Dental Tribune

Ombudsman: NHS fails to communicate
Six per cent of complaints made against dental practitioners, complaints service details in new report

A new report published by the Health Service Ombudsman shows a significant rise in the number of complaints where the NHS has failed to provide an adequate remedy or proper apology when things have gone wrong.

The report, Listening and Learning, which gives an overview of NHS complaints made to the Ombudsman in 2011/12, includes real-life examples of responses given to people who have complained about the NHS. The Health Service Ombudsman, a free and independent service for anyone who is unhappy with NHS services, is calling on the NHS to improve the way it deals with complaints on the ground.

Ombudsman, Julie Mellor said: “All too often the people who come to us for help are unhappy because of the careless communication, sincere apologies and unclear explanations they’ve received from the NHS. A poor response to a complaint can add to the problems of someone who is unwell, struggling to take care of others or grieving. The NHS needs to get better at listening to patients and their families and responding to their concerns.”

The report shows that complaints about the NHS not acknowledging mistakes in care have increased by 50 per cent. NHS hospital, specialist and teaching trusts received the most complaints, with 45 per cent, while the Healthcare Commission received the least, with just one complaint.

The Ombudsman received 1,057 complaints about general dental practitioners in 2011/12; six per cent of the overall complaints made.

A spokesperson for Dental Protection said: “Poor communication is a factor that features in more than 70 per cent of the cases currently handled by Dental Protection, either as the sole cause of a complaint or as a contributory factor. It is for this reason that DPL provides members with an opportunity to attend a series of interactive small-group workshops free of charge.”

Dr John Milne, chair of the BDA’s General Dental Practice Committee, said: “While dentistry has received a relatively small proportion of complaints within the NHS it is important that we are not complacent about patients’ needs and expectations. Good communication between dental practitioners and their patients is essential to ensuring ‘good’ dental and oral health-care outcomes for patients as well as the profession.”

The NHS needs to get better at listening to patients and their families and responding to their concerns.”

News in Brief

Dentists sue Two dentists are suing the owner of a crane left dangling over midtown New York after Hurricane Sandy, for damages incurred from losing a week’s worth of business while they were evacuated. Sandy’s high winds caused the giant crane to snap backwards, forcing the businesses in the area from Monday, 29th October until late the following Sunday evening. Barry Musikant and Caroline Stern said their dental practices were among the businesses affected by the mishap, and Musikant also had to evacuate his home. Musikant and Stern are seeking unspecified damages. Named as defendants were the crane’s owner, Pinnacle Industries, and contractor Lend Lease; they could not be reached for comment. As reported in the New York Daily News.

FDI Dr Stuart Johnson, Chair of the Dental Practice Committee, will be leading the FDI dental amalgam task team at the next meeting of the International Negotiating Committee on Mercury (INC 5), set to take place in Geneva from 15 to 18 January 2013. The main subject of discussion will be the Chair’s call for a global legally binding instrument on mercury. In the draft, the Chair explains his new approach to dental amalgam. Although the Chair’s singling out of dental amalgam clearly demonstrated the impact of FDI’s work on the work of INC, Task Team members are holding discussions to ascertain how far the new draft meets their requirements and to formulate a common position to be suggested to member states regarding proposals for amendments to the draft treaty.

Bogobrush Bogobrush, a new handheld toothbrush made out of 100 per cent biodegradable materials, has been launched this week. As reported in M Live, Bogobrush was co-founded two years ago by brother-sister duo John and Heather McDougall. The siblings, and children of a dentist, said they had the idea of bringing more environmental sustainability to people’s daily routines. Each toothbrush is made of bamboo and has biodegradable nylon bristles. Bogobrush is teaming up with non-profit health centre Covenant Community Care to distribute the toothbrushes to less fortunate people in the Detroit area. Bogobrush will donate one toothbrush for each one it sells. More information can be found at bogobrush.com.

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register today at scottdental.co.uk and we will pay the VAT when you order your new Belmont equipment from us.
New dental education centre opens

A new state-of-the-art dental training centre has been opened at Northwick Park Hospital.

The training centre, which is a joint enterprise between London Deanery, and the North West London Hospitals NHS Trust, was opened November by Barry Cockroft, Chief Dental Officer at the Department of Health.

The training centre has a clinical suite with 15 phantom head units with operating microscopes, and a medical emergencies simulation suite with a computerised mannikin to simulate medical emergencies and a debriefing room to assess performance of dental teams. It also has a decontamination suite, enabling teams to train in the latest decontamination requirements.

The Northwick Park DEC will be available for lectures and hands-on training, and also has facilities for producing educational webinars.

Elizabeth Jones, Dean of Postgraduate Dentistry, said: "This is an exciting initiative for North West London and I am delighted it has come to fruition. It will give dentists and dental care professionals a state-of-the-art environment in which to learn new skills and practice what to do in emergency situations, among other things."

David McVittie, Chief Executive of North West London Hospitals NHS Trust, said: “We are delighted to have worked closely with the London Deanery on this initiative. We are also delighted to be in at the start of a revolution in dental and oral healthcare, particularly in light of the extreme-ly successful maxillofacial service that we have on site here.”

Thames Valley forms Dental Local Professional Network

PCTs within Berkshire, Oxfordshire and Buckinghamshire have recently begun testing the outline proposals for a Local Professional Network (LPN) across dentistry by forming the Thames Valley Dental LPN. The network, which has been formed to improve oral health in the Thames Valley is made up of local clinicians, a medical director, commissioning managers and a consultant in dental public health.

Dental LPNs are the future for local professional clinical leadership and will have an important role in informing the decisions which commissioners will make regarding all dental services from April 2013.

The Thames Valley Dental LPN is currently engaging with dental clinicians across the region and is encouraging them to attend a forum on either Tuesday 4th December 2012 or Thursday 17th January 2013 in order to learn about the upcoming changes post April 2013 and to share their opinions.

Please email tvd.lpn@nhs.net for more information or to register your interest.

Implant surgical kit released

The Dr Nilesh Parmar Surgical Kit includes everything needed to expose, retract, place, augment/graft and suture almost all implant sites. It comes with two surgical instrument cassettes, designed to fit almost all autoclaves and washer disinfectors.

Dr Parmar said: “When I first started placing implants, I was astonished at the sheer variation in surgical instruments available. It took a few years of experience before I knew which instruments I liked and didn’t need.”

A spokesman for Hu-Friedy added: “We have an excellent global reputation for our periodontal and surgical instruments and part of our focus strategy is to target young dentists who are starting out in implant dentistry. We understand that Nilesh is a well-respected, talented clinician, with exceptional attention to detail – a perfect partner for Hu-Friedy.”

For more information, please contact Atif Ramzan (Clinics and Education Manager UK & Ireland) at Hu-Friedy on aramzan@hu-friedy.com or 07800 762079.

Patient and surgeons responsible for implant success

A study recently published in the Journal of Oral Implantology shows that characteristics of both patient and surgeon can affect the success of dental implants. The 10-year study found that patient risk factors such as grinding teeth or diabetes increase the odds of implant failure, and it also associates higher implant failure rates with surgeons who have less than 5 years of experience.

The study examined failure rates for factors including type of prosthesis, surgeons’ experience level, smoking, diabetes, bruxism, and implant location—maxillary or mandibular. The implant failures in this study appeared to be affected by patient risk factors, such as diabetes, rather than by implant-related factors, such as location and length of implant.

Twenty-nine per cent of patients with a dental history of bruxism in this study experienced implant failure, with more than 28 per cent of patients with diabetes also suffering implant failure.

The number of years and surgeries performed by the oral surgeon also had an impact on the success of the implants, with surgeons who had performed less than 50 implants being twice as likely to fail. An implant was considered successful if no implant loss occurred and bone loss was less than 3mm as assessed by peri-apical radiograph.

Your chance to work with the GDC

The General Dental Council (GDC) is looking for two new members to join its Appointments Committee – one registrant and one lay person.

Successful applicants will be responsible for appointing individuals who deal with complaints against dental professionals as part of the GDC’s statutory Fitness to Practise process. They will also help develop systems for induction, training and performance management of those appointed.

Deadline for applications is 5pm on Friday 16 November 2012. Interested applicants can find out more by visiting the GDC website.
Editorial comment

Come see us at BACD

This week sees the Dental Tribune team living it up in Manchester for the British Academy of Cosmetic Dentistry (BACD) annual conference. This three-day annual event is now in its ninth year and is one of the best events for all things cosmetic.

I love going to conferences like this; the intimacy of the event means you get chance to meet with people and make new connections in an environment that is not as time-pressured as large-scale events. Also the calibre of speaker is always very high and I am really looking forward to continuing my dental degree by osmosis listening to the likes of Basil Mizrahi, Rafi Romano, David Bloom, Bobbi Anthony and DT regular contributor Mhari Coxon.

