DENTAL TRIBUNE

The World's Dental Newspaper · United Kingdom Edition

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News in brief

Access stories from around England

Greek solution

George Kiosses, a Greek dentist, believes he may have the answer to a shortage of affordable dentists in the Great Yarmouth area. He has set up a new private practice there but says his 'subscription membership scheme' will be reasonably priced.

Derbyshire rescue

New NHS dental practices are to open in Derbyshire as part of a £3.3m investment. Two new surgeries will be opening in April and May to treat patients who have previously struggled to find an NHS dentist.

Poor advice

Report comes from Maidstone of a patient seeing an 'NHS dentist'. She was told the work she needed to a painful tooth would cost £250 even on the NHS (some mistake surely), but in any case the dentist didn't have the skills to carry out the job, nor did he think any local NHS dentist would have the necessary equipment. He advised her to look for private treatment.

Turned away

A heavily pregnant woman was turned away from her dental check-up in Preston. When she arrived for her appointment, the six-months pregnant mum was shocked to be told her NHS dentist could no longer see her as the practice had been told it had already dealt with too many NHS appointments and had reached its quota.

Devon despair

An Exeter mother is at her 'wit's end' as she desperately searches for free dental treatment in the city for her young children. Samantha Harry has registered her four children with four dental practices over the last five years only to be told after about a year of treatment that they are no longer taking NHS patients.

Cancer sufferer

A cancer patient has been forced to pay for private dental treatment as there are no NHS dentist places left in Rochdale. He told a local paper: 'The only advice (from the PCT) I was offered was to keep trying by constantly ringing around dentists randomly in the forlorn hope that they may have had a cancellation.'

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International news

Stories from USA
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Don't be fooled that there is such a thing as the 'best' pension plan. Retirement planning depends on your circumstances, says Ray Prince

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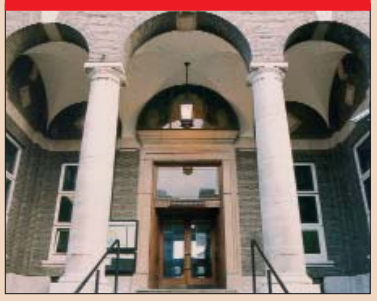

What do patients think?
There are many benefits to involving patients in research says Dr Susan J Cunningham from orthodontic department Eastman Dental Institute

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Forensic dentistry
An interview with forensic dentistry specialist Professor David K. Whittaker, of Cardiff University Wales

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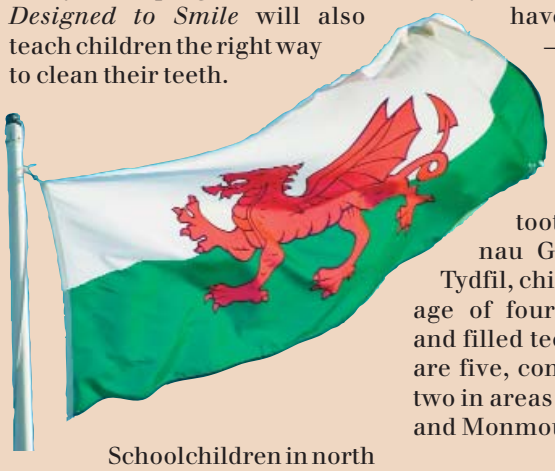
Pupils to get free toothbrushes in Wales

Children in Wales aged between three and five will be given free toothbrushes and toothpaste to stem unacceptable rates of dental decay. The programme called *Designed to Smile* will also teach children the right way to clean their teeth.



Schoolchildren in north Wales and parts of south east Wales will be targeted first in pilot projects. Launching the scheme Welsh health minister Edwina Hart said: 'Rates of tooth decay in Wales are unacceptable for what is almost a totally preventable disease. Some of our children have some of the worst teeth in Europe. We need to reverse the trend if we are to meet our dental health and child poverty targets.'

The minister said the toothbrushing schemes would provide children with the tools they need to develop and maintain good oral health from an early age. She added: 'We intend to work towards every child being provided with free toothbrushes and fluoride toothpaste.' Older children aged six to 11 will also be given advice on teeth cleaning. A total of £4.6m is being put aside for this project.

Professor Ivor Chesnutt, from Cardiff University School of Dentistry, said there was lots of evidence to show regular toothbrushing was 'crucial' to good oral health. 'We know that for many children at greatest risk of dental decay, cleaning their teeth or having their teeth cleaned does not form part of their daily routine,' he said.

More than half of all five-year-old children in Wales have some tooth decay – rates are highest in deprived areas and experts say that some children in Wales have 'never seen a toothbrush'. In Blaenau Gwent and Merthyr Tydfil, children have an average of four decayed, missing and filled teeth by the time that are five, compared to less than two in areas such as Ceredigion and Monmouthshire.

But the British Dental Association said the scheme does not go far enough and children should also be taught how to use fluoridated mouthwashes properly. Stuart Geddes director of the British Dental Association in Wales, said, 'We need to educate young children about how to look after themselves and I would hope this scheme does not stop at simple tooth brushing. I would like to see it including mouth rinsing with a fluoride mouthwash. In the absence of water fluoridation, this is another way of getting fluoride into contact with teeth.'

He continued: 'If we can get a complete programme of oral health, which includes tooth brushing and mouth rinsing, that would be even better. I believe this is very much for the benefit of children, especially in the not-so-well-off areas of Wales where some of them have never seen a toothbrush, let alone toothpaste.'

In contrast to England the Welsh Assembly Government has announced that it will freeze dental patient charges for the second year running, to help maintain wider access to NHS dentistry.

However before the English feel too hard done by, a similar scheme was started there back in 2001. Free toothbrushes and toothpaste were given to a million children over the following three years, as part of a £1 million dental health scheme launched by the then Health Minister, Hazel Blears.

The *Brushing for Life* project targeted the 21 health authorities with the highest levels of dental decay - 11 in the North West, five in Yorkshire and five in London. As part of the project health visitors gave out free packs including a toothbrush, toothpaste and leaflets to the parents and carers of young children, demonstrated correct tooth-brushing techniques and gave oral health talks in nurseries and playgroups.

