

NSW Dentist

THE MAGAZINE OF THE AUSTRALIAN DENTAL ASSOCIATION NSW BRANCH | JULY 2019

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**ADA NSW LAUNCHES
FILLING THE GAP
DENTAL CHARITY**

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NSW Dentist

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MEMBER NEWS

REGISTER TODAY FOR MY HEALTH RECORD

NSW dentists are encouraged to register with the My Health Record (MHR) system after latest figures revealed more than 90% of general practices have signed up to the scheme.

New Australian Digital Health Agency (ADHA) data has also shown there was a 52% year-on-year increase in the number of prescription records uploaded by GP organisations.

In addition, in the 12 months to April 2019 there was also a 60% increase in the views of clinical documents by GP organisations and a 13% increase in the number of shared health summaries uploaded by GP organisations to the MHR.

The MHR acts as a 'one stop shop' for individuals' health records and also allows Australian healthcare providers to view and add to their patients' health information.

"The MHR is an accurate and safe way to store and update patient health records," ADA NSW President Dr Neil Peppitt said. "It ultimately allows health professionals to treat patients in an even more efficient and effective way.

"ADA NSW encourages all our members to register for the MHR program."

ADHA figures earlier this year showed that nine out of 10 Australians now had a MHR.

To register and for more information on MHR, visit www.myhealthrecord.gov.au

2019 DENTAL HEALTH WEEK
FIRST CALL FOR VOLUNTEERS

5-9 AUGUST, 2019

Join the ADA Tooth Fairy, ADA NSW staff and volunteers again this year to inform and educate the community about good oral health awareness in Dental Health Week. Last year's event at the Martin Place stand in Sydney was a huge success. The exhibit was exposed to more than 20,000 people over the two days and awareness material was handed out to 5,000 people. The stand will be in Martin Place on 5-6 August again this year in the same location. To volunteer your time and meet the community face to face, email communications@adansw.com.au



DHW 2018

VISIT YOUR LOCAL SCHOOL DURING DHW

As part of 2019 Dental Health Week, we encourage members to visit a local childcare centre or school to speak about the importance of good oral hygiene. This is very worthwhile activity that can take as little as 20 minutes but will provide a lasting impact in your community. If you would like our Media Officer, Stuart Turner to call you about promoting your upcoming visit in the media, please email stuart.turner@adansw.com.au. To download oral health promotion packs on our website, visit the Members' area under Resources.

2019 QUEEN'S BIRTHDAY
HONOURS FOR EXCEPTIONAL
DENTISTS

Professor Elizabeth Martin, Dr Steven Cohn, Dr Richard Chan and Dr Douglas Thornton from NSW were among a distinguished group of dentists' recognised nationally in this year's Australia Day Honours list for significant service to the profession.

The Queen's Birthday Honours system of honours and awards recognise, celebrate and thank those who make a difference, achieve their best, serve others and whose actions set them apart to enrich our community.

Congratulations to these outstanding NSW recipients and ADA NSW Members:

Officer (AO) in the General Division – Professor Elizabeth Martin

Professor Martin from Oatlands was awarded an Officer (AO) in the General Division for her distinguished service to dental education as an academic and researcher, and to professional organisations.

Member (AM) in the General Division - Dr Steven Cohn

Dr Cohn from Castlecrag was awarded a Member (AM) for his significant service to dentistry, particularly to endodontology. Dr Cohn is also a highly sought-after presenter of courses offered by NSW CPD.

Medal (OAM) in the General Division - Dr Richard Chan; Dr Douglas Thornton

Dr Chan from Northbridge for his service to dentistry and Dr Thornton was awarded for his service to dentistry in the field of oral and maxillofacial surgery.

To see the full list of 2019 Award recipients, including recipients from other Australian States, visit www.gg.gov.au

WORLD HEAD AND NECK CANCER DAY
27 JULY 2019

Almost 5,000 Australians are expected to be diagnosed with head and neck cancer this year – but dentists can play a significant role in helping keep them alive. World Head and Neck Cancer Day is taking place on Saturday, 27 July and aims to highlight the several types of head and neck cancer.

More than 17,000 people are thought to be living in Australia with head and neck cancer, which includes cancers of the tongue, gum, mouth, salivary glands, tonsils, pharynx, nasal cavity and larynx. There is currently no screening for head and neck cancer available in Australia and about 1100 people are expected to die from one of those cancers in 2019.

Symptoms of head and neck cancer can vary, but may include blood in saliva, problems with dentures, loose teeth and difficulty with chewing and swallowing. A suite of resources to help identify head and neck cancer and support affected patients are available from the Beyond Five support group.

Established almost five years ago, Beyond Five is a national not-for-profit organisation providing access to comprehensive information about head and neck cancer.

ADA NSW encourages members to visit Beyond Five's website (www.beyondfive.org.au) and discover more about the role they can play in identifying head and neck cancers among patients.



NATIONAL DIABETES WEEK

National Diabetes Week runs from July 14-20 and dentists can play an important role in helping both identify and minimizing the effects of the condition.

About 1.7m Australians have diabetes, which is the fastest growing chronic condition in Australia according to Diabetes Australia.

One person every five minutes on average develops diabetes, which has associated problems including heart disease, blindness and amputations.

Gum disease puts patients at much higher risk of developing both pre-diabetes and Type 2 diabetes, while there are also several oral health tips for people with diabetes. These include encouraging regular brushing and visits to the dentist, flossing and drinking tap water.

More information is available via www.diabetesaustralia.com.au and www.adansw.com.au



REGISTER NOW

Upcoming Division and Study Group Events

adansw.com.au/events/calendar

26 July: Newcastle Division Meeting

Topic: *Braham Pearlman Memorial Dinner*

Presenter: Chris Griffiths
Location: Newcastle Club, 40 Newcomen St, Newcastle

CPD Hrs: 1

31 July: Central Coast Division

Topic: TBC

Presenter: TBC

Location: Gosford Golf Club, 22 Racecourse Road, Gosford

CPD Hrs: 1.5

19 August: St George Division Meeting

Topic: *New Paradigms in Dental Prescribing & Patient Management...*

Presenter: Andrei Tutoveanu

Location: Shipwright's on the Marina, 739 Princes Hwy, Blakehurst

CPD Hrs: 1.5

SAVE THE DATE

Online registration coming soon to: adansw.com.au/events/calendar

22 August: South Coast Division Meeting

Location: Lagoon Restaurant, Stuart Park, George Hanley Dr, North Wollongong

18 October: North and North West Division/Study Group

Location: Quality Hotel Powerhouse Tamworth, 248 Armidale Rd, East Tamworth

1 November: Western Division Meeting

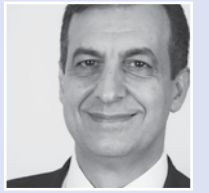
Location: Orange Ex Services Club, Anson Street, Orange

For event enquiries, call our CPD team on 02 8436 9932.

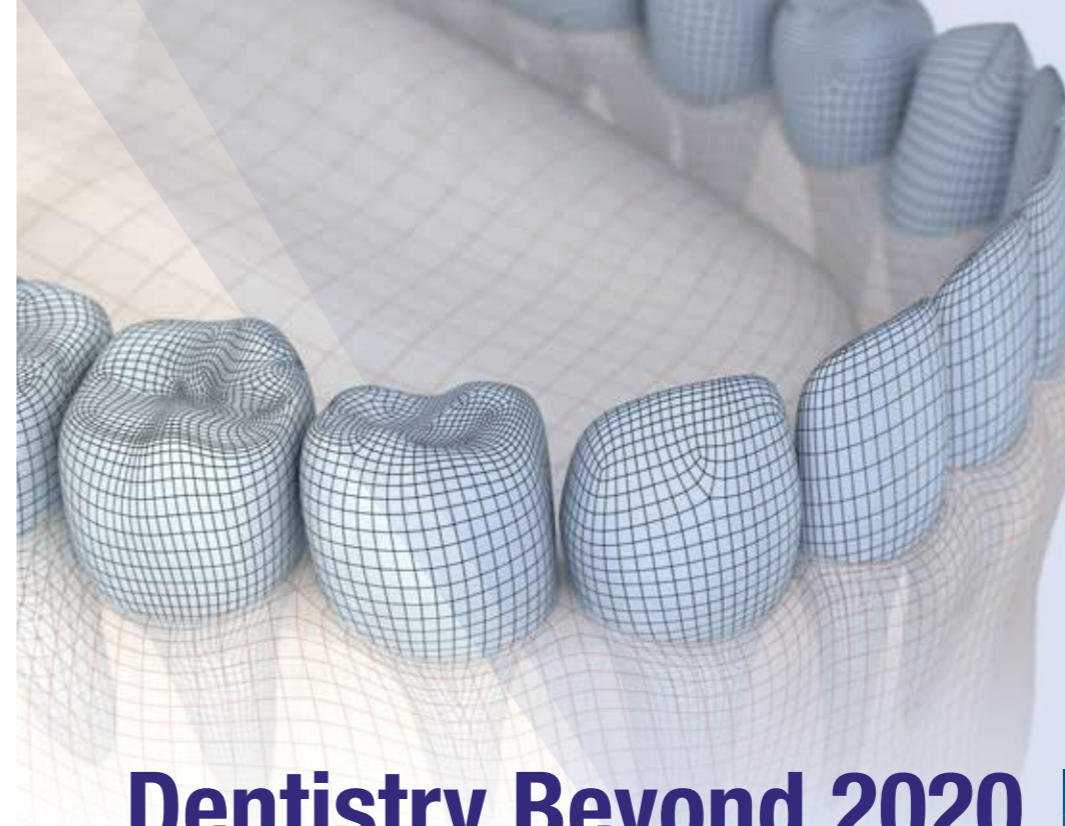


ADA NSW President, **Dr Neil Peppitt**, announces the formation of a new charity to expand ADA NSW's benevolent programs

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ADA NSW CEO, **Stes Stengos**, considers the impact of new technology on the dental profession.