The Dental Tribune team will be based from the Healthcare-Learning Smile-on stand (Stand 21) so please come along and say hi! In return you can receive a complimentary copy of one our specialist portfolio of journals covering the implant, cosmetic and endodontic sectors.

The gift that keeps on giving

Stuck for Christmas gift ideas? Bridge2Aid are offering gift cards as the perfect present; continuing to give long after Christmas day has been and gone.

Each denomination results in a specific purchase or covering of costs that will benefit people in the Bridge2Aid community:

- £10 buys one head lamp for a Clinical Officer, who often has to work without electricity.
- £15 pays for kerosene, needed to run the pressure cookers employed to sterilise dental equipment.
- £20 provides oral health education packs for six Clinical Officers, used to raise awareness of good oral health in rural communities.
- £35 purchases training materials and resources for six Clinical Officers, for use before, during and after participation in Bridge2Aid’s practical Dental Training Programme.
- £60 pays for an instrument kit, to be donated to a Clinical Officer once training is completed.
- £125 covers the costs of one post-training visit by a Bridge2Aid team member to a District Dental Officer and a Clinical Officer to ensure that they are working in a safe way.

To purchase a gift card or for further information, please email Kerry Dutton at fundraising@bridge2aid.org.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? Please write to The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA or email lisa@healthcare-learning.com
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Speaker: Alison Grant
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Speaker: Dr Vesna Zivojinovic-Toumba
Date: 29th November 2012

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Patients mass tested after blunder

The Centre for Health Protection has been informed by the University of Hong Kong Health Service’s Dental Unit that it treated hundreds of patients with improperly sterilised instruments last week. More than 254 people, including staff and students, are reported to have received dental treatment under these conditions between 19 and 2 November.

Meanwhile, the university has issued an apology and called in affected patients for blood tests to rule out infection with bacteria or viruses such as Hepatitis B and C and HIV. In addition, follow-up tests will be conducted six months after the incident, it said.

The kind of dental instruments used for the procedures and the reasons for the negligence were not disclosed; however, university officials said that the possibility of infection is likely to be low since the instruments had passed through some steps of the sterilisation protocol. They have set up a task force to look into the incident and review the unit’s procedures on infection control.

The blunder came to light last Friday after a nurse enrolled in the unit found that instruments were not marked as having completed the full sterilisation protocol.

More than 38,000 treatments are performed annually at the clinic, a university spokesperson told Dental Tribune Asia Pacific.

Sheffield GDP wins chair of new BDA English Council

Dr Jim Lafferty, a general dental practitioner in Sheffield, has been elected as the inaugural Chair of the British Dental Association’s (BDA) new English Council. The English Council exists to advise the BDA Principal Executive Committee (PEC) on all matters relating to policy in England, and to liaise with BDA’s branches and sections.

Dr Lafferty brings extensive experience of representing the profession, both locally in Yorkshire and at national level, to the role. He is a former member of the General Dental Council and both the BDA’s General Dental Practice Committee and the Representative Body, and chaired the Annual Conference of Local Dental Committees in 2012.

Dr Lafferty said: “The BDA, and the profession it represents, face a challenging period in England. A new contract for general practice is being tested, new commissioning structures are imminent and regulation is in the spotlight. Against this backdrop of upheaval the BDA is also changing, with new representative structures coming into being and the way that members are served being reviewed.

“In joining the BDA Councils for Northern Ireland, Scotland and Wales, the new English Council has a vital role to play in ensuring that the members it represents have a loud and effective voice. I am honoured to have been elected to Chair the Council and will do my utmost to deliver that voice.”

Dr Lafferty will be assisted by Dr Nilesh Patel, who has been elected to serve as Deputy Chair. Dr Patel is a general dental practitioner in Buckinghamshire and a former member of the BDA’s Executive Board, the body that was superseded by the new PEC earlier this year.

New dental association launched

Dental Fusion Organisation (DFO), a new association formed to support and represent dental professionals working in primary dental care, improve oral health and provide social and clinical training for members, was launched on 9th November.

The association has no governing body as DFO members vote directly on every major issue through Web and postal voting. If the members approve, one of the first campaigns will be to reverse the demise of the small independent family practice.

“At the launch of DFO we called on our members to contribute to the debate by describing their experiences of bullying whilst their parents will be asked how this affected their children,” says Chief Executive Derek Watson, pictured. “This will be delivered mainly through a series of webinars which enable dentists to learn at any web-enabled PC, tablet or smartphone.”

So far 15 lunchtime webinars have been organised, including Management Monday, Financial Friday and a course on improving your IT skills. These are open to all, but DFO members are entitled to priority registration and verifiable CPD.

Anti bullying campaign by ortho practice

Research from the Journal of Orthodontics shows that being bullied is significantly associated with orthodontic treatment need, with 15 per cent of adolescents aged 18-14 examining a orthodontic treatment report being bullied.

In light of this, Inline Orthodontics, a specialist orthodontic practice in Stevenage, is conducting an anti-bullying campaign during Anti Bullying Week between 19 and 25 November 2012.

To help coordinate the campaign a meeting was held to discuss ways in which professionals in Stevenage can help young people who are being bullied. Key members of the local community, including local dental professionals, were invited to contribute.

Young people were also asked to contribute to the debate by describing their experiences of bullying whilst their parents will be asked how this affected their children.

Jonathan Alexander-Abt, Principal Orthodontist at Inline Orthodontics commented: “Bullying for whatever reason is deplorable and should never be tolerated. This research shows that a significant number of children are being bullied because of the position and appearance of their teeth. As a Specialist Orthodontist I feel that it is important to raise awareness of this and reassure young people that there is something we can do to help them”.

For more information about Inline Orthodontics’ Anti Bullying Campaign visit www.inlineortho.co.uk.
EAO reaches out to patients with new implant guidebook

With an ever-increasing number of implant solutions available on the market, finding information about the right treatment option has become difficult, particularly for patients considering such treatment. In order to help non-professionals find answers, the EAO will be presenting a new patient information guidebook and website today at its annual scientific congress in Copenhagen.

The 75-page book, to be officially launched during the organisation’s general assembly, aims to provide comprehensive answers to more than 50 questions related to dental implants, such as the general function of these devices, treatment and possible complications like peri-implantitis. It will be published in five languages, including English, French and German, and will be available for purchase to EAO members. The website, which will be an integral part of the EAO’s online platform, will feature additional communication tools and educational materials like videos.

“Throughout the years, the EAO has worked hard to produce work that will improve dental implant treatments,” remarked EAO president Prof. Søren Schou from Denmark. “We are pleased to be able to share our knowledge with patients too.”

ADI brings together world implant experts at 2013 Congress

The Association of Dental Implantology (ADI) is hosting their biennial Congress from 1 – 3 May 2013 at the Manchester Central Convention Complex, with the focus on complications, risk management and prognosis of implant treatment.

Delegates will be able to participate in lectures from internationally acclaimed speakers, visit the specialist implant exhibition and network with colleagues from the global implant industry.

The presentations will cover the full spectrum of topics relevant to anybody who is involved with dental implantology or is planning to enter the field. The Congress will feature lectures on the complete dental implant process, from consultation, placement and after-care to associated risks and complications. It will also include sessions on many specific aspects involved in the running of a dental implant service, such as legal considerations and managing patient expectations.

For the full programme and to confirm your registration, visit www.adi.org.uk/congress2013

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The Digital Dentist

Ian Buckle looks at how technology has influenced dentistry

E verything is turning digital and dentistry is no different. The vast majority of practices have been utilising computers and practice management software for many years but there have also been great advancements in the clinical uses of digital dentistry.

Digital Photography

With the advent of inexpensive high quality cameras, dental photography has become an absolute must for any dental practice. There are three main uses for dental photographs: records, communication and treatment planning. Having a visual record of a patient is an extremely useful adjunct to written notes in monitoring a patient’s condition - periodontal, tooth surface loss, tissue lesions etc.

Perhaps the most important usage is for communication. Once the patient can see what the dentist can see, treatment is no longer something that the patient will see for themselves and will actively ask the dentist for solutions to their problems. We are a very fortunate profession in that our patients place huge trust in us but once our patients can see and understand their problems in a photograph, treatment become common sense.

Photography is also essential in communicating with other members of the dental team from specialists to the laboratory technician. Photographs are essential in creation of the diagnostic wax up, helping to convey the foundation shade of a prepared tooth, to illustrate (together with study models) approved provisional restorations and to provide feedback to the laboratory about the definitive restorations.

Finally, photographs are imperative in visualising the possibilities during treatment planning. Not only do they allow the dentist to plan treatment without the patient being present but also to help work out how best to fit the teeth within the framework of the patients face for function and aesthetics. For example, rest position, E position and tipped down smile views will, together with other views, aid in planning the vertical and the horizontal position of the upper incisors, critical for aesthetics and phonetics.

