GDC “must do better” says regulators’ Regulator

CHRE publishes report showing failings in FTP processes

The publication last week of an Audit of the General Dental Council’s initial stages fitness to practise process by the Council for Healthcare Regulatory Excellence (CHRE) has been deemed to create further concern about the organisation’s performance.

The audit, published on Monday 5 September, identifies a number of significant issues with GDC processes including inadequate information gathering, ongoing weaknesses in explaining the closure of cases, extensive unexplained delays in the referral of cases and poor recording and management of case information. DAMNINGLY, the review also says that GDC assures that it would take action to address weaknesses identified by previous CHRE reports have either not been fully implemented or have failed to have any noticeable effect. The audit follows a critical review of the GDC by CHRE in July.

“The publication of the report comes on top of BDA concerns about the GDC’s priority setting and is likely to damage the confidence of both patients and dentists in the body. It now must concentrate on addressing the concerns this report identifies and demonstrating it is a competent force in the regulation of dentistry. Dentists and patients alike need a regulator that they know is reliable, professional and fit for purpose,”

Peter Ward, Chief Executive of the BDA, said: “This report is a catalogue of errors that asks profound questions about the GDC’s ability to fulfil one of its core responsibilities. It does not reflect favourably on an organisation that has undergone significant change in recent years, with a poorly-managed move away from professional self-regulation and a massive expansion in the professionals it registers.

“We were pleased that the CHRE identified areas for improvement and the major reform programme currently underway is aimed specifically at addressing those deficiencies. We were pleased that the CHRE found no evidence of cases having been closed too early, or of closure decisions that were considered unreasonable – both are critical in terms of patient protection.”

The CHRE report states: “We are confident that the GDC is now aware of the work it needs to do to achieve the necessary improvements to its FTP processes, and that it has plans in place to achieve those improvements within a reasonable timeframe.”

The GDC states that progress is already being made in achieving these improvements and regular updates are given at the GDC’s Council meetings.

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News Brief

Tooth cupcakes

As a dentist-in-training Erica moulds teeth out of many materials, including amalgam, resin, wax, and acrylic; however, recently her creations have taken on a slightly more edible design! Erica has started her own brand of cakes and cookies from medical and dental related to seasonal designs! Her creations include EKG cookies and lately she has upped her game and created incredibly realistic molars.

Erica added that she hoped her molar cupcakes would be a big hit as, unlike the real sensation, they don’t have to be cut and consumed immediately.

“Those are the best part of the job for me,” she said. “But there are still many other things to do.”

Erica claims that the anatomies of the molar cakes are pretty accurate! (She even plans to make them sugar-free!) Her cupcake making was a project she had set herself during Hurricane Irene, when Erica expected to lose power. To make the molar like shape Erica moulded crumbled up baked cake and frosting onto the cupcakes and then covered them with a thin layer of pre-rolled icing.

In her blog that the cakes were a celebration to the start of the new school year and Erica added that she hoped her creations and fillings for her future patients will come out as pretty as her cupcakes (but definitely less sugary!)

What a pretty packet

Putting the gruesome and graphic images aside, young people are still attracted to tobacco displays. The findings come from a study, published in the journal Nicotine and Tobacco Research, which found out that young people who recall seeing tobacco displays in shops are more likely to start the habit. According to a report, Cancer Research UK-funded scientists, who interviewed 950 youngsters, aged 11 to 16, who did not smoke, found out that 27 per cent of them were susceptible to smoking, as determined by their views on whether or not they thought they might smoke in the future. What’s more, four-fifths of the youngsters said that they had noticed behind-the-counter tobacco displays. The findings come from a study, published in the journal Nicotine and Tobacco Research, which found that young people who recall seeing tobacco displays in shops are more likely to start the habit. According to a report, Cancer Research UK-funded scientists, who interviewed 950 youngsters, aged 11 to 16, who did not smoke, found out that 27 per cent of them were susceptible to smoking, as determined by their views on whether or not they thought they might smoke in the future.

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It was World Oral Health Day 2011 on 12th September and the theme of this year's event was ‘Noncommunicable diseases (NCDs)’, which are sometimes called chronic diseases.

The aim of the day was to increase awareness on oral health, including the impact that oral diseases can have on the body and a person’s general health. All around the world countries took part, with photo competitions and various events to raise public awareness. The day also brought an opportunity for schools to promote oral health to pupils of all ages.

Partners from public health associations, dental education and businesses also took part in the day, and announced the launch of the European Platform for Better Oral Health, which is intended to help improve oral healthcare and reduce the cost of oral diseases in Europe.

The platform’s website www.oralhealthplatform.eu was launched by the platform’s members, including the European Association of Dental Public Health, the Association for Dental Education in Europe, Wrigley Oral Healthcare Programs, GlaxoSmithKline Consumer Healthcare and the Council of European Chief Dental Officers.

Further help was given to associations by the FDI, who launched the WHPA Action Toolkit.

The Action Toolkit, which is aimed at prevention and targets people with certain behaviours and health issues who do not consider themselves to be ill, has been described as a practical tool that nurses, pharmacists, physical therapists, dentists and physicians can use when communicating with patients and the public on NCDs. The Toolkit includes:

- A Health Improvement Card
- A guide for professionals on using the Health Improvement Card and discussing its contents with patients and public
- A guide to the Health Improvement Card for patients and public
- Cover “Together making a difference against NCDs”

For more information on the toolkit, please click here. http://www.fdiworldental.org/content/fdi-produces-media-kit-world-oral-health-day-2011-choice-of-theme

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You’ve got the whole world in your mouth
Editorial comment

This week I want to tell you about something important that is happening in the background as we speak – the creation of an editorial board for DTUK and its portfolio of specialist titles (Cosmetic Dentistry, Implants and Roots).

Whilst not unique, the creation of the editorial board marks an important step in DTUK’s evolution. To maintain the quality of the articles and clinical studies we provide, the time has come to enlist the support of clinicians, dental professionals and those close to the sector.

This does not mean that I don’t want to hear from readers who want to submit articles; in fact I want to hear from more of you! Email me Lisa@dentaltribuneuk.com with your article suggestions.

Look out in the next issue for a list of Editorial Board members.

Just a quick note about the rugby as I write this after the first weekend; England were unsurprisingly nervy, boys please don’t make us sit through a performance like that again!! Roll on Georgia..."
Lifetime blood donation ban to be lifted

The lifetime ban on blood donation by men who have had sex with men is to be lifted following an evidence-based review by the Advisory Committee on the Safety of Blood, Tissues and Organs (SaTTO).

The recommendation, which has been accepted by the health ministers in England, Scotland and Wales, means men whose last sexual contact with another man was more than 12 months ago will be able to donate, if they meet the other donor selection criteria.

Men who have had anal or oral sex with another man in the past 12 months, with or without a condom, will still not be eligible to donate blood.

The change will be implemented by NHS Blood and Transplant (NHSB and T) in England and North Wales on Monday 7 November and by the Blood Services of Scotland and Wales on the same date.

The news comes as another positive step forward following the review from earlier this year, when the Department of Health confirmed that the policy which currently prevents HIV-positive surgeons and dentists from working in the UK would be reviewed.

The Advisory Committee, comprised of leading experts in the field, joined by patient groups and key stakeholders, carried out a rigorous review of the latest available evidence including:

• the risk of infection being transmitted in blood
• attitudes to compliance with the donor selection criteria

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The change means the criteria for men who have had sex with men will be in line with other groups who are deferred from giving blood for 12 months due to infection risks associated with sexual behaviours.

Public Health Minister Anne Milton said: “Blood donations are a lifeline, and many of us would not have loved ones with us today if it was not for the selfless act of others.”

“Our blood service is carefully managed to maintain a safe and sufficient supply of blood for transfusions. Appropriate checks based on robust science must be in place to maintain this safety and the Committee’s recommendation reflects this. It is important that people comply with all donor selection criteria, which are in place to protect the health of both donors and transfusion recipients.”

Professor Deirdre Kelly from the Advisory Committee on the Safety of Blood, Tissues and Organs said: “Around two million individuals generously donate blood every year in the UK to save patients’ lives. The SaTTO review examined the best available scientific evidence for UK blood donor selection in relation to sexual behaviours. Our recommendation takes account of new data that have become available since the last review in 2006, as well as scientific and technological advances in the testing of blood.”

“Adherence to the donor selection criteria is vital to maintain the safety of the blood supply, and donors need to be assured that the criteria are evidence-based. We are confident that this change maintains the safety of the blood supply.”

Dr Lorna Williamson, NHS Blood and Transplant’s Medical and Research Director said: “NHS Blood and Transplant’s priority as a blood service is to provide a safe and sufficient supply of blood for patients. We welcome this review and its conclusions. It gives us an opportunity to broaden our donor acceptance on the basis of the latest scientific evidence.”

Lack of confidence in sector future

According to a new hit to their profit margins, they are the most positive of the primary healthcare respondents overall.

The findings of the report also included that:
• Dentists are responsible for the only positive figure in the index research; plus 12 say that they have a positive outlook in the short term (gauged over 12 months). This figure is reflective of the significant contract changes that the profession has already experienced, especially those that have already opted out of the NHS.
• In contrast however, dentists’ collective long term confidence (gauged over five years) falls significantly to minus 64. This is the greatest shift in confidence of the three sectors.
• Overall confidence in the future of the dentistry sector reflects concern around finances and growing competition: 85 per cent of dentists are expecting further financial pressures over the next five years and 91 per cent expect increased competition in the market place over the same period.
• Nearly half (45 per cent) of dentists expect to see an increase in profits over the next twelve months, with 55 per cent expecting profits to remain flat.
• 41 per cent of dentists have experienced claw back in the last twelve months for NHS underperformance.

A significant 84 per cent of dentists are saying that financial pressures have increased over the last five years and on this basis, we could see a lot of older dentists selling up and retiring from the profession in the very near future.

To view the full Healthcare Index please visit www.lloyds-tsb.com/healthcare

Feedback saves dental clinic

Plans to close Leighton Buzzard’s community dental clinic on Bassett Road have been dropped by NHS Bedfordshire thanks to a group of patients.

