# Dental Tribune

The World's Dental Newspaper · United Kingdom Edition

Published in London | www.dental-tribune.co.uk | Vol. 10, No. 3


**BERGMAN SPEAKS**

The Henry Schein Chairman and CEO about public-private partnerships in dentistry and their importance for the improvement of oral health worldwide.

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**AQUACARE**

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# Dental Tribune survey sees majority of British dentists rejecting Brexit

## More than half would vote against the United Kingdom leaving the EU

**By DTI**

**LONDON, UK:** Were it up to dentists, the UK would remain a member of the European Union after the national referendum in June. According to an online survey conducted among *Dental Tribune Online* readers between February and March this year, a slight majority of dental professionals would vote for staying in the EU rather than leaving it.

After analysing the results of the poll, *Dental Tribune* found that more than 55 per cent of dentists who participated in the survey intended voting against Britain leaving the EU, while 44 per cent were in favour of a Brexit.

Less than 1 per cent were still undecided on the issue, but perceived an overall more negative future should Britain decide to split from the Union.

Similar responses were given by the participants when asked whether a Brexit would have positive or negative consequences for the country. A larger share of dentists, however, replied "I do not know" to this question.


*Britons have to decide on 23 June whether they want the UK to remain a member of the EU.*

The overall majority of respondents to the survey said they will definitely vote in the referendum. Only one in ten did not intend to participate in it.

The poll was conducted among 16,000 recipients of the *Dental Tribune UK & Ireland* weekly newsletter, with almost half of all replies from dentists in southern England, particularly London, which made up almost 20 per cent of the survey respondents. There was less participation by dentists from the northern regions, with slightly less than 30 per cent taking part in the poll. Only one in ten respondents were from the Midlands.

Dentists from Scotland, Wales and Northern Ireland, who made up 12 per cent of the participants in the poll, were split, with almost the same number voting for the Brexit as voting against it.

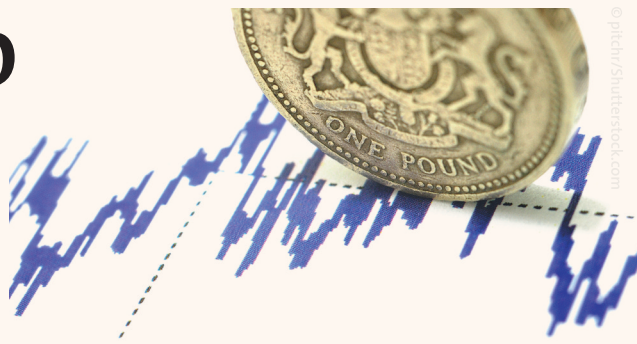
Almost one-third of those who responded to the survey said they were in private practice, while one-quarter said they were employed in the National Health Service. Forty per cent worked in practices that offered both NHS and private dental care services.

Regarding the age of the respondents, more than half were between 30 and 50 years old, followed by a large group aged 50 to 60.

Britons have to decide on 23 June whether they want the UK to remain a member of the EU. Mirroring the results of the *Dental Tribune* survey, the latest national polls indicate that the slight majority of the population will vote to stay in the UK. However, 10 per cent of eligible voters have still not decided which way to vote. Prominent political and economic figures have argued that a decision to leave the EU will have widespread negative consequences for the UK.

# Profits of private practices leap over those of NHS in 2015

## Eight per cent rise a direct result in fee income




**By DTI**

**LONDON, UK:** For the first time in over a decade, private dental practices in the UK have achieved greater profits last year than their NHS counterparts. On average, profits in private dentistry increased to £140,129 per principal according to the latest figures released by the National Association of Specialist Dental Accountants and Lawyers (NASDAL), approximately £10,000 more than reported by NHS practices.

The last time private practices were more profitable was in 2004/2005. The leap is a direct result of an 8 per cent rise in fee income, compared with NHS practices, whose income through fees only grew by 4 per cent last year.

