Dental Tribune

The World's Dental Newspaper · United Kingdom Edition

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News in brief

Full advice

The Department of Health has now published its full advice to dentists and practice staff on local decontamination. *HTM 01-05 Decontamination in primary care dental practices* updates and expands on the version published last October.

Joke apology

The BBC has apologised for a joke made by one of its presenters about jockey Liam Treadwell's teeth, shortly after he had ridden a 100-1 outsider to victory in the Grand National. The broadcaster said it had received 1,477 complaints from viewers upset after presenter Clare Balding joked about the state of Mr Treadwell's teeth in a TV interview after the race.
'Give us a big grin to the camera,' said Balding.Then she added: 'No let's see your teeth. He hasn't got the best in the world but you can afford to go and get them done now.'
The BBC said in a statement 'Clare Balding had no intention whatsoever of upsetting or embarrassing Liam Treadwell, but she fully accepts that she should not have raised the subject with him at that time.'

Lost dentures

A man in Southampton is appealing for the return of his £500 denture plate after he left it on a wall. Denis Grimwood left the shoulder bag containing the denture plate when he was cycling back to his home in Portswood. He stopped briefly for a rest and left his bag on the wall in Southampton Common. He returned to the wall 15 minutes later when he realised he had left the bag behind but it had gone.

Whale tooth

A whale tooth found by Charles Darwin during his famous expedition to the Galapagos Islands will be put up for sale this autumn. Darwin's 1831 voyage on the HMS Beagle laid the foundation for his subsequent work on evolution.The whale's tooth is inscribed with a picture of the Beagle sailing through rough seas against a mountainous backdrop.
The memento was decorated by James Bute, a Royal Navy marine private who served aboard the ship, according to the auction house, Bonhams. It said the memento is expected to fetch up to 50,000 pounds when it is offered for sale during the auctioneer's travel and exploration-themed sale in London on 16 September.

www.dental-tribune.co.uk

News and opinions

Easter dentist
Read why one dentist turned into an Easter Bunny when he gave his young patients Easter eggs containing a toothbrush, some toothpaste and a guide.
▸ *page6*

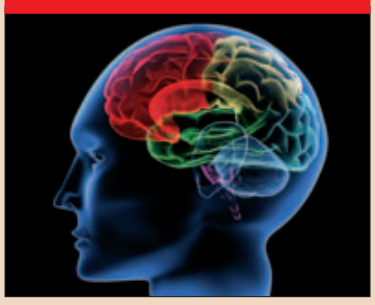
Practice management

Lease holes
Are you are a dentist looking to purchase either a practice with an existing lease, or set up a squat with a new lease? Beware of your statutory rights.
▸ *page10*

Clinical

Maximum strength
If you have had adhesive failures, you probably don't believe the success rates of the leading cosmetic dentists for their indirect adhesive restorations.
▸ *page17*

Education



Patient psychology
There are many dental patients who are so self-conscious about their teeth and smile that they let their mouths dictate their level of confidence and happiness.
▸ *page22*

Kid's hospital dental treatment 'worrying'

Researchers have called the rise in the number of children having dental treatment in hospital 'worrying'.

Nearly 30,000 children a year attend hospital to have teeth pulled out or be treated for decay, an analysis of hospital data has shown.

Researchers who analysed hospital data in Plymouth's Peninsula Dental School called it 'worrying' that the number of under-17s hospitalised for dental treatment had been rising since 1997.

The findings, which were published in the British Dental Journal, revealed that children from poor areas were twice as likely to need treatment as those from more affluent families.

The figures showed there were 517,885 individual courses of dental treatment in NHS hospitals for children up to the age of 17 between 1997 and 2006.

The total number of children needing treatment was 470,113 and 80 per cent of admissions involved tooth extraction - in two-thirds of cases because of tooth decay.

The peak age for children needing teeth taken out was five.

Professor David Moles, who led the study, said yearly rises in hospital admissions had come despite rates of tooth decay and infection remaining steady.

The reasons for this would have to be identified 'in order to cut the number of admissions, improve dental care for children and ultimately reduce the financial burden to the NHS', he said.

The study found that children from poorer backgrounds were particularly at risk, being twice as likely to need treatment as those from more affluent areas.

Dr Paul Ashley, head of paediatric dentistry at University College London's Eastman Dental Institute, the second author of the study, said: 'Two aspects of the study are particularly worrying - the rise in the number of general anaesthetics being given to children, and the widening gulf in dental health between social classes.'

He said general anaesthetics could be fatal to children.'

The researchers wrote: 'Caries (tooth decay) is a preventable disease yet the number of children being admitted for elective extractions of teeth due to caries was increasing yearly. Further investigation to determine some of the underlying reasons for this trend is required.'

Peter Bateman, chair of the British Dental Association's (BDA) Salaried Dentists Committee, called on water fluoridation to be used to address the gulf that has developed between the social classes.

He said: 'This research highlights the stark inequalities in the oral health of England's children. Those from socially deprived backgrounds are far more likely to have undergone extractions under general anaesthetic than their peers from more affluent backgrounds. The reasons for the apparent trends in this period are not clear and require, as the authors of the study acknowledge, further investigation.

He added: 'What is clear though is that dental caries is a preventable disease and it is a tragedy that social class remains such an accurate predictor of oral health.

Water fluoridation, as the longstanding scheme in the West Midlands illustrates, has great potential to address this divide. The BDA was pleased to see the successful outcome of the consultation on the introduction of such a scheme in Southampton earlier this year and would like to see local people in other areas of the country given the same choice.'

The Department of Health claimed the findings have been affected by changes brought in in 2001 which means that anaesthesia is now given in hospitals - rather than dental surgeries - for safety reasons.

A spokesman claimed that 'there has been no increase in tooth decay in the period covered, which pre-dates the new dental contract.

He added: 'Preventative oral healthcare has actually improved substantially thanks to the new dental contract.' DT

CIC explores 3D imaging

This year's Clinical Innovations Conference features a talk on three-dimensional imaging in implant and restorative dentistry, covering recent advances and how they impact on day-to-day clinical work.

Speaker, Dr Andrew Dawood, will explore the integration of the latest generation of digital imaging equipment into the dental practice, and how manufacturing technology has revolutionised cutting edge dental treatments.

Dr Dawood has a wealth of experience in maxillofacial and craniofacial reconstruction, having been involved in the treatment of patients at St Bartholomew's, The Royal London and University College Hospitals.

Having delivered lectures on a range of subjects that include dental implants, zygomatic implants, guided surgery and the best approaches to surgery planning, Dr Dawood is a knowledgeable speaker with a firm grasp of contemporary issues facing dentists.

A recognised expert in the fields of periodontology and prosthodontics, Dr Dawood's passion lies in implantology, the application of dentomaxillofacial imaging and associated research, and this lecture will enable him to identify and explore how the latest advances can assist today's dental team.

