No ‘quiet life’ for Cameron as NHS debate rages on

Prime Minister defends NHS reforms, stating ‘we cannot afford not to modernise’, while resistance builds from medical associations

Last week Prime Minister David Cameron, (pictured), gave his speech on NHS Reforms, arguing that “fundamental changes” were required for the UK to catch up with European health care standards.

The general feeling throughout his speech was that without change, children will be poorly educated, patients will be unhappy with the NHS and public faith in law and order will be crushed. Adding that change should not be “put off any longer” Mr Cameron made it clear that “quietly standing still” was no longer an option. Mr Cameron added that there will be “new powers for GPs, who can join together in consortia, take control of NHS budgets and directly commission services for their patients. “We are spreading choice, saying to any parent or patient: you can choose where your child gets sent to school or where to get treated and we’ll back that decision with state money.”

Mr Cameron confronted the fact that although there will be rising pressure on funds, technology and new medicine. “Put another way” Mr Cameron said, “it’s not that we can’t afford to modernise; it’s that we can’t afford not to modernise.”

There has however been some concern over the proposed changes, one of which we see GPs taking control of commissioning care. Commenting on the changes during a BBC interview, the Prime Minister said there was “enthusiasm” among the medical profession for the changes; however, according to other reports, the Royal College of GPs, the British Medical Association and trade unions have insisted that the upheaval is unnecessary.

The underlying issue lies with the fact that Britain requires for the UK to catch up with what they spend elsewhere for their healthcare.

As further reports have suggested, this year will be a critical time for the Coalition’s public service reforms, as they begin a process that will modernise public services, such as health, education and justice.

At this time of writing the Health Bill has yet to be published, however, what has been described as an “overhaul” of the health service will most certainly come into practice as Primary Care Trusts will continue to be scrapped, and power and financial control will be handed to GPs.

Many have reportedly volunteered to pilot the reforms, demonstrating the appetite for change.

www.dental-tribune.co.uk
A year of communication

As Alison Lockyer, (pictured), marks her first year as Chair of the General Dental Council in January 2011, she’s urging more registrants to get involved in the regulator’s work.

“New Year is traditionally a time to make resolutions but the GDC is already ahead of the game with its corporate strategy now firmly in place. Instead it’s time for us to really get down to business with delivering the results we’ve promised registrants.”

One of the biggest commitments in the strategy is to review GDC Standards for Dental Professionals. Alison said: “Our strategy pledged to ensure policy is developed on the basis of consultation and evidence. The Standards review is an example of this. Work is picking up pace in 2011 with a series of events helping us listen to the people who will be most affected by the changes we make – dental professionals. We know from the calls and emails we get that there are plenty of people with views on the standards we expect registrants to meet. Now is the chance to help shape this work. We’re holding free registrant events across the UK from January onwards with workshops about this important issue.”

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Participation can count as two hours verifiable CPD. Details are on our website www.gdc-uk.org. The Standards review is one of a number of key projects moving forward in 2011.

Alison added: “We’re looking at a number of other important issues. At the heart of this work is our aim of delivering regulation which is proportionate, targeted, consistent, transparent and accountable. Revalidation remains a focus for regulators and we will continue to seek the views of registrants as well as members of the public and other interested parties as we refine our draft plans. We’re also gathering views on the GDC’s Scope of Practice guidance – is it helpful or restrictive? Are there skills registrants think should be included but are missing?”

Alison had one clear message for dental professionals for 2011: “We believe one of the biggest strengths of the GDC is its 96,000 registrants. They are the ones who make the most visible difference to patients’ lives and we want to learn from them. Taking part in consultations, coming to events or even emailing us some feedback can help us learn from their insights. I hope 2011 will be a year of communication for us all.”

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Editorial comment

All eyes are on the government this week as the long-awaited updated Health Bill is published. David Cameron has already begun his defence of the Bill before its publication in a speech delivered at Parliament. Medical associations have been expressing their concerns, calling the reforms ‘an upheaval’ or ‘unnecessary’.

Does any of this sound familiar? I can hear the low mutterings of dentists saying ‘welcome to our world’. Of course, the Health Bill will have an effect on dentistry, and Dental Tribune will have comment and analysis on those parts of the Bill which will shake our world even more.

In other news, a shameless plug for Smile-on’s upcoming Clinical Innovations Conference, to be held May 6-7 in London. With an excellent line up of speakers, including Julian Webber, Nasser Barghi, James Russell and Eddie Scher, this really is the place to be for the latest developments in restorative and aesthetic dentistry (and you may even get to speak to me!). Go to page four for more details.

BADM salary survey

The British Association of Dental Nurses has launched its on-line 2010/11 Dental Nurse Salary Survey. The survey will cover the tax year which ended April 2010, and is open to all dental nurses in the UK. The salary information gathered by the survey will be used to lobby the GDC, MPs and other relevant authorities for a more realistic ARF for dental nurses.

The survey, which will close on 51 March 2011, will be conducted through the EVENT facility and several thousand dental nurses will be sent an e-mail invitation to participate. Others can access the survey via a link on the BADN’s website: www.badn.org.uk. Participants will also be able to forward a personalised message to dental nurse colleagues inviting them to participate.

ARF survey results

• 97 per cent considered the increased fee of £120 to be too high for dental nurses
• 97 per cent felt that there should be a separate, lower, ARF for dental nurses
• 89 per cent felt that there should be a lower ARF for part-time workers
• 79 per cent paid their own ARF with no financial assistance from their employers. Employers of 16 per cent paid respondents’ ARF in full and five per cent in part
• Of that five per cent, just over half paid between £50 and £40 towards the ARF, a quarter paid between £40 and £50
• 94 per cent stated that they would re-register in July 2011 – although most pointed out that they had no choice if they wished to continue working as a dental nurse!
• Of those respondents who stated that they would not re-register in July 2011, 68 per cent stated that it was because they could not afford the ARF/fee leaving the profession
• 85 per cent expressed their willingness to lobby MPs regarding the ARF
• 20 per cent considered that an ARF of between £50 and £60 would be appropriate for dental nurses; with 19 per cent each considering ARFs of £60-£50 and £60-£70 appropriate for dental nurses.

11 per cent considered an ARF of £70-£80 acceptable, whilst 14 per cent considered £40 to be the acceptable limit for dental nurses.
BDA calls for a rethink

Proposals to introduce revalidation for dentists would be likely to increase paperwork, reduce the number of patients seen and add another layer of regulation. That’s the verdict of the British Dental Association (BDA), which expressed its response to the General Dental Council’s (GDC) consultation on revalidation for dentists. The BDA argues that the proposals are onerous, bureaucratic and inappropriate, and out of step with the GDC’s repeatedly-expressed intention to develop a system which is proportionate.

Furthermore, it says that the evidence base for the proposals is unsound and that pilots for the proposals carried out in 2009 failed to cover a representative number of practitioners. It also calls for the proposals to be subjected to a full cost-benefit analysis.

Dr Sue Sandersson, Chair of the BDA’s Executive Board, said: “It is important that standards for professional revalidation in dentistry are transparent, consistent, and proportionate, and offer reassurance to patients. The BDA supports measures that meet those criteria. We also agree with the view expressed by the Working Group on Non-Medical Revalidation that the intensity and frequency of revalidation must be proportionate to the risks inherent in the work a practitioner is involved in.”

“The BDA supports the work of the GDC as the regulator of dentistry in the UK, but we have some serious concerns about the proposals put forward in this consultation and the wider context in which they have been presented. The circumstances confronting dentistry have changed since these proposals were initially mooted and it would be sensible to look at them again to assess the cost of changes and the benefits they might deliver. We would welcome the opportunity to input into that process.”

The BDA’s full response to the consultation can be accessed at: www.bda.org/dentists/education/revalidation.aspx.

Clinical Innovations Conference 2011

Education and training provider, Smile-on, is hosting this year’s Clinical Innovations Conference, along with the AOG, the Dental Directory, FGDP and the ESCD. Now in its eighth year, the Clinical Innovations Conference (CIC) will be held on 6th and 7th May at the Royal College of Physicians in Regent’s Park, London.

Promise to be the biggest conference yet, the CIC programme has been put together with the aim to update participants on new technologies, materials and techniques in dentistry.