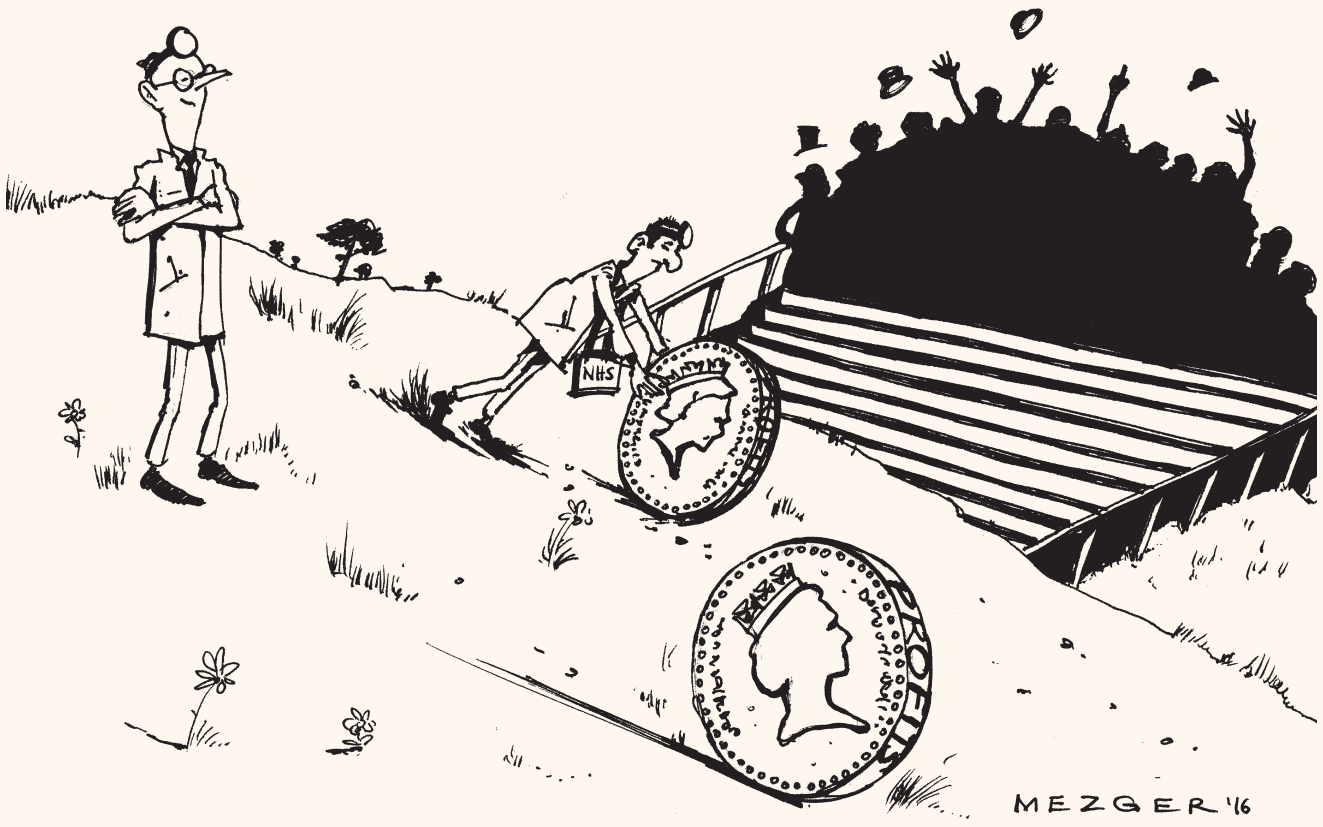
Overall, all types of practices experienced a sustained recovery of profitability in 2015 compared with 2014, according to Humphrey & Co. partner Ian Simpson, who presented the figures on behalf of NASDAL on Tuesday.

However, Associates' profits decreased slightly last year and this could be attributed to increased insurance and subscription costs, he said.

"It's positive to see that the UK dental market has continued to grow at a rate of around 4.4 per cent with relatively unchanged costs and prolonged recovery in profitability," NASDAL Chairman Nick Ledingham remarked.

The figures were collected through tax reports and accounts provided by accountant members of NASDAL across the UK. They are published annually in March and reflect the finances of dental practices and dentists for the most recent tax year, according to the association.

*The annual Pound rolling has begun*




# Periodontitis: Faster cognitive decline in people with Alzheimer's

**By DTI**

**LONDON & SOUTHAMPTON, UK:** A number of studies have demonstrated that poor oral hygiene, a common problem among elderly patients, is a risk factor for developing Alzheimer's disease. Now, a joint research project led by scientists at the University of Southampton and King's College London has provided further evidence that periodontitis could be associated with increased dementia severity and a more rapid cognitive decline in Alzheimer's patients.

Fifty-nine non-smoking patients with an average age of 77.7, mild to moderate dementia and a minimum of ten teeth who had not received treatment for periodontitis in the past six months participated in the study. The patients underwent dental examinations by a dental hygienist at baseline and at the six-month follow-up. In addition, blood samples were taken to measure inflammatory markers in their blood.

