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BDSA Sports Day great success  
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Don’t be scared of Oct 31, celebrate!  

In our exclusive interview with teeth whitening expert Dr Wyman Chan, we hear that it’s all white now that the law surrounding hydrogen peroxide use is changing...

This week marks the date that sees the long-lobbied for clarity in the protracted debate over the legality of tooth whitening.

According to the amendment carried last year by the European Commission, tooth whitening products containing up to six per cent hydrogen peroxide can now be supplied to patients for use as a take home product, providing certain conditions are met.

Dr Wyman Chan, a dedicated teeth whitening dentist, has been following the developments, and believes that dental professionals should be embracing the freedom that the law amendments have given, not be wary of them.

He said: “It’s exciting, it’s excellent news, and I think we all should celebrate. Dental professionals, dental practitioners who are practising teeth whitening should celebrate, should go and have a party. It’s the first time in so many years that we can do teeth whitening legally from October 31. Before then, even now, we’re doing it technically illegally. So that’s why I’m so happy because I am a dedicated teeth whitening dentist. It’s the only thing I do and now I can do it without fear.”

One thing that Dr Chan has noticed is that although the amendment is supposed to bring an end to the confusion over what can and cannot be done with regards to the supply of teeth whitening products to patients, it seems that for many it isn’t clear what the law is changing. “I’m bemused by the debate going on in forums and also the position taken by many reputable bodies - I won’t name any of them. I think they didn’t read the documents properly - I think they have got it wrong.”

That’s my opinion. Maybe I’m wrong, but I’m confident I’m correct. Let me explain why I think that. Because this is not new law, this is an amendment. They’re amending an...
Dr Wyman Chan at work in his practice

existing law. Actually it is a Directive - 76/768/EEC Annex III.

This Directive covers the use of hydrogen peroxide in consumer products across four sectors including hair and nail products; however for dental professionals it makes the most striking impact. The amendment states: The SCCS (Scientific Committee on Consumer Safety) considers that the use of tooth whitening or bleaching products containing more than 0.1 per cent and up to 6 per cent of hydrogen peroxide present or released from other compounds or mixtures in these products may be safe if the following conditions are satisfied: an appropriate clinical examination is carried out in order to ensure there are no risk factors or any other oral pathology of concern and that exposure to these products is limited so as to ensure that the products are used only as intended in terms of frequency and duration of application. These conditions should be fulfilled in order to avoid reasonably foreseeable misuse.

Those products should therefore be regulated in a way that ensures that they are not directly available to the consumer. For each cycle of use of those products, the first use should be limited to dental practitioners … or under their direct supervision (if an equivalent level of safety is ensured. Dental practitioners should then provide access to those products for the rest of the cycle of use. (European Union Council Directive 2011/84/EU)

Dr Chan believes that the confusion is many think the Directive is looking at tooth whitening as a whole, including in-surgery (power) whitening. In fact, as a cosmetic directive it is just concerned with whitening products that are supplied to patients (consumers) for take home use. He said: “It’s great news for dental practitioners because now the level is raised from 0.1 per cent (which was ineffective as a treatment) to six per cent, which is very effective. With six per cent take home we can get excellent results. It doesn’t matter what product you use, with six per cent you will get results. So the clarity we now have is nothing to do with the debate people are having at the moment – which is about chairside [whitening]. This has nothing to do with chairside – they are amending the law around oral hygiene products.

“The original Directive came into force in 1976, regulating products directly available to the consumer as over the counter products. That’s why it was limited to 0.1 per cent hydrogen peroxide because of daily use and long term exposure. I agree with the cosmetic commission of the EU that it should be regulated, that the level should not be more than 0.1 per cent because you can swallow a lot of toothpaste and mouth rinse into the stomach every day. So it was correct at that time, 1976. In the early 1990s teeth whitening became popular, it became the norm. In 1976 there was no such thing as home whitening, it was brand new technology. Things seemed to be moving too fast for the EU – they needed to catch up with the new technology.

“They’ve (SCCS) been debating for years the safe amount for consumer self-dosing application, and there’s a lot of evidence from scientists, and they all agree that up to six per cent is safe for the consumer to take home. Of course this is after they’ve had a clinical examination - there are conditions attached which I think is fair, for example they need to be examined by a dentist so now take home whitening is officially a dental procedure. In addition the first use should be by a dental practitioner, or supervised by a dental practitioner, so now home whitening is very much the practice of dentistry.”

Another big issue regarding whitening is the rise of people outside of dentistry providing tooth whitening services to the public. With the law amendment, Dr Chan says this can help put a stop to this, protecting patients further. “I think this amendment has plus and minuses. A plus is that there are a lot of non-dental professionals – I’ll not call them beauticians, as many are mechanics and bricklayers trying to make some fast money - giving customers hydrogen peroxide to take home with them so that will be stopped now. Trading Standards Agencies can stop anything illegal in home whitening. For a non-dental professional to use products with more than 0.1 per cent – that is illegal. If a non-dental professional continues using hydrogen peroxide at 0.1 per cent or less you won’t see results. But by using six per cent you do see results. All that is illegal now, so I’m quite happy.

“On the other hand, for those non-professionals who are just doing it chair side, then unfortunately this is outside the remit of Trading Standards regulation. But the General Dental Council has said all along that teeth whitening is a practice of dentistry. So the General Dental Council can prosecute illegal activity – it can close them down.”

In an attempt to help dental professionals understand tooth whitening and what can be done, Dr Chan has partnered with Healthcare Learning Smile-on to develop a new educational programme on the subject. “I’m really excited about it, because when it comes to legality a lot of dentists are still confused because a lot of companies are withdrawing chair side products and we need to review the literature. A lot of clarity has to be made in this field. We’ll be able to supply dental professionals with the supporting documents about whitening so you can cover the legality but it will also aim to teach them about the modern ways of doing teeth whitening effectively. There is a lot of talk that chair side whitening is all about dehydrating the teeth but that is just not true. I do a lot of chairside whitening. You need a lot of knowledge to make it work. This programme is so important because you’ll learn how to do it properly. We talk about chairside whitening, home whitening, how to deal with patients with sensitivity.”

To review the amendment to the whitening Directive go to http://ec.europa.eu/con-sumers/sectors/cosmetics/documents/directive/76-768/eeec consolided-version-of-cosmet ics-directive-76/768/eecc

Dr Wyman Chan at work in his practice

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Editorial comment

This week is a landmark time for dental professionals who supply tooth whitening to their patients. Finally it will be possible to provide patients with home whitening kits that will provide results that won’t make you looking over your shoulder for the nice guys and gals from Trading Standards.

Tif Qureshi, president of the BACD, has released this statement: After many years of uncertainty regarding the legality of tooth whitening in the UK, the BACD welcomes the amendment to the UK cosmetic regulations as a result of European Council Directive 2011/84/EU that finally legalises tooth whitening by dental professionals.

Dental professionals hope that this change signals the beginning of a new era for patient safety, in which only registered dental professionals will be providing tooth whitening treatments. This would be in accord with the view of the GDC that tooth whitening is the practice of dentistry.

We commend the work the GDC does protecting patients and re-affirm our support for its work prosecuting non-dentists illegally providing whitening. We call on Trading Standards departments across the UK to embed their approach in tackling non-dentists who illegally provide whitening treatments and continue to put the public at risk.

