Dwindling patients access NHS dentistry

Fewer people are now seeing an NHS dentist than they were before the new dental contract was introduced in 2006, according to official figures.

More than 27 million people visited their dentist in England in the two-year period ending December 2008, representing 53.4 per cent of the population.

But the figure was 900,000 less than the number seeing dentists before the new dental contracts were introduced in April 2006.

Findings from the NHS Information Centre revealed that 27.5m people saw a dentist in the two-year period ending in December 2008, a rise of 500,000 from the figure three months earlier in September 2008.

But the number of patients seen was still 5.1 per cent less than the figure in the two-year period ending 51 March 2008, when 28.1m patients were seen, immediately before the new dental contracts were introduced.


This represented a 1.1 per cent increase on the previous period ending in September 2008 but a 3.4 per cent decrease on the numbers of adults seeing a dentist in the two-year period before the introduction of the new dental contract.

The amount of children visiting dentists was also down by 200,000 (2.4 per cent) on the pre-contract figures.

John Milne, chair of the British Dental Association’s General Dental Practice Committee, praised the improvement in access during 2008 and said: ‘Although these figures mean that there are still many people who wish to access a dentist but cannot do so, the increased number of people who can is good news.’

He added however ‘as well as maintaining this improvement, it is also important that the Department of Health gets to grips with the problems facing dentists as they seek to provide care and work with them to embrace Lord Darzi’s vision and help them to deliver high quality care.’

The conclusions of the current inquiry into dental services being led by Professor Jimmy Steele, which are expected in the summer, will need to be the subject of consultation with the profession and any reforms arising from them will need to be properly piloted before they are implemented.

Chief Dental Officer, Barry Cockcroft, acknowledged the confidence that the NHS will continue to build upon this improvement and said: ‘Today’s data shows that over the last two quarters of 2008, the number of patients accessing an NHS dentist in a two-year period increased by nearly 540,000’.

‘Today’s data shows that over the last two quarters of 2008, the number of patients accessing an NHS dentist in a two year period increased by nearly 540,000’

We want to ensure that every person who wants to access an NHS dentist is able to do so and have invested a record £2bn in dentistry and set up a national access programme to help the NHS deliver this. The tide is turning and we are now seeing access to NHS dentistry starting to increase.1

He added that in 2007/08 there were 655 more NHS dentists than the year before, and with 25 per cent more students each year since 2001, there will be more to come in the future.2
Swine flu dentistry link

Bad dental hygiene could increase the risk of swine flu, according to the British Dental Health Foundation.

The National Dental Survey carried out by the British Dental Health Foundation as part of National Smile Month found that dreadful dental habits are helping spread germs as 40 per cent of the UK population admit to picking their teeth with their fingernails.

The survey found that people are also picking their teeth with everyday items such as earrings, credit cards, paperclips, paper and even screwdrivers.

Foundation chief executive Dr Nigel Carter said: ‘Hygiene warnings have been made consistently for decades but few people take action to change their habits.

We need to ensure that dentists can provide treatment a real priority because we urgently need to improve our nation’s dental health.’

The Conservatives have outlined in a document titled ‘Health and patients’ safety: a way forward’ for the current GP contract.

Conservatives said they would bring back registration so den- sities either do not seem to exist or, if they do, don’t bother to take appropriate steps to do something.

The full guidance can be found on the Department of Health website at www.dh.gov.uk

All patients should be screened for symptoms of flu before attending the practice by telephone and again on arrival at the practice, said the DH.

Tories unveil new dentistry reforms

by giving dentists the power to charge them for failing to turn up.

Shadow health secretary Andrew Lansley said: ‘Dentists are fed up with the flayed system of perverse incentives that Labour have introduced.

We will make preventative treatment a real priority because we urgently need to improve our nation’s dental health.’

The Conservatives have pledged to properly pilot any new re-forms they bring in.

John Muir, chair of the British Dental Association’s (BDA’s) Gen- eral Dental Practice Committee, said: ‘The dental contract that was introduced in 2006 has created significant problems for dentists and patients alike.

Those problems have been well documented, by the BDA, patient groups and the Health Se- lect Committee.

In seeking to address those problems it will be important to afford accurate incentives to all and ensure that dentists can provide modern, preventive care.

Also vital is engagement with the profession in developing the de-tail of these proposals and properly testing new arrangements before they are implemented. The BDA looks forward to discussing those de-tails and discussing them further.’

Lib Dem health spokesman, Norman Lamb, argued that the government’s new dental con- tract is not working, but said: ‘I am not sure that the Tories are suggesting will work. It could create turmoil in the health serv- ice. We are looking into this issue as we feel it is a priority.’

Surely it is far more sensible to take relatively simple mea- sures to prevent it occurring in the first place rather than wait- ing till they are in pain and rushing off for treatment.

The CD-ROM produced by Smile-On provides the com- plete solution to the problem. It comprises the whole of Ellis Paul’s one-day Hands-On Course but with additional tech- niques such as rubber dam, and a whole section on exercises.

Recognising that it is not only dentists but dental nurses, therapists and hygienists also suffer occupational back pain, it shows how the same preventative techniques apply to them as well. Thus it is for the whole team.’

For more information please call Laura McKenzie on 020 7400 9898 or email info@smile-on.com

Preventing back pain

A n e-learning solution giving practical help on how to prevent occupational back pain has been launched.

The CD Rom Perfect Posture for the Dental Team, was pro- duced by Smile-on in conjunc- tion with Ellis Paul, who has more than 50 years of experience in teaching perfect posture and four-handed dentistry in the UK and overseas.

Studies have shown that 80 per cent of dental professionals suffer from back or neck pain caused entirely by working in distorted postures.

This is a symptom of an un- derlying condition which can vary from merely an unpleasant pain to a permanent musculo- skeletal lesion.

At best it makes life miserable - at worst it causes absence from work (with often considerable loss of income) and frequent vis- its to physiotherapy and orthopaedists.

In some cases it has forced den- sities into premature retirement.

This e-learning programme, which is also available online, aims to prevent pain, disability and depression of work standards due to musculoskeletal problems.

Just a few of the techniques shown include using the five variables, better access and vi- sion, direct and mirror vision, soft tissue control, aspiration and instrument handling, plus cor- rect stools and seated posture.

A spokesperson for Smile-on said: ‘Back and neck pain is pre- ventable and amazingly most dentists either do not seem to know this or, if they do, don’t bother to take appropriate steps to do something.

Certainly awareness of the impor- tance of oral health, with respect to linking gum disease to heart disease, diabetes, strokes, premature births, low birth-weight babies and, in re- cent early studies, infertility.

Yet awareness of these im- portant overall health links is low.

Two-thirds remain unaware of possible links to heart disease, four in five knew nothing of the links to strokes or dia- betes, while 84 per cent of re- spondents had no clue of potential risks posed to pregnant women.

The public could be put at risk by poor dental hygiene habits yet awareness of these links is very low, said Dr Carter.

Gum disease in partic- ular has been linked to serious health is- sues. It affects most people at some point in their lives, so there is no excuse for ignoring good dental hy- giene.

People should take care of their gums by brushing teeth twice a day with fluoride tooth- paste, cleaning between teeth with floss or an interdental brush, cutting down on how of- ten they take sugary snacks and drinks and visiting the dentist regularly, he added.

The Foundation’s National Dental Helpline is available with expert advice for the public on 0845 065 1188.

National Smile Month pro- motes good oral healthcare un- der the tagline ‘Look After Your- self, Brush for Health’ and is sup- ported by Oral B, Wrigley’s OR- BIT Complete sugarfree gum and Trico Dental Insurance.

The Department of Health (DH) has issued guidance to dental practices on what to do if

Conservative health spokesman Norman Lamb, agreed that the swine flu outbreak turns the NHS into a ‘war zone’.

Dr Carter added: ‘The dental contract that was introduced in 2006 has created significant problems for dentists and patients alike.

The profession in developing the de-
Guest comment
The laboratory experiment

My technician told me that the current climate is not easy for dental labs, which have to cope with a 20-30 per cent increase in materials purchased from abroad. With a decline in output since 2006, many laboratories are struggling to find money for future investment and are forced to constantly evaluate the service they provide in terms of cost, quality and value. With the decline in the pound forcing the cost of materials up and rising competition from overseas laboratories, it is clear that something has to give, but it is also clear that neither dentists nor patients benefit from these changes.

