OFT campaign gives patients ‘Right to Smile’

Consumer and competition authority initiates drive to encourage patients to know their rights before visiting their dentist

The Office of Fair Trading has launched a new campaign to help patients understand more about their rights when visiting the dentist.

The ‘Right to Smile’ campaign is supported by organisations such as the BDA, Oasis, IDH, Which?, NHS Choices, the Department of Health, the Welsh Government, the Scottish Government and Citizens Advice.

Judith Frame, OFT Head of Campaigns, said: “While the UK has one of the highest standards of oral health in the world, and satisfaction levels among patients are high, our report found that people are often confused about what they’re expected to pay, and don’t always have the information they need.

This campaign aims to help patients get clearer about what they can expect, and more engaged when making decisions about their choice of dentist and treatments.”

A Which? spokesperson said: “We support the ‘Right to Smile’ campaign to help consumers understand their rights when visiting the dentist. It’s vital patients are given clear, timely and transparent information on the proposed treatment and the costs and how to complain if something goes wrong.”

Fake dentist kisses patient

A fake dentist from Florida has been arrested for kissing his female patient’s buttock. John Collazos had been practising dentistry without a licence, directing his services towards migrants. A woman complained to police about Collazos after attending an appointment with him for toothache. According to the patient, Collazos gave her an injection in her buttock to relieve the pain, and subsequently kissed the wound. Collazos has been charged with four counts of practising without a licence, another four for using equipment without a licence, and one count of battery.

Dallas star dies of mouth cancer

TV star Larry Hagman, best known for his role as JR Ewing in the hit series Dallas, died of tongue cancer on Friday 23rd November, having been diagnosed with the disease in October last year. Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, hopes this latest high-profile case will help spread the message and raise awareness about mouth cancer. Dr Carter said: “Larry’s passing is a reminder of how deadly mouth cancer can be. Latest figures show more than 6,000 cases have been diagnosed in the UK. Without early detection, half of those will die.

Oral HIV test

According to Time magazine, OraQuick, the first in-home HIV test kit that received FDA approval for over-the-counter sale directly to consumers, is one of the best inventions of 2012. “With just a swab of saliva, OraQuick can identify the antibodies that signal HIV infection within 20 minutes. It’s the first do-it-yourself test for HIV—the same one that health professionals use but without the trip to a doctor’s office or the need to wait days for results,” the magazine reported. Douglas Michels, president and CEO of OraSure Technologies, manufacturer of the kit, said: “The OraQuick In-Home HIV Test is a breakthrough product in the fight against HIV and AIDS because it empowers more people to learn about their HIV status in the comfort and privacy of their own homes. It has been a real milestone in the battle against the disease.”

GDC suspension

Council member suspended from office

Barry Cockcroft, Chief Dental Officer for England, said: “Giving patients good information is key to a high quality service. We are delighted to support the Office of Fair Trading’s campaign. This material will help patients make informed choices about their dental care.”

Dr Martin Fallowfield, Chair of the BDA’s Principal Executive Committee, said: “As the OFT acknowledges, and research by the BDA and other organisations con-
Earthquakes responsible for teeth grinding

The stress of Canterbury’s earthquakes could be damaging people’s teeth, a Christchurch dentist says.

New Zealand Dental Association (NZDA) Canterbury president Donna Batchelor said the region’s dentists had noticed a growing number of people seeking treatment for teeth grinding, with stress believed to be the cause of the problem.

Some people were seeking treatment for fractured cusps, where the pointed chewing surface of the tooth was broken off from grinding.

“There’s significantly more patients coming through with that,” Batchelor said. “You can’t stop it if it’s something that’s coming from an internal thing.”

Dentists were working more closely with counsellors and family doctors to support stressed patients, she said.

The earthquakes had also seen dental work become less of a priority for some families.

“There’s so many other things to worry about. A lot of people are possibly leaving things more until there’s an issue,” she said.

For elderly people, getting across town to their dentist had become a challenge, and more dentists were now taking the time to go to them, such as visiting rest homes to check on patients with dentures.

Batchelor said the region’s dentists had been stressed since the quakes, with many losing their premises in the February 2011 quake.

Many were still working out of temporary premises or sharing space with other practitioners.

Others were worried about losing the premises they had. A Rangiora dental clinic was forced to move at short notice in March because its building was deemed to be quake-prone, she said.

World-renowned dentistry expert Professor Ray Bertolotti will speak to a group of Canterbury dentists today about alternative treatments.

Bertolotti, a clinical professor of biomaterial science at the University of California, is donating all proceeds, more than $18,000, to the Canterbury NZDA.

The suspension was imposed at a meeting of the Council on 15 November 2012 in accordance with the GDC’s procedures. The Privy Council has been notified of this decision and the suspension will remain until the Privy Council reaches a decision on whether or not to suspend or remove him under the General Dental Council (Constitution) Order 2009.

The GDC will not be making any further comment at this stage.
As you will have seen from the news on the front page (or did you turn straight to this to see what I had to say?) the Office of Fair Trading has backed up its report (first reported in DT Vol.6 No.15, June 4-10, 2012) with patient awareness campaign highlight patient’s rights to treatment at the dentist.

This is being complemented with videos and an information sheet, tailored to each country in the UK. To see the video, go to the OFT’s YouTube channel and take a look – probably worth it as you can bet your patients probably will.

Last week saw the ninth annual BACD conference in Manchester. It was an exceptional conference with some really world class names speaking at the event. I have to say my favourite (and I did go to more than one, I promise) was a lecture by Rafi Romano on Current Innovations in Aesthetic Orthodontics. I am hoping to get a clinical case study from him for an upcoming 2013 issue of Dental Tribune, watch this space!
Stevenage dentist struck off

A dentist based in Stevenage in Hertfordshire has been struck off by the General Dental Council (GDC) following a public hearing into allegations of dishonesty.

The allegations heard by the GDC’s Professional Conduct Committee are in connection with incidents that occurred between January 2009 and October 2010 when Jonathan Anyetei (Registration No. 58109) was practising as sole principal at the Dental Surgery, 15 Town Square Chambers, Stevenage, Hertfordshire SG1 1BP.

The Committee found, among other things, that Mr Anyetei had:

- Failed to ensure that appropriate cross infection control standards were adequately complied with – for example clean and dirty areas in the surgery were not clearly defined.
- Failed to ensure that legal requirements relating to health and safety in the workplace were satisfied – for example The Fire Precautions (Work Place) Regulations 1997.
- Failed to ensure that appropriate cross infection control standards were adequately protected against Hepatitis.

In addition, on 50 July 2010, the Hertfordshire Primary Care Trust terminated Mr Anyetei’s General Dental Services Contract, under which he provided NHS dental services, but he continued to hold himself out as providing NHS dental services. The Committee found that his conduct in that respect was dishonest, unprofessional and not in his patients’ best interests.

The Committee said:

“Dishonesty is a serious matter in any person. In the case of a dentist, dishonesty is a betrayal of trust which sits at the heart of the dentist/patient relationship. The public and profession have the right to trust a dentist’s integrity. The public also rightfully expect a dentist to maintain appropriate measures in place for sterilisation and to prevent cross infection. You placed staff and patients at totally unnecessary risk of serious harm. The Committee noted the seriousness of the charges proved, and was in no doubt that this constituted misconduct.”

In the circumstances the Committee determined that the only appropriate and proportionate sanction to maintain the standards of the dental profession and public confidence in it, was that of erasure.

Mr Anyetei’s registration was immediately suspended and unless he exercises his right of appeal, his name will be erased from the register.

Effects of tooth whitening under inspection by EU

The Council of European Dentists (CED) is currently conducting a one-year survey on possible negative side-effects of tooth whitening and bleaching products. The committee has called upon dentists in the EU to report their own and their patients’ observations.

The survey includes tooth whitening and bleaching products that are not freely available on the market to consumers, that is, those that contain between 0.1 and 6 per cent hydrogen peroxide. It runs until 51 October 2015. The initial results will be reported to the European Commission by the end of next year.

GDC sets out new guidance for employers

The General Dental Council (GDC) has put new guidance in place for anyone employing trainee dental nurses or dental technicians.

The previous guidance in this area was put in place during the transitional period for dental care professionals – meaning they could register with the GDC without having a formal qualification. This ran from 51 July 2006 to 50 August 2008.

Since then what was meant by the term “in-training” has been reviewed and new guidance has now been agreed.

The guidance contains a number of key points, including:

- Employed and enrolled or studying on a recognised programme that will lead to GDC registration; or
- Studying on a recognised programme that leads directly to GDC registration.


Polar bear enters dentist’s chair

A team of vets at a Scottish wildlife park have given a polar bear root canal treatment.

The vets were called in after the usually-playful Arktos was feeling subdued, leading staff at the park to discover a problem with his upper left canine tooth.

Arktos, who weighs 75 stones, was sedated and placed on an operating table made up of scaffolding poles and thick planks. His tooth had become damaged at the tip and rotted through, causing the polar bear to need root canal treatment.

After three hours, the treatment was successfully completed.

Douglas Richardson, animal collection manager at the park, said the vets and park staff were pleased with how the operation went.