And we call on the beauty industry to ensure that its members, and those who train them, understand the new legal framework and leave whitening to those who can provide it legally, safely and in the best interests of patients; the dental profession.

The future’s bright, the future is six per cent hydrogen peroxide!

ARF freeze ‘inadequate’

The GDC’s decision to freeze the Annual Retention Fee (ARF) at £120 for dental nurses in 2013 is “inadequate” says Nicola Docherty, President of the British Association of Dental Nurses.

The decision shows that the GDC is “out of touch with registrants” says Nicola. “We have supplied the GDC with detailed information on dental nurse salaries, showing that the £120 ARF causes considerable financial hardship to dental nurses. We have also requested that the GDC lower the ARF for dental nurses to a fee more in line with salaries - instead of charging dental nurses the same ARF as hygienists and therapists - and that they implement a special fee for those working part time.”

A recent salary survey conducted by BADN shows that the majority of Registered Dental Nurses are paid between £10,000 and £20,000 per year - in contrast with hygienists and therapists, whose recommended starting salary is £26,000. However, the GDC has decided to continue charging one ARF to all Dental Care Professionals, completely disregarding the fact that dental nurses earn less than half that of hygienists and therapists.

“BADN has always supported, and continues to support, registration in principle, as being in the best interests of the patient. However, the GDC’s heavy-handed and insensitive implementation, including the imposing of an unreasonable ARF, has alienated many dental nurses and must be rectified as soon as possible” said Nicola.
**Confidence amongst dentists has increased dramatically since the start of the year, according to the latest Lloyds TSB Commercial Healthcare Confidence Index, with short term optimism rising from minus eight per cent in January, to nine per cent, a positive shift of 17 per cent.**

This boost to sentiment follows a fall in confidence in the start of the year, possibly on the back of concerns about how NHS contracts would be delivered in the longer term and the stresses around the CQC. Compared with children from schools randomly assigned to a control group. The children in the intervention group also showed markedly improved beliefs about the importance of healthy dental behaviours and had better gingival health than those in the control group.

Jas Matharos, Director at NHS England, said: “An interesting figure to emerge out of the latest report is that 58 per cent of dentists definitely want to be involved in promotions.”

**Commenting on the survey results, Ian Crompton, Head of Healthcare Banking Services at Lloyds TSB Commercial, said: “It is encouraging to see overall confidence returning to the dentistry sector. There are still concerns across many areas and the funding and impact of new NHS contracts, but dentists are perhaps becoming more proactive in their approach to primary care professionals, such as doctors, who remain quite pessimistic.”**

“By adopting a forward looking approach to practice management and an increasingly flexible attitude to service provision, dentists are in a better position to adapt to new regulations going forward.**

“We have a successful history of advising and supporting businesses in the healthcare sector, in a range of disciplines. Our team of relationship managers have a strong knowledge and sound understanding of the challenges facing these businesses and we are determined to ensure that they remain financially fit for the future.”

**Confidence in children improves dental health**

A new study, published in the Journal of Dental Research has found that an intervention designed to bolster their “sense of coherence” in children from the schools that participated in an intervention had normal gingival health than those in the control group.

“This is a hugely important study in the dental literature. While there is some evidence in dentistry of the benefits of a sense of coherence, much of this work is cross-sectional so we don’t really know if sense of coherence really brought about any possible change,” said study co-author Sarah R. Baker, PhD, a health psychologist at the University of Sheffield in an interview with Medscape Medical News. “Our study is the first intervention study to show that an increased sense of coherence can influence oral health,” she said.

In the study, 12 different primary schools were randomly assigned to the intervention group or the control group. Fifth graders, aged 10 to 12 years, participated. Students assigned to the intervention group received seven sessions over two months focused on child participation and empowerment. Each session lasted 50 to 40 minutes. The four first sessions were classroom-based activities, involving didactic learning, games, and discussions. The last three were health-related school projects that included all students and staff, and involved brainstorming, planning, evaluation, and implementation. The intervention was delivered by six teachers who went through specialised, intensive one-day training.

Results indicated that compared with the control group, the children who received lessons in sense of coherence had mean scores on the oral health-related quality-of-life questionnaire that indicated fewer functional limitations and other problems due to dental pain than those in the control group. The children in the intervention group also showed a greater sense of coherence.

**Dissolvable strip offers pain relief for burns**

A dissolvable oral strip has been developed to immediately relieve pain from burns caused by ingestion of hot foods and liquids, such as coffee, pizza, and soup.

Lead researcher Jason McConville, PhD, and colleagues from University of Texas at Austin, designed the strip for controlled delivery of a local anaesthetic that pacifies inflammation, a therapeutic polymer. Benzocaine, commonly used as a topical pain reliever in dental products, and throat lozenges, was chosen for its non-irritating properties.

The strip is applied direct to the burned part of the tongue, cheek or roof of the mouth. It sticks to the affected area and won’t interfere with normal day-to-day activities, as it quickly dissolves for instant pain relief and promotes healing.

“We found these strips to be non-toxic, which has huge potential for anyone who burns their mouth while eating and drinking hot foods and that’s just about everyone,” said McConville. “The strips look and behave similar to breath freshening strips that you might find in your local drugstore.”

Now based at the University of New Mexico, McConville and his team, will explore creating a stronger oral strip to treat more severe burns lasting longer than two-three days. The next step in furthering their research will be to test the strips in humans and experiment with taste-masking.

**Old magazines pose health risk in dentist waiting rooms**

Monica Synes, a dentist in Lyme Regis, Dorset, says she recently instructed staff to stop keeping old magazines within a specified schedule, should ensure that magazines are in good condition and free from obvious contamination. This advice will be kept under review and may be modified in the event of any future community infection outbreaks.

A spokesman for Dorset PCT said the current advice to practice owners is that patient waiting areas should be kept clear of magazines to reduce the risk of inadequate regular effective cleaning. He added: “There is no specific requirement for practices to remove magazines within a specified time period; however, practice owners, as a part of cleaning schedule, should ensure that magazines are in good condition and free from obvious contamination.”

This advice will be kept under review and may be modified in the event of any future community infection outbreaks.

The Healthcare Confidence Index was first published in August 2011 and is now in its third wave. It aims to provide an insight into the attitudes and opinions of primary healthcare providers; GPs, dentists and pharmacists, over the next one to five years.

To view the full Lloyds TSB Commercial Healthcare Healthcare event of any future please visit www.lloydstsb.com/healthcare and to take part in the next Healthcare Confidence Index visit www.healthcare-confidenceindex.co.uk.
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## East Sussex practice offers free dental implants

Dental practice has performed complete dental implants for free after winners were nominated on Facebook.

Brighton Implant Clinic’s charity, The Smile Foundation, provides dental implant treatment to those in need of urgent surgery, but without the means to cover its costs.

The Smile Foundation launched a Facebook page earlier this year to change the lives of people who need dental implants after oral neglect caused by dedicating their lives to helping others.

“I’ve always wanted to give something back for the support I’ve had in my life. The Smile Foundation is a way for me to use my dental skills to help those less fortunate than myself,” said Dr Bruno Silva, Head surgeon at Brighton Implant Clinic.

In 2006, Donald Rodríguez, a carer, suffered a severe stroke, causing the paralysis of his left side. His dental health suffered enormously as he lost the ability to brush his teeth, resulting in serious gum disease and infection. For both mental and physical wellbeing, the dental implant procedure was essential to his continued health.