The HSC found that the number of complex treatments such as crowns, bridges and dentures had fallen by 57 per cent since 2006 whilst at the same time extractions were rising. The initial promise of dentists having more time for preventative care seems to be superseded by the reality that for some this new system offers little more than unrealistic targets, with every complaint raised by the profession answered with the ambivalent term ‘swings and roundabouts’. The rising cost of lab-work, materials and cross infection procedures illustrates the inflexibility of this approach and acts to further undermine confidence in the future of the NHS.

Whilst the retail price index stands at 3.2 per cent recommendations from the review body on doctors and dentists pay have set dentists pay rise at just over a fifth of one percent, which in real terms means a pay cut. Clearly prudence by central government needs to be exercised especially in our current economic climate but why should individual practices be left to pick up the tab when providing a national service? Perhaps it is here where government needs to rethink the sensitive balance between cost, quality and value when deciding on future commissioning.

The tightening of cross infection regulations in dental practices is surely a good thing. As times change, so does our understanding of how we face the challenges of modern day dentistry. Unlike hospitals, dentists face a delicate balancing act between providing healthcare and running a business. Hospital doctors in this respect do not have any direct financial burden if choosing a treatment option which is not cost effective, whilst dentists still do. So when a change in regulations such as the introduction of single use endodontic files or washer-disinfectors is introduced, GDPs directly feel the pinch. In a hospital setting this may not be such a problem, but in general practice making large investments such as these can have a bigger impact.

Regardless of which side of the fence you sit on, the question lingers on: is the NHS providing a service based on cost, quality or value? Of course the answer is probably a little bit of each, but as the cost of dentistry rises within the confines of a rigid, target driven contract what should we expect to give? And do the general public really expect cross infection controls (suitable more for complex brain surgery than general dentistry) at any cost?

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* Graphical representation based on SEM photography; for illustration only

About the author
Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice.
Champagne and canopies were flowing in style for leading industry figures earlier this month to celebrate the launch of the Lava chairside oral scanner (Lava C.O.S) for the first time in the UK.

The tried and tested product, which has already been rolled out in the USA for the past 12 months, is capable of delivering an uninterrupted ‘digital workflow process’ to dentists and technicians.

Designed with breakthrough technology that allows for quick, real-time 3D video capture of the tooth anatomy, it allows precise-fitting restorations, and offers patients the convenience and comfort of digital impressions.

Practices and authorised laboratories can now work in partnership and control the entire process of impression taking—by replacing traditional methods with digitally enhanced technology, and producing accurate results through the advanced software.

More than 140 million impressions are carried out worldwide each year, yet many dental laboratories still receive ‘inadequate models’ before even commencing lab procedures. 3M ESPE has recognised that even the most experienced of practitioners, using the very best materials, can encounter difficulties with impressions. This is why 3M ESPE has provided this revolutionary solution.

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3M ESPE’s technology has been hailed as a major breakthrough by patients and dental professionals, with the company’s new ‘digital workflow process’ providing a more comfortable method for taking an accurate impression, while streamlining the entire procedure for indirect restorations.

For further information about the Lava chairside oral scanner and the 3M ESPE digital workflow process please visit www.3mespe.co.uk/lavacos or call us today on 0845 602 5094.

Dr Nigel Carter and Steve Tidman
Free check-ups on the cards?

Every five-year-old would get a free dental check-up at school under a Conservative government.

The £17m scheme would mean children would be shown how to brush their teeth properly and told about the dangers of eating too many sweets and drinking sugary drinks.

Around 680,000 children would benefit from the scheme.

Figures obtained by the Tories reveal that on average, children have at least one filling, extraction, or episode of tooth decay by the time they are five.

Check-ups were first introduced in schools back in 1918.

However, Department of Health guidelines published in 2007 removed the obligation on primary care trusts to give dental screening to schoolchildren.

New figures show that 64 per cent of Primary Care Trusts (PCTs) are no longer screening children following Labour’s dental reforms – and only 25 per cent have a screening programme that is widely available to schoolchildren.

Shadow health secretary Andrew Lansley, the Shadow Health Secretary, described Labour’s ‘neglect’ of preventative dentistry as ‘shameful’.

‘Not only has the Government missed opportunities to encourage better health outcomes for children and parents, but Ministers are quietly abolishing a long-standing programme which helps to protect children’s oral health.’

He revealed that under a Tory government, every child at the age of five when they go to school will have dental screening.

On the BBC’s Politics Show, he said: ‘We’ll find £17m from within the planned dentistry budget, in order to do that - that’s 680,000 children and then from that, we will also be a position to be able to look at where tooth decay is in those children and we want to change the contract so that dentists have a greater incentive for preventative work, including contracts to look after children, whether or not their parents are having NHS dentistry.

We have to make sure that we put the investment where it’s needed, which is in prevention, rather than cure. The evidence internationally, it’s absolutely clear, if we can have children whose teeth are good when they are younger, we are likely to have adults who have good teeth for the rest of their lives.’

However, the Government has disputed the Tories’ figures and claims the UK has the lowest rate of tooth decay among 12-year-olds in Europe.

The Chief Dental Officer, Barry Cockcroft, said: ‘PCTs can still decide to carry out the screening if they wish but most PCTs have decided to target their resources at the significant inequalities that exist rather than carry out blanket screening which is considered ineffective.

When we removed the mandatory requirement, the decision was supported by the British Dental Association.

Currently around 70 per cent of children see a dentist in each two year period so to introduce further screening at school would create a huge degree of duplication.

PCTs are now developing locally targeted initiatives in their own areas to meet their own particular circumstances, surely a better way to target inequalities.’

The British Dental Health in the Nation campaign cast doubt on the scheme claiming the Tories’ planned £17m spend would be better spent on effective preventative measures.

Compulsory screenings became optional for Primary Care Trusts in 2007 after the National Screening Committee heard evidence highlighting a lack of impact on future oral health with isolated screenings failing to solve dental problems.

Foundation chief executive Dr Nigel Carter said: ‘While we wholeheartedly support Mr Lansley’s commitment to increase the focus on preventative dentistry, compulsory school screenings are simply a waste of money when there are far more effective measures available.

We live in an age of evidence-based medicine and dentistry and the evidence is overwhelming that school dental check-ups are not effective. Indeed, far from improving pupils’ oral health they have been shown to increase existing disparities.

Screenings are not a preventative measure since they diagnose existing decay. Instead the proposed additional budget would be best spent on real preventative measures from water fluoridation to targeted programmes in schools with the application of fluoride varnishes and supervised brushing.

He added: ‘These measures have proved extremely successful at reducing child decay levels when implemented in the Scandinavian countries. We particularly need to target high-need areas with dental resources. The Foundation would welcome an opportunity to work with the Shadow Health Team in developing their future dental policy.’

Oasis scoops new contract

Oasis Healthcare has been awarded another NHS contract and is to open a new dental surgery in Carlisle to ease waiting lists in the town of Workington. Oasis Healthcare Ltd has received permission from Allerdale Council to change the first floor of an empty unit in Workington into a surgery.

The surgery will create 11 jobs and provide NHS dental care to more than 1,000 people.

NHS Cumbria, the primary care trust, is to manage the appointments in partnership with Oasis. The site has been chosen as it is accessible by public transport to people living outside the town centre.

The Workington surgery is part of a £17.75m scheme to create 70,000 NHS dental places in west Cumbria.

Manchester company, Oasis Dental Care Ltd, which has more than 140 practices in the UK, is also planning to open surgeries in Maryport, Whitehaven and Egremont.
Teddy bear dental programme

Dental students from Barts and the London School of Medicine and Dentistry have developed an oral health programme, which uses teddy bears to help reduce the fear and anxiety children have, when they visit the dentist.

The student led programme, dubbed Teddy Bear Hospital (TBH), has been running in the London borough of Tower Hamlets for children aged from three to seven.

The dental students have been visiting schools in Tower Hamlets and children have been bringing in their teddy bears to be treated by the dental students.