The presence of periodontal disease at baseline was associated with a sixfold increase in the rate of cognitive decline in participants over the study period. Periodontitis at baseline was also associated with a relative increase in the pro-inflammatory state over the follow-up period.

The researchers concluded that periodontal disease is associated with an increase in cognitive decline in Alzheimer's disease, possibly via mechanisms linked to the body's inflammatory response.

As the study only included a limited number of participants, the authors stated that the findings should be validated in a larger-cohort study. In addition, they highlighted that the precise mechanisms by which periodontitis may be linked to cognitive decline are not fully understood and other factors might also play a part in the decline seen in participants' cognition alongside their oral health. However, the current evidence is sufficient to explore whether periodontal treatment might benefit the treatment of dementia and Alzheimer's disease, they said.

Periodontitis is a common disease in older people. The World Health Organization estimates that 15–20 per cent of adults aged 35–44 worldwide have severe periodontal disease. The condition may become more common in Alzheimer's disease because of a reduced ability to take care of oral hygiene as the disease progresses.

Higher levels of antibodies to periodontal bacteria are associated with an increase in levels of inflammatory molecules elsewhere in the body, which in turn has been linked to greater rates of cognitive decline in Alzheimer's disease in previous studies.

Dr Mark Ide, from King's College London Dental Institute and first author on the paper, said: "Gum disease is widespread in the UK and US, and in older age groups is thought to be a major cause of tooth loss. In the UK in 2009, around 80 per cent of adults over 55 had evidence of periodontal disease, while 40 per cent of adults aged 65–74 and 60 per cent of those older than 75 had less than 21 of their original 32 teeth, with half of them reporting periodontitis before they lost teeth."

The study, titled "Periodontitis and cognitive decline in Alzheimer's disease", was published online on 10 March in the *PLOS ONE journal*.



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**Published by DTI.**

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# A new global language for dental professionals

**Primespeak launches patient communication series in the UK**

*Participants of Primespeak's take-off seminar in Manchester.*

**MANCHESTER, UK:** Many dentists find it difficult to communicate the right treatment options to patients, who through false or incomplete information on the Internet present to practices with unrealistic expectations. While the majority of patient communication training programmes available today often focus on one or more fixed strategies at a time, there are other concepts that aim to make this process more natural and less stressful for the dentists. One of them is Primespeak, an import from one of Australia's leading practice management companies, which is currently making its large-scale debut in the UK.

First introduced to the market here by Sydney-based Prime Practice three years ago, the seminar series is now on an extended road tour in the UK, stopping in cities like London, Birmingham, Bristol and Belfast, throughout the year and is made possible through a partnership with Henry Schein company Software of Excellence. The series was recently launched at a premier event in Manchester with 40 participants, where *Dental Tribune* had the opportunity to speak with some of the programme's directors and trainers.

According to Prime Practice General Manager of Education and Training Patric Moberger, one of the key objectives of the programme is to help patients take responsibility for their own teeth and to understand the damaging consequences of not looking after them. In order to achieve this, the programme provides a number of tools and strategies that, when applied at the right time and in the right combination, can help dentists gain patients' compliance with treatment, particularly those who do not truly understand the options before them.

*Patrick Moberger*

"Primespeak is applied at its optimum for patients who think that nothing is wrong because there is no pain involved. It is quite like high cholesterol: you do not feel the consequences until it is too late," Moberger explained. "By stepping away, we let the patient come to you ask for a solution instead of recommending something they may not understand and thus want to get involved in."

"Normally in sales you move towards the patient with a solution. All the tools that we are using with Primespeak however are counter-intuitive to sales training. The role that the dentists and the team have here is to make the patient understand that things are going on in their mouth and that they offer the right solutions for them," he added.