Bruno Silva saw Donald as an ideal candidate for The Smile Foundation, so carried out the dental work, removing the infected teeth of the upper and lower jaw, and replacing them with new, strong dental implants. The procedure would have cost £12,500.

The Smile Foundation is using Facebook as a voting platform, where social networkers can vote for those who deserve treatment. Using Facebook has allowed patients to interact with one another and write why their nominations deserve free treatment under the charity.

This year with the help of Facebook Dr Silva has begun offering regular opportunities to win a ‘smile makeover’ tending to the winner’s every need. So far we have seen hundreds of cases where people’s teeth simply need to be restored.

The prize is open to UK residents who are between 21 and 99 years of age. The contest closes on November 29th at 5.50pm.

## Young dentists call for DFT guarantees

Young dentists are calling for support for their demand for Government to guarantee all graduates from UK dental schools a Dental Foundation Training (DFT) place. The demand comes in the British Dental Association’s (BDA’s) newly-published YDC Asks, a mini-manifesto for young dentists developed by the organisation’s Young Dentists Committee (YDC).

The Committee is asking those who support it to sign a Government’s petition founded by YDC Chair Dr Martin Nimmo. The petition argues that the failure to allocate DFT places to UK graduates who have taken on large amounts of debt in order to complete their studies.

The launch of the petition follows a recent admission by the Department of Health (DH) that 35 UK graduates from the 2011 cohort have not been allocated DFT places. Each graduate, DH acknowledged, will have cost the public purse approximately £130,000 to train.

Dr Martin Nimmo, Chair of the BDA’s Young Dentists Committee, said: “It is perverse that students who have striven hard to pursue a career in NHS care are being denied the training places they need to fulfil that ambition. This is a significant waste of taxpayers’ money, and a tragedy for the graduates who have taken on large amounts of debt in pursuing their vocation. Given that there are some areas of the UK where patients who wish to access NHS care cannot do so, it is also nonsensical.

“I urge all current and potential members of the profession, and taxpayers, to join young dentists in calling for a guarantee that this farcical situation will never be allowed to happen again.”

YDC Asks also expresses concerns that robust data should be used in workforce planning, that barriers to young dentists becoming practice owners are mounting and that careers in dental academia and specialist training must remain viable options for young dentists.

## Link between rheumatoid arthritis and tooth loss

Researchers in Australia have found that those with rheumatoid arthritis are likely to develop periodontal disease.

According to doctoral candidate Melissa Cantley from the University of Adelaide, gum disease influences and alters healthy tissue within the mouth.

The research found that mice who suffered from periodontal disease would suffer greater bone loss within the joints, and that mice who had rheumatoid arthritis showed signs of major bone loss in the jaws.

Research studies are currently being carried out to see if it is possible to reduce symptoms of rheumatoid arthritis by treating only periodontitis. Researchers hope that it will be possible to help relieve rheumatoid arthritis by treating mouth conditions such as periodontal gum disease.
IDH show they’re good sports

Integrated Dental Holdings (IDH) support Dentist’s Sports Day to show human side of corporate dentistry.

IDH, the UK’s largest dental employer with over 1,000 dental staff members across numerous practices and university dental school locations, is encouraging dental employees to get involved in this year’s Dentist’s Sports Day. IDH’s support for Dentist’s Sports Day is to show the human side of corporate dentistry.

As the largest dental employer in the UK, IDH sponsored the event, whilst providing water and fruit for the players from one of their mobile dental units. In a first for this typically student-only tournament, IDH teams competed in both the football and netball leagues.

Alex Handley, Graduate Recruitment Partner at IDH commented on the day, “Despite getting unceremoniously thrashed by the competition we had a great day! We got to spend time with the students on a social level and had the chance to tell them, in an informal setting, about the career opportunities at IDH. We have a year round presence in all UK Dental Schools where we are able to educate the students on the dental employment market, and we welcome every opportunity to support the next generation of clinicians.”

The NHS already faces challenges around maintaining its workforce during times of increased sickness, so it is vital to reduce the impact of flu spreading to patients and colleagues this winter.

Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of the people in their care will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season, a much higher incidence than expected in the general population.

Director of Nursing Viv Bennett says: “Flu can kill, so health staff are being reminded to get vaccinated against flu to cut the risk of it spreading to patients and colleagues this winter.

The NHS already faces challenges around maintaining its workforce during times of increased sickness, so it is vital to reduce the impact of flu spreading to staff, colleagues, patients and families.”

Health staff encouraged to get flu jab

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Four days in London: MSc Residential

Ken Harris tells all from the second Residential of the MSc in Restorative and Aesthetic Dentistry

Wow, what was I drinking last night? Ah, I remember now, it’s the second MSc residential course, and I’m not in Kansas anymore. I’m in London, and the upcoming four days constitute one of the highlights of this MSc course. The venue nestles close within the shadow of the Tower of London, and just a rinse and spit from the iconic Tower Bridge.

Answers on a postcard

First question, first day; “why are we filling white teeth with silver fillings?” answers on all three sides of a postcard please. An ecstasy of derision. We rose up as one to express goodwill and just a rinse and spit from the iconic Tower Bridge.

However, Aurora in her saffron robe soon gave way to Apollo in his flaming chariot, and I made my way snail-like to school, complete with shining morning face, to begin the first of two days covering indirect restorations. Our guide into the porcelain underworld (and hopefully out the other side) was to be the effervescent Prof Nasser Barghi from San Antonio. Here is one (adopted) Texan who energetically placed posterior composites, carefully placing posterior composites, and just a rinse and spit from the iconic Tower Bridge.

“A fire alarm had us all outside at 3.00 AM appreciating Tower Bridge by moonlight, as well as a few other eye-opening sights. An ecstasy of fumbling then back to bed.”

First question, first day; “why are we filling white teeth with silver fillings?” answers on all three sides of a postcard please.

Standing room only

Richard III with the excellent Mark Rylance in the title role, what a piece of luck, but standing room only available, at the admittedly bargain price of just £5.00. However, after more than three hours of standing (its Shakespeare’s second longest play) I needed a very large steak and something red and chateau-bottled as a restorative. A memorable evening was complete with a stroll home along the south bank of the Thames, through certain half-deserted streets with the city stretched out against the darkening sky, like a patient etherised upon a table.

The final day began with a hands-on root canal session in the company of the irrepres-sible Dr Daniel Flynn and some extracted teeth. Despite a wide range of nickel titanium to play with it still seems the 5 most important tools remain irrigation and irrigation. “Plus ça change”

Fataally flawed

The afternoon session introduced us to the wacky world of Research Methods. We listened first in bemused silence, progressing into unsettled mutterings and finally erupting hilariously into abortion. As suspected, it’s not just me who spends anordinate amount of time carefully placing posterior composites.

“A fire alarm had us all outside at 3.00 AM appreciating Tower Bridge by moonlight, as well as a few other eye-opening sights. An ecstasy of fumbling then back to bed.”

However, Aurora in her saffron robe soon gave way to Apollo in his flaming chariot, and I made my way snail-like to school, complete with shining morning face, to begin the first of two days covering indirect restorations. Our guide into the porcelain underworld (and hopefully out the other side) was to be the effervescent Prof Nasser Barghi from San Antonio. Here is one (adopted) Texan who by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weekends by teaching 44 weeks...
Setting up on your own
Puja Patel discusses Unincorporated Business Structures

Setting up your own practice is an exciting career move for any practitioner. There will be a myriad of decisions that will need to be made. The first and most obvious is ‘Where do I start?’.