Dentistry Beyond 2020

The pace of technological change is ever increasing in most areas and dentistry is no exception. I'm old enough to remember watching the *Beyond 2000* TV show in the 80's and 90's and remember marvelling at the things the future would bring. Many of those things are not yet part of our everyday lives such as flying cars, holographic TV's with smell-o-vision and holidays on Mars.

An interesting one in the healthcare space was that healthcare would be so advanced by now and food would be so nutrient dense and life-sustaining that people who took proper care of themselves could essentially live forever. And, should they die, they could always opt to be suspended in ice and reanimated at a later date. No mention of what condition their teeth would be in!

Innovation and technology are continually helping to improve almost every aspect of our lives, and dental care is no exception. It is amazing how an increasing number of disruptive innovations are becoming available for improving oral health as a patient, or upgrading dental practices. These innovations will provide new possibilities in oral healthcare and will shape the Australian dental industry and the patient experience.

Here are a few interesting innovations for dental health:

Smart Toothbrushes

Smart Bluetooth-connected toothbrushes with Apps. These combine a variety of sensors in the handle to track in real time how you are brushing your teeth. Some have games for children and can sense if you are brushing too much or little and if you are using too much pressure or scrubbing too hard.

Augmented Reality (AR)

Augmented Reality is being used to enhance learning in courses and practicals. Through augmented reality, dental models are being demonstrated to students and it is enabling students to compare their sculpting to the reference models. AR is also being used to give patients a virtual view of the smile they could soon have.

Virtual Reality (VR)

As with augmented reality, virtual reality can be used as a teaching tool to reach many students and dentists globally and make them feel they are in the room with the presenter by using VR goggles. For patients, some studies have shown that VR can be used as an effective distraction tool in dentistry.

Teledentistry

Teledentistry uses video conferencing technology and specialised intraoral camera to allow dentists to do examinations and consultations on patients in remote locations. This reduces travel for clinicians, reduces travel for families and provides faster access to specialist dental care.



This is truly a *Beyond 2000* story I would not have believed. Dental regeneration looks at using stem cell technology to allow teeth to heal themselves! In April 2016, *Newsweek* reported that scientists from the University of Nottingham and Harvard University developed dental fillings that allow teeth to heal themselves. The tooth filling works by stimulating stem cells to encourage the growth of dentin allowing patients to effectively regrow teeth that are damaged through dental disease. More research and clinical studies are being undertaken in this field and no doubt in the coming few years we will be hearing more about the advantages of dental stem cell technology for tooth repair and regeneration.

These innovations are very interesting and will no doubt change the face of dentistry and unlike the hover car and smell-o-vision may become commonplace in the not too distant future. For the most part, the benefits of these technological innovations will be most beneficial in the hands of the trained professionals – the dentists.



Addressing 'the tooth' about oral hygiene: NSW dentist Dr Mark Wotherspoon and team celebrate new invention

Hitting the Mark with a **great new invention**



Mark Wotherspoon laughs if you describe him as a pioneer, but he is the brains behind a unique invention which could help improve oral hygiene standards across the world.

Dr Wotherspoon and his team of business partners are currently finalising plans for the launch of the Dr Mark's HyGenie, for the home care of all types of removable dental appliances.

The all-in-one device cleans, stores and protects all types of removable dental appliances, making life much easier for users.

Dr Wotherspoon, who is based in the NSW Riverina city of Wagga Wagga, said he hoped his device could help transform dental health care.

"I think this is an innovation that was long overdue for dentistry and oral hygiene," Dr Wotherspoon said. "There are hundreds of millions of dental appliance wearers worldwide and, if my experience in 30 years of general practice is anything to go by, the vast majority of them struggle to properly and regularly care for their dental appliances at home.

"Anything that saves our patients time, simplifies home care, reduces loss or breakage risk and improves oral hygiene is a good thing."

The device, which is aimed for launch in September or October, features a built-in series of 'clustered' brushes that rotate in opposite directions, washing all surfaces of an appliance simultaneously.

Dr Wotherspoon has also developed a dental-appliance specific liquid soap for use with the device, which can 4clean and dissolve existing stains and calculus buildup.

The device can also store most dental appliances, making it a 'one stop shop' for users.

Dr Wotherspoon, who conceived the idea for the device about five years ago,

said the general reaction from colleagues here and abroad is one of surprise that something like this has not been developed earlier.

"At the recent International Dental Show in Cologne, our product range was universally described as clever, simple to use, affordable and very likely to be successful with both practitioners and the public," he said.

"I think it essentially replaces, or at least offers a fully functional alternative, to the traditional denture brush and air tight plastic case we have supplied our patients for the last 40 or so years.

"I am excited to be so close to our market launch, but with so much to do just yet, we'll hold off celebrations until we know our professional and consumer customers are happy."

Dr Wotherspoon said he hoped his invention could play an important role in improving the oral health of residents in aged care facilities or anywhere people require assisted living.

"Anecdotally, carers often struggle with the notion of touching and handling someone else's false teeth," he said.

"Even those who take on the chore of effectively and efficiently washing these appliances are concerned by the care and time this takes to do it 'by the book' and also the possibility of dropping and breaking the expensive and very difficult to replace prosthesis.

"The issue of improving dental health care for older Australians, especially those in aged care homes, is a massive one. I hope my device will help older Australians care for their teeth better."

The married father-of-three started his dental career in remote WA before

working in the Australian Army as a Dental Officer. He then settled in Wagga Wagga and private practice about 30 years ago.

Dr Wotherspoon said there were simple ways other dentists could generate ideas for their own inventions.

"The best advice I was given was to pin on the wall of your study an A3 sheet of paper, use a marker pen to map out 20 or so different sized boxes and then anytime an idea, silly or sensible, big or small, comes to mind, write it down," he said.

"After a while, see what ideas pull together and have the courage to go from there."

For more information, visit www.drmarkshygenie.com

HOW THE HYGENIE WORKS

Serves as an alternative to traditional denture brush and air tight plastic case for patients

Uses 'clustered' brushes rotating in opposite directions, washing all surfaces of dental appliance simultaneously.

After cleaning, converts into a storage case for the dental appliance

Hear Dr Mark Wotherspoon discuss his new invention – and listen to more terrific podcasts with dentists sharing their expertise – by visiting www.adansw.com.au/CPD/podcasts/dentalpractitioner



Are you a NSW dentist pioneering an invention, either individually or in your practice? Let us know by emailing communications@adansw.com.au



NSW Dentist, Dr Mark Wotherspoon, is preparing to launch Dr Mark's HyGenie



By **Dr Stefanie Toerien**, ADA
WA Branch member dentist

How Gaining Informed Consent can Avoid Buyer's Remorse

It's a shocking experience when a patient asks for their money back. An experience every dentist can do without. And when it happens, it leaves you wondering what you've done wrong and what you could have done differently. Just the other day a colleague shared with me how, out of the blue, a patient asked for their money back.

She made a beautiful anterior crown for her patient. She invested hours explaining the treatment and carrying out the procedure. And had even shown her patient in the mirror, before cementing the crown, asking for their feedback.

And then, a few days later, the patient returned asking for their money back. It left her perplexed, confused and wondering why suddenly the crown, that a few days ago was perfectly fine, had so many problems. She's even questioning her communication style, thinking that perhaps she didn't recognise a personality trait in her patient, a red flag, signalling that she should have referred her patient, and wondering what she had done wrong.

The patient doesn't want her to rectify any problems. They just want their money back. Apparently, they even threatened to complain to the Dental Board. She's facing a tough decision: does she for peace sake cut her losses, pay the lab bill and give their money back or argue the toss and struggle with time consuming paperwork, sleepless nights and headaches?

Either way, when a patient asks for their money back, you wish you could ask for the dental device back before refunding them - but dentistry is different. Every device is custom-made and fitted, so you can't get the crown back and you can't resell it.

So why does a patient suddenly change their mind? Allow me to explain by asking you this...

Experiencing post-purchase regret

Have you ever felt a sense of regret after having made a purchase? Regret about spending your money, feeling annoyed and frustrated, wondering whether you've made the right decision and questioning whether you should have bought anything at all.

Perhaps, you've even returned your purchase and requested your money back regretting the decision you've made only a few days ago. Your patients also experience regret after they've invested in your high value products and services.

Or even worse, they regret spending money and ask for a refund, rationalising it in a way that makes sense to them but not to you. Post-purchase regret (also known as Buyer's Remorse) stems from internal cognitive conflict, specifically post-decision dissonance, which creates regret. It's essentially internal conflict between what you desire and what you want to avoid. And it's activated post-purchase.

The Approach Motivational System

Buyer's Remorse engages the Avoidance Motivational System. Feelings like guilt and regret associated with Buyer's Remorse, reflect the activation of the avoidance motivational system. It's an instinctual system that encourages you to move away from anything you perceive as negative or threatening. In contrast, the approach motivational system has you

moving towards anything you perceive as positive.

What happens when these motivational styles conflict with each other? In the example above, the patient went to the dentist because they 'presumably' saw it as a positive. And after a perfectly fitted crown, somehow the perception shifted to negative. Was it a con right from the start? Should my colleague have seen a red flag? Or was it the fact that price kicked in and they decided they really couldn't afford it?

Extrinsic Persuasion and Attunement

When the Approach Motivational System is in control focusing on what you desire, the Avoidance Motivational System is powerless.

In this case, the patient thought it important enough to move towards a dental solution, but then something happened. After purchasing the crown, the move towards system switched off and the moving away from system took control.

When these two motivational styles are in conflict it creates post-purchase dissonance. You either perceive your purchase as valuable and you're happy to keep it. Or the perceived threat of spending money takes over, causing you to change your mind and ask for your money back.

When the approach motivational system is switched on, patients can easily be talked into dental solutions

without necessarily having to see the value in their purchase. If a patient feels as though they've been talked into a dental solution, post-purchase feelings can trigger the avoidance motivational system and internal conflict occurs.

Reducing Buyer's Remorse

How do you reduce Buyer's Remorse, the frustration of patients asking for refunds and your financial losses that go hand in hand with this?