Digital Radiography and CBCT

Digital radiographs offer many benefits to both the patient and the dentist. Lower radiation doses, immediacy of result and no more processing chemicals are just three of the many reasons for moving to the digital age. The fact that the images get filed automatically to the patient’s record is just an added bonus.

Radiographs have always been very useful but are also limited in the fact that they only provide a two dimensional image. The advent of cone beam computed tomography has allowed the dentist to see a three dimensional image and the step forward is truly amazing. Orthodontic planning has been enhanced, periodontal and endodontic problems can be fully visualised and implant planning and placement have been moved to a new level.

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For further information on this introductory course, basic Core Curriculum of learning and team events, please contact:

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Digital Scanning and Impression Taking

Whether it is the impression or the model that is scanned, somewhere along the way many jobs that enter the dental laboratory become digital. These days it is possible to scan the preparation in the patient’s mouth together with the opposing teeth and bite registration and go straight to the digital phase.

There are many advantages to taking digital impressions. Not only does it do away with the need for (and cost of) impression materials but it also allows the dentist to check tooth preparation immediately. Initially this can be a little bit scary (did my margins really look like that?) but the improvement that can be made is both considerable and very worthwhile.

Once a preparation has been scanned the information can be sent electronically to the dental laboratory (e.g. Cerec connect) for construction or the dentist can utilise CAD/CAM technology themselves to design and mill the restoration. Such technology can allow the patient to have a custom restoration delivered while they wait.

The applications of digital impressions are huge. Already they can be used in orthodontic systems (Invisalign amongst others) to plan tooth movements and provide virtual treatment objectives. In the restorative process it is possible to “mount” the scanned models on a virtual articulator, a digital wax up to be produced and provisional restorations to be milled and ready to place at the preparation appointment.

Perhaps one of the most exciting advances of the digital era is the combination of CAD/CAM and CBCT particularly in implant placement. The digital impression camera is used to scan the implant site and adjacent teeth. The software generates a virtual 3D model and the dentist can design the future implant crown. The 3D model with the implant crown is then superimposed on the CBCT image. This allows the clinician to position the implant with reference to the planned prosthesis and the available bone structure. From this a stent can be milled to assist in precise positioning of the implant.

Summary

While conventional methods are not about to disappear overnight, digital technology offers many and significant advantages to both dentists and patients in convenience, accuracy and productivity.

If nothing else, invest in a good quality digital camera designed for dental use and let your patients see what you see. You’ll be amazed at what you see and what your patients will ask for. The return on your investment will be manifold.

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**About the author**

As The Dawson Academy’s Clinical Director, Dr. Buckle lectures nationally and internationally on functional and aesthetic dentistry. He is involved directly with the hands on courses of the Core Curriculum, seminars, & study clubs and provides continuing education to dental professionals more recently across Europe. He spends approximately two-thirds of his time in practice and the other third as an educator. He believes this balance keeps him on the leading edge of both disciplines. Ian qualified from Liverpool University in 1985. He has over 20 years experience in general practice both in the Private sector and with the National Health Service. A member of the American Academy of Cosmetic Dentistry (AACD), British Academy of Cosmetic Dentistry (BACD), British Dental Association (BDA) and Association of Dental Implantology (ADI) he completes over 100 hours of postgraduate education every year and lectures nationally and internationally on functional and aesthetic dentistry. Ian Buckle runs a Private Practice in the picturesque village of Thornton Hough on the Wirral concentrating on comprehensive reconstructive, aesthetic and implant dentistry.

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“If nothing else, invest in a good quality digital camera designed for dental use and let your patients see what you see.”
Don’t take complaints lightly

Dilhani Silva talks complaints

Andrew Mitchel’s resignation from his Chief Whip post and my colleague attending a course on complaints handling prompted me to write this. We live in a world where we are regulated by so many authorities, and more importantly we live in a media led world. Escalated complaints can cost you your job, five years of education, your reputation, and your life for that matter.

On a personal note complaints rise due to lack of communication skills and The Dental Defence Union is advising dental professionals to brush up their communication skills to help avoid complaints. Responding to news from the Dental Complaints Service (DCS) that complaints about private dental treatment rose by 17 per cent in the year to April 2012, the Dental Defence Union (DDU) says that in its experience, many complaints involve communication problems of one sort or another.

There is an old saying that if you can talk properly you can get away with anything, even murder. We live in a multi-cultural society; English is not our mother tongue. In my experience, different cultures express themselves differently.

The heart of the dental clinic is the receptionist; she is the ambassador who carries the patient to the surgery. She could be the most glamorous and attractive receptionist but lack of communication skills can send the patient downhill. A receptionist is important to give clear and precise answers on the phone, and to maintain a neutral tone of voice is of paramount importance.

Confidence
Of course the dentist has to maintain effective communication skills to treat patients. Some people may believe that only manual dexterity is needed to do the treatment. I completely disagree as the patient should have confidence and total trust in their dentists. In order to gain their trust the dentist should be able to convey the treatment plan. To be able to have a decent conversation is not enough, are you giving treatment options, answering their questions without jar-gon when they raise concerns, and willing to apologise when things go wrong? Patient satisfaction is more important in this day and age than ever.

Many practitioners have a treatment coordinator today. It is a very good way of giving the patient tremendous experience through the patient journey at the surgery, and it also saves time for the dentist to do more clinical work on the patient. The patient feels they are being given a personalised service and that they are being given a bespoke approach.

The surgery can avoid complaints by providing clear and concise treatment plans and financial options. Also, the whole dental team should speak from the same page: the patient should always feel that they are being treated by the best team, from the receptionist to the dental nurse and dentist. Having eye contact when you talk is very important; I have a pet peeve about people closing their eyes even when they sing a song when they talk!”

Happy ending
The successful conversations will always lead to a happy ending. Sharing meaningful and practical information with patients will educate patients. It is our duty to educate and explain things in a more layman’s term and what is in their best interest. Listen to the patient’s needs and the patient can be confident that their treatment is being provided by a fully competent professional, or is transferred or referred to one to do so.

Take responsibility and do not take complaints lightly. Discuss issues at staff meetings and learn from mistakes. Educate staff members and improve communication skills. Communication cannot be taught from a book; it is your attitude, which can be changed by correct planning and control. Body language also plays a key role in communication; let us not forget that actions speak louder than words.

In a nutshell, to avoid controversy, keep away from complaints.

The heart of the clinic is the Receptionist.
When I graduated from the Faculty for Dental Technicians in Warsaw Medical School in 1987, I had no idea that my profession would change so much over the course of the next quarter of a century. At that time, I enthusiastically welcomed every new innovation, many of which I pioneered the use of in Poland.

Looking back today after more than 20 years, I can confidently say that dental technology has undergone a profound technical revolution. After all, nowadays, it is difficult to imagine a modern dental technician's laboratory where CAD/CAM technology remains unknown.

My first experience with CAD/CAM was in 2004 when I decided to buy a device from DeguDent. I intentionally use the word 'device' here, since it was not what we would today consider a CAD/CAM system based on scanning and virtual modelling. However, I was overwhelmed by the potential this machine offered me at the time. For a brief while, dental technicians and dentists were divided into proponents of and opponents against CAD/CAM. The latter were mainly against the system because of ignorance and a fear of new technology. I myself used the machine for two years until at last I succumbed to the temptation and bought another technical novelty.

I first saw this machine, produced by Wieland, at the International Dental Show in Cologne. The thing that was so innovative about it and such a great advance on previous models was the 5Shape scanner that was able to scan the model and transfer data to the CAD software, thereby making it possible to produce a virtual model of the construction.

The system was such a breakthrough and the possibilities it offered so enormous that in 2006 I began using the 4820 model. The volume of orders that my laboratory handled increased dramatically, since in contrast to the DeguDent machine, which could initially cut four-unit and later seven-unit bridges, Wieland's CAD/CAM system allowed me to cut 14-unit constructions from various types of material (plastic, steel, titanium).

Based on my own observations and many years of experience, I can boldly say that the greatest progress in terms of technology has been achieved by scanners. The newer machines have only increased the amount of bone that can be cut and accelerated cutting speed. It is the scanners that have ensured revolutionary advances in the development of CAD/CAM.

A major role in the development of scanners has been played by 5Shape, which is currently the undisputed leader in the field. A modern user of CAD/CAM has all he needs to ensure a perfect prosthetic appliance, ie everything from a temporary crown right up to complex implant-supported restorations. Moreover, all the work can be done today in virtual articulation, which overcomes the technological problems that traditional methods faced.