Before deciding to establish your own practice, make sure you understand what’s involved, the most critical steps, the timetable and costs. It will take thought, planning, management skills and appropriate advice.

First, you will need to decide if you are going alone or with a colleague and if the latter, in what type of entity. Here, we look at unincorporated business structures.

A single-handed ownership where you are the only dentist in a new environment can be a daunting position. Therefore, many dentists (who are not buying an established practice) opt to start from scratch with a colleague.

There are various forms of joint venture and it is important to choose an at early stage the most suitable arrangement. The two forms of unincorporated joint ventures which may be familiar to dentists are expenses sharing arrangements and partnerships.

Expense sharing arrangements can be distinguished from partnerships by the degree of integration between the dentists. It is important that dental practitioners understand the differences between expense sharing and partnerships to ensure their business is protected and that there are no nasty surprises at a future date.

The expense sharing arrangement is most commonly used where dentists operate separate dental practices but in close proximity. Whilst they continue to trade as distinct businesses, the parties agree to share common expenses such as common areas, staffing costs, utilities or marketing.

A partnership is an integrated joint venture and the dental business is the business of the partnership rather than of the individual parties. A partnership business is a closer relationship than that envisaged by an expense sharing arrangement.

Whilst many dental practitioners in partnership set out with the express intention of being a partner, there are a number of dental practitioners who believe they operate under an expense sharing arrangement when in fact they are partners. This can lead to entirely unforeseen and undesirable consequences.

NHS dentists face particular problems with such a mix up as it has the potential of putting the NHS contract in jeopardy. GDS Contracts can be made with an individual dental practitioner, a partnership and a dental corporation. Accordingly, where multiple dentists are signing up to a single GDS Contract, they are almost certainly doing so as a partnership. PDS Agreements differ in that they cannot be made with partnerships and are instead entered into by a group of individuals (although they are likely to be in partnership by virtue of this arrangement).

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Dental practitioners who sign an NHS contract as a partnership, are holding themselves out to be a partnership to the PCT and are jointly responsible under that NHS contract for the obligations under that contract.

If you are looking to operate your new dental practice under an unincorporated business structure, think very carefully how you wish the relationship with your colleague is to be governed.

Puja Patel is a member of the Commercial Team at Lockharts and works primarily in advising dentists, dental care professionals and dental corporate bodies on the commercial aspects of dentistry.

Business
What’s in a name?
Alun Rees discusses the dental identity crisis

That by which we call a rose. By any other name would smell as sweet.”
Shakespeare - Romeo & Juliet.

I think it’s fair to say that a lot of dentists struggle for an identity of their own. Are you a dental surgeon, a dental practitioner or “just” a dentist? Many change descriptions as they progress through their careers; certainly I believed dental surgeon had a certain ring to it when I was doing my hospital resident posts. Pomposity usually precedes deflation as it was when I asked for patients to be referred to the department of oral and maxillo-facial surgery and was asked by nurses and porters, did I mean the dental clinic?

To add to this where do you work? A quick look at Google would have you believe that what were once just “practices” are now anything from surgeries, smile centres, dental care, family dental health care centres, implant clinics and spas.

I have nothing against differentiation and during the first decade of practice ownership I changed the name of what I called the place where I went to work several times. Initially I implied ownership of an area by taking the suburb’s name and adding the word dental. Next I was influenced to promote health (nothing wrong with that) so I became the suburb “dental health care centre”.

Eventually I came from behind the names and realised that if I wanted to be successful on my own terms it was me that people wanted to see. The process wasn’t without wobbles, I had got so used to being part of a “thing” that I shied away from just being me but once I became comfortable with it I was happier and so were the patients.

They wanted a relationship with a real human being whose name they knew, someone who they trusted and to whom they could refer their friends when requested. So I became Alun, their dentist.

Then we made it harder to become a patient, whenever a potential new patient rang to make an appointment the first question asked was, “can I ask who referred you because Alun usually only sees new patients on referral from existing patients.” That was said even when I was desperate for patients but once I became comfortable with it I was happier and so were the patients.

At this point I’d like to introduce the difference between a transaction patient and a relationship patient and why it’s important to attract the latter to your practice if you want long-term success. Very few people are entirely comfortable letting someone who they don’t know very well and may, therefore not fully trust, work in what is a very sensitive area. Don’t forget, no matter what you call yourself, your area of expertise is the mouth and most people don’t leap out of bed in the morning with the cry, “Fantastic, dentist today, hope it’s a long appointment!”

So what’s the difference?
Transaction patients.

- Interested in price alone
- They believe all dentists are the same
- They love Groupon or other discount offers
- They show no loyalty, you keep the practice open for them on Saturday and by Tuesday they have found someone else
- They want the best deal you can give them and are never afraid to ask
- Ask for referrals and they want to know what’s in it for them
- You make very little profit

On the other hand...

Relationship patients

- Seek trust and confidence
- They want to use friendly companies with familiar people and reliable products
- They are lifetime patients.
- They will pay more and they know it
- They find it emotionally tiring to shop around
- Ask for referrals and they are flattered and pleased to help
- They are profitable over the long term

Exclusivity does not mean unavailability, in fact quite the opposite. Your business depends upon you being able to give the support and service to your patients that you would expect to receive yourself.

Nor does it mean that you have to be the only visible name and face of the business. Your qualities as a leader will be tried and tested so you have to absolutely sure in what you are trying to achieve. Your team and their experience give him a strong understanding of what others go through to build a successful practice. He has seen many different approaches and learned his own lessons in the real world. Alun now runs Dental Business Partners to offer specific and specialized support for dentists, by dentists. He has served as a media representative for both the BDA and BDHF and is an authority consulted by the media and featured on BBC Radio, Sky TV and various radio stations. Raised in South Wales, Alun has family roots in West Cork where he spends as much time as work allows. In other spare time, he works as an authority on BBC Radio, Sky TV and various radio stations. Raised in South Wales, Alun has family roots in West Cork where he spends as much time as work allows. In other spare time, he works as an authority consulted by the media and featured on BBC Radio, Sky TV and various radio stations.
Apprenticeships

Jane Armitage looks at apprenticeships as a suitable staffing solution

Working in a busy dental practice can sometimes become hectic, how often do you have a rota and have to redo it as suddenly as this can happen? Yes we have the support of agencies but this comes at a financial cost.

Induction
A good induction programme will benefit both parties. However with agency staff although you will give an overview of what is expected it is not in depth as there isn’t the time, that nurse is required in surgery to cover at short notice so if you haven’t the time to do a full induction and having just done an overview who’s at fault if something goes wrong?

During last winter the viruses struck and at one point we had several staff off sick at the same time which meant juggling clinics, finding relief staff which obviously are unsure where anything is (which can add even more pressure to the day). We worked through it but it did make me think of an alternative suitable back up.

There’s nothing worse than having to cancel a list especially due to staffing shortage, this should never happen. Normally patients will accept illness or circumstances happen, however I found myself in this position only a few weeks ago. The reason for cancelling was a parental bereavement to one of the dentists even in this sad circumstance but a couple of members of the public weren’t amused. So cancelling due to staffing problems is not a good idea.

In the past if we have a vacant post I would advertise and employ a qualified nurse suitable for the position. The advantage of this is the qualified part and also it delivers a service to the patients and it maintains the current staffing levels. Even though staffing levels are fine, an extra pair of hands is always welcome.