He said: “Arktos really is a lucky bear and we were delighted to be able to save his tooth.

“In the wild the infection would have tracked through his system, causing him a great deal of pain and discomfort and, over the longer term, it could eventually kill him.”
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Parents responsible for dental fears

A new study conducted by scientists at the Rey Juan Carlos University of Madrid highlights the important role that parents play in the transmission of dental fear in their family.

Previous studies had already identified the association between the fear levels of parents and their children, but they never explored the different roles that the father and the mother play in this phenomenon.

América Lara Sacido, one of the authors of the study explains that “along with the presence of emotional transmission of dentist fear amongst family members, we have identified the relevant role that fathers play in transmission of this phobia in comparison to the mother.”

Published in the International Journal of Pediatric Dentistry, the study analysed 185 children between seven and 12 years and their parents in the Autonomous Community of Madrid. The results were in line with previous studies which found that fear levels amongst fathers, mothers and children are interlinked.

The authors confirmed that the higher the level of dentist fear or anxiety in one family member, the higher the level in the rest of the family. The study also reveals that fathers play a key role in the transmission of dentist fear from mothers to their children as they act as a mediating variable.

“Although the results should be interpreted with due caution, children seem to mainly pay attention to the emotional reactions of the fathers when deciding if situations at the dentist are potentially stressful,” states Lara Sacido.

Consequently, transmission of fear from the mother to the child, whether it be an increase or reduction of anxiety, could be influenced by the reactions that the father displays in the dentist.

Amongst the possible implications of these results, the authors outline the two most salient: the need to involve mothers and especially fathers in dentist fear prevention campaigns; and to make fathers to attend the dentist and display no signs of fear or anxiety.

“With regard to assistance in the dental clinic, the work, with parents is key. They should appear relaxed as a way of directly ensuring that the child is relaxed too,” notes the author.

Businesses pledge for more fruit and veg

More fruit and veg will be added to ready-meals, and supermarket fruit and veg sections will be expanded as part of a new drive to encourage everyone to get their 5-a-day. Public Health Minister Anna Soubry announced today.

The move comes as part of the latest Responsibility Deal pledge, aiming to encourage action across the food industry to help people eat more fruit and vegetables. This includes foods right across the board - fresh, frozen, canned, dried and juiced products, as well as fruit and vegetables in pre-prepared food, such as ready-meals.

Eating five portions of fruit and veg a day helps to lower the risk of serious health problems, such as heart disease and some cancers, but figures show that two thirds of people still don't eat enough.

The new pledges include:

- ALDI will increase the amount of store space dedicated to fresh produce and feature their own brand Super 6 fruit and vegetable lines in their promotional activities including TV advertising.
- Iceland will offer coupon deals on fruit and vegetables, increase their promotion to its customers using new website and social media features, as well as introduce new fruit and vegetable products.
- LIDL will rebrand its entire fruit and vegetable range making it more appealing - particularly for children - with fun characters and jokes on kids' packs.
- Subway will launch a new campaign fronted by elite athletes Louis Smith and Anthony Ogogo, two of Subway's Famous Fans, to promote their choice of a Low Fat Sub personalised with their favourite extra salad items.
- Co-operative Food, Morrisons, M&S, Sainsbury's, Tesco, Waitrose, General Mills, Mars, caterers 5685, Brakes, C&H & Co Catering and the British Frozen Food Federation have also signed up to the pledge.

**Tooth whitening company prosecuted**

The General Dental Council (GDC) has prosecuted illegal teeth whitening company Pearl Teeth Whitening Limited.

The Company, trading as Pearl National, was charged under section 45 of the Dentists’ Act 1984, which states: “A body corporate commits an offence if it carries on the business of dentistry at a time when a majority of its directors are not persons who are either registered dentists or registered dental care professionals.”

A representative of Pearl National admitted guilt at Doncaster Magistrates’ Court on Friday 23rd November.

During sentencing, District Judge Bennett said: “It is clear from their website that Pearl National operated from a large number of locations and from the facts of the case presented to me, that they employed unqualified people to provide teeth whitening to their customers.”

He added that it occurred to him that the company “must have received a lot of money and had never filed accounts at Companies House.”

The court has fined the firm £5,500 and ordered them to pay £4,000 towards the GDC costs.
GDC makes patient information more accessible

Researches found that as body mass index (BMI) increased with age, so do the number of cavities. These findings were published in the online Journal of Pediatric Health Care article, “Childhood obesity and dental caries in homeless children.”

The study examined the physicals of 157 children, from 2-17 years old, from a homeless shelter. Most were from single-parent families headed by women with one or two children.

While studies in Brazil, New Zealand, Sweden and Mexico have shown a relationship between obesity, dental health and poverty, few US studies have examined how the three factors are linked.

The findings support reports from the Centers for Disease Control and Prevention that obesity and poor oral health have doubled since 1980, raising the risk of diabetes and other health problems, as well as issues with self-esteem.

Poverty contributes to poor dental health by limiting access to nutritious food, refrigerators to preserve food and even running water in some homes, said Maguriete DiMarco, associate professor at the Frances Payne Bolton School of Nursing at Case Western Reserve University.

“Many people do not realise,” she said, “that dental caries is an infectious disease that can be transmitted from the primary caregiver and siblings to other children.”

Another problem for children of poverty is access to dental care, where families lack the financial means and transportation to make and keep an appointment. And some working poor may not qualify for Ohio’s Childhood Health Insurance Program, which subsidises health and dental care reimbursements to providers.

“There are no easy solutions,” DiMarco said, “especially with the homeless population.”

Free copies of Smile and Smile EasyRead, and downloadable translations and audio files can be downloaded from the GDC website: www.gdc-uk.org.

Is your dental partnership legal?

NASDAL are advising all dentists to think twice before going into a dental partnership with a family member.

Some smaller practices comprise a partnership between a dentist and their spouse, but if the spouse is not a General Dental Council (GDC) registrant, this may be illegal.

Nick Hancock is a Chartered Accountant and a NASDAL member who was recently asked for advice by a dentist in partnership with his wife who was the practice manager. “Regrettably, I had to inform the dentist that he should dissolve the partnership. Under The Dentists Act 1984 it states ‘... an individual who is not a registered dentist or a registered medical practitioner shall not carry on the business of dentistry ...’”

Damien Charlton, a member of the NASDAL Lawyers Group says there is one exception. “When the practice holds a General Dental Services (GDS) contract, the National Health Service Act 2006 permits certain non-GDC registrants - including a GDS practice employee - to enter a GDS contract. The Dentists Act specifically states that receiving income under a GDS contract is not deemed, for the purposes of that Act, to be carrying on the business of dentistry.”

He added: “It’s essential that the partnership formed for the purposes of the GDS contract is kept separate from any private work carried out by the practice because it is only receipt of income under a GDS contract that falls within the exception to the definition of “the business of dentistry. This means (amongst other things) keeping separate sets of accounts and ensuring that the non-GDC registrant does not receive any income from the non-GDS parts of the practice.”

Dentists in an ‘illegal partnership’ are strongly advised to dissolve it. Once the partnership has dissolved, the registered dentist can continue to trade in a different format. This could be as a sole trader, a limited liability partnership or as a limited company. It is essential that you seek expert financial and legal advice to ensure that the structure you choose complies with the complex rules and regulations which govern the business of dentistry.

Is your dental partnership legal?

BDA Scotland welcomes new director

Put Kilpatrick has been appointed as the new Director of the British Dental Association (BDA) for Scotland. She will take up her post in January 2015 and brings to the post extensive experience in the healthcare sector including operational and strategic management, policy development, and postgraduate teaching and research.

Graduating from the University of Dundee, Pat joined the Graduate Training Scheme for NHS management before going on to senior roles within NHS Scotland including Director of Clinical Development at NHS Argyll and Clyde and Director of Planning at North Glasgow University Hospitals Trust. She led the National Task Force on the development of Primary Care Trusts in Scotland in 1997.

As Academic Director in the School of Management at the University of Stirling, she developed the first MBA postgraduate degree programme designed to develop the management skills of both doctors and dentists.

Latterly her career has been in consulting. She joined Tribal Consulting in 2006 as a Director within their national advisory team, before going on to launch her own business in 2010.

Pat said: “Dentistry in Scotland faces a complex set of challenges. I look forward to playing my part in helping the profession overcome them and advancing the cause of oral health in Scotland.”
Regulations and relative risks

The only thing worse than over regulation is bad regulation, says Neel Kothari

My biggest pet hate at the moment is the sheer number of unenforceable policies designed to induce a culture of fear and promote the practice of defensive dentistry. In my opinion the only thing worse than overregulation is bad regulation and by keeping the profession at a safe distance from the construction of such regulations, this not only renders the policies as ‘short term’, it severely erodes the profession and its ability to self regulate.

The promise of a cut in bureaucracy by the incumbent government has quickly evaporated, leaving dental practice managers trying to understand complex protocols and policies designed for small hospitals and clinics rather than a general dental practice.