While there are many reasons why people buy products and services, it's often a case of 'getting talked into buying'. Convinced by skilled sales people that they need a certain product and consequently buying into the process of needing something.

This way of selling is the most common method of persuasion. A method using facts, figures and rational language, persuading clients with

narratives that a product or service will be beneficial to them. It's the client getting convinced by someone else. It's called extrinsic persuasion. With extrinsic persuasion the client gets talked into a decision, rather than coming to a decision by themselves.

And when talked into a decision they're easily talked out of their decision. Persuaded with ease by someone else, or convincing themselves internally to change their mind. When extrinsically persuaded, clients are less likely to defend their decision and post-decision dissonance occurs more readily which leads to Buyer's Remorse.

It happens mostly as a result of dentists moving too quickly from examination to solution. When you move too quickly there's a lot of built-in assumptions. As a dentist you want the best for your patients and the solutions you offer are based on sound clinical

It's putting yourself in their shoes and looking at things from their perspective. It requires an ability to put aside your needs and becoming 'them-centric'.



Helping a young dentist to thrive in their career

HURRY
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Wednesday 24 July 2019

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For further information

Tim Escott, ADA NSW Marketing and Communications Specialist
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Applications are now open for the 2019 ADA NSW BOQ Specialist Recent Graduate Bursary supporting the career growth and development of a young dentist.

ADA NSW and BOQ Specialist have had a longstanding relationship supporting the dental profession. As part of this partnership, ADA NSW and BOQ Specialist launched the Bursary last year for recent graduates.

The Bursary will be used on career development training within the world class ADA NSW Centre for Professional Development with \$5,000 in financial support.

It recognises a recent graduate who has gone above and beyond by demonstrating a commitment to high quality ongoing professional development. The successful applicant will be required to demonstrate that commitment and outline a clear path as to how the Bursary will advance their career.

ADA NSW President Dr Neil Peppitt said he was delighted to again offer the Bursary for recent graduate members to help them gain an edge in a competitive talent pool.

"BOQ Specialist has been a long serving industry partner and supporter of ADA NSW. We are committed to providing high quality continuing professional development for our members and this will help develop the professional and clinical skills for a dentist of tomorrow," Dr Peppitt said.

BOQ Specialist CEO Hugh Lander said BOQ has been providing distinctive banking solutions to dentists for 30 years and understand the need for young dentists to follow their career trajectory.

"We recognise the importance of continued professional development in refining dentists skills," Mr Lander said. "The purpose of the bursary program is to reward the commitment of recent dental graduates in ongoing education and training to deliver the highest quality of care to their patients."



Dr Wayne Sherson

Sex, Drugs, and Rotting Teeth

Headline, Hype or Health issue?

In our media dominated world, headlines on sexual health and illicit drug use regularly challenge us to read, listen and watch, purportedly informing us, but inevitably searching for ratings, readership, shares and likes. In 2013, Hollywood star Michael Douglas, famously told The Guardian newspaper "oral sex caused my cancer". Are these headlines just hype or are there important oral health issues lurking beneath? Should it be our professional role to discuss these issues with our patients, and how do we remain objective in doing so? As dental professionals are we equipped with the knowledge and skills to assess, diagnose and advise in matters of sexual health and illicit drug use?

Let's take a moment to consider just a few of these recent headlines.

Why oral cancer threatens men – Scientific American Nov 2018

There has been an unprecedented increase in [non-alcohol /tobacco associated] oropharyngeal carcinoma over the past decade with human papilloma virus (HPV), significant in cervical and anorectal cancer, identified as the causative agent. However, HPV alone can't explain the sudden change in incidence. What has been the role of changing social norms around sexual promiscuity and oral sex? Is there a gender bias and why? How do we approach taking a sexual health history in our clinical practice? Issues of presentation, diagnosis and management are of vital importance.

End to AIDS in sight – Guardian May 2019

HIV infection rates in Australia are suddenly dropping significantly. Can this be attributed to effective treatment alone or are other factors at play? Has effective treatment changed the oral presentation of HIV and has a cure for HIV been found? Pre exposure prophylaxis [PrEP] for HIV is now available on the PBS and close to 10,000 Australians are accessing it, but how effective is PrEP and are there side effects influencing oral health?

Australians spent \$9.3bn on drugs in 2018, wastewater shows – Guardian Feb 2019

Illicit drug use in Australia is common and widespread across the community and studies monitoring wastewater provide some surprising and challenging findings. The estimated annual consumption of illicit drugs in Australia includes: 10 tonnes of Methamphetamine [ice], 4 tonnes of Cocaine, 1 tonne of MDMA [ecstasy] and 700kg of heroin. What is the impact on the oral health of those partaking? Can harm minimisation strategies be implemented in dental practice to improve their oral health? Importantly, how do you have open and honest discussions on illicit drugs and record them, considering you may possibly be documenting illegal behaviour?

Hepatitis C drugs not being accessed by thousands of Australians... – abc.net.au Feb 2018

Hepatitis C is Australia's most common notifiable infectious disease affecting over 200,000 people. If left untreated it has high morbidity and mortality rates. However, a cure for hepatitis C is available with new treatments now listed on the PBS but less than half of those infected have accessed treatment. How do you help identify and guide patients in your practice to undertake treatment?

Are there specific oral health care needs for those infected with Hepatitis C?

Sydney dentist suspended, patients warned of exposure to blood borne viruses – SMH Aug 2018

What are the risks of transmission of blood borne viruses [BBV's] in your practice? Do you need to treat a patient with a BBV differently?

Clearly, from these few examples, headline information alone is not adequate and evidence-based knowledge and an objective approach is essential. ADA NSW Centre for Professional Development is presenting a program on oral health, sexual health and illicit drug use, providing answers and perspectives for these complex oral health issues in your practice.



Dr Sharon Liberali, Dr Beata Rumianek and Dr Wayne Sherson will be presenting, *Sex Drugs and Rotting Teeth* at ADA NSW CPD, on 22 November 2019.

See the CPD program guide or visit www.adacpd.com.au/courses for details.





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EXPAND YOUR LOCAL ANAESTHESIA TOOLKIT

By Dr Steven Parker

Profound local anaesthesia is essential for the provision of modern dentistry. Dentists are generally familiar with only two injections – infiltrations and the standard Inferior Alveolar nerve block. Whilst these serve the profession well, there are occasions when adequate anaesthesia cannot be achieved using only these two techniques - most commonly this occurs with mandibular teeth.

Most dentists have experienced a 'mandibular slump' where they seem to 'miss' a few blocks in a row. At these times, it is extremely helpful to be familiar with alternative techniques such as the Vazirani-Akinosi (VA block) mandibular block, also known as the 'closed mouth' block.

The VA block anaesthetises the following branches of the mandibular

nerve: the inferior alveolar, lingual, mental, incisive, and mylohyoid nerves within the pterygomandibular space, and 75% of the time it will also anaesthetise the long buccal nerve.

It therefore provides anaesthesia to the mandibular teeth to the midline and associated lingual periodontium and gingiva, as well as the labial periodontium and gingiva of the mandibular anterior teeth and premolars to the midline and possibly the buccal periodontium and gingiva of the mandibular molars.

Because the VA block uses a closed-mouth technique, it is particularly helpful in patients who have limited mouth opening whether that be due to anatomical or arthritic considerations or trismus due to infection or trauma. This block is also very useful in patients who have a large tongue or buccal fat pad that obscure the view of the normal intraoral landmarks. I'm sure all dentists are familiar with the 'combative' tongue!

The injection is relatively simple to perform. It is given much higher than a conventional block and will therefore usually result in a higher success rate. In a lateromedial plane, the point of insertion is medial to the coronoid process and lateral to the maxillary tuberosity. In a superioinferior plane, the point of insertion is at the height of the mucogingival junction of the maxillary teeth.

CLINICAL TIPS



AND EXTRACTS

The needle (long) is advanced posteriorly until the hub of the needle is adjacent to the distal aspect of the second molar tooth. After aspiration, a full cartridge is slowly deposited. After having taught this technique to hundreds of dentists over the last 18 years, I am always pleased to hear from course participants that it is a straightforward injection to give and a comfortable injection to receive.

The CPD course *Pain Control in Dentistry* will be held on 19 July 2019. Book at www.adansw.com.au/CPD/Courses

MINIMISING POST-OPERATIVE ADJUSTMENTS

By Dr Clarence Tam

It is frustrating for all of us when we have placed and replaced anatomy into a restoration only to remove the rubber dam, check the bite, and kazam!

Yes, that's the heart wrenching word for "crap, it's so high". This is the case exhibited in this patient (pictured), who incidentally has generalised moderate attrition with patches of exposed dentin on virtually all posterior teeth.

Tips for minimising post-operative adjustments:

- 1) Try to approximate the angle of declination of the triangular ridges as noted in the pre-operative situation.
- 2) Try to mark the occlusion with articulating paper before you place the rubber dam so you will have an idea about 'hard limits', literally.



- 3) Try to approximate cusp heights from the facial and lingual to match the 'flow' of the line connecting adjacent cusp tips.
- 4) Note the position incisocervically of the central fossa and fissure in the adjacent teeth but also of the pre-operative tooth and try to mimic this.
- 5) Identify plunger cusps in the opposing dentition and gently recontour these as required.



Dr Clarence Tam's CPD course *Achieving Anterior Aesthetics* will be held 29 - 30 August. Book at: www.adansw.com.au/CPD/Courses

Clinical Tips and Extracts is a monthly column for sharing helpful hints with colleagues.

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CSU regains the Roland Bryant Cup

Professor Roland Bryant reports unseasonably pleasant conditions in the usually cold climate of Orange greeted participants and spectators participating in the 10th annual Roland Bryant Cup.

The sporting competition is between students of NSW's two dentistry schools - University of Sydney (blue outfits) and Charles Sturt University (in red). Following the University of Sydney taking the RB Cup for the first time last year, expectations were high that they may have started a trend because of admissions changes at CSU and the steady increase in the proportion of Canadian students at the University of Sydney.