The lecture will benefit dentists by bringing the new generation of 3-D imaging equipment into the practice. Advances mean that even the most complex cases can become much more straightforward and predictable, opening up new avenues of opportunity. Dr Dawood will highlight to delegates how implant and restorative procedures can benefit in particular.

With a faster, more straightforward and less invasive approach, superior results are facilitated and patients receive even higher standards of care while the dental team enjoys an easier and more efficient process.

A spokeswoman for the Clinical Innovations Conference 2009 said: 'The conference is a unique opportunity to discover what is happening at the forefront of aesthetic and restorative dentistry.

By benefiting from the remarkable expertise and far-reaching experience of the speakers, delegates will be able to return to their practices energised and inspired, ready to make immediately beneficial changes to how they work – great news for patients and practice colleagues alike.'

The conference will be held on 15-16 May at the Royal College of Physicians in Regent's Park, London.

For more information, and to ensure your place, call Smile-on on 020 7400 8989, email info@smile-on.com or visit *www.clinicalinnovations.co.uk* DT

Free digital camera!

Dental Tribune is urging all readers to report the views of all dentists and patients following the recent and phenomenal launch of *Patient Tribune* in our March 16 issue.

The outstanding positive feedback from *Patient Tribune* readers proved that it was extremely well-received by patients and dentists in the majority of dental practices.

Launched in association with Denplan, we would like you to respond to the following questions by the end of this month..

A free digital camera is up for grabs for one lucky reader who responds to this survey following our raffle draw in June.

• How many of your patients have read *Patient Tribune*?	☐ Only a few	☐ Quite a few	☐ Many
• What did you think of the look and feel of the publication?	☐ Excellent	☐ Good	☐ Average
• What is the feedback on *Patient Tribune*?	☐ Excellent	☐ Good	☐ Average
• Did you read any of the articles yourself?	☐ Yes	☐ No	
• How informative did you find it?	☐ Excellent	☐ Good	☐ Average
• How useful is it to educate your patients?	☐ Excellent	☐ Good	☐ Average
• Did you look at any of the advertisements?	☐ Yes	☐ No	
• Would you like to receive the next issue?	☐ Yes	☐ No	

• Any other comments… _____

_____

Please either cut out and fill in, or send the whole page to Laura McKenzie by June 1, to:
Patient Tribune questionnaire, FREEPOST RLUS-AGCE-ZYER, Smile-on Ltd, 19–21 Hatton Garden, London, EC1N 8BA

More dental services for Leeds

NHS Leeds has proposed to provide dental care for an extra 8,000 patients across west Leeds.

Plans were put forward for consultation to increase dental services throughout the whole of Leeds with several areas benefiting from an enhanced service. It is expected that new patients in Pudsey, Wortley and Farnley will be able to sign on from September 2009.

Richard Lewis, a Pudsey councillor, has welcomed the move.

He said: 'The current situation has put a huge amount of pressure on existing NHS dentists.

The problem of dental waiting lists has been ongoing for many years with hundreds of people unable to access dental care simply because dental practices have opted out of NHS-led services and have gone private instead.

I am glad that the NHS is prioritising dental care for local people and encouraging dentists to establish practices in areas where it is most needed.

Hopefully those people of Pudsey with problem teeth will soon have a solution right on their doorsteps and I would urge anyone currently without dental care to sign up for the new service in September.' DT

BDA calls for nominations

The British Dental Association is calling for nominations for people wishing to sit on its Representative Body. There are currently vacancies in nine of its branches. If there are more nominees than vacancies, an election will follow in the branch concerned.

The Representative Body is the British Dental Association's (BDA) most important committee. At its three meetings each year, the Representative Body receives regular reports including those from the Executive Board and the autonomous committees of the BDA, representing all the constituent parts of the profession.

There will also be key issues for decision-making at each meeting, including reports and papers on policy issues. In June each year, the Body decides the subscription fee for the next membership renewal.

The Representative Body elects the majority of members of the Executive Board, which in turn has closer scrutiny of the day-to-day activities of the Association. The reports from the Executive Board at each meeting of the Representative Body include issues in regard to the strategic direction of the Association, operational planning and topical matters affecting the profession.

Members of the Representative Body also have the opportunity if they wish, to work in other areas of the BDA's work.

Nominations must be received no later than 5pm Monday 11 May 2009. Copies of the nomination form can be downloaded from the BDA website, www.bda.org, or by contacting Ian Morley (tel 020 7535 5841).

Candidates should note that the next meeting of the Representative Body is Saturday 20 June 2009, and the next scheduled meeting after that is Saturday 10 October 2009. DT

BDA's Associate Day

The British Dental Association is holding an Associate Day to give recently graduated associates the most up to date information on NHS rules and regulations, recruitment and taxation and the legality of their contact.

The workshop on 6 May is designed to empower them to make the best possible decision to take their career forward.

The workshop will cover how to find the right job, where to look for jobs, the pros and cons of working for corporate bodies and family practices and CV preparation. It will also help the graduates prepare for interview and look at what practice owners are looking for.

The Associate day will be run by Abalene Odell and the resident British Dental Association (BDA) advisory team, with a guest speaker from HM Revenue & Customs to clarify all Tax and National Insurance issues.

The workshop will be held at the BDA London. The cost will be £26.50 for BDA members. The seminar is limited to a maximum of 40 delegates.

For further information or if you wish to reserve a space, please contact Jenny Wei on 020 7563 6884. DT

International Imprint

Executive Vice President Marketing & Sales Peter Witteczek *p.witteczek@dental-tribune.com*

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Chairman Torsten Oemus *t.oemus@dental-tribune.com*

Managing Director Mash Seriki *Mash@dentaltribuneuk.com*

Editor Penny Palmer Tel.: 0207 4008979 *penny@dentaltribuneuk.com*

Director Noam Tamir *Noam@dentaltribuneuk.com*

Advertising Director Joe Aspis Tel.: 020 7400 8969 *Joe@dentaltribuneuk.com*

Marketing Manager Laura McKenzie *Lauram@dentaltribuneuk.com*

Dental Tribune UK Ltd
4th Floor, Treasure House
19–21 Hatton Garden
London, EC1N 8BA

GDPUK round-up

There was a mixed bag of comments on GDPUK last week, reflecting the variety of topics encouraging discussion on the forum

Professor Jimmy Steele continues with his review of NHS dentistry. Eddie Crouch says he has confidence in this investigation. Do you? You can read the Professor's blog at ***http://tinyurl.com/d7s2qu***. It certainly makes for interesting reading, although the conundrums discussed are the same as topics that have been mulled over for years on GDPUK. An example would be a debate about a patient with problems from a molar. The tooth had an honest and reasonable standard root treatment provided under NHS contract, and the patient chose a crown that could only be provided under private contract. Subsequently, problems from the root treatment were diagnosed, and the conundrum became apparent – seeing as it was a repeat of root treatment which should have been in the hands of an endo specialist, who should pay?