The 2011 conference will host a line-up of highly prestigious international speakers alongside exhibitors offering the latest dental technologies from around the world. Confirmed speakers are: Nasser Barghi, Wyman Chan, Eddie Lynch, Tif Qureshi, Raj Rajabayan, Raj Rattan, Wolfgang Richer, James Russell, Julian Satterthwaite, Eddie Scher, Liviu Steier, Mahesh Verma and Julian Webber.

The conference holds opportunities where you can:

• Learn truly innovative solutions to achieve superior results
• Gain hands-on experience in the latest techniques
• Take away tips you can start putting into practice immediately
• Question and debate all ideas
• Receive your core subject ‘Medical Emergency’ certificate

A spokeswoman for Smile-on said: “Together with the AOG we have brought together an impressive programme that will be both inspirational and motivating, preparing your practice for the future and ensuring that you too are at the leading edge of dentistry.”

After the success of last year’s CIC, the Clinical Innovations Conference is growing and the 2011 conference is expecting delegate numbers in excess of 500 highly motivated dentists who are passionate about learning.

To accompany the event, Smile-on and the AOG are pleased to announce The Annual Clinical Innovations Conference Charity Ball, which will be held on Friday 6th May. With more than 500 people expected this promises to be a night to remember. Traditional dress is encouraged.

For more information call 020 7400 8899 or email info@smile-on.com.

Is asthma linked to caries?

A recent thesis presented at the Sahlgrenska Academy has concluded that children and adolescents with asthma have more caries and suffer more often from gingivitis (gingival inflammation) than people of similar age without asthma.

The work presented in the thesis examined children, adolescents and young adults in the age groups three, six, 12-16 and 18-24, with and without asthma. The first study revealed that three-year-olds who suffer from asthma have more caries than three-year-olds without asthma.

The scientists have also compared the oral health of adolescents aged 12-16 years who had long-term moderate or severe asthma with that of adolescents of the same age without asthma. Marin Stensson, dental hygienist and researcher at the Department of Cardiology, Institute of Odontology at the Sahlgrenska Academy said: “Only 1 out of 20 in the asthma group was caries free, while 15 out of 20 were caries free in the control group.

“One factor that may have influenced the development of caries is somewhat lower level of saliva secretion, which was probably caused by the medication taken by those with asthma. Adolescents with asthma also suffered more often from gingivitis than those without asthma.”

The work presented in the thesis also examined the oral health of young adults aged 18-24 years, with and without asthma. The results from this age group were nearly identical with those in the group of 12-16 year-olds, although the differences between those with asthma and those without were not as large. Stensson points out that the care system.

Cloudy with a chance of fluoride

What if your toothpaste could tell you whether you needed to leave the house carrying an umbrella? Or how hot the day was going to be?

Odd as this may sound, a new product that does just this is currently being created by David Carr of MIT’s Media Lab. The prototype product, “Tastes Like Rain” is a one of a kind invention that uses a computer and weather information from the internet to dispense different flavours of toothpaste depending on the weather.

One blog on the new toothpaste dispenser said: “The prototype is currently hooked up to a small Linux computer that pulls forecasts, using custom software to compare previous and current temperatures and divvy up the flavours.

“In this case, toothpaste is modified to dispense one of three flavours depending on the weather. If it’s mint, you know it’s colder out than yesterday. Cinnamon means it’s hotter. Blue stripes indicate precipitation.”
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Recommending an Oral-B® electric toothbrush is one of the best ways to help your patients achieve better oral health for life. That’s because Oral-B® electric toothbrushes can help patients:

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Please visit oralb.com for more information.

* vs a standard manual brush.
Reference: 1. Data on file, P&G.
$0.5m donation for dental initiative

King’s College London Dental Institute’s Flexible Graduate Programme has received recognition with a $548,000 donation from Henry Schein, Inc. The money will fund training, scholarships and awards.

Professor Nairn Wilson, Dean and Head of the Dental Institute, commented: “King’s College London Dental Institute is grateful to Henry Schein for its most generous support of the Institute’s innovative Flexible Graduate Programme which is anticipated to include 220 students in more than 50 countries in 2011.”

The donation included: The supply of a package of dental products and materials to each first-year graduate student commencing the Flexible Graduate Programme; Five Henry Schein Scholarships per annum to support graduate students on one of the Flexible Graduate programmes; A Henry Schein Events Programme to support professional networking activities. The donation also included the Henry Schein Excellence Award which will honour a Flexible Graduate Programme graduate each year for exemplary application of their new knowledge and understanding.

Cancer strategy could save 5,000 lives a year

‘Improving Outcomes – A Strategy for Cancer’, sets out how the Government, NHS and public can prevent cancer, improve the quality and efficiency of cancer services and move towards achieving outcomes which rival the best in Europe.

Overall, these plans will drive up England’s cancer survival rates so that by 2014/15 an extra 5,000 lives will be saved every year.

The strategy – backed with investment of more than £450 million to increase earlier diagnosis. This money will fund increased GP access to diagnostic tests and more testing and treatment in secondary care. It will also go towards Public Health England – the new public health service – to promote screening and raise awareness of the signs and symptoms of cancer.

Over the Spending Review period, this will allow for primary care access to more than two million extra tests, in addition to funding increased testing and treatment in secondary care. Tests include:

- Chest X-ray – to aid in diagnosing lung cancer
- Non-obstetric ultrasound – to support the diagnosis of ovarian and other cancers
- Flexible sigmoidoscopy/colonoscopy – to support the diagnosis of bowel cancer
- MRI brain scans – to support the diagnosis of brain cancer

In addition, the Government will provide extra investment to increase access to radiotherapy and ensure all patients are able to get this critical treatment.

‘Improving Outcomes – A Strategy for Cancer’ is the first of a number of outcomes strategies to be published following on from the White Paper, Equity and excellence: Liberating the NHS.

Outcomes strategies will play a crucial role in translating the underpinning principles of the Coalition Government’s reforms of the health and care services into the steps it needs to take to drive improvements health outcomes; putting patients and the public first, empowering professionals and strengthening local accountability.


Get ‘Up To Date’ with P&G

Oral-B has released the dates for their 2011 ‘Up To Date’ scientific exchange seminars with guest speakers Prof Trevor Burke, Prof Iain Chapple & Prof Nicola West. The lectures are aimed at dentists, dental hygienists and therapists.

Clinical dental professionals are invited to attend a complimentary CPD accredited evening event at one of ten locations:

- Torquay (Imperial Hotel, 16 Feb), Sheffield (Kenwood Hall, 8 Mar), Birmingham (National Motorcycle Museum, 10 Mar), Reading (Hilton Hotel, 5 Mar), Cardiff (St David’s Hotel, 7 Apr), Warrington, (The Park Royal, 14 Apr), Newcastle (The Life Centre, 5 May), London (The Life Centre, 5 May), and Milton Keynes (The Park Royal, 14 Apr),

Every delegate is invited to enjoy a complimentary meal at the beginning of the evening and a free gift which retails at £150. Contact Julia Fish on 07585-508550 or e-mail julia@abcommunications.com.

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Every delegate is invited to enjoy a complimentary meal at the beginning of the evening and a free gift which retails at £150. Contact Julia Fish on 07585-508550 or e-mail julia@abcommunications.com.
Staff support for B2A

Practice Plan, the leading provider of practice branded dental membership plans and Bridge2Aid, a charity providing primary dental care and education to communities in Tanzania, have always had a very close relationship. From sponsored walks and bike rides, to event sponsorship, design support, Christmas cards or physically travelling over to Tanzania to carry out restoration work, Practice Plan has endeavoured to support the worthwhile charity year-upon-year.

However, the company has now decided to go one step further and actually delve into the heart of the charity and financially support the people on the ground in Tanzania, and so, Practice Plan now covers the salary for one of the charity’s employees, a Community Support Worker called Kibibi Kengia. Chief Executive of Bridge2Aid, Mark Topley explained: “Practice Plan’s sponsorship of Kibibi on our Community Development team has been a huge benefit to our programme at Bukumbi. It allows us to commit confidently to regular work with a vulnerable and marginalised group of people, and bring hope, dignity and encouragement on a weekly basis. We’re very grateful to Practice Plan for their continuing support which is helping to change lives in Tanzania.”