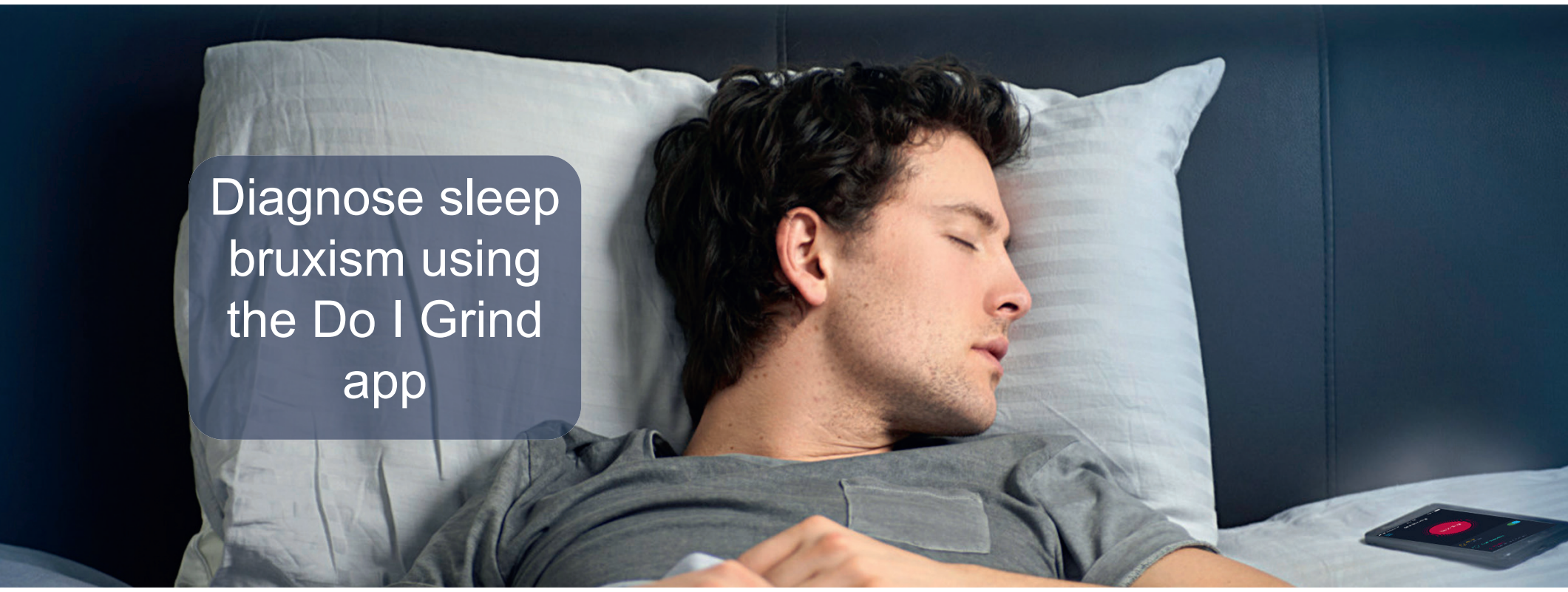
Feedback from dentists who participated in Primespeak seminars held in Australia and the US, where the series has been available to dental professionals for many years, has been very positive and encouraged the company, together with word of mouth, to bring the concept to the UK. In addition to the live seminars, it offers master classes, private consultations with a trainer and a library of online training videos. Seminars for dental assistants and front-end staff are under consideration. Participants at the seminar in Manchester responded positively to the programme.

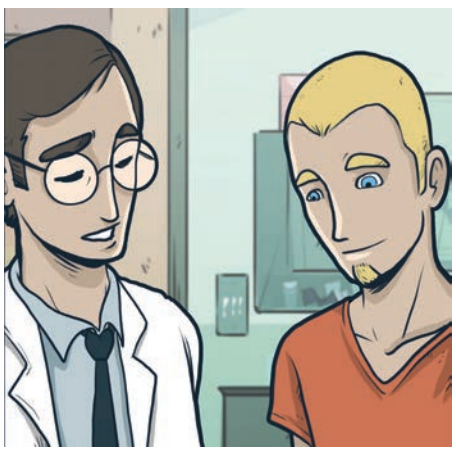
"If a dental professional is looking to build trust quickly with patients, save time and gain greater acceptance of treatment, that person should come to a Primespeak Seminar. Time very well spent," commented a dentist from Hull.

Another participant from Glasgow said: "I cannot recommend this course enough. It will remove the pressure when interacting with patients and is key to avoiding sales pitching perception."

Primespeak is holding its next seminar in June in Birmingham. Dentists or dental staff interested in registering for the programme can obtain more information at *primespeak.com/uk*.