For instance, let’s look at the costs and the risks associated with Legionnaires disease and the need for a risk assessment and regular water testing. If you get a ‘profession company’ (apologise for the inappropriate use of the word professional) to carry out a full risk assessment and test the water sources you could easily pay more than £500 for the privilege. Money well spent or a complete waste of time? I guess that’s a matter of opinion.

Low risk

A risk assessment of dental unit waterline contamination carried out by Caroline Pankhurst in 2005 concluded that ‘the risk to respiratory health from bacterial contaminants in dental unit waterlines is very low’ and at the Second Annual All Island Symposium on the Public Dental Services the reports state that one in three homes contain Legionella, but there is a very low attack rate in an outbreak, just 2-5 per cent. Legionella flourishes in all water types in temperatures of 20-45 degrees Celsius, and likes stagnation, sediment and scale. It goes on to further state that ‘There are no proven cases of Legionnaire’s disease linked to dental treatment’. The question then becomes, is forcing dental practices to adhere to Legionella testing a cost effective way to promote public policy? And should practices really divert time and money away from front line services?

Relative risk is something that seems to be completely absent from the architects of HTM01-05, which may go some way to explain why the DH review of HTM 01-05 has been further pushed back to 2013-14 and why the BDA as our trade union has pressed for the immediate removal of the unnecessary and burdensome restriction on instrument storage times, which the DH has conceded is not evi...
...dence based on a number of occasions.

On my recent CQC practice inspection, I was told by my CQC inspector that I should have a sign saying ‘dirty’ to indicate which side of the clearly marked division tape that dirty instruments are to be placed. My immediate response was, no. Even though this is probably a show of personal defiance, I really do not want a sign saying ‘dirty’ anywhere in my room. Now some of you may think stop being silly and just play the game, whilst others may agree with my position, but either way, what a complete waste of time and money to make dentists mark the areas of their surgery ‘clean’ and ‘dirty’ and then pay someone else to enforce this.

The reality of modern day dentistry is that central government is far more concerned with the perception of how clean our instruments look and feel rather than the skill with which we use them. The move towards getting our instruments to be ‘sterile’ rather than ‘clean’ is not only expensive and time consuming to achieve, but does not address the fact that the relative risks of using ‘clean’ instruments is very low. After all restaurants don’t steam sterilise their knives and forks, yet we are all happy to put them in our mouths. Now I am not trying to compare a night out with dental treatments, but are the relative risks to people still the same?

Outcomes
My understanding is that the CQC is monitoring things on an ‘outcomes’ basis. So let’s look at things on an outcomes basis. Since the introduction of the nGDS, CQC and HTM01-05, dental practices have seen a massive reduction ranging from nurses taking bloods without gloves and smoking outside whilst wearing hospital tunics. Let’s not forget that they are treating people who are seriously sick and not simply carrying out dentistry in relatively healthy patients.

The relative risks to patients are clearly much higher compared to a general dental practice, yet nevertheless I have to spend my lunch breaks debating whether I should have a sign saying ‘dirty’ in my surgery, which until I absolutely have to will not be doing. Furthermore, why am I told that I need a sign showing me how to wash my hands every time above my sink? This is one of the first things that we learnt at dental school and simply just adds to the clutter of useless posters that do little to improve standards for patient care. Why not get dental nurses to hold open a textbook every time we prepare a cavity or a crown for a tooth?

Apologies for the rant. I will try to cheer up in time for my next article.

About the author
Neil Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Sawston, Cambridge as a principal dentist at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at U.C.L’s Eastman Dental Institute.
You can not get used to Africa  
You either like it, or you don’t, but you can’t get used to it, says Erik Ahlbom.

Werner and his wife Natalie, both from Belgium, are running one of the countless NGO’s (Non Government Organisations) that keeps Uganda ticking over and that together with other kinds of foreign aid makes up more than 40 percent of the gross national product.

In spite of Werner and Natalie’s best efforts, Uganda is still struggling with poverty. Half the population, that is 15 million people, don’t have food security. That same group of people have little or no access to health care and dental care. There is one dentist for every 158,000 people in Uganda, compared to one for 3,000 or so, in the UK. Infected teeth can fester for years, which not only makes the sufferer miserable, but also according to the WHO, accounts for a loss of working and school days comparable to Malaria or HIV, thus perpetuating poverty. Unlike the headline catching diseases, no billions of dollars are going into research, no massive projects are being launched by the UN and no Nobel prizes are handed out. It’s a silent, slow burning disaster. That’s why Linda Dobinson, the practice manager, Maria Shilling, the dental nurse and myself, a dentist, from the Port Erin Dental Surgery in the Isle of Man, have signed up for this DENTAI D mission.

Kanungu
I am writing this on a rickety bus, travelling to the Kanungu district in south western Uganda, near the Rwandan border. I’m trying to keep the pen steady to the paper, while the red dust that much of Africa seems to be made up from slowly penetrates every nook and cranny in the vehicle. We are carrying on the bus a portable dental hospital that can be set up in anything that has a roof on it! This can be set up in anything that has a roof on it!

Along the road I can see small towns or villages with small, one room brick houses, fire burning outside for cooking and sometimes one small business or another going.

The roads are occupied mostly by lorries, sometimes with the flated packed with people and numerous Chinese or Indian 125cc motorcycles with anything up to eight (8!) passengers. It is not safe, the accident rate is horrendous by UK standards. 10 people die every day on the Ugandan roads, according to ICCU (The Injury and Control Centre Uganda) and the motorcycles, or Boda Boda, as they are called here, are involved in 70 percent of these deaths. Having ridden motorcycles myself since the early 1980’s, I find it easy to believe.

Beaten track
The quality of the road is steadily deteriorating as we get further off the beaten track. Stephen, our driver, is in spite of a lifetime on these roads, struggling to keep us going at more than 30Mph.

Stephen is a good man. A father of three, when not driving the bus, he is helping out in the clinics, looking after children that have lost their teeth after an extraction, or provides oral hygiene instruction for them. His dance routine that goes on for various offences, or swept away in an area, there is nothing to back up, so when a parasite strikes and destroys the crop in an area, there is nothing to help and the result is a local famine that never reaches our media. No headlines, no UN planes dumping food, no Band Aid. Just hunger.

Not enough
Still, when everything is going well, it is not enough. Most children get enough calories in the day, but not enough protein, leading to stunted growth in children and difficulties in following classes in school, if they have one to attend. When there is some protein, say eggs or beans in a household, the parents are sometimes faced with the choice of feeding their children with it or to sell it to get cash for things like shoes or school fees. We sometimes see the effect of this in our clinics as well. Children are sometimes exhausted, unable to stand up properly after simple extractions. A sugary drink helps this very quickly, strongly indicating that food was the problem in the first place.

It would be easy to dismiss Uganda as failed and hopelessly corrupt. As always, the truth is far more complex than that. The Ugandan government, unlike many of its European counterparts, is in full control of their territory. And efforts are being made, although slowly, to lift Uganda out of the poverty trap.

There is one dentist for every 158,000 people in Uganda, compared to one for 3,000 or so, in the UK.

Between the villages, the roadside is strewn with small farm houses, surrounded by a small patch of land where Matooke, a kind of banana that is cooked and is a bit like a potato, beans or cassava, is growing. The people in them are surviving on subsistence farming, meaning that they can only just survive, as long as all goes well.
About the author

My dental career started in 1983, when I qualified as a dentist from Gothenburg University, Sweden. I then spent the next 18 years in remote parts of northern Sweden, working where few other dentists wanted to work. In 2000 I emigrated to the UK and then went on to the Isle of Man in 2006. Last year I finally found another job that very few dentists want, and went to volunteer in Uganda.

Kampiringisa is a very well disguised blessing for some children.

Free from corruption

Other efforts are being made as well. There are Ugandan dentists working with DENTAID, trying to build up a structure of dental care, free from corruption. Ambrose Matsika, Apollo Mukiza, Gilbert Rwamwitani and Sam Kiwira are unsung heroes of their country. They are skilled, dedicated and work hard for little return for themselves. DENTAID’s work would be very difficult without them.

We are on the way to Kinkiizi, near the borders of Rwanda and Congo. Although the Ugandans in our team say that this is a safe area since a few years back and that the Ugandan military now have full control of the territory, I have seen enough BBC news over the past twenty years to feel a twinge of apprehension anyway.

Seeing patients

Once there, we will set up our portable dental hospital, cleverly designed by the DENTAID engineers in the UK, an operation that grows more efficient by the day. We will start seeing patients inside one hour of switching off the bus engine and keep going all day. Then we will do it again and again. Then we’ll go home, try and get the red dust out of our clothes and try to understand what we have seen and done. I’ll go through my pictures and relive the joy and the heartache that I’ve experienced and I’ll feel a twinge of guilt over my easy life.

So, did I get used to Africa? Of course not. No one does.

But I will return.
If Traditional Marketing Is Dead - Is Social Media Next?

Rita Zamora looks at how not to lose your following

Social Media told delegates that social media is not an option, it’s a requirement. Dr. Timimi has been quoted as saying, “This is not marketing; this is the right thing to do.”

Revisit your mindset
When the leaders in healthcare social media say that social media is not a marketing tool, what does this mean for your practice and your social media strategy? It may mean that all we need to revisit our mindset. It’s time to see social media more like communication tools and communities rather than marketing tools. Social media communities are two-way communication channels, not just one-way channels to push out marketing messages. Right?