The announcement came after proposals for a modern, high-quality community dental service across Bedfordshire were approved in Luton. Currently, Community Dental Services (CDS) has 13 clinics across Bedfordshire and Luton. Although the clinics contain specialist equipment, have the services to treat patients with special care needs, and provide access for those in need, a number of the clinics only run part time.

Furthermore, the buildings in which the clinics are held no longer meet new standards.

Originally it was planned that five clinics would be closed to ensure that CDS could deliver a more efficient service. NHS Bedfordshire wrote to those patients that would be affected and when they learnt that the clinic at Leighton Buzzard would be closed they stated in their feedback the difficulty they would face with regards to travel. As a result, the proposed closure of the Leighton Buzzard clinic was dropped.

Tony Medwell, NHS Bedfordshire’s Head of Primary Care Commissioning, was quoted in the www.leightonbuzzardonline.co.uk saying: “These changes across Bedfordshire will enable CDS to provide the same full range of high quality services for the same number of patients in a far more efficient way. That is essential at a time when the NHS has to get the best possible value for the taxpayers’ money.”

“However, following feedback from patients using the Leighton Buzzard clinic, it was clear that it would have been more difficult for them to travel to the nearest clinic compared to patients using clinics in other parts of Bedfordshire.

“This feedback has been valuable in helping us to develop proposals to ensure we have clinics spread across Bedfordshire and Luton which continue to offer good access for patients”

Ian Crompton, head of healthcare banking services for Lloyds TSB Commercial, said: “Our findings suggest that further consolidation is expected in the dentistry profession, with many expecting to see a rise in the number of groups of multiple practices.

“As with any significant change, those most able to take advantage of new arrangements will be the ones who adapt the quickest, looking for fresh opportunities and new partnerships.”

Despite the relatively low levels of confidence reflected by the index findings, only 22 per cent of dentists said that they were not confident that they would find someone to take over their business when they retire.

Ian Crompton added: “Although dentists are more optimistic in the short term, take away the relative stability of a current NHS contract and they appear to share the same financial fears as GPs and pharmacists.”

The Community Dental Service’s mobile unit and home visiting service to patients living in residential care are both unaffected.
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BADDN decides not to proceed with conference

The current difficult economic climate, and the fact that few dental nurses are able to obtain funding from their employers, has caused BADDN to reluctantly decide not to proceed with the 2011 National Dental Nursing Conference, which was to be held in Glasgow in November.

“Although we have been able to keep the cost of Conference the same since 2009, there is even less funding available for dental nurses to attend Conference,” said outgoing President Sue Bruckel. “The cost to delegates of £120 for the two day Conference is already considerably less than the actual cost, which is closer to £5-400 per person, at a conservative estimate. We manage to keep the cost down to just £120 through sponsorship from dental trade companies, by speakers waiving their usual fees, and because our organisation staff the Conference in house and give up their weekend to actually run it. BADDN receives no official funding; unlike Denarters, for example, or NES, who can therefore put on events with only a nominal fee to delegates, we have to fund Conference through sponsorship and delegates’ fees.

“The majority of General Practitioner dental nurses have always had to pay themselves to attend Conference; and often have to take annual leave to attend as employers will not allow study leave or contribute towards the cost of their dental nurses fulfilling their CPD requirements. Traditionally, there has always been a strong core of dental nurses from other sectors of dentistry attending Conference, because employers such as PCTs or Denarters have provided partial funding. However, this year, even that funding has been severely curtailed or even withdrawn. This, together with the GDC’s outrageous demand for £120 registration fee for every dental nurse, means that very few dental nurses are able to afford Conference.

We have therefore had to make this very difficult decision.”

The Presidential Inauguration of incoming President Nicola Dochnety and the BADDN AGM will now be held on Saturday 22nd October at Dental Showcase, courtesy of the BDDA. There will also be a buffet lunch, sponsored by Phillips Sonicare. Dental nurses wishing to attend the Inauguration and lunch, and current BADDN members wishing to attend the AGM, should contact Katie Ball at katie@baddn.org.uk.

BADDN will be reviewing their Conference strategy later this year and hope to run an updated, more compact 2012 Conference.

The public reveals its thirst for knowledge

An analysis of more than 150,000 enquiries from the public over the past five years reveals which dental issues are most important to the public. The British Dental Health Foundation has been providing an independent and impartial dental helpline since 1997. New data released by the Foundation reveals the top five most common enquiries from the public and some of the trends over the past five years.

In 2006, five issues accounted for well over half of all enquiries, 14 per cent lower compared to five years ago. Implants, crowns and bridges and other removable appliances now top the list with around one in seven (13 per cent) of all enquiries. The greatest changes concern the NHS, with significantly lower enquiries relating to dental charges (-8 per cent), NHS Regulations (-4 per cent) and Finding a Dentist (-11 per cent). Prosthetics (11 per cent) and Complaints (8 per cent).

In 2011, the same five issues accounted for 44 per cent of all enquiries, 14 per cent lower compared to five years ago. Implants, crowns and bridges and other removable appliances now top the list with around one in seven (13 per cent) of all enquiries. The greatest changes concern the NHS, with significantly lower enquiries relating to dental charges (-8 per cent), NHS Regulations (-4 per cent) and Finding a Dentist (-11 per cent). Prosthetics (11 per cent) and Complaints (8 per cent).

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Overall, the public has remained fairly consistent with its information needs over the past five years. We are pleased that the number of calls regarding oral hygiene is increasing. A greater awareness of consumer rights in all aspects of everyday life is also spreading into dentistry, with more and more callers seeking information on legal issues.

“The Foundation’s Dental Helpline is staffed by qualified dental nurses and costs, on average, £9 per call. It continues to be funded entirely by charitable donations and we hope the dental profession and trade continue to support this unique and important part of patient communication.”

Bold approach puts workers at heart

Manchester’s The Lowry will play fitting host to the latest in an exciting series of CPD events created by Baxi Partnership Healthcare.

Speakers Dr Simon Gallier, John Grant and Pat Langley will focus on offering dentists new ideas to help tackle the challenges of practice ownership, including the latest guidance and advice on dental law and regulatory compliance, as well as exploring a completely new business model for dentistry.

The lectures are free, and food will be served; and delegates will be awarded 1.5 hours’ CPD. The next two venues are: Manchester (4th Oct) The Lowry, 5.50pm registration for a 6pm start; Leeds (5th Oct) De Vere Village Hotel, 6pm registration for a 6.30pm start.

If you cannot attend any of these dates but are interested in learning more about the challenges of practice ownership, please contact Simon Gallier directly at simon.gallier@baxipartnership.co.uk or visit www.baxipartnershiphealthcare.co.uk to find out more.
Myth buster - DH strikes back

The following statement was published by the Department of Health (DH); email us to let us know what you think.

**MYTH:** The Health Secretary will wash his hands of the NHS

The Bill does not change the Secretary of State’s duty to promote a comprehensive health service.

**MYTH:** Bureaucracy will increase significantly

We are abolishing needless bureaucracy, and our plans will save one third of all administration costs during this Parliament.

**MYTH:** You are introducing competition in the NHS

Competition will not be pursued as an end in itself. We have said that competition will be used to drive up quality, and not be based on price. Nor will we allow competition to be a barrier to collaboration and integration.

**MYTH:** You are privatising the NHS

Claims that we aim to privatisethe NHS amount to nothing more than ludicrous scaremongering. We have made it crystal clear, time and again, that we will never, ever, privatisethe NHS.

**MYTH:** Private patients will take priority over other patients

The NHS will always be available to all, free at the point of use and based on need and not the ability to pay. Nothing in our proposals will enable private patients to “leapfrog” to the front of NHS waiting lists.

**MYTH:** NHS hospitals will be managed by foreign companies

Even if independent sector management is used, NHS assets will continue to be wholly owned by the NHS. And there would be rigorous checks to ensure that any such independent provider is reputable and fit for purpose.

**MYTH:** The Bill hasn’t had proper scrutiny

The Bill has so far spent longer being scrutinised than any Public Bill between 1997 and 2010 - 40 Committee sittings, and over 100 hours of debate. Even Opposition MPs acknowledged that every inch of the Bill has been looked at.

**MYTH:** The NHS doesn’t need to change

The NHS does need to change to meet future challenges of an ageing population and rising costs of treatment. The independent NHS Future Forum confirmed the NHS must change to safeguard it for the future.

**MYTH:** You are introducing EU competition law in the NHS

The Bill does not change current UK or EU competition legislation or procurement legislation or the areas to which they apply.

**MYTH:** These plans were not in the Coalition Agreement

The Coalition Agreement clearly said doctors, nurses and health professionals will be handed freedom to decide what is right for their patients; that we will establish an independent NHS board; that patients will be in charge over their care; and that we will cut the cost of NHS administration by a third to reinvest into the front line.

DT

• Email lisa@dentaltribuneuk.com with your thoughts on the statement.
The truth from the trenches

In this three part series Dental Tribune’s Laura Hatton explores the forgotten history of the dentist’s role during World War I

The beginning of this re-search began with a remarkable conversa-tion with a gentleman named Richard Fowler, who enlight-ened me about a close family friend and a noteworthy dentist, Sir Harry Baldwin. Being the godson of Sir Harry Baldwin’s only child, Mary Baldwin, Rich-ard was able to reveal the intriguing story of Sir Harry, which captured my imagina-tion. Born in 1862 into a family of drapers in Nottingham, Harry developed a passion for dentis-try and after qualifying in 1884 he became acquainted with Sir Charles Tomes, and worked alongside him at the Cavendish Square Practice for many years. In 1915 Harry became President of the Metropolitan Branch of the British Dental Association (BDA), and in 1915 was ap-pointed President of the Section of Ondontology. Harry’s later life was intertwined with vari-ous connections to the Royal Family, becoming dentist and surgeon dentist to Queen Victo-ria and King George V, and as will be uncovered in the second part of this series, he was a fa-vourite of Queen Mary.

Richard had heard the sto ries, held the mouth casts of Queen Victoria, and what began as a history of an astonishing Victorian gentleman who had introduced Plaster of Paris to Britain and created the amalgam filling, turned into a re-markable story with a histori-cal climax. Together, with the help of Richard and the archive material which he donated to King’s College London, the story of Sir Harry Baldwin unfolds in the midst of World War I, where his role in society arguably changed dentistry forever...