In recent evidence to the House of Commons Health Committee chief dental officer Barry Cockcroft said: 'We have a scheme called *Brushing for Life* which is linked to Sure Start where in some areas PCTs buy packs that we provide and then they are distributed through the Sure Start network with some oral health advice as well. The take up is very good in some areas and we need to do more of this. We re-launched the scheme a number of years ago and we are pushing that very hard in local communities.' DT

The new dental contract – full of holes and causing pain?

On March 6, the Patients Association launched a survey which asked Primary Care Trusts in England how they are responding to the new dental contract and the needs of their patients

The Association sent a questionnaire to each of the 150 Primary Care Trusts (PCTs) in England, under the Freedom of Information Act. A total of 112 questionnaires were returned giving a response rate of 75 per cent. In summary:

- The majority of PCTs say they are satisfied with the level of funding and the latest increase. Most confirm that the funds are ring fenced.
- But: PCTs complain there is widespread lack of funds for orthodontics and other specialist treatments
- There is increasing concern for the preventive role of dentistry in detection of oral health disease.
- Patients are confused about the new contract, new charges and NHS availability – complaints have risen
- PCTs now commission dental services for their area, but the results reveal a lack of creativity in commissioning
- There is confusion about the commissioning role of PCTs
- The mixed bag of access to service, emergency and out of hours care, and preventive campaigns revealed in this survey 'does not constitute a national health service for dentistry

Funding

All PCTs said that funding had either been ring fenced or floor funded – in practical terms the same thing, but two of them said funding had been transferred to other services, but less than ten per cent of it.

Asked what services they found difficult to fund. Most cited orthodontics and other specialist care. Compared to the previous year, the vast majority of PCTs indicated an increase in their dental funding in 2007/ 2008 on average 4.4 per cent increase on the previous year. The majority of PCTs were generally satisfied with their dental funding (57.6 per cent).

The Patients Association were critical of the response that only just over a third (37 per cent) were using their funding to attract new dentists to their area, but out of the additional money the PCTs had to fund an increase in contact values which will have taken most of the increase. This also explains why nearly three quarters (70.2 per cent) of PCTs said that they use less than 10 per cent of their dental budget to attract new dentists.

Access to NHS treatment

The survey showed up some confusion about what 'access to NHS dental care' means. In answer to one question the PCTs said that, on average, 1.3 per cent of their population remained without access. On the other hand only around half of their population 'were currently receiving NHS dental care'. The Patients Association found these responses incompatible, but the discrepancy is probably due to the fact that not all people who are without a dentist actually want one.

Figures for dentists who have left the NHS reflect previously published Government data. The vast majority of PCTs (92 per cent) said that fewer than 10 per cent of dentists had left the NHS entirely; 81.9 per cent of PCTs indicated that fewer than 10 per cent of dentists in their area opted out for NHS fee paying adults only. However, 1.1 per cent of PCTs replied that 30 per cent to 50 per cent of dentists had opted out. The vast majority (95.9 per cent) of PCTs said that they successfully offered alternative care for patients whose dentist has opted out of NHS care.

Treatments offered

PCTs were asked if they were aware of any particular treatments ceasing to be offered by NHS dentists and 31.3 per cent of PCTs confirmed they are aware that this was happening.

They reported reductions in the following treatments:

- Root canal work - 89.7 per cent
- Bridges - 51.7 per cent
- Dentures - 37.9 per cent
- Crowns - 27.6 per cent
- Dental extractions - 3.4 per cent
- Other 17.2 per cent: included periodontal treatments and domiciliary care.

On orthodontic treatment, the Patients Association commented: 'This is an area of dentistry which falls increasingly into private care despite its expense. Child patients requiring orthodontic treatment need it without delay. The NHS scheme, using a scale of severity, allows only the most severe cases to be dealt with. Yet nearly half (40.6 per cent) of PCTs indicated that they allocated less than 10 per cent of their dental funding to orthodontic treatment.

'It is open to question how the small sums allocated to orthodontics square with the statements in this questionnaire that a complete dental service is offered to their populations. The general standards of access to orthodontic care differ widely from the access patients have to other parts of NHS care, but there is no clinical reason why this should be so.'

Dentists

Over a third of PCTs (38.2 per cent) have sought to recruit dentists from overseas. Almost all of those who did (91.9 per cent) indicated that Poland is an ideal place to recruit dentists.

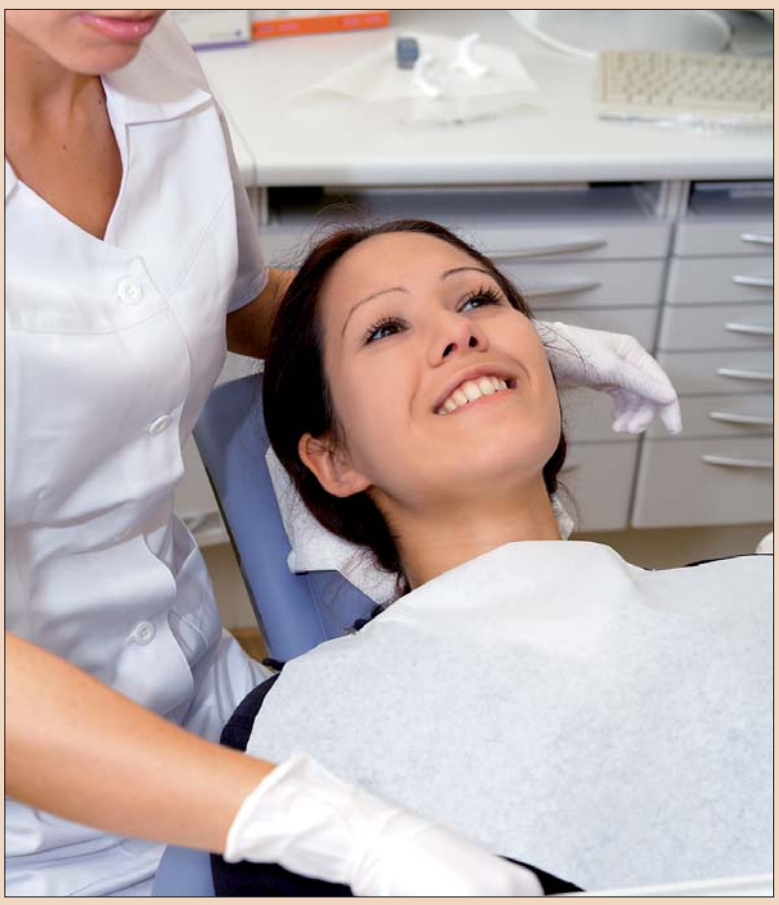
Asked about the 'ideal profile for a dental practice after 2009, about a quarter (25.5 per cent) of those PCTs answering this question, detailed the 'importance of putting in place multi-skilled practices with several dentists in practice together in order to comply with clinical governance guidelines'.