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WOLF LED CORDLESS CURING LIGHT £ 159

The Wolf light curing light, is a high-performance light source for polymerization of dental materials. It consists of a charger and a cordless handpiece powered by a rechargeable battery. The unit is designed for use on a table and cannot be wall-mounted. The light source is a high-performance light-emitting diode (LED).

In contrast to halogen lights, the emitted light specifically covers the light wavelength between 430 and 480nm. The polymerization performance is so high that the exposure times can be reduced by 50% in comparison with a conventional halogen light (with light intensity typically ranging from 600 to 800mW/cm²).

Selected filling composites can be cured in as little as 5 seconds if the light guide can be placed in close proximity to increment.

‘There’s nothing worse than having to cancel a list especially due to staffing shortage, this should never happen’

come which is why I decided to look at employing an apprentice nurse. My reason for this was although at that point we were fully staffed, if we could train an apprentice from scratch they would work to our protocols and hopefully quickly adapt. I personally think that if a young person has already enrolled at College for the dental nurse course that shows they already have an interest; the requirement is they enrol but then need to find a placement.

At the time of writing the cost to the practice is £2.60 per hour for employees aged 16 – 18, there is a slight increase coming in October. This rate is not set in stone and can be increased at the discretion of the practice.
Extra money can always be paid as an incentive. The apprentice NMW applies to all 16-to-18 year olds and to those aged 19 and over in the first year of their apprenticeship.

If the apprentice is aged 19 and/or has completed their first year of the apprenticeship you must pay the national minimum wage appropriate for their age.

There is also the cost of supervision and training supplied by the college, the National Apprenticeship Service will match the employers commitment to hiring apprentices by covering in full the training costs or if over 19 a very small fee will be payable by the practice.

The college course is NVQ-based with day release once a fortnight.

At the moment there is an employers' incentive grant scheme available until funding ceases early next year.

This is aimed at eligible employers offering employment through the apprenticeship programme. This scheme assists by providing wage grants to anyone recruiting an apprentice. The criterion is The National Apprenticeship Service will provide 40,000 Apprenticeship grants to employers recruiting 16 – 24 year olds with a value of £1,500.

The £1,500 is in addition to the training costs of the apprenticeship framework which are met in full for ages 16 – 18 and 50 per cent for those aged 19 – 24.

Eligible employers must have never employed an apprentice before or who have not been in a position to commit to employing an apprentice again within the last 12 months.

I believe this is worth knowing; it’s a small amount but it's money that is available.

Looking back this has been one of the best decisions I have made. It’s a cost effective way of training with no strings attached. Down sides being after two years you are likely to have become attached to this apprentice who is aware from the onset there is no guarantee of a permanent job on qualification. This decision then lies with you do you employ them or start the process again.

‘Looking back this has been one of the best decisions I have made. It’s a cost effective way of training with no strings attached’

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‘Apprenticeships provide back-up staff who know your practice policies’
Workplace communication skills are quite possibly the most written about interpersonal skill. The reason for this being that people’s sense of wellbeing is directly linked to the quality of their communication with their colleagues. Many dental professionals recognise that top-down communication in dental teams frequently leaves a lot to be desired. In some cases this is due to the fact that implicit rules that have evolved over many years which set the tone of workplace communications.

Since the introduction of care quality standards, there is a requirement for practices to develop explicit communication protocols characterised by clearly defined policies, procedures and protocols. The objective of these protocols is to provide a communication framework that will ultimately equip dental teams to provide the highest possible standard of dental care to patients. An important part of patient care is ensuring that patients have positive experiences every time they contact the practice. These positive experiences in face-to-face interactions can stem from the warmth and friendliness shown by teams and on a more formal basis the language and protocols used in written communications. Most practices have established guidelines in place for face-to-face interactions, however many still need to put into place protocols and procedures to govern the tone of the written word in the following formats; letters, notices and reports. Written communications can be effective communication channels, as long as they are constructed correctly and abide by the following guidelines:

Letters
Letters to patients should have a businesslike but amiable tone. They should be concise and factually accurate. All references and details in the content of the letter should be checked and correspondence proof read before being sent out, as errors can cause confusion. Attention must be paid to the correct use of grammar, punctuation and paragraphs, with avoidance of the use of abbreviations, jargon, or colloquial language. Letters must be signed by the appropriate person e.g a report will be signed by the dentist as verification of the information within. But a less formal letter to a patient can be signed by an administrator.

Presentation
Letters must be produced on practice stationery. The layout...
must be reader friendly and attractive using the house style and font. Correspondence with patients will include new patient letters to introduce the practice; these letters provide important opportunities to set the tone of the relationship between the practice and the patients.

In most cases template letters will be made available ready to be personalised for use. Templates should be signed off by the practice management and in a format that prevents errors in adding personalised content. In some cases styles and formats could be used to appeal to patients based on their age or demographic.

Emails
Whereas the etiquette for letter writing is generally understood, this is not the case for email etiquette. In many cases these days email is the preferred method of communication. They are fast and effective, but to ensure they project the correct image of the practice, guidelines should be in place, since emails sent out from the practice reflect upon its friendliness and professionalism. Therefore measures should be put in place to ensure that the language used is polite, courteous, and appropriate. Stringent measure should be taken to ensure confidentiality is maintained and your computer equipment is virus guarded.

Practice protocols should be agreed about checking for incoming emails and about the required speed of response. Practices should ensure their email is set up correctly. It should identify the sender, display the subject matter in the ‘subject’ bar and signatures should provide the information legally required for business emails.

The patient experience is built up on many levels. Most dental teams understand the influence of face to face communications. If they can raise the standard of their written communication skills up to the level of their face to face communications, dental teams will make progress in building lasting respectful relationships with their patients.

These communication topics are covered in my new dental reception course Purely Practical Reception Skills Please email glenys@glenysbridges.co.uk for details.

‘Correspondence with patients will include new patient letters to introduce the practice; these letters provide important opportunities to set the tone of the relationship between the practice and the patients’
Need a new challenge?

Michael McCallion of FT&A Medical Recruitment offers jobseekers and candidates some useful advice...

**D**o you find yourself clock watching after lunch?!

**Do** you spend Sunday nights dreading the upcoming Monday morning?

Is the role not fulfilling your expectations?

A new challenge is required then. What should you be bearing in mind if you wish to get the job of your dreams? Let’s start at the beginning:

- Your CV. This may seem an obvious thing to say but it needs to be said because so many professionals still get it wrong. Do your best to avoid any gaps in the employment history. If there are gaps, make sure that you can adequately explain them. Not everyone is fantastic at spelling but you can get it checked by someone who is! Don’t embellish or lie – it will catch up with you. An on the ball recruitment agency will be able to review your CV and offer you advice on how and where to improve it.

- How far will you travel? It is wise to be realistic – particularly if you will be beholden to public transport!

- CBG, GDC etc. As you would expect these all need to be in order and up-to-date.

- Do you have good, solid references? Are you sure? It is not uncommon for some candidates to find that what they thought were references expressing how wonderful they were and an ideal employee, are quite different.

- What type of role is it that you are looking for? Temporary, permanent – have you considered a locum appointment? The more flexible that you can be, the more posts will be open and available to you.