Many of the participants from USyd had travelled to Orange the previous evening to be on time for the 9am kick-off in the men's soccer competition. While the number of spectators changed throughout the day, there was a good crowd on hand to watch as USyd repeated the 2018 result, with a 4-2 win. As in all the competitions, the commitment of participants was very evident and fortunately there were very few injuries.

In the Women's Soccer, USyd proved to have two notable 'star performers'. Despite many players going down with muscle cramps, there were periods of quality soccer before USyd again ran out the winners, 5-0.

An early lunch was held at the ground in warm and sunny conditions. Representatives of the three Sponsors (ADA NSW, Guild Insurance and A-dec) were present for much or all of the day. The assistance of sponsors was much appreciated in supplying t-shirts (with names), helping the payment for facilities/referees, supplying food and drinks for lunch, assisting with accommodation and supplying fun mementos including hats and plastic frisbees.

This year marked the first time when a mixed frisbee competition took place. Many of the spectators had no idea about the rules for a frisbee competition, but they soon learnt. It proved to be a very skilful and exciting event. Many short passes were on display but also some long adventurous throws (with a one-in-two chance that the passer's team would catch the floating frisbee).

The result was the closest possible with CSU winning 9-8. With much to play for, competitors and spectators made their way by a fleet of cars about 3-4 kilometres to the excellent indoor sporting facility at Kinross Wolaroi School.

Men's basketball is always a contact sport and a firm hand can sometimes be needed by the referees to ensure control. But things didn't exactly go to plan when the two scheduled referees failed to show up. We were therefore very grateful that a spectator who was a qualified basketball referee (and dentist) was able to step in and control the game. One looks away as competitors regularly take a tumble to the floor with concerns for 'dentistry-destined' hands. Somewhat unexpectedly, CSU won the basketball game by 72 to 53.



Frisbee in flight



Mixed Frisbee teams

While all this was going on, the female participants for the dodgeball competition were finalising rules and warming up throwing arms. Spectators usually find dodgeball the competition at which they become most vocal. CSU managed to win 3-1 and win the RB Cup for 2019 - the first time a side has come back from being 2-0 down.

Thank you to all participants for the spirit in which the events were played and to the organisers/leaders of the two teams - Alex (USyd) and Rogina (CSU). Between approximately 150-180 people attended or participated at some part of the day. It was great to see a number of staff present as well as parents to watch proceedings unfold.

Next year, the event returns to Sydney. Spectators all very welcome to drop in for an hour or three for the next instalment of the Cup!

Sponsors with Roland Bryant; Adam and Paul from A-dec, Tammi from Guild, Briana from ADA



Women's soccer - two teams



Start of women's Dodgeball



Dr Jane Pinchback,
Advisory Services
Peer Advisor.

This is the final in a series of five articles which have appeared monthly in the NSW Dentist this year. As with the previous four, this article identifies a single area of clinical practice based on data analysis of patient complaints/legal claims received during the preceding year. To recap, the five most represented areas of practice in patient complaints/legal claims during 2018 were...

THE TOP FIVE COMPLAINTS AGAINST DENTISTS

No 5

The aim of presenting the current data set is to get you thinking about those areas of practice where you might be at risk. By understanding issues common to the profession in general, you might consider how best to strategically mitigate problems or, better still, become aware enough to be able to avoid the pitfalls altogether.

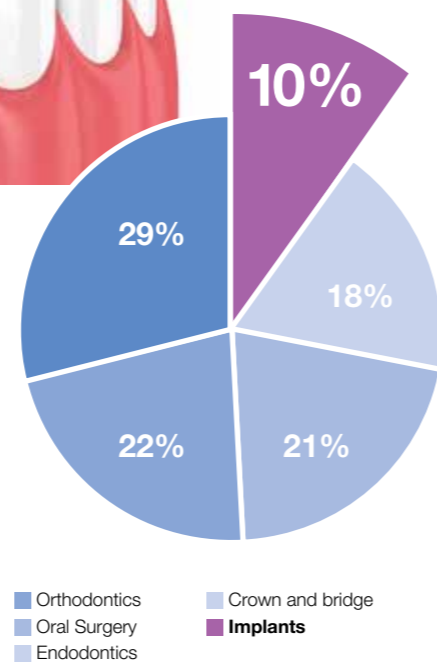
At the outset, it is important to acknowledge that:

- A.** given the exponential uptake of this treatment modality in recent times, and
- B.** considering the complexity, cost and surgical nature of implant treatment, the volume of complaints related to implant treatment is reassuringly low. Having said this, the dollar value associated with defending implant claims is almost always high and the time taken to resolve the issues which arise can be lengthy. For these reasons, practitioners

responding to implant-related complaints often find the process to be harrowing, stressful and emotionally-charged.

Common issues:

As with any clinical modality, adverse outcomes can arise as a result of incorrect or incomplete diagnoses (poor case selection), poor treatment planning, poor treatment execution, procedural complications and/or a lack of post-treatment maintenance. Specifically, when examining restoration of edentulous spaces with implant-supported



prostheses, the professional regulatory body in NSW (the Dental Council), has regularly and repeatedly raised the following concerns in relation to implant cases:

- The use of mini-implants in situations where they are not clinically indicated. This includes inappropriate design of the prosthesis, inappropriate loading of the implant/s and also gives rise to consideration of scope of practice issues - whether the clinician is sufficiently trained for the procedures being undertaken
- Failing to consider relevant medical and/or social factors. As with any surgical procedure, it is necessary to take into account the patient's habits and their past and present **medical and medication histories** when evaluating whether treatment is likely to

#5 AREA OF COMPLAINT: IMPLANTS

be successful and in determining the possible risk to the patient of undergoing surgery

- Whether there was an adequate pre-operative assessment of the quantity and quality of bone available. For the placement of implants, the gold standard requires the use of 3D imaging. Practitioners appearing before the Dental Council of NSW have found that the professional officers do not condone the use of OPGs when treatment planning an implant case
- Sometimes patient expectations on the longevity of treatment can be formed based on media/ promotion/ advertising. So, clear messages need to be communicated prior to treatment to keep expectations in line. This goes to having an adequate consent process in place
- Surgical complications – paraesthesia, haemorrhage, perforations, devitalising an adjacent tooth/teeth, inhalation/ ingestion of components, etc. – often due to poor planning and/or treatment execution
- Failure of restorative components
- Loss of an implant, post-operative complications – particularly when poorly managed or not recognised
- Implants placed but unrestorable - good treatment planning will take into account the intended final positions of the prosthetic components.

In a nutshell, poor planning and/or treatment execution often leads to poor outcomes with the attendant heartache, repercussions and cost. Consider whether a mentor, senior colleague or study group may be helpful in the planning and follow up of your cases.



CASE EXAMPLE + + + + +

Dr X received a letter from a former patient titled “**Letter of Demand for Compensation due to nerve damage and financial losses incurred.**” In part, the letter said “...since my disastrous appointment with you...I have been suffering from a great deal of oral discomfort...including bad taste, metallic taste, furry tongue on the side of my mouth where the implant failed...I believe Dr X has either severed the lingual nerve or damaged it...”

A review of the clinical records for the case revealed that:

- An implant had been placed in the lower right molar region by a specialist periodontist
- The patient had failed to attend for follow up appointments (including torque testing) before having the implant restored
- Another dentist in Dr X's practice constructed the implant-supported crown
- The RFA, when the patient consulted Dr X, was recorded as being “*implant exquisitely tender to palpate*”
- The implant-supported crown was successfully removed during the appointment with Dr X under local anaesthetic. A healing cap was placed to facilitate comfortable function and the patient was referred back to the specialist. She failed to attend.

After the appointment with Dr X, the patient contacted the practice by telephone – she said there was a metallic taste in her mouth and she complained of having thick, powdery saliva. Dr X prepared and posted a referral for the patient to consult an Oral Medicine specialist. The details of the telephone conversation and referral were noted in the clinical record. On receiving

the claim, Dr X contacted the oral medicine clinic and was sent a report which showed the patient had been diagnosed with **sub-acute bacterial sialadenitis of the right parotid salivary gland coupled with xerostomia.** Treatment and follow up tests had been recommended but the patient had failed to attend any further appointments with the Oral Medicine specialist.

In this case, it was evident from the records that:

- The treatment provided by Dr X did not contribute to the failure of the implant
- The injection performed by Dr X did not sever or damage the patient's lingual nerve
- The symptoms reported by the patient and attributed to Dr X's treatment had been assessed by a specialist as originating from an underlying salivary gland pathology.

This claim was able to be successfully denied. This highlights how valuable it can be to diligently follow the Dental Board of Australia's *Guidelines on Dental Records* and to maintain comprehensive clinical notes. Good records are a clinician's best defence when facing any kind of legal claim.

+ + + + +

AVOIDING PROBLEMS An excellent summary of the “golden rules” for successful implant dental treatment delivery can be found in the April edition of this magazine. As well as the recommendations noted in this article, we remind practitioners, as always, of the importance of maintaining excellent clinical documentation. After all, writing dental records is part of every patient encounter, every day. Getting this aspect of practice right has the potential to save you significant time and angst.

WHAT TO DO IF YOU RECEIVE A COMPLAINT

The Advisory Services team welcomes enquiries around any aspect of dental clinical practice or patient care. If we are unable to help you, we can generally put you in touch with an organisation or individual who can. Please don't hesitate to get in touch if you have any queries or would like to have a confidential discussion about a particular patient or situation. We are here to help you.

Peer Advisors are available 9am – 5pm, Monday to Friday and can be contacted on (02) 8436 9944 or advisory@adansw.com.au

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FROM THE CRADLE TO THE GRAVE

medical implications
in dental treatment

ADVISORY SERVICES



Dr Vicki Rozos reviews
the changes affecting
Health Care Workers.

CDNA updates guidelines for working with Blood Borne Viruses

So much of what we do as clinicians relies on the *primum non nocere* (first, do no harm) principle and the Communicable Diseases Network Australia's (CDNA) Guidelines are in keeping with that. They illustrate the current expert consensus on the evidence in relation to health care workers (HCW) and their blood borne viral (BBV) status. The BBVs include hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV), and these viruses are transmitted primarily by blood to blood contact. Current antiviral treatment of the BBVs is very effective at preventing their spread. All HCWs should be vaccinated against HBV.