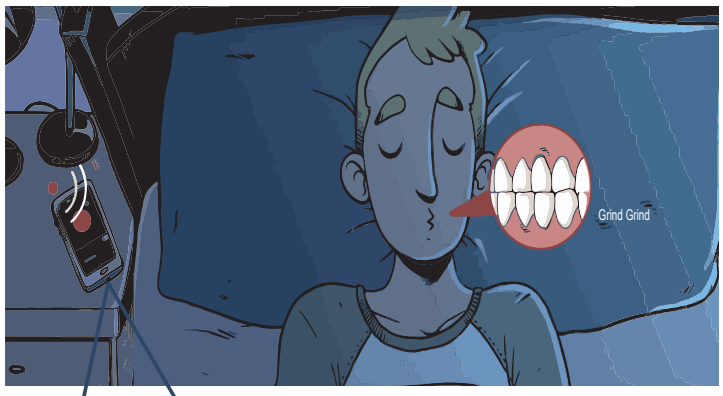
# Bruxlab

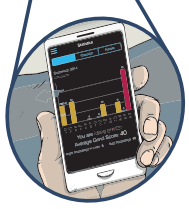


1

Dentist suspects possible sleep bruxism and prescribes the Do I Grind App



2

Patient records possible tooth grinding sounds during sleep

3

Algorithm filters possible tooth grinding sounds and reduces 8 hours of recording to 5 minutes

4

Sleep Bruxism YES/NO according to ICD-10 criteria

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# Sugar, sugar...honey, money

By Aws Alani, UK

**The sugar tax is finally upon us, but are corner shops or supermarkets for that matter likely to worry about this potentially threatening change to their flagship product line? The tax targets all drinks and equates to a tax of 24 pence per litre on those with the most sugar content. This could potentially equate to an increase in the price to the consumer, but bearing in mind that soft drinks are more accessible and cost less in the UK than water in many Third World countries, it is doubtful that things will change markedly.**


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There is the argument that taxing tobacco has had an effect on the uptake of smoking and the consequent addiction, but the evidence for this is relatively sparse and weak. Although a worthy initiative, taxing drinks may result in a greater squeeze on those who can afford it the least and I doubt whether little Jimmy will stop his tearful tantrums for penny sweets as a result of a celebrity chef's campaign as our sugar saviour. As a child of the eighties, these celebrity-led campaigns remind me of rock bands who decided that African poverty should be on the agenda, but this does not seem to be as important to them now. It would appear that it is easier to tax sugar than to provide funding for dentistry; unfortunately, there is unlikely to be a symbiotic decrease in caries as a result.

One could argue that sugar pollutes much in the same way that inefficient power stations do. The societal repercussions need to be managed by all, with no or little comeback for the fizz producers. As carbonated drinks are so popular, these juggernaut companies are powerful and, as a result, denting their progress with a tax is unlikely to truly positively affect the general health of the population. In 2014, the UK soft drinks industry was worth £15.7 billion, with over 14.8 billion litres in overall consumption, which represents a steady and exponential growth that is likely to continue. One interesting observation is the slow demise of the 330 ml can—it being replaced by the 500 ml plastic bottle. The larger bottle may represent better value for money, but is less likely to represent better health value, especially since a resealable bottle is more likely to be sipped over hours than a can once opened.

Overconsumption of sugar causes an inordinate amount of health problems. Indeed, Type II diabetes and obesity are leading causes of death and disability in the US, the birthplace of the canned, likely red, refreshment. These life-threatening conditions are in addition to our experiences of sugar-laden drink devastation. In contrast, but just as worrying, the emerging evidence shows that low-/no-calorie drinks (49 per cent of drink consumption in 2014) actually fuel hunger and trick one's stomach into thinking that calories are on the way, only to be disappointed, resulting in further food-seeking behaviour. The ordering of diet beverages in all-you-can-eat restaurants may not be as ironic as I first thought!

Erosive tooth wear seems to have been forgotten amongst overweight toddlers needing ear-to-ear clearances. From bulimics who like to taste but do not like their waist to the energy drink crew who prefer machismo gothic graphic designs, the younger generation is likely to experience more dissolution of tooth tissue. At the other end of the spectrum, obese patients are more likely to develop diabetes, which in turn makes them more susceptible to periodontal disease.

Society's gluttonous overconsumption is manufacturing pathology unheard of 50 years ago. Lest we forget the ageing population among the tabloid's sugar mania of the young—polypharmacy is likely to increase caries owing to a variety of co-morbidities, such as a dry mouth or heavily sugar-supplemented medication. I have seen restorations seemingly intact for generations in hospital notes only to sprout caries at the cavity margin within months of a new medicine being prescribed. Is there a pill for every ill or do pills allow ills to be masked by other ills while slowly swelling corporate turnovers?

> "Society's gluttonous overconsumption is manufacturing pathology unheard of 50 years ago."