- Salary. Quite possibly number one on your list! It is of course a vital part of the process and one of the most important reasons for choosing or not choosing a role. Your expectations need to be realistic however. It is tough out there and many dental professionals can have an overvalued opinion of what they are worth. Have in mind the minimum that you will consider and be open and honest about the numbers with any potential employer. There is no point in accepting an offer that you feel is too low and then whingeing about it for months to come – a frank dialogue is in everyone’s best interests.

- Conditions and Benefits. These can be somewhat overlooked as many push for the salary above all else. A mistake – pension provision, holidays, flexible working hours can make a ‘maybe’ job become a ‘definitely’.

- Appropriate dress and appearance for interviews. This may come as somewhat of a surprise in a recruitment article for a professional magazine. In our experience though it is actually quite common for candidates of any education to get it spectacularly wrong when attending interviews! All we suggest is that you give this some consideration – what is the role? Who am I meeting? What level of seniority will I be looking to hold?

- Register with agencies that you can trust. It generally doesn’t cost anything to join an agency but choose with care.

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**Raising Finance?**

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

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

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

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

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

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**Frankly Speaking**

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DISCLAIMER: I am not paid for promoting or mentioning any dental materials. I will simply explain the preferred products that I use in daily practice, as well as on my training courses.

TIP 13: Laser Gingival Contouring (Figs 1, 2, 3, 4)

I use a soft tissue diode laser to carry out artistic, minimal gingival contouring changes. By placing the zenith positions of the upper teeth in the correct positions allows more natural and attractive looking smiles. The theory and techniques to do this can easily be learnt, and the prices, of lasers has come down a lot over the years.

I also use a “hard tissue laser” to correct gummy smiles by doing gingival contouring followed by the removal of bone subgingivally by up to 2mm to recreate the biologic width. This allows faster healing times, no need for incisions (ie a non-surgical osseous recontouring technique) and minimal or no post-operative discomfort. The key point is that laser energy has a sterilising effect and promotes faster and better healing.

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TIP 14: Fibre-Reinforced Composite Dentistry (Figs 5, 6, 7)
I strongly advocate dentists to learn about fibres in dentistry. I use the everStick range of fibres for numerous minimally invasive procedures including:

- Periodontal splinting
- Fixed retainers after orthodontic treatment
- Replacing a missing incisor, premolar or molar tooth (studies show success rates of over 10 years)
- Extraction of a tooth, resecting the apical portion of the root and splinting it to the adjacent teeth in the mouth
- Making a custom fitting fibre post, which is then used to make a bonded composite core, before crown preparation
- Reinforcement of large composite direct restorations

Have a look at my practice website at www.smiledesignbyash.co.uk/general-dentistry/fibreglass_dentistry and also the website www.sticktech.com.

TIP 15: Customised Composite Shade Tab (Fig 8)
It is a good idea to purchase a blank shade tab that GC make, which can then be used to make a customised shade tab with the different colours of composites you have in your composite kit. This will allow accurate shade matching ability when doing more demanding anterior composite build-ups using the layering technique. My preferred composite products I use in practice are G-aenial for the anterior teeth and Kalore for the posterior teeth. Have a look at www.gceurope.com to find out more about these composite products, as well the very good App that GC have developed to help dentists in complex anterior build-ups using the layering technique.

TIP 16: Use of Luxacore (DMG), Luxabond (DMG) and EverStick Posts (Sticktech) to do a bonded Post/Core build up (Figs 9, 10)
I use everStick Posts (0.9mm and 1.2mm fibres) to anatomically adapt the flexible fibres in the prepared root canal after the root filling. Root canals are never circular in cross section, which is why this technique is superior than using pre-fabricated fibre posts, which are circular in cross section. I use Luxabond as the bonding system, and Luxacore to cement the post and build up the core simultaneously. The tooth can then be prepared minutes later. The whole clinical technique can be viewed on a video (part of a series) on my Academy website at http://www.theacademybyash.co.uk/Clinical-Cases-Videos/porcelain-veneers-prep-videos.html.

TIP 17: Composite Veneers (Figs 11, 12, 13, 14, 15, 16)
I have done a lot of porcelain veneers over the years. However, increasingly I am using composite as a material of choice in a number of cases. Following simple orthodontic treatment using the Inman Aligner or 6 Month Smiles, teeth can be straightened quite well. Composite can then be used to make minor improvements (typically after teeth whitening has been done). This particular case shows the before and after of a patient that required five anterior composite veneers. The patient was a bruxist and I was not keen on providing porcelain restorations in this case. The teeth were roughened slightly on the labial surfaces without any local anaesthetic needed. The veneer build-ups were done under rubber dam using a putty index made from diagnostic wax ups (to give an accurate reference to the palatal aspects of the teeth so that a thin enamel palatal “wall” could first be built to help with the rest of the layering technique). The patient was delighted with the result, which only required one long appointment.

TIP 18: The “Spade” Instrument (Figs 17, 18)
The instrument shown here (which I call the “spade”) is a great instrument to help with easy and quick shaping of labial surfaces of teeth that require composite veneers, as well as during addition of flowable composite material when making trial smiles using Luxatemp (DMG). It is a Hu-Friedy instrument and the reference code is TNCCIB.

TIP 19: Learn to do the Inman Aligner and 6 Month Smiles (Figs 19, 20, 21, 22, 23, 24, 25, 26, 27)
I have found the UK courses to learn about the Inman Aligner and the 6 Month Smiles braces to be excellent. I now use both these braces in clinical practice for the benefit of my adult patients. Visit www.inmanaligner.com and www.6monthsmiles.com to find out more.

TIP 20: Luxatemp (DMG) and Luxaglaze (DMG) for Temporaries (Figs 28, 29, 30)
Luxatemp is a 5-star Reality rated product and rightly so! It is the number one choice for making trial smiles by the leading cosmetic dentists in USA and UK. I have been using it for many years, and B1 is my favourite colour. You can get Luxatemp Fluorescence or Luxatemp Star (stronger - if you require more durable transitional restorations to last longer in the mouth). The use of Luxaglaze light cured varnish will significantly improve the appearance and stain resistance of the temporaries.

TIP 21: Use of a Speed Increasing (Red Ring) Handpiece to perfect Preparations (Fig 31)
I highly recommend the use of a speed increasing handpiece in an electric motor. Friction grip burs under water spray can be used to get smooth, precisely prepared and finished tooth preparations. I have been using NSK handpieces for many years in my practices and recommend the Ti-Max X9S1 handpiece. You can contact Alex Breitenbach at NSK on 07900 245516 for more advice on NSK handpieces.

TIP 22: Natural Die Material Shade Guide (Ivoclar) (Fig 32)

Create æ-motion
with G-ænial from GC
The all-round composite for aesthetically invisible single and multi shade restorations.
Introducing the age-specific shade selection system.

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- AE - Adult Enamel for adults
- SE - Senior Enamel for your senior patients

Selecting the right shades has never been easier!
This is an essential shade guide to have for doing Smile Makeovers properly. The prepared teeth can be matched carefully with reference to this shade guide. The ceramist technician can then ultimately produce model dies of the matched colour. This will help with precise colour matching as the porcelain build-ups are done. You need to write down the “Stump Shade” colour eg ND37.

TIP 25: Using a Top Dental Laboratory (Figs 35, 34)
My private practice is in Chigwell, Essex. I use Rob Storrar from Am-dec Dental laboratory (www.am-dec.co.com) based in Basildon for Smile Makeovers for my patients.