Many clinicians are under the impression that if they contract a BBV, that would end their career. This is because unfortunately, under the previous version of the CDNA guidelines (2012) some HCWs (including students) living with a BBV could not perform exposure prone procedures (EPPs).

Why do we need CDNA Guidelines?

Even with best practice infection control procedures, due to the nature of EPPs, HCWs are at a higher risk of acquiring a BBV from a patient and also of passing a BBV on to a patient. When HCWs living with a BBV are complying with the Guidelines, the risk of passing on a BBV to a patient is minimised. The Guidelines also support healthcare workers to get timely testing and treatment.

What is an EPP?

EPPs are procedures where there is a risk of injury to dental staff resulting in exposure of the patient's open tissues to the blood of the staff member. These procedures include those where the dental staff's hands, even when gloved, may be in contact with sharp instruments, needle tips or sharp tissues

(spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

The Guidelines consider EPPs to include, but are not limited to, maxillofacial surgery and oral surgical procedures, including the extraction of teeth (but excluding extraction of highly mobile or exfoliating teeth), periodontal surgical procedures, endodontic surgical procedures, and implant surgical procedures.

What is different in the new Guidelines?

The Guidelines now allow healthcare workers living with a BBV, who were excluded from performing EPPs under the previous guidelines, **to now be eligible to perform EPPs** provided they comply with these Guidelines. They must still take reasonable steps to know their BBV status and should be tested for BBVs at **least once every three years**.

They are also expected to:

- have appropriate and timely testing and follow up care after a potential occupational exposure associated with a risk of BBV acquisition

- have appropriate testing and follow up care after potential non-occupational exposure, with testing frequency related to risk factors for virus acquisition
- stop performing all EPPs if diagnosed with a BBV until the criteria in the Guidelines are met
- confirm that they comply with these Guidelines by declaration when applying for renewal of registration. This is also a requirement under the Dental Board of Australia's Guidelines on Infection Control.

Does this mean I can go back to performing EPPs after previously being excluded?

Dentists who were restricted or become restricted from performing EPPs may again be eligible to perform EPPs provided they meet the criteria outlined in the Guidelines and obtain clearance from their treating doctor with relevant expertise in accordance with the Guidelines.

What happens if I don't comply with the Guidelines?

A Dentist performing EPPs who does not comply with the Guidelines can be notified to AHPRA, to the Dental Board of Australia and to the public health authorities.

Worldwide, since widespread availability of antiviral medication, there has not been a published case of transmission of a BBV from an effectively treated HCW to a patient. It's refreshing to see the CDNA Guidelines changed in 2018 to reflect this.

This event will be followed by the ADA NSW Gala Charity Winter Ball

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• **DR PETER SERB**
Medical considerations in the treatment of periodontal patients

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Pharmacological considerations to promote safe dental treatment

• **A/PROF. MARK SCHIFTER**
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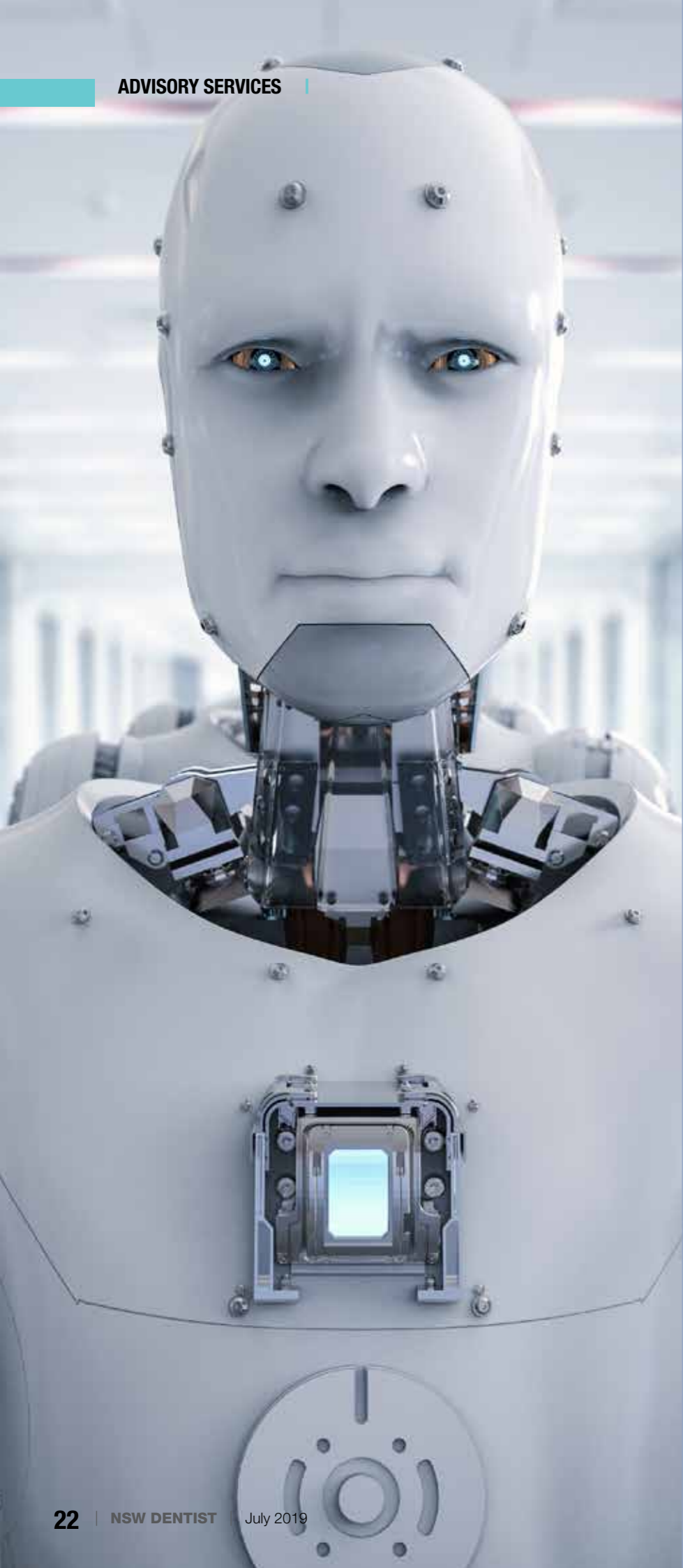
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NOT ALL IN THE LINE OF DUTY

QUESTIONS WITH
Dr Martin Nash
ADVISORY SERVICES PEER ADVISOR



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Hi Martin,

I have read that it is acceptable and sometimes even desirable to terminate the doctor – patient relationship on occasion. I have a particular patient in mind who I would love to see the back of, but I am also concerned that ‘terminating’ them could cause me grief afterwards. My question is about how that is likely to play out.

Thanks, **The Terminator**

Dear Dr T,

Unsurprisingly, this is an issue that resurfaces on a regular basis, and achieving a desired disengagement can be truly liberating. If it is so socially acceptable to dispense with an unloved life partner, how hard can it be to fire a nasty, ungrateful, lying, scheming patient, whose mere presence in the appointment book provokes feelings of fear and loathing in the most even tempered of practitioners? As in many simple looking tasks of people management, the reality may prove more challenging than one might think.

ADA NSW Advisory Services actually has one of our famous ‘Information Sheets’ on this very subject, but it is certainly a challenge worthy of a deeper exploration. Happy to email a copy of this or one of the other Info. Sheets to any member too, of course.

No-one appreciates personal rejection, and the clinical divorce seems to carry an extra sting: *‘I can’t bear to spend even those paltry few hours a year with you ever again, even if you are paying me handsomely for the privilege’ / ‘My dentist hates spending time with me even more than I hate going there...’*; see what I mean? The trick is to de-personalise the message as much as possible. It is important to be straight forward and open as well as tactful, in order to soften the mortal blow.

THE LETTER

If you are as cowardly and confrontation averse as I am, you too may be attracted to the written separation proposal. It can be a beautiful thing, in that it also takes care of that most essential requirement of an effectively documented record of events. No *‘he said, she said’* nonsense with this approach. A written advice also has an air of finality to it, so less opportunity for pathetic requests to give it one more try – the die is well and truly cast!

There are obviously a number of circumstances where such precipitate action is contemplated. To me the one that springs readily to mind is that patient who seems to feel that their uninformed opinion of what is required in the way of appropriate treatment is on a par with that of a highly trained and experienced health practitioner; they actually expect to dictate their treatment plan on that basis. Please don’t get me wrong, every patient has the right of veto over any

proposed treatment plan, but that is certainly not the same as insisting that their dentist follows some crazy illogical treatment plan of action. We all know that having your arm twisted to provide poorly conceived treatment is no defence when the inevitable results come to pass. This type of patient also often chooses to attend only when some dental disaster has occurred, and consequently avoids ever addressing the whole oral health picture; a dependable recipe for a poor outcome, which they will be only too willing to blame you for entirely.

We have some experience in editing a practitioner’s draft *‘cease to treat’* letter - always a good idea to have the wording checked by an objective fresh set of eyes, and we are happy to offer that. Any language which could be interpreted as discriminatory should be carefully avoided, as this can have legal risks. Inflammatory language is also usually quite counterproductive. Try this wording out:

*Dear ...,
A successful professional relationship requires a level of mutual trust and respect between practitioner and patient. Unfortunately I believe that this no longer exists between us and means that I may no longer be the best person to provide your dental treatment. I certainly respect your right to make your own decisions about your treatment, but I feel that another dentist might be able to meet your expectations more effectively. I will of course try to assist in every way possible to allow a smooth transition by providing a copy of your health records to you and/or your new dentist.*

Kind Regards

Or what about?:

*Dear ...,
I understand how busy you are, but your repeated late cancellations are creating a problem for us. Many of our costs are fixed regardless of whether we are seeing a patient or not; when an appointment is not kept or is cancelled late, we cannot easily fill that gap which another patient would have been grateful to have. Unfortunately we cannot make any further appointments for you for this reason. I will, of course, try to assist in every way possible to allow a smooth transition by providing a copy of your health records to you and/or your new dentist.*

Kind Regards

THE DILEMMA

This is all sounding quite wonderful so far, but your perceptive question concludes: *‘I am also concerned that ‘terminating’ them could cause me grief afterwards. My question is about how that is likely to play out.’*

What could possibly go wrong?