If a dental practice is sold, PCTs appear to have two different approaches. Some have a strict policy of no guarantee that the contract will be passed on to the new practice owner, if there is greater need in other areas. Other PCTs adopt a more informal approach, merely giving advice to the new practice owner on the content of the contract.

The average Unit of Dental Activity (UDA) value is of £22.90. Asked if they anticipate harmonising UDA values across the PCT area in April 2009, 62.2 per cent of PCTs said they had no such intention.

About three quarters (76.5 per cent) of PCTs indicated that they permitted dentists to have child only contracts. Of those that did 53.3 per cent anticipated continuing permitting dentists to have NHS limited contracts after April 2009.

Only four per cent of PCTs had agreed any uplift of fees locally for endodontic treatments following the recent 'single use instruments' advice. DT



How are patients faring after two years of new contract?

Patients Association demands

The Patients Association have acknowledged an educational grant from Denplan, which made work on the survey possible. As a result of the survey the Patients Association has called on the Government to:

- Examine the co-payments system for dentistry as the basis for expanding the availability of treatments elsewhere in the NHS.
- Ensure early diagnosis of serious oral illness e.g. cancer by giving patients the same level of preventive care as is now planned for other specialties in the NHS. Primary Care Trusts (PCTs) must offer a complete and safe NHS dental service to their population, which was intended to be a main benefit of the new contract.
- Remove the postcode lottery for patients which results from poor or weak commissioning by PCTs. Where PCTs offer an excellent, creative commissioning structure, they should take over the dental commissioning role of those that do not. Renewed guidance on best practice in commissioning should be issued.
- Require PCTs and dentists to ensure patients are fully aware of the important changes to their NHS dental service and charges, thereby minimising patient anxiety and financial waste.
- Ensure the same level of coverage and availability of specialist treatments, e.g. root canal, orthodontics, as applies to other specialties in the NHS.
- Require PCTs to ensure dentists comply with latest infection control guidance.

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The Eddie Crouch case continues outside court

Mr Justice Collins delivered his split verdict in this case at the end of February, finding in Eddie's favour on one point, but against him on the other. The case has now stimulated comments from the Department of Health (DoH) and the British Dental Association (BDA).

The BDA was 'delighted' that Eddie Crouch had won his case against an unreasonable clause inserted into his Personal Dental Services (PDS) agreement with South Birmingham primary care trust (PCT). The PCT had changed the model contract to give it the right to terminate his agreement for no cause at any time and on a period of notice that it could determine.

The BDA supported Dr Crouch's case because of the consequences losing may have had for all dental contracts. It says it 'committed significant resources' in support of this element of the claim and believe that its submissions materially assisted his victory. The BDA did so because it believed not only that the PCT had misinterpreted the regulations, the model contract and the guidance, but that the clause 'did not reflect the policy intention of the Department of Health'.

The DoH has also issued guidance to PCTs about the case. It said that Mr Crouch had 'challenged the legality of a clause in his PDS agreement allowing the PCT to terminate the agreement at any time'. The DoH had supported the PCT in Court and continues to maintain that the PCT had always had the right to insert this clause but, in effect, the judge had moved the goalposts, by reinterpreting the PDS regulations.

The DoH says PCTs were 'required' to include such a clause allowing them to terminate an agreement without a reason provided they gave notice. There was, of course, no such talk before the contract started when the Department of Health was at pains to reassure dentists that contracts could only be ended by a PCT if there was a good reason. But of course in those days they wanted people to sign up to it.

The BDA did not support Eddie Crouch in his second point, which was lost, that the PCT had a responsibility to hold a public consultation exercise or needs assessment prior to awarding contracts. It took this action on the advice of a QC. The BDA's Executive Board points to the 'very significant costs the Association has devoted to legal review of the 2006 NHS changes'. The Board did not consider that it would have been 'a proper use of members' money' to have sought judicial review against the Department of Health for the whole of the 2006 changes and the way that they were implemented.

BDA members may well ask what is a 'proper use' of their money if it is not to support them in their struggles with the Department and challenge the legality of this unpopular contract even if there is little prospect of winning the case. At least the profession would know where it stands. DT

Department of Health makes its position clear

GDP-UK round up

Tony Jacobs rounds up the latest issues from his growing GDP-UK emailing list. The HSC inquiry has been widely discussed and illegal dentistry by beauticians continues to pose a worry

The Health Select Committee (HSC) inquiry into dentistry has been food for thought and comment on GDP-UK of late. In the past, colleagues have shared Hansard online, and read through pages of dry evidence, questions and answers between committee

GDP-UK founder Tony Jacobs.

MPs and their carefully selected witnesses. These days, the HSC is recorded for broadcast, and the proceedings can be viewed through the Parliament's website. A long session showed John Renshaw and Eddie Crouch interviewed, as well as John Taylor, the retired chairman of the old DPB.