Society is forever changing and food is now at the centre of how we relate and connect with each other. From Instagram posts of freshly cooked home meals to wedding cake bliss after inordinate tastings, it seems to be important to everyone. As a result, food is an emotive issue that affects oral and general health in ways that may not be readily apparent to our patients. I have an old friend in Florida, who I visited last year. He is a specialist in periodontology and runs a successful, swish, modern referral practice. As a matter of routine, he tells patients they need to stop carbohydrate intake post-surgery. Once patients understand that this improves outcomes owing to decreased plaque build-up on the wound edges, they are receptive to this brief change in their diet. He also advocates periodontal medicine while identifying stress as a risk factor for periodontitis.

Research by Prof. Iain Chapple in Birmingham investigating the effect of diet on periodontal disease confirms that one is what one eats and the gingivae follow suit. Purely taxing sugar may not impact on its consumption. Patients need to be motivated to take ownership of their health and relate this with foresight to repercussions in the future. It is this lack of responsibility and potential blame shifting by patients that not only results in poorer health, but also makes providing National Health Service care for all increasingly impossible if prevention is the best cure. This commonly occurs when patients claim to be unaware of the oral health effects of smoking and the related exacerbation of periodontal disease, only for it to become important when teeth are all but held in by the last tenuous Sharpey fibre. Owing to their own lack of awareness or lack of engagement with a toothbrush, they can request some sort of compensation or pursue a litigious course likely to involve an expensive implant-based restoration. What may escape the lawyers and the patient is that previous periodontal disease is a significant risk factor for implant failure, and so the cycle is likely to continue. Patients are responsible for their own health and the lack of recognition of this cannot be the fault of the clinician.

> "...food is an emotive issue..."

Successful dental care requires collective effort between the patient and the dentist. Health care is a partnership in which both sides have different responsibilities and active roles, but if the clinician provides a service for ailments that the patient could have prevented, the question of self-governance arises. Patients have a right to health care, but they also have responsibilities derived from the principle of autonomy. The patient's physical and mental integrity should always be upheld and respected. In contrast, autonomy identifies the human capacity to self-govern and choose the most appropriate pathway to protect that integrity.

As such, capable patients exert some control over lifestyle choices that influence their well-being. Unfortunately, regardless of the imminent extra tax on the already dirt-cheap confectionery, the innate responsibility held by the patient to self-govern will always trump our advice, treatment, knowledge or collective experience.

***Aws Alani*** *is a Consultant in Restorative Dentistry at Kings College Hospital in London, UK, and a lead clinician for the management of congenital abnormalities. He can be contacted at awsalani@hotmail.com.*

# Poor root fillings result of stress and financial pressure in dentistry

By DTI

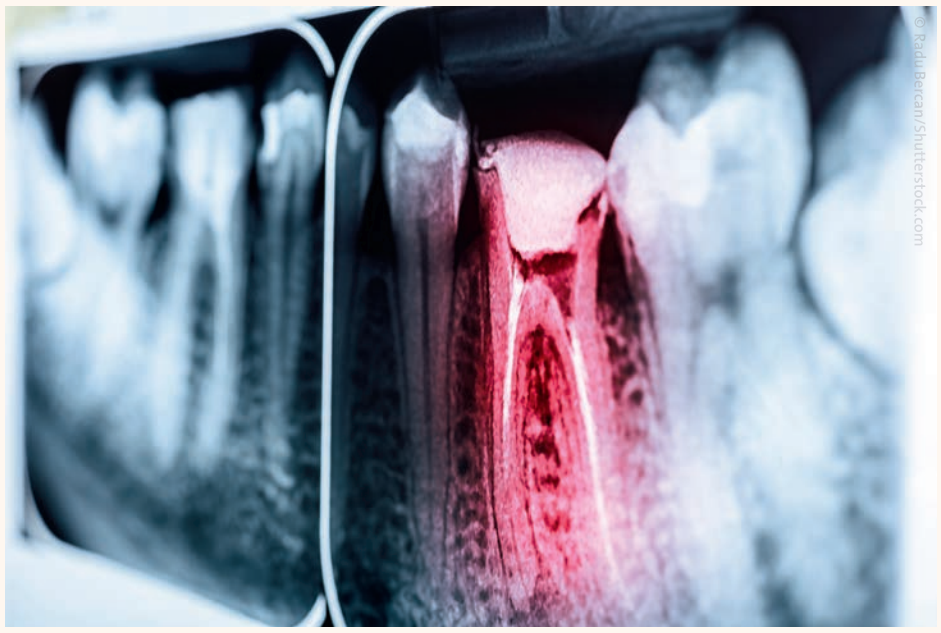
**GOTHENBURG, Sweden:** A new survey has linked the quality of root fillings to the level of stress dentists experience in performing the procedure and the fee charged. Some dentists reported that "good enough" was often a more realistic goal than optimal quality in light of the complexity of root fillings and insufficient time allocated owing to the associated treatment tariff, among other reasons.

