products in the surgery, she can advise us on what does and doesn’t work for patients and this is an invaluable part of the development process.”

The emphasis placed on the abilities and welfare of its staff is definitely one of Tandex’s biggest selling points. The overall impression one gets when speaking to Janni is that this is a company that cares, about its customers, its products and its staff. Some of the Tandex employees have been with the company for over thirty years and their loyalty inspires Janni herself to keep striving for perfection and pitching in where needed, even if that means donning work gear to spend a day on the factory floor.

Tandex’s dedication to quality and customer care is obvious, and it is this that drives the company:

“As a small company we are in an excellent position to listen to every piece of customer feedback and we use this feedback when designing new items. The most important things for me are that our products are of the highest quality and our employees look forward to coming to work in the morning. After all, if you don’t enjoy your job, you can’t do your best work!”

From the quality of its products, it is easy to see how Tandex has accumulated 80 years excellent service to the dental industry and, with the enthusiasm shown by Janni and her staff, it is easy to see how it will continue to thrive in the future.

For more information on any of Tandex’s range of products for better oral health, please visit www.tandex.dk
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Email info@smile-on.com or call 020 7400 8989
ISAs: A flexible, tax-free investment

Richard Lishman discusses the best ways to choose an ISA that works for you

UK interest rates are at unprecedented lows and are likely to remain so for some time yet, meaning that most ordinary savings accounts offer miniscule payouts, even to those who have accrued a substantial amount of reserves over the years. In this environment, it is tempting for savers to ‘live for the moment’ and forget about putting aside some assets to meet the costs of old age or unexpected future expenses. Individual Savings Accounts (ISAs), however, possess a number of attributes that differentiate them from a regular account.

Tony Blair’s Government introduced ISAs in 1999 to replace the earlier Personal Equity Plans (PEPs) and Tax-Exempt Special Savings Accounts (TESSAs). These vehicles were often accused of excluding the less wealthy, whereas ISAs were and are designed to be available to all savers, regardless of their existing wealth. Cash ISAs cost just £1, making them effectively free. The ability of ISA holders to withdraw funds from their accounts at any time also appeals to those with fewer assets, who may dislike the idea of locking up funds that may be necessary to insure against unforeseen expenditure.

The main attraction of ISA products for most, however, is their exemption from taxable status. Interest on cash ISAs and dividends on stocks and shares are both tax free, meaning test for those receiving age-related allowances from the Government.

The ease of managing ISAs is another important factor working in their favour. It is a simple procedure for investors dissatisfied with the performance of their existing account to transfer their funds to another ISA provider or fund (although it is not allowed to have more than one cash ISA and one stocks and shares ISA per tax year).

The flexibility of cash ISAs can also be found in the make-up of stocks and shares ISAs. For those wishing to undergo the risks inherent in betting on the stock market (the investor must accept the possibility that up to five percent of the non-cash part of the investments could potentially be lost) it is permissible to allocate funds to investment trusts, UCITS authorised funds, public debt securities, government bonds and deposits interests as well as ordinary stocks and shares.

Stocks and Shares ISAs also allow their owners to spread their assets amongst any number of different funds and fund managers, diversifying their range of share options and thus reducing risk. The ease and potentially higher rewards of investing in equities (given current low interest rates) ensured that sales of stocks and shares ISAs increased to £3.9billion during 2010, making it the best year for them since 2001.

Between now and April 5th 2012, investors can put up to £5,340 into their cash ISAs and £10,680 into their stocks and shares ISAs, giving them a financial advantage in terms of the interest they gain through the allocation of large sums of money at an early point in the tax year (the annual allowance cannot be carried over into the next year, so it has to be used before the deadline). Nevertheless, those unable to make a significant investment at the present time would do well to note that the latter part of the tax year always sees the emergence of a variety of new ISA products, which draw in customers by offering generous interest rates.

At a time when living standards and real wages are being driven down by a UK economy experiencing a shaky recovery from the financial crisis, it makes sense to look around for financial investments that have the potential to provide greater security and freedom for people wishing to save money for big purchases, insure against unexpected crises or supplement their pensions. ISAs remain one of the best ways for people, whatever their means, to build for the future. Picking the best one for your specific needs on your own, however, can be disorienting and time-consuming; the advice of an independent financial adviser can prove invaluable.