Some of the exchanges were interesting. John Taylor quoted evidence that paying dentists by piece work makes them more productive, and more cost effective for the tax payer. All sides agree that change from the old system was needed. Colleagues thought the HSC was more sympathetic to Crouch and Renshaw, and more hostile when interviewing the chief dental officer (CDO), later in the session.

I think that many of the CDO's ideas are based on his experiences of working in a true partnership in a practice where there was a unique PDS contract not piloted elsewhere. In evidence, the Department of Health continues to state that the pilot PDS schemes were used to draw conclusions. As a result, some of the features are being discarded.

Colleagues in the GDP-UK group also discussed the pros and cons of running an in-house payment plan for their practices. Many colleagues have done this themselves, and continue to manage the processes, while others are happy to use a service provider.

A further issue highlighted was a very carefully worded debate about 'highly productive associates'. Colleagues were cautious in how they addressed this subject as there was talk of some practices shedding associates who were previously 'highly profitable' under the old GDS. Some colleagues felt this phrase should not be used, either.

The illegal practice of dentistry by beauty salons concerns many colleagues, and the stance of the GDC in using legal means to stop this practice of dentistry by non dentists was welcomed by GDPs.

Merrill Lynch's valuation in its part purchase of IDH made colleagues think about the 'million pound practice'. Is there one near you? DT

GDPUK welcomes new members at its new website, *http://www.gdpuk.com*. There are money saving benefits to being a member, which is free. GDPUK is always seeking to improve the benefits to members.

High costs and long waits are forcing patients to go abroad says survey

Record numbers of British patients are travelling abroad for medical and dental treatment because of the high costs, long waits and infection risks of care in Britain, according to a survey conducted by the agency *Treatment Abroad*. The growth in medical tourism is being fuelled by cut-price private treatment, offered in combination with package holidays to exotic destinations including South Africa, South America and Malaysia. An estimated 100,000 people travelled abroad for treatment in 2007, up from 70,000 in 2006.

High costs and the difficulty of finding an NHS dentist have made dental tourism the fastest-growing category of medical tourism, with Hungary the most popular destination for dental treatment. Of patients contacting *Treatment Abroad*, 43 per cent were seeking dental care, it said.

Keith Pollard, its managing director, said: 'Dentistry is the biggest part of the business. The number of providers targeting the UK at the moment is phenomenal. It is driven by the high prices charged in the UK and the difficulty of finding an NHS dentist. When you find a private dentist, the prices are shocking.'

Savings of thousands of pounds have been reported by British patients having crowns and implants in Hungary compared to the cost in Britain. Of 648 people who contacted the *Treatment Abroad* website and responded to its questionnaire, the majority said saving money was their chief reason for travelling. Almost two thirds said they had chosen to go abroad to avoid NHS waiting lists and more than half said they were worried about hospital infections.

British medical and dental organisations warn that providing follow-up care for patients treated abroad is more difficult and complain that British doctors are increasingly having to sort out complications from treatment provided elsewhere. They say standards of training, regulation and infection control may all be lower than in the United Kingdom.

The European Commission is expected to publish draft plans which would open its borders to medical tourists, allowing citizens of any of the 27 member states to seek treatment in a neighbouring country with their home country, in certain circumstances, picking up the bill. If the proposals are approved, the expansion of choice will focus attention on the performance of the NHS against other health systems on the Continent.

Budapest: the favourite place for 'dental tourists'

A spokesman for the Department of Health said: 'The vast majority of those who travel abroad for treatment do so for surgery that is not available on the NHS, and the numbers doing so are a tiny fraction of the 350 million patient treatments the NHS carries out each year.' DT

Steve Gates (Denplan MD) and Sharon Ellis (head of human resources) receive their award.

Denplan receives *Sunday Times* award

For the fifth consecutive year Denplan has risen through the ranks of the *'Sunday Times 100 best companies to work for, 2008'* listing, for mid-sized companies. At the awards dinner held at Battersea Park Events arena, London, hosted by the BBC's Fiona Bruce (on February 28) Denplan again moved up the listings to secure sixth position – a rise of two places from 2007.

Steve Gates, managing director said: 'These awards are a real testament to the team here at Denplan, which continually rises to meet the exciting challenges facing UK dentistry today. As the organisation's leader it's hugely gratifying to know that Denplan commands such high levels of commitment and loyalty from its employees, without compromising their work-life balance. This winning attitude is the key to our success as a leading provider in our field.

'Dentists nationwide recognise how they too benefit from this ethos, which makes us the number one choice for those looking to move into private practice. Five years ago we entered the list at number 62 and year on year we've continued to rise. This is our highest position yet and a great achievement. My thanks go to everyone at Denplan for expressing their views so positively and making it such a great place to work.'

The *'Sunday Times 100 best companies to work for'*, for mid-sized companies, is open to all companies in the UK employing between 250-5,000 people and is designed to distinguish between 'the good and the most outstanding companies'.

Based in Winchester, Denplan employs over 300 people and provides products and services to over 6,500 member dentists and 1.8 million patients, nationwide. DT

Hove practice faces massive clawback

Bosses of an award-winning dental surgery say they may have to close because of their NHS contract problems. The Toothsmart surgery, in Portland Road, Hove, may stop treating NHS patients. Colette Murphy, who runs Toothsmart with husband Zoy Erasmus, says the practice has been struggling to break even since the Government introduced the controversial dental contract in April 2006.

Mrs Murphy told a local newspaper that the primary care trust (PCT) had told them that there is no problem with access to dental care, yet the figures show fewer people are visiting the dentist. 'We have been working flat out and have not had a holiday, yet are struggling to break even. It cannot be right,' she said.

Mrs Murphy is in dispute with the PCT, which says the practice owes £96,000 over work which has not been carried out. She said: 'The PCT pays surgeries for the work at the start of the year, but because our targets are so unrealistic we simply cannot do all that work. If we have to pay those clawbacks we will eventually have to stop treating NHS patients and close half the surgery, because it is simply costing us too much to keep treating people on the NHS.'