1. If money is owed to you, you may well never see any of that. Re-settling the patient may involve an element of **‘buying your way out’** (money well spent? - you be the judge!)
2. The patient may retaliate by accusing you of providing poor treatment all along and demand a refund of fees, or worse
3. A nasty complaint might find its way to the Health Care Complaints Commission
4. You may be attacked mercilessly on Social Media
5. If the clinical records are not exemplary, it is extremely challenging to manage such events, even if there is little truth to the various allegations.

When is it possibly not such a good idea to terminate the professional relationship?

The duty of care that a practitioner owes a patient extends to ensuring that no foreseeable harm comes to a patient from any action or omission of the practitioner. There is no doubt that, prior to the decision to discontinue treatment, the patient’s condition must be stabilised. This does not mean that all treatment must be completed. If a patient is in the middle of a treatment plan (eg orthodontics), it behoves the treating practitioner to ensure that they are not *‘abandoning’* the patient midstream - suitable arrangements must be offered if it is not practical to complete treatment, or at least achieve *‘stabilisation’*.

Hope that helps, Martin.

**If you have any questions,
please email Martin at:
martin.nash@adansw.com.au**

FROM THE TEACHING CLINICS AT SYDNEY OLYMPIC PARK AND MACQUARIE UNIVERSITY



AUTOTRANSPLANTATION OF TEETH

- 10 year old male with previous 11/21 trauma at early age and subsequent infection, dilaceration and non viability of these teeth
- As patient had associated dental crowding orthodontist recommended consideration of autotransplantation of redundant 15/25 to the extracted 11/21 sockets
- Dentally it is important success related to open apices on the transplanted teeth
- Surgically use implant drills to fashion sockets
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Putting your ducks in a row

ENSURING PROPER EMPLOYMENT PRACTICES ARE IN PLACE



Practices should adopt proper employment and engagement practices to develop a positive culture and assist in fostering relationships between management, employees and contractors.

A failure to follow proper employment practices can leave the practice open to risk, reduce morale and threaten the overall success of the business.

Engagement Models: Contractor or Employee?

There are a number of different ways an individual can be engaged in a practice. In some circumstances, dental professionals are engaged as independent contractors (as an alternative to the traditional employment relationship) as this provides the individual with more autonomy.

However, the Fair Work Act 2009 makes it an offence to unlawfully classify an employment relationship as an independent contracting arrangement. On this basis, if a practice is considering engaging an individual as an independent contractor it is important that there is proper consideration of some of the factors used to determine the true nature of the relationship.

Who is a Contractor and Who is an Employee?

Whilst there is no black and white answer to this question, common considerations include whether the individual is able to work for other businesses, sets their own start and finish times and has the ability to sub-contract or delegate work.

Independent contractors differ from employees as they are essentially 'in a business of their own', providing their services in commercial terms. Independent contractors are not entitled to paid entitlements such as annual leave or personal/carers leave under National Employment Standards.

Employment Types

If it is determined that the employment model is the most appropriate in the circumstances, the next relevant consideration is what type of employment should be entered into. The three most common types of employment are full-time, part-time or casual.

Full-time employees are engaged to work on average 38 hours per week, whilst part-time employees are engaged to work less than 38 hours per week and are generally guaranteed a regular pattern of work. If a practice engages a part-time employee who is covered by the Health Professionals and Support Services Award, the Award requires that written agreement is reached as to the number of hours to be worked each week, days the employee will work and start and finish times of each shift.

Permanent employees receive entitlements including, but not limited to, annual leave personal/carers leave, notice of termination, public holidays off with pay and guaranteed hours of work. Casual employees generally work irregular hours and are not guaranteed any particular pattern of shifts. A casual receives an additional 25% loading on their base rate of pay in lieu of not receiving paid leave entitlements available to permanent employees.

Ensuring a Successful and Smooth On-Boarding process

Written Contracts:

Employment contracts set out the key terms and conditions of the employment including items such as the type of engagement, rates of pay and hours

of work. A failure to enter into a signed employment contract can present risks to both parties as it means there is no clear governance as to the agreed terms of engagement.

If the practice is engaging a health professional as an independent contractor (and not an employee), it is also prudent to record the terms of the engagement in a written independent contractor agreement.

Documents to be provided at time of engagement:

When entering into an employment relationship, employers must ensure that they provide a new employee with the following documentation:

- Fair Work Information Statement;
- Tax File Number Declaration;
- Superannuation Standard Choice Form; and
- If the employee is a casual employee engaged under the Health Professionals and Support Services Award, a copy of the casual conversion clause.

A failure to provide employees with this documentation at the start of their employment results in a breach of the Fair Work Act 2009 and may also impact on an employee's ability to comply with their tax and superannuation obligations.

Whether you are an employee, employer or have HR questions, please contact the ADA HR Advisory Service on 1300 232 462 for further assistance.

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BY SIMON PALMER

The fish was this BIG!

and other valuation distortions

When someone is looking to buy or sell a practice, they are often presented with an appraisal of the practice that has been prepared by the other party in the transaction. While the results of the practice's trading may be clear, there are numerous appraisal techniques to choose from, and often some creativity applied when using them.

Terms like "Production/Revenue", "profit", "EBIT" and "expenses" are of course fundamental to any valuation technique, and there should be an objective universal definition of what they mean. Unfortunately, as you will see, they can be manipulated by people who are self-taught, or trying to push their own agenda.

Here are some of the creative approaches to valuations that can distort value.

1. Average of the past 3 years' production or profit.

Some people will attempt to value a practice using a calculation that includes an average of the past 3 years' production or profit.

For a buyer, the most recent year should be far more relevant, interesting and worth much more

consideration than the years that preceded it. Someone using the average of the last 3 years' production or profit in their calculation is understating the importance of up-to-date information and dampening it. This could be intentional or not.

The distortion this creates is:

- If a practice is growing over time, averaging the last three years could reduce the valuation.
- If a practice is slowing over time, averaging the last three years could increase the valuation.

People who average results over three years say that their rationale for this is to dampen the effect of an unsustainable spike or temporary decline in fortunes. However, unless there are

undisputed reasons to suspect that the most recent year's figures are unsustainable (the cancellation of CDDS, or CDBS for example) or a temporary lapse, it is extremely difficult to be conclusive about whether a recent one-year spike or decline is temporary or the start of a trend.

If no good reason is given for the averaging of 3 years' figures in your valuation calculation, then to do this is to dilute the most valuable information unnecessarily. If the previous year's results are considered in a valuation, it should be using a weighted average, where the most recent results are worth more than previous results.

2. A Vendor's invisible income

A practice is said to be valued using invisible income if its calculation includes revenue:

- a. that the practice has collected in cash (and was never invoiced).
- b. that the practice would have collected if they hadn't given discounts.
- c. that the practice would have collected if the principal had worked more (if they are inflating the revenue because the principal took more time off in his last year in hours per week or weeks per year).
- d. that the practice would have collected if the principal had done clinical work that they can't do (if I did ortho, the production would have been \$XXX...).

Invisible income is money that the practice didn't verifiably receive. No one can prove it came in, or that it would have come in if the principal worked more or didn't give discounts. As such, it cannot be counted in any serious practice appraisal and would inflate a valuation without verifiable merit.

3. A Buyer's discounted income and discretionary expenses

A practice appraisal can be deflated unnecessarily if a buyer:

- tries to discount income from clinical work that the buyer isn't interested in or doesn't do. For example, the buyer appraises the work without implant income, or orthodontics, if they themselves don't do implants or orthodontics.

- Tries to deduct discretionary capital improvements that they would want to make post sale (e.g., a refit or a fit-out and equipment of another surgery).

The true value of a practice is what it would be able to achieve if it was put to wider market. Not what it is worth to a specific buyer. If the wider market could replicate the clinical skills of the exiting dentist, there is no reason to discount it. If capital improvements are not necessary to operate that practice and achieve the results that it is being sold under (if they are discretionary), there is no reason to include them in an appraisal.

4. A Vendor's invisible expenses

Sometimes a practice's value may be inflated by invisible expenses. This can happen if a practice's calculation of profit includes discounted expenses that won't be passed on to the purchaser. The most common invisible expenses include when the vendor:

1. Owns their own premises and isn't paying themselves the same level of rent that they would charge to someone else if they sold the practice.
2. Is paying themselves less than market rate for their services (i.e., less than 35-40% if they are a dentist).
3. Has family members working for them and is paying them less than a market rate salary and/or having them do tasks for free that the purchaser would need to pay someone to do.

5. "The fish was this big"

There is no established database of what businesses sold for or what valuation techniques were used to value them. Dentists asking around trying to identify market knowledge are often left with unreliable narration by buyers or sellers trying to make themselves look better in the story. Buyers have been known to understate what was paid and sellers have been known to overstate what they received (or leave out the onerous terms and conditions of the sale), in order to make themselves seem more astute at negotiation.

Buyers and sellers valuing a practice based on half-truths communicated from a party to a transaction like this could be wildly underestimating or inflating a practice's value.

Conclusion

While formulas do exist for valuing a practice, it is important to realise that:

1. It is impossible to reduce every practice in Australia to a single formula that can be used across the board in every circumstance. Every valuer will tell you that there are different methodologies that are more appropriate in different circumstances.
2. There are a lot of attributes of a practice, like opportunities and risks, that affect value and cannot easily be put into any formula. For example, a formula cannot account for a big residential development going up nearby or one suburb being more attractive to buyers than another. A formula also cannot account for underutilised or overutilised attributes of a practice.
3. The variables in some formulas are prone to creative interpretation (as seen above) by amateur valuers.