At the beginning of World War I no specialist hospitals existed for soldiers who had received facial injuries whilst fighting on the front line and it became clear that these men desperately required experts to attend to their injuries. Al-though such hospitals were set up in France, Britain had not followed suit and it was to take months of perilous travel and detailed documentation before serious action was to be taken. The milestone began on the morning of December 31st 1915 in a military hospi-tal on the front line in France; when a gentleman of fair hair and a 5ft 9in build walked into one of the largest rooms of a military hospital in France; Hospital Dentaire de Paris. Even with his dental know-how and 53 years of life experience be-hind him, nothing was going to prepare him for the scenes that lay before his eyes: the gentle-man, Harry Baldwin, was about to witness some of the most extensive jaw cases of the Great War.

As Harry walked through the room hundreds of soldiers lay before him; many of these men, some barely old enough to be enlisted, had exten-sive loss of tissue in the lower part of their face. Harry spent the morning observing and documenting the degree of shrapnel damage that had maime-d and disfigured the sol-diers, noting how all the cases were of the same levels of re-constructive treatment. How-ever, it wasn’t until Harry found himself observing a false eye surgically enclosed into the flesh of a piece of cheek that he realised that this was no ordinary hospital: the era of reconstructive surgery had commenced.

War injuries

On 3rd January 1916 in Lyon, Harry’s perception on the treat-ment of jaw cases was signifi-cantly altered. He had spent the last few days witnessing horrific scenes and facial injuries at the Hospital Dentaire de Paris and had worked alongside Dr Frey at the Val-de-Grâce, however his journey was to lead him to the hospital Service de Stomato-logic de Lyon, in the presence of surgeon dentist Dr Pont. Record-ing every step, Harry watched in fascination as Dr Pont attended to an officer that had suffered what had been classified as a “war injury to the jaw”.

To clarify what was com-monly labelled as “war in-juries to the jaw” I will refer to a speech that Harry made on his return to Britain: The term was implied to those who had suffered severe injuries of the maxilla, or in other words, wounds that had been caused by bullets, pieces of shell, or bombs striking the bone at high velocity. “The effect of these impacts”, Harry ex-plained, “is to comminute the bone and generally destroy or completely carry away some sector of it. Pieces detached, and likewise teeth, frequently have so great a proportion of the mo-men-tum of the bullet imparted to them that they themselves act like projectiles and tear through the soft tissues in a radiating manner, infliting very large flesh wounds.”

Harry devised how such in-juries could be classified into six sections or types, determining the true extent of the damage and the treatment that would be best suited for treatment. Type 1 wounds were fractures of the jaw caused by a gunshot wound where there was no dis-arrangement in the line of teeth; Type 2 were single fractures of the mandible with lateral dis-placement (this tended to cause a loss of articulation); Type 5 were single fractures with ver-tical displacement; Type 4 were cases with two or more frac-tures with loss of substance (this level of injury was usually caused by a shell); Type 5 were gunshot wounds to the maxilla that had caused complications, such as possible haemorrhage and teeth embedment; Type 6 cases were the most severe in-juries and as Harry explained, the most distressing of cases (in these instances most of the anterior portion or more of the bone and soft tissues had been “carried away”).

The Service de Stomatologic de Lyon was one of the first in France, accommodating 850 cases, which were assembled in six large hospitals; five oth-er hospitals were annexed to the central hospital, Hôpital de Stomatologie et Prothèse Bucco-Faciale. One of these hospitals

‘The appearance of the patient is often ghastly, mastication is impossible, speech is very difficult, and when the chin and symphysis are gone there can be no control of the saliva...’

The soldier on this particu-lar afternoon had suffered a Type 4 injury, and with his fate in the hands of the dental sur-geons, the soldier was put un-der the effect of ethyl chloride (a form of anaesthetic that had proved popular during the War). Harry recorded the procedure in detail:

“Dr Pont used a shankspoon in the pocket of a sinus and reserved for jaw injuries that had been com-plicated by wounds of the eyes...”

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The Service de Stomatologic de Lyon was one of the first in France, accommodating 850 cases, which were assembled in six large hospitals; five other hospitals were annexed to the central hospital, Hôpital de Stomatologie et Prothèse Bucco-Faciale. One of these hospitals...
In the beginning
It became obvious to Harry that hospitals such as this were a necessity to the survival of soldiers during the war and on querying the situation further he was invited to read the hospital’s first annual report. The Hospital Service de Stomatologic de Lyon begun in September 1914 as an ambulance of 50 beds, which was located in the presence of a school and strictly reserved for wounded men that it would not be impossible to create them; he went on to confirm that Harry’s concerns would be pressed upon Surgeon-General Russell at the War Office, as he was the man “who was really responsible for dental and jaw treatment in the Army.” Mr Bennett further mentioned how a French correspondent had declared that the majority of the dental profession in France was to be utilised in dental work for the Army. For Harry this information was invaluable and was soon to become the backbone of his campaign.

Rewriting history
On his return to Britain Harry had come equipped with enough evidence to launch an appeal to create stomatological hospitals in every district in Britain. His message amplified how such hospitals offered a chance for those soldiers who had become mutilated wrecks to return to society as men presentable and happy, and not as objects of horror and commiseration.

In one of his earliest speeches on his return, Harry related how the failure to create a stomatological service early in the war had resulted in soldiers coming back to the hospital, with their mouths sewn up and distorted; many of them had

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The new EMS Swiss Instruments Surgery stand for unequaled Swiss precision and innovation for the benefit of dental practitioners and patients alike – the very philosophy embraced by EMS.

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difficulty speaking, and there were numerous fractured jaws. He confidently stated in several of his speeches that any form of work on the jaw and face should be undertaken by dentists, and not by doctors.

In a lengthy and detailed debate, Harry emphasised on the evidence of surgical failures carried out by doctors, and exclaimed that: “One has seen cases where useful teeth with live pulps have been extracted, whilst septic roots have been allowed to remain. In other instances the soft parts have been sewn up around bony fragments which were still displaced...”

Harry continued voicing his knowledge, sharing his message that if France was doing it then so should Britain:

“I suggest that all is not being done in this country which should be done for soldiers wounded in the jaws and face; and in order to assist matters I also venture to suggest that a Care Committee for soldiers wounded in the jaws and face should be formed, the object of which Committee would be to promote the interests of such cases not only whilst still in the Army, but also after their discharge.”

Harry continued his campaign. Aspiring to work the heart strings of compassion by exercising hard felt shock tactics, Harry delivered a presentation of the wounded soldiers; the exhibition was filled with photographs and models of various cases.

Harry's voice had reached the masses and his efforts hadn't gone unnoticed.

On 10th April 1916, after much communication between Harry, the British Red Cross Society and the Order of St. John of Jerusalem in England, Parliament and the Joint War Committee, King George V personally granted permission for Harry Baldwin and his fellow dentist, Dr. Hrn, to visit the military hospitals in France with provisions and services to be provided at their every need. Orders were written to the military hospitals of France and Britain; however, having read a selection of cases documented by Sir Harold Gillies, the doctor who pioneered plastic surgery, it becomes apparent that the strength each dental surgeon mustered from within during the Great War was an incredible accomplishment and deserves, without a shadow of a doubt, the utmost respect and honour, and a recognised place in history.

**Making history**

On 29th February 1916 Harry made a proposal for a ‘Care Committee for Soldiers Wounded in the Jaws and Face’. His voice travelled fast and on the 2nd March 1916 The Times newspaper ran a headline ‘Dentistry in War: Special Hospital Needed in London’. It was here that the story of the role of the dentist was revealed to the public eye, describing the scene that existed before the dental surgeons: “The jaw may be broken, a piece of bone may have actually smashed out of it. The loss of that piece of bone, that tooth socket, can only have one result if left untreated – deformity of a permanent character. Many of these cases are now in existence... At present this work is being done gratuitously by the consulting dental surgeons.”

With the media behind him, Harry’s voice had reached the masses and his efforts hadn’t gone unnoticed.

On the 10th April 1916, after much communication between Harry, the British Red Cross Society and the Order of St. John of Jerusalem in England, Parliament and the Joint War Committee, King George V personally granted permission for Harry Baldwin and his fellow dentist, Dr. Hrn, to visit the military hospitals in France with provisions and services to be provided at their every need. Orders were written to the military hospitals of France and Britain; however, having read a selection of cases documented by Sir Harold Gillies, the doctor who pioneered plastic surgery, it becomes apparent that the strength each dental surgeon mustered from within during the Great War was an incredible accomplishment and deserves, without a shadow of a doubt, the utmost respect and honour, and a recognised place in history.

Although Harry's diary is still currently being transcribed, what can be devised from his notes is that Harry continued visiting the hospitals in France, taking notes and recording treatments and cases in his diary. His sketches dictate the level of expertise and science that captivated the dentists of the time; pages upon pages of Harry’s diary are dedicated to drawings of the equipment used, sketches of clamps and hinges that attached jaws back together, case studies of jaws with chunks of bone missing, teeth askew and fractured jaws, all of which were accompanied by an idea of treatment.

**Alleviating pressures**

As a final act of his campaign, Harry wrote to Mr. Goshen on the 20th November 1916, regarding the outlook of one of the hospitals in France. In his letter Harry described the insufficient flow of men being discharged from the front line hospitals and proposed the idea of freeing up the military hospitals on the front line by sending soldiers to specialist dental military hospitals.

Harry argued his case and articulated his passion and determination into words of reason; what followed was a dedicated committee and an influx of maxilla facial hospitals.

**A place in history**

In 1918 Harry, along with many of the dental surgeons and dentists that treated thousands of wounded soldiers, was knighted for his services during the war.

It may be hard to truly imagine the harrowing images that were set before Harry’s eyes throughout his time spent in the military hospitals of France and Britain; however, having read a selection of cases documented by Sir Harold Gillies, the doctor who pioneered plastic surgery, it becomes apparent that the strength each dental surgeon mustered from within during the Great War was an incredible accomplishment and deserves, without a shadow of a doubt, the utmost respect and honour, and a recognised place in history.

• I would like to thank Richard Fowler for giving me the opportunity to write this article and for the resources that he donated to King’s College London. I would also like to thank the staff at the Archive Department at King’s College London for their help and guidance whilst completing my research.
King’s College launches a Diploma in Periodontal Practice

King’s College have announced their Diploma in Periodontal Practice which commences on 6th January 2012.