About 6,000 fewer adults and 900 fewer children have visited NHS dentists in Brighton and Hove since April 2006. A spokesman for Brighton and Hove City Teaching PCT said: 'There are NHS dental places available in the city now, and if this practice moves away from NHS dentistry we would use the money to provide replacement NHS places at other practices instead. The NHS dental contract gave practices an agreed amount of money in exchange for an agreed quantity of treatment. The quantity was agreed with each practice on the basis of the activity levels it had been delivering previously.

Something to squawk about in Hove

'When a practice delivers less activity than it had contracted for, we ask it to refund the money it has been paid for the proportion of work it has not done. The Toothsmart practice provides excellent care to its patients and we want to see that continue. We have been working intensively with the practice to help it find a way forward, but have not yet agreed a solution.' DT

Rogue salesmen using scaremongering tactics

The local Strategic Health Authority (SHA) has taken the unusual step of issuing a statement reassuring patients that NHS dental services remain widely available in the North-East. It follows reports that door-to-door sales staff have been trying to get members of the public to sign up to private dental policies by telling them that it is difficult to get an NHS dentist in the region.

According to the SHA, access to NHS dentists in the north east is the best in England. A recent report from the Information Centre found that 61 per cent of adults in the north east had visited a dentist in the last two years compared with 52 per cent nationally, while 59.5 per cent of adults and 73.9 per cent of children in the region had seen an NHS dentist at some point in the 24 months leading up to 30 June 2007. A spokeswoman for the SHA said: 'If people are approached, they are advised to get in touch with Trading Standards.'

SHA condemns door-to-door salemenheir award

Professor Jimmy Steele, of Newcastle University Dental School, said: 'That is quite shocking. It seems that people have been employed to generate business in this way. They are scaremongering, playing on people's fears.' While there was a 'widespread belief' that it was difficult to get an NHS dentist in the North-East, Prof Steele said he thought this was untrue.

The North-East SHA's dental adviser, David Landes, said it appeared there was a 'rogue' salesman or saleswoman who had been operating in County Durham and South Tyneside. While Mr Landes conceded that in some areas of the region NHS dentistry was 'not as good as the NHS would like' and that some people in rural areas had to travel to get treatment, he said people were still able to see an NHS dentist.

A spokesman for the Association of British Insurers said the sale of any form of insurance was strictly regulated and advised anyone who was unhappy not to sign any documents and to get in touch with the company's head office. DT

Minister lightly grilled by committee

Minister and CDO perform an unusual double act before the Health Select Committee

Traditionally the responsible minister gives the final evidence before a select committee, to answer or avoid questions that have arisen in other evidence sessions.

As health committee chairman, Kevin Barron, told the minister Ann Keen, when she appeared before him on March 6, 'Most of the questions that are going to be asked today are going to be directed you,' although he said she might wish to 'field them on occasions'.

Taking the catches that day were chief dental officer (CDO) Barry Cockcroft and civil servant, David Lye. Despite the chairman's wishes most of the questions were 'fielded' by the minister's supporters rather than by her. This gave the unfortunate impression of a minister unsure of her facts and not in charge. This was compounded when the CDO referred to her as 'Ann' rather than 'Minister'.

One committee member challenged the minister to accept that 'some PCTs are actually currently incapable of properly commissioning dental services'. Ann Keen thought 'incapable' was a bit strong but she agreed that there was 'very, very strong evidence that some PCTs need much more support'.

Another raised the issue of a quarter of a million fewer patients received NHS care in the first year of the contract; which meant the new the new arrangements were a failure. The minister deflected this to the CDO who said that the full effect of opening new practices would not show for two years after their opening. There was much questioning about access, waiting lists and workforce planning. The CDO said there was 'no workforce shortage and there are enough people who want to provide services if the PCTs offer them for tendering'.

Another issue raised by committee members was the department's relationship with the profession which had 'certainly not been good'. The minister said she had had a very good meeting with the BDA. She wanted to work with the BDA along with other professions related to dentistry in 'the same way as I work with every other part of the NHS'. She continued: 'We do recognise the professionalism of a dentist, the quality of the work they do and also, by us having regular oral checks, other more serious conditions can be diagnosed by the dentist and the rest of the oral health care team'.

The independent MP Dr Taylor feared he was living on a different planet from everybody else'. Dr Cockcroft had said he got no negative vibes, but the MP found that every time he sat in the dentist's chair he got negative vibes all the time, mainly centered around Units of Dental Activity (UDAs). The committee had heard suggestions for change in the system, but the CDO said what was needed was to 'let it settle down as it is'.

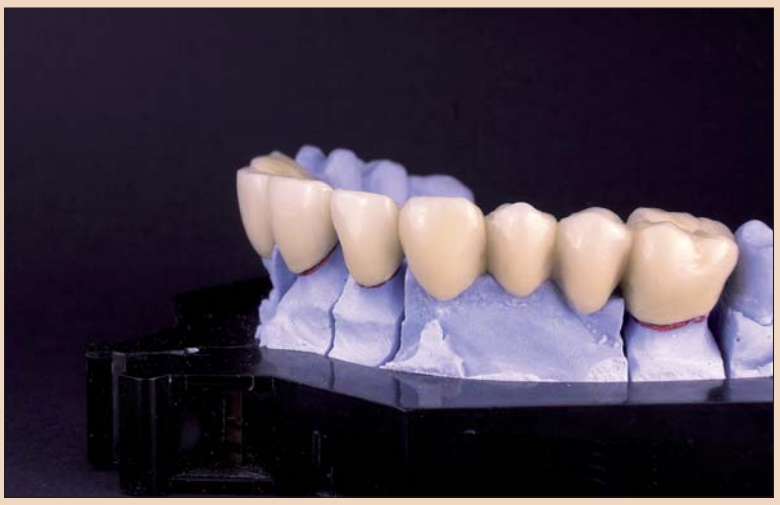
There was much questioning about UDAs and also the removal of patient registration, something that the committee appears to believe should be re-instated. Whether such ideas appear in its final report however, remains to be seen. DT

Concern grows in USA over lead in crowns from China

An Ohio woman has claimed that high levels of lead were found in her dental crownwork, which, she says, was made in China. She had received a three-unit dental bridge and after having an adverse reaction to her dental work, and having it removed, her dentist disclosed that the work had been sent to a dental laboratory in China.