Patients today require fast and inexpensive therapeutic solutions, while ensuring the highest standard of work. CAD/CAM systems help reduce
production costs significantly. Hence, the high purchase price of investing in a CAD/CAM system pays off. The limitless opportunities it offers for co-operation between laboratories also attest to the superiority of CAD/CAM technology. Just as the development of airlines made rapid relocation to any corner of the globe possible, so CAD/CAM promotes work between laboratories from all over the world. And herein probably lies its greatest success: international co-operation that connects people brings its own benefits and satisfaction. There have been many occasions in my professional practice when

‘The ideal is to combine the possibilities offered by CAD/CAM with the artistic abilities of the dental technician’

I have performed work to order without ever being face to face with clients. This is proof of the importance of Internet communication in the dental industry.

Obviously, the CAD/CAM system is only half the story, for the hands of the dental technician are still irreplaceable when it comes to veneering porcelain substructure. No system can apply porcelain in such a way that the restoration looks like a natural tooth. Hence, the ideal is to combine the possibilities offered by CAD/CAM with the artistic abilities of the dental technician. A properly prepared construction, good marginal seal and the choice of material are all very important factors, but the final finish of the crown still depends on the aesthetics attained through the skill of human hands. The work of the dental technician requires knowledge of many different materials and how they are fashioned, as well as extensive manual skills in working easily with both colour and shape.

A long-standing acquaintance of mine, the outstanding master of dental technology Klaus Müterthies, stresses repeatedly that form takes precedence over colour. The patient focuses first on the way the prosthetic restoration harmonises with his natural teeth. If the form is disturbed, colour defects appear together with details that do not have too important an influence on the overall appearance of the crown.

Although the majority of patients do not know how to assess a prosthetic restoration accurately, I have noticed a growing awareness among them of the quality of the work. This is increasing in proportion to general advances in people’s lifestyles. The majority of us want to remain young and look beautiful forever. Hence, more and more people view dentition in terms of the need not only to restore missing teeth but also to correct those they still have. A good example of this is the boom in orthodontics, and the demand for teeth whitening
and improving their smile using veneers.

Another very important factor in prosthetic art is that it requires the collective effort of an entire team - everyone from an attending dentist, an orthodontist, and a surgeon/implantologist, right up to a dental technician. I have had the great fortune to work with partners who have chosen to work in the same area of technological development and aesthetic prosthetic work. One of the doctors working closely with my laboratory on a daily basis often remarks, “as the dentist so the technician and vice versa”. Probably, these words reveal how close the ties have always been between the dental technician and the dentist. The restoration case study I will present here reflects my belief that prosthetic work is a combination of modern technology with its skilful use and a high level of artistry in the hands of the technician.

Case report
A 27-year-old female patient presented to our dental office to achieve a more aesthetic smile. At the age of 17, she had suffered an accident (she was hit by a swing), as a result of which her tooth #21 had shifted significantly in an upwards direction owing to significant bone atrophy and root resorption (Fig 1). The young age of the patient and her still progressing bone growth did not augur success.

Only when she was 27 did she pursue improving her appearance. The situation required that she undergo an implant procedure and have a prosthetic crown placed. The first problem that emerged during the preliminary analysis prior to the implant procedure was that the amount of bone and the thickness of the bone plate would have forced us to add grafting material. The patient did not consent to such a solution and expected a predictable cosmetic effect with the stress on very good final aesthetics.

In the first stage, we made a Maryland bridge (Fig 2). Such a solution provided protection for the patient during the osseointegration period. Several months after the surgical procedure, the implant (in this case Ankylos, DENTSPLY Friadent) was exposed. It turned out that the implant was positioned in an excessively palatal direction. The challenge was to restore a symmetrical line to the patient’s cervical margins, as well as a natural biological gingival margin. The backward position of the implant required the use of an angled abutment of 50°. Unfortunately, the system we used effectively restricted such an approach, since at the time that the above procedure was performed it was still impossible to achieve customisation in a dental laboratory (this is definitely possi-
A decision to make an all-zirconia abutment with an angle of inclination above 15° is quite risky. Hence, the solution we adopted was to modify the crown while not changing the shape of the abutment. Such an approach requires the attending dentist to play a major role in the process so that the preparation and transfer of the emergence profile of the abutment and prosthetic crown correspond perfectly to the natural tooth. Using composite material, the doctor shapes the temporary restoration to retain the place for the final crown for a period of several weeks so that it later can serve as a model for the definitive crown. It is important to remember that as the gingiva is being shaped the patient must at all times be provided with a temporary restoration, guaranteeing support for the soft tissue.

Therefore, the doctor transferred the emergence profile with the help of a doubling of the bur and then scanned. An image of the scan was modified by superimposing a second scan over the projected emergence profile of the crown. Both parts were joined together in the CAD programme and the structure thereby created was cut from the Provi Disc composite material (Robocam), which is often used for temporary restorations. At this stage, the best approach is to try in the cut-out substructure and if necessary improve its size and shape. Only if the fit is perfect will a substructure be cut out from zirconium dioxide.

The choice of material is something that should be considered very carefully. Observing the rule of what, where and when? the choice will depend on the position of the abutment, its colour characteristics and the quantity of light diffusion needed. The last factor has a great impact on the natural appearance of the prosthetic restoration. For this very reason, I try above all to use all-ceramic materials, especially in the anterior section.

The material used in the present case study was zirconium dioxide (Robocam), which is processed in a machine supplied by the same company called RoboMill 5. The machine mills all available soft materials and the water cover makes it possible to cut IPS e.max ceramics (Ivoclar Vivadent).

Following a consultation with an attending dentist, it was agreed that owing to the large superstructure of the mucosal section on the vestibular side the restoration would have to be screw retained. Such a solution ensures that the patient's oral hygiene can be examined frequently in that area. The abutment and crown were joined together in the laboratory in order to avoid any possible complications owing to excess cement left after the restoration had been placed in the patient's mouth. The part serving as the emergence profile of the crown from the gingiva was not covered with veneering porcelain. It was only polished to a shine without covering it with glazing. The surface of the zirconia prepared in such a way has a greater chance of adhering tightly to the patient's gingiva.

The present case study confirms that modern prosthetics could not exist without modern solutions such as CAD/CAM.

What other innovations will surprise us in the not-too-distant future? Will traditional layering and firing of ceramics be replaced by other methods?

**Acknowledgements**

I would like to thank my wife, Dorota Michalik, for her artistic veneering of the prosthetic restoration presented, as well as Dr Krystian Owczarczak, for his great contribution as a dentist, and with whom I carried out the clinical case study.

All the prosthetic restorations were made using the CAD/CAM Robocam, and the materials used were Robocam zirconium dioxide, IPS e.max (Ivoclar Vivadent) and Vision veneering ceramics.

**Summary**

What other innovations will surprise us in the not-too-distant future? Will traditional layering and firing of ceramics be replaced by other methods? This remains an open question, but perhaps the profession of the dental technician will soon be limited to working only and exclusively with computers.

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**About the author**

Robert Michalik graduated from the Faculty for Dental Technicians in Warsaw Medical School in 1987. After two years of work in the Medical University's dental laboratory, he opened a new dental laboratory, Inter-Dent, which he is still running. In 2003, he was the first in Poland to start working with dental CAD/CAM systems. In 2007, he began development of the first Polish CAD/CAM system in collaboration with Delcam and Shape. Also in 2003, he submitted an application to patent a method of creating telescopic crowns with intermediate crowns. He is the author of several articles for the trade press. Laboratory Inter-Dent UL. Pustułeczki 25 02-813 Warsaw Poland info@inter-dent.pl
The most important years in implantology

Dr Georg Bach gives a personal retrospect on the development of implants

It all started with an inquiry from a well-known professional journal of implantology asking for a contribution to acknowledge their having been in business for 15 years. Then there was the incidental telephone call by an academic teacher who had accompanied and supported me in my first steps in implantology. When I asked him about the upcoming publication project, I received a spontaneous and surprising reply, “The last 15 years - those were the most important years in implantology”!

This from a renowned university professor who was instrumental in establishing implantology - I was impressed. Later on I had to ask myself, “Is this really true?” The result of my tracing this development is this article - a personal retrospective.

Phases of implantology
If one considers oral implantology with regard to its major developments, three phases are evident: (i) the empirical and experimental phase; (ii) the mass phenomenon of implantology; (iii) the arrival of implantology in universities and science.

Looking back at these past 15 years, I will barely touch on phase II, but will discuss phase III fully. This entails different directions and priority areas that colleagues working in implantology experienced. When I browsed through implantology textbooks and journals from this period, I realised even more that implantology had undergone considerable change in this relatively short period of 15 years. I would like to recount my highlights of implantology from this period in the following paragraphs.

Farewell to the tristesse of papers
A seemingly minor issue to start with: the variety and quality of dentistry-specific print media and of digital media, particularly print layout, has developed substantially during the past 15 years. This holds true not only for implantology, but also for dentistry as a whole. The appearance of some professional journals up until the mid-1990s was reminiscent of an official legal amendment, but amazing things have happened since. The quality of colour printing (which is the norm now, but used to be subject to a surcharge for authors who wanted to include colour images), the accuracy of images, the paper - all of these make for a high quality appearance and leave a lasting impression on the reader. This has clearly been an advantage also for implantology because now highly complex correlations can be more easily conveyed and “sometimes a picture is worth a thousand words”. Ideally, e-learning and electronic professions.