For my Academy, I have a close working relationship with Castle Ceramics (www.castle-ceramics.com). It is a real pleasure to have technicians who are passionate, knowledgeable, skilled, artistic and who have a good understanding about occlusion.

TIP 24: Cementation with Vitique (DMG) (Fig 35)
Vitique is my number one choice for cementation of multiple porcelain restorations when doing a Smile Makeover. I use the base and catalyst together (even if I am cementing porcelain veneers). My favourite colours are Transparent and B1 shades of the base, and I use the “low viscosity” catalyst. There is adequate working time with this cement to work in a stress-free manner. I also use Vitique to cement in porcelain inlays, onlays and all porcelain crowns.

TIP 23: Using a Top Dental Laboratory (Fig 35)
One of the best rewards for me in private practice is seeing the emotional reaction when a patient sees their new smile for the first time. We celebrate this important moment in the patient’s life by presenting her with a nice bouquet of flowers, a signed card by the dental team with the before and after photographs. We also celebrate with non-alcoholic champagne served in crystal glasses on a silver tray. Our patients are genuinely touched by the special effort we go to during this “Celebration”. We also send the patient for a complimentary photo shoot with a professional photographer. The patients love the photos taken showing their increased confidence, because of their new smile.

They get a complimentary photograph from the photographer, and we get the images that we want for our marketing use eg to go on the website as a case study. Please have a look at the Reveal for Dina, one of my patients who had a complex Smile Makeover, on my Academy website at http://www.theacademybyash.co.uk/Clinical-Cases/Videos/porcelain-veneers-the-reveal.html.

Summary
I have mentioned DMG a number of times as I genuinely believe they make world-class dental materials. You can visit their U.K. website if you want more information ie uk.dmg-dental.com/start.uk. You can also contact Paul Willmer from DMG on 07530 450598.

I hope you found these 25 Clinical Tips useful. However, clinical skills are only one of the important jigsaw pieces needed to create a successful and profitable dental practice. You can visit my informative teaching website www.theacademybyash.co.uk for a lot of useful articles, videos and other material free of charge. Also have a look at the practice website for patients www.smiledesignyash.co.uk.

If you would like-to chat to me to find out more about the unique and inspiring 8-day Hands-On Smile Design & Occlusion Course I offer, then you can email me at training@theacademybyash.co.uk or phone me on 07971 291180. You can also have a chat with my Manager Cheryl on 020 85000544, in case I am not available.

This popular Course occurs only twice a year, and I limit the training to six dentists per Course.
The aim of orthodontic diagnosis is to identify dento-alveolar, skeletal and functional alterations in the maxillo-facial complex. Diagnosis and treatment planning are based on a combination of study models, intra-oral and extra-oral images, and radiographs, traditionally consisting of panoramic and cephalometric radiographs. Cephalometric analysis (CA) plays an important role in diagnosis and treatment planning.

Traditional CA is based on three different X-ray projections: latero-lateral teleradiography, postero-anterior teleradiography and axial projection. However, conventional radiographs are limited because they provide a 2-D representation of 3-D structures. The traditional system, analysing the three dimensions separately, is insufficient because dento-facial alterations often take place in 3-D space.

Thus, the limits of traditional CA are:
• Errors in radiographic projection, resulting in enhancements and distortions
• Operator errors in the measurement systems
• Errors in the identification of the cephalometric landmarks owing to superimposition of anatomic structures
• Inability to evaluate the three dimensions of the craniofacial complex.

The recent introduction of CBCT in combination with computer software allows the application of this new methodology to different fields of dentistry, including its successful use in orthodontics.

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University of Milan, 44 skeletal Class I normodivergent patients were selected from an archive of 500 CBCT scans. The cephalometric diagnosis of a skeletal Class I normodivergent relationship is based on the School of Milan. The same patients were then analysed with 3-D cephalometry. The results allowed the identification of a normal range of values for each measurement (Table II).

The 3-D technique goes beyond the limitations of 2-D analysis in many ways:
- effective representation of true 3-D morphology of the cranial structures without distortion, avoiding projection and identification errors
- reduced operator bias because the measurements are performed automatically
- simplicity and repeatability in the identification of landmarks
- ability to obtain CA using the three dimension
- dento-skeletal alterations can be analysed in 3-D in order to determine appropriate treatment.

Combined orthodontic and surgical planning
The introduction of 3-D imaging techniques has revolutionised the planning phase of combined orthodontic and surgical treatment. The use of the computer, together with dedicated software, allows for a fast, precise and standardised procedure. 3-D virtual planning entails the following:

- CBCT scan
- high-definition impression
- reference aligner
- digital scan cast
- CBCT digital cast interface

Using virtual planning, it is possible to obtain the virtual surgical treatment objective and the virtual orthodontic model. High-definition impressions are obtained using polyvinyl siloxane, which guarantees well-defined details while allowing for the double-pour method. Double-poured casts are necessary to obtain an adequate scan and require the use of both a full cast and individual dental elements selected from a second cast. Single dental element scans allow for proper analysis of contact points. An optical cast scan is performed using structured-light scanners, which produce a 3-D image captured by a camera. In this manner, a group of points is determined by the software, which then determines the coordinates of the acquired points and finally creates the 3-D image (Fig. 5).^5

Moreover, the digital dental cast is then combined with the CBCT scan, which allows for a very detailed analysis of both the bone (through the CBCT scan) and the dental structure (through the cast scan). CBCT does not provide enough data regarding all the dental details necessary to produce the orthodontic model (Fig. 4).^6

In order to superimpose the two records properly, a specific three-contact point bite registration wax, known as the reference aligner, has been introduced. The reference aligner needs to be applied to the teeth when the high-definition impressions are taken. It is made of Moyco (an extra-hard wax) and consists of a supporting
arch and three spheres. These are made of calcium-based glass, which has cast-pouring radiopaque properties. The wax is applied during CBCT and is placed between the cast arches during the optical scan (Fig 5).

It is remarkable that the wax thickness does not significantly influence the accuracy of the radiographic scan and consequently the results of the CA. The software is able to recognize the presence and size of the spheres in the CBCT scan and matches them to those corresponding areas on the cast. This is currently the only method that allows for an overlap with an error margin of less than 0.1 mm. Once the data has been collected, it is possible to perform different kinds of analyses before the surgical treatment. The software presents powerful segmentation tools that allow the splitting of the maxillofacial complex from the mandible, providing two separate images.

This feature is relevant in orthodontic and surgical planning for calculating bone movement. The clinician can select the tissues to be moved following a procedure similar to the manual one. For example, it is possible to select the osteotomic lines in order to simulate a forwards or backwards mandible shift, finding the exact shift needed (in mm) to properly correct the malocclusion (Fig. 6). Once the bone correction has been finalised, it is possible to create a 3-D orthodontic model and display the resulting dental correction to be obtained by the end of the treatment.

Finally, shifting back the bone structure (and the dental arch with the final model) to the original maloccluded position, it is possible to obtain the target cast to be reached before the surgical treatment. On the cast, it is then possible to build successive images using CAD/CAM techniques to track progress towards orthodontic presurgical treatment.