Aidan Mohammed, who helps run the programme, said: ‘It has proved to be an exciting opportunity for both the children and teddy dentists. The children have learnt about oral health in an interactive way, working in small groups as well as on a one to one basis. The key has been organisation and the use of child friendly language such as ‘sleeping juice’, ‘tooth shower’ and ‘tickling stick’.

The programme is recognised as a valuable learning tool for both children and students. The aim is to increase awareness on the importance of oral health as well as stimulate collaboration among the dental students to promote oral health care in the community.’

She added: ‘The experiences have benefited everyone, to the extent that the dentists recognised the value of being involved and because oral health still remains a significant problem in Tower Hamlets, developed a series of dental related workshops with the goal of reducing dental fear, promoting oral health and ultimately preventing and reducing dental disease in this group of children.’

The dental workshops offered include tooth brushing, visiting the dentist and healthy eating.

The students also run a Teddy Bear Hospital ‘Safety Day’ once a year for more than 180 children.

The children, teddies, and teddy dentists take part in interactive activities based on health and safety in the home.

The campaign has attracted various sponsors, such as GSK and various dental professionals.

At the end of each clinic, the children go home with a ‘goodie bag’ including a toothbrush, tooth paste and timer.

Practice Plan challenge

The dental plan provider, Practice Plan, is competing with thousands of other companies from around the world, to walk 10,000 steps a day for 125 days.

The team of seven from Practice Plan, are taking part in the office fitness programme, the Global Corporate Challenge (GCC).

The scheme is designed to increase staff fitness, promote teamwork, foster a positive, competitive spirit, and support the workforce to be active, healthy, and more productive.

Managing director of Practice Plan, Nick Dilworth called it ‘a fantastic opportunity not only for the group of seven who are officially competing in the challenge, but for the whole company to get fit and healthy’.

He added: ‘We are encouraging everyone to join in with the daily walks, as the wellbeing of our staff is hugely important. A healthy body is a healthy mind.’

The walking challenge begins on 21 May and runs up until 22 September, and will see 50,000 individuals globally competing to walk the furthest distance over the course of 125 days, with 10,000 steps being the daily minimum.

The average person walks around 5,500 steps a day, but the recommendation from the World Health Organisation is 10,000.

Therefore, the Practice Plan team members are in a bid to walk a combined total of 8,750,000 steps over the course of the competition, meaning 551,558 calories burned, 3,480 miles travelled and 1,167 hours of completed stepping time.

Every morning, team members will pop on their pedometers in order to track the number of steps that they take and will compete in various walking events to notch up their running total.

The results will be fed into a website that shows teams and organisations how they measure up against each other.

The company is organising a number of challenging walks for the team of seven, and are encouraging all of their staff to get involved, in order keep fit and healthy.

The money that the GCC generates from registration fees is spent on research into conditions such as heart disease and diabetes.

Expenses saga continues

An MP, who works three days a week as a dentist, has been accused of claiming on expenses for repairs to his dental surgery in Putney, southwest London.

The MP for Mole Valley in Surrey, Sir Paul Beresford, has been dragged into the expenses row by the Daily Telegraph, over his leasehold property in Putney, which incorporates a dental practice and a flat.

The newspaper has alleged that he used taxpayers’ money to subsidise his dental surgery.

In 1992, when he was elected as Conservative MP, Sir Paul worked out a deal with the House of Commons fees office where he charged three quarters of the running costs of the property to the taxpayer, claiming three-quarters were used for parliamentary duties.

He said the flat was used as a second home and the patient waiting room doubled as his private lounge in the evenings.

In 2007, Sir Paul increased his practice and took over a larger share of the running costs, reducing his claim to 50 per cent of the expenses at the property. He said none of it was used to subsidise the dental surgery.

He said he claimed £3,521 for 2007 to 2008, which includes claims for gutter cleaning, roof repairs and council tax.

He said he has claimed nothing for 2008 to 2009, as he didn’t use the flat and went home instead.

Chairman of the Mole Valley Conservative Association, Colin Crispin, has given Sir Paul his total support and said he will still be their candidate at the next election.
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References

2. Gallagher A, Sowinski J et al. The effect of brushing time and dentifrice on dental plaque removal *in vivo*. [Accepted for publication in *J Dent Hyg*]

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Aquafresh
GDPUK round-up

Tony Jacobs picks out the most recent best snippets of conversation from his ever-growing GDPUK online community

GDPUK members have been following the developments of the Jimmy Steele review of NHS Dentistry with interest, and have been able to view reports of his group’s travelling roadshow across the country. As well as gathering evidence and forming opinions, it seems that the ideas Professor Steele is describing are being modified as he and his group travels, meeting dentists and stakeholders.

One piece of evidence though might be disconcerting – at his event in London, only about 50 interested people turned up. Maybe too many false dawns? Colleagues are hoping that this report will be published before the LDC Conference in June, but perhaps its publication the week after is more realistic. Ann Keen, Minister responsible for dentistry, has said in Parliament that the Department of Health will consider this report very carefully. Time will tell.

In the meantime, on GDPUK, literally hundreds of other topics have been discussed. Here is an idea of some of them: waterline cleaning, publication of the final version of HTM 01-05, the passing of former GDPs and BDA president Alan Fearn, incorporation of a dental practice, the bankruptcy of a well known dentist, using operating microscopes, and buying a netbook.

A number of the group have much to say about orthodontics and some of the latest techniques have been discussed, including Damon and Six Month Smile. Such forums continue to discuss differing computer systems and act as self-help groups regarding their software installations.

Clinical cases have also been discussed, good pictures and good advice dispensed. Sometimes the poster knows the answer, and is looking for reassurance or almost setting a quiz.

The subject of what a practice should do if a course of treatment has been completed (often a substantial one) and sadly the patient dies having been satisfied with the completed treatment, in receipt of the invoice but before settling the invoice. This subject has been tackled on GDPUK, in the past and there are always two sides to the discussion. One idea is to uphold the lofty aims of the profession and void the invoice. The other side of the coin is to be aware that a care home, telephone company, credit card company and so on will continue to address their bills to the executor of the deceased. It is, of course, one of the duties of an executor to settle bills such as this. What would you do? Come and tell us at http://www.gdpuk.com

About the author

Dr Anthony V Jacobs
started the GDPUK emailing list in 1997, and the group membership is now just under 2,000. The list is read in all corners of the UK dental profession as well as by laboratories, and the trade and dental industry. Qualifying in London in 1976, Dr Jacobs is now in partnership with Dr Stephen Lazarus, practicing at 406 Dental in Manchester. He enjoys his profession, and takes pride in providing both simple and complex gentle dentistry, as well as caring for families in a relaxed atmosphere. Dr Jacobs has a long-term commitment to continuing professional development, both for himself, and for the profession in general through his mailing list. He has been a member of the British Dental Association (BDA) since 1975, and is presently chairman of the Bury and Rochdale Oral Health Advisory Group, as well as vice chair of the Bury and Rochdale Local Dental Committee (LDC). Dr Jacobs also sits on the committee and helps to organise the annual conference of Local Dental Committees.

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Information on tap

Keeping your staff up to date with new treatments on offer in your practice is easy with a touch-screen system. Amy Rose explains

In the modern dental arena, the word ‘multidisciplinary’ seems to be on everyone’s lips. Indeed, the idea of flexibility and offering a wide range of services has permeated our entire culture. We can now visit supermarkets where we can buy insurance, TV’s, fresh fruit, mobile phones and magazines under the one roof. The era of the niche service is, perhaps, behind us.

As far as the dental industry is concerned, in order to retain a competitive edge it is important to be able to meet all of the needs of patients. Everyone in the UK wants an efficient, convenient service, and patients are no different. They want to be able to visit their local practice and get the service they desire, whichever the field of treatment.

Know your market

Dentists now tend to have much longer lists of available treatments. Having recognised the need for particular services such as whitening, many practices have invested in the training and equipment necessary to do this, taking advantage of the market.

Revolutionary new touch-screen systems, available as kiosks or desktop models, give practices an easy to use, stylish and effective way of educating patients. However, it is not just patients that need to be educated about new services. It is staff, too.