About the author

Richard T Lishman of money4dentists.com is a specialist in financial advice for dentists across the UK manage their finances and is a Financial Adviser who help people across the country to manage their money and achieve their financial and lifestyle goals. For more information call 0845 333 5880 or email info@money4dentists.com

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SERIAL OFFER - SPRING 2011

DENTAL CHAIRS AUTOCLAVES SUCTION PUMPS X-RAY UNITS
The role of the scapegoat

Dave Martin discusses giving hygienists and therapist direct access

I took the plunge in 2002 to work as a self-employed therapist in general dental practice. Nine years on and things seem to be getting a little worse for the employment of therapists. This is rather puzzling, not to mention worrying, as many training centres (especially in my region of the North West) were set up to deal with the short fall in dental access. My understanding is that dental therapists were to be trained to help alleviate dentists’ workloads. I can’t help thinking that something has gone wrong somewhere.

I speak from my own experience so appreciate that this might not be generalisable, but when I qualified it wasn’t so hard to secure a post. To get full time therapy work has been difficult so my week involves a combination of therapy and hygiene. When I worked in bigger practices it was only the principal who referred to me for restoration work, because the associates were unprepared to lose money or a UDA value for referring. Restorations that are referred to me and other therapists are usually beyond repair or without recent radiographs and extractions are referred on non-cooperative children or needle phobics.

Sometimes I have felt like a scapegoat with a preponderance of difficult or non-cooperative patients referred onto me. Experiences and anecdotes shared at conferences and local meetings only consolidate this fact alongside many different concerns about below par dentistry and treatment purely for financial gain. I appreciate that I appear to be rocking the boat but I may add that I have been fortunate to work with some excellent fellow professionals so I do not tarnish everyone with the same brush.

Our experience of undergraduate training means that boundaries, remits and legalities are drummed into us so we qualify with a good perception of what is right and what is wrong. You only have to look at the number of hygienist or therapist cases in the back of the GDC gazette to get a pretty good idea that we abide by the rules. Guided by our professional ethics, and the GDC mission statements, we always have the patients’ best interest at heart. It seems we have to go to extra lengths and plough through red tape to even get ourselves into general practice but looking at the coal face of dentistry it seems we have to prove ourselves worthy of even straightforward referrals. Why?

We are competently trained and able to provide a high standard of primary care dentistry. The entry level requirements for our academic courses may not match those for dentistry but this does not render us second rate in terms of our clinical competence. There is clear evidence of the value and benefits to a dental health system of appropriate and successful usage of dental therapists which is seen across the globe for many years, so why is it not seen in the UK?

Therapists in Canada, Malaysia, Tanzania, China and New Zealand all have direct access with great effect. It is interesting to note that in Malaysia after 50 years of direct access not one case has been brought against a dental nurse (therapist). Malaysian dental nurses are currently in the process of trying to get their mission statements, we always have the patients’ best interest at heart, so appreciate that this might not be generalisable, but when I qualified it wasn’t so hard to secure a post. To get full time therapy work has been difficult so my week involves a combination of therapy and hygiene. When I worked in bigger practices it was only the principal who referred to me for restoration work, because the associates were unprepared to lose money or a UDA value for referring. Restorations that are referred to me and other therapists are usually beyond repair or without recent radiographs and extractions are referred on non-cooperative children or needle phobics.

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down! This is in contrast to medicine’s upward referral system in which a doctor will refer a patient to a specialist if s/he is unable to deal with a particular problem, or a practice nurse will refer up to a doctor if s/he cannot deal with a condition. It’s time dentistry is brought in line with medicine!

We are all trained in intraoral and extra oral assessments included in our remit and we have comprehensive training in spotting potential suspicious lesions. We all treat caries and periodontal disease yet I don’t see how we do this effectively without being able to identify, or dare I say, diagnose these diseases.