Another topic colleagues like to discuss on a web forum, which they don't get a chance to discuss in other media formats is about the value of precious metals, and how best to turn these assets into a different more tradeable commodity. Colleagues have shared ideas on how best to do this. Some keep any waste until they retire, some sell small amounts regularly. Some use one of the Assay Offices for the smelting and assay, while some use travelling scrap dealers. The relative merits of those two approaches were discussed.

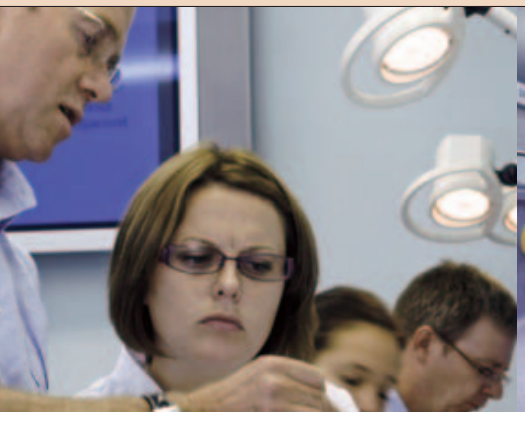
Postgraduate education to improve one's understanding of orthodontics for younger dentists was aired. Younger colleagues realised they had had little experience on qualification. Notes were compared on how to go about gaining more knowledge and experience.

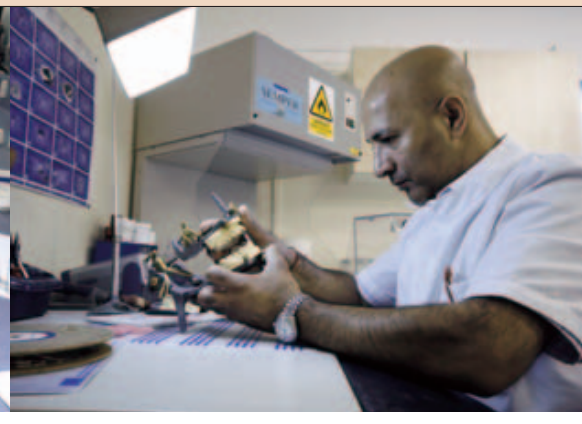
There was much unprompted happiness from the grass roots of the profession when the result of Eddie Crouch's poll win as the UK's most influential dentist was announced. Eddie is genuinely popular, and continues to take his stand against the Department of Health (DH) to the brink. Many dentists get their heads down and get on with making a living, Eddie has really stuck to his principles, and kept up his battles.

The impending closure of the Paternoster lifts at Birmingham Dental School attracted comments, many colleagues remember these potentially dangerous lifts. A search of You Tube found many videos to illustrate the thread on the forum. Apparently a similar system is still working at Sheffield University, so perhaps they are going strong at other academic institutions around the world. DT

About the author

Dr Anthony V Jacobs,
52 is a GDP in the suburbs of Manchester, in practice with partner Steve Lazarus at 406Dental (***www.406dental.com***). He has had roles in his LDC, local BDA and with the annual conference of LDCs, and is a local dental adviser for Dental Protection. Nowadays, he concentrates on GDPUK, the web group for UK dentists to discuss their profession online, ***www.gdpuk.com***. Tony founded this group in 1997 which now has around 7,000 unique visitors per month, who make 35,000 visits and generate more than a million pages on the site per month. Tony is sure GDPUK.com is the liveliest and most topical UK dental website.





Postgraduate Dental Education

The Postgraduate Dental Education Unit (PGDEU) is one of the UK's leading dental education centres offering an established portfolio of courses for qualified dentists who wish to develop their knowledge of the latest methods, equipment and techniques in implant dentistry and orthodontics. The wide range of programmes on offer are delivered by leading professionals, academics and researchers using a wide variety of educational tools.

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The only MSc Orthodontic programme specifically for general dental practitioners enabling them to pursue a flexible training pathway that can be taken over a period suited to individual circumstances.

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Simplified digital impression-taking

As the only system in the world that uses the principle of triangulation for intra-oral measurements, the Cerec system is setting higher standards in CAD/DAM technology with Cerec AC and the Cerec Bluecam camera. Never before have intra-oral scans been made as fast, sharp, or accurately in 3-D. Whole-jaw images broaden the indication spectrum and, with virtual models, allow the dental office and the dental laboratory to work together impression-free.

Fig. 1: CEREC Bluecam Intra-oral Scanner. (Image: Götte)

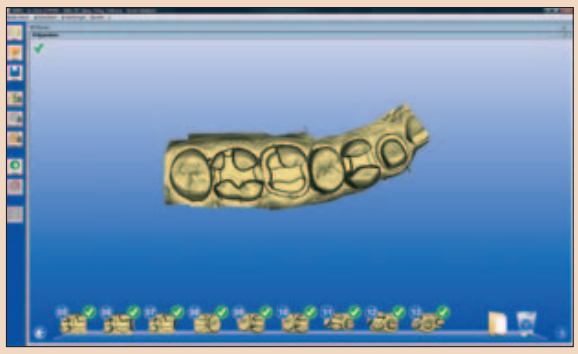

Fig. 2: Quadrant scan with preparations, created from automatically joined individual images to yield a 3-D preview. (Image: Götte)

The acquisition unit of the CEREC 3D system – called CEREC AC (acquisition center) – has been equipped with a new camera (Bluecam). CEREC AC replaces the previous CEREC 3 acquisition unit; however, the new software still supports the CEREC 3 camera. CEREC AC is compatible with both milling units – CEREC 3 milling unit and CEREC MC XL (extra large).

The advantages of an improved intra-oral image-capturing system do not stop at producing larger restorations chairside. The simplified inclusion of the adjacent teeth and the opposing jaw makes it possible to improve the occlusal and functional design, and the more exact measurement of the preparation enables an increase in the information content of the image. Furthermore, intra-orally recorded 3-D data sets of gnathic situations offer new diagnostic possibilities.

The heart of CEREC AC is the Bluecam camera. Instead of infrared light, Bluecam emits shortwave blue light produced by diodes. In addition, the lens configuration is new: aspherical lenses bundle the light beam and orient it parallel to the image sensor (CCD). The light sensitivity has been increased, the image capture time shortened by 50 per cent, and the image sequence accelerated. The projection matrix still employs the tried-and-tested light-stripe grid.

Faster, sharper, blur-free

As a result, the new Bluecam offers higher image accuracy in the clinical situation: the measurement depth has been increased by 20 per cent and the focus depth deepened to 14 mm. The sharpness of individual images has been heightened, and marginal blurring eliminated. Blur control (automatic capture), the sensitivity of which can be pre-selected, checks the intended image, and the camera automatically takes the image only when it is certain there is no blurring. In quadrants and across the dental arch, any number of pictures can be taken as an overlapping sequence.