‘This from a renowned university professor who was instrumental in establishing implantology - I was impressed’

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The end of dogmas
While implantology was marked by many dogmas from its beginning and the mid-1990s, this had changed at the time when our 15-year observation period began. However, implantology was later called into question in its entirety. Whether it was healing times, waiting times after ablation or prosthesis concepts - everything underwent scrutiny. On the one hand, some of these dogmas did in fact prove to be no longer sustainable because of remarkable developments, especially improvements in implant surfaces. On the other hand, the mark was at times overshot in the elimination of other dogmas, creating the need to back-track. This was a painful experience for both patients and implantologists.

One dogma that we encountered in the observation period was that of a strict refusal of immediate implant placement. There is general consensus today, however, that under suitable conditions an immediate implant placement can be a high quality and sustainable alternative to established procedures. One clinical case shows an immediate implant placement in the maxillary anterior teeth: the extraction and implantation; a firmly seated supra-construction implant (Fig 1), transfer into the oral cavity (Fig 2), and the condition immediately after insertion of the implant crown (Fig 5).

The prospering of the implant market
A welcome variety of new implants, implant forms and prosthesis options has become a reality in the past 15 years. Special implants were developed for special indications so that now even a mandibular molar can be replaced by a corresponding sized implant (Fig 4). These protheses share other characteristics as well: the acquisition of products and entire firms in order to expand or supplement their product portfolio and their pressling on to the field of digital dentistry (CAD/CAM, planning, etc) into which these global players invest large sums of money. Revenues must be generated so that these investments can be made - and they are still made, albeit declining owing to the economic crisis.

Still, the implant market is booming. Although the consistently two-digit annual growth rates some implant manufacturers had started to become used to have become more moderate today, a great deal of novelty can be made with implants. As a result, an ever-increasing number of implant suppliers and systems make it impossible for the individual user to keep track. Aside from new systems, an increasing number of generics are being launched on the market.

Focus on red-white aesthetics
The President of the German Society for Dental Implantology (Deutsche Gesellschaft für Zahnärztliche Implantologie), Prof Frank Palm, aptly remarked: “What was celebrated as a triumph for some colleagues 20 years ago is today taken to court.” Dentists who practised implantology were not prepared to find themselves confronted with a debate that had spread from North America to Europe; that of red-white aesthetics. This new focus on achieving the highest possible aesthetics for implant-prosthetic treatments was linked to implantology and distance itself from surgery, which had been dominant up until that time.

In the early phase of implantology, the main focus was on safe placement and the best possible placement in the bone, sometimes even at the expense of subsequent prosthetic treatment owing to unfavourable placement of the artificial anterior tooth. Now, however, prosthetic standards and issues have become the centre of the discussion. Placement techniques were modified and new techniques were established in order to satisfy these requirements. Patients no longer accept, or only occasionally, accept demanding and complex cases like the following case.

Both implants in the anterior maxillary region were placed too far buccally, and there was a gap of 5.5 mm between the implant shoulder and the cementoenamel junction of the adjacent teeth (Figs 8–10). Treatment with a long-term temporary restoration would only have yielded an unsatisfactory aesthetic result. However, under certain surgical and dental conditions - as shown in our second example - superior results are made possible for a period of ten years can be achieved even with challenging initial situations. In 1999, an immediate implant was placed in region 12. The following images show the steps of treatment (Figs 11–13). The first image shows the condition after ten years (Fig 14).

This development was made possible mainly by massive improvements in the area of augmentations, which can now be performed with significant reliability for a period of ten years can be achieved even with challenging initial situations. In 1999, an immediate implant was placed in region 12. The following images show the steps of treatment (Figs 11–13). The first image shows the condition after ten years (Fig 14).

The battle of healing times
It was but an episode, yet one that caused an incredible future at the time: the debate about shortened healing times. Stimulated by a media hype in which the specialised press only played second fiddle and the lay press appeared to be in the lead, the healing times of some implant manufacturers were inflated. Values were corrected downwards almost on a daily basis. Some manufacturers went along with it, while others remained firm. Some participants felt they needed to be at the forefront, others stayed out of it. A short but remarkable ascent was followed by a rapid crash.

A personal highlight for me was an article in a tabloid newspaper that said, “Extraction in the morning; directly followed by augmentation and implantation; a firmly seated supra-construction implant can be placed and then endless servings of spare ribs!” As can be seen from this euphoric statement, some got carried away, which led to painful back-track. What remains is the realisation that, owing to improved surfaces and other conditions, the long healing times recommended in the early phase of implantology can in fact be reduced considerably, but not at any cost.

New options for improving the implant site
The afore-mentioned dominance of prosthetic implant-
The success of an implant system cannot be determined by one single feature alone. Just as with all natural systems, the delicate balance is maintained by the interaction of different but equally important features. The ASTRA TECH Implant System supports this natural balance through a unique combination of interdependent features— the ASTRA TECH Implant System BioManagement Complex™. It is designed to ensure long-term clinical success by stimulating bone growth, providing bone preservation, soft tissue health and architecture. To put it simply: function, beauty and biology in perfect harmony.

‘It was but an episode, yet one that caused an incredible furore at the time: the debate about shortened healing times’

Establishing virtual implantology

It seems easy to figure out what the old-school fraction must have thought about the new planning and placement options for oral implants. This fraction had already had a hard time accepting the development from surgical to prosthetic implantology, and they were strictly against the new digital procedures that were emerging incredibly quickly. With the rapid spread of dental volume tomography, which opened a new dimension to dental image diagnostics, a multitude of planning programs and aids were placed on the market.

The suggestion by some opinion leaders to define validity and establish standards with regard to these new techniques, which are generally based on 3-D X-ray data, was especially frowned upon. I feel that a good compromise has been reached, owing to anticipatory and serious discussions held during consensus conferences and congresses, as well as at universities and within the dental associations.

These new techniques are immensely helpful in the treatment of complex cases, and they are even indispensable for highly complex cases. The treatment of simple cases usually does not require the use of these techniques. In fact, they should not be used in such cases owing to the radiation exposure when obtaining 3-D data.

Of promises and realities

Themes of the congresses during the first decade of the observation period contained generally positive statements and depicted new opportunities in implantology, which exceeded the then current options by far and expressed a belief in boundless growth. This coincided with many technology was only possible because many new and safer augmentation procedures were established during the observation period, enabling dentists to design the osseous bed for the implant as desired. Revolutionary augmentation procedures in the area of the maxillary posterior teeth, which had been the focus of discussion in the first year of the period in question, constituted another important approach for real progress.

Thanks to surgical techniques for sinus lifts, which underwent an incredible number of modifications also with regard to less invasive procedures, it was possible to treat areas of the jaw that had previously been considered impossible or that could only be restored for implantation by way of highly invasive orthodontic procedures. While initial sinus-lift procedures were generally reserved for highly specialised centres, they have now become common knowledge in implantology and are offered and performed extensively.

‘It was but an episode, yet one that caused an incredible furore at the time: the debate about shortened healing times’

Of promises and realities

Themes of the congresses during the first decade of the observation period contained generally positive statements and depicted new opportunities in implantology, which exceeded the then current options by far and expressed a belief in boundless growth. This coincided with many
positive statements and evaluations by implant manufacturers and distributors. However, all this changed considerably during the past five years.

Suddenly, new topics were given priority, which shaped specialists’ conventions – topics that had previously been partially suppressed if not well. I remember only too well the implant congress held by a very important American implant manufacturer in 1988, where I reported on a concept for the treatment of peri-implantitis developed at the University of Freiburg and was then rebuked by the main speaker, who was from the USA, during the ensuing panel discussion. He asserted that he had “not seen one case of peri-implantitis in 20 years of implantology - this phenomenon does not exist and, if it occurs, it can only be attributed to a lack in skill on the part of the implantologists.”

How times have changed. However, troubleshooting and complications in implantology and even the word ‘failure’ have been mentioned in the themes of many congresses held by leading professional associations of implantology in the past years.

Patients’ expectations

While a consistently positive and at times even euphoric tone prevailed regarding the topic of implants for many years, a few critical voices and later increasing criticism emerged at the beginning of the observation period. This was - concurrent with a noticeable increase in the number of implants - based on the considerable increase in implantology failures and complications.

The following images depict total implantological failure - the loss of a purely implant-supported complete maxillary restoration caused by an initial peri-implantitis (Figs 15–17), leaving profound osseous defects.