BSDHT and BADT joined forces on the 23rd of February and invited the newly formed GDC to an evening of presentations from both associations. The setting was Chandos House, just a stone’s throw from the GDC headquarters in London. Sally Simpson (President BSDHT) and Kia Stearns (Chair BADT) chaired the evening’s talks and past BSDHT president Margaret Ross gave an inspirational presentation on education.

Margaret made it clear that training of hygienists and therapists is equal to that under graduate training; in fact in some schools hygienist/therapists come out with far more clinical experience than under graduates. She approached the subject of direct access head on with great effect. This was followed by presentations from clinical hygienist Michaela O’Neil and clinical dental therapist Charlotte Wake who talked about their daily working life and how direct access would improve their patients care.

Dentist Graham Dindol then talked about skill mix within his practice and how he utilises both hygienist and therapists successfully with no detriment to quality of patient care. Dentist Tony Newton from the British Dental Health Foundation then provided a short synopsis on how direct access would enhance the oral health needs of the public.

Finally Mike Wheeler, past president of the BSDHT, rounded the event up perfectly highlighting the excellence of dental hygienists and therapist work and thanking the GDC for their support throughout the years in expanding the remit of DCP’s and recognising skill mix within the field of the clinical world of dentistry.

The evening was also a fantastic opportunity for both associations to meet the new lay members of the GDC. They come from all walks of life and are very experienced in regulation of different aspects of health care. They are surely a great asset to the new GDC and hopefully will provide balanced views for direct access to improve quality of patient care and a greater integration and true skill mix within their practices. With new pilots schemes underway throughout the UK DCPs should be well placed to provide a great service in line with the Department of Health’s main objectives of provision of dental care to the nation.

With consultation and robust educational objectives, therapists and hygienists can hopefully take on patients directly freeing more time up for the dentist to see emergencies or provide advanced care thus improving access and availability. This after all is what we were trained to do. Dentists can be assured of a preventive focus for delivery of patient care and a greater integration of patient and therapists and hygienists can be assured of a preventive focus for delivery of patient care and a greater integration of patient and therapists and hygienists.

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*Finance is subject to status and for business purposes only.
Members of dental team do not always have a say in the choice of their team colleagues. They must trust that when recruiting new colleagues their managers will select someone who is compatible with the existing team. Even if they select with the team culture in mind, it is part of the nature of interpersonal relationships that from time to time you will reach a point where although you know that you should ‘talk’ with a colleague, you prefer to avoid a potentially difficult conversation for fear of it turning out badly and making matters worse.

Neuro-Linguistic Programming (NLP) is a psychological approach often used to reinforce workplace relationships. This approach places great importance upon accentuating the positive, so rather than worrying that things will become confrontational, it advocates that you go into the conversation expecting things will go well.

Even when viewing the situation using a positive frame of mind, the biggest obstacle could well be deciding on how to open the conversation. One possible way to proceed would be to open with “I’d like to get your point of view about…” To make this work, mentally rehearse the conversation through many possible variations and responses, and consider what you would do to bring it back on track if need be.

Before you can build strong and durable workplace relationships with colleagues with whom you do not instinctively see eye-to-eye, you need to understand how the other person’s views and responses differ from yours, then using this information try to get a sense of their ‘difficult behaviour’.

On the whole, we are naturally drawn towards people who are like us and share our outlook and interactive style. However, a truly effective and efficient team is one that accepts people of all styles and recognises that each individual has a valid contribution to make.

Look at the styles below and consider: 1. Which is your natural interactive style? 2. What are your colleague’s styles? 3. What is the style of your ‘difficult person’?