The Diploma will be delivered over two years on alternate Fridays. This innovative course is designed for dentists, therapists and hygienists wishing to enhance their periodontal knowledge and clinical skills whilst continuing to work in clinical practice.

The programme is delivered through seminars, lectures, hands-on practical sessions in our brand new clinical skills lab as well as direct clinical supervision of patient treatment supervised by specialists.

The course is specifically designed for the dentists, therapists and hygienists who would like to improve and enhance their knowledge and clinical skills to the level appropriate to work as a Healthcare Professional with Special Interest in Periodontology. Accreditation has been sought with the Faculty of General Dental Practice.

Applicants should have at least two years post-qualification experience in clinical practice.

For a chance to meet the staff and view the teaching facilities there is an opening evening on 19th October from 6pm – 8pm. Please RSVP to sarah.taylor15@nhs.net if you would like to attend.

For more information about the course please contact the course Director, Mr Matthew Garrett Matthew.garrett@nhs.net or call 020 3299 5283.

To apply for the course please send a copy of your CV and two references to Miss Sarah Taylor sarah.taylor15@nhs.net

Interview dates: 25th October 9.30 – 12.30 & 1st November 10.00 – 12.50

Course fees: GDPs £7,500 per year; DCPs £5,000 per year

University of Warwick gets funding for new chair

The University of Warwick has been given funding by The Dental Directory for a new Chair that will focus on primary care.

The donation from The Dental Directory has attracted matched funding which will fund the new post for a number of years and is a significant donation to Warwick’s 50Forward fundraising campaign, which aims to raise £50m by 2015 when the university will celebrate its 50th anniversary.

The Dental Directory’s Founder, Gordon Mills, said: “We wanted to give something back to dentistry and primary care is where the focus of our work has been for 40 years so it seems right to put resources into funding work in that area. The University of Warwick has an excellent reputation, is only a little older than we are and it is a perfect partnership.”

The new Chair will be appointed later this year and Edward Lynch, Head of Warwick Dentistry says the University of Warwick is delighted: “This will enhance the work Warwick Dentistry does with practicing dentists who want to continue their education and research but more importantly will set a high benchmark for standards of education and research in primary dental care and its impact on public health.

“It is a fantastic philanthropic gift and we are very grateful to The Dental Directory without whom this would never have happened.”
The scariest thing that can happen to an MSc student whilst on holiday with their laptop with two deadlines looming two weeks apart is that they lose Endnote and all their references!! For those of you not so wrapped up in searching and quoting references, Endnote is a software which integrates with Word so that you can search for references online and ‘cite while you write’ (How cute!) It is brilliant and I am in awe BUT... According to the helpline guy, Endnote cannot uninstall itself. According to my laptop, it was gone. Along with my hard searched-for references. Of course there is an online back-up facility which had I properly done the start-up tutorial I might have used, but I’m more of a plug and play kind of girl so – I lost everything!! Luckily for me, I had brought some hard copies of the papers that were most relevant to the assignments I was working on – but I did spend a significant amount of holiday time indoors while my wonderful mother entertained the kids and I shouted ‘I’ll be there in a minute’ at regular intervals.

The so-called Fisch treatment planning cases (anagram of Eddie Scher and Fiona Clarke) have dominated our lives for this unit. We had four altogether with two weeks between deadlines. The most frustrating thing was that we received the marks and feedback for Fisch 1, two days after we’d handed in Fisch 2 and have not received any other results. There have been many teething problems with this being the first year of the course – but this is one I genuinely hope Smile-on and Manchester can solve for subsequent years. The learning would be greatly enhanced by feedback on what the markers are expecting, so that you can improve and alter your technique for subsequent assignments. Otherwise, there is a feeling of sending your work into a black hole... Many of us struggled with this, and knowing when to stop with the justifications and the references. Hours upon hours have been spent on these cases - each one is worth 10 per cent of Unit 5 (Managing complex cases).

We are officially finished with our webinars now which is strange. Unit 5 was finished with two hrs from Paul Tipton on managing wear cases – very good although there seemed to be multiple technical problems. Eddie gave us more insights and a very informed session from his hygienist. Harris Sidelsky wrapped it all up and that’s it. More deadlines looming with our End of Unit Assignment due in September having transformed itself from a short answer question to ‘write an article for dental update’ on a subject linked to Unit 5 – or a case study (there was much moaning and groaning from the class). We have four posterior cases to write up, and our complex case, and then the small matter of the dissertation...

I did receive an email asking me how much time I have devoted to this course. I guess the answer is it comes in waves and depends how organised you are and how busy the rest of your life is. And how much time you spend looking up references and reading papers which is the ‘fun’ distracting bit but can lose you hours of your life – and you still haven’t answered the question. Right – focus...justifications for posterior direct composites here we come.
Nothing to fear but fear itself

Dr Fine explains the rationale for the Fear of Dentistry Programme

Taking the fear out of dentistry

The Fear of Dentistry Programme was originally created by Dr Vivian Ward, a consultant in Periodontology, and then developed further by UCL Eastman. The reasoning was that we as dentists can be very poor at dealing with patients who have a real fear or phobia of dental treatments. I was drawn to this programme because I’ve been in practice for 36 years now, so I have a fair amount of experience, but very occasionally I have an intensely phobic patient and I’m not entirely sure of the best way to help them through their treatment and ease their fears. I really believe there’s a huge need for this type of course.

Estimations

It has been estimated that, around 50 per cent of the population don’t get regular check-ups - that’s 50 million people. Of course, a lot of people simply can’t afford to or don’t want to for some other reason. However, a large proportion doesn’t regularly attend the dentist for check-ups because they’re terrified to do so.

Psychology

The Fear of Dentistry Programme delves into the psychology of fear in incredible detail, looking at neurological, psychological and biological factors. All of the speakers are highly respected in their field and they are very enthusiastic about getting involved in this new programme.

The course takes place at UCL Eastman Dental Institute where practitioners will be required to attend one day a fortnight for about six months, a total of 11 days. Fear of Dentistry is aimed at dentists in general practice as well as those in community dentistry. The latter are faced with a lot of children and disabled patients, who are more likely to be in need of special care, which requires special skills.

Understanding fear

Course content provides the means of managing and providing treatment for this demanding group of patients. Initially, the programme focuses on understanding fear and the emotional aspect of going to the dentist, and moves on to psychological methods of reducing fear in the practice. We also aim to teach practical methods of treating anxiety, including the use of hypnosis. Pain management by

UCL EASTMAN DENTAL INSTITUTE

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- AND OVER SIXTY YEARS OF EXPERIENCE

Eastman CPD Programmes in Restorative Dental Practice

The Eastman invites all aspiring general dental practitioners to enrol on our Restorative Dental Practice Programmes. These are directed and co-ordinated by Chris Louca, Andrew Eder, Nick Frankel, Ken Harper and Rob Stone. Teaching is delivered by Eastman Faculty supported by highly respected visiting clinicians.

UCL Certificate in Restorative Dental Practice

This 28 day course runs at approximately fortnightly intervals (subject to timetabling) over 12 months and commences in January 2012. Delivered through seminars, lectures and practical sessions in state-of-the-art skills laboratories, it provides a highly supportive learning experience.

Topics covered include:

- Treatment planning
- Critical literature appraisal
- Plastic restorations and adhesive dentistry
- Current practice of periodontology
- Modern endodontic techniques
- Occlusion in relation to restorative dentistry
- Restoration of anterior and posterior teeth
- Replacement of missing teeth
- Participants’ nurses and hygienists courses

Programme is approved by the Faculty of General Dental Practice (UK) for accreditation towards its Career Pathway.

UCL Diploma in Restorative Dental Practice

Successful completion of the UCL Certificate Programme allows progression to a structured Diploma in Restorative Dental Practice which is delivered over 24 days at approximately monthly intervals over 2 years. The Diploma comprises modules in advanced restorative dentistry and a clinical logbook. Topics covered include minimally invasive dentistry, temporomandibular dysfunction, tooth wear, advanced endodontics, full and partial dentures, periodontal surgery, restoration of dental implants and applied clinical dental materials.

UCL MSc in Restorative Dental Practice

The Eastman has also developed an additional practice-based dissertation module which will allow those who have successfully completed the Certificate and Diploma programmes to progress to a part-time MSc in Restorative Dental Practice.

Closing date: Applications are encouraged by 31 October 2011. Places are offered on a first-come-first served basis and early application is advised.

For further information, please contact:
Miss Nisha Gosai, Registry Officer
UCL Eastman Dental Institute
256 Gray’s Inn Road
London WC1X 8LD
+44 (0)20 3456 1092
+44 (0)20 3456 1274
e: academic@eastman.ucl.ac.uk
w: www.eastman.ucl.ac.uk

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Managing children
Managing children is a big part of the course, and we also look at how different cultures respond to fear, as there may be cultural issues that come into play.

One aspect of the programme that I’m particularly keen on comes after graduates have got the basic knowledge and understanding of fear and phobia: I want them to come along and present their own cases. This will be carried out in an informal setting with their peers as the reviewers. This will take place near the end of the course by which time they will have discovered a lot, know their audience very well and will have gained some practical experience within their own practices. Presenting their own cases to their peers is recognised as a very good learning experience.

Strong basis
As the course develops I will be providing more input, whether it’s to make changes or add something to the content or delivery. When launching a new programme, you have a strong basis; however we need to be adaptable to amendments and updates to meet the needs of the graduates.

For this reason, I believe it’s very important to gain formative feedback from the first two or three groups that take part in any new course. Before the programme starts, and at the end of each section of the course, I will ask them to complete a questionnaire to enquire:
(i) what they hope to achieve by doing the course, (ii) if their expectations have been met and (iii) their views on course development. At the end of the course they get a final survey to sum up their experiences and give us feedback on future course improvements. This information is vital to ensure a relevant and successful programme.

As the course develops and more people go through the system, we will be building up a group of experts in the field of fear control and patient management. This means that we will effectively have a database of practitioners who are ready, willing and able to manage those potential patients who at the moment avoid visiting the dentist due to fear.