The patient then had the restoration sent to a chemical laboratory for analysis. The documentation of the dental material analysis of this patient's restoration showed unsafe levels of lead in the porcelain on the restoration. In the wake of this report, the American Dental Association (ADA) has issued a warning.

The ADA says 'there is no appropriate use for lead in manufacturing dental prosthetics,' and the association is working with the federal regulatory agencies and the dental laboratory industry to 'determine the specifics' of the incident and determine 'whether it is an isolated case or indicative of a larger problem.'



Porcelain or China?

In a statement, the ADA says it is informing all member dentists about the news reports, and it has contacted appropriate federal authorities, including the Food and Drug Administration and the Centers for Disease Control and Prevention. 'We have begun our own investigation into the safety of both foreign and domestically produced dental crowns and other dental prostheses,' it says. 'However, our investigation should not be viewed as a substitute for necessary oversight and enforcement by the federal and state government agencies responsible for protecting the public's health and safety.'

The ADA adds that it is taking the reports 'very seriously,' but 'there simply isn't enough information available to presume that the presence of lead in dental crowns or other prostheses is widespread.' Only 15 to 20 per cent of dental prostheses used in the U.S. come from foreign labs, and China accounts for only part of that share. The Association advises patients to discuss any concerns about the safety of their dental crowns or other prosthetic devices with their dentists and suggests questions that could be asked.

UK response

The story aroused the interest of the UK media. Richard Daniels, the chief executive of the Dental Laboratories Association, (DLA) told the press that the number of potentially dangerous imports was rising. 'At this point nobody knows what the health risks are,' he said. 'The fact is the majority of NHS work will be coming from China or India in the next five years. We need to be moving towards proper regulation of the industry. It's not just a matter for the NHS either - many of the big corporate groups also have agreements with factories in China to make their fixtures.'

David Smith, a board member of the DLA, said: 'The worst case scenario is we'll end up with a large number of people in the UK with mouths full of lead and they've got no idea that that's the case. In theory what happened in America should never happen here as there are regulatory bodies which should prevent these problems in the UK.

'But the truth is, if the situation isn't addressed then it is only a matter of time before there is a similar case as in the States. We've watered down all the rules in such a way that you could drive a bus through them. In the end, the whole system is profiteering. Any savings made by outsourcing the work to China are never passed on to the patient.' DT

News from ADA at San Antonio, Texas

Debuting at the 2008 ADA Annual Session in San Antonio, Texas, the ADA is building an interactive, educational center at the San Antonio convention center for its attendees. The Live Operatory Center, will take place in the Gallery; a 15,000 sq. ft. area located in the exhibit hall, adjacent to registration. In the Live Operatory Center, attendees experience emerging technology in a hands-on environment that will provide them with assistance in their daily diagnosis and treatment planning.

The Live Operatory Center is a unique blend of product training and continuing education. This high tech environment is the first of its kind in the dental meeting arena and will allow attendees to earn up to 3.5 hours of continuing education (CE) credit for their attendance in three disciplines, while being exposed to the latest technology and products on the market. The ADA's goal is to provide attendees with knowledge that they can use as consumers on the exhibit floor, and skills they can take back and implement in their practice.

All dental procedures and patient demonstrations in the area are displayed on multiple 60-inch flat screen monitors, featuring detailed images collected from inner-oral cameras and hand-held camera operators. This high-tech, cutting-edge center will be divided into three distinct educational disciplines:

- The Laser Pavilion
- The 3-D Imaging Center
- The CAD/CAM Stage

The Laser Pavilion:

Working together, the ADA and the Academy of Laser Dentistry, have designed a new model for educating dental professionals on the safe and effective use of laser technology and the benefits of adding lasers to their practice. The Laser Operatory takes up roughly one-half of the Gallery and is divided into two separate rooms: a lecture room; and a workshop room. Forty participants at a time will attend a 45-minute lecture, immediately followed by a 75-minute hands-on workshop. This design will allow the Annual Session to accommodate 560 attendees between Wednesday afternoon and Sunday. The cost per person to attend the course will be US$95.

The 3-D Imaging Center:

In 2007, the ADA conducted live patient scanning with four 3-D imaging machines in one of the Education in the Round (EIR) classrooms. This was the first time this type of demonstration had ever been done at a major medical meeting.

For 2008, the ADA is expanding this program and moving the 3-D imaging to the Live Operatory Center. The 3-D Imaging Center will encompass 1/4 of the Gallery and feature four of the companies that participated in 2007, along with two new companies for 2008. Lead lined glass protection shielding will be built in the Gallery and will remain up during the duration of the Annual Session. This will allow for a five-day exposure to 3-D imaging for attendees, as opposed to one day in 2007. In addition, the ADA will be able to accommodate six machines, as opposed to four in 2007.

CAD CAM Stage:

The remaining 1/4 of the Gallery will have two mini-theaters with seating for 40-people in each. One theater will house the equipment for the CEREC system from Sirona and the other will have the E4D system from Schein. Attendees will have the opportunity to attend a 45-minute presentation on CAD CAM dentistry from each company that will include a full demonstration of the making of a crown from the point that the prep is done and conclude with the delivery of the crown on a typodont.

The Preliminary Program and online registration and housing for the Annual Session will both be available in April at *www.ada.org/goto/session*. International dentists who join the ADA as affiliate members received a special discounted registration to the Annual Session. Contact the ADA by e-mail, international@ada.org, or call +1.312.440.2726 for more information.

The 10th Dimension – the power of 10...