Stay informed

These new systems are ideal vehicles for in-depth information about new treatments. Reception staff, and of course members of the dental team, can access the systems and find out as much as they need to about the new services. With several ‘tiers’ of information, ranging from basic to more technical content, the reception staff can acquire sufficient knowledge to answer any patient queries about the new treatments – saving a great deal of time for dentists, who really need to be focusing on treatments rather than answering emailed questions about procedures.

Staff can access the information at any time, just by tapping their fingers on the screen, refreshing their knowledge and enriching their understanding. Imagine the benefit to patients, who discover that the front desk team know all about the new treatments.

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- Statim complies with EN13060 and the 2006 RKI Hygiene guidelines

About the author

Amy Rose has over six years’ experience in the dental profession, working predominantly in a marketing capacity. Amy currently heads up the dental design and marketing team at Dental Design Ltd. For more information call 01202 677277, email contact@touch-ed.co.uk or visit www.touch-ed.co.uk
If recession proofing is that easy…

Andy McDougall, Spot On Business Planning insists you can still deliver great business results against all odds

There is no escaping the fact that we are now in recession. Even if we try to ignore the dire economic climate, the constant badgering by the media ensures recession stays at the forefront of our minds. And while it can certainly be depressing, I don’t think it is such a bad thing because as business owners, our one priority is to remain aware and vigilant about what is going on around us. How else can we take the necessary steps to remain profitable and stay in business!

A healthy business

I have seen claims in the industry that people will help you to recession-proof your business. Wow, what a boast! If only George Bush and Gordon Brown had followed that advice, we wouldn’t be in this mess. So yes, a rather dubious claim. There is no such thing as recession-proofing your business, but there are well proven ways to sandbag it; that is, to take appropriate and calculated steps to manage it in a way that gives you the best chance of surviving the recession and coming out with a healthy, robust business that is ready to take advantage of better times.

Managing risk

There are two ways to analyse your business using traditional commercial techniques: you look internally and externally. What’s the big difference? Internal factors are things you have much more control over while you can exert little or no influence on external ones. External factors usually generate opportunities on which we should capitalise and threats that we must factor into our business plans. Just because we have little influence over external factors doesn’t mean they can be ignored. In fact quite the opposite. We must determine the opportunities and threats and make decisions on how to tackle them. Threats bring risk. Risk cannot be eliminated; it is outside our control, but we can ascertain risk, we can be acutely aware of its impact, and when we follow this line of thinking, while we cannot eliminate it, we can manage it.

Business planning

In traditional business thinking, we use techniques such as SWOT (Strengths; Weaknesses; Opportunities; Threats) and

Money Matters

Time to talk about dry mouth?

Approximately 20% of people suffer symptoms of dry mouth, primarily related to disease and medication use. More than 400 medicines including tricyclic antidepressants and antihistamines can cause dry mouth and the prevalence is directly related to the total number of drugs taken.

Ask your patients

Some patients develop advanced coping strategies for dealing with dry mouth, unaware that there are products available that can help to provide protection against dry mouth, like the Biotène system. Diagnosis may also be complicated by the fact physical symptoms of dry mouth may not occur until salivary flow has been reduced by 50%.

Diagnosing dry mouth

Four key questions have been validated to help determine the subjective evaluation of a patient’s dry mouth:

1. Do you have any difficulty swallowing?
2. Do you have any difficulty swallowing?
3. Do you have any difficulty swallowing?
4. Do you have any difficulty swallowing?

Clinical evaluations can also help to pick up on the condition, in particular:

- Use of the mirror ‘stick’ test - place the mirror against the buccal mucosa and tongue.
- Checking for saliva pooling - is there saliva pooling in the floor of the mouth? If no, salivary rates may be abnormal.
- Determining changes in caries rates and presentation, looking for unusual sites, e.g. incisal, cuspal and cervical caries.

Consequences of unmanaged dry mouth include caries, halitosis and oral infections.

The Biotène formulation supplements natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths. The Biotène system allows patients to choose appropriate products to fit in with their lifestyles.

Products specially formulated for dry mouth

- Biotène Oral-Balance Saliva Replacement Gel
- Biotène Oral Balance Liquid

Hygiene Products

- Biotène Dry Mouth Toothpaste
- Biotène Dry Mouth Mouthwash

The range is appropriately formulated for the sensitive mucosa of the dry mouth patient.

- Alcohol free
- Mild flavour
- Sodium Lauryl Sulfate (LSI) free

The Biotène formulation:

- Helps maintain the oral environment and provide protection against dry mouth
- Helps supplement saliva’s natural defences
- Helps supplement saliva’s natural antibacterial system - weakened in a dry mouth.

Samples available from www.gsk-dentalprofesssionals.co.uk

5. Dawes C. Physiological factors affecting saliva flow rate, and sugar clearance, and the sensation of dry mouth in men. (Dent Res 1997; 75c Special Issue: 640-653

Biotène is a registered trade mark of the GlaxoSmithKline group of companies.
PESTLE (Political, Economic, Sociological, Technological, Legislative, Environmental) to help us ascertain the threats present in our business environment and to analyse how our future may face very different market conditions to that of previous years. Welcome to business planning! So many graveyard dental businesses have fallen victim to the last year plus 10 per cent approach to “planning”. They have done OK for years and suddenly the markets harden and they find their businesses in decline and they don’t know how to respond because their training has equipped them for all things dental and nothing commercial. There has never been a more crucial time to learn more about business and more about your own business, and business planning is one of the best ways to get a grip of both.

Sandbagging your business

We are all victims of the recession but what can we do if it’s outside our control? There are three types of people in business: those who watch what happens; those who wonder what happened and those who make it happen. Which category do you fall in? There is a recession, there will be winners and losers, and what camp you fall into depends on your business philosophy. We can’t recession-proof our businesses but a more realistic expression for dealing with our current economic climate is “sandbagging” – not a guarantee but a means of taking all the measures within your control to ensure you have a greater chance of survival.

How do you approach the problem? It is called business planning. Business Planning is not a budget (a budget is a financial representation of everything that happens in your business); it is not last year plus 10 per cent; it is not a 200 page manual that lacks focus and it is not a vision that you came up with on a fun-filled team away day that got you feeling great for a brief moment before reality dawned once again. Business planning is a tangible means of delivering your goals. It will transform your results, even with businesses where sales are flat year on year. I can demonstrate businesses that have followed a business planning methodology and achieved 25 per cent more profit year on year – how better to beat a recession!

Planning and control

In a previous article I talked about quarters and halves, which all make a radical difference to the bottom line. You don’t have to find huge savings in one place; lots of small savings here and there add up. Whether it’s associate’s pay, the cost of your accounting or the way you control the gp per cent, it all contributes to a radically improved bottom line. Good business managers plan the things to do and then ensure these chosen things are done correctly; planning and control or the two Es, effectiveness and efficiency. Effectiveness means planning to do the right things, and efficiency means doing these chosen things well – to the best of our ability.

Therefore, can you be recession proof – I doubt it, but with professional business planning and performance management to keep your results on track, you can deliver a great result against all odds and market trends.

There are three types of people in business: those who watch what happens; those who wonder what happened and those who make it happen. Which category do you fall into?

About the author

Andy McDougall has over 25 years experience of business planning and brings techniques and expertise from a wide range of commercial and competitive business sectors. Andy now delivers business-planning services to help members of the dental community to respond to the dynamics of an increasingly commercial and competitive environment. He helps businesses to reach the next level and to turn around poor performance. To find out more about his business planning services, contact info@spoton-businessplanning.co.uk or call 07710 382559.
For details on how you and your practice could be in with a chance to win £1 million with DENTSPLY, please visit www.dentsply.co.uk.

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Don’t get caught

The right protection policy will help you save up to £75,000 in the event of a tax investigation. Frank Pons explains

With the tax authorities becoming more and more pro-active in dealing with investigations, and with sole traders, partnerships and limited companies under greater risk of being scrutinised, there has never been a better time to protect yourself and your business.

There are several different enquiries to which your business might be subjected, and the tax authorities do not need to give you a reason as to why they have chosen you out of all those other honest and diligent dentists.