To find out more about the fundraising Practice Plan does, or to see how they can support you, please call 01001 084155 or visit www.practiceplan.co.uk for more details.

An innovative device which cancels out the noise of the dental drill could spell the end of people’s anxiety about trips to the dentist. Experts at King’s College London, Brunel University and London South Bank University, who pioneered the invention, have developed the device to help phobic’s attend the dentist more easily.

It is believed that many people’s fear of the dentist is rooted in the ubiquitous noise of the dreaded drill and is the prime cause of anxiety about dental treatment; however with this new device, the patient will be able to listen to their favourite tunes on an MP3 player. The headphones used with the device use noise cancelling technology, with inbuilt resistors that dull low frequency wavelengths.

The device works by using an ‘adaptive filtering’ technology, where the headphones block out certain wavelengths, allowing the dentist’s voice to seep through unaffected. Containing a microphone and a chip that analyses the incoming sound wave, the device produces an inverted wave to cancel out unwanted noise.

Although the product is not yet available to dental practitioners, King’s is calling for an investor to help bring it to market.
Living in the post-Christmas haze

Elaine Halley provides us with an MSc update

This will be my shortest blog to date as it is currently the 3rd January and I am coming out of the post-Christmas haze with the stark realisation of the amount of work I need to cover before the next two deadlines of 17th January and 28th January. The scene at the moment as I have unplugged in my laptop to finally face-up to the detail of what I need to accomplish, is that I have a three year old asking me to put the skirts on her Playmobil princesses and a nine year old piano practice to lull me into concentration mode. And it is snowing AGAIN – although not badly, but still a good motivation to stay inside!

So, we have the final assignment of our clinical research module to complete. This involves composing a research question, designing a structured search using terms such as Boolean Operators and MeSH terms – I’ll definitely need to refer back to my notes as I think the Christmas port must have deleted the part of my brain which studied that in November! What research question will I come up with? Something to do with bonding I think, maybe even direct dentine bonding as I am such a Magne disciple (or is it groupie?). Or I could do something on bacterial testing in peri? The dilemmas continue... somewhere along the line I have to discuss relevant outcome measures and ethical issues so maybe I should start from there and work back? Oh help...

Then there are the final six clinical case studies for module three. I have at least been organised enough to have the cases ready with all the photos uploaded (this takes forever in itself – I’m sure Smile-On will improve this platform for future students) – I only (!) need to write up the case reports – oops, not quite, I’ve got five but I still need to find someone who needs complex whitening – know anyone with tetracycline staining in Perth? Send them along to me....!

So, Endnote references at the ready – here I go... Nothing like starting the New Year with a healthy dose of stress!!

About the author

Elaine Halley BDS, ENGDP (UK) is the BACD Immediate Past President and the principal of Cherrybank Dental Spa, a private practice in Perth. She is an active member of the AACD and her main interest is cosmetic and advanced restorative dentistry and she has studied extensively in the United States, Europe and the UK.
Infection control

Richard Musgrave discusses the importance of effective surface decontamination

With the ever increasing focus on the importance of infection prevention and control, particularly since the recent outbreaks of MRSA and C.Diff, the need to enforce stringent decontamination protocols has never been more relevant. Infection control has and always will be a subject of paramount importance in medical and healthcare environments; however, in recent years there has been an increased level of awareness, both within the field and amongst the public, of the risks associated with sub-standard cleaning procedures. This in turn has highlighted the obligation of every member of the dental team to strictly adhere to infection control procedures.

It is essential that all work surfaces and floor coverings are continuous, non-slip and where possible, jointless. It is a well-established fact that surfaces are especially vulnerable to contamination from potentially infective microorganisms, and as such require strict and systematic decontamination that will significantly reduce the risk of infection to both patients and staff alike. Arguably the most effective way of ensuring that decontamination is executed as effectively as possible is a technique known as ‘zoning’. Zoning is a preliminary step to surface disinfection, focusing on clearly defined areas that are prone to contamination and involving the separation of contaminated and clean areas along with the allocation of dedicated space to ‘dirty’ and ‘clean’ instrument storage. When zoning, the areas that must be included are:

- Dental chair and spittoon
- Work surfaces
- Controls/switches
- Floors

Practices must ensure that appropriate and sufficient training is given to all members of staff, and document it as evidence. It is essential that dental nurses always deal with treatment areas, although it is acceptable to employ a cleaner to take care of floors and public areas. When staff go through the process of cleaning and disinfecting, it is then that, damage and wear come to light, enabling them to be dealt with quickly so as to avoid bacteria and dust accumulation.

Recent research indicates that the regular use of commercial bactericidal cleaning agents and wipes is effective in maintaining cleanliness whilst potentially reducing viral contamination of surfaces. In the last few years, infection scares have highlighted the very real need to ensure that decontamination protocols, such as the one below, are followed:

- Treat your patient
- Discard all disposable protection
- Remove and discard all disposable end fittings from the suction unit
- Disinfect the chair and hand controls
- Clean and disinfect surfaces, chairs, spittoons and other risk areas
- Add new disposable protections and fittings

- Treat your last patient
- Clean and disinfect all work surfaces, including those not visibly contaminated
- Clean and disinfect surgery floors
- Always clean from the cleanest area towards the dirtiest

The importance of strict and effective cleaning and decontamination cannot be overemphasised, it is essential to all dental practices and should be adhered to by all staff members.

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About the author

Richard Musgrave With a background in the industry spanning 18 years, Richard brought his knowledge and experience to schülke five years ago. Initially working to develop both the range of infection control products and also the acclaimed infection control training division, Richard is now responsible for the UK marketing team.
Dentists give three cheers for the return of Citanest®

Dentsply celebrates the relaunch of popular anaesthetic

On October 22nd 2010, DENTSPLY Marketing Director Gary Marvin sat down to chair a press conference on the re-release of Citanest – the local dental anaesthetic that had proved one of the company’s biggest success stories. The release had caused quite a stir, as the product had proved a favourite amongst dental practitioners for over a decade. The point of this press conference, said Gary, was to reassure the dental industry that Citanest was back for good.

The Citanest story began in 2000 when DENTSPLY acquired the licence to produce it from the pharmaceutical company AstraZeneca. DENTSPLY quickly established the product as a market leader but when manufacturing was moved to a new site, supply was rapidly outpaced by demand. This served to reiterate the popularity of the anaesthetic, as the Citanest-shaped gap in the market proved hard to fill. Containing felypressin in stead of adrenaline, Citanest is unique in the world of dental anaesthetics as it can be safely administered to all patients without the risk of cardiac problems and, as it does not contain latex, is also the ideal choice to eliminate the risk of allergic reaction. Just as effective as lidocaine-based anaesthetics but 40 per cent less toxic and with excellent tolerance levels, Citanest, with its patented active ingredient octapressin, is a safe and reliable choice for any dentist.

Forced to switch back to lidocaine based products or plain solutions containing no vaso constrictors, many dentists were initially chagrined at the loss of their favourite product. It quickly became clear, however, that the reason for this sudden lack of Citanest came not out of a problem with the product, but a problem with the manufacturing plant. Once dentists understood that the delay in re-releasing the product was due to DENTSPLY’s determination to ensure complete patient safety and quality control, the battle for more supplies became a waiting game, as practitioners and suppliers sat back and counted the days until Citanest was once more on the shelves.

That day came a little over four months ago, when Citanest was officially re-released. Not wanting to rush into things and risk disappointment, DENTSPLY held off on its press conference and set about securing an initial two dealers for the product, so that the team could be certain of keeping a close eye on supplies and making sure that stocks never ran low. With stocks of Citanest plentiful and the product assured to be of the highest quality, DENTSPLY could release them for the profession, along with its accompanying accessory, the self-aspirating anaesthetic syringe.

The key to the administration of local anaesthetic is the avoidance of blood vessels during the injection. This has proved problematic for many years as, in testing to make sure no blood vessels have been hit by aspirating (withdraw the bung a little and reinserting it), the dentist can, with a slight shake of the hand, accidentally re-enter in the wrong place, with potentially serious effects. With the self-aspirating syringe however, aspiration requires little movement from the practitioner. This product has had excellent feedback from practitioners and, combined with the unique properties of Citanest, provides one of the safest available methods of anaesthetising dental patients. DENTSPLY are also reintroducing Xylocaine, which is an effective, highly local, traditional anaesthetic with a better tolerance rate than many other brands. Xylocaine will be available in plentiful supply.