...a series of articles by Dr Ed Bonner BDS MDent, Sloan Fellow London Business School, practice coach and development consultant

The importance of induction

Induction can be defined as an introduction or initiation, or the act of carrying these out. Unfortunately it is observed more often in the breach than in the act. We give a great deal of thought about selecting a person to fill a vacancy, but not enough to ensure that the person's admittance and entry to the practice is a smooth comfortable process. Is it sufficient to say, 'Welcome to the practice, I hope you will be happy here – if you have any problems give me a call'? I don't think so!

I've recently read a management handbook called *Excellent Employment*, but regrettably the author fully bears out my point. More than a hundred pages are dedicated to the selection process, and then a half page to induction, which, even if the ultimate in brevity, is worth quoting in full: 'Once you have found your amazing new recruit with the fabulous attitude and all the skills you required, don't abandon them. Finding great people is only a small part of the employee equation; you have to find a way to retain them. Think back to those times when you took on a new job. Was there an induction programme or were you just left to work things out for yourself? Were you given a buddy or a mentor, someone to look after you during that first week or so, or were you left to get on with it alone? Did anyone sit with you at regular intervals during your first three months to tell you how you were progressing, or were you left to guess?' That was it.

Were you just left to work things out for yourself?

Very good, but only a hint of a taste, let alone even one course of a meal.

Who needs induction?

All of the following should be subject to an induction programme;

- All full-time, part-time, and temporary employees
- Those returning to work after a lengthy absence
- Temporary staff
- Work-experience students (with these, one should do a risk assessment with school or education authority)
- External contractors such as builders.

Purpose of induction

1. One should never assume levels of competence in respect of key subjects, including infection control, health and safety, personal protection, ionising radiation, and managing emergencies
2. Effective integration
3. Retention of new staff
4. Creates opportunities to communicate and establish policies and procedures
5. Demonstrates who is responsible for what, sources of advice, and lines of responsibility
6. Demonstrates the mission and vision, and values and principles of the practice
7. Creates an understanding of organisation culture
8. Assists with 'managing' attitudes and behaviours
9. The induction period enables the new employee to learn quickly whether he/she wishes to remain in the job
10. By complying with legislation, which a proper induction process obliges one to do, the risk of later litigation and prosecution is significantly reduced.

Structuring induction

Pre-employment: starts with offer-of-employment letter; involves learning, enables preparation; health &safety policy statement;

Initiation and employment on probation: One should appoint a competent "buddy" to mentor the newcomer, who should also be encouraged to shadow other employees. Induction includes a specified probationary period during which the new employee has a formal opportunity to learn enough about the practice in order to become a fully-functional member of the team in the shortest time possible. It begins with assigning the 'new' employee the responsibility of becoming familiar with the practice manual (assuming this exists!) The purpose of the manual is to provide the foundation and principles on which the practice is established and defines the boundaries or scope of its operation i.e. its policies and procedures. During this period the employee will learn the likes and dislikes of the employer and other members of staff and also of the patients.

Post-probation: this is based on periodic reviews – are aims and objectives being achieved? The purpose is to identify further training needs.

Lack of induction leads to

1. Lack of understanding and responsibility
2. Low motivation
3. Low morale
4. Increased complacency
5. Inefficient, ineffective and unsafe work practices
6. Failure to work to full potential
7. Mistakes leading to accidents
8. Unsafe practices leading to ill-health
9. Employees leaving, leading to increased recruitment costs
10. Risk to protection of patients.

It is apparent from the foregoing that proper induction of members of temporary and permanent, full- and part-time staff is an essential part of the process of successful employment, and is ignored at one's peril. DT

Part of the content of this article follows the approach of Jane Bonehill, a former dental nurse who now runs DenMed, and I would like to thank her for allowing me to refer to her methods.

Information via the written word

The fourth in the new managing information series of articles, by Dr Ed Bonner

Is writing a skill required by your average dentist in practice? Not really. If one doesn't have the necessary skill, one can buy it, but it don't come cheap! Being able to write decently however is a great gift, and used intelligently, can be invaluable in disseminating information. At its most basic, we need to be able to write up our *treatment plans* in a legible and coherent manner so that our patients will be encouraged to take up the treatment offered. *Brevity* in this respect is a talent most under-valued – it is not necessary to write the bible every time you send a patient a letter! We must be able to *note treatment carried out* in a manner not only suitable for us but for others who might later access it to comprehend exactly what we have done, what was said, and what might have gone wrong. Failure to do is probably the most consistent finding in negligence cases.

Keep it short and snappy

Creative writing is a boon in marketing your practice, whether via *brochure*, *leaflet*, *website*, advert or *advertorial*. Here again, your average dentist gets lost up his own fundamental as he tries to include every last detail within a limited space: trying to pour a quart into a pint bottle. One should heed the words of one of our most illustrious playwrights, Alan Ayckbourn: "A common mistake in beginners is to be so obsessed with content that they are in danger of creating something to heavy to move anywhere!" If you remember nothing else from this article, do not forget that if you expect your patients to spend more than a couple of minutes reading your brochure or website you are probably being wildly optimistic, as probably am I thinking that you are still reading this article.

If I cannot say what I want to say in 600 words, be it in an article, website, or brochure, I run the risk of being a bore. I spend more time filleting out superfluous words than writing them in the first place. Not everyone is or should be a comedian, but a touch of *humour* never goes amiss, especially when dealing with as serious a subject as dentistry! The length of sentence should vary: long sentences mixed up with shorter ones make a tastier salad than sentences of uniform length.

What is important however is the message you are trying to sell to your reader or patient. The writing technique I employ is the same as that which I apply in my consultancy, The 10th Dimension: distill everything essential into no more and no less than 10 points. Sometimes you have to *condense* from, say, 25, at other times you may struggle to find 10 points of importance, but this can be a highly disciplined and *creative way of disseminating information*. To illustrate the point, I have highlighted each important word or phrase in the above text. DT

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What's in a (practice) name?