Develop skills
Practitioners who decide to participate in the Fear of Dentistry Programme will learn and develop the skills and knowledge they need to help this kind of patient. I have no doubt that it will assist them to establish an excellent reputation with their local colleagues and build their practice. As time goes on it would be desirable to have an alumni group, who could meet regularly and exchange views, experiences and discuss new ideas. 

For more information or to register please contact:

The Programme Administrator
UCL Eastman CDP
125 Gray’s Inn Road
London WC1X 8WD

t: +44 (0)20 7905 1234
t: +44 (0)20 7905 1267

w: cpd@eastman.ucl.ac.uk
w: www.eastman.ucl.ac.uk

About the author
Dr Peter Fine is a Senior Clinical Teaching Fellow at the UCL Eastman Dental Institute and Co-ordinator of its new Fear of Dentistry Programme, which launches in spring 2012. The course is the first of its kind for UCL Eastman, examining the phobia of fear and providing practical methods of treating patients who are acutely affected by it.
VT, as it was intended to be

Andy Lane details his vision for private vocational training

It has long been recognised that the first 12 months in practice after graduation sets the pattern for the rest of your practise career. Bad habits learned at this stage can be difficult to break, so a small group of far-sighted individuals decided to start a scheme where new graduates could work in practices that met the highest standards, be overseen and mentored by experienced, ethical practitioners who could help shape their careers, passing on lessons that had been learned the hard way.

In recent years though, the NHS has taken over the running of the Vocational Training scheme completely and excluded dentists who have chosen to take their practices into the private sector from training. Sadly, this has meant the exclusion of many of the very people who have invested so heavily in their own postgraduate education and practices.

And this is where the concept of Private Vocational Training was born. The idea is that it removes a lot of the immense frustration felt by graduates who are currently compelled to enter NHS practices, forced to accept positions they may not be comfortable with and then, even where they are happy, often find that they cannot remain in that practice once their first 12 months are over.

It also answers concerns of many independent practitioners who are frustrated at the problems they have attracting new graduates into their practices without being able to offer structured FD1 training.

Importantly, it also provides NHS VT equivalence, so there will be no difficulties in obtaining an NHS performer number if required at a later date.

Private VT sets out to address three main concerns:

1. A shortage of FD1 training places. It is rumoured that the Department of Health is unlikely to be able to fund enough NHS VT places in August 2012 to satisfy demand from the number of dental graduates expected to qualify at that time.

2. Selection process. The newly introduced national recruitment process is inflexible. We believe that selection should remain a much more personal process, with potential foundation dentists able to apply to the practice(s) of their choice, and mentors able to choose the foundation dentist they feel will best match the character of their practice, patients and staff.

3. Extension of employment beyond FD1. It is very disruptive to practices, patients, mentors and foundation dentists themselves to have to look for a new job so soon after becoming established in a practice. Private VT FD1 dentists will be encouraged to stay on in their training practice, enter an FD2 scheme if they wish and work towards further postgraduate qualifications.

Private dentist, Chas Lister, who will be both a mentor and Regional Adviser in Private Vocational Training (South West), told us: “At last! Dentistry is starting to prove it can look after itself! Where better to start than a training pathway...”
for the new graduate. As Government cuts inevitably wash off on the student end of the profession, there can be no better time for the profession to be able to offer an alternative pathway into General Dental Practice.

"After many years of discussion, the time is adjudged right by many to begin offering a form of accredited training in private practice. Andy Lane and Private VT Ltd are to be congratulated and encouraged in every way.

"The path of the new graduate is a very tough one to be on. For any new dentist who aspires even at that early stage to excellence in practice, independent of the restrictions of the whims of the Government, the way forward has been hard to map out for too long. The forthcoming expected over-supply of newly graduates into GDP can only exacerbate the desperation felt by many heading for qualification.

"As the confidence and the value of private practice in the UK has risen to at least the same as the Government spend and beyond, it makes sound professional sense that a Private Vocational training pathway should be established which can then set in motion the lifelong journey of Continued Professional Development.

"Private VT has to be the most exciting grass roots development in dentistry for many a year."

So how do you become a mentor?

1. Fill in the application form via the website – www.privatevt.com – or call operations manager Anne Grogan on 01457 821800 to register your interest

2. Private VT will then contact you and explain the scheme in more detail, collect more information about both mentor and practice, and arrange for a visit to discuss the scheme

3. Sign the contract and pay a deposit, ideally before the end of November to be included in the initial launch to final year students

4. Place mentors' and practice profiles on the Private VT website for potential FD1s to access

5. Mentors may also advertise the position in other places, eg BDS

6. A maximum of 40 mentors will be selected for the 2012-2013 course, largely on a first-come first-served basis for those fulfilling the criteria for selection

    Competition for places in the carefully selected practices is expected to be tough, but those who are successful can expect:
    - A gentle introduction into the real world of general dental practice with a full appreciation of the value of the services you can offer within a sustainable ethical framework, with an agreed salary to reduce the potential for additional stress caused by financial concerns
    - Support for you to develop the numerous skills, both clinical and non-clinical, that are required to make general dental practice enjoyable and rewarding in the long term
    - Everything you need to pass the MJDF examination within your first year in practice, and encouragement to become involved in academic research, further examinations and a route towards specialisation in your chosen field

How do graduates apply for a place?

Visit www.privatevt.com and either apply direct to the mentor practices listed or ask Private VT to pass your details on via the website. The mentors involved will be on the site from late November onwards. The aim is to have each graduate place finalised by April 2012, to start in practice in August 2012.

Private VT Ltd has been jointly developed by Dr Andy Lane and Chris Barrow. Andy told us where his vision began: "My own experience of being left to my own devices to fill in the gaps in my knowledge after leaving university, compared to what I was able to provide as a trainer and course organiser in the late 1980’s and early 1990’s, convinced me that Vocational Training is the most important contribution we can ever make to the quality of dentistry in the UK. The first year after qualifying can be lonely and traumatic, particularly without the appropriate support, and it can be an inspiring and fulfilling time when you have the freedom to develop, both as a person and as a valuable member of a profession.

"Vocational training is where the habits of a lifetime can be established and honed, and, just like when you have passed your driving test, it’s when the learning really starts. In my own case the first two years I spent in a busy NHS practice were nearly my last; I hated my job so much I was on the verge of re-training for another profession.

"Luckily I switched to a new practice, found a couple of amazing mentors and started attending some very valuable courses that completely changed my perspective and mapped out what has been a very enjoyable and successful career. It was this experience that originally made me keen to become involved in VT back then, but in 1991, with the then "new contract", many of our training practices, my own amongst them, left the NHS in order to form an independent practice. Sadly though, these most valuable trainers were lost to the VT schemes because they didn’t fulfill the criteria laid down by the government. Vocational Training began to lose its independence with an inexorable move to something that was more and more controlled centrally by the Department of Health. It was at this point, nearly 20 years ago, that many of us voiced the opinion that we should organise a Private VT Scheme in order to compensate for this loss of choice for new graduates.

"The aim of Private Vocational Training is to reclaim Vocational Training for the profession, returning the scheme to the original concept of providing new dental graduates with the ideal start to their careers, working in some of the UK’s most prestigious practices, under the direct mentorship and guidance of some of the UK’s most inspiring general practitioners with excellent support and training from the world’s top lecturers and trainers in a wide variety of subjects, both clinical and non-clinical."

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- Treatment Planning
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Restoration of Implants
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- Smile Design
- Periodontology
- Endodontics
- Orthodontics
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Price held at 2010 levels**:

Manchester from: £349 + VAT per day
London: £449 + VAT per day

Duration: 14 days
CPD: 6 hrs per day
Deposit: £500 (Manchester) / £600 (London)

"The great benefit of the Tipton Training course was that there was a much stronger emphasis on how to utilise this knowledge and apply it in every day clinical scenarios, enabling me to implement the skills learnt on the course almost immediately."

Dr Simon Wyatt

For more information please visit our website:
www.tiptontraining.co.uk

"Andy Lane has been involved in providing postgraduate training for dentists since 1985. After he co-founded the British Society for Occlusal Studies. He has set up a number of private practices and has provided some of the first hands-on, fixed appliance orthodontic training for GDPs in the UK. As Adviser in General Dental Practice, Andy ran the Preston VT Scheme and more recently he has been taking over organisawing, and teaching courses, the British Society for Dentists Seminars and courses.

Chris Barrow was recently voted the 2nd most influential person in UK dentistry and runs the Dental Business School.

For more details go to www.privatevt.com or email andy@privatevt.com

*2010 Price Offer only available on bookings made before 31 September 2011. Last year’s Manchester Restorative Course 2010 priced from £349 per day plus VAT. The current Manchester 2010 Price Offer £349 per day plus VAT only available on Manchester ‘Thursday’ courses. **Deposit reduces to £150 if paid within 7 days of course date. Deposit is non-refundable and non-transferable except in cases of medical emergency. DT2011F10 £50 of the course fee is a contribution to the cost of the Intentional Dentistry Fund which helps trainees with the cost of their training. Offer valid to October 2011. Call 0161 250 7870 for further information. DT2011F11 Deposit £500 (Manchester) / £600 (London)
F or a number of years now the dental profession has been fragmented. We have split ourselves into sections and, in part, have remained distant from one another. The tendency to separate has been strengthened as the different specialties have become fur-

from one another. The tendency to split ourselves into sections and,

often, rarely meet with their imme-
diate colleagues heightens the iso-
lation and separation which many practitioners feel. I have known of practices where the partners communicate only via internal email and meet only at staff Christ-

mas outings.

The animated interaction and chatter witnessed during the meal breaks at most courses is a demonstration of the starvation of shared information and mutual support which many colleagues feel. In some cases, sadly, profes-

sional loneliness can have disas-

trous results, with some turning to life threatening behaviour as a way of managing their desola-
tion. The growth of magazine and web-based CPD undertaken in one’s own home, while of in-
mense benefit to the busy practi-

tioner, has exacerbated the iso-
lation. In earlier years the dentist seeking further knowledge had to go out to hear the lecture or un-
dertake the ‘hands-on’ training. This led us most of us to mix with colleagues, sharing experiences which made us aware that the events which we were shaping our lives were similar to the happen-
ings in others’ lives.