Use a specialist

An Aspect Enquiry can be over in a few days, or it can drag on for weeks. You will probably need to supply documentation to support entries made on the tax return, focusing on one area such as interest from a building society account, and you can be fined for withholding the necessary paperwork. It is unlikely that you have the expertise required to deal with the tax authorities as they closely examine and pick over the most minute details, and it is always best to turn to an accountant or investigation specialist who is well-versed in dealing with HM Revenue & Customs and understands every subtle nuance of the tax return.

Although the Aspect Enquiry can be comparatively straightforward to deal with, providing you have both the means to prove the accuracy of the tax return entry or entries and the expertise to present your case effectively, failure to do either may result in the tax authorities opting for a full enquiry. This could take months.

Even with the support of an experienced accountant or investigation specialist, you can still end up with an enormous bill. Fortunately, tax investigation insurance policies are available, giving you peace of mind in case you end up having to prove your innocence.

The leading provider of tax investigation insurance policies provides a TaxMaster policy that can be extended to include Aspect Enquiries. One of the many benefits of such a policy is not only that it gives you peace of mind, but also that it also covers Full Enquiries in the event that the tax authorities might extend the investigation to cover the whole tax return, and VAT disputes. Other policies include the PAYeMaster that covers all approved professional fees incurred in dealing with PAYE and NIC disputes.

About the author

Frank Pons

A qualified chartered accountant and tax expert, Frank Pons founded PFP in 1984, the first company to recognise the need for and provide dentists with tax investigation insurance. For more information, contact PFP on 0845 307 1177, email info@pfp.uk.com or visit www.pfponline.com.
The law is clear, and has recently been changed in England and Wales. If you die intestate (without leaving a valid Will), there are new statutory provisions for surviving spouses and registered civil partners and the state will distribute your assets according to strict rules.

If you die leaving a surviving spouse/civil partner and children your surviving spouse/civil partner will inherit the first £250,000 of your estate as a statutory legacy, together with your personal possessions. The remainder is divided equally between your surviving spouse/civil partner (50 per cent entitlement) and your children (50 per cent entitlement), with your surviving spouse/civil partner receiving only an income entitlement (life interest) from their half share and the children inheriting absolutely their share at the age of 18 or when they marry, whichever is the earlier. On the death of your partner their life interest will be divided equally among the children, but their interest will be an absolute interest i.e. they will be entitled to the capital.

Some examples

Suppose you were a husband who died without making a valid will, leaving a wife, two young children and an estate of £900,000. The estate would be divided as follows:

- Your widow would receive the statutory £250,000, your personal possessions and the income for life from £325,000 (half of the £650,000 remaining).
- The children would each receive £162,500, held in trust until they reach 18 (the other half of the £650,000 remaining).

When your widow dies, her life interest in her £325,000 will be shared equally between the two children, but they will receive absolute entitlement to this money.

If you died leaving the same sum but had no children, your widow would receive the first £450,000 of the estate (half of the total value) as a statutory legacy, together with your personal possessions, and also half of the remainder. The other half of the remainder, in this case £225,000, would pass first to any surviving parents; if there were no surviving parents, it would pass to your brothers and sisters or their children and then remoter family.

Assessing your options

If you haven’t made a will, you need to ask yourself urgently if these statutory provisions are right for you and your family. For example, if you have a partner and children, and something happened to you, would you want your partner to be left with just £250,000 and only a life interest in half the balance of your estate?

If you have a partner but no children, are you happy that they may not inherit all of your estate?

If you’re in a long-term relationship which is not legally recognised, are you happy that your partner will not inherit any of your estate on your death? You may wish to remember nephews, nieces, godchildren or friends, and the state makes no provision for individual legacies. What will happen to family heirlooms on your death?

Food for thought?

It should be. The circumstances of life change over time, and accidents happen every day. Making a will, and keeping it up to date, is the very best form of family insurance.

About the author

Claire Borsoi is a member of the IPW (Institute of Professional Will Writers) and is also a chartered accountant with Humphrey & Co, a member of the ASPD. You can contact her on 01323 730631.

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I
n a rapidly unfolding and ever evolving digital dental landscape, we have seen tremendous advances in 3D imaging, modelling, and manufacturing which have transformed the fields of restorative dentistry and implant surgery. There has never been a more interesting time to be working in dentomaxillofacial imaging and 3D technology.

Cone beam computed tomography
Those working in implant dentistry were perhaps the first to appreciate the benefits of three-dimensional imaging, which then took the form of Computed Tomography (CT) scanning as provided by hospital CT scanners. When I started out in implant dentistry, I reserved the use of CT scanning for only my most challenging surgical cases, perhaps scanning just one in 30 to 50 of my patients. At this time, x-ray doses were high and “flap” surgery was the norm. Back then, I often found it hard to justify the x-ray dose, which of course was considerably higher, even compared to the hospital scanners nowadays, but perhaps what really prevented me from more frequent use of this powerful imaging modality, was that it was hard to see how access to the image data would actually alter treatment, or substantially benefit my patient. (I still believe that “seeing” with your fingertips has a lot to offer, as does examination under local anaesthesia at the same time as close-by procedures such as extractions.)

Years ago it was so exciting to carry out second-stage surgery and find that my first implants had osseointegrated. Our patients were thrilled to be rid of their dentures, and had few, and low expectations. Now a fine nuance of positioning makes all the difference to the results we achieve for our much more cosmetically aware patients, who expect so much more from us.

Transforming the practice environment
Embracing recent developments in imaging, particularly the use of Cone Beam Computed Tomography (CBCT), has transformed my own implant and restorative practice. Firstly let’s...
look at x-ray dose. Dentomaxillofacial CBCT scanners have been designed specifically for hard tissue imaging. There can be little or no justification at all for using hospital CT scanners for this purpose, as studies have shown that CBCT can offer at least as good, if not better imaging than a hospital CT scanner, but at a considerably lower x-ray dose. As it happens, the dose is actually rather similar to that of conventional tomography, which also makes conventional tomography obsolete as 3D imaging has so much more to offer.

Dose can be still further reduced by carefully selecting a scan volume which captures the region of interest only, and this has the further benefit of allowing for the resolution of the imaging in this smaller volume to be increased (Figure 1), without raising doses to an unacceptable level. This means that CBCT is also becoming important in endodontics and periodontics, revealing the 3D intricacies of convoluted root canals and infra bony lesions. So images are clearer, and x-ray dose is lower, particularly with newer generations of CBCT scanners, which are faster and are equipped with higher resolution sensors.

Viewing and studying 3D image data on screen helps to familiarise the surgeon with the actual clinical situation, reducing intra-operative uncertainty, improving accuracy and speed. To be able to achieve this with a substantially lower x-ray dose makes me that much happier to refer for imaging.

But what has really changed the landscape for me, is that we can now do so much more with the image data than simply hold a film up to the light or ‘left click’ to make an on-screen measurement; we have the ability and the tools to allow us to interface with our patients.

Computer Aided Design

With recent developments in computer aided design (CAD) software, our imaged volume of three-dimensional data will act as an interface between the patient data on our system, we are able to construct an on-screen virtual environment, with which we can interact.

SimPlant and NobelGuide (Figure 2) are examples of implant planning software packages that allow you to “design” your surgical treatment. This is all very well, but of limited benefit if you are not able to make your design reality, though slightly more useful as a diagnostic tool than simply viewing the data.

Here too, recent developments have transformed our capabilities.

Because, if we can transfer our computer planning back to the patient, then what we are doing on-screen really represents an interaction with our patient. To put it another way, it represents an interaction between machine and human.

Rapid manufacture

As a keen potter, (I am sure all dentists are potters, or sculptors, or should be), when I see an object I want to gauge its size, walk around it, hold it in my hand, have a sense of its texture, caress it... interact with it.

Simply viewing on-screen, even in a simulated virtual environment, just does not do enough for me.

I now see the scan as a portal. A portal to a virtual environment, just does not do enough for me.

What we see in our minds eye, and what we design on our two-dimensional monitor can actually be fabricated. We can move from real to virtual, and virtual to real, at the touch of a button. We do this using our scanners as a mechanism to input data to our CAD software; we alter this data and then use Rapid Manufacturing (RM) to fabricate the result of our interaction.

We can use the CAD data to directly fabricate a drill guide, for minimally invasive implant surgery (Figure 3).