By Sheree D. Whatley

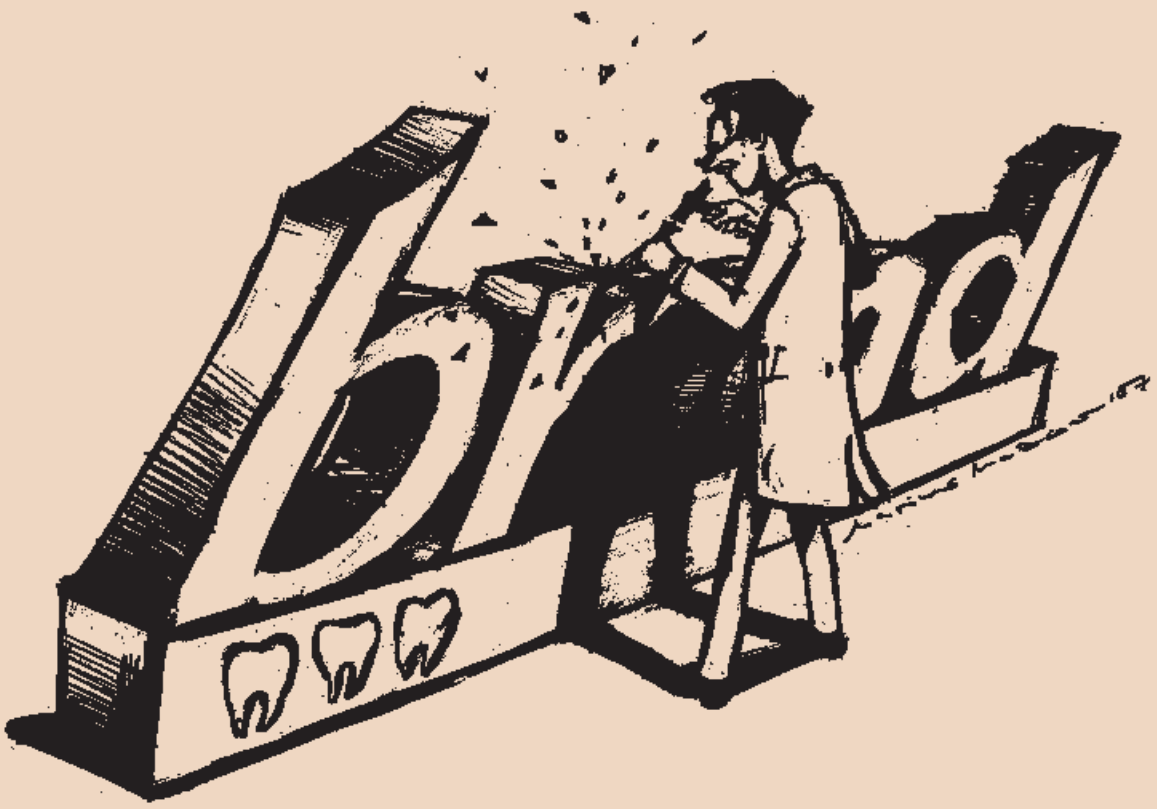

Illustration by Marius Mezger

So how important is the practice name? On a scale of 1 to 10, is it a 1 or a 10? Let me illustrate my point by using the experience of a well-established and very successful practice, based in Hertfordshire, U.K.

This practice was set up in 1957 by Bernard Bloom. In 1990, Bernard's youngest son David joined and persuaded his father to move to new premises and call the practice "Bloomsbury Dental." Jay, a contemporary of David's from Newcastle Dental School, joined in 1998, and Bernard retired shortly thereafter.

As the reputation of the practice grew, it became clear that with a name like "Bloomsbury" many potential customers mistakenly thought the practice was in Bloomsbury, London, or was an offshoot of a practice based in London, with the same name. It was therefore difficult for David and Jay to accurately assess how well they were doing with so much confusion. Nor could they measure the effect of all their marketing efforts. They soon realized that "Bloomsbury" said nothing about the ethos and culture of their practice. It was clearly time for a change.

Obviously, the change encompassed more than just the "name." David and Jay readily understood that they needed to have a clear, concise and consistent message expressed and implemented by everyone in the practice. Their rebranding exercise had to sum up the complete customer experience. It had to establish their unique identity. It wasn't just the direct branding: name, logo, business philosophy, and website. More importantly, it had to do with the way that their customers, and potential customers, would think about their practice.

So what did they rename their practice? David and Jay changed the name to "Senova Dental Studios – Our Passion, Your Smile." "Senova" means "new smile," much more apt for two of the U.K.'s leading cosmetic dentists. How successful has the change been? On a scale of 1 to 10, David and Jay feel it's a 10, and their customers seem to agree. Check out their Web site *www.senovadental.com*.

So why do David and Jay feel that it's a 10? While undergoing the rebranding exercise, David and Jay appreciated that customer loyalty arises not so much out of rational considerations but more on the basis of emotional affinity and personal connection. For them, customer retention and referral had always been a key part of their success. They needed to build on this by ensuring that the customers felt even more welcome and valued. They wanted to do more for their customers than anyone else did and even more than their customers would expect. They wanted to show their customers that they meant a great deal to them.

They had introduced the spa concept to the practice in 2005; recognizing that few people look forward to a trip to the dentist even though they know that the end result is going to leave them looking and feeling so much better than before. During long, and often messy procedures, David and Jay's patients are cocooned in their own soothing and calming world with a choice of music and films to watch, booties and blankets to keep them warm, hand treatments to aid their relaxation and crucially, dental bibs that keep them dry and their clothes completely protected.

Remember when I said they wanted to do more for their customers than anyone else? Yes, they have invented dental bibs that offer total protection and comfort. The idea was sparked by David's wife who, while undergoing a smile-lift, was unnecessarily distressed by having the neckline of her outfit and hair soaked in the process. She advised David, that the spa concept was let down by the inadequacies of their dental bibs. David challenged her to come up with something better, so she did – CollarDam.TM

Remember, small business branding is about getting your target customers to see you as their preferred choice. Building a brand isn't just about what you do; it's about what you do to differentiate yourself from everyone else. Your brand should articulate the total experience of doing business with you. It should be a dependable, consistent and yet special experience every time. DT

About the author

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