We knew we were not alone

Our hospital, academic and com-
munity colleagues usually had regular meetings with their peers which allowed experiences to be shared and when problems arose they were able to seek advice and support. The camaraderie amongst these groups has always been much greater than amongst general practitioners in the small family

We are all part of the same

small family

The fact that most general prac-
titioners work in their own small segment of a practice and, quite

often, rarely meet with their imme-
diate colleagues heightens the iso-
lation and separation which many practitioners feel. I have known of practices where the partners communicate only via internal email and meet only at staff Christ-

mas outings.

The animated interaction and chatter witnessed during the meal breaks at most courses is a demonstration of the starvation of shared information and mutual support which many colleagues feel. In some cases, sadly, profes-

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Dentistry, now a learned profession in its own right, has always been tagged onto the coat-tails of medicine; stuck on like the tail on the donkey. But we have developed skills and expertise, both practical and academic, which make us deserve of greater respect than we receive.

I am aware that some folk feel that there is a certain degree of kudos being associated with the Royal College of Surgeons and can never be anything other than another adjunct.

There can be Faculties for each Specialty, orthodontics, oral surgery and others, as exist at present and the Faculty of General Dental Practice would be an integral part of the College. The lectures which each Faculty provides would be available to any other College members so that there would be an ability to broaden one's knowledge in a way which is easier than it is today.

The College would be 'Our College'. Owned and run by us for the profession.

Working in level partnership with the other colleges, in medicine, nursing and other professions, we can encourage our younger graduates to aspire to college membership by ensuring that the status and the incentives of making it worthwhile and many senior colleagues will be attracted by the status and the incentives. The re-accreditation process which is coming via GDC will not present any problems to a College Member who demonstrably keeps their post-graduate education up to date and there could even be a reduction in the costs of Professional Indemnity as it would be recognised that members of the college are less likely to infringe the basis of practice behaviour.

The college can be based almost anywhere because it would simply rent premises as now, but with the use of computer technology, much of the college can be 'virtual'. Live streaming of lectures to post grad centres such as MANDEC, LONDREC and others will mean that any important lecture being given in any part of the UK could be enjoyed by colleagues joining together as if the lecture were taking place in that room. Of course, some physical office and lecture facilities would be necessary and there would still be the need for the annual study days and dinners but premises for these occasions can be acquired, as now, by renting appropriate premises.

There would be little need for additional finance as the present business models should serve well and, in fact, the union of the Faculties into one college should produce cost efficiencies as the secretarial and other functions can be shared without the loss of individual autonomy.

With the erosion of self regulation the profession is at a very low point regarding its self esteem. We feel we are being treated as second class citizens but we should be respected for the skills and knowledge we devote to our patients. We are worthy of that prestige and respect. Most patients trust us to behave in a professional manner – and most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do. Our self esteem has been eroded by successive assaults by the NHS which has demeaned most of us do.

The creation of our own college will help to restore self esteem. 

**About the author**

Lester Ellman qualified in Glasgow and has been a GDP since then. He was former Dental Adviser to Manchester PCT for 14 years and former member of GDC’s Executive Committee and past Chair of GDPC. He is a member of BDAs Executive Board and member of BDAs Audit Committee.
First Transitional Support Programme for newly qualified hygiene therapists

Mentoring and support for the newly qualified from Philips

In the modern age of greater professionalism and accountability dental hygienists and therapists are now required to maintain standards and identify their learning and educational needs. As new graduates, they are also challenged to adapt rapidly as autonomous practitioners into a new and unknown team and clinical environment where expectations from the employer and patient have to be met.

To help them immediately after graduating Philips is launching the first Transitional Support Programme for newly registered Hygiene Therapists at a seminar during the BDTA Showcase at the NEC on 20 October 2011.

"After graduating I worked on a British military base in Germany and was expected to continue a successful schools dental health programme with the “on base” infant and middle schools. Upon reflection I was unprepared, felt isolated and guided only by the limited experience I gained from my training and previous role as a dental nurse. Having a professional guide in my first year would have made the transition from qualified dental hygiene student to professional practitioner more effective," commented Mark James RDH, one of the three mentors who has set up the Transitional Support Programme.

'Preceptorship', an initiated period of guided instruction, was introduced in the NHS following the implementation of Project 2000 and is now embedded in a range of regulatory and employment guidelines and as a result healthcare professionals receive ongoing instruction post qualification.

The aim of the Transitional Support Programme is to empower novice Dental Hygiene Therapists providing guidance and development in their learning journey to becoming consolidated, independent, autonomous practitioners. This innovative pilot programme is being launched this summer, based upon the guidelines of the General Dental Councils Standards for Dental Professionals, preceptorship policies of the Nursing and Midwifery Council and the Health Professional Council, Care Quality Commission requirements (Support leading to level 3)

Tempdent Dental Recruitment and Training are celebrating their 15th anniversary this year. Tempdent is the UK’s leading specialist dental recruitment agency and training provider. They successfully provide locum and permanent dentists, hygienists/therapists, dental nurses, dental office staff and a variety of dental courses/qualifications to the dental profession across the UK.

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  - Patient and staff management
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  - The Dental Radiography Certificate
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care and treatment delivery to service users safely and to appropriate standards) and the need for mentoring as part of continuing professional development and eventual revalidation.

“The period of time following registration as a Healthcare Professional can be a challenging time” - Dame Christine Beasley, DBE Chief Nursing Officer (England), Preceptorship Framework for newly Registered Nurses, Midwives and Allied Health Professionals. 2009.

After initial registration there is little provision for guided preceptorship or mentoring support for newly graduating Hygienist Therapists within that crucial first year of clinical practice. Consequently they begin the challenging task of autonomous practice largely unguided in stark contrast to the support given to nursing and midwifery graduates who are preceptored and then mentored within and beyond the first year.

The Transitional Support programme will comprise four main elements; supporting learning in practice; providing professional guidance; developing an events programme and professional role modelling for students, enabling newly registered practitioners to take responsibility for their own professional and career development.

Commenting on the inception of the Transitional Support Programme, Mentor Tim Ives stated:

“I have been in dentistry since 1982, in a variety of roles and locations worldwide and I can honestly say that this is the most exciting project that I’ve been involved with, not only because it’s an opportunity to give something back to the profession and ultimately the patients, but also because we’re pioneering something new and innovative.”

Philips has co-opted three highly experienced clinically based Dental Hygienists to pilot the Transitional Support Programme and will be approaching universities and academies to encourage them to engage with the scheme.
three; Tim Ives, Mark James and Joanne Dickinson, will undertake accredited training from a course specialising in clinical mentorship and establish pre-graduate contacts and links with the aim of promoting the benefits and validity of the Philips’ Transitional Support Programme.

In the first year after graduation participants will have access to their mentors in a number of ways; via a professionally moderated forum, email or telephone. Access to the online facility will be via a portal on a Philips’ professional website which can only be accessed after they have registered on the programme.

Another of the Mentors, Jo Dickinson stated: “This innovative programme will be for the newly qualified Hygienist/Therapist to enhance clinical skills and self-confidence in a structured transition. It acknowledges the new DCP as a safe, competent practitioner who aims for best practice at the outset of his or her career”.

There will be three Philips’ supported national meetings each year where invited guest speakers will provide educational and developmental support in subjects relevant to the newly qualified Dental Hygienist/Therapist. In addition a Professional practice link is being established where participants can access the clinical environment of the preceptor. The preceptor will encourage the opportunity to reflect upon, apply, receive feedback on and develop knowledge, skills and values they have already learned.

For those taking on the guiding roles the benefits of the Programme will be skill-enhancing as they will be embracing the responsibility to develop others professionally, give feedback on individual practice and share knowledge and experience, in addition to acting as a role model through the process. They will develop appraisal, supervisory, mentorship and supportive skills which will help those they are guiding to a lifelong appreciation of professional development and high career aspirations.

“This will help give our health professionals the best start possible. Through preceptory we must strive to NURTURE and DEVELOP our new registrants to develop life long careers.” Ann Keen MP Parliamentary former Under Secretary for Health, said in November 2009.

Patricia Rawsthorne, Professional Relations Manager of Philips Oral Healthcare responsible for the development of the Transitional Support Programme concluded: “For the profession as a whole, and the public too, the benefits of this Programme include the attainment of a high standard of practice with care as the ultimate priority at all times (in accordance with CQC and GDC professional standards). It will also bring about a cohort of skilled, empowered practitioners who act with integrity and uphold the reputation and image of the profession. Philips is delighted to be able to support Professionals in practice in this innovative new way.”

For more information about the Transitional Support Programme visit the new dedicated website set up by Philips for the programme www.philips.co.uk/dp. There you will also be able to view interviews with the three mentors who will tell you more about the programme. You can also email catherine.domanski@positive-comm.com to register to attend the launch seminar about the programme at the BDTA on 20 October 2011.

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Dr. Ian Cline
27th September 7.30pm

ChemFil™ Rock – A Breakthrough Glass Ionomer?
Professor Roland Frankenberger
18th October 7.30pm

Successful Endodontic Treatment
Dr. Carol Tait
23rd November 7.30pm

Covering all the Angles - The Theory of Technique and How to Get it Right in Practice
Barbara Lamb
30th November 7.30pm
Providing options

Neel Kothari discusses how clinicians can provide options for patients to reduce the impact from snoring

**Mandibular advancement splints (MAS)**

Mandibular Advancement Splints (MAS) are appliances which posture the lower jaw forwards in order to assist in opening the patient’s airway. This maintains the patency of the airway by replicating the effects of a mandibular jaw thrust and holds the jaw in the recovery position. As discussed in the first part of the series, during sleep the tongue drops back, the muscles below the jaw relax, which leads to a restriction of air flow. As air passes through the smaller aperture its velocity increases and in some people this causes the soft tissues to audibly vibrate, giving rise to the snoring sound. The snorer has to work extra hard to overcome the air resistance, often depriving the individual of oxygen.

No matter what approach is adopted or materials used, best practice principles should be maintained. These include minimal encroachment into the tongue and freeway space, forward protrusion without excessive vertical opening, tooth rather than soft tissue borne, the use of biologically compatible robust materials and that the jaw joints are not held in a fixed position for a protracted time.

Many of the earlier mandibular advancement splints made in both arches to help posture the jaw forwards is much the same, the materials used to make these and their relative costs remain varied.