The 3-D image catalogue manages the individual images on the screen. The software assesses their usefulness, marks and rejects useless scans, and joins the images to form a complete row of teeth (matching) and a virtual cast modelled on the natural example. Images acquired at the beginning of the sequence, the quality of which may have been lessened owing to the presence of rubber dam or cotton rolls, are automatically exchanged for a suitable image pair as soon as this is found. In this way, inadequate images are quickly replaced. In vitro studies in the laboratory at the University of Zurich in Switzerland have shown that the image accuracy deviates from the reference measurement of a master laboratory scanner by only 19µm—this is equivalent to one-third of the diameter of a human hair. This means Bluecam's accuracy is similar to that of stationary laser scanners. Such precision increases the marginal fitting accuracy of the restoration; thus, less excess occurs during adhesive luting, which in turn takes less time to remove.

Because of the image depth and focus depth, it is not necessary to keep an exactly determined distance from the preparation; the camera's prism window can be placed directly on the tooth, which makes image acquisition easier, particularly in the distal region. The Autocapture function, responsible for actually taking the image, engages automatically upon ensuring that the image is in focus. Hence, there is no need to operate a footswitch, which requires eye–foot coordination. This means that an entire quadrant can be scanned in 30 seconds. The blur control makes the image sequence and menu operation accurate and simple; thus, this phase can be delegated to the dental assistant. If the acquisition unit has a wireless or WLAN connection to the milling unit, the system can operate without power with no data loss for up to six minutes, thanks to its own optional, uninterrupted power supply – ideal for changing location during the milling/grinding phase.

As when constructing crowns with CEREC 3D, fissure axes and cusps of the adjacent teeth are analysed – if desired, the antagonists' morphology is also analysed – and incorporated into the occlusal surface calculation. The software adjusts the occlusal contact points and sliding planes of the crown construction to the occlusal surface of the antagonist. The wall thickness of the projected ceramic framework is checked beforehand, as are the insertion paths of the abutment crowns. After designing the restoration, the data set can be transmitted to the milling unit or the practice's laboratory, or sent via LAN or wireless LAN to the dental laboratory. In the rapid milling mode of the CEREC MC XL milling unit, a four-unit bridge can be produced in about 20 minutes. Composite resin blocks by Vita (CAD-Temp) and Merz (artBloc Temp) can be used to fabricate the provisional restoration. The milling preview shows the size of the block required and the positioning of the restoration in the material – ideal when using ceramic blocks with integrated, density-determined enamel/dentine colour progression (VITA TriLuxe, Ivoclar Multishade).

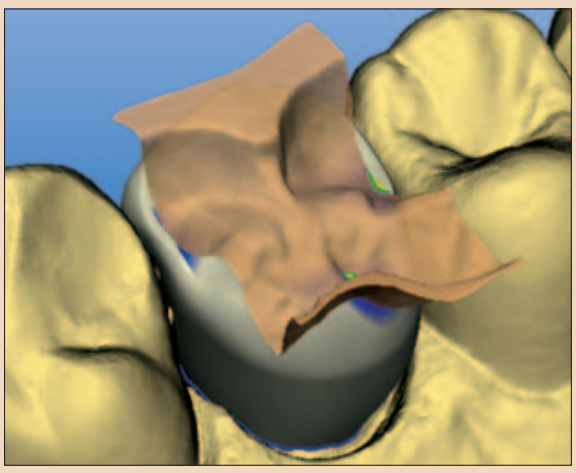

Fig. 3: Crown restoration: adjusting the counterbite for occlusal surface design, region 24. (Image: Götte)

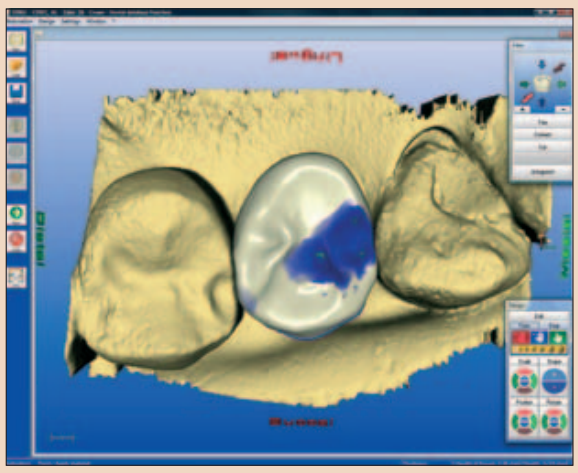

Fig. 4: Completing the crown's occlusal surface. (Image: Götte)

Up to four-unit bridges chairside

Bluecam takes about 30 seconds to scan a complete quadrant and is suitable for scanning stone casts. In addition, bite records with static and dynamic occlusion are digitised and prepared for functional articulation of the restoration. After selecting bridge tooth databank, the preparation for a four-unit bridge can be scanned with Bluecam. This enables the construction and chairside manufacture of long-term, provisional composite-resin restorations employing the CEREC milling unit, which broadens CEREC's indication spectrum considerably.

The virtual cast, online

Using the CEREC Connect system, the digital data of the optical impression, even of the whole jaw, can be sent from CEREC AC to the dental laboratory. This enables the cast-free manufacture of the restoration. In the future, it will be possible to manufacture a physical cast using these data from a portal, for dental laboratory use. In this manner, all single-tooth restorations could be manufactured, such as inlays, onlays, partial crowns, veneers, crowns and temporaries. For crown-and-bridge frameworks of up to four units, any dental laboratory lacking a CEREC milling unit will in the future be able to access the Internet portal infiniDent to have a cast manufactured, which will serve as the starting point from which the laboratory itself can manufacture the framework. Thus, CEREC AC and CEREC Connect together offer the smallest possible initiation into the CEREC system, which can be expanded upon to any extent desired. Every inLab laboratory can make use of this option to accept work from impression-free practices and manufacture all-ceramic crowns and bridges using CAD/CAM technology.

With the milling unit CEREC MC XL, the new CEREC 3D software and CEREC Connect, CEREC AC sets a new standard in restorative dental treatment. The system's ease of operation allows a constant and time-saving workflow in the dental office. The progressive technology also offers new opportunities for highly efficient cooperation with the dental laboratory. In addition, the modular nature of the CEREC system, its consistent development, and its total compatibility with all system components, including the lab-side system inLab, ensure complete treatment flexibility and sustainable investment security. DT

Fig. 5: Crown 24 after adhesive insertion. (Image: Götte)

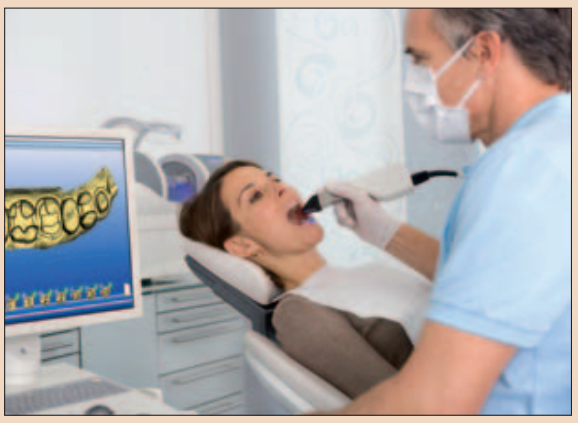

Fig. 6: CEREC AC showing Bluecam and Quadrant Scan. (Image: Sirona)

About the author

Dr Helmut Götte
studied dentistry at the University of Munich were he graduated in 1993. Today, Dr Götte runs a fully digitalised, paperless dental office in Bickenbach, Germany. He has been using CEREC since 1996 and is a member of German Society of Computerized Dentistry.