‘The key to the administration of local anaesthetic is the avoidance of blood vessels during the injection’

For more information, or to book an appointment with your local DENTSPLY Product Specialist, call: 0800 072 5315 or visit www.DENTSPLY.co.uk
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Sterile clear aqueous solution containing prilocaine hydrochloride 30mg/ml and Octapressin (felypressin) 0.03 i.u./ml.

USES:
Dental infiltration anaesthesia and all dental nerve block techniques.

DOSAGE & ADMINISTRATION:
Usual adult dose is 1–5ml. Children under 10 years 1–2ml. A dose of 10ml (6 cartridges) should not be exceeded. Elderly or debilitated patients require smaller doses.

CONTRA-INDICATIONS, PRECAUTIONS, WARNINGS ETC:

Contra-indications:
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Precautions:
Caution must be taken to avoid accidental i.v. injection as it may give rise to rapid onset of toxicity. Use cautiously in the elderly, patients with epilepsy, severe or untreated hypertension, severe heart disease, impaired cardiac conduction or respiratory function, liver or kidney damage or poor health, if high blood levels are anticipated. Avoid injection if site is inflamed. Facilities for resuscitation should be available. Side effects: Extremely rare in dental practice and usually the result of excessive blood concentrations. Nervousness, dizziness, blurred vision, tremors, drowsiness, convulsions, unconsciousness, hypotension, myocardial depression, bradycardia and possibly respiratory or cardiac arrest. Allergic reactions. Methaemoglobinaemia; consider giving 1% methylene blue i.v. 1mg/kg over 5 minutes.

Pregnancy:
Use with caution during early pregnancy. Prilocaine enters mother's milk with no general risk at recommended doses. Interactions: With sulphonamides e.g. cotrimoxazole. Vasopressor properties of Octapressin should be considered. Observe caution when concomitant use with other amide-type local anaesthetics. PHARMACEUTICAL PRECAUTIONS: Store below 25ºC. PACKAGE QUANTITIES: Box of 100 cartridges. LEGAL CATEGORY: POM. PRODUCT LICENCE NUMBER: 04690/0028. DATE OF PREPARATION: February 2007. FOR FURTHER INFORMATION CONTACT THE PRODUCT LICENCE HOLDER: DENTSPLY Limited, Building 1, Aviator Park, Addlestone, Surrey KT15 2PG. Adverse events should be reported to DENTSPLY or the MHRA. More information can be found at www.yellowcard.gov.uk. CITANEST® is a trademark of DENTSPLY International and / or its subsidiaries.
The ‘third way’ to open a dental practice

Dental Tribune speaks to Ideal Dental Care’s Peter Thompson and looks how an idea sparked in the Mid-Atlantic began a rollercoaster journey into practice ownership

Haven’t come across a dentist yet who doesn’t have a strong opinion on the dental contracts which came into force in April 2006: A quick trawl of the BBC news archives is a great barometer of the strength of feeling with headlines ranging from ‘NHS dentistry set back 20 years’ through to ‘Success rise amid dental crisis’ and everything in between.

For me, personally I had huge issues with constraints, which I felt were being put upon me to deliver the quality of care that I felt my patients deserved. Going private was the natural transition from what I was doing already so that it wasn’t a big deal.

By 2006 I’d built up the business in Fleetwood, Lancashire to seven dentists and therapists. Puí-Líng Tsoi had also become my business partner and we bought the next-door building and expanded the practice and quickly took the number of dental professionals up to 11.

“For me, personally I had huge issues with constraints, which I felt were being put upon me to deliver the quality of care that I felt my patients deserved.”

And that was it – we’d reached the absolute capacity of our existing location.

Opportunity
But we wanted to expand. So when the new contracts came in it gave us the opportunity to review what we wanted from the business and how we were going to grow it.

It still sounds flippant when I say it now, but I approached one of the UK’s leading super-markets to discuss the idea of putting practices inside their emporiums. Not only did I manage to get my foot through the door but I got to a point where they put an offer on the table. It still brings a wry smile to my face to this day thinking how much I’d achieved simply getting to that point.

But the offer wasn’t right and simply didn’t take us in the direction we wanted to go. So it wasn’t actually that hard a decision to step away and reconsider our options again.

Eureka Moment
We mulled it over for a few months and then during a break away from it all I had that...
eureka moment while halfway across the Atlantic on a sailing holiday. Franchising was the answer.

Franchising is one of the biggest industries in the UK but is often regarded as hidden. That’s because people buy licences to operate businesses under the umbrella of all sorts of well-known brands. This can range from fast food restaurants to opticians. And if it could be done in optometry there was no reason why it could not be done in dentistry. In fact some less courteous than myself would say that it speaks volumes about dentistry that our industry hasn’t progressed enough to embrace new business models, such as joint venture partnerships sooner.

In casting a closer eye over the clinical fence at optometry there’s one company that is head and shoulders above everyone else and has nearly become the byword for opticians.

And just like their brilliant advert which says ‘should’ve gone to Specsavers’, I did, figuratively speaking. Let’s face it, they were never going to throw open the doors and give us chapter and verse of how they’ve done it, but I give us chapter and verse to throw open the doors and face it, they were never going to throw open the doors and give us chapter and verse.

It was crucial to understand how they took a clinical service and created a turnkey operation. It was also fascinating to see how they built a brand and made it more visible and accessible to the public.

As hard as Pui-Ling and I tried to break down every aspect of our business in order to create a blueprint which others could easily follow, we struggled. This was largely because we were too closely immersed in it ourselves.

‘If it could be done in optometry there was no reason why it could not be done in dentistry. In fact some would say that it speaks volumes about dentistry that our industry hasn’t embraced new business models, such as joint venture partnerships, sooner’

So we called in expert help from FDS North, a company which specialises in creating franchises. FDS North is headed up by one of the UK’s foremost experts on franchising, Tony Urwin, whose credits include the development of the Clarks Shop Franchise and also being at the helm of the Walt Disney expansion into the Middle East. Tony and his team crawled all over our business in order to break every aspect down into constituent parts.

They created an operations manual which outlined the processes in easy chunks for anyone wanting to run an Ideal Dental Care practice. A lot of the work is done for franchisees in terms of finding premises, fitting out surgeries and other aspects such as the accounts, but the manual also identifies everything from payment facilities to customer service policies. There are also all the stringent protocols for the level and quality of dentistry the patients receive.

Brand identity

Hand in hand with the creation of the operations manual was the development of the brand identity of Ideal Dental Care. Here again we couldn’t hope to do it on our own and called in some more experts. The creators from a top North West agency developed the identity of Ideal Dental Care, including all the various collateral, such as logos, signage, uniforms, website and advertising.

And with all that done we took the proposition to market and it’s been very well received. We have launched practices such as the one in Sheffield and one we’re about to open one in Scotland. We’ve also acquired a three-story pub which we’re currently converting into our new HQ which will have state-of-the-art conferencing and training facilities.

Credible and Established

While we’re delighted at the progress we’ve made in a very short period of time one thing has become very obvious: Franchising, although a very credible and established method of enabling people to set up and run their own businesses, is still very new for dentistry. But the tide is turning and, as we’ve seen from the rise in our enquiry levels, there is a growing interest in what is often referred to as the ‘third way’ to set up a dental practice.

Specsavers started in 1984 and now look at optometry. I’m hoping Ideal Dental Care will be at the forefront of positive and beneficial development of dentistry, which will make it easier for talented dentists to set up their own practice.

Ideal Dental Care is a joint venture partnership which has a number of practices in England and is about to open its first one in Scotland. For more information visit www.idealdentalcare.co.uk.
So, what are the top 10 KPIs?

Using a man in a boat as an example, Mike Hutchinson draws on his experience to provide some Key Performance Indicators to benchmark your practice.

One of the most pleasurable jobs I have to do is being the Master of Ceremonies (that is a posh way of saying ‘the man on the mic’) at the local village regatta in Port Navas. I stand in the back of a pick-up truck with a microphone and people bring me beer throughout the afternoon, whilst I witter away to my heart’s content reporting on all things from lost mobile phones to the arrival of the RNLI helicopter, from cakes for sale in the field to who’s winning the rowing!