However, in line with the consistently positive evaluation of implants and the persisting promise that the use of implants would yield optimum results always and often publicised by the lay press - our patients’ expectations have increased considerably in the past 15 years. Patients assumed that, regardless of the individual situation, he or she would always receive the optimum results. In this regard, it seems reasonable to maintain a self-critical development and to concede that we did not always contradict this general assumption vehemently enough.

And then what was bound to happen, happened: at times, the result was not what the patient had expected. An awkward situation arises when the dentist, based on the initial diagnosis, considers the result to be successful and the patient considers it a failure. A longstanding expert sums up this situation accurately by stating that, “Two-thirds of all pending court proceedings were filed by patients whose expectations were disappointed.”

Rather unfortunately, the increasing number of court proceedings are mostly related to implantology. It cannot be by chance that the premiums for mandatory professional liability insurance have increased considerably.

Emerging criticism

German periodontists Dr Thomas Kocher referred to implantology as “the red light district of dentistry”. Whether this evaluation is justified is a matter to be decided individually. Personally, I do not agree with this evaluation, but a grain of truth might be found in its reference to overtreatment. In this regard, the expectation in favour of implants, even when not indicated, is a concern voiced increasingly by periodontists and those in favour of conservative treatment. We have to address this issue by individual evaluation of each patient, as well as through academic discussion. Implant versus tooth preservation has been a frequent debate at conventions and implant symposia in recent years. In my opinion, this would not have been possible ten years ago.

Trouble-shooting concepts

Unexpected complications, such as implant fracture and failure of implant supra-structure connections (Figs 18–21), necessitated the development of surgical and prosthetic trouble-shooting concepts and modification of constructions in implant and abutment design. However, these were not readily available and have not yet been finally agreed upon. In other words, they cannot be said to be common knowledge in implantology, at least not in the treatment of peri-implantitis. Similar statements can be made with regard to perimplantology arguments, where a pleasing variety of surgical techniques and materials is listed, but not generally valid scheme has been agreed upon.

The fact that the need to develop and convey these trouble-shooting concepts is generally recognised today and that these concepts are yet widely supported by the participants on the implant market is gratifying. The specialist press has made a valuable contribution here and continues to do so - numerous articles that received a great deal of attention during the past 15 years are those that dealt with implantology and implant-prosthetic troubleshooting.

Digital implantology

I consider the establishment of 3-D diagnostic imaging, with all associated possibilities, to be the significant development during the 15-year observation period. It is true that only implantologists used the new 5-D technology of treating the initial phase of dental volume tomography (because they made up the group of dentists who could actually afford this expensive equipment); nevertheless, 5-D technology constituted a quantum leap for dental diagnostic imaging as a whole.

Today, we have almost unbelievable possibilities at our disposal that even the greatest optimists would not have considered possible 15 years ago: highly complex patient cases can now receive minimally invasive treatment and have implants placed even without the need for augmentation.

Our first case shows a highly atrophied mandible, in which four implants could be placed without any prior augmentation owing to 3-D data and planning (Figs 22–24). Three erroneous diagnoses are sometimes also employed to clarify facts when complications have arisen, for example neural lesions after implantation (Figs 25 & 26) and bone necrosis after administration of bisphosphonates, and erroneously diagnosed as peri-implantitis (Fig 27).

My personal conclusions

It is difficult to draw a conclusion regarding the development of implantology over the past 15 years because it has been so multifaceted and rapid. To conclude, I would therefore like to quote my academic teacher and former supervisor, Prof. Wilfried Schulli, who, as a founding member of the International Team for Implantology, was undoubtedly among the pioneers of implantology and has contributed to improving implantology through his university work: “Who would have thought that implantology could develop like it did in less than twenty years.”

This very true statement encompasses many aspects: the admiration and appreciation of what has been achieved, the satisfaction with having initiated a procedure that is considered to be the safest in the entire field of medicine, and some criticism regarding any development in oral implantology that did not turn so well or went off course.
TRIPOD - A new protocol for immediate loading
Dr Jean-Nicolas Hasson et al looks at complete maxillary implant-supported prostheses

Immediate loading of complete maxillary implant supported bridgework is an increasing request by patients who have high aesthetic and functional demands and attach great importance to a neat appearance and their self-image. Since 1977, positive results have been obtained in immediate loading but these were limited to mandibular, bar-retained removable dentures. In 1997, Tarnow et al published a study showing similar results for maxillary and mandibular full-arch, implant-supported bridgework, and, more recently, the focus has turned to the development of computer-based techniques for improved results. Highly sophisticated technical tools such as Nobel-Guide (Nobel Biocare) and the SAFE SurgiGuide® (Materialise Dental) have entered the market and related techniques such as All-on-4 (Nobel Biocare) are being promoted to help meet patients' demands. All techniques are based on full maxillary bridgework with a screw-based retention. The screws-retained bridgework allows all procedures to be performed during the treatment ie impression taking, bridge modification and repair for aesthetic or functional purposes.

Amongst the more challenging difficulties in carrying out such a therapy is implant positioning, especially for a single crown in the anterior region. Precise placement is essential in achieving good aesthetics, phonetics, function and cleanability. Most of the time, implant placement has to be within the limits of 0.5mm (Fig 1). Another factor to consider is the possible loss of alveolar bone after tooth extraction, leaving a minimal residual volume, and thereby increasing the difficulty of the procedure.

The positioning of implants depends on the guide's positional accuracy in a definitive place at the time of the surgery and on the accuracy of the guide itself. In the case of NobelGuide, accurate positioning depends on the patient's ability to bite reproducibly and precisely, with even gingival thickness and consistency, and assumes that bone shows a similar degree of hardness at different screw-retention sites. Unfortunately, as recently reviewed by Schneider et al and detailed by Valente et al, the deviation between entry point and orientation consistently differs between the

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planned and actual position of the implants. This generally accounts for the results obtained by guides used in flapless surgery. Other failure factors may be related to poor cooling ability during the drilling procedure.6

As cited above, inaccuracies may arise from the positioning of the guide or of the patient, or be related to the radiological technique itself. In the case of flapless surgery, the position of the guide is conditioned by the thickness and consistency of the underlying soft tissue, as well as the patient’s ability to bite precisely in a replicable manner. In addition, there is always some degree of patient movement during the CT scan, which can hardly be controlled, an inaccuracy termed a ‘mechanical artefact’. Of course, any study performed on cadavers or models cannot reproduce this particular radiological aspect.7, 8 Other inaccuracies are related to the radiological equipment itself and include geometric, hardening and threshold artefacts. Geometric artefacts are related to the ability of software to reconstruct a 3-D space based on the serial addition of 2-D images that are filtered by the software.9, 10 Hardening artefacts are due to the different densities of adjacent objects. An X-ray beam is composed of individual photons with a range of energies. As the beam passes through an object, it becomes ‘harder’, that is, its mean energy increases because the lower-energy photons are absorbed more rapidly than higher-energy photons.11 The last significant artefact, the digital artefact, is due to the segmentation masks that are used to obtain volumes. In order to obtain a mask, an interval of radiodensity is defined by choosing the Hounsfield values at both ends of the tissue(s) under interest. By using this method, an area of lower or greater density can be discarded and missed in the final volume. This may be particularly true when digitally producing a surgical template based on hard or soft tissue. Finally, images produced by available techniques are too unreliable to be used directly for this type of treatment. We propose a new protocol in this article with the aim of reducing inaccuracies in terms of reliability, aesthetics and function.

TRIPOD: Description of a new clinical technique

Initially, a treatment plan is performed to adequately evaluate a case, propose alternate solutions and decide whether the patient is a suitable candidate for a fully implant-supported maxillary bridge. This requires a first assessment that includes a possible wax-up and a radiographic stent for visualising the crown position on the CT scan, as well as an evaluation of a potential need for bone- and soft-tissue augmentation procedures. Patients often present with their own cement-retained bridgework on natural teeth in place that, when adequate, may be used as a reference guide for implant placement. It is essential to evaluate the implant site within the maxillary bone precisely. In order to perform these measurements, a Positioning TRIPOD and a Computing TRIPOD need to be determined.