Dr Götte can be reached at
helmut.goette@goette-online.de

Oral health link to premature births

Poor oral health during pregnancy can contribute to the risk of giving birth prematurely, of having a low birth weight baby or the newborn child getting an infection, according to new research.

A team of researchers from Queen Mary University of London, found bacteria from a mother's mouth can be transmitted to her unborn child via the blood and amniotic fluid in her womb.

This may contribute to the risk of a premature delivery, a low birth weight baby or infection of the newborn child.

The researchers tested the gastric aspirates (stomach contents containing swallowed amniotic fluid) of 57 newborn babies and found 46 different species of bacteria in the samples.

Two of the species of bacteria were recognised as coming from the mouth and are not normally found elsewhere in the body.

These particular bacteria, Granulicatella elegans and Streptococcus sinensis, are known to be able to enter the bloodstream and have previously been associated with infections such as infective endocarditis, an inflammation of the lining of the heart cavity.

Researcher, Cecilia Gonzales-Marin, said: 'Our studies show that sampling the stomach contents of newborn babies by using gastric aspirates can provide a reliable method of microbial identification.

Our research group is using DNA techniques to confirm if bacteria from the newborn matches the bacteria in the respective mother's mouth.'

Details of the findings were presented at a meeting of the Society for General Microbiology in Harrogate. DT

No more Assault charges

A dentist, who refused to treat a Muslim patient unless she wore a headscarf, has been cleared of assaulting a policewoman.

Omer Butt, 32, was alleged to have hit the officer twice on her right knee with his Audi, following an argument over parking.

However Bury magistrates ruled that the Crown Prosecution Service had not proved beyond all reasonable doubt that an offence was committed.

Dr Butt, of Unsworth Smile Clinic dental surgery in Bolton, denied assaulting Pc April Stevenson in Parr Lane, Unsworth, on October 21 last year.

The magistrates heard that police were called to a car park behind Dr Butt's Unsworth Smile Clinic dental surgery following reports an Audi was blocking other cars.

Pc Stevenson told the court she raised her right arm to make a clear 'stop' signal but was still hit.

Alan Rogers, chair of the magistrates' bench, said a video recording of the incident did not show the car moving towards the officer.

'The video shows after the alleged first instance that she [the officer] is relaxed and in no obvious discomfort,' said Mr Rogers.

'There is no medical evidence of the injuries. We find that the allegation of assault has not been proved.'

Dr Butt said he was undergoing counselling over 'trusting people in authority' after several incidents with the police in which he had been subjected to spot checks while driving.

Dr Butt said he did not see any stop signal and made no contact with the officer.

Dr Butt was reprimanded for serious professional misconduct by the General Dental Council in 2007 when he refused to treat a Muslim patient unless she wore a headscarf. DT

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Representatives criticise pay rise

Representatives of England's salaried dentists have joined with industry bodies in criticising the NHS dental pay rise.

Representatives of dentists working in salaried primary care dental services, hospitals and academia have all criticised the award, arguing it will not help staff and morale problems in their respective fields.

Dentists look set to get a 0.21 per cent increase in earnings following a recommendation of the Review Body on Doctors' and Dentists' Pay.

The 0.21 per cent rise is based on a formula that, taking estimated decreased expenses into account, suggests GDPs will actually see a 1.5 per cent increase in net incomes.

However the Dental Practitioners Association, claims that as the Retail Prices Index is currently 3.2 per cent—anything less than this is effectively a pay cut.

Peter Bateman, chair of the British Dental Association's (BDA's) Salaried Dentists Committee, has now added his voice to the criticism.

He said: 'While we appreciate the current economic situation in Britain and the need for restraint in determining pay uplifts, it is also important that the effect of these uplifts is properly considered.

We know that almost two thirds of PCT-run salaried dental services across the UK are already struggling to recruit dentists. This uplift will do nothing to improve our ability to recruit, and could even exacerbate the problems we and the vulnerable patients we treat face.'

Keith Altman, chair of the BDA's Central Committee for Hospital Dental Services, is also critical of the award.

He said: 'Dental staff working in hospitals are very disappointed by this award which will do little for the morale of dedicated professionals working with very limited resources. Those in training grades in particular need reassuring that a career in hospital dentistry is valued in order to encourage entrants to this branch of dentistry.'

While Professor Paul Wright, chair of the BDA's Central Committee for Dental Academic Staff, has expressed concern that the poor pay award will affect recruitment of dental academic staff.

He said: 'The future of the dental profession depends on the education of the dental workforce of the future. The Dental Schools Council Clinical Academic Staff Survey published in June 2008 showed that dental academic staff levels are unchanged since 2000, despite a huge increase in the number of undergraduate dental students and dental care professionals in training.

While senior academics receive parity with their senior colleagues in the NHS, the training paths and career progression for academic staff are much more challenging and there is a financial penalty to be paid in lifetime earnings.

Assuming the award is translated to dental academic staff, the relative incentives for various careers within dentistry remain unchanged and this will do nothing to encourage recruitment.' DT

Easter bunny dentist

Children were given Easter Eggs filled with toothbrushes and toothpaste

A dentist in London turned into an Easter Bunny when he gave his young patients Easter eggs containing a toothbrush, some toothpaste and a guide to healthy brushing.

London-based dentist Anoop Maini, founder of Aqua Dental Spa in central London, faced a personal dilemma deciding what to give young members of his family for Easter.

'Kids all over Britain will be eating chocolate this Easter, and why not? At Aqua Dental Spa we believe in general dentistry with a difference. Good oral hygiene does not mean you have to completely avoid chocolate and sugary foods, but it's important that you have a balanced diet and take care of your teeth.

With our egg, kids get their sweet treat but are then encouraged to think about their teeth and take care of them,' he said.

Maini's 'Good Egg' was made from chocolate also packed full of dental goodness, including a tube of toothpaste, a good quality brush and information on better brushing.

The eggs were given out free to patients at Aqua Dental Spa as a healthy and tasty alternative Easter gift for friends and family.

Mr Maini said: 'This is about educating adults and children alike.