**Style 1- Checkers, these:**
- Consider and analyse facts and data
- Pay attention to detail
- Reflect before taking action
- Are patient and systematic
- Like to be systematic
- Tend to be perfectionists
- Withdraw under pressure

Style 2- Commanders, these:
- Initiate action
- Act before analysing
- Multi-task
- Are results focused
- Are deadline driven
- Get it done rather than get it right
- Want to control others
- Style 3 Collaborators, these:
- Are sociable
- Put priority on relationships
- Are patient
- Are low risk
- Want to take time to get people’s opinions
- Lose sight of achieving the task in their preoccupation with people’s feelings
- Style 4 - Communicators, these:
- Are articulate
- See the big picture
- Enjoy relationships and recognition
- Seek opinions and ideas
- Are impatient
- Are keen to get it done

Understanding how your natural style directs your responses is starting point for allowing others a right to their responses. The basis of good working relationships is one of respect, tolerance and understanding on the part of all parties concerned. This type of relationship can only be forged through acceptance of how others perceive you, and how they react to your personality and style.
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GSK creates aquafresh ultimate - a major toothpaste launch
GlaxoSmithKline Consumer Healthcare (GSK) is committing £15 million to this in-mould category with the launch of Aquafresh Ultimate – a new premium toothpaste designed to deliver high-market place novelty. Aquafresh Ultimate provides whole tooth protection by strengthening the tooth above the gum line, whilst its unique fluoride formulation helps to keep the gum seal tight and healthy, protecting what’s vulnerable below it.

With its range of product benefits and the great taste which consumers come to expect from Aquafresh, the NDG will appeal to the whole family, especially to mums who believe that it is essential for healthy teeth and are willing to invest time and money to achieve this. Aquafresh Ultimate, which is also available in a whitening variant, comes in a stand-up carton-less tube with shelf-ready trays for maximum stand out. The cartons feature a tooth graphic, utilising Fresnel lens technology to provide holographic images on Key surfaces. Combined with the Aquafresh logo and three-dimen...
A Higher Profile for Bruxism

Bruxism Awareness Week 2011 will run October 24-30

With more than half the adult population of the UK believed to suffer from bruxism, it’s no surprise that dentists who are aware of the condition report that up to 85% of their patients present the symptoms associated with persistent clenching and tooth grinding. However, since bruxing is generally sleep-related, the patient is frequently unaware of his/her unconscious oral movements, and all too often the dentist will assume their tooth wear is the result of ageing or normal mastication.

Dentists whose patients present with unusual sensitivity to pain or pressure should immediately suspect bruxism and check the dentition for stress fractures, cusp fractures and abfractions. Once the telltale signs of bruxism have been identified, the traditional dental solution has been often an occlusal splint, which separates the molars by a layer of hard plastic, to prevent damage to the teeth. However, for those patients whose clenching on the layer of plastic continues to be problematic, a new design of device, that provides a biting surface on the front teeth only, has shown to be highly successful. In order for highly intense clenching or grinding to occur, the back teeth must be in contact with each other, or on a provided substrate, like the traditional dental splint. The new design, termed an “NTI device” prevents the back teeth from touching each other, thereby keeping clenching and grinding intensity to a fraction of its potential.

Realising the low levels of awareness of bruxism among both the public and dental clinicians, staff at S4S, the exclusive supplier of the NTI-tss mini anterior Bruxism splint, decided to take action, and in October 2010 inaugurated the first ever Bruxism Awareness Week. S4S Commercial Director Neil Bullement explains:

“...needed to create an event to highlight Bruxism because it so often goes undiagnosed and causes a great deal of unnecessary suffering. We produce occlusal splints in our laboratory and had already sponsored training for GDPs in this area, so we thought the next step was to go national and really make people aware of the condition. We decided that the best way to do this was to make dentists themselves more aware of bruxism so that they, in turn, could help their patients. We encouraged dentists to attend training courses on the use of splints and gave out ‘Bruxism Awareness’ packs, which contained marketing materials such as posters, patient information leaflets and badges. The initiative was a massive success. We had requests from 200 different practitioners for packs and estimate that up to 350 practices participated in the event.”

During the first Bruxism Awareness Week S4S also raised more than £500 for Help 4 Heroes, a charity that supports wounded service men and women, as service personnel frequently suffer with the condition.

Bruxism Awareness Week this year will run from 24th – 30th October and repeat the successful format of 2010 but on a larger scale. To learn more about Bruxism Awareness Week or to request a free information and promotion pack, please contact S4S on: 0114 250 0176 or email: info@s4sdental.com
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**Saturday 20th August 2011**
Heathrow Holiday Inn, London. For room reserverations call Reena Sherchan:
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