And most exciting of all we can prefabricate (Figure 4).

Whether your interest is digital panoramic, cephalometric or 3D imaging – at J. Morita you always get the best device for the most precise diagnoses. As a pioneer in volume tomography we are familiar with the high requirements of diagnosticians. Our wide variety of devices and choice of combinations provide you with the sharpest imaging of details down to 80 μm.

From the first step, upgradable 2D devices, to the basic version Veraviewepocs 3De and the high-quality X-Ray CT Unit 3D Accuitomo 170, one thing always remains unchanged: You obtain the highest imaging quality from the lowest effective radiation dose and the shortest scan times. Nothing is more elementary than the correct diagnosis.

Thinking ahead. Focused on life.
We can make a model of our patient’s jaw, and study that, and practice the surgery on this before we carry out the procedure (Figure 5). I am prone to keeping models of my more complex patients’ jaws in my pocket, for contemplative moments. Or we can use the model to make a drill guide that can be fitted in a patient’s mouth, to allow us to interact with our patient more directly.

Further examples of CAD

Elsewhere in our brave new digital dental world, there are many examples of the use of CAD in the dental Laboratory. NobelProcera and Lava software are examples of CAD systems, which allow prostheses to be designed for teeth or implants, and then manufactured using various RM techniques. It is only a matter of time before these types of parallel CAD systems are ‘merged’, plan your implant placement, design the bridge; implement!

With the right level of care and attention to detail, we will be able to move from an on-screen surgical plan to finished implant prosthesis without impressions, without flaps and with total accuracy.

In the course of a series of short articles, I look forward to exploring some of the current and future possibilities offered by developments in our digital world.

Andrew Dawood is a registered specialist in Periodontology and Prosthodontics, clinical director of cavendishimaging.com in London, and has honorary attachments to the Department of Maxillofacial Surgery, Barts and the Royal London Hospital Trust and University College Hospital, London. Andrew Lectures extensively in the UK and abroad on topics related to imaging, dental Implants, and restorative dentistry. He also operates a centre for postgraduate education, and hosts regular meetings and seminars from the cavendishimaging.com premises in London, Oxford, and Birmingham. To contact him call 020 7975 2777 or email info@cavendishimaging.com.
Question: I read the recent ‘Ask the Experts’ article on ozone (J Esthet Restor Dent 2007;19:303–5). Can you provide more information and clarify the question about whether ozone is a useful means of caries treatment?

Answer: Thank you for the opportunity to comment briefly on the recent report published in the journal on research with the HealOzone (KaVo, Biberach, Germany). Ozone cannot do everything and certainly should not be a treatment isolated from our individualised preventive oral health care. To be effective, ozone must be prescribed in sufficient concentration for an adequate time and must be delivered into the lesions.

Antimicrobial effectiveness of ozone

Ozone is one of the most powerful antimicrobial agents we could use in dentistry and clearly, there are enormous advantages to kill pathogens. The recent piece in the Journal of Esthetic and Restorative Dentistry (JERD) correctly mentioned a few of the papers that have proven the antimicrobial effectiveness of ozone but does not discuss the limitations of the biofilm studies.

Less than one log reduction of bacteria was measured after using ozone gas above biofilms in the culture media, which was a similar reduction to that achieved by using 0.2% chlorhexidine or photoinactivated disinfection. However, ozone will react immediately with the reductants in the culture media, and the authors did not bubble the ozone into the biofilm. It is recommended that ozone be delivered under pressure into a lesion by pressing the delivery tube onto the carious surface so that it can penetrate the lesion. In vivo lesions (unlike artificial biofilms) contain many molecules (such as iron) that increase the antimicrobial effectiveness of ozone in caries.

Ozone, even at a very low dose and a short time of application, achieved a 57% reduction in biofilm and a 65% reduction in viable bacteria in model dental unit water lines. Also, a high level of biocompatibility of aqueous ozone on human oral epithelial cells, gingival fibroblast cells, and periodontal cells has been found.

Management of root caries

Ozone reverses shallow non-cavitated root caries lesions as part of a full preventive care regimen, which includes reducing the frequency of consumption of fermentable carbohydrates, increased use of fluoride-containing products, and improved oral hygiene.

The recent JERD piece described one study that successfully treated root caries with the Heal-Ozone. Other studies have also proven the successful reversal and arresting of root caries using the Heal-Ozone. However, ozone would not be effective to manage, for example, a cavitated 3-mm deep root caries lesion adjacent to the gingival margin. The outer caries would need to be removed, leaving about 1 mm of caries over the pulpal floor prior to ozone treatment and restoration.

I am puzzled as to the concern about the lack of response of the control lesions despite the use of 1,100-ppm fluoride toothpaste by the subjects in the root caries studies. Most of these subjects would have been using a 1,100-ppm fluoride toothpaste while they were developing the root caries, so it should not be expected to achieve more reversal of these lesions. Some had in fact been using toothpastes containing at least 1,450-ppm fluoride while their teeth were developing these root caries lesions, prior to enrolling in the study.

It was stated incorrectly that the large antimicrobial reduction in root caries after HealOzone treatment was because of the control samples of caries being ‘consistently larger than the posttreatment sample,’ which is not true.
However, it did not mention the con-
showed no overall significant dif-
mend by the manufacturer nor
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tigation of the oxidative con-
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What makes a successful implant practice?

Through motivational case presentations and a greater sense of teamwork between restorative and surgical practices, doctors can build successful implant practices. Dr Roger P Levin explains

Implants represent an untapped source of growth for many practices. According to market research firm Kalorama Information, dental implants are poised to reach US$4.5 billion in global sales by 2012. Unfortunately, many restorative and surgical practices are operating far below their potential when it comes to implants.

What is hindering the growth of dental implants? In most instances, insufficient patient education is the culprit. When implants are presented to every candidate as an exceptional value that can last over a lifetime, many patients will agree to implant treatment.

Patients need to think of implants as a standard quality of care option, not as an expensive luxury. It is important for you to present the many benefits that implants offer while emphasizing that no other service provides the functionality, fit and feel of natural teeth. Practices that improve their implant case presentations will see a significant increase in implant production.

Based on more than 24 years experience consulting to implant practices, Levin Group recommends the following Greenlight Case Presentation strategies for implants:

1. Make your implant presentation exciting. Free-for-service procedures like implants have to be presented with a higher level of enthusiasm to motivate patients. Doctor and staff enthusiasm, effective visuals, clear explanations, compelling comparative stories and a strong recommendation to have implant procedures performed are vital to a fee-for-service case presentation. This approach is different than simply telling patients that they need a crown on a broken tooth and that insurance could probably cover approximately 50 percent of it. The key is to recognize patients need a higher level of motivation to accept a recommendation for implants.

2. Focus on benefits, not the technical details. After a brief clinical explanation, you should make powerful benefit statements such as:
   - “When you get your implant, you’ll have a fuller smile and improved confidence.”
   - “Implants will give you a better quality of life.”
   - “Say goodbye to food restrictions! You can bite into a crunchy apple, chew your foods easier and avoid uncomfortable digestive problems.”
   - “Future bone loss will no longer occur when you have implants.”
   - “There is no extra work involved for you to care for your implants. Regular brushing and flossing along with routine dental examinations are all you need.”

3. Don’t perform a ‘wallet biopsy.’ Offer the ideal treatment to every patient. Making assumptions about treatment affordability or patients’ ability to pay can derail a case presentation right from the start. In this age of casual dress, CEO’s wear jeans and retail clerks dress in suits. Don’t try to guess a patient’s wealth or desire for treatment by how they dress.

4. Offer flexible payment options. Cost is always the final obstacle during case presentation, especially for services not fully covered by dental insurance. Levin Group clients incorporate The Four Financial Options into their practices to achieve case acceptance for implants and other services. The four options include:
   - Five per cent courtesy for full payment upfront
   - Half of the fee upfront and half before completion of treatment
   - Credit cards
   - Third-party financing

Not many people can pay for implants out-of-pocket. By offering flexible payment options, practices make implants affordable for more patients. Some practices are hesitant to offer third-party financing because they’re afraid of losing a few percentage points of their total fee.