While the parties to a transaction may want to save themselves some money by using "established valuation techniques" to come up with a price via a Do-It-Yourself valuation, by doing so they may be costing themselves far more. There is no substitute for independent, arms-length appraisals or market testing the practice via competitive tension.

Simon Palmer will be presenting at ADA NSW CPD later this year.

Exiting Your Practice and Maximising Your Outcome

Saturday 21 September 2019
9.00am – 4.30pm
CPD: 6.0 hours

Essential information related to selling your practice



Essentials for Starting or Joining a Practice

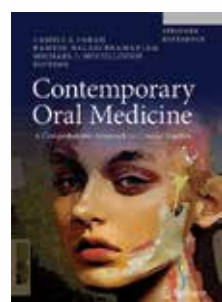
Friday 20 September 2019
9.00am – 4.30pm
CPD: 6.0 hours

Critical considerations dentists establishing and running their own business





NEW AUSTRALIAN ORAL MEDICINE TEXTBOOK



Contemporary Oral Medicine: a comprehensive approach to clinical practice. 2019

Edited by Camile S. Farah, Ramesh Balasubramaniam and Michael J. McCullough Springer

Australian authors and editors Farah, Balasubramaniam and McCullough together have an enviable wealth of clinical, teaching, research and publishing experience in the specialty of Oral Medicine which they have used to great advantage in curating this important new textbook.

Published in 2019 by Springer, this three volume work, comprising of 45 generously illustrated chapters with nearly 2,500 pages of information written by 149 world expert authors from 25 countries, is a culmination of four years of dedicated work.

The scope of the textbook covers the complete pathophysiology of disorders and conditions affecting the oral and maxillofacial region, providing detailed guidance on diagnostic evaluation and treatment with numerous clinical cases included. It aims to fill a gap in the evolving oral medicine space by including chapters on orofacial pain and dental sleep medicine. It offers a fresh holistic approach to clinical practice

The book is divided into three volumes

Vol. 1 – covers foundation and diagnostic head and neck sciences in oral medicine

Vol. 2 – covers oral and maxillofacial diseases and disorders

Vol. 3 – covers orofacial pain and dental sleep medicine

Of great significance to the dental community both in Australia and Internationally, this work acts as both a reference book for dentists and medical practitioners, and as an invaluable textbook to be devoured cover to cover by oral medicine specialists and trainees.

CPD COURSES

Periodontics in General Dentistry: part 2 incorporating the surgical phase...

Periodontology 2000 79(1) 2019. This issue of Periodontology 2000 is entitled Treatment trends in Periodontics and aims to bring together a variety of research that has direct clinical relevance to the practitioner such as the article below. Included in our Wiley subscriptions you can access the full text via the Wiley icon on the Library home page that was presented in this section last month or email the library@ada.org.au for assistance.

Experimental and clinical studies on plastic periodontal procedures (2019)

AB Novaes Jr. & DB Palioto Periodontology 2000 79(1): 56-80

ONLINE RESOURCES

ANATOMY TV 3D Human Anatomy for Dentistry



3D Human Anatomy for Dentistry is a medically accurate and detailed 3D interactive rendering of human anatomy based on imaging data.

The platform has been recently re-designed to provide a more contemporary, intuitive and consistent experience. Diagrams can be rotated, and layers can be added or removed using the controls at the bottom of the module. Clicking on the image will name it and provide a descriptive paragraph on the right hand side of the screen. It also offers fully selectable 3D illustrations of dental conditions such as caries, abscesses, gingivitis, and periodontal disease.

A short explanatory video is available <http://www.anatomy.tv/primal/dentalanatomypackage/>



Example of information available

A COMPREHENSIVE SERVICE:

- An extensive range of dentistry specific books & DVDs.
- Electronic books to read online.
- Electronic extracts from books or journals sent via email.
- Reading lists for continuing professional education.
- Journal alert service.
- Personalised search service.

If you can't find what you're after or don't have the time to search, we can search for, scan and email any relevant information to you.

Simply contact us on library@adansw.com.au, (02) 8436 9960, browse the online library at www.ada.org.au or visit us at 1 Atchison Street, St Leonards, NSW.



In memory of + + + + +

DR SYDNEHAM DOBBIN AM BDS MICD FPFA | 1924 – 2019

Dr Sydenham Dobbin was a Member of the Order of Australia, Bachelor of Dental Surgery, Master Fellow of the International College of Dentists and Fellow of the Pierre Fauchard Academy. These post-nominal titles paint a picture of a man and career that was arguably without parallel.

Syd was born on 13 July 1924 in Sydney's Enmore and the second son of Molly and Cecil Dobbin. He was educated at Taree and later at North Sydney Boys' High School. During the Depression years, Syd and brother Fred enjoyed a carefree life in the outdoors on Cabbage Tree Island at Old Bar with their maternal relatives on the family dairy farm.

Once Syd completed school he signed up for the RAAF as a pilot. His early training was at Temora and then on to Flight Training School at Point Cook. He was seconded to the RAF during World War II as part of 287 Squadron flying Supermarine Spitfires and 578 Squadron flying in Handley Page Halifax four-engined heavy bombers.

After returning from his overseas service, Syd met Patricia Margaret (Trish), who was still in service, at the welcome home party of one of his Air Force friends. They were engaged three weeks later. It was a great love story and they managed to notch up 70 years of happy marriage.

Syd studied dentistry at the University of Sydney under the Commonwealth Reconstruction Training Scheme (CRTS), graduating in 1950. Immediately on graduation Syd took a short service commission in the Royal Australian Army Dental Corps of the newly formed Australian Regular Army. He was the first dentist to hold a commission in the Regular Army. On discharge in 1952, he decided to buy a practice in Yass where he continued to work until his retirement in 2001.

A number of dentists in NSW in the late 1940s showed an early interest in fluoridation, the most active and prominent of whom was Dr Noel Martin, then a lecturer in the Faculty of Dentistry, University of Sydney. Dr Martin had inspired Syd's interest in fluoride during lectures when he was a dental student. Syd was elected to Yass Council in

1953 and continued to press for water fluoridation. On 22 June 1956, the Yass fluoridation plant was turned on by the Minister for Health and Yass became the first town in mainland Australia to fluoridate its water supply.

Syd Dobbin served on Yass Council for 30 years, with nine as Mayor. Syd noticed very early after fluoridation the reduction of caries in the teeth of Yass children. A study of dental conditions in Yass after six years of fluoridation showed a 60% decrease in tooth decay in 5-year-old children.

Syd believed that a general dentist in a NSW country town could also further the cause of dentistry on greater levels. Among his achievements on this front, Syd was invited in 1972 to the Fellowship of the International College of Dentists and became a Fellow of the Pierre Fauchard Academy in 1975.

A special moment arrived in 1986 when Dr Sydenham Dobbin was awarded Member of the Order of Australia in the Australia Day honours list for his services to dentistry and his community. Syd managed to find the time to lecture on the efficiency of water fluoridation in various Australian states and on preventative dentistry in countries such as Western Samoa, Cook Islands and Singapore.

Syd worked hard all his life and put his four children Michael, David, Jennifer and Shane through boarding school. His significant achievements as Yass Mayor and time spent volunteering over decades almost too many to mention.

In my mind Dr Sydenham Dobbin is one of those great Australians and will not be forgotten by his family, the dental profession and, importantly, the people of Yass.

He was truly a remarkable man.

By Dr Stephen Daymond



+ + + + +

EMPLOYMENT

DENTIST REQUIRED - BYRON BAY

Dentist required in one of the most desirable places in Australia if not the World, Byron Bay. 1 hour from Gold coast 2 hours from Brisbane. Byron has over 2.2million tourists a year. We are a very busy eco digital dental surgery. Cerec intra oral scanner and digital x-rays.

Very well equipped and only minutes from the ocean. Can offer up to 4 days a week work and flexible with days and times. Lots of emergency work and between 20 to 30 new patients a week. Can offer luxury accommodation in the complex above the surgery.

If this sounds like you, call Mauro on 0412 120 002. Email: bytesofbyron@yahoo.com.au

DENTIST REQUIRED - EASTWOOD

We are seeking a motivated dentist join our practice in Eastwood in Sydney, NSW.

Successful applicants will have:

- Excellent communication skills with patients
- Be confident in all forms of restorative dentistry and emergency care
- Good work ethic and desire to expand skill set
- Minimum 4 years of experience
- Available 2-3 days per week.

Modern practice with all facets of dentistry performed including Orthodontics, Implants, Wisdom tooth extractions, Botox and all general dentistry.

We are looking for someone responsible and compassionate to join and grow with our team. If this is you, please email your resume to the details below.

All enquiries:
Email: wangxiaoxiao5@hotmail.com

PROSTHODONTIST REQUIRED - CANBERRA

Canberra Prosthodontics seeks a Prosthodontist for an immediate start two days per week. This position will build to full-time (four days per week), potentially quite quickly. The right candidate will have ample opportunity to engage in all facets of prosthodontics. Canberra has an excellent referral base and great collegiality between specialists and general dentists. Younger candidates welcome, with excellent mentoring assured. This would suit someone with a long-term view to settling into a successful practice over time.

CANBERRA

Suite 7 Lidia Perin Medical Centre
12 Napier Close
Deakin ACT 2600

Phone: 02 6232 5709
Mobile: 0404 073 689
Email: john@cbrpros.dental
www.cbrpros.dental

FOR SALE

FOR SALE. GOONELLABAH, LISMORE - FIVE YEARS OLD AND GROWING

\$380,000 + SAV

General family practice established 2014 and is open six days a week. Current structure is three dentists working over six days, plus dental therapist two days per week.

There is also additional income from another dentist renting one of the five dental chairs.

The practice is located within a medical centre, GP Super Clinic, with a constant flow of patients. Leased equipment includes OPG Lat Ceph, ceiling mounted TVs and most Kavo equipment is five years old. Owner has three young children and needs to sell.

Goonellabah is a growing suburb with new housing developments currently under construction. Temperature is warm most of the year.