No matter what approach is adopted or materials used, best practice principles should be maintained. These include minimal encroachment into the tongue and freeway space, forward protrusion without excessive vertical opening, tooth rather than soft tissue borne, the use of biologically compatible robust materials and that the jaw joints are not held in a fixed position for a protracted time.

Many of the earlier mandibular advancement splints made available, the short term financial advantages in their usage is considerable.

**Non-adjustable mandibular advancement splints**

One piece mandibular advancement splints, as shown in Fig 1, posture the jaw in a fixed position to open the airway. The main advantage compared to semi-adjustable or adjustable appliances is the cost, which is considerable lower, but in the longer term they may need more frequent replacement. The dentist’s role here is to take impressions of both arches, as well as communicate with the laboratory the degree to which the mandible needs to be advanced. The vibration of the soft tissues that result in snoring can differ from time to time. For example, many patients anecdotally mention the increased impact of snoring with alcohol consumption and in this particular situation the lack of adjustment can be considered a disadvantage.

**Adjustable mandibular advancement splints**

Two piece appliances such as the ‘Sleepwell’ device, shown in Fig 2, allow the patient to adjust the position of the mandible for ideal effectiveness and can also be adjusted at a later date using thermoplastic materials suffered with issues relating to retention, comfort, compliance and long term viability. As such, the use of rigid ‘custom-made’ materials is now regarded to have a more positive outcome for the patient. A recent study comparing an acrylic custom-made and a thermoplastic proprietary intra oral appliance for the treatment of mild sleep apnoea (Vanderveken OM et al Am J Respir Crit Care Med, 2008) found the acrylic custom-made appliance to be more effective, but with this also comes an increase in costs. Many sleep centres around the UK do currently use thermoplastic moulded mandibular advancement splints to varying degrees of success and, whilst there are alternative materials available, the short term financial advantages in their usage is considerable.

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Appliances like the ‘Sleepwell’ are also supported in the literature (Barnes et al., 2004 Am J Respir Crit Care Med) for the treatment of mild to moderate sleep apnoea. However an accurate diagnosis is needed for which a sleep study confirms the definitive diagnosis.

Adjustable cobalt chrome mandibular advancement splints

Appliances such as the ‘Somnowell’ device, as shown in Fig 3, use a skeletal frame on both arches linked with a piston-rod connector which gives freedom of jaw movements except in the posterior direction. The benefits of using CoCr for MAS appliances were described in the literature (S.P Ash & A.M. Smith J of Orthod 2004). The use of CoCr means that the laboratory fees are higher and the provision of this type of appliance also require a facebow recording and a higher degree of clinical accuracy.

However, in the longer term it presents with excellent durability and longevity in the oral cavity, as well as having additional benefits such as improved oral hygiene and minimal intrusion into the tongue and freeway space. Given that that CoCr does not absorb moisture, it is far harder for micro-organisms to colonise the material and its relative high strength helps to keep the bulk down, compared with alternative materials. For many years CoCr has established itself as the standard for partial denture construction and its clinical advantages are well documented.

CoCr is not currently in widespread usage for MAS and the relatively higher production costs may discourage many practitioners from exploring this option. That being said, how much would you be prepared to pay for a good night’s sleep?

For the purposes of this article I have presented only a few of the many options currently out there. For those dentists who wish to offer MAS to their patients or even wish to help their own snoring issues, an understanding of sleep related breathing disorders is essential and a structured training programme offers the best way to carry this out. Remember that even though MAS may be effective for mild to moderate sleep apnoea, the SIGN 2003 guidance only supports their usage for snorers with mild sleep apnoea with normal daytime awareness. As such, whilst we as a profession may be in a position to help simple snorers, we are not always in the best position to diagnose and treat the more moderate to severe forms of sleep apnoea, which is a potentially a life threatening condition.

About the author

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

Fig 1 Adjustable Mandibular Advancement Splints. Figure 3 (courtesy of Somnowell)
N
owadays we are saturated in logos and brands in a myriad of shapes, sizes and colours, all competing for our attention. The brand of any company, including your practice, is essentially a grouping of elements that provide it with a unique face and personality. If designed well and applied consistently with care, flair and imagination, it will go a long way to ensuring the practice is perceived and talked about as highly attractive.

The most important roles of the brand, beyond providing the practice with a unique face and personality everyone will easily recognize, are the following:

• Delve consistent messages about what the practice is all about
• Build and preserve the desired perception about the practice
• Clearly convey what the practice offers to its audience

In order to preserve the uniqueness of your brand you must apply it consistently on everything your viewers see.

The importance of brand continuity
Cathy Johnson offers advice for getting your dental practice noticed consistently

There’s no point investing in a stunning new identity, yet leaving an old unbranded sign on display. On the contrary, a striking image beautifully displayed can do a magnificent marketing job for you, simply by being there – reinforcing your brand by making a favourable and memorable impression on all who view it. Inside the practice, make sure your brand is an integral part of your interior design scheme.

Be proud
Likewise, with your practice literature, ensure your practice logo is featured in exactly the same way on all items of stationery, welcome packs, referral packs, patient newsletters and internal literature. Any advertising you do should follow the brand guidelines and it goes without saying that your website must be designed in line with everything else.

There are numerous opportunities to get your brand noticed in a range of applications. Repeat, repeat and reinforce your message. In addition to uniforms, name badges and carrier bags, some practices now have branded cups, saucers and hot towels within the practice and branded toothbrushes and flaps to take home. There are plenty of companies producing promotional accessories that give you the opportunity to get your practice seen outside of your own four walls. Most people love a freebie and there's nothing worse than being your own best-kept secret. I have actually heard the words: “we’ve spent money on these brochures so we’re not going to hand them out too freely”. Yet this is surely a fundamental business error that completely misses the point – what use is a brochure when it is hidden away?

If, at present, you don’t have the budget to rebrand across the board, start with the brand identity and gradually reinforce the items most in need of a facelift. This way you can plan ahead, ease cash flow and gradually reinforce your brand over, say, a year or two. However, remember that brand continuity is key so delaying things may be a false economy. Look at where you are now and where it is that you want to be in one, three, or five years’ time. You’ll know when it feels right to go the whole hog and give yourselves the “wow” factor.

Case Study
Number 45 Dental in Chichester opened in May 2008. From the outset, as contracts were being signed on the property, the owners focused on choosing a name for the practice and commissioned interior designer in conjunction with planning the internal decor and, by putting the graphic designer in touch with the interior designer; they ensured continuity of style and colour throughout. The welcome pack, stationery, signage and website are all fully co-ordinated. The result: an impressive and stylish achievement that received a Best New Practice nomination.

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. Cathy’s success is built on more than 25 years of experience as a graphic designer combined with in-depth understanding of the needs of the dental profession. She and her team are based in London and work with practices across the UK and abroad.

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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. Cathy’s success is built on more than 25 years of experience as a graphic designer combined with in-depth understanding of the needs of the dental profession. She and her team are based in London and work with practices across the UK and abroad.

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Is a mobile app right for you?

The Apple tagline may state “There’s an app for that”, but with the popularity of mobile websites soaring, marketers are beginning to question whether an app is right for every business. With more than 425,000 available in Apple’s App Store alone, the glut of options available to consumers means most apps disappear without trace.

The future of the mobile app is dividing opinion amongst marketers. Some see them as a way to enhance the service they provide customers but others predict they will eventually become obsolete for marketing purposes. To avoid the latter, a mobile app must offer benefits above and beyond what can be expected from a desktop or mobile website. It must also be considered repeatedly useful and engaging – by patients, not you!

Apps may be innovative and fun but they’re not right for everyone. Consider the following:

Do build an app that...
- Makes use of the unique capabilities of the device, such as the camera, calendar, motion sensor or global positioning system (GPS)
- Emphasises experiences that can’t be replicated on a website, such as viewing rich media content on a tablet
- Encourage users to share content with friends through social media
- Performs a function that is actually useful to your patients

Don’t build an app that...
- Only has functions that are easier to use on a mobile website
- Focuses on transactions where patients will want to do research outside the app
- Requires huge amounts of data to be downloaded and updated on the move
- Is designed for a mobile platform your patients don’t use

Why mobile sites are taking over

Unlike apps, which must cater for the growing number of mobile devices and operating systems, each of which requires different app technology, the mobile web is open to everyone. One size fits all if you like. This alone gives mobile websites a far greater reach than mobile apps. Furthermore, mobile websites are generally less expensive than a single mobile app, bearing its own financial considerations.

General browsing capabilities are better served through a mobile-optimised version of a website - if you are just trying to find generic information, a mobile site will be quicker, easier and will not require you to store large amounts of info on your phone. Plus, you still benefit from the inbuilt functionality on mobile devices which make it easier for users to perform certain tasks. This includes the ability to make calls and get directions to your practice at the click of a button.

Already, between 15 per cent and 20 per cent of all searches originate on a mobile device and this number is set to rise exponentially in the next year. Until such time as apps make better use of the technology available, I would recommend a website optimised for mobile to any dental professional looking to exploit the infinite potential of the mobile marketplace.

Need advice on how to best capture the mobile market? Speak to one of the Dental Design team on 01202 238 469 or visit www.dental-design.co.uk – your marketing success is our priority.

About the author

Amy Rose-Jones is the Marketing Manager at Dental Design Ltd, the leading website design and marketing agency for the dental profession. With more than 9 years experience in a marketing capacity, Amy has helped hundreds of practices throughout the UK to build and develop a lasting web presence through a blend of creative and marketing skills. Like us on Facebook: www.facebook.com/dentaldesignltd Follow me on Twitter: www.twitter.com/dentaldesign Find me on LinkedIn: www.linkedin.com/in/amyrosejones
Providing facial aesthetics in general practice

The growth of the non-surgical aesthetic market in the UK has been phenomenal over the last 10 years and it shows every sign of continuing. As reported by the International Association for Physicians in Aesthetic Medicine (IAPAM) and other aesthetic medicine associations, there were 14.6m cosmetic minimally invasive procedures performed in 2010, and 5.4m of these were Botulinum Toxin. Physicians who incorporate these procedures into their practices, should reap significant rewards in 2011 and beyond. The allure of improving one’s appearance, without the surgeon’s scalpel, is a very strong incentive for the continuing growth in demand for the facial aesthetic industry.

