Is something rotten in the state of GDC?

GDC Chair resigns amidst rumours of no confidence vote, divisions within the Council causing concern amongst dental professionals

In a move which has thrown open the deep divisions within the General Dental Council (GDC), Alison Lockyer, Chair of the GDC, has resigned from her position of Chair and her seat on the Council.

With rumours circulating amongst dental grapevines that there was to be a vote of no confidence, Dr Lockyer issued the following: It is with regret that I have decided to resign from my post as Chair of the General Dental Council, and from my appointment on the GDC.

It would not be appropriate at the moment for me to go into detail about my reasons for resigning, suffice to say that, over the last few months, there have been issues that have caused me concern.

I remain passionate about the importance of protecting the public through professional self-regulation.

The situation at the GDC has caused concern amongst many of the professional organisations in dentistry, who are calling for an explanation of the situation to restore confidence in the regulator.

A statement by the British Dental Association (BDA) said: "The BDA is seriously concerned at the suddenness of Dr Lockyer's resignation and the observation she has made in the statement. We are calling for the situation to be clarified as a matter of urgency."

The profession's confidence in the regulator depends upon the integrity and robustness of the decisions it makes and it is important that the Chair is elected by the Council.

Dental Protection has also voiced its concerns at the situation. Kevin Lewis, Dental Director, said: "Dental Protection has been voicing its concerns for some time now that certain aspects of the GDC's work left a lot to be desired. The Fitness to Practise procedures were a case in point, as recently confirmed by the largely critical CIRRE report, while some of the recent policy decisions also suggested a fundamental lack of understanding of the dynam ics of the profession and its relationship with the public."

"The dignified departure of Alison Lockyer as GDC Chair, and the measured but pointed terms of her public comments as she left office, should set alarm bells ringing that something profoundly disturbing has been happening at the GDC. It is clear that the departing Chair has formally raised concerns with the relevant authorities about the internal operation of the GDC at a senior level and, these concerns surely warrant thorough investigation if public and professional confidence is to be maintained. Divisions are self-evident between some of the lay and professional members, and also between some Council members and the GDC Executive and staff. This is not good news for patients, and coincidentally it is not good news for the profession either at a time of such enormous challenge."

The GDC is remaining tight-lipped about the current situation. A statement issued on behalf of the GDC said: Alison Lockyer has resigned as Chair of the General Dental Council and as a member of the Council.

We would like to thank Alison for her service as Chair since January 2010 and as a member of the Council since 2003 and wish her well for the future.

The GDC will now consider the process for appointing a new Chair and any interim arrangements needed to ensure the continued smooth running of business. According to reports, the GDC will meet this week to appoint an interim chair, with a successor to be elected at the Council's September meeting, when hustings will be held.
Only one toothpaste gives non-stop 12 hour protection from bacteria...

In a job which can only really be akin to the England football manager’s job in terms of popularity (or possibly the Chief Exec of the CQC), Dr Lockyer had the unenviable task of trying to balance her position as head of the regulator with her position as a GDP, something which must have not sat well on more than one occasion. I wish Dr Lockyer all the best in getting back to the ‘quiet’ life of doing day to day dentistry.

I’m looking forward to seeing many of DT’s readers at this week’s BDA Conference and Exhibition in Manchester. The event is boasting to be the biggest and best, and the line-up does seem impressive. One piece of news to note is that at the time of going to press, Secretary of State for Health Andrew Lansley’s speech has been switched from Thursday 19th May to Friday 20th May at 11.15am.

Also, don’t forget to come by Stand A18 and say hello, leave your feedback and maybe even leave your card to be asked to write an article or two for us! See you there...
A call from the front line

Coming back to civilian life after leaving the services, not through choice but through disability caused in the line of duty, can be a challenging period for a former Royal Marine and the adjustment may be fraught with hurdles and disappointments. One example that has been receiving attention recently is the offer to the hundred or so medically discharged Royal Marines leaving annually, who have been kept dentally fit by the Armed Forces, a choice of free dental care in the community where they settle.

Now, sympathetic dental practices can join a national scheme, The C Group and SmileStar, formerly known as the Marine Dental Care Campaign, to help some of those former Royal Marine personnel with free basic dental care for life. Already more than 60 practices around the UK are signed up to the scheme.

The inspiring scheme is being run by The C Group, a Royal Marines charity whose mission is to mobilise the business community to support the Royal Marines together with SmileStar Ltd, an organisation with charitable status based in Devon. Royal Marines applicants will be introduced to the scheme through the normal resettlement process and those who are interested will be passed through to SmileStar for appropriate administration and details of their nearest participating practice.