Rowing Race

Invariably the weather is fine and the tide is full. This year, one of the events was a father and child rowing race. It is precisely what it says on the tin: One father, one child, one dinghy (with oars). The idea is to row around a simple course. The first home wins. Simple!

I enjoy badgering people to have a go. In particular people who are down on holiday and perhaps don’t often get a chance to be on the water. One chap, who I assumed was the father of the child in the dinghy (no DNA testing this year), had clearly never rowed a boat before, or possibly even been in a boat. He sat at the back, rowed the boat backwards, whilst his daughter looked down helplessly at him from an angle of about 50 degrees.

This caused a huge amount of amusement amongst the crowd and any number of people came up to me and helpfully suggested I should ‘tell him what to do’.

‘Tell him what to do’

Well, needless to say, I didn’t. After all, in my experience I could not be sure that he even thought he needed help. So for me to start shouting instructions at him would be pointless. However, as the ‘race’ continued, it became quite clear. He was overtaken by everybody – even the man with the dog hanging over the bow and barking at everyone (that’s the dog barking, not the man). He made very little progress and in order for the event to continue before all the water drained out of the creek he was eventually towed back by the rescue boat and received enormous cheers from all those standing on the quay.

I was thinking about this just the other day. He had all the right qualifications: He was the father; he had a child; he was in a dinghy (with oars). So what was the problem?

Well, by looking around him, he very quickly realised that he was not very good at rowing, or at least lacked the skills to enable him to be a better rower. So he had the qualifications, but lacked the skill. Now we are getting somewhere!

New skills

I see this many times over in...
some of the practices that I visit. They are very much like the guy in the boat. They are qualified to be there, so they think they should be, but often have absolutely no idea how they are doing against the rest of the pack. But if they did, do you think that might motivate them to do something about it? Maybe to learn some new skills?

Well of course they should! Most dentists are trained to be dentists, not businessmen. Running a business needs skills in finance, marketing, sales, operations, people management, client experience and personal development (like leadership and vision).

But getting skills is only half the story. Like the poor guy in the dinghy, for part of the race he had absolutely no idea he even needed help. That was until he started measuring his own performance against the rest of the duds (and children and dinghies).

**Benchmarking**

So, what about benchmarking? There are, of course, hundreds of things you could measure. So here is a selection of my top ten monthly KPIs (Key Performance Indicators) that we regularly bench mark amongst our clients:

1. Principal ADY – Good old ‘average daily yield’
2. Associate ADY – No hiding here, simply the bigger the better
3. Hygienist ADY – Ditto
4. Wages as a percentage of gross fees – We are talking about non-fee earners here. Often this can be the practice’s single biggest overhead
5. Fixed costs per surgery – This has been phenomenally revealing in the current economic climate
6. New patients – This is new patient registrations. The lifeblood of any practice
7. New patient conversions – The acid test for selling skills
8. Number of surgery hours available – Where 60 hours in a week is the base line, multiplied by the number of surgeries
9. Net Profit – After drawings or owners salary
10. Net Profit as a percentage of the principal’s income – This is where many dentists realize that everyone in the building is earning more than they are!

I guess the proof of the pudding is in the eating. Measuring things means you focus on them. Sitting with a group of dentists just a couple of weeks ago we found the average increase in turnover was a staggering 54 per cent in the past year.

So, what do you think of that then? Can you think of a better way to win a rowing race other than to:

a) Measure yourself against your immediate competitors
b) Train in all the skills needed to row?

I am yet to find a dentist without a cutting-edge, hard-nosed competitive spirit!

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**A-dec 300**

Simple. Smart. Streamlined.

A-dec 300 is designed for the health of your practice. Because your every movement counts, every detail matters. That’s why A-dec 300 is setting a new benchmark for optimal ergonomics, smart efficiencies, and lasting value. By asking what’s going to help you feel great at the end of the day, A-dec has arrived at a treatment room solution that ensures an easy, continuous flow that is as healthy as it is natural.

In a world that demands dependability, A-dec delivers a proven solution without a single compromise.
Choosing the right designer is one of the most important decisions you’ll make when rebranding your practice. Yet you may not know where or how to begin.

First steps

As with other services, personal recommendation is always a great place to start, although bear in mind that design is very much a matter of personal choice and what may suit one person may not work for another. Still, at the very least, a positive referral should indicate who is professional, efficient, reliable and pleasant to work with.

Over years or recent months you may have admired the logo, literature or website of other practices, so you may like to find out who the designer was and investigate further.

Google is there at your disposal and it is easy to view design portfolios online. Spend time looking at the work designers have produced for other people and make a note of what you like. You should also check the designer’s credentials to see if they have the necessary qualifications and experience. You are looking for someone who is a trained designer (more accurately, a graphic designer) and one who has worked for several years in the dental industry as a specific discipline. Dentistry is business unlike any other and your chosen designer must know it inside out in order to fully appreciate your requirements.

Check out the designer’s testimonials and don’t be afraid to make contact with anyone who has been quoted for a more detailed appraisal.

Do beware of people or agencies offering too much of a multi-disciplinary ‘we do absolutely everything’ approach – you will rarely have the budget to do everything at once and besides, you want real expertise not a ‘jack of all trades’. Remember that it is your right to be selective. As with dental products, laboratories and related services, it is wise to choose your providers individually rather than buy from a supermarket-style one-stop shop.

Make a connection

This stage is vital. After admiring their work you must also have a conversation with your selected designer to see if you have good rapport. Whether this is face-to-face or over the telephone, it is always best to speak with the person who would actually do the design work not just the MD or a sales person. This way you will be able to see whether you ‘connect’ and feel comfortable communicating and expressing your requirements.

You could think of this as the sort of conversation you have with a patient prior to a treatment plan, where both of you discuss the options prior to agreeing on the desired outcome and chosen route. The designer should, first and foremost, listen and then ask lots of pertinent and searching questions.

If you feel blinded by jargon or ‘marketing-speak’, be justified in being put off! Direct communication is key to a good working relationship and there is nothing weirdly mysterious about the design process – a good designer should answer anything, you ask, simply rather than complicate matters.

By the end of the conversation, you want to be totally confident that the designer has fully grasped your vision – in other words that they really ‘get it’. The degree to which you ‘connect’ with any designer you speak to
will enable you to confidently commit to the particular person who is right for you. Just as in other professional relationships, you should instinctively know when the chemistry is right.

**Agree the budget**

Get clear on your budget from the outset and ask what the fees are so you know what to expect. Just as you charge a reasonable sum for the work you do based on your skill and experience, so do designers. It’s an ancient adage but still very true: pay peanuts and you get monkeys. Set aside a reasonable sum as the budget and think of it as an investment. Remember, patients chose your practice based on your sign, your welcome pack, your website etc long before they sit in that hugely expensive chair you’ve tempted to buy!

**Sit back and relax**

Once you’ve chosen the right designer for your practice, agreed the cost and given them a comprehensive brief - let them get on with it. Again, there’s a parallel with you and your patients. Just as you expect your patients to let you get on with the job once they’ve made a commitment, don’t be tempted to interfere with the design process. You will be consulted throughout and if you’ve chosen the right designer who you know you can trust, rest assured that they will do their absolute best for you. Relax and look forward to being thrilled by the result – as you surely will be.

In the next article, I’ll write about how to woo prospective and existing patients directly, immediately and with minimal effort.

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**About the author**

Cathy Johnson specialises in design for dentists and will design your practice image, stationery, welcome packs, referral packs, external signage and website to raise the profile of your practice and attract the patients you are looking for. She also writes and produces a biannual patient newsletter, branded for you to send to your patients. For more information contact Cathy Johnson Design, Telephone: 020 7289 1215. Or you can email Cathy at: cathy@cathyjohnsondesign.com. Additionally, visit www.cathyjohnsondesign.com

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**OSSEOINTEGRATED IMPLANTOLOGY COURSE**

**Osseointegrated Implantology Courses**

**Sunday 11th September - Friday 16th September 2011 Inclusive**

**Sunday 27th March – Friday 1st April 2011 Inclusive**

This intensive format is ideal for delegates who wish to participate in a course over 6 consecutive days – Fee £2200

**Topics covered include:**

- examination and treatment planning
- dealing with the patient within the practice
- anatomy, physiology
- biomaterials
- sterility
- surgical templates
- surgical techniques (to include bone augmentation and advanced surgical techniques)
- implant impression techniques
- jaw registration
- articulation
- periodontal consideration (to include maintenance protocol and guided tissue regeneration)
- Connecting teeth to implants
- Detailed literature review.