The term ‘Positioning TRIPOD’ is used to denote the selected pre-existing three fixed points (Fig 2) in the mandible or maxilla, which can be based on:

- Teeth that are stable enough to support the surgical guide during surgery
- Implants placed in posterior areas
- Temporary mini-implants that will be removed at the end of surgery

The choice of appropriate bases for the Positioning TRIPOD is critical for its accuracy. Owing to its compressibility, soft gingival tissue has to be avoided. Problems with remaining teeth may arise due to advanced periodontal disease causing excessive mobility. In some cases, temporary mini-implants are used, but often the amount of maxillary residual bone is so reduced that these implants only interfere with definitive implant placement. Nevertheless, they may be used when no other alternative is available. Anecdotal cases in which there is sufficient bone for temporary and definitive implants at the same time have been reported, but are rare. The best choice is to use posterior-placed implants before inserting anterior implants. In this case, an extremely precise positioning is not required since the large volume of the corresponding teeth provides some degree of freedom to the laboratory technician designing the prostheses. These posterior areas often require some bone reconstruction (such as sinus lift or onlay bone grafts), thereby prolonging time to loading. The corresponding implant can be wax-up only the most precise positioning for radiographic templates and surgical guides, but also for the occlusal guide and impression tray, since all these parts will be screw-connected to these previously placed and osteoncrafterized implants. In order to transfer the planned implant position from the planning software to the surgical guide, a Computing TRIPOD is necessary. This Computing TRIPOD is made with three SKypan X reference pins (Irrident) placed on the radiographic template with the reference plate (Fig 5a). The patient is scanned with the radiographic template fixed on the Planning TRIPOD. The position of the standardised X-ray opaque reference pins is detected by the software, building the Computing TRIPOD (Fig 5b), and used to calculate the implant coordinates (Fig 4). This data is then set in the transfer table (Fig 5b) to place the drill sleeves accordingly and transfer the radiographic template into a surgical guide (Fig 5b).

Some days prior to the full-arch surgery, once an adequate TRIPOD has already been planned and initial implants placed, an initial impression (Fig 6) will be taken for the model to prepare the impression tray, occlusal guide, surgical guide from the radiographic template, as well as the provisional prostheses. The surgical guides are produced in sterilisable resin with radiopaque sleeves (DéPlaque). Special attention is given to the impression tray that will extend to all maxillary surfaces, but room for the impression material is exclusively limited to the planned implant sites. They must be ready at the time of surgery.

On the day of the surgery, the practitioner begins by reducing all remaining crowns that would interfere with the surgical guide, which is then placed on teeth or preferably screwed onto previously placed implants forming the Positioning TRIPOD (Fig 7). A CT is performed to verify all drilling...
sites. If any modification has to be done, there is still time to adjust the drill sleeves to adequate positions and to re-sterilise the guide.

The next step is the transfer of the occlusion to the articulator. Usually an occlusion guide is engineered before surgery and screwed into an adequate position. It is then adjusted and some silicone material is added to ensure a perfect bite (Fig 8). The transfer is made to the articulator before starting surgery. It is sometimes possible to retain a molar before starting surgery. It is sometimes possible to retain a molar with compromised prognosis until the end of definitive prostheses, thereby keeping a reference point of initial occlusion.

When all materials are sterile, surgery can be initiated under the usual conditions. The flap is raised, the remaining teeth planned for extraction are removed and the surgical guide is placed on teeth or screwed onto implants. Holes of 2.0 and 2.8mm are drilled through the sleeves using the VECTOdrill™ (Thommen Medical) with a smaller tip fitting in and following the prepared drill hole. Control of the depth is visual, since depth marks on the drills can be easily seen on the facial aspect of the surgical guide. Speed and torque are according to the manufacturer’s instructions. Cooling is performed on the facial side (Fig 9); the flap is maintained properly by the guide on the palatal side. Once the drilling has been completed, the surgical guide is removed and the last step of implant site preparation is done using implant-specific drills, bone spreaders or piezozsurgery inserts. The choice of the implant relies not only on the diameter, but also on the implant length and profile to achieve the best possible implant stability. Implants with advanced surface technology, providing additional security in the early healing phase such as the super-hydrophilic Thommen implant lines SPßELEMENT (cylindrical profile) and SPßCONTACT (conical-cylindrical profile) with INCELL® (Thommen Medical), are preferred. In order to perform immediate loading, the implant should be inserted with a minimum torque of 25Ncm. If the bone provides poor primary stability, then a two-stage approach is required to ensure proper osseointegration before placing the prostheses. SPIßVARIO™ multi abutments (Thommen Medical) are connected to the implants by selecting proper width, height and angulation. Next, impression copings are connected to the SPIßVARIO™ multi abutments and bone-grafting material such as Biooss® (Geistlich) is then spread on the facial bone in order to avoid facial bone resorption. All synthetic bone graft material is covered by a thin and long-lasting membrane such as Remotis® (Thommen Medical) and flaps are sutured with particular attention to ensuring wound closure.

The impression tray is connected to the initially placed implants and silicone material is injected into the tray around implant transfers where room has been preserved for the impression material (Fig 10). Once the impression tray has been removed, protective caps are positioned on the SPIßVARIO™ multi abutments in order to maintain gingival spacing during the last laboratory prosthetic phase. A panoramic X-ray is performed to ensure proper positioning of implants and abutments, and to ensure that no radiopaque sterile silicone material remains.

The maxillary plaster model is trimmed to leave space for abutment analogues and plaster is poured to fill this open space after the impression tray has been secured to the trimmed model (Fig 11). The modified model simulates the oro-pharyngeal occlusion.

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multaneously shows two parts: the first part corresponding to the initial impression and the other corresponding to the second impression (Fig 12). The provisional prostheses are fitted to the model and occlusion is validated. When this laboratory phase is over, the protective caps are removed, and the prostheses are screwed into position (Figs 13a & b). If well done, occlusal adjustments should be minimal, even perhaps none being required. Thommen SPI®VARIOmulti temporary caps on customised material to close the screw channel and the patient is advised to treat the temporary bridge works in a gentle manner.

Sutures are removed after ten days. The aesthetics are re-evaluated three months after surgery, before initiating the final prostheses, owing to subsequent loss of tissue volume. Additional temporary bridge work is often required to test that the final aesthetic will be adequate before proceeding with the definitive prostheses. The final prostheses are either manufactured as a casted bridge using SPI®VARIOmulti caps or by CAD/CAM technology such as NobelPoreca from Nobel Biocare.

Discussion
There are multiple technical benefits of the TRIPOD procedure. Precision implant placement is achieved by removing positional and mechanical artefacts, particularly when the actual surgical guide is screwed onto stable implants. In other words, there is no movement evoked by a bite variation or tissue differences, and if the patient moves during the CT scan, the guide moves with the anatomical structures. However, there is no way to conquer geometric, hardening or digital artefacts. There is still room for a small degree (<1mm) of freedom in implant placement and, if necessary, final correction can be done after the initial drilling with the 2.8mm drill. This results in a maximum freedom of approximately 0.7 mm in diameter for a final implant site with a diameter of 3.5mm. However, considering that the last drill at the crestal ridge is just half of this value, this freedom corresponds radially to 0.35mm, providing an opportunity to adapt the implant site preparation to anatomical conditions slightly. This distance of 0.5mm is sufficiently important to become particularly significant for leaving some buccal bone, but it is still small enough to be handled by the dental technician and facilitate further implant placement. Nevertheless, the initial implant placement cannot exceed this limit, which evokes the necessity of very precise initial drilling and, at the time, an additional step to verify that the surgical guide is actually suitable for use. Compared to flapless techniques, open flap surgery not only allows the visual opportunity for controlling bone site preparation, but also retains precious keratinised tissue that is important for both marginal tissue stability and volume. The patient’s reaction to this procedure, with its associated pain and discomfort, still has to be examined in future studies.

Another benefit of this procedure is that stability is maintained throughout the surgery, since all materials used can be sterilised, which is not the case with common guides such as NobelGuide or the SAFE SurgiGuide®, which are both made of a stereolithographic resin and are currently not capable of undergoing sterilisation. In addition, the precision of the procedure allows the impression tray to remain unmodified - and thus sterile - throughout the surgery.

Yong and Moy* state that implant loss was probably primarily related to the absence of proper contact and a higher removal torque at two weeks than unconditioned implants did. This aspect should be particularly useful in the early stages of healing and prevent additional security in this crucial phase. In addition, this company provides implants of various diameters, length and profiles to satisfy various implant site requirements and which provide the best possible stability.

Conclusion
The TRIPOD protocol is based on our latest clinical expertise the vast developments of implant placement software and computer-guided implant dentistry. The efficiency of the technique must still be validated by analysis of implant survival in different clinical situations, specifically investigating adequate positioning between planned and final implant and the need to verify the surgical guide after the learning process has been completed. Finally, a study on patients’ satisfaction with the procedure in terms of pain and aesthetic outcome needs to be performed. We must still determine whether the benefits of performing flap surgery in combination with surgical guides outweigh the related discomfort and pain for the patient: does this pose a major problem for patients, are the final aesthetics improved by preserving keratinised tissue, and does such a technique fulfill expectations, even considering that bone volume loss is often difficult to limit in these areas?

The proposed TRIPOD procedure is certainly more labour-intensive than current flapless guide systems, since a flap has to be raised and no definitive prostheses are placed right after surgery. Nevertheless, it is also more versatile because maintaining or increasing initial bone volume in the treatment plan and is adapted to the individual situations. The risk of failure is considerably reduced by connecting immediately placed implants to osseointegrated implants. Furthermore, this procedure allows using the last millimetre, as typical cases show reduced bone volume and require the widest and longest implants within anatomical restrictions. Although knowledge and close collaboration with the laboratory technician is required, this procedure allows using the last millimetre and predictability for success, and will certainly be adapted to different practical situations and one-day procedures.