Colonel Hutton, the Chief Executive of The C Group, who has supported the scheme from its inception, explained: “Coming home and trying to settle into normal life is harder than people imagine and routine procedures such as going to a dentist can be immensely daunting.

What SmileStar and its network of supporting dentists are offering is choice. A man can decide whether to go with the NHS system or take the opportunity to receive basic private dental care for free. This is a great offer and will help those who live in areas where NHS surgeries are working at capacity or where travel requirements may be excessive. There are numerous reasons to help these men who have served their country so bravely. This scheme will offer an extra helping hand to aid their rehabilitation. Practices around the country are signing up to the scheme to help in their area – we’ve been totally overwhelmed by the support the campaign is receiving already.”

At the launch of the scheme, which will take place on June 22nd in Ashburton, presentations will be given by Colonel Jim Hutton of the Royal Marines.

Sixty four practices around the country have already joined the scheme. The Devon Dental Centre of Excellence, the Plymouth Dental Centre of Excellence and other Devon based practices such as Totnes’s Riverview Dental and Bovey Tracey’s Quality Dental Care. Of the 27 Marines that have taken up SmileStar’s offer we have currently managed to place 15 of them and are waiting for practice’s to come up in the following areas to place the other 12 Marines.

Newport
Portsmouth
Yeovil
Poole
Lympstone
Cowen
Dover
Bournemounth
Taunton
Somerset
Mid Glamorgan, Wales

Interested practices can find out more or register by calling Sam Cutts, Smilestar at sam@mpc-ltd.co.uk or 01584 654070.

A call from the front line

Eighth Clinical Innovations Conference Hailed A Success

Organised by health-care learning provider Smile-on, the AOG and the Dental Directory, the Clinical Innovations Conference 2011 impressed delegates yet again with its topical programme of lectures covering many of the latest developments in restorative and aesthetic dentistry.

More than 350 attendees gathered at the Royal College of Physicians for the two-day conference and exhibition which featured some of the leading names in dentistry today including the likes of Dr Julian Webb, Dr Eddie Scher, Dr Wyman Chan, Dr Tif Qureshi and Dr Eddie Scher, Dr Wyman differing the likes of Dr Julian Web - chan presenting at the event

rturning to clinical lectures for dental care which featured several highly relevant lectures for dental care professionals on subjects such as risk management, decon tamination and medical emergencies.

The turnout was high and the atmosphere electric but nevertheless the conference’s relatively small size made for a more personal experience, featuring several ‘hands-on’ lectures and a compact exhibitors’ area where delegates could speak to suppliers in person.

Along with picking up plenty of valuable new skills and techniques, attendees were also able to receive up to 14 hours of verifiable CPD along the way.

For more information about the event call 020 7400 8889 or visit www.smile-on.com

Dr Wyman Chan presenting at the event
Dental visits considered ‘a luxury’

Simplyhealth’s Annual Dental Survey 2011 shows that patients could be risking their dental health with over a quarter of the population viewing visits to the dentist as a ‘luxury’.

The survey of 10,000 U.K. patients has found that men are the worst offenders with more than a third considering dentist appointments non-essential. Almost 19 per cent stubbornly believe they can take care of their teeth themselves. However, women are no ‘tooth fairies’ either, with 45 per cent saying dentist visits are ‘too expensive’ compared to 55 per cent of men.

James Glover from Simplyhealth’s dental advisor, Michael Thomas, said: “It’s surprising that so many patients see visiting the dentist as a luxury. We’re not talking about a holiday, or a new car, but protecting your dental health, which is an everyday health need.”

Younger patients place far less importance on their dental health, with almost a third (31 per cent) of 18-24 year olds saying visiting the dentist is a luxury, not an everyday need. This may be why only half have seen a dentist in the last year. In contrast 25 per cent of over 55 see the dentist as a luxury, but 71 per cent have seen the dentist in the last year.

Practising dentist and Simplyhealth’s dental advisor, Michael Thomas, said: “Everyone wants nice, white teeth, but this won’t happen if people aren’t prepared to put any effort into caring for them. It’s really important that patients take the time to brush their teeth twice a day and regularly visit their dentist.”

“This isn’t just important for the health of their teeth, but also for other health issues for example, research suggests that poor oral health is associated with a greater risk of a stroke and heart disease.

“Dentists can provide so much information and guidance that people aren’t taking advantage of. For instance Simplyhealth’s research has found that only 34 per cent would think to speak to their dentist about identifying oral cancer.”