If you have treated your Facebook and Twitter communities more like marketing and sales tools, the good news is you can change your strategies if needed. Learn to be thoughtful about how often and what you post or tweet. Note I have always recommended, and still do, conservative amounts of light and positive content - show your human side and a bit of personality - yet that should never mean abandoning your core values.

Lastly, a reminder to all of us that we have a choice on how many annoying images, rants, or disturbing or useless material we view on social media newsfeeds is rubbish and ridiculous content, then it’s time for you to reevaluate who you are following. Remember: what we read, see, listen to, and most importantly, the people we interact with in social media is our choice. These media channels can be extremely beneficial and loaded with rich, valuable content—or they can be rubbish. It is completely our choice what we wish to see, read, and fill our minds with.

Be mindful about what you choose to post and view on Facebook and Twitter. I choose to protect my psyche, enhance my intelligence, and grow relationships with people I respect and enjoy—in real life and on Facebook. You and your practice can either contribute to the beneficial rich content being shared on social networks (and help social media thrive) or you can contribute to the noise at risk of being shut off. Which will you choose? Are you accidents or are you both consume and post on social media?

Social Media

‘Now more than ever, it’s crucial to watch your content mix’

‘Dr. Timimi has been quoted as saying, “This is not marketing; this is the right thing to do’

About the author

Rita Zamora is an international social media marketing consultant and speaker. She and her team co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email rita@ritazamora.com.
Infection Control Tribune

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The American Dental Association has launched its newly revised ADA Practical Guide to Effective Infection Control DVD and workbook.

The materials are designed to provide guidance to dentists and their staff about infection control and occupational health and safety in the dental office, according to the ADA.

The 40-minute DVD shows easy-to-follow steps to implement infection-control techniques correctly, safely, and efficiently during clinical procedures. The corresponding workbook provides more in-depth coverage of the various topics covered in the program. The workbook’s four sections include the fundamentals of infection control, disinfection and sterilisation, infection control during clinical procedures, and special considerations.

The guide includes the following:

• Safety protocol in the event of a possible exposure to blood borne pathogens
• How to wear and dispose of personal protective equipment, such as gloves, gowns, and masks
• Infection control during radiographic procedures

The workbook and DVD sells for $135 for ADA members and $202.50 for non-members. To order, visit www.adacatalog.org.

R
search presented at ID-Week 2012™ shows that a specific spectrum of ultraviolet light killed certain drug-resistant bacteria on the door handles, bedside tables and other surfaces of hospital rooms, suggesting a possible future weapon in the battle to reduce hospital-associated infections.

Researchers at Duke University Medical Center and the University of North Carolina Hospital System used short-wave ultraviolet radiation (UV-C) to nearly eliminate Acinetobacter, Clostridium difficile or vancomycin-resistant enterococci (VRE) in more than 50 patient rooms at the two medical facilities.

“We’re learning more and more about how much the hospital environment contributes to the spread of these organisms,” said lead researcher Deverick J Anderson, MD, an assistant professor of medicine at Duke and co-director of the Duke Infection Control Outreach Network.

In their study, the Duke and University of North Carolina researchers questioned whether UV-C could be utilised to eliminate three of the most problematic germs and improve the cleanliness of patient rooms.

The study focused on general medical and intensive-care units of the two medical centres and identified patients with infections from the targeted bacteria.

After the patients were discharged, the researchers obtained multiple cultures from each of five specific locations in the hospital rooms and bathrooms - “high-touch” areas that included bed rails, remote controls and toilets. A special machine with eight UV bulbs mounted on a central column was then positioned strategically in each room and turned on for as long as 45 minutes to eradicate both vegetative bacteria and bacterial spores. Fifteen more cultures were taken from the same locations in every room, and the pre- and post-treatment bacteria counts were compared.

The numbers of bacterial CFUs, or colony-forming units, fell precipitously. Fifty-two CFUs of Acinetobacter were seen before irradiation, but only 1 CFU after irradiation - down 98.1 percent. As for VRE, the proportion decrease was nearly the same - 719 CFUs before and 15 after, a 97.9 percent drop.

“We would never propose that UV light be the only form of room cleaning, but in an era of increasing antibiotic resistance, it could become an important addition to hospitals,” Anderson said.

Ultraviolet Light Effective in Hospital Infection Control
Centralisation of dental instrument decontamination?

Andrew Smith gives his take on the suitability of central sterilisation centres for the decontamination of dental instruments.

With the rush to improve instrument decontamination facilities in general dental practice a frequently overlooked option is centralisation by a Sterile Service Department. Consider, by the time a practice has spent time determining throughput capacity calculations for the new washer disinfector and vacuum steriliser, optimising layout, ensuring appropriate water and electricity supply and factoring in the loss of space within the practice premises, it might not seem such a bad idea to let someone else take the strain! In addition there are all the daily, weekly, quarterly and annual tests of the equipment, continual staff training and the ever-increasing pile of record keeping... will you and your practice have the capacity and the willpower to cope?

So, is there another way? In Scotland a third way is in active use in a number of directly managed clinical dental units. Of course these operate under different conditions and patient numbers to many general dental practices but if Tesco and Amazon can deliver to your doorstep why not dental instruments?

A series of papers in the British Dental Journal in the late 1980s discussed the difficulties in the organisation of the surgery working to implement microbiological (and infection prevention) principles. These workers highlighted the nature of dental treatment (aerosol generation), the National Health Service legacy, surgery and equipment design. The second paper from this group highlighted centralising decontamination into a separate room serviced by hatches from the different surgeries. Perhaps the time has now come to consider an extension of this idea whereby the central in centralisation is now the central sterile supply department located locally?

A published report investigating this option is interesting since the practitioners approached with an option...
of participating in the project ‘did not feel that the central supply was feasible given the required turnover of instruments’.

The podiatry service on the other hand were more amenable and ‘...considered daily and weekly checks to be impractical due to lack of staff & time’. The costing involved are quoted in figures from that era and the comments make interesting reading since the initial costing of setting up the centralisation was ‘...offset by greater elapse time available on turnover times and loss of maintenance costs’. There has been no further work published on this topic since, although this was an option investigated in proposals put forward by an early Glennie report. However, at that time it was considered that the Central Sterile Supply service could not cope with the demand of reprocessing all instruments from general dental practice.

With the passing of time and implications of the capital and revenue costs for upgrading local decontamination units it should be noted that there are some working examples of centralisation of dental instrument reprocessing. These have been operational in a number of directly managed dental centres that have had their local decontamination removed and are being serviced by an off-site sterile supply department. In one particular example of an eight-chair dental facility, the instrument turnaround time is 24 hours and the unit has a dedicated storeroom for sterilised instruments and a dedicated room for dirty returns. Feedback from the dental service indicated that no major issues were identified with turnaround times, processing loss or damage to instruments, although the stocks of instruments purchased to accommodate the increased turnaround time were over-estimated by a factor of 3:1. The set-up demanded adoption of a more standardised tray set-up with unusual or rarely used items available as supplemental singly packed instruments.

Of course centralisation of a directly managed unit does not compare with a general dental practice but perhaps the adoption of a different business model whereby a dental practice specifies a tray content (including handpieces) and rents these from the sterile service department. This of course presupposes that a sterile service department in the locality has the capacity and facilities to cope with dental trays and handpieces. However, imagine a practice where instrument decontamination is now the responsibility of a Sterile Service manager and the practice can get on with what it does best and treat patients.

References

Imagine a practice where instrument decontamination is now the responsibility of a Sterile Service manager and the practice can get on with what it does best and treat patients.

About the author
Andrew Smith is Professor of Clinical Bacteriology and Hon Consultant Bacteriologist based at Glasgow University and NHS Glasgow and Clyde where he is the local consultant for Oral Microbiology and Medical Device Decontamination. Professor Smith sits on several local and national committees overseeing medical device decontamination. Research interests include optimising methods for the decontamination of a wide range of medical devices and investigations into microbial virulence factors. His latest projects relevant to vCJD and dementias also include Rosavirus studies support the potential for iatrogenic transmission of variant Creutzfeldt Jacob disease through dental procedures and Dental treatment and variant Creutzfeldt Jacob Disease in Great Britain.
A major three-year trial led by researchers at UCL, in partnership with the Health Protection Agency, has shown that giving one-to-one feedback to healthcare workers makes them twice as likely to clean their hands. The Feedback Intervention Trial (FIT) is the first such trial to be done in a large number of hospitals anywhere in the world. Carried out across 60 wards in 16 hospitals that were already implementing the English and Welsh Cleanyourhands campaign, the study showed that an intervention that coupled feedback to personalised action planning improved hand-hygiene compliance by up to 18 per cent on Intensive Therapy Units (ITUs) and 15 per cent on Acute Care of the Elderly (ACE) wards. It was also found that soap use increased by 50 per cent.

“This is a landmark trial, as until now there has been no randomised controlled trial evidence showing which interventions improve hand hygiene compliance in modern hospitals,” said principal investigator Dr Sheldon Stone (UCL Medical School at the Royal Free Hospital). “It is also the first trial to use behavioural sciences to change health care workers hand hygiene behaviour.”