People might think it's crazy for a dentist to give kids chocolate but this is better than other eggs they will get this Easter. They are still delicious but contain a healthy message that I hope children will remember for the rest of their lives. It's the Easter gift that keeps on giving.' DT

Green Party calls for cash

The Green Party claims that access to an NHS dentist all depends on 'geographical accident'.

In the report, *A Green New Deal for the NHS*, it claimed that between 55 and 60 per cent of NHS practices are not taking on new NHS patients.

The information based on Freedom of Information Act research, revealed that access to NHS dentists can range from one dentist per 1,000 people - to as little as one-quarter of that, depending on where people live.

The new policy report claims that little more than two-thirds of children visit NHS dentists and the situation is getting worse.

It also found that some Primary Care Trusts have no NHS dentists taking on new patients.

The percentage of children who visited NHS dentists fell from 70.7 per cent in March 2006 to 69 per cent in June 2008.

Less than half of the adult population is accessing NHS dentistry, and the numbers are continuing to decline, said the report.

The Party wants £1.8bn funding for NHS dentistry

The Green Party is calling for the government to increase funding by £1.8bn to 'restore NHS dentistry to what it should be'.

Green Party health spokesperson Stuart Jeffery said: 'The dental service received £2.1bn of direct funding in 2007/08.

If the current NHS dental service was provided free at the point of use, the total cost to the NHS would increase by £531m to a total of £2.6bn.

If the NHS wanted to provide free dentistry to 75 per cent of the population (from the current 50 per cent, assuming that some people will want to remain private), the total level of funding would need to increase from £2.6bn to £3.9bn.

As the NHS currently provides £2.1bn, an increase in funding of £1.8bn would be required for patients to have dentistry free at the point of access.

He added: 'It seems little to ask to restore NHS dentistry to what it should be - a service that Britain can be proud of.' DT

Oasis Healthcare expands

One of the UK's biggest healthcare chains has bought up to four dental practices in a flurry of deals.

Oasis Healthcare, which was founded in Norwich, has acquired practices in Dereham, North Walsham, Hull and Fareham.

In 1999, it had just four practices.

It has gradually been growing and 20 years on, the deal will take its network in the UK to over 160 branches.

Grahame Cox, the firm's marketing director, said: 'Oasis is committed to expanding its network to give as many people as possible in the UK access to high quality dental care and customer service.

Our team has been working round the clock to finalise all the details and this is an indication of the level of commitment and support the dentists and their patients will get from being part of Oasis going forward.'

Oasis was acquired by Duke Street Capital for £135m in 2007. DT

Volunteers tackle Tanzanian tooth decay

Twelve volunteer dentists from the UK have just returned from Tanzania where they have been extracting teeth from more than 100 people a day.

Martin Anderson, from the Wessington Way Dental Practice in Sunderland, was among the volunteer dentists who have just returned from a fortnight in the East African country. The 54-year-old went out with the charity Bridge2Aid, which was founded three years ago by Ian and Andie Wilson.

One of the aims of Bridge2Aid's work 'is to train local Tanzanians who have basic medical knowledge one-to-one, so that by the time we leave they can remove teeth from the many people who are in pain,' said Mr Anderson. He revealed that there are so many people in pain, our first priority is to get them out of pain, so we don't do fillings.

Tooth decay has increased in the area, due to a Coca-Cola bottling plant, which pays workers partly in free Coca-Cola, according to Mr Anderson.

The volunteer dentists from Britain trained 12 clinical officers while they were in Tanzania and over the three years Bridge2Aid has been in the country, 60 officers had been trained and more than 800,000 people treated. DT

JHA stake up for sale

The largest private dental chain in Britain, James Hull Associates, is currently in talks to sell a 30 per cent stake to a private equity firm in a deal which values the business at about £230m.

The business was founded by dentist, James Hull, 48, with just a single practice in Newport in South Wales, in 1987.

JHA wants to use the cash raised to expand into the Continent and the Middle East.

It has received first-round offers from four bidders, one of whom is known to be Axa Private Equity, which lent JHA £15m in August last year.

Hull, still a practising dentist, holds a 57 per cent stake in the firm and finance house Hutton Collins owns the remaining 43 per cent. DT

Blended learning:

An ideal combination for general dental practice

King's College London Dental Institute is one of the largest Dental Institutes in the world and offers a wide range of postgraduate programmes. Most popular of these are the blended learning degrees. Blended learning is described as 'a learning solution that incorporates a mix of online and face-to-face elements'. Busy practitioners can therefore choose their time and place to study the academic components of the modular courses online and focus on the face-to-face intensive courses for the hands-on learning experience. These residential components are available annually in the UK and some as also available in India.

The MSc Advanced General Dental Practice is aimed at dental practitioners who wish to develop their clinical skills and expand on BDS level knowledge. It covers a range of topics from clinical skills to practice management to enable dentists to run a successful and rewarding dental practice.

Our new MSc in Aesthetic Dentistry is very popular and offers advanced training in invasive and non-invasive techniques for hard and soft tissue aesthetic treatments.

The MClinDent in Fixed and Removable Prosthodontics (FRP) is currently our most popular programme and covers more advanced skills. This programme includes most of the components listed in above degrees but goes on to train dentists in managing advanced clinical problems such as severe tooth wear, TMJ dysfunction, aesthetic challenges, replacement of missing teeth and occlusal treatments. It is ideal for those aspiring to be competent to run a high quality private practice tackling the more demanding clinical problems. This programme is also available at MSc level for those undertaking parts of the MClinDent degree pathway.

Similar MSc programmes are currently available in Dental Public Health and Dental and Maxillofacial Radiology. We are about to launch an MSc in Maxillofacial Prostheses.

The mode of delivery for all our blended programmes, has been designed to enable dentists to remain in dental practice while training, allowing them to maintain clinical contact and establish a dental practice using skills learnt on the programme. The residential courses of approximately 9 days duration, held at one of our training centres, will provide the supporting face-to-face tuition in clinical skills. The training centres are in London and India, both providing the same programme taught by King's staff and lead to the same King's Masters Degree. Examinations are held in the student's home country with one written paper per module.

The success of the programmes comes from the balance between interactive online content, which includes ready access to the King's College London e-library, and the intensive annual 9 day block face-to-face teaching courses which provide the hands-on elements essential to a dental programme. The courses also include one-to-one tutoring for the final year of study and advice for the clinical work carried out in practice.

The MSc programmes run over 3 years (4 years for MClinDent FRP and MSc Dental and Maxillofacial Radiology) through part-time training. For any dentist not wishing to sign up for the full MSc (180 European credits) or MClinDent (360 European credits) then it is usually possible to complete a shorter course leading to a Certificate (60 credits) or Diploma (120 credits).

All courses are quality assured, independently verified and are taught by experts from the King's College London Dental Institute and other centres of excellence around the UK.