According to the study, which was conducted as part of a doctoral thesis at the Sahlgrenska Academy, only half of all root fillings that are performed in the Swedish public dental service are of good quality. Moreover, more than one-third of root fillings show signs of apical periodontitis, which can lead to acute symptoms, such as pain and swelling, and may even spread and become life-threatening in some cases.

Aiming to investigate the reasons dentists accept technically poor root fillings, Lisbeth Dahlström, a senior dental officer and researcher at the Sahlgrenska Academy, conducted group interviews with 33 dentists from the Swedish public dental service.

The results showed that treatment was often associated with negative feelings, such as stress and frustration, and it was common for treatment to be performed with a sense of a loss of control owing to the perceived technical difficulty. Another cause of dentists accepting poorer root fillings was that allotted time for treatment according to the fee charged was insufficient, participants reported.

"The dentist then finds they are facing a dilemma, to 'go back' to the treatment, to optimize quality, or to offer care within the framework of the compensation and, thus, risk accepting an incomplete root filling," Dahlström explained.




*A survey among Swedish dentists has established the potential for improving the quality of root fillings and thus reducing persistent inflammation associated with inadequate treatment.*

Regarding quality, the dentists interviewed reported uncertainty as to what constitutes reasonably acceptable quality. According to Dahlström, they often stated that "good enough" was a more realistic goal than optimal quality. However, despite the difficulties experienced, the survey also showed that the dentists wanted to provide good treatment and that they were very concerned about their patients, the researcher said.

In order to improve the quality of root fillings, Dahlström suggested measures such as increased opportunity for continuing education, time for discussion and exchange of experiences at the workplace, as well as investment in equipment that enhances treatment, shortens the time needed and improves visibility.

Each year, approximately 250,000 root fillings are done in Sweden and it has been estimated that there are at least 2.5 million root-filled teeth affected by periapical periodontitis.

Dahlström defended her thesis, titled "On root-filling quality in general dental practice", on 4 March.

# "I do not think we are doing a good enough job"

## An interview with Henry Schein Chairman and CEO Stanley M. Bergman

**Henry Schein has been supporting the Senior Dental Leadership Programme (SDL) since its launch in 2007. Last month, the company's long-term Chairman and CEO Stanley M. Bergman delivered the keynote address for SDL's tenth anniversary meeting in London in the UK. *Dental Tribune* had the opportunity to sit down with him during the event to discuss the motivation behind the initiative, as well as public-private partnerships in dentistry in general and their importance for the improvement of oral health worldwide.**

*Stanley M. Bergman*

**_Dental Tribune:_ Mr Bergman, in your keynote at this year's SDL Meeting, you talked about some of the key aspects that have made your company one of the leaders in oral health care worldwide. Could you summarise these for our readers?**

**Stanley M. Bergman:** Henry Schein has been a very successful company by focusing on doing well by doing good. This requires balancing the five constituents that comprise our Mosaic of Success—customers, suppliers, investors, Team Schein, and society. One part of the mosaic is our commitment to society, which makes us different from others in the industry. With our public-private partnerships, we work with government as well as non-governmental organisations, customers and suppliers to make a difference in society. This enables trust, and with trust you can move things forward—like advancing oral health, for example, by bringing together academia, professionals, public health officials and businesspeople from around the globe.

**The SDL Programme tries to do exactly that. Is this why your company has supported this initiative for such a long time?**

The SDL is clearly the epitome of a public–private partnership. So far, it has been pretty successful in bringing together all members of the dental community, including representatives of dental schools, like Harvard and King's College here in London, as well as public health officials from around the world and the private sector.

There has been very good research in the last decade with regard to oral health. What we learnt from that is that we have to focus not just on the teeth but on the whole body. Good oral care results in good general health, which then results in a good quality of life. We use SDL to get that message out to all constituents of the dental community around the world.

**With dental diseases still occurring in epidemic proportions around the world, according to reports, is there a general lack of leadership in the profession?**

I would not exactly call it a lack of leadership. As you mentioned, however—and the latest statistics show this—it is a sad fact that there are over three million people in the world suffering from dental caries alone. Unfortunately, oral diseases—in addition to psychological diseases—are still not recognised as non-communicable diseases (NCD) by the World Health Organization (WHO) and, as a consequence, their improvement is not considered to be beneficial for better quality of life and bringing health care costs down.