* About the author
Dr Jean-Nicolas Hasson
5 Rue du Werkhof
68100 MULHOUSE
France
Tel. : +33 3 89 56 31 12
Fax : +33 3 89 56 31 12
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New Beginnings

In this series we follow Pia Mint as she takes on a new challenge

Pia Mint began her dental career at 16 years of age during 1998. She was initially employed as a trainee dental nurse/receptionist at Mr Boyle’s dental surgery. Mr Boyle was nearing retirement, so in 2002 he sold the practice to two brothers, with plans for expansion and modernisation. Initially they employed two more dental nurses and appointed Pia as their receptionist/practice manager.

The new owners found Pia’s knowledge of the practice and its patients extremely valuable. They were content to concentrate on clinical matters and to leave the administration to Pia. Over the following years the practice and the dental team expanded to become a four-chair practice providing 50 sessions per week of mixed NHS-private general dental care. Pia asked if the practice would fund her to take a practice management qualification, but the owners convinced her that she was doing a great job and would not benefit from taking a course.

By 2010 Pia had married and was expecting her first baby. Her baby was born in December and then she took maternity leave until September 2011. Nina, one of the dentist’s partners covered Pia’s practice management duties during her maternity leave. Whilst Pia was on leave was a significant turnover of staff. Some of the dental nurses had mentioned to her that they felt there had been an agenda to get them out, so that Nina could choose her own staff and secure her control over the practice.

When Pia returned to work many of the system and procedures she had developed over the years had been replaced by vague ill-defined procedures, which only Nina could operate. On her return to work she was ill at ease with the changes and wanted to reinstate her tried and tested policies and procedures. Even although Pia was back at work Nina continued to attend and the relationship between Pia and her employers deteriorated. This saddened Pia. On one hand she knew that she could settle for the new regime or accept it was time for new challenges.

She mentioned how she was feeling to one of the reps and before long she had a phone call from Jon-Luke Endeavour and his partner Hugo Hope, owners of Endeavour and Hope Dental Surgery. They knew Pia by reputation and wanted to offer Pia the new position of practice manager at their dental centre.

One of the reasons Pia accepted the practice manager appointment at Endeavour and Hope dental surgery was because they were keen to introduce a patient-centred philosophy based on the sort of quality systems and procedures that she had introduced over her years as practice manager at her previous practice.

The Endeavour and Hope dental surgery is located in a large detached house in an affluent Midlands suburb. Dr Harold Patterson established the practice in 1979. Jon-Luke and Hugo purchased the practice in 2009. During the past year the practice has undergone massive changes. Plans to re-brand the practice had been discussed to make the practice more attractive to private patients. The practice is well placed in a residential road very close to a busy shopping and commercial centre. Since her interview, Pia had started to read articles published in the dental press on dental practice management. She feels enthusiastic about joining a practice with like-minded owners where she can put her ideas into action.

On Pia first day she was the first to arrive at the practice.
It was exactly 9am when she knocked on the locked practice door. The brass plaque on the door stated that the surgery hours were 9-5pm Monday to Friday. It was 9.02am on Monday morning and the practice was still closed. A number of seemingly unsurprised patients were forming an orderly queue at the front door. It was 9.05am when the receptionist arrived and opened the door. The patients filed into the waiting room but the receptionist disappeared into another room and then reappeared to establish which patients were present. Pia approached the reception desk and introduced herself:

“Hello, I’m Pia.”

“Have you got your appointment card?” the receptionist asked abruptly.

“I’m here to start work” Pia replied.

“Are you sure? ... Okay then...I suppose you’d better take a seat for now and I’ll ask him when he gets in!”, the receptionist said, giving Pia a cold, steely stare.

At this point Pia considered walking out the door and going home. Was this practice’s patient-centred ethos fact or fancy? Considering that deterioration in the relationship between herself and her previous employers she was wondering whether she had jumped out of the frying pan into the fire!

At 9.10am Hugo Hope arrived in a flustered rush and went directly into his surgery. Pia got up from the waiting room and knocked on his surgery door. Dr Hope opened the door and seeing Pia said, “Hello... I’ll be with you in a minute... I’m just getting changed... I’m running late as usual. You know what Monday morning traffic is like?”

At this Pia asked the receptionist where their staff placed their belongings carelessly discarded in this unlocked room.

Pia said to herself “Either I stay and work on this practice, or I go now... Which will it be?”

If I decide to stay, am I up to the challenge? Will I get the support I need? Can I make this practice into the place Jon-Luke and Hugo described when they interviewed me?”

What do you think Pia should do?

Answer: Pia was very disappointed when the Endeavour and Hope practice fell short of the description given to her at the job interview. If they really did understand the CQC standards and were prepared to make changes to realise the ideals they had discussed, Pia should stay and make the dream into reality. Pia should set herself the target of making Endeavour and Hope the best ever dental centre.

If Pia is to succeed she needs a plan. She will need to:
- Define clearly and in detail, what the practice needs to achieve. (The ideal scenario)
- Conduct a gap analysis
- Plan the steps to move from where they are now into the ideal scenario.

Preparing the plan is relatively simple. Making it happen will not be at all simple. Pia is going into a practice where the team have had their fill of new management initiatives, each of which has raised expectations and failed to deliver. As a result new ideas are responded to with the “They’ve been on another course!”

She needs to fully understand this and find ways to engage the team.

Pia needs to begin by establishing the parameters of her new job role. In particular she needs a clear job description. She needs to clarify the boundaries and permissions for the whole team. Pia needs to win the respect of her new colleagues and the support of her new boss. She must achieve this without compromising her authority, by producing tangible results, small successes, and all fairly quickly. Pia would find the support of fellow practice managers, through her local practice managers’ network to help keep her focused on her goals.

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Why improving your practice is a mystery – part 13
The GDC doesn’t require you to love your colleagues, says Jacqui Goss

When I first started visiting dental practices doing consultancy work some years ago, I was surprised at how often I had to play the role of intermediary. I’d worked as a manager, including in dental practices, so I knew that staff don’t get on with each other all the time. But it still amazed me how often a member of a dental practice team would say: “Oh, I didn’t know (so and so) felt that way.” Practice owners would also comment (for example): “I wish I’d known (so and so) wanted to work extra hours.”

It was not that staff didn’t speak to each other or that principals and managers ignored team members – they just didn’t communicate. And do you know what? It’s still happening all these years later.

I’m no longer surprised at adopting a liaison role – telling each person what the other will say to me but not directly to their colleague. Sometimes it’s because the subject matter is a bone of contention and I need to act as a mediator. Often, it’s because one or other person doesn’t feel confident enough or sufficiently empowered to speak up.

For example, in team discussions about changing the practice opening hours there’ll often be a member of staff who contributes very little. Then I come on the scene doing some consultation about, say, front of house staff training and that person tells me in confidence that they wanted to work extra hours and earn more but the opportunity went to another team member. When I confer with the practice manager they’ll often exclaim (with some frustration): “I wish I’d known that!”

Sometimes, I come across team members who just do not get on. They may be clinical and non-clinical staff, managers and dentists, hygienists and front of house staff or any combination of these roles. There is, to coin a phrase, a clash of personalities. Quite often these occur in small practices with only a handful of staff and the situation invariably arises when something disturbs the equilibrium – a new person joins or someone gets promoted.

I’m not about to dive into trait theory (if only I could) or expound the Myers Briggs model of personality – let’s keep this simple. Surely, if you’re working in or applying for a job in a small dental practice you need the ability and disposition to...
Simply adding some ‘softening’ words can turn what may be interpreted as an aggressive demand into a consultation or request. For example: “I’ve done a treatment plan for patient so and so, perhaps you’d like to look at it,” or “I’m going out at two o’clock so can you get it done by then please?”

If you’re someone who is reluctant to speak up during team meetings (and these events should be managed in a way that no one has such concerns), rather than keep what you want to say to yourself, at least indicate that there’s something on your mind. You can do so during or at the end of a meeting by simply saying (to whoever is chairing it): “Can I speak with you about that afterwards?”

If you have an ‘issue’ with another team member, don’t bottle it up – speak to them about it. If necessary choose a setting that is relaxing (for both you and them) – suggest having a coffee together at lunchtime or after work. It can be helpful to include another team member – but not your best mate. Ask someone along who will be dispassionate and not likely to take sides. And try to remember that while your ‘beef’ is important to you, in the great scale of things (Life, the Universe and Everything in the Hitchhiker’s Guide to the Galaxy series) it is probably less significant and certainly not worth erecting a barrier with a colleague over.

Now if you’ll excuse me, I have to go and break up an argument between my two teenage daughters...
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www.wh.com

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