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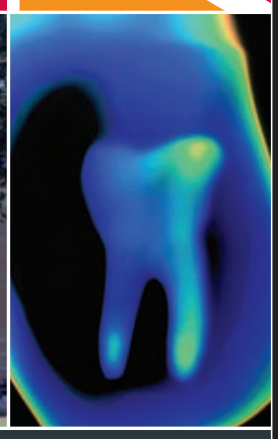

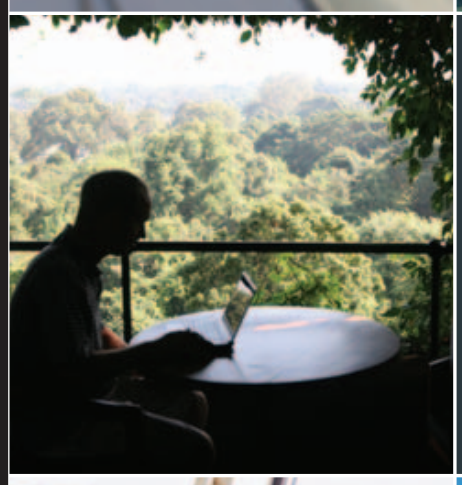

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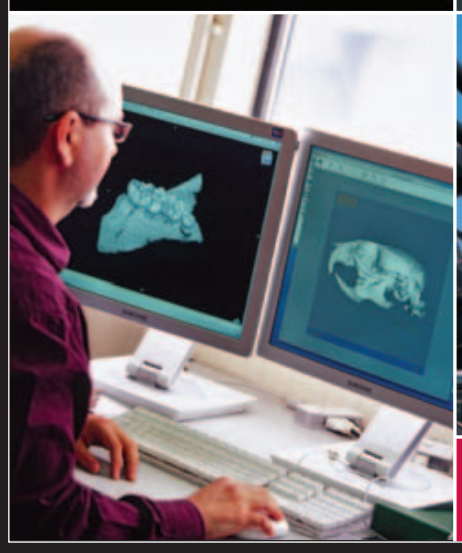

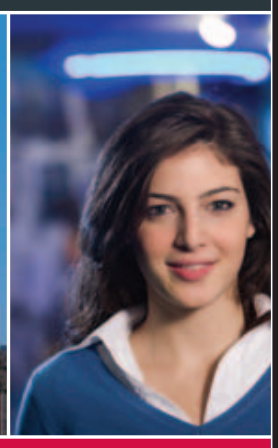

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Baby teeth extraction 'pointless'

A study has found there is no evidence to prove that the practice of extracting baby canine teeth, to make way for adult canines that are breaking through the gum in the wrong place, has any benefits.

The study *Extraction of primary (baby) teeth for unerupted palatally displaced permanent canine teeth in children* which was published in Issue Two of the Cochrane Database of Systematic Reviews 2009, found there is no evidential basis for the practice.

In a systematic review, the Cochrane researchers were unable to identify a single high quality study to support the practice.

Lead author of the study, Nicola Parkin of the Department of Oral Health and Development at the University of Sheffield, said: 'The recommendation of extracting the baby canine is in fact based on one uncontrolled study that was carried out over 20 years ago.'

It is common for adult upper canines to grow in the wrong place.

Normally adult canine teeth erupt in the mouth around the age of 12 years and, in approximately 2-3 per cent of the population of 12 year-old-children, these teeth become displaced in the roof of the mouth.

The new study found there is no evidential basis for the practice

Displaced canines can cause damage to neighbouring teeth as well as unfavourable movement of other teeth and, more rarely, cysts.

One way of avoiding canine displacement and encouraging the eruption of the adult canine is to remove a child's baby canine tooth at around 10 to 13 years, under local anaesthetic.

The most commonly cited evidence for this practice comes from one trial, carried out in 1988, in which a group of children with canine displacement had their baby canines extracted, according to researchers.

A major flaw of this study was the absence of a control group. Two other studies considered for the review did have an untreated control group, but had to be excluded because of inadequacies in reporting.

Dr Parkin added: 'Extracting the primary canine may help the secondary tooth to emerge correctly, but at this time we can't provide any hard evidence.

Greater attention to the design and reporting of studies is needed to improve the quality of clinical trials on this topic.' DT

Managers call for dental benefits

Nearly three-quarters of managers and directors believes that companies are responsible for looking after the oral health of their employees, according to a survey.

The Simplyhealth's Annual Dental Survey, surveyed 255 human resources (HR) managers/directors via independent research agency Opinion Matters, and found 71 per cent of employers think that companies should offer dental benefits.

While 40 per cent of companies who do offer dental benefits believe they help to 'increase employee engagement', according to the research.

James Glover, corporate director at Simplyhealth, said: 'Despite companies seeing their value, only 56 per cent of respondents actually offer dental benefits.

However, of these employers offering dental benefits, nearly half believe they help to reduce absence for dental health problems, and 48 per cent believe it makes it easier to monitor time off for dental appointments.

These results are crucial since they demonstrate the value dental benefits bring to the employer.

When looking at the barriers to implementing dental benefits, it may be unsurprising to learn that the main one is cost, with complexity coming a close second. However, with the perception that access to good dental care has become difficult, employers who are serious about the well-being of their staff should be looking seriously at making provision for dental treatment.'

Directors believe that companies are responsible for their employees' teeth

With the UK now in a recession, the results were very different to the survey held which looked at the same issues last year.

The survey found that 84 per cent of HR Managers are concerned that their employees cannot afford to look after their oral health, compared to 73 per cent last year

Sixty-four per cent of HR Managers think that introducing dental benefits would improve staff morale, compared to 51 per cent last year

While 56 per cent of HR Managers believe dental benefits would help reduce sickness absence and 54 per cent believe they would enhance recruitment and retention. DT

Research day for DCPs

The Faculty of General Dental Practice (UK) has organised a research day dedicated to dental care professionals.

The event will be held on 13 June, 10am-4pm, at The Royal College of Surgeons in London.

The one-day event will be held in partnership with the British Society of Dental Hygiene and Therapy (BSDHT).

It will include presentations from dental care professionals (DCPs) who have carried out or contributed to research projects.

There will be morning and afternoon plenary sessions to review the presentations and guide DCPs on their best route into research, whether by setting up a practice-based research project, or knowing where and how to review the latest research literature on a relevant topic.

The final presentation from Ken Eaton, one of the faculty's two national research facilitators, will give ideas on how the Faculty of General Dental Practice (FGDP UK) can help DCPs in their research, including examples of DCP research projects from around the world.

To find out more and sign up for the research day for DCPs, email Marina Harris, president of the British Society of Dental Hygiene and Therapy: marina.hyg@virgin.net DT

The dental team: Is yours troubled or terrific?

Consider your team for a moment. Does the thought cause you to roll your eyes and sigh in despair? Some days they're good, other days they're so-so, and on the worst days they are just plain bad. But they are your team.