> "There is still too much focus on the profession or on restorative procedures or aestethics."

The challenge we face is that the dental profession is not doing enough to make sure that oral disease is viewed as a key component of the NCD category. There is still too much focus on the profession or on restorative procedures or aestethics. While I think we are all a bit to blame for not getting the message out, I still see dentists who are focused too much on today versus the long-term, macro picture. It is our job, through public–private partnerships, for example, to make sure that this changes. This way, we would end up with not only significantly lower health care spending but also a healthier world in general.

**With all the work that the SDL Programme and other oral health initiatives have done and are doing, how far do you think we have come in achieving this goal?**

The science is very new. There have been a number of studies published only in the last seven to eight years that show a direct correlation between oral health and other health areas, like cardiology. Dental schools like Harvard are advancing this research and many others will hopefully follow. However, there are other areas, such as cancer, where we have made good progress, but have not told people that around the globe about 150,000 people die of oral cancer each year. I do not think we are doing a good enough job to convince the world of the importance of oral health.

**Where do you think the main impetus has to come from?**

It has to come from the profession itself. I think the FDI World Dental Federation is doing a good job in this regard and I am quite optimistic that it will lead us in this area. We need to make the WHO understand the importance of this. Sadly, there is only one dentist in the WHO right now. There should be more.

> "I believe that the only way to achieve better health is through more preventive care."

Also, dental schools are not taking a strong enough position on health care. It is part of their history that they would not necessarily be part of the medical school system. I remember the big fight over the New York University dental school a decade ago. There are also other dental schools that are connected to medical departments or institutions. We need more and more of that. Dentistry has to be part of total care.

**In your home country, the upcoming presidential election has put health care and its delivery in the forefront of the debate. Which system do you generally consider to be better for achieving improved health?**

Generally, I do not think that one system is better than the other. I am a free-enterprise person and therefore I think you have to allow those who wish to have a private system to have it. For those who cannot afford private insurance, the government has to provide some amount of care. I believe that the only way to achieve better health is through more preventive care. It is not about building more hospitals, but preventing people from getting sick. That is what health care reform is all about.

**Thank you very much for the interview.**

# Career opportunities and work–life balance in dentistry

By Dr Christine Bellmann

**Dentistry is among the most rewarding professions and has a much broader scope of practice than ever before. Young dental professionals who have finished their studies and received their diplomas will have to individually decide on their career pathways. This choice is both exciting and difficult, as there are numerous options and opportunities to consider.**

The transition from dental student to young working dental professional requires extensive adjustment. At university, students are told how to work, what to learn and what goals they need to fulfil. During practical work on patients, they are supervised by experienced dentists.

As a working professional, it is now up to each individual to assess patients on his or her own and to judge their needs and treat them accordingly. It is not just dental skills that are put to the test, however, as there are also other important skills that a working professional will need to have. These may be skills that are not taught at dental school, such as communicating with the patient, co-workers and assistants, as well as financial aspects and legal issues in the dental clinic. Acting correctly and appropriately is a substantial challenge, and may be overwhelming for some individuals. Being aware of those requirements is the first step to a successful transition.

Every graduate dental student has to decide where and how to embark on their professional careers. The majority of young dental professionals lay the foundation of their careers in private or public dental clinics, but some also remain at university to engage in research or teaching careers. Whichever way is chosen at this stage, it does not need to be the final decision. Paths can be changed and new ones explored, but the decision should be thought through, as the initial years in any profession form and influence one's future career path.

Working in a dental office outside of university provides multiple options and opportunities. Dental practices come in every size and shape. There are small clinics and very large practices. Some have a specialisation or orientation; others are general dentistry practices. Each model has, for every individual, certain advantages and disadvantages, depending on one's expectations and goals. A larger clinic, with more dentists, usually gives everyone more flexibility in relation to working hours and vacation planning, as well as in case of illness. Smaller teams can have the advantage of being forced to take more responsibility, from which great knowledge can be gained in living the concept of "learning by doing".

Working in a clinic that has a certain specialisation will help a young graduate if he or she wishes to specialise in the same field, as knowledge can be gained during the daily workflow and, in combination with a postgraduate course, it can make the perfect choice. Choosing the right clinic can be challenging and sometimes the best choice is to go with one's intuition.