There will be guest speakers on the following subjects:

- **Dr Joe Omar** on ‘Medical Emergencies’
- **Dr Alan Cohen** on ‘Medico – Legal Aspects’
- **Mr Sean Goldner** on ‘CT Scanning’
- **Mr Keith Rowe** on ‘Laboratory Techniques’

There will be hands-on session on the surgical, prosthetic and laboratory phases, and the delegates will attend a CT scan appointment with one of the patients on the course.

This course is suitable for the application of all different osseointegrated implant systems. Delegates who complete the course are eligible for the **ICOI Fellowship**, without further examination. This course carries 36 hours of CPD accreditation.

Course accredited for MFDS, MDS, and FFGDP. Colleagues are welcome to arrange to come and view our practice.

For more details please contact our Practice Manager.

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Fellow of the International Congress of Oral Implantology
A distinguished list of delegates from across the dental profession arrived at Mercedes-Benz World in Surrey ready for a wild ride over a bumpy track. But it was not all about fast cars as the day began with an exclusive symposium entitled ‘Driving Innovation in Oral Care’, hosted by Oral-B. The event brought together leading experts in the demographics of oral health in the UK, biofilms and oral disease, and gave delegates the opportunity to view the very latest in oral care product technology.

Attended by more than 70 professionals, key opinion leaders and the dental press the symposium was chaired by Prof Jimmy Steele, Head of Dental Institute was next to address the audience. His presentation titled ‘Oral Health at the Eastman Dental Institute’ was an early introduction to the subject for oral health. People under the age of 45 had received through the subjects of biofilms and antimicrobials in the prevention of oral diseases, notably periodontal disease.

Prof Steele stated that more people are keeping more teeth for longer, and focused on 45-year-olds as representing the key turning point for oral health. People possessing far more healthy teeth than their age equivalents in modern history.

He posed the question what was the agent acting as the catalyst for this change? Fluoride toothpaste; demonstrating that the capacity of population-wide technologies to make a real contribution to oral health should not be underestimated.

Prof Ian Needleman from the Unit of Periodontology, International Centre for Evidence Based Dental Health and listed implants and adhesive dentistry as the subjects of biofilm research and evidence support- ing point for oral health. People possessing far more healthy teeth than their age equivalents in modern history.

Prof Needleman succinctly summarised the situation that ‘we are our biofilms’. In relation to oral health this is specifically dental plaque and he acknowledged that controlling and manipulating plaque as a biofilm rather than attempting to eliminate it was the appropriate strategy. Increased sophistication of biofilm research methods would reap huge benefits in developing effective technologies, he predicted.

Listing five antimicrobials; chlorhexidine, triclosan, essential oils and antimicrobials in Dentistry took the audience through the subjects of biofilms and antimicrobials in the prevention of oral diseases, notably periodontal disease.

Listing that although humans are made up of billions of cells only 10 per cent are mammalian, Prof Needleman succinctly summarised the situation that ‘we are our biofilms’. In relation to oral health this is specifically dental plaque and he acknowledged that controlling and manipulating plaque as a biofilm rather than attempting to eliminate it was the appropriate strategy. Increased sophistication of biofilm research methods would reap huge benefits in developing effective technologies, he predicted.

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Research and evidence supporting the right claims made to benefit oral health. Pro-Expert toothpaste is proven to protect against plaque, gum problems, caries and the prevention of erosion, calculus formation, dentine sensitivity, staining and bad breath.

The newly formulated all-in-one approach, supported by 15 years of clinical development and more than 70 research papers and presentations, was given thorough explanation by some of the researchers involved in its development as well as through a research and development exhibit.

The accompanying exhibit by the Research and Development Group of Procter and Gamble’s Oral-B brand, located at the London Innovation Centre (LINC) in Surrey, also introduced those attending the symposium to the newest research technologies. These technologies can be used to measure the therapeutic efficacy of oral health products as well as predicting the oral health status of an individual or group. Delegates were invited to take a closer look at these technologies, including going through the plaque grading process using dental plaque image analysis (DPIA) technology.

Delegates in the afternoon were then let loose on the driving track in some top of the range Mercedes cars, allowing for some frustrated wannabe rally drivers to show what they could do with some serious horsepower!

This event brought attendees up to speed with the latest thinking in oral disease management and perspectives of the oral health of the UK population and it was extremely interesting to see how far our understanding of the microbiology of biofilm and the prevention of erosion, calculus formation, dentine sensitivity, staining and bad breath.

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Get a life; get life insurance

Dino Charalambous provides some top tips for getting the right life insurance

Life insurance is not something that many of us enjoy considering – who likes thinking about their own mortality?! However, for the benefit of our loved ones it needs to be dealt with. So, what should I be thinking about?

1. Make sure you buy enough cover - take into consideration your mortgage, loans, credit cards, plus any additional money for your children’s education.

2. If you have stopped smoking in the last 12 months, you may be able to save money on your monthly premiums by changing your existing policy.

3. If your life insurance policy is more than five years old, you may be able to access cheaper premiums as the premiums for insurance policies have become more competitive over this time period.

4. The younger you are when you take out a Life Insurance policy the cheaper the premiums will be. If you need life cover, don’t put it off – the younger and healthier you are, the cheaper it is.

5. Paying guaranteed rates could be costly in the short term but more cost effective in the long term.

6. Arranging your policies be added to a life insurance policy. Premiums will be higher, however you will be covered for 50-40 Critical Illnesses, depending on the insurer. Always read the policy documents carefully before you buy to ensure you know what’s covered and what’s not.

7. A level life insurance policy will pay out a set lump sum amount if you die within the term, providing an income for your family that can also be used to repay any outstanding debts, such as your mortgage.

8. If you are purchasing life insurance simply to repay any outstanding mortgage at the time of your death, you should consider a decreasing term policy. These policies decrease in value over the term in line with your outstanding mortgage balance. Then, if you die within the term, the payout is sufficient to repay your mortgage and protect your dependents from the debt.

9. Critical Illness Cover can be added to a life insurance policy. Premiums will be higher, however you will be covered for 30-40 Critical Illnesses, depending on the insurer. Always read the policy documents carefully before you buy to ensure you know what’s covered and what’s not.

10. Critical Illness Cover can be added to a life insurance policy. Premiums will be higher, however you will be covered for 50-40 Critical Illnesses, depending on the insurer. Always read the policy documents carefully before you buy to ensure you know what’s covered and what’s not.

11. Forgetting to mention a relatively minor health issue could result in your policy not paying out due to non-disclosure. Whether it is a smoking habit, a bad back or occasional pins and needles, make sure your insurance company knows about it. If in doubt, tell your insurer.

12. Additional options can be added to your policy for a few pence more per month, e.g. Illness Cover and Premium Protection.

13. Price comparison websites do just that… compare prices. They do not provide advice. To get the best advice and find the correct cover for your situation, it is important to speak to a Professional Insurance Adviser.

‘Whether it is a smoking habit, a bad back or occasional pins and needles, make sure your insurance company knows about it. If in doubt, tell your insurer’

Raising Finance?

DO engage the services of an independent firm to liaise with the Banks on your behalf – will ensure proposal is packaged for best chance of a positive response and also to negotiate best terms.

DO ensure you provide an accurate summary of your current position including all savings and existing borrowing.

DO ensure your CV is up to date with particular focus on any past Managerial experience.

DO expect the Bank to want you to put down a contribution towards the purchase.

DO undertake your own research of the local area and find out why the current owner is selling.

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Frankly Speaking

Get it while you’re young: Life insurance is cheaper the younger and healthier you are

Dino Charalambous

Dino Charalambous has been a Mortgage and Protection Broker for more than seven years and provides a professional service for his clients in mortgages, life insurance, critical illness cover, income protection and general insurance. Where possible, he likes to provide face to face interviews so he gains a full understanding of his clients’ requirements. Dino will take charge of any application and follow it through to the end so that there are less potential hassles for clients. This also ensures his clients have the appropriate cover for their needs. The dental sector is his main focus and he has worked with many dentists over the past seven years and many of his friends are dentists!