‘By offering flexible payment options, practices make implants affordable for more patients’

Four habits of highly successful implant practices

In the course of consulting to thousands of dental practices, Levin Group has noted four characteristics common to highly successful implant practices:

1. Their philosophy is, ‘Dental implants are the treatment of choice for any patients missing teeth.’ They challenge themselves clinically to make dental implants work for any patient with missing teeth.

2. Doctors and teams understand that patient education is critical. They never assume that the patient knows about or has ever heard of dental implants. Analysis indicates that people who are familiar with dental implants do not necessarily request implant treatment. Instead, they tend to rely on the recommendations of their dentist.

3. These practices have a mindset that patients will want dental implants. In successful implant practices, team members are delighted to talk to patients about dental implants and feel confident that patients will accept implant treatment barring any contraindication or financial considerations.

4. A strong sense of teamwork exists between the surgical practice and the referring doctor. This pertains to education and close communication for implant case planning and treatment. Highly successful restorative practices not only work to continually educate themselves, but they also follow implant cases throughout the entire treatment process. These restorative practices take a pro-active approach, communicating with both the patient and the surgical practice from the initial referral to the restoration and follow-up. Of course, surgical practices should also provide updates on the patient’s progress during the placement phase of treatment. Strong communication throughout the treatment process ensures greater case acceptance, more patient referrals and increased implant production.

Conclusion

With millions of potential candidates in Europe, implants are a massive untapped source of revenue that has thus far evaded most dental practices. Given the numerous benefits that implants provide to edentulous patients, practices should regard implant treatment as a standard of care for every patient missing teeth.

Through motivational case presentations and a greater sense of teamwork between restorative and surgical practices, doctors can build successful implant practices. Implant dentistry enhances not only patient lifestyles, but also practice productivity – truly a win-win situation for the patient and the practice.

Dr Roger P Levin will be presenting his seminar, ‘Achieve Explosive Implant Growth: Triple Your Implant Practice (Despite the Economy),’ on June 26th 2009 in London. Don’t miss this chance to learn how to increase case acceptance and achieve greater productivity.

For more information, please call Perio-Implant Europe Ltd on 01276 469 600, email info@implantsuccess.com or visit www.implantsuccess.com.

About the author

Dr. Roger P. Levin, DDS, is founder and chief executive officer of Levin Group, Inc., a leading dental practice management consulting firm. For more than 20 years, Levin Group has helped thousands of general dentists and specialists increase their satisfaction with practicing dentistry.
Spring forward
BOS members Fiona Ryan and Zahra Sheriteh report on the recent British Orthodontic Society’s spring Meeting in Dublin

The British Orthodontic Society’s Spring Meeting was held in the Royal College of Surgeons in the heart of Dublin. Following lunch, BOS Chairman Peter McCallum, opened the proceedings with the announcement that the annual meeting would be held in Dublin for the first time, following the enthusiastic响应 from the Irish Orthodontic community.

The conference was attended by over 300 delegates from around the world, including 250 from Ireland and 100 from the rest of the world. The presence of leading orthodontists from around the world made it a particularly exciting event for local orthodontists.

Session 1 - Contemporary Orthodontics

This session was chaired by Callum, BOS Chairman, who introduced the first speaker, Dr Sarver from the University of Iowa, USA. Dr Sarver is widely recognized as one of the most influential orthodontists in the world and has made significant contributions to the field of orthodontics.

Dr Sarver presented an overview of his work on the use of Invisalign, a revolutionary orthodontic appliance that has revolutionized the field of orthodontics. He highlighted the benefits of Invisalign, such as its visibility, comfort, and convenience, and emphasized the importance of orthodontic treatment in improving patient outcomes.

Dr Sarver also discussed the technical aspects of Invisalign, including the use of computer-aided design (CAD) and computer-aided manufacture (CAM) to create customized orthodontic appliances.

Session 2 - Aesthetics and Orthognathic Surgery

This session was chaired by Dr Peter Huntley from the Royal College of Surgeons in Ireland. Dr Huntley highlighted the importance of aesthetics in orthodontics and the challenge of achieving a perfect smile.

The session included presentations on the use of soft tissue lasers in orthodontics, the use of Invisalign in cases with openbite, and the use of computer-aided design and manufacture in orthodontics.

The final presentation before lunch was given by Dirk Wiechmann, who discussed the use of lasers in orthodontics to achieve optimal treatment outcomes.

Session 3 - Aesthetic Orthodontics

The final session of the day was chaired by Ashley Latter, who is a leading expert in the field of aesthetic orthodontics. The session included presentations on the use of Invisalign in complex cases, the use of Incognito in cases with severe malocclusions, and the role of technology in improving patient outcomes.

The session concluded with a presentation on the use of 3D imaging and software in orthodontics, highlighting the potential of these technologies in improving treatment outcomes.

Complex cases

Dirk Wiechmann returned to present a selection of complex cases treated with Invisalign. This was truly impressive! Dr Wiechmann described the use of custom-made Extra Torque (ET) wires in complex Class II division two malocclusions as well as the use of oblique bicuspid archwires to manage open and deep bite cases. The use of both lingual and bicuspid auxiliaries allowed excellent control of tooth movement during space closure.

After a welcome tea-break, David Sarver once again took to the stage, introduced by David Bowden, BOS President. The final topic for discussion was new technologies – soft tissue lasers and CAD-CAM braces. Continuing on the mini-aesthetic theme, Dr Sarver introduced the concept of using soft tissue diode lasers as part of adjunctive orthodontic treatment. Uses for this technique include aesthetic enhancement, such as improving gingival topography, idealizing crown proportions, crown lengthening, and resolving crowns height asymmetries, in addition to treatment management, for example, eliminating pseudopockets.

The benefits of using diode laser to ablate soft tissue; including precision, haemostasis, and the need for topical anesthetic only, were illustrated.

Finally, Dr Sarver concluded his presentation with an introduction to custom-made Computer Aided Design/Computer Aided Manufacture (CAD/CAM) fixed appliances. The Insignia system uses 3D imaging and software which produces customised brackets and wires which theoretically yield optimal finishing. The possibility of using this software together with digital images of the patient’s smile has been explored by Dr Sarver in his quest to provide a perfect smile to suit every patient.

If you would like more information about the BOS, visit www.bos.org.uk.
The upcoming 2009 National Dental Nursing Conference will be held at the Cheltenham Chase Hotel, near Cheltenham, on October 23 and 24, 2009. Although the programme is still to be finalised, we can tell you that it will include talks on forensics, chiropractics, cross infection, professional indemnity, dental technology, change management and possibly implants. If you attend, each delegate will be eligible for up to eight hours verifiable CPD.

What it costs
The conference fee of £120 for current BADN members (£190 for non-members) includes full lecture programme (including attendance at both opening and closing ceremonies), conference handbook, verifiable CPD certificate, online registration, lunch on both days, a place at the presidential reception and dinner, breakfast canapés, refreshments (tea/coffee, biscuits, Danish pastries and cake), a business folder, as well as cheese samples courtesy of the English Cheese Board. Other sponsors include the British Dental Trade Association, Colgate and Schulke.

Beautiful surroundings
Situated in 15 acres of grounds at the foot of the Cotswold hills, the Cheltenham Chase Hotel has 122 spacious bedrooms and free parking for more than 200 cars and is situated just a mile from Junction 11a of the M5, under five miles from Cheltenham and Gloucester and under an hour (approximately 55 miles) from both Birmingham and Bristol. All bedrooms have air-conditioning, in-house movies, tea and coffee-making facilities and wireless high-speed internet technology. BADN has negotiated a special rate of £90 per night for a double or twin room (£45 per person per night) or £80 per night for a single room. However, there are also a number of other hotels in the immediate area.

Feeling fit?
For those who want to arrive the day before Conference, the hotel’s health, fitness and spa Reflections has a 14-metre swimming pool, sauna, steam room, Jacuzzi, gym, aerobics studio and beauty treatment rooms. Use of the leisure facilities is included in your stay, but BADN have negotiated special rates for delegates arriving early – just £20 for an express back, neck and shoulder massage and £15 for an express facial, bronze manicure or bronze pedicure. (These rates are only valid for pre-booked treatments on October 22, 2009.)