“The study suggests that the NHS should explore using the FIT intervention and learn how to implement it, as used properly it can be a really powerful tool. The intervention, which couples feedback to personalised action planning, could be included in infection control teams’ audit and appraisal systems in order to reduce the burden of healthcare associated infection on hospital wards.”

The intervention process involved a four-week audit cycle, with healthcare workers observed for 20 minutes. Immediate feedback was given after the period of observation, and the person was then helped to form a personal action plan for better hand hygiene. The effect was stronger on ITUs than ACEs, where it was easier to implement. The more frequently wards carried out the intervention, the stronger its effect.

In addition to observing and measuring hand-hygiene compliance, the amount of soap and alcohol hand-rub used each month was also collected as another measure of hand-hygiene compliance for each ward. This also gave a better picture of the total weekly usage, as such data was not subject to any observational bias.

“Although audit and feedback is often suggested as a way of improving hand hygiene, this study puts its use on a firmer footing than previous non-randomised studies, providing the strongest evidence yet that this is an effective way to improve hand hygiene when coupled with a repeating cycle of personalised goal-setting and action planning,” said Dr Stone.
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The antimicrobial stewardship programme

Why is it important in dentistry? asks Andrew Smith and Noha Seoudi

The antimicrobial stewardship is a cornerstone of infection control in any healthcare setting. Its judicious use can significantly reduce the incidence of Clostridium difficile infection through optimising antimicrobial prescription along with implementing good infection prevention measures in hospitals and primary care (Nashwani et al., 2011).

The importance of the programme became fundamental in an era of widespread nosocomial and community-acquired infections such as methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Staphylococcus aureus (VRSA), vancomycin-resistant Enterococcus (VRE), Pseudomonas aeruginosa, Acinetobacter spp., extended spectrum beta lactamase producing Enterobacteriaceae and Stenotrophomonas maltophilia. With the increasing risk of encountering these multi-resistant microorganisms in the dental practice, we believe that the dental team members have a duty of care toward their patients and the community to avoid establishment and dissemination of such infections (O’Leary et al., 2011). Therefore, they should be trained on the appropriate use of antimicrobial agents for prophylactic and therapeutic purposes.

There is a consensus between the guidelines of the American Heart Association (AHA, 2007) and the National Institute for Clinical Excellence (NICE, 2008) that the benefit of endocarditis prophylaxis for dental treatment is unproven. Therefore, NICE recommended no antibiotic cover for any patient receiving dental treatment. However, the AHA recommended antimicrobial cover only to those patients who are classified as “at risk” of infective endocarditis. In- testament to their patients and the community, believing that the dental team members have a duty of care toward their patients and the community to avoid establishment and dissemination of such infections (O’Leary et al., 2011). Therefore, they should be trained on the appropriate use of antimicrobial agent for prophylactic and therapeutic purposes.

There is a consensus between the guidelines of the American Heart Association (AHA, 2007) and the National Institute for Clinical Excellence (NICE, 2008) that the benefit of endocarditis prophylaxis for dental treatment is unproven. Therefore, NICE recommended no antibiotic cover for any patient receiving dental treatment. However, the AHA recommended antimicrobial cover only to those patients who are classified as “at risk” of infective endocarditis. Interestingly, Thornhill and colleagues (2011) excluded any significant increase in the incidence of infective endocarditis and its complications following the implementation of NICE guidelines in the hospital of England despite...
a 78.6 per cent reduction in antibiotic prophylaxis prescription (Thornhill et al., 2011).

Palmer and colleagues (2000) observed many inappropriate doses and frequencies of antimicrobial prescription, falling outside the guidance of the Dental Practitioners Formulary (DPF), when they evaluated the antibiotic prescription pattern by general dental practitioners from ten different health authorities in England (Palmer et al., 2000). As a general rule, the majority of dento-alveolar abscesses respond well to incision and drainage without the need for antimicrobial treatment apart from cases with evidence of spread of infection or systemic involvement such as lymphadenopathy and/or raised body temperature. The prophylactic antimicrobial therapy before wisdom teeth extraction and implant surgery is not currently recommended, provided that good surgical and aseptic techniques are maintained (Martin 2010).

We believe that, implementing prescription audits and feedback is one of the most successful strategies for the antimicrobial stewardship programme which can be easily implemented in the dental practice. Also the Department of health approach “start smart and focus” can be adopted in the dental practice. This concept advise to “start smart” by avoiding any antimicrobial prescription in the absence of clinical evidence of bacterial infection, use the available guidelines to initiate a prompt effective antimicrobial treatment if justified, document any antimicrobial usage, obtain culture before the initiation of antimicrobial therapy, prescribe single dose only of antimicrobials for surgery prophylaxis if justified. The following step is to “focus” which means to review the diagnosis and the continuing need for antimicrobial treatment after 48 hours of prescription, make clear plan of actions “antimicrobial prescribing decision”, and document the decision (ARHAI, 2011).

References:

The prophylactic antimicrobial therapy before wisdom teeth extraction and implant surgery is not currently recommended, provided that good surgical and aseptic techniques are maintained.

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Superbugs ride air currents around hospital wards

Hospital superbugs can float on air currents and contaminate surfaces far from infected patients’ beds, according to University of Leeds researchers. The results of the study, which was funded by the Engineering and Physical Sciences Research Council (EPSRC), may explain why, despite strict cleaning regimes and hygiene controls, some hospitals still struggle to prevent bacteria moving from patient to patient.

It is already recognised that hospital superbugs, such as MRSA and C-difficile, can be spread through contact. Patients, visitors or even hospital staff can inadvertently touch surfaces contaminated with bacteria and then pass the infection on to others, resulting in a great stress in hospitals on keeping hands and surfaces clean.

But the University of Leeds research showed that coughing, sneezing or shaking the bedsheets can send superbugs into flight, allowing them to contaminate recently-cleaned surfaces.

PhD student Marco-Felipe King used a biological aerosol chamber, one of a handful in the world, to replicate conditions in one- and two-bedded hospital rooms. He released tiny aerosol droplets containing Staphylococcus aureus, a bacteria related to MRSA, from a heated mannequin simulating the heat emitted by a human body. He placed open Petri dishes where other patients’ beds, bedside tables, chairs and washbasins might be and then checked where the bacteria landed and grew.

The results confirmed that contamination can spread to surfaces across a ward. “The level of contamination immediately around the patient’s bed was high but you would expect that. Hospitals keep beds clean and disinfect the tables and surfaces next to beds,” said Dr Cath Noakes, from the University’s School of Civil Engineering, who supervised the work. “However, we also captured significant quantities of bacteria right across the room, up to 3.5 metres away and especially along the route of the airflows in the room.”

“We now need to find out whether this airborne dispersion is an important route of spreading infection,” added co-supervisor Dr Andy Sleigh.

The researchers are hoping that computer modelling will help them determine the risk. The findings have been compared to airflow simulations of the mock-up hospital rooms and the research team have shown that they are able to accurately predict how airborne particles can be deposited on surfaces.

The international design and engineering firm Arup, which designs hospitals, part sponsored the study, Phil Nedin, director and global healthcare business leader at Arup, said: “We are looking at healthcare facilities of the future and it is important that we look at key issues such as infection control. Being involved in microbiological studies that inform airflow modelling in potentially infectious environments allows us to get a clear understanding of the risks in these particular environments.”

The paper “Bioaerosol Deposition in Single and Two-Bed Hospital Rooms: A Numerical and Experimental Study” is published in the journal Building and Environment.
Latest thinking in risk management
Shaun Howe reviews this year’s Dental Protection Premier Symposium

I consider myself very lucky to receive an invite to Dental Protection’s Premier Symposium most years. This outstanding event takes place around late November, early December each year and brings together some of the latest thinking in risk management as well as supporting the work of dental professionals in practice and research by offering the Premier Awards which encourages the improvement of patient care in six key areas: ethics and professionalism, record keeping, infection control, team working and skill mix, consent and communication and health and safety.

The line-up is invariably impressive and this year again provided great education, reasons why we should reflect and also extremely entertaining. Whilst there is an obvious emphasis on risk management this is not the whole beast and as the variety of speakers showed, it had something for all the team to learn.

Professor Trevor Burke gave a presentation titled “Fools rush in...”; the main thrust of his discussion was regarding the evidence base that is sometimes used to support the use of various materials as well as the longevity of restorations. He cleverly used several blank slides during his presentation to demonstrate the lack of evidence for certain materials; this man is so engaging and as the talk progressed he used numerous versions of the song “fools rush in” to highlight aspects of his presentation.

A tough act to follow but Dr Lloyd Searson of Kings College certainly rose to the occasion with his presentation “...where angels fear to tread” where he discussed how poor planning of implants, their placement and selection criteria, can lead to future problems and he stated “poor planning today will lead to problems tomorrow”. A really interesting lecture that examined the evidence around why implants fail and also discussed the pitfalls for practitioners placing implants in the aesthetic zone which can produce its own set of complex issues. This was all combined with an examination of the levels of training that some feel adequate to place implants against perhaps more conventional accepted standards.

“When good enough” was not just good enough was presented by Dr Jason Leitch who is the Clinical Director of the Quality Unit in the Health and Social Care Directorate NHS Scotland. I have met this enigmatic gentleman on a few occasions and it is always a pleasure to hear him talk. He realised that the inequalities of healthcare standards in his native Scotland were outrageous and twisted as parts of Glasgow would have a very low life expectancy compared to other more affluent areas where there may be as much as a 15 years difference. But it was/is not as simple as that; he highlighted how that by applying set standards regardless of location that the patient journey is improved as well as the outcomes. This is however compounded by the lack of available funding due to these constrained times we are experiencing. Informative, clever and witty and he was quite kind to those who examined the evidence for certain materials yet examined the weak evidence base that is sometimes used to support the use of various materials as well as the longevity of restorations. He cleverly used several blank slides during his presentation to demonstrate the lack of evidence for certain materials; this man is so engaging and as the talk progressed he used numerous versions of the song “fools rush in” to highlight aspects of his presentation.

To finish the day we were treated to some new core CPD by Professor Mark McGurk who examined “Medical Risks in a complex world”. The first part concentrated on looking at and identifying lesions in and around the oral cavity and he also demonstrated that our inability to receive and full social and medical history from our patients is letting us and patients down. The simple act of ticking boxes has taken us away from really “drilling down” with our patients to examine those risk factors that we should really be paying attention to especially when our patients have a history of smoking, alcohol use and long-standing very complex medical histories. He also highlighted the very new risks presented to us by new medications that we as practitioners may not be paying enough attention too.

A thoroughly entertaining day which any team could have attended; you should perhaps consider it next year and I hope I get invited again.

About the author
Shaun trained and qualified in the Royal Army Dental Corps in 1993. He works in the NHS and privately full time in Derbyshire and Nottinghamshire. He sits on the GDC Fitness to Practise Panel from 2005-2006 at which time he became one of three DCP Local Advisers in Dental Practice. Shaun is currently the Membership Leader for Philips Sonicare and is currently training in Membership to become part of their Transitional Support Programme. Shaun has a keen interest in Clinical Governance and is an FGDP trained practice appraiser. He currently sits on the Editorial Board of DENTALTRADE and Dental Tribune and contributes to these. He has spoken widely in groups all around the UK drawing on his experiences in the RAF and his work with Dental Protection.

By Shaun Howe
What’s the worst that can happen?
Michael Sultan discusses treatment planning

When I was young, my mother – bless 'er – always used to say to me, “Michael, you should always ask a girl to dance – after all, what’s the worst that can happen? She can only say no!”

Oh how wrong she was… Children can be very cruel sometimes, and as a shy young man growing up into the world I learnt, as I suspect many of us have over the years, that my mother was wrong, and her philosophy of always asking a girl to dance would on occasion lead to my complete and utter humiliation.

Advice But now, many years later, in my work as a dentist I do still find myself thinking about my mother’s advice, and that age-old phrase, “what’s the worst that can happen?” Though obviously used in a completely different context, I do find it an interesting phrase, and one that particularly applies to the process of treatment planning.

As dentists, sometimes we are involved in doing a treatment that if it fails could have a worse outcome than the second option that may be less desirable for the patient, but safer. Unfortunately, we can’t always avoid it. It may be the case for example that the patient can’t afford to pay for a replacement, or health and age factors mean they are unsuitable for alternative procedures. In some cases it may even be something as simple as the patient is adamant they don’t want to lose their tooth.

In endodontics I can think of numerous instances where a patient’s call for a “heroic” procedure can sometimes lead to the result being far worse than the initial complaint. If it works, then great – amazing – you’ve saved a tooth that most dentists would have signed to extraction. If it fails, however, then even extraction may have been a better option long term.

A good example of just this type of risky procedure might be apical surgery on a tooth with both an uncertain prognosis and a failing endodontic procedure. The surgery may involve removing a lot of buccal bone that may make an implant harder to do later should there be no healing.

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extensive and expensive treatment, such as resecting roots and teeth from larger bridges to keep the restoration going for longer in an elderly patient. Often we know that it’s a compromise – it’s fairly obvious what we’re waiting for! With an aging population and life expectancy ever-increasing, compromises that we may have once made in a 65 year old we may now have to make in an 85 year old instead.

With patients on average living a lot longer than in the past, I do find myself increasingly dealing with patients in their 70s who ask me if it’s worthwhile spending money on a complex and risky endodontic procedure when it may be cheaper and easier just to have the tooth out instead.

This poses something of a dilemma. If the patient were in their 50s say, you could outline with some degree of certainty the advantages and disadvantages of having a fully restored natural tooth for the next 20 years, as compared with a large gap. To have this discussion with a 70-year-old however, it may be a case that they will have a gap for a few more years, or they may yet live another 50 or more! The oldest patient I’ve treated for root canal therapy is 100 and she certainly didn’t want her tooth out!

Genetics
This then brings me on to the question of genetics. Before attempting herodontics to try and salvage a dodgy tooth, maybe we should ask the patient questions about their family background. Are their parents still alive? How old were their parents when they passed away? Though somewhat morbid, these sorts of questions may well help to gain a rough idea of life expectancy and whether to go for a compromise now and regret it later (in say 10 years’ time when the patient really is elderly), or to bite the bullet and do definitive treatment whilst the patient is fit enough to manage long periods in the chair but also to heal clinically.

When heroic procedures work, they can be fantastic; they can give a great feeling of satisfaction to the clinician and of course the patient benefits by retaining their tooth. But these things must be taken in careful consideration. Heroic procedures “beyond the normal call of duty” don’t always work, and if they fail, then sometimes the outcome will be worse than the initial complaint. For this reason we should always carefully weight up the risks, consider all the possible implications, and ask ourselves, very seriously, “what’s the worst that can happen?”

About the author
Dr Michael Sultan BDS MSc DFO FICD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CDP, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practices. For further information please call EndoCare on 020 7224 0999. Or visit www.endocare.co.uk

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Complete the Jigsaw pt 2

Michael McCallion of FT&A Medical Recruitment offers practices and principals some useful advice to find that right member of staff...

You’ve bought the practice of your dreams. You have invested a considerable amount of time, effort and money into kicking it out to your exact specification. You almost have the team of your dreams to go with, but not quite. There is that one key position that still needs to be filled. Whether it be associate, hygienist, practice manager or nurse, it can be difficult to find that perfect person to be that final piece. What advice can we give to make the process run more smoothly?

• Sit down and plan exactly what and who you want. I wouldn’t be telling tales too much if I told you that a large number of principals come to us who haven’t really thought the role through or who the ideal applicant would be. Be honest and open about this – it will save a lot of time and trouble in the long-run.

Pay peanuts, get monkeys

• Salary. If you pay peanuts, you will get monkeys. Have a realistic expectation of what the role is worth. You cannot expect staff to buy into your practice vision and go the extra mile if you do not reward them accordingly.

Specification

• Prepare a full job specification. Leading on from the last point, you need to consider:
  - Duties and responsibilities of the role
  - Pay and Conditions
  - Temporary, Permanent or Locum?
  - Start Date
  - Staff Benefits
  - Contract and Terms
  - Probationary period

• What form will the interview process and procedure take? The days of an informal chat in the saloon bar of the Dog & Duck have gone! Do not be afraid to go to multiple interviews. If you are still not sure then don’t feel that you have to make a decision. Take a step back and ask yourself why you are unsure?

The headline of the process. When choosing an agency make sure that:

- Their fees are open and transparent
- They are experienced with a high profile in dentistry
- They are experts within the sector
- Their approach to candidate selection is rigorous
- They are members of the Recruitment and Employment Confederation
- Having chosen your agency, ensure that you talk to them.

About the author

Michael McCallion in Business Development Manager of FT&A Medical Recruitment. Michael has huge experience in healthcare recruitment having worked in the sector for over 7 years, initially helping provide the right medical and dental staff to the MoD and the NHS. He then worked as Business Development Manager for an agency that supplied the private as well as the public sector.

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FT&A Medical Recruitment

You cannot expect staff to buy into your practice vision and go the extra mile if you do not reward them accordingly!
Setting Up On Your Own

Andrew Lockharts-Mirams and Puja Patel look at Corporate Business Structures

Last month, we looked at the types of unincorporated business structures that a dentist can opt for when setting up a new practice. This month, we will focus on corporate business structures.

One of the hot topics at the moment is incorporation. Traditionally, dental practices have operated as sole practitioners, principals or partnerships; however, the tax benefits available through incorporation are tempting increasing numbers of dentists to give their business a legal personality of its own.

Specialist dental accountants have estimated that a typical dental practice a practitioner could save considerable sums annually by incorporating. The savings are achieved by reducing or eliminating the amount of tax paid at 40 per cent and reducing the national insurance liability. There may be some additional administrative costs associated with operating as a company but these are likely to be minimal compared to the level of savings that may be achievable. We certainly recommend that specialist dental accountant advice is obtained from a member of National Association of Specialist Dental Accountants and Lawyers (‘NASDAL’) about the financial implications of incorporation in relation to your own practice before making any decisions.

Quite apart from the potential savings, there are other benefits that can arise on incorporation, particularly with regard to the limitation of liability and the ability of companies to transfer their business by means of share transfers. As a sole practitioner or partner, while the majority of the practice’s liabilities are likely to be covered by insurance, if things do go wrong, a dentist could suffer huge personal losses.

Where there is a company structure, the company is a legal person in its own right and bears the liability itself. Shareholders are only liable for the fixed amount expected to be paid for their shares when they become shareholders (in most cases this amount will have been paid on subscription) if the company goes under. Note, however, for new companies or those with minimal capital, banks and land-
About the author

Andrew Lockhart-Mirams is the Senior Partner of Lockharts Solicitors and leads the Commercial Team primarily specialising in business advice and structures in dentistry and commercial aspects of dentistry.

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

Practice Management

lords may still seek personal guarantees from the directors.

Whereas a partnership business is owned and managed by the partners themselves, with a company there is an important legal distinction between the shareholders as owners and the directors who are responsible for running the company. In a small dental practice, the shareholders and directors are likely to be the same people but it is nonetheless important to maintain the distinction between the two roles. Some issues, as a matter of law, can only be decided by the shareholders.

Directors’ duties are heavily regulated. For example, a director has a statutory duty to promote the success of the company, to exercise independent judgment, to exercise reasonable care, skill and diligence in performing his duties and to avoid situations in which he might have an interest that conflicts with the interests of the company. Although the liability of members is limited, directors could be personally liable if they breach certain duties (for example, if they allow the company to trade while insolvent).

Note also that a dental body corporate under the Dentists Act 1984 must have a majority of directors who are dentists or dental care professionals.

However, if you are looking to provide NHS services at the practice, incorporation of an NHS practice is not without obstacles. The following should be borne in mind.

- PCT consent – Whilst PDS practices will be familiar with obtaining PCT consent for any contractor changes, GDS contractors have the freedom of utilising a partnership mechanism to buy and sell the practice. Generally, incorporation would provide some flexibility over the sale of the practice (through sale of shares) but some PCT’s may request the insertion of ‘change of control’ provisions in the NHS contract, or seek to reduce the contract value, which may hinder or prevent the future sale of the practice and thus the subsequent realisation of goodwill.

- PDS contractors should also note that unlike GDS, the NHS Act 2006 limits the type of shareholder who may hold shares in the company. These limitations effectively require all of the shareholders to be individuals eligible to hold a PDS Agreement in their own right. However, it is worth noting that the class of individuals who can hold a PDS Agreement is broader than with GDS and includes employees of NHS practices.

Understanding incorporation and its suitability for your business are important initial considerations and we recommend that you obtain specialist legal and accounting advice before making any decisions.

Next month: Financing the Practice and Choosing the Right Location and Premises.

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**DENTAL TRIBUNE** United Kingdom Edition • November 26 - December 3, 2012

**30 Industry News**

**Smart Christmas Offer**

Now’s a great time to get your patients motivated by investing in the Oral-B Tri-Brush with SmartGuide.

What better way to start Christmas than by getting your patients motivated to buy Oral-B products?

**Dental Sky**

Dental Sky hold a funding day on 27th September for Dentaid Uganda project. With the assistance of their customers, the sales team were able to raise money by holding one of their famous Vendour Day events. Customers were offered amazing deals on Dental Sky’s own brand products; M.E & Modabo, Cleys and Dento Vatios, and Carlos Sutfelt, the General Manager, made a pledge that ten per cent of the promotions proceeds would go directly to Dentaid to assist with their work in the rural villages of Uganda.

Andy Jong, Dentaid’s CEO, commented “Dental Sky has certainly reached for the sky on behalf of Dentaid, raising a fantastic £2015 total from their Dentaid Vendour Day. Our thanks go to them and their customers: this gift will make a life enhancing contribution to our oral health projects in Uganda, chosen by the Dental Sky team to be the recipients of their support.”

**A Fragrance to suit your mood**

PracticalCare® 100 surface disinfectant gels are now available in 4 fragrances. Natural, flower, fruit and lemon.

A fragrance to suit your mood. Buy 200 gels before the end of November for only £2.59 + VAT (100 gels for 50 pence). PracticalCare® 100 Economy vials should be used with confidence to decontaminate non-sensitive surfaces and equipment in treatment areas and decontamination rooms. Surfaces to be decontaminated and areas to be left sterile should be free of debris and not have a layer of dust or debris on top which could contaminate the area.

**Pouch Sealing machine that seals pouches on a roll.**

Pouch sealing machines have been the norm for several years in the UK. However there is a more economical choice available, which comes in rolls. Bandied “Zeta Roll”, these pouches-on-roll will come in different sizes and are proven to stay sterile for a longer period than traditional pouches. You can cut and weld them to the exact size you need by using a pouch-sealing machine. Zhermack are running an offer of buy the machine (ZEBO) and get 4 rolls of pouches (£2 medium sizes 75mm x 200mm, 2 large sizes 100mm x 200mm, worth £91).

**Seeing is Believing**

The new LED operating light from Takara Belmont provides excellent light output over their projected lifetime, which is a staggering 40,000 hours or around 25 years for the average user. The ten shaodless-beams emit excellent light colour immediately making it ideal for colour matching as well as reducing eye fatigue. As individual requirements and preferences vary the light can also be adjusted between 4000K and 5000K.

Environmental considerations come first, and the LED emulates less heat and consumes less power, offering an estimated 80% power saving over a traditional halogen bulb. Cross infection matters have also been covered; the unit has a touchless sensor to turn the light on/off as well as allowing the user to switch to a compatible mode setting so you can work unattended without having to worry about the increase in energy consumption. As the 10 LED lights are spaced in a one-piece cover there’s no risk of dust or mist build-up and the unit is easily cleaned.

The 1000 Series is available in an either a unit, ceiling or track mounted option. Having developed operating lights for over 40 years the company is confident in the quality of their equipment and therefore all units carry a 5 year warranty. For more information call 020 7715 0333.

**It Doesn’t Have To Be A Rich-Handed World**

Patients won’t need any assistance navigating their way into the new Compass Treatment Centre from Takara Belmont; with a delivery unit that can rotate either ‘A’ air or ‘E’ electric specification and can be ordered with or without the hand piece cycle!

The Compass also benefits from Takara Belmont’s free 5 year extended warranty, but the practice will still need a vacuum autoclave in order to sterilize pouched instruments.

Flexible options are also available on the Compass, it can be supplied as either ‘A’ air or ‘E’ electric specification and can be ordered with or without the hand piece.

The Compass also benefits from Takara Belmont’s 5 year extended warranty, offering additional peace of mind when purchasing capital equipment.

To find out more about the Compass Treatment Centre from Takara Belmont please call, without obligation, 020 7715 0333.

**It’s more than just a toothbrush**

Oral-B toothbrushes have been the favourite of UK dentists themselves than any other brand. And it’s not just your patients who can save this Christmas. If you haven’t already tried the top of the range Triumph 5,000 you can purchase a sample pack for just £3.85, and experience why they’re universally acclaimed and are used by more UK dentists themselves than any other brand.

For more information contact your local representative or dental dealer. The Christmas pack will be available until the end of December and is available from CTS (0173 776 5400), DBS (0845 6011006), Dental Directory (01276 391 101 and more) and www.dentaldirectory.co.uk.

**Prestige Medical announces even faster cycles on Optima!**

The popular Optima autoclave is currently capable of processing up to four times as many instruments as other leading autoclaves on the 200mm wide x 200mm deep tray. Optima is a major jump forward in performance compared with other instruments as it is considerably quicker than current models.

The Curaprox UK stand was a hot spot for its top quality and great offers on Curaprox products and latest innovations, as well as “Curapex AD®”. The Chlorohyde range of products, with a unique non-staining formula, includes alcohol-free mouthwash and SLS-free toothpaste and gel.

- Hydrosonic Electric Toothbrush: provides a market-leading 42,000 waves per minute for a brilliant and easy clean.
- CPS Prime interdental brushes: fast to the fore with any other interdental brush on the market.
- Profi pro cleaning tool: determines the ideal interdental brush size for your patients.
- IAC personalised prescription: interdental recommendations for patients to keep and refer to.

Helping patients of all ages and backgrounds to achieve a healthy smile, dental professionals can rely on products developed by Curaprox UK. For more information please call 01480 862084, e-mail info@curaprox.co.uk or visit www.curaprox.co.uk.

**Web:**

**Zhermack – UK Tel. 07870 6908911**

**Email:** grahambrown@zhermack.com  
Web: zhermack.com

**Biodental Laboratories demonstrate innovative cleaning products at the BDSHT**

This year’s BDSHT conference was another great success. Among the most popular stands on the exhibition floor was BTL, where the new WhiteWash Laboratories range of products gave regular talks on their range of innovative tooth cleaning products. WhiteWash Laboratories’ Whitening Strips Use a patented slow-release formula that is specifically designed to meet sensitivity while also delivering the exact amount of mint flavoured whitening gel to evenly and effectively whiten teeth. Not only are they combi-dose tabs, but they are also completely safe as per new European legislation, and can be taken away by patients on the very same day. As well as Professional Whitening Strips, the WhiteWash Laboratories team also demonstrated their Nano Silver Whitening Toothbrushes and Professional Whitening Toothpaste with Silver Technology – both of which make perfect partner products to enhance your practice’s income streams.

For more information call 0944 68 69 150, e-mail info@thewhiteswashlaboratories.com, or visit www.thewhiteswashlaboratories.com

**Prestige Medical announces even faster cycles on Optima!**

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Helping patients of all ages and backgrounds to achieve a healthy smile, dental professionals can rely on products developed by Curaprox UK. For more information please call 01480 862084, e-mail info@curaprox.co.uk or visit www.curaprox.co.uk.

**So, let Plandent take care of your infection and Freecall 0500 500 322 today.**

Plandent supply all of your disinfectants from a choice of manufacturers including Zhermack, ChairSafe, Curaprox and SteriPack. Types of disinfectant include: 2% glutaraldehyde, 70% ethanol, 3% glutaraldehyde, 2% peracetic acid, 2% peracetic acid (4% peracetic acid), 2% thymol, 0.5% chlorhexidine and 0.5% chlorhexidine.

**For information on the full range of Kemdent disinfectants, ChairSafe, Curaprox and Steripack visit the Kemdent website www.kemdent.co.uk. For further information on special offers or to place orders call Helen on 01733 772256 or visit our website www.kemdent.co.uk.

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Aesthetics risk assessments: an obligation for businesses

Under the Control of Asbestos regulations 2012, business owners have clear responsibilities for dealing with the material, which is linked to several types of cancer and other illnesses. Anybody holding an obligation to repair or maintain a non-domestic property, or controlling access to a building, has a duty to ensure an assessment is carried out to predict if asbestos is likely to be present.

This applies to all properties. Even an assessment reporting that a building was constructed after the asbestos ban and therefore the material is not present must be undertaken. Further advice must be taken to determine the risk posed, identify which parts of the property are affected and list the measures to be taken. These should monitor the condition of the asbestos, ensure it is properly maintained or safely removed, and make its location known to any person likely to disturb the material. The emergency services should also be aware of its location.

Goodman Legal, Lawyers for Dentists, has many years’ experience in providing legal services to dentists setting up their own practices. Ray Goodman is the Chairman of NASDAL, a lawyer group and a member of ASDF.

For more information call Ray Goodman on 0113 797 6000 or email ray@goodmanlegal.co.uk or visit www.goodmanlegal.co.uk

End of an era draws near for historic dental practices

Growing legislative pressure will soon see an end to period houses being used as dental practices, predicts Roger Gullidge of Roger Gullidge Design.

The demands of legislation including HTM 01-05 and the Disability Discrimination Act are incompatible with the challenges of seeking Listed Building Consent, Conservation Area Consent and Planning Permission, he says.

‘If you apply for Listed Building Consent to divide up rooms in a classic Georgian or Victorian Terrace to fit in a Local Demolition Unit, you are not likely to succeed says Roger. The whole process becomes unviable and you will essentially be compelled to move. The ability to extend and modify newer buildings, and the reduced complexity involved in connecting them to modern communications networks, makes them far more practical locations for dental practices. The wider availability of parking spaces and improved disabled access can also make them more appealing to patients.

Roger Gullidge Design is a specialist design and project management consultancy specialising in the dental sector. Call 01278 794442 or for more details visit www.rogergullidge.com

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Finally Sider will undertake a complete Project Management Service, including installation and post installation service support, to enable these dreams to become reality.

For further information call Sider Dental Systems on 01952 582900 or email johnc@ sider.co.uk

Nobel Biocare: ‘take your business forward’

Dr Joe Bhat is a Specialist in Prosthodontics and Oral Surgery and a Fellow of the International Team for Implantology (ITI). He is principal dentist at Moor Park Specialist Dental Centre in Midhurst and a client of Nobel Biocare.

‘Nobel Biocare is big enough to handle the requirements of any size practice, whatever the level,’ says Dr Bhat. ‘They have a wide spectrum of protocols that allows them to look after clinicians who have done thousands of implants to people who have just started. This makes everything achievable for your practice.

‘Nobel Biocare have the expertise of a company that implicitly understands the product and offers clinical guidance as a matter of course.’

For more information on Nobel Biocare please call 0208 756 3300, or visit www.nobelbiocare.com

Straight and contra-angle handpieces portfolio is now complete – Sirona launches the economy-class T3

Compact and robust: The high-quality T3 handpieces create a cost-effective workflow.

Continuing success story: The new T3 models are the perfect complement to the Sirona product portfolio.

“With the T3 we have extended our handpiece portfolio in terms of breadth and depth,” explains Frank Paech, Product Manager at Sirona. “Regardless of the concept a dentist opts for in his or her practice, we are now positioned to supply the right handpiece. Following the introduction of the T3 alongside the existing T1 and T2 models our portfolio of straight and contra-angle handpieces is now complete.”

Sirona’s outstanding technical know-how manifests itself in the economy-class T3 handpieces.

The T3 Economy instruments from Sirona are of the highest quality and pay for themselves time and time again. With the ISO interface, this robust range of instruments is compatible with all current micromotors and is therefore absolutely universal.

Contact us for further information: Sirona Dental Systems 0845 871 5480 (www.sironadal.co.uk)

Spry Toothgel with xylitol – the perfect way to keep childhood caries at bay

We all know it’s important parents introduce their children to good oral hygiene and comes from one of the earliest age.

To help give children the best start possible, recommend Spry Toothgel with xylitol for the perfect way to keep dental caries at bay.

Xylitol is a naturally occurring sweetener that is proven to be a powerful tool in the fight against tooth decay. Thanks to its unique chemical composition, xylitol is unfermentable by the bacteria that cause caries, reducing their ability to proliferate and adhere. This makes xylitol an excellent tool in the fight against tooth decay. Thanks to its unique chemical composition, xylitol is unfermentable by the bacteria that cause caries, reducing their ability to proliferate and adhere. This makes xylitol an excellent tool in the fight against tooth decay.

Available in a handy 60ml tube, Spry Toothgel is a great way to introduce children to one good oral hygiene habit from an early age. To help give children the best start possible, recommend Spry Toothgel with xylitol for the perfect way to keep dental caries at bay.

Based on all natural ingredients, Spry Toothgel is completely safe for infants and toddlers – great for the value conscious family who want to make teeth cleaning even more fun.

For further information contact Anyone 4 Tea Ltd on 01428 652131, or visit www.anyone4tea.com

Waterpik® Complete Care – more effective brushing and flossing in one device

The first part of Waterpik® Complete Care comprises the brand new Sensonic® Professional Plus handpiece, incorporating high performance sonic technology for more effective cleaning. Featuring T3 handpieces, the Waterpik® Water Flosser cleans the deep between teeth and below the gumline, removing harmful bacteria that traditional flossing can’t reach. Indeed the product is so effective, the Waterpik® Water Flosser has been scientifically proven to remove 99.9% of plaque biofilm after only a 3-second treatment. For complete convenience in a streamlined, single unit, Waterpik® Complete Care offers easy and more effective brushing and flossing, all in one device.

For more information please speak to your wholesaler or visit www.waterpik.co.uk Waterpik® products are widely available in Boots stores, Argos and selected Holland & Barrett.

For further information or details on all Waterpik® products please visit www.waterpik.co.uk

New Apex Locator from Qudent

Qudent have introduced a new apex locator to their range. The new Wopex™ Apex Locator is a truly unique, highly precise measuring device for accurately locating the working length of the root canal.

The Wopex™ features a clear colour LCD screen of featuring a 0.01mm and audible signals. The measurement is not affected by the environment e.g. wet or dry canals, which is a real benefit to the user.

The unit comes complete with two lip hooks, four m Burr holders and is competitively priced at £298 + VAT

For more information please contact Qudent on 01903 211737, or email enquiries@qudent.co.uk

INDUSTRY NEWS 29

November 26 - December 5, 2012

DENTAL TRIBUNE United Kingdom Edition

Everyone Benefits with the Inman Aligner

The Inman Aligner uses gently opposing forces to straighten anterior teeth safely and quickly Training courses for the appliance enable practitioners to familiarize themselves with angling and online support formats are on-going help and advice through complex cases.

Dr Talbot finds the principal benefit of the Inman Aligner

“I first heard about the training course through one of the Inman Aligner instructors,” he says. “I decided to attend as I knew the benefit it could have on my patients due to the speed and convenience of the appliance, as well as the benefit to my practice as an additional service.

“The format of the course was well laid out, the hands on elements helped me to understand the theory, and the speakers presented really well.

“I would certainly recommend the course. It is a great practice builder as the patients love the speed of the appliance and they tell everyone about it!”

For more information on the Inman Aligner training courses, please visit www.anyone4tea.com or phone 0845 366 5477

Or visit

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For full details, course dates and venues contact Penny Parry on: 020 8255 2070 penny@umdprofessional.co.uk

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\(^{*}\) Based on \% hydraulic conductance reduction