Virtual surgery has a twofold objective: firstly, to verify that the planned shifts are in fact feasible; and secondly, to position the cast according to the ratios needed to build the surgical splint, which will be used during the surgical procedure. The digital cast superimposition reduces the treatment planning phase, as it is not necessary to reveal the facial arch or to use the articulator. In fact, all the data can be sourced from the combination of the CBCT and cast scans. Recent studies focus on the enhancement of the system through the development of an intra-oral scanner, which will allow direct 3-D impressions, skipping the conventional impressions, which although precise can be influenced by manual errors.

Although complex, using software offers many advantages because it enhances both orthodontic and surgical techniques, while ensuring a very high quality result.
nique allows for a standardised procedure and easy quality checking, in comparison to traditional operator-performed techniques, which are open to inaccuracies.

Creating customised multi-bracket appliances

In virtual orthodontic and surgical planning, it is possible to create a digital orthodontic model once the bone bases have been shifted towards their proper position. The latest dental shift software is able to perform single-element segmentation automatically. The operator can obtain a full 3-D visualisation of the dento-alveolar relationship and can consequently modify tip and torque, rotate and shift dental elements in the 3-D space in order to simulate the orthodontic treatment.

In order to display the results of the pre-surgical orthodontic treatment immediately, the software shows two overlapping images, differently coloured to distinguish the initial situation from the ideal one (Figs 7 & 8). As a result, a digital model is created, containing all the details to reach a functional occlusion.

The first step in the process of creating a customised bracket is possible thanks to CAD/CAM technology. The CAD/CAM technique entails two phases: the design phase (CAD) and the manufacture phase (CAM), performed through computers that send instructions to milling machines in order to create the end-product. These machines work either through removal (such as a CNC cutter) or through addition—sterolithography (SLA), 3-D print or plastic materials/composites, laser sintering (SLS) or laser fusion (SLF) of metal materials.

The elements that allow the bracket customisation depend on its base. The base is designed through the CAD software and placed on the centre of the dental surface. The software will then allow us to customise the bracket (Figs. 9 & 10). In designing the bracket, it is possible to distinguish between a partial and a complete customisation. The first entails the customisation of the size and shape of the bracket portion facing the dental surface, but features a standard angle in the non-customisable portion of the twin bracket. Complete customisation entails the additional modification of the angle between the bracket base and the twin portion. This is the ideal, considering that the spatial parameter of the dental elements might vary according to the different malocclusions.

Once the design phase has been finalised, the brackets are ready for manufacture by a milling machine. These machines, which mill very small items, need to be run in a standardised environment with maintained conditions to guarantee high precision while minimising the possibility of errors. Consequently, the higher the precision required, the larger the milling machine will be. It is also necessary to place the machine in a dedicated environment with a special floor cover with amortising panels that stabilise the cutter and partially absorb the vibration produced.

Moreover, a very small cutter of approximately 0.001 mm needs to be used. For example, considering that the smallest cutters can remove up to 5 per cent of a millimetre each time, three to four passes will be required to create the mesh facing the tooth (Fig 11).

The technological progress represented by CAD/CAM as described is based on the digital design feature and the computer-automated manufacturing process. The main advantages are better control of the production process and a significant reduction in operator-driven errors, while enabling the use of sophisticated materials, such as Grade 5 titanium, which was not possible with traditional techniques.

Editorial note: A list of references is available from the publisher.

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The Dental Company
Choosing the right people
Michael Sultan discusses the importance of staff

Staff are fundamental to any business. This is especially true in dentistry where nursing staff in particular work “on the front line”, speaking and interacting with patients, guiding them through their treatment, and putting them fully at ease.

As anyone who has ever set up their own business will appreciate, finding the right staff can be a very difficult task, and even when you think you’ve found the right person, sometimes it just doesn’t work out. In these cases, it can often be just as hard to get rid of team members as it can be to employ them in the first place!

So, finding the right staff can be a challenging process – one made even more testing by the time commitments we must make to the general day-to-day running of our practices. Of course the solution is to make sure we employ the right people in the first place, but very often this is not as easy as it may seem.

A part of the problem stems from the fact CVs just don’t tell us what we need to know. They depict a very two-dimensional view of a person, and are often filled with the same phrases (such as “team player”, “good timekeeping”, “excellent organisation” etc) that make is extremely tricky to distinguish between candidates. And things aren’t always made easier at the interview stage either. Often we will find we ask the wrong questions, or aren’t able to sufficiently judge potential employees based on a short, and very formal conversation.

How then, are we supposed to find out what people are really like?

Here at EndoCare, we’ve recently taken to asking candidates a set of questions they might not normally expect. Aside from all the regular sorts of questions you might field in an interview, we’ve devised a few extras that we think help us to learn a little more about the people who want to come and work for us.

Naturally, these questions are all “loaded” in a sense, but equally they’re not designed to bring about any kind of fixed response. Ultimately, they help us build a better picture of “who we’re really dealing with”, and hopefully, they give candidates a similar impression in turn.

One of the first questions we like to ask is: “What did your father do?” This isn’t a middle-class type of question designed to judge a person’s background. More it is a question designed to shed light on a candidate’s work ethic, and their general approach to working life. For example at EndoCare, we pride ourselves on going the extra
mile for patients, and so we like to employ people who share our same ethic for work, whose parents may have imparted upon them some sense of going beyond the normal hum-drum of 9–5. That’s why we’re always interested to learn of candidates whose parents may have worked long hours – who may have demonstrated the need to go that little bit further to “get the job done”.

Another question we like to ask is, “What did you want to be when you were young?” and as a follow-up, “What did your parents say?” As an employer, naturally we look for a positive attitude in our employees. We are also looking for people who demonstrate some sort of aspiration. Though I doubt many people can honestly say they wanted to be a dentist, or a dental nurse growing up, the responses we tend to get are an interesting reflection on the people we’re interviewing. For example, those with parents who would crush their aspirations (even if they wanted to be an astronaut!), tend, in general, to be less aspirational as individuals and less motivated to push themselves to enhance their careers. Obviously there’s an element of generalisation here, but the conversation that emerges from the questions “What did you want to be when you were young?” really can shed some interesting light on a person!

Our third and final question we like to ask potential employees is, “Are you ‘touchy feelies’?” or the slightly more refined question, “Are you a warm, empathetic person?” From experience, empathy and compassion are two elements to a person’s nature that just can’t be taught. Either you’re a naturally warm person, or you aren’t. There really isn’t an in-between here. For someone working in the caring profession that is dentistry, empathy is absolutely critical. That’s why at EndoCare we rate empathy and warmth of feeling as two of the most important facets to any of our members of staff.

‘The conversation that emerges from the questions “What did you want to be when you were young?” really can shed some interesting light on a person!’

Of course there’s no right or wrong answer to any of our questions, and even with the last one the answer is never going to be as simple as yes or no. What these questions do is give us an opportunity to learn a little bit more about the people we may potentially employ. Obviously these questions won’t work for everyone as each business is different, and each dental practice will have its own way of doing things. At EndoCare for example, we want genuine hard working, aspirational people who are fundamentally caring at heart, and so we form our questions appropriately.

So, when the time comes around to find a new member of staff, ask yourself, what are your practice values? How do your staff members reflect these values? Though these might seem like simple points to consider, they really do require an awful lot of thought. After all, staff are important – they are at the heart of everything a dental practice does – and for this reason, it pays to choose your questions carefully!

About the author

Dr Michael Sulli- ham BDS MSc DFO FRDI is a Specialist in Endodontics and the Clinical Direc- tor of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively in postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPOD University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2009 he became clinical director of EndoCare, a group of specialist practices.

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