About the author

Get a life; get life insurance
Over-dentures

Dr Anagnostopoulos presents an interesting case

When I was in dental school, one of the teachers who was known to be very successful professionally, revealed that the key of his success was his knowledge over the “secrets of the dentures”. It did not make sense to me at the time as good denture making was thought to be a process shared between the ritual of the sequence of the production stages and a “good technician”. A non-successful denture was always to be blamed on the ability and/or willingness of the technician or perhaps the lower standards of their cheaper service. Having gained experience as a dentist, I now know that my teacher was right.

Patient Experience

From the beginning of my practice, I have seen patients requesting a new set of dentures while they were already holding a relatively new set which they never actually managed to use. Despite the fact that this set would appear to have reasonable suction and restore some of the lost features, such as vertical dimension, teeth to show when they smiled etc., the patient would find it uncomfortable and would therefore not use it. Chatting about their problem, they would talk about the various other sets made which had simply ended up in the bedside drawer.

Most bizarrely and invariably they would end up wearing their old set with the completely worn down teeth, badly discoloured, without any trace of stability and teeth “smiles” drawn under the lips. Features such as angular cheilitis, deep diagonal lines from the corners of the mouth to the chin and massively reduced vertical dimensions were overlooked as part of the ageing process. In some instances these sets had even been used for two decades, without any maintenance being done to compensate for the gradual changes of the underlying tissues and in particular the bone resorption. Problems were usually more dramatic with the lower denture due to the centrifugal pattern of resorption. The denture was left with unnecessary long flanges to sit over the melted away ridge, causing sores over the coronally moving muscle attachments. The result was: unhappy patients who were unable to maximise the use of the - anyway limited - potentials of the full dentures. In many cases problems like social avoidance and varying degrees of eating disorders would follow. As for the aesthetics, premature ageing occurred due to unsupported remodelling with deep lines at the peri-oral region and dentures would move even when the patient was talking. The list of the facts causing frustration is endless. So, what can be done? Is there something that could alleviate or - even better - remove all the frustration?

Well, the answer is that a lot can be done. For those patients who are unfortunate enough to lose all of their teeth at one or both jaws, the answer is to start as a minimum with a good set of dentures. This set should then have to be maintained every two-three years by means of a reline. It should eventually be replaced with a new set every six-seven years. This is the minimum to compensate for changes that naturally occur due to bone resorption and the space gradually developing between the tissues and the denture base. Following these guidelines, you can maximise the maintenance of the original facial features and muscle functionality. Do not forget that the changes occur slowly but steadily and, before you know, those teeth have disappeared under the lips, the lower jaw moving forward as the body adapts.

Implant Placement

The only way to maintain the alveolar bone is the placement of dental implants which, by stimulating, will be kept there with a much slower rate of change. Using dental implants we can retain a denture.

Most bizarrely and invariably they would end up wearing their old set with the completely worn down teeth, badly discoloured, without any trace of stability and teeth “smiles” drawn under the lips. Features such as angular cheilitis, deep diagonal lines from the corners of the mouth to the chin and massively reduced vertical dimensions were overlooked as part of the ageing process. In some instances these sets had even been used for two decades, without any maintenance being done to compensate for the gradual changes of the underlying tissues and in particular the bone resorption. Problems were usually more dramatic with the lower denture due to the centrifugal pattern of resorption. The denture was left with unnecessary long flanges to sit over the melted away ridge, causing sores over the coronally moving muscle attachments. The result was: unhappy patients who were unable to maximise the use of the - anyway limited - potentials of the full dentures. In many cases problems like social avoidance and varying degrees of eating disorders would follow. As for the aesthetics, premature ageing occurred due to unsupported remodelling with deep lines at the peri-oral region and dentures would move even when the patient was talking. The list of the facts causing frustration is endless. So, what can be done? Is there something that could alleviate or - even better - remove all the frustration?

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Implant Placement

The only way to maintain the alveolar bone is the placement of dental implants which, by stimulating, will be kept there with a much slower rate of change. Using dental implants we can retain a denture.
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In case of high expectations with regard to reduced functionality, four implants would support an over-denture which improves retention and stability, almost functioning as a bridge or as a conventional bridge, depending on budget.

For the maxilla, a minimum of four implants splinted with a cast or milled bar, bearing ball attachments will provide a secure highly retentive platform for an over-denture. Additionally, the use of Cr-Co reinforcement can allow the freeing of extensive palatal coverage.

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The free palate has assisted him to overcome serious gagging reflexes, so that he finally can enjoy his life again (Figure 4-31).

Friday 6th and Saturday 7th May 2011
The Royal College of Physicians, Regent’s Park, London

Already confirmed to speak are:
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About the author
The author of this article, Dr Evangelos Anastopoulos, provides implant dentistry to practices through MediMatch Dental Laboratory. With their long term work relationship they have managed to achieve high standards of success with a variety of challenging cases. For further enquiries, please contact MediMatch on 08444993888 (option 5).
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Age and Endodontics

Michael Sultan discusses how and when to treat ageing patients effectively with endodontics

The high standard of oral healthcare and the evolution and change within everyday dentistry has never before been so rapid as it is in dentistry today. The rise of more complex dental treatments and techniques and the recent innovations of products and therapies have introduced many professionals to higher standards in practice. However, what is becoming apparent is that endodontics is becoming more difficult as the population ages and this sector is driving the change within the profession.

Today’s society has led to an increase in patient’s expectations to maintain their natural teeth. Patients no longer expect or are resigned to having dentures as their parents and grandparents did, they want their own teeth and they are more inclined to keep up with regular maintenance and more advanced treatments to ensure this happens. Just having a tooth out is no longer an option as it can lead to further ramifications, which are more difficult to deal with. As the patients age they may have specific health issues which may make them more prone to dental health problems. This may be as a result of medication; however, the Root Canal Treatment (RCT) itself may be harder to perform.

There is sometimes a need for more extensive treatment to rescue a tooth after many years of service, and more patients are opting for RCT to retain the natural tooth and to safeguard large and complex restorations. A patient that presents with severe toothache due to dental decay would have had limited options years ago, with extraction being the most common treatment. However, with the increased prognosis and likelihood of a successful treatment, patients are much more likely to opt for this treatment rather than extraction.

Treating an older patient becomes more complex and challenging due to several factors including:

• The reduction of space in the pulp
• Sclerosis of canals
• Treatment area may be through crowns and bridges
• Elderly patients may not be able to tolerate longer chair times

The medical history of a patient can also make RCT a preferable treatment. For example, a patient undergoing cancer treatment or radiotherapy, or taking bisphosphonates and anticoagulants may avoid extraction, as RCT would have less knock on effects to their general health.

The patient’s age and health status are of course considered before dental treatment; however, another factor that must be explored is the medications they are taking. Anti-depressants, diuretics and diabetics medication may lead to...
reduced saliva flow and a dry mouth, which encourages caries. This is also a common factor in age itself.

As age increases, the incidents of decay and root caries rise and this may be compounded by the patient having less sensitivity to pain and therefore, less early warning signs of decay.

Decay around previous crowns and restorations is a familiar theme in ageing patients who need RCT and these treatments can become more difficult and may also be more time consuming. This poses a problem in people who require shorter appointments for health reasons and also comfort. Often the RCT is a re-treatment of an existing root filling where there has been leakage and this has to be re-addressed.

Utilising the best and most modern equipment is the only way to ensure the most efficient work without compromising on quality. Clear visualisation into treatment areas through a powerful light source is essential. Microscopes and loupes are ideal tools for increased vision into the work area, especially whilst working through crowns and searching for very sclerosed and receded canals. For efficient canal preparation and to really speed up preparations, I find nickel titanium instruments to be excellent.

It is also crucial to mention that an incredibly important aspect of successful RCT is the comfort and confidence of the patient. Often people are nervous following a lifetime of poor experiences at the dentist and the reputation that surrounds treatments such as root canal therapies. Understanding a patient’s reservations and concerns will help you complete treatment fast and efficiently.

The possibility of successful treatment has increased with more efficient diagnosis, treatment therapies and the opportunity to both treat and re-treat teeth if necessary. Root Canal Treatment is certainly desirable by both patients and professionals and in most cases, preferable to extraction and the knock-on effects of losing a tooth.