Most of the time they show up when they're supposed to and together you take care of the patients. So you simply accept what you consider to be the trials and tribulations of people working together day-after-day. But what if you could take the good days and double, if not triple, those? What if you could build on the strengths of each individual? What if each person could sincerely enjoy coming to work and contributing fully? What if you could make all this team stuff actually work for your practice? Maybe it's time to turn those 'what ifs' into realities. Read on.

We spend a lot of time talking about dental teams — their effectiveness, their cohesiveness, their efficiency, their productivity, etc. Google the word 'teamwork' and you'll get 23.5 million hits. Search for books on teamwork on Amazon. com and you'll find nearly 39 thousand to choose from. For all of our interest in teams – dynamics, operations, successes, structures, advantages, challenges, the team is largely in the Neanderthal stage in it's evolution, still lumbering along. As Ken Lencioni, leadership guru and author of the best-selling book '*The Five Dysfunctions of a Team*,' describes it, 'Teamwork remains the one sustainable competitive advantage that has been largely untapped.'

What's more 'teams' are frequently composed of individuals whose skills are vastly under-utilised. According to J. Richard Hackman, author of '*Leading Teams: Setting the Stage for Great Performances*,' most teams generally leave unused enormous pools of member talent.

Many dental teams struggle to truly maximise their effectiveness. They face the daily challenge of merely getting everyone on the same page let alone heading in the same direction. Often they simply avoid taking action necessary to create high performance teams. Dentists become frustrated with team members because they don't like the way employees handle certain procedures, tasks, or patient interactions, yet they routinely make excuses for those individuals rather than give constructive direction. 'Patty is new, so there's a learning curve we have to consider.' 'Ellen is great at what she does, but she has difficulty dealing with some people.' 'Joe is a really nice guy, but he's afraid to mention a problem until we have a crisis.'

Conversely, team members complain that dentists don't give enough direction, feedback, or refuse to hold others accountable. They'll assert that certain team members get preferential treatment or that the office politics interfere with any real effort to change or improve systems. Some team members will become immensely frustrated with their inability to fix what they see as a problem or inefficiency because the practice has 'always done it this way.' Others shun discussion of those issues that make fellow team members or the doctor uncomfortable for fear of making waves.

Workgroup or teamwork

Take a look at your practice environment. Does your office foster a culture of teamwork that is built on trust and respect or does it operate more like a workgroup? Many dental 'teams' function more like workgroups. In workgroups, people are primarily concerned with their own job and output. They have little or no interest in what their coworkers are doing. In fact, they see their coworkers as their competition. This ineffective attitude leads to a loss of efficiency and production. The office feels disorganised; there is a general acceptance of poor or mediocre performance fueling a 'that's just the way things operate here,' attitude, and high turnover is common. Worse yet, conflict, turf wars, and pettiness are all too frequent.

In this type of environment, it is not uncommon for the doctor to dismiss the value of taking steps to strengthen the dental team. They'll dismiss or belittle the concept of 'team' with comments such as, '*My staff and I work pretty well together, and I don't want to spend time on intangibles.*' Intangibles? An ineffective team costs time, money, patients, staff, and stress – five pretty tangible things, wouldn't you say.

Answer the following questions about your team:

- How many times during the past year did you wish a member of your team would handle a patient, a procedure, or a situation differently? *How much do you think it cost your practice?*
- How many times during the year were you managing conflict between team members? *How much do you think it cost your practice?*
- How many times did you feel like one or more members of your team were heading in the opposite direction of the rest of the group? *How much do you think it cost your practice?*
- How often were you frustrated by team members' inability to solve problems or take necessary action? *How much do you think it cost your practice?*
- How often were staff meetings either dead with silence or dominated by one or two people? *How much do you think it cost your practice?*
- How many good ideas surfaced but were never implemented? *How much do you think it cost your practice?*
- How many times did you hear the words, '*It's not my job.*' Or '*I thought that was Jane's responsibility*'? *How much do you think it cost your practice?*
- How often were you faced with a two-weeks notice? *How much do you think it cost your practice?*
- How many patients did you lose in the last 12 months? *How much do you think it cost your practice?*
- How many times did you feel like the practice should be doing better financially, that work should be less stressful and more rewarding? *How much do you think it is costing you personally?*

But just how do you build the team that not only works together but truly excels together? It starts with a clear vision and a solid plan to implement the vision. The team has to know where they're going before they can be expected to actually travel in the same direction. Successful teams work toward a common purpose and hold themselves and each other accountable for the team's effectiveness and efficiency.

Effective team fundamentals

Effective teams produce concrete and measurable results. But it doesn't just happen. Oftentimes, practices have employees that together could become an outstanding, highly effective team. Individually, most of the members are dedicated, hard working, and knowledgeable, but they simply don't know how to function effectively as a group.

They don't know how to establish team goals and to identify the strategies to achieve those goals. But show them the possibilities of working as a team and give them the tools to function as one, and you begin to build the high performance group.

Start with the fundamentals of the highly functioning team. No. 1: Individuals need direction and a basic understanding of how their day-today work fits into the practice's overall goals. That begins with the practice vision and goals coupled with individual objectives. Help each employee understand their specific part in realising the established objectives. Staff members who are able to see the relationship between their roles and practice goals are much more effective and far more motivated to succeed than those who feel they are just another cog in the wheel.

And, most importantly, use job descriptions to give employees the direction they need to carry out their duties effectively. Employee job descriptions are essential to clearly articulate exactly what is expected and why carrying out specific duties is essential both to the individual's success and that of the practice.

In addition to clearly explaining duties and expectations, talk to your employees. Give them feedback regularly. Catch your employees doing something right and tell them every day. Ongoing feedback is absolutely essential in any business environment, but in a small business, particularly a dental practice, in which the success for failure of each system hinges on the performance of a small collection of employees, it is critical. Feedback from the doctor and other members of the team is the only means individuals have to better understand what they can do to improve their own performance. And it's one of the most essential resources for continuously assessing what is working and what isn't in your practice.

Create a culture of teamwork

Team members need to know they can trust each other. They need a process for managing conflict, which is inevitable and occurs on every functioning team. They need to understand what their individual strengths and weaknesses are as well as those of their teammates. Team members need to feel included in the process. They need to feel valued for their contributions, and they need to feel empowered to make decisions and take action when it is in the best interest of the practice.

Team members need to know how to communicate with each other. A true team environment encourages individuals to risk speaking up, to ask for help, and it gives them a safety net to make mistakes. It also creates a strong environment for solid constructive feedback. Effective team members turn team priorities into individual priorities. They understand that their role affects not just themselves but everyone else as well. Take steps to turn your staff into a highly effective team and enjoy the benefits of significantly greater practice efficiency and effectiveness and far less daily stress and anxiety. DT

About the author

Sally McKenzie
is CEO of The McKenzie Company, Inc. a nationwide dental management, practice development and educational consulting firm. McKenzie Management provides knowledge, guidance and personalised systems. E-mail: **sally@thedentistsnetwork.net**.