There’s also a contrast in patient’s attitudes to dental health. On one hand, two thirds say they wouldn’t date someone with bad teeth and more than 60 per cent believe that poor oral health can influence career progression. Yet, 41 per cent say they’d prefer to have dinner with the in laws than get their teeth checked.

Almost 50 per cent would rather take out the rubbish and 41 per cent would prefer to clean the toilet.

Smiles top attractiveness poll

A ‘smile’ has topped a poll identifying the most important physical features when it comes to attraction between men and women.

A smile was rated highly by 56 per cent of respondents, closely followed by faces (55 per cent) and eyes (54 per cent). Dress sense, body shape, hair and height were also measured, with the latter bringing up the rear on 25 per cent.

Interestingly, it was a non-physical attribute – personality which was the clear winner of the survey. Ninety per cent of respondents rated this human attribute most important when it comes to attraction.

The results have been published as part of the British Dental Health Foundation’s annual campaign – National Smile Month – now in its 35th year. This year the theme is ‘The Smile Factor’, which aims to remind patients that their mouth, teeth and smile is fundamental to all aspects of their life – whether career, personality, relationships, attraction or all-round good health.

Despite the importance of smiles and teeth to everyday life, many people appear to have a poor image of the nation’s ‘Smile Factor’. The survey reveals that only 25 per cent believed that the nation had ‘good teeth’, and approaching half the population were not happy with their smile or teeth - stained or yellow teeth being the most common concern (57 per cent).

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “As a nation we probably spend more time and money looking after our hair and the clothes we wear, rather than caring for our teeth. The survey is a great reminder that we should be giving greater attention to our teeth – not just because it improves oral health – but because it gives us the confidence to smile, which makes a huge difference to our relationships, careers and overall image.

“During National Smile Month, we hope everyone will consider what they can do to improve their Smile Factor. Hundreds of dental practices across the U.K will be supporting the campaign and it’s an excellent time to tell their help and advice.”

BDA museum close to major acquisition

The BDA’s museum has its sights set on a rare oil painting as its next key acquisition. The Dentist, painted in 1929 by Sir John Lavery, features dentist Conrad Ackner in situ treating his patient, the artist’s wife Lady Lavery.

The painting is significant in terms of both dental and art history, being the only known accurate depiction of the early twentieth century dentist in a surgery, and by one of the leading portrait painters of the time.

A rare find, the painting is set in Ackner’s Welbeck Street practice in London and reveals aspects of the clinical environment including an early x-ray machine and headlamp, examples of which are in the museum’s collection.

Using the painting as a centre piece, plans are in place to mount an exhibition including a scrapbook compiled by Ackner’s staff, which lists the King of Norway and actress Marlene Dietrich amongst his patients.

The first time the two items will be seen together, they will be a highlight on guided tours and be featured during events and as part of the museum’s school programmes.

The BDA is appealing for donations to help acquire the painting so that it can be made a permanent part of its collection. Currently on loan and on display in the BDA’s Information Centre, it has been independently valued at £60,000. While funding has already been sourced through the Art Fund, the MLA/V&A Purchase Grant Fund, the BDA and private donations, a shortfall of £20,000 remains before the list price can be met.

Head of BDA Museum Services, Jason Finch said: “The opportunity to purchase this unique painting is too good to miss and we are desperately close to our target.

“Not only is the work historically significant in its rarity, it also provides us with an accurate depiction from which the dental profession and public can gain valuable insight into the history of dentistry.

“We are calling on all interested parties to help us keep this important work at the BDA permanently, in what, we believe is its rightful home.”

To make a donation, or for further information, individuals should contact Jason Finch by phone on 0207 555 5852, or by email at jason.finch@bda.org.uk.

A ‘thank you’ that raised $1m

Oscar-winning actor Michael Douglas, who was diagnosed with throat cancer last year, headlined a fundraiser for the Montreal Hospital, the hospital that first detected his disease.

During his speech at the event, Douglas recalled the devastating moment when he was diagnosed with cancer and how Dr Saul Frenkel of Montreal’s Jewish General Hospital had requested a biopsy. Previously, several American doctors had failed to diagnose the cancer and had, according to reports, said Douglas was in good health. It was soon discovered that the cancer was at an advanced stage.

To show his gratitude to the Montreal Hospital, Douglas offered to help raise money for the McGill University-affiliated hospital by signing himself up as the honoured invitee for a $375-a-head gala dinner, with VIP tickets selling