Most dentists are unaware of the benefits that facial aesthetic treatments can have as an adjunctive therapy in dental practice. A beautiful smile is not only determined by the colour and position of the teeth but also extra-oral soft tissue, including lip, cheeks, nasal labial folds, marionette lines, chin, and jowls. These treatments are as essential to aesthetic dentistry cases as porcelain veneers, composite-resins and bleaching. It seems that as dentists, the profession has become so tooth-centric, that the importance of the perioral areas to look as good as the teeth can be forgotten. The demand and versatility of the products and treatments is ever increasing, not only for ‘wrinkle reduction’ treatment, but for a host of other problems; hyperactivity, reducing pore size, muscle spasm,TMJ and bruxism cases, to mention but a few. Botulinum treatment can often be used in conjunction with dermal filler therapy as a non-surgical alternative to high lip linens. In the past the only treatment available involved aggressive treatment plans, involving periodontal flap surgery, crown lengthening, possible orthodontics and crown and bridge therapy. Although the results are long lasting the disadvantages are obvious; the number of appointments, high cost and the possible complications. The advantages of non-surgical treatment is the close to immediate results in one appointment, non-invasive and often much cheaper! The advantage is the requirement of repeated treatments; however it is not important, to increase the patient’s choices!

Dentists should be aware of the clinical benefits as well as the financial rewards that go with performing total facial aesthetic therapy. With proper training, dentists are among the best qualified to provide this type of care. They are the only healthcare professionals that can practice total facial aesthetics; not only can the teeth be treated cosmetically but, with further training, the facial aesthetic procedures can be enhanced. Dentists have the added advantage of having a detailed knowledge of the facial anatomy and proficiency with local injections. Many already possess the skills and experience of running a business, with an existing loyal clientele that know and trust them.

When incorporating facial aesthetics into practice, it is often helpful to follow a few fundamentals:
• Undertake appropriate and ongoing hands-on training. Keep up to date with the trends in aesthetic medicine and attend regular courses, such as those offered by Quality Conferences.
• Develop a successful business plan, integrating aesthetics procedures into your practice and building and extending the patient base.

Aim to maximise profits by offering the more profitable aesthetic procedures, tailored to meet client’s specific needs
• Be open to offer more procedures to your patients thereby maximising the potential for each patient
• Become proficient in aesthetic patient consultations, making your clients aware of the procedures available at the practice.

The field of facial aesthetics is constantly evolving which makes it not only challenging and exciting, but also very rewarding.

Quality Conferences next Facial Aesthetics seminar is to be held at the prestigious Ardencoe Country Club on November 4, 2011. This will be an overview of most of the points raised in this article and give a greater insight into the field of facial aesthetics.
Dental Managers' Health and Safety Induction (1 hour Verifiable CPD)

• DCP Radiography and Radiation Protection (5 hours Verifiable CPD)

• Radiography Update Course (5 hours Verifiable CPD)

The training courses offered by dbg trainers include:

Virtual planning for optimal implant placement – Sirona presents 3D X-ray renovations

In assisting patient counselling and precise treatment planning, an avatar generated by a computer program provides assistance to the dentist and makes it easier for the patient to understand the proposed treatment. The basis for this is provided by the digital technology of modern implant systems, GALILEOS and ORTHOPHOS XG 3D.

With its integrated planning (IP) Sirona has brought the prospect of the virtual patient a step closer. Thanks to the integration of a 3D scanner in GALILEOS, 3D software and the additional database of the implant planning software, it is possible to provide a 3D overview of the tooth region, the neighboring structures and adjacent tissues. The software provides the user with the opportunity to plan and simulate an implant position and check the implant options.

Oral Cancer: can it be prevented? Can oral cancers be diagnosed at an early stage? Are oral cancers preventable? Is the patient better off with all tumours eradicated? Is early detection important? Is late detection of oral cancers better than early detection? Can you prevent oral cancers from becoming aggressive?

In assisting patient counselling and precise treatment planning, an avatar generated by a computer program provides assistance to the dentist and makes it easier for the patient to understand the proposed treatment. The basis for this is provided by the digital technology of modern implant systems, GALILEOS and ORTHOPHOS XG 3D.

Vigilance that can prevent a nightmare disease

Cancer of the oral cavity is on the rise. The incidence of oral cancers is doubling every 10 years. Tobacco is still the most common cause of oral cancer. But being aware of risk factors and managing patients with oral cancer could lead to a better outcome.

If you’re a busy dental professional with little time to spare, then the CORE CPD Online Resource Centre could be just what you need to help you maintain your reputation was well known to me. “There are various modules related to these anxious patients. A series of lectures, seminars, interactive sessions and demonstrations will take place on a day per fortnight and offer 6.5 hours of verifiable CPD each. Students have access to a series of case studies and interactive online seminars, which they can choose to work through on their own or with a tutor. The course is designed to provide students with the knowledge and skills they need to effectively manage patients with oral cancer.

For more information on either course or to enrol for October 2011, please contact Dr Doshi for more details.

For more information about the course or to apply, please visit www.corecpd.com
Bionorics UK appoint Ken O’Brien as National Sales Manager

Ken O’Brien, whose advanced implant technologies, biological products and computer-guided surgical software have benefitted more than 850 clinical sites worldwide, has been appointed Ken O’Brien to work as National Sales Manager from its UK base in Berkhamsted.

Ken O’Brien says of his new role “Bionorics is an exciting company with innovative products. In particular Laser-Lok and its soft tissue attachment already used with the Laser-Lok implant system is now available to dentists throughout the UK. The latest Laser-Lok 3mm dental implant incorporates many special features. It is the first 3mm implant with Laser-Lok attachment system – a biologic seal and maintain cortical bone on the implant collar and is designed specifically for extremely small size ridge and posterior regions. Clinical tests show the Laser-Lok 3mm dental implant system to be more than 20 per cent stronger than a 3.3mm implant. Over the years, we have found the soft tissue attachment is effective when immediately loaded. The broad array of prosthetic options makes the Laser-Lok 3mm implant template highly versatile. High quality restorations and each implant treatment completes with a 1,000 g cap screw/abutment loading. Unlike virtually all other dental implants on the market, Laser-Lok implants have micro channels – a series of cell-laden (approximately 10 microns) circumferential channels on the collar that are perfectly created using laser ablation (nanotechnology). The micro channels provide a repeating nanostructure that maximises surface area and enables cell proliferation and collagen microfractures to interdigitate with the Laser-Lok surface. The Laser-Lok 3mm dental implant system is available in 10.5mm, 12mm and 15mm lengths.

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For more information simply contact your local The Dental Directory Business Consultant, call 01488 503 586, or alternatively visit www.dentaldirectory.co.uk

Bionorics most advanced implant Bionorics UK confirms that Biohorizons’ Laser-Lok 3 mm dental implant system is now available to dentists throughout the UK.

The Waterpik® Nano Water Flosser—gentle, effective, affordable

The Waterpik® Nano Water Flosser is small and quieter than previous models and comes with 3 pressure settings to suit various levels of sensitivity, making it ideal for multiple users. It features an integrated LED display which allows the user to confidently operate the device, so don’t get left behind. Incorporate the procedures that are available on the Nano Water Flosser.

The Waterpik® Nano Water Flosser is small and quieter than previous models and comes with 3 pressure settings to suit various levels of sensitivity, making it ideal for multiple users. It features an integrated LED display which allows the user to confidently operate the device, so don’t get left behind. Incorporate the procedures that are available on the Nano Water Flosser.

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Specialist orthodontist Dr. Derek Mahony launches his UK 3-year course “The full face philosophy”

Dr. Derek Mahony has been running courses for general practitioners in orthodontics for 20 years and has been heard by over 10,000 dentists worldwide.

He is launching his 3-year programme “The Full Face Philosophy” – a Mini Residency in Orthodontics for the first time in the UK, starting January 2012. The programme has been taught with great success in Australia and the US, and differs from other courses in that it focuses not just on the alignment of teeth, but also on the facial balance, as well as identifying the cause of the malocclusion. His philosophy is that appliances alone will not make you a good orthodontic clinician, and any orthodontic problem is not only a tooth problem, but should be studied through aspects of development and function. Dr. Mahony says “For orthodontic treatment to be successful, at any level, it is essential for the general dentist to have a thorough understanding of normal facial growth and development, and to possess the skills to recognize developing malocclusions. My courses are aimed at providing this information, so the general dentist will be able to increase their skills in orthodontic diagnosis and treatment planning. We supplement the clinical teaching with the use of typodonts and a number of practical exercises, including wire bending and bracket positioning.”

Dr. Mahony is aware that some of his specialist orthodontic colleagues do not agree with GPs being taught orthodontics, he says “In regular surveys we have undertaken, we note that general dentists who have completed my orthodontic training programmes tend to refer more patients to their Orthodontic Specialists than before they had learnt orthodontics because they are more highly trained as to which cases to refer and when is the appropriate time to commence orthodontic treatment.”

The programme starts with modules on orthodontic diagnosis and cephalometrics, with a strong emphasis on preventative or interceptive orthodontics, particularly in the mixed dentition. Then come modules on the treatment of Class II and Class III malocclusions. The mechanics are based on passive self ligation, and later in the programme more difficult malocclusions are taught, such as vertical growers and open bites. There are modules on periodontics, implantology, restorative/orthodontic interface, biomechanics and aesthetic appliances and the management of TMD. The concept of long term stability, via the use of retention strategies, is taught, and the doctors are also exposed to the possibility of working with OMFS surgeons in the correction of severe skeletal malocclusions.

Following the courses doctors can upload case records and questions onto www.fullfaceglobal.com for advice and peer review; observe clinical procedures and treat their own patients at a UK clinic run by one of Dr Mahony’s experienced UK colleagues, whose experienced team can assist and support.

Specialist orthodontist
Dr. Derek Mahony
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Pensions legislation has undergone major changes again and some dentists may fall foul of the new rules without even being aware, resulting in an unwanted additional tax bill.

A new Special Report reveals what you need to know and how to take action with regards to your own pension and retirement planning.

Just call the 24 HOUR PRE-RECORDED LINE today and we’ll send you a free copy of ‘The New Pensions Rules - What Dentists Need To Know’.

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