Email: drkimdavies@hotmail.com

FOR LEASE

DENTAL ROOM FOR LEASE SYDNEY CBD

Well appointed dental surgery, office, reception and sterilising area for lease in Sydney CBD.

Would suit GP or Specialist. Surgery is self-contained, but part of specialist practice suite of rooms. Good Adec equipment. Great view over Hyde Park. This is an exceptional opportunity for a clinician to establish themselves or start a branch presence in the CBD. Situated in a building with good dental practice infrastructure, both clinically and for equipment services. Sterilisation, digital x-ray and separate telephone services all available.

All enquiries to Julie-Ann at
Email: reception@parkstreetprosthodontists.com.au
Phone: 02 9264-3894

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To post a job listing visit:
www.adansw.com.au/Advertising/Job-Board

To find out more call: 8436 9900

* Excluding GST

The University of Sydney School of Dentistry Postgraduate coursework program in Prosthodontics

Applications open 6th June 2019 and close 26th July 2019 for 2020 intake

All applications are now submitted online via this link:

http://sydney.edu.au/future_students/course_search.shtml

For Dental Graduates:

Interested in expanding your dental expertise? Postgraduate Coursework applications are now open to dental graduates for the Doctor of Clinical Dentistry (Prosthodontics), Graduate Diploma in Clinical Dentistry (Advanced Restorative) and Graduate Certificate in Clinical Dentistry (Advanced Restorative).

Application deadline is 26th July 2019

For further information:

Email: tracey.mcclure@sydney.edu.au



THE UNIVERSITY OF SYDNEY

PROFESSIONAL ANNOUNCEMENTS



Dr Michael Tame BDS, FFD(OSOM)RCSI, MFDS RCS (Ed), MFDS RCPS (Glas), DipSurgDent

Dr Angus Kingon BDS, MSc, FRACDS, FDS RCS, FICD

Dr Robert Weld-Moore BDentSci, D.Ch.Dent, BA, MFDS RCS

We are pleased to announce the continuation of our Oral Surgery practice in Pymble following the retirement of Dr Graydon Smith.

We continue to offer consulting and surgical services in our rooms: Willendon, 45 Grandview St, Pymble 2073.

General Anaesthetic operating services can be provided at the following locations: Chatswood Private Hospital, Pittwater Day Surgery and The Sydney Adventist Hospital (SAN).

For all enquiries and appointments:

P: (02) 9449 6344
E: receptionpymbleoralsurgery@gmail.com
W: www.eastcoastoralsurgery.com.au

SPECIALIST ANNOUNCEMENTS



Dr George Tsai, Specialist Periodontist

BSc, BDS, MBA, DClinDent (Syd), FRACDS (Perio) wishes to thank his referrers for supporting our referral based practice.

GT PERIODONTICS AND IMPLANT SPECIALIST CENTRE

SYDNEY address: 15 Railway Ave, Wahroonga NSW 2076
Phone: (02) 4023 7181

NEWCASTLE address: 68 Belford St, Broadmeadow, Newcastle NSW 2292
Phone: (02) 4023 7181

Email: info@gtperio.com.au
Website: www.gtperio.com.au

Referrals on Periodontics or Implant Placements are welcome. Online referrals are available and we look forward to hearing from you.



Dr Stephen C Harlamb, Endodontist
Editor-in-Chief – Australian Endodontic Journal

Hon. Clinical Educator in Endodontics – University of Sydney
Director – International Association of Dental Traumatology

BDS, MSc, MHLaw, MRACDS(Endo), FPFA, FICD, FIADT

Dr Harlamb is pleased to announce the opening of his new rooms in Burwood, where he has been providing specialist endodontic services to the Inner and Greater West of Sydney for over 23 years.

Now located at
Level 1, Suite 14, 12 Railway Parade Burwood NSW 2134

Dr Harlamb offers all aspects of endodontic treatment and trauma management as well as IV sedation for the apprehensive patient.

Phone: (02) 9715 2344
Email: info@harlambendo.com
Website: www.harlambendo.com

SPECIALIST ANNOUNCEMENTS



Dr Anand Prabhu
SPECIALIST PERIODONTIST

With great pleasure, I announce the opening of my solo specialist Periodontics practices in Wagga Wagga and Hamilton NSW. I am now able to consult and treat patients in rooms designed and set up for periodontal treatment, oral plastics and dental implant surgery. I look forward to working with you to provide your patients with exceptional care.

Wagga Wagga Periodontics
177 Edward Street
Wagga Wagga NSW 2650

Newcastle Periodontics
70 Donald Street
Hamilton NSW 2303

Phone (02) 4911 9040
Mobile 0415 690 820

Dr Anand Prabhu
BDS(Sydney) GDCD(Adelaide)
DClinDent(Adelaide) FRACDS(Periodontics)
Specialist Periodontist



Dr Chinh Nguyen BDSc, MDSc, FRACDS, MRACDS,
Dip (Sedation & Pain Control)

Dr Udit Bhatnagar BOHDS, GDipDent, DCD
(paed dent)

Dr Nguyen is pleased to announce the opening of his second Specialist Paediatric Dental Practice in Summer Hill from July 2019.

LIVERPOOL Suite 105, 161 Bigge Street,
Liverpool NSW 2170

SUMMER HILL 194 Old Canterbury Road,
Summer Hill 2130

P: (02) 9600 6848
E: reception@specialistkidsdentist.com.au
W: www.specialistkidsdentist.com.au

Providing comprehensive paediatric dental care to children and those with special needs for over 20 years. We offer a wide range of behaviour management services including oral/nitrous/intravenous sedation and general anaesthesia. We look forward to working with you to provide exceptional dental care to your patients' needs.



Dr John Cho BDS (Hons), MDSc Pros

Canberra Prosthodontics seeks a Prosthodontist for an immediate start two days per week. This position will build to full-time (four days per week), potentially quite quickly. The right candidate will have ample opportunity to engage in all facets of prosthodontics. Canberra has an excellent referral base and great collegiality between specialists and general dentists. Younger candidates welcome, with excellent mentoring assured. This would suit someone with a long-term view to settling into a successful practice over time.

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Suite 7 Lidia Perin Medical Centre
12 Napier Close
Deakin ACT 2600

Phone: 02 6232 5709
Mobile: 0404 073 689
Email: john@cbrpros.dental
www.cbrpros.dental



Dr Khaled Zoud, Oral and Maxillofacial Surgeon BDS (Hons), BMed (Hons), FRACDS (OMS)

Is pleased to offer specialist Oral and Maxillofacial services at the following locations:

BURWOOD
Suite 101, Lvl 1 21-23 Burwood Road,
Burwood NSW 2134
Phone: (02) 8021 2728 **Fax:** (02) 8021 2723
Email: info@wisdomcentre.com.au

WESTMEAD
Suite 40, Lv 3, Daher Centre, 163-171
Hawkesbury Road, Westmead NSW 2145
Phone: (02) 9633 4552 **Fax:** (02) 9893 8801
Email: reception@westmeadomfs.com.au

www.wisdomcentre.com.au

Referrals for wisdom teeth, other difficult teeth, exposure of teeth, apicoectomy, bone grafting, sinus lifts, dental implants, oral pathology, facial trauma, orthognathic surgery and TMJ disorders are welcome. We look forward to hearing from you.



Dr Eduardo Alcaino, Specialist Paediatric Dentist BDSc (Hons) MDSc (Paeds) FRACDS MRACDS Grad. Dip. Clin. Dent (Sedation) – USYD, Clinical Associate Lecturer – USYD, Master Int. Bus Law – USYD.

It is with great pleasure to announce the opening of our CBD branch practice opposite Town Hall station for the delivery of specialist paediatric dental services at:

CBD
Mezzanine Level, 99 Bathurst Street
Sydney NSW 2000
Phone: (02) 9715 3711
Email: reception@sydpd.com.au
Web: sydneypaediatricdentistry.com

Burwood (main practice)
Suite 201, 21-23 Burwood Road
Burwood NSW 2134
Phone: (02) 9715 3711
Email: reception@sydpd.com.au
Web: sydneypaediatricdentistry.com

Referrals can also be made online:
sydneypaediatricdentistry.com/professionals/
referring-a-patient/

specialist dental suite

We are an accredited multi-disciplinary team of specialists in **PARRAMATTA** looking forward to assisting your patients' needs. Established for over 15 years, we strive for excellence in patient care and are grateful for your support.

Our Specialists:

Periodontics and Implants
(including Saturdays)

• Dr Guy Paton • Dr Sweta Paliwal
• Dr Khai Nguyen • Dr Olivia Nova

Prosthodontics

• Dr Prashant Patel
• Dr Dhruvad (Sid) Siddhanta

Orthodontics – Dr Larry Uria

Endodontics – Dr Varayini Yoganathan

Oral and Maxillofacial Surgeon

• Dr Winston Hee

Paediatric Dentist – Dr Diane Tay

Shop 1&2/ 17-21 Hunter Street
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1 Varios Combi Pro Perio Set comprising: PERIO-CHAMBER / PERIO-Hose / PERIO-Handpiece / Perio-Mate Nozzle tip / Perio-Mate Nozzle tip remover / Perio-Mate powder

+ 1 EXTRA
Varios2 VA2-LUX-HP
Scaler Optic Handpiece

+ 1 EXTRA
Perio Handpiece

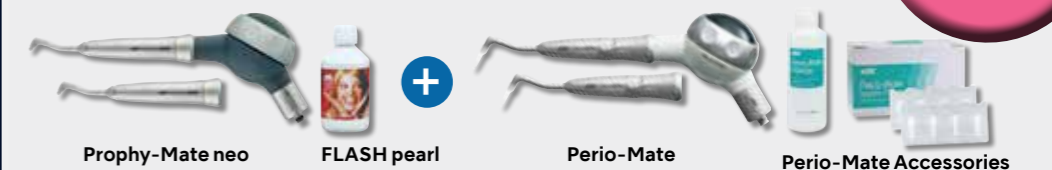
+ 2 EXTRA
Prophy Handpieces

+ 1 EXTRA Perio Mate
Disposable Nozzle Tip
(Pack of 40)

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