About the author

Dr Michael Sultan
BDS Msc DFO is a specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman UCL, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2009 he became clinical director of EndoCare a group of specialist practices. To talk to a member of the EndoCare team call 020 7224 0999 or email reception@endocare.co.uk or for more information please visit www.endocare.co.uk

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Certificates in, Aesthetic Dentistry, Conscious Sedation and Pain Management in Dentistry, and Osseointegration’s 19th Annual Meeting, European Association for Osseointegration, promote patient satisfaction and reducing the risk of litigation following a missed diagnosis of periodontal disease.

Talking Points in Dentistry is an extensive restorative treatment regimen, with particular emphasis on the aesthetic outcome of treatment. Nicola and Roger will also touch upon the management of patient expectations in a contemporary practice.

Talking Points in Dentistry is free to attend, and a light evening buffet will be provided for delegates.

Dental professionals interested in attending their local event should visit [www.pcd-dentistry.co.uk](http://www.pcd-dentistry.co.uk) or email Laura Goffah at talkingpointsteam@scp.com.


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The London Centre for Implant and Aesthetic Dentistry has relocated to its new premises at 28 Wimpole Street. The modern practice now boasts three state-of-the-art surgeries, a waiting room, a laboratory in the planning and a growing team of highly trained professionals.

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In 2006, practice incorporation became a viable business option and one that many dentists have since been using to their advantage. As incorporation has become a more popular choice among dentists, it is looking at, a number of Banks’ Regional Healthcare Teams have invited Ray Goodman of Goodman Legal, to visit them to discuss the benefits of dental practice incorporation.

Dentists are seeing the same issues to be considered when incorporating a dental practice, and the many positive returns that running your practice as a limited company can bring.

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Going to see family... in Cambodia

Chris Baker from Corona Design & Communication reports on two dental students’ humanitarian elective...

Earlier this year, two fourth year Glasgow University dental students, Richard Field and Charlotte Payne, undertook a humanitarian elective to aid the orphaned children of Phnom Penh. As you may be aware, Cambodia is a country very much in transition that is struggling to overcome the memory of the Khmer Rouge and its genocide more than 30 years ago.

Richard and Charlotte worked with the charity Cambodia World Family which is a small NGO with the mission of providing free dental care for the orphaned, handicapped and abandoned children of Phnom Penh.

The project had six key goals:

1. To gain experience of training and managing Cambodian staff
2. To treat the disadvantaged children that were sent from 82 institutions to the clinic
3. To perform dentistry to all first year children would now have oral health instruction classes.
4. To help teach the staff and Khmer students from the local university
5. To improve administrative systems and infection control
6. To maintain and improve children's facilities

Richard was surprised at how well the centre was run when they arrived. “Whilst many of the practices would not have been satisfactory according to UK standards, staff were working with what they had. We felt that for us to demonstrate ‘better’ practices would have confused some of the staff to the detriment of patients. We found that we worked with the staff as part of the team rather than in a managerial capacity.”

As well as working at CWF, Richard and Charlotte also volunteered at Toutes À L’École – a French run school that take girls from underprivileged families in Phnom Penh. They provide them with a full education using the international French Baccalaureate syllabus. One interesting point that both students noted was that the children they interacted with at this school, who were from slightly better circumstances, had teeth in a much poorer state. This was due to the fact that they had a small amount of pocket money that was generally spent on sweets. Plus ça change! An oral hygiene program was suggested to a French school whose pupils were particularly affected and the administrator gave permission to Richard to run oral hygiene classes.

Richard explained that, “the English teacher acted as my translator and my intention was that if he saw my instruction several times, he would be able to continue the classes after we left. I tried to make the classes as interactive as possible so that the kids would better retain the information. Interestingly, when asked, ‘Which foods are bad for teeth?’, the answers were hot, cold and hard foods. The children associated any food which gave them pain, as bad for their teeth. Through further discussion, we did arrive at the answer ‘those that contain sugar’. A popular drink in the region is sugar cane juice and the children were shocked when I explained the harm that such drinks can do.”

Lessons then continued with an oversized mouth model and toothbrush illustrating the proper way to brush. The English teacher confirmed that all first year children would now have oral health instruction classes.

As it transpired, goals 4,5 and 6 proved to be difficult to meet. Richard commented, “the dental school is large but very poorly equipped. There were only five articulators available for the whole school and we didn’t have an opportunity to teach. In regard to infection control, the team followed good practice in hand washing and changing gloves between patients. We did identify some areas for improvement such as using fresh tips on the etch and fissure sealant for each patient but staff pointed out they only changed tips when they broke as they didn’t have sufficient tips. While we weren’t comfortable with this, we did ensure that tips were wiped with disinfectant between patients. The waiting area for the children already had a DVD and selection of toys and as a consequence we didn’t feel we could add to this.”

Richard and Charlotte obviously expected that people’s knowledge and attitude towards dental hygiene would be very different in Cambodia than in the UK. What they did not expect was the children’s willingness to accept dental treatment with no fuss. They found this to be (in the main) in complete contrast to their experience of children in Glasgow! Perhaps they were more aware in Cambodia that dentists were there to help them?

Richard feels that the whole experience has benefitted both he and Charlotte, not just as dentists but also as people. It allowed them to appreciate the facilities that we all take for granted in our clinical environment. Last word to Richard - “a national health service can play such an important part in a population’s health and if there were one in Cambodia, it may speed the country’s road to recovery. However, it has also illustrated to me that a population can take a health service for granted when one is freely available in the UK.”

If you would like to support the work of CWF then you can find more information or donate at: http://www.cambodiaworldfamily.com/

For the French school you can donate online at http://www.toutes-a-l-ecole.org/CarteB.html or by cheque addressed to ‘Toutes à l’École’ and posted to: Toutes à l’École 150 boulevard du Général de Gaulle 92580 Garches.
AOG and Smile-On, in conjunction with the Dental Directory and the Faculty of General Dental Practice (UK), will again be hosting the 2011 Clinical Innovations Conference (CIC). Now in its seventh year, the CIC promises to be bigger and better than ever, with a wealth of top speakers, including the AOG’s President, Pomi Datta, who said: “Last year’s conference and the dinner brought together innovators and thinkers of this millennium. We are going to build on that with our partners and friends. We want to make this the most exciting annual event in Europe.”

Taking place on the 6th and 7th of May 2011 in the iconic and impressive setting of the Royal College of Physicians, which is situated in the heart of London, the CIC promises to offer all members of the dental team some unmissable learning opportunities and the chance to gain up to 14 hours of verifiable CPD.

With innovation once again the main theme, dental professionals can expect to learn more about the latest developments within the field of endodontics from the likes of Julian Webber, occlusion from Raj Rayan OBE and an opportunity to discover the benefits of practising minimally invasive orthodontics with speakers Tif Qureshi and James Russell.

Other confirmed speakers include: the internationally acclaimed Nasser Barghi, Joe Omar, Peet van der Vyver, Eddie Lynch, Bob McLeish and Wyman Chan, amongst many others.

On Friday the 6th, attendees will also have the opportunity of attending the Conference Charity Ball, which will be held at the fashionable Millennium Mayfair Hotel. Last year’s proceeds went to the AOG-sponsored project in Chitrakoot to repair cleft lips and palates and provide dental treatment for 500 villages in one of the most rural parts of India.

Secretary of the AOG, Dr Nishan Dixit, is thrilled to once again be involved with this dynamic gathering: “As one of the UK’s fastest-growing dental organisations, we are a body that not only values professional standards but also understands the need for innovation within dentistry, as well as the vital role that continuing education plays within the profession. We also hope that CIC delegates will join us in striving towards ‘the greater good’, our organisation’s motto, at the Conference Charity Ball, which promises to be a really fun and glamorous occasion, all in aid of a good cause.”

Given the record attendance rates at the 2010 event, delegates are advised to book early to avoid disappointment. Early bird registration entitles those who book before 7th February 2011 to a 15 per cent concession. Members and clients of affiliated sponsors and co-organisers may also be entitled to special rates, so get in touch with the organisers to find out more.

For more information, visit www.aoguk.org - For early bird offers, or to book, visit: www.clinicalinnovations.co.uk/ or call 0207 400 8967.
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