How to register
Conference registration will be available online through the conference page of the BADN website – www.badn.org.uk. Or you can send your email details to conference@badn.org.uk with “2009 Conference” in the subject line. Delegates to the 2008 conference will receive an invitation by email shortly.

Don’t worry if you’re coming to the conference on your own – we’ll look after you. If you would like to share a twin room with another delegate, just email us to let us know (conference@badn.org.uk) and we’ll try to match you up with another delegate. If you would like to travel to Cheltenham with other delegates, email your details and we’ll put your details on the conference page of the website so other delegates from your area can contact you.
Time to listen

In unsteady times, patients might feel more vulnerable, so it’s wise to make sure you’re dealing with your patients in the right way to make them feel comfortable, says Mhari Coxon

You may have noticed that our country is in a bit of a pickle financially just now. I don’t mean to sound ghastly about this, I am just not sure how to describe the situation. This global crisis will filter down and affect everyone in some way. I am grateful that, working in a service industry, as of yet, my book remains full of regular patients and there is still a steady stream of new clients on our day lists. My position is looking hellish but thankfully I am a long way off retiring yet. How many patients will be interested in forking out thousands for cosmetic work over the next year or so remains to be seen.

The stress that those not experiencing good fortune in their career must feel is hard to comprehend. Redundancy is on the increase, a four-day week is being bandied around as a solution in a lot of firms, and I am finding more and more people coming in not sure if they will have a job when I see them next. It is not surprising then that clients are apologising for their mouth before they even hit the chair. They know they have not cared for their mouths well since their last session as there have been other things on their mind.

Stress in relation to health

In times of personal crisis, our normal routines can be altered drastically, leaving us vulnerable to all sorts of things. Our eating habits can be less than ideal; we can skip meals and eat convenience food more often. Our alcohol consumption/cigarette use can go up. Our workload increases and we find a new set of priorities which don’t include yoga and flossing. We do not sleep well or exercise enough because we are tired. Illness seems to sneak up easily and linger for longer than it should. When stressed our saliva flow can be significantly reduced, creating a higher risk of caries and periodontal pathogen growth.

Relapse phase

A combination of even a few of these things can tip the balance in the favour of disease. This often puts our clients into a relapse phase with their maintenance care and we need to support them well to allow them to find some motivation to keep caring for their oral health. We can’t fix the economic downturn, but we can help them survive it without new dental disease.

Using communication skills

And so it is important to remember the communication skills we have. Bearing in mind the ‘Four Es’ is helpful when relating to our patients. These are: engagement, empathy, education and enlistment.

We need to make sure we are engaging with our patient as they feel now. A person who has been made redundant is a different one to the person we knew in a secure job a few months ago. Reassess the clients’ personal situation in the most empathetic way you can.

Make sure you re-engage with your clients and spend time listening to what they have to say. Empathising with their situation rather than sympathising can help them to feel understood. Giving them some time to tell you how their life has

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changed can be valuable, but also must not dominate the entire appointment.

This communication phase can help to reduce the patients' need to be defensive when discussing their oral hygiene with a professional. No one likes to be told off anyway, but even less so when life is pressured. Wagging your finger and saying: 'You should be brushing in the evening you know', is not going to curry favour with the average client just now.

We then have to re-enlist them as supporters of the treatment plan, to ensure their health parameters do not fluctuate out of the boundaries of health. This can best be achieved by using indices to show how things are. Science telling you are in trouble is less offensive than your hygienist telling you off. We have microscopes in surgery, which help us to assess the quality of the clients’ biofilm growth.

Clinically there can often be a reactivation of stable sites at times of stress in clients. This is when regular screening of bleeding, plaque and pocket depths will make it easy to see how the body is coping. I sometimes pop those with a previous history of caries back on high fluoride toothpaste during times of stress as a prevention measure.

Keep disclosing

And so we come back to disclosing each patient. Sometimes it can be a good motivator to kick-start their routine. If the patient is not ready to take up the routine of care again, we are better to leave motivational change, and use the disclosing to create a road map for a good disinfection of the mouth. This will help the patient and perhaps they will feel more able to cope by the next maintenance session.

Support through maintenance

The other way we can support our patients is by reducing the time in between their maintenance sessions to help keep them in that healthy zone. If finances are an issue, perhaps shorter sessions, closer together, over the next year would be a good way to support health. Obviously we need to consider the patients financial situation in this too. But, in my clinic at least, you can have eleven hygiene sessions for the same price as one crown so it really is a simple case of insurance. When you put it to patients like that it can help them to understand the need for continued care and how it is an investment in the long term.

Have a look at www.periodontalnutrition.com for some good advice for patients and great information about general health in relation to periodontal health.

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@cpdfordcp.co.uk.

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Dental Tribune
United Kingdom Edition · June 8–14, 2009
Industry News 27

750th Aquacut Quattro Installed

Bexleyheath, in Kent, is now fi-
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Abrasion is concerned! The
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Infected with common sense

CODE, the Association for
Dental Practice has just laun-
ched an Infection Prevention
Kit to make it easy as pos-
sible for all dentists to comply
with the new decontamination
guidance HTM 01-05 from the
Department of Health.

The CODE Infection Preven-
tion Kit is a collection of practi-
cal tools, which distil the new
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sections to make compliance
with all aspects of cross infec-
tion control, sterilisation and
decontamination manageable.

The kit is provide free to
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stand-alone product for £50
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Infecting with common sense

CODE, the Association for
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can our practice offer that a
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1

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EAPD Agree on updated Fluoride Guidelines

The European Academy of Paediatric Dentistry (EAPD) convened in Athens in November 2008 to agree guidelines on the use of fluoride in children. Paediatric experts from 25 European countries attended the workshop that was generously sponsored by P&G.

The proposed guidelines were approved unanimously by the EAPD Board and Council during their annual meeting in Helsinki on May 14-16th, following a 6 months discussion in order to achieve the highest level of consensus. The updated guidelines will appear shortly at the Academy’s site (eapd.net) and will be published in the Academy’s official journal, European Archives of Paediatric Dentistry.

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DAY 7: Trek halfway to summit to acclimatise. 5 hrs
DAY 8: Trek to the summit for sunrise. Return to Horombo Hut. 15-17 hrs
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This accreditation seminar is aimed at General Practitioners, providing you with all the knowledge and skills required to begin using The Clearstep System right away.

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Once accredited, further your orthodontic expertise with our hands on course, where you will learn sectional fixed skills and other methods to reduce your costs and treatment times.

Clearstep Advanced Techniques
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Comprehensive invisible orthodontics made easy

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**ESSENTIAL KNOWLEDGE**

**Dr. Howard Stean**
Clinician, author and tutor

**Course in Aesthetic Restorative Dentistry**

September 2009 – 2010

5 months one Wednesday per month

- Suitable for newly qualified and experienced dentists
- Fully updated syllabus with state of the art illustrations
- Practical exercises and assisted study

The Course venue in Kew, West London is conveniently located and timed to be accessible from most parts of the UK

The Course is eligible for 30 hours Verifiable CPD & a Certificate will be issued

- Fee of £2250 (plus vat) that includes Course material and buffet

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**Implantology Mini Residency**

**ONE YEAR SURGICAL & RESTORATIVE IMPLANTOLOGY COURSE**

with **Dr Mark Hamburger, Specialist Prosthodontist**

An implant course to provide you with the necessary knowledge and skills to start a successful career in implants.

The course is aimed at general dental practitioners looking to integrate implant dentistry into their patient care.

The course provides:
- All necessary education to comply with the GDC guidelines as set out by the Faculty of General Dental Practitioners, UK and the Royal College of Surgeons, England
- Compliant with GDC guidelines for 185 verifiable CPD points.
- Benefit from over 20 years of clinical knowledge & experience.

The course:
- 18 full days spread over a 14 month period, located in Harley Street, London.
- Maximum of eight candidates per course.
- Each candidate will place and restore at least two implant cases under the direct supervision of Dr Mark Hamburger. In addition: treatment planning, surgical and restorative observation of all course patients.

Guest speakers:
- Dr Henri Thuau, Consultant Maxillo Facial & Oral Surgeon
- Dr Jo Omar, Medical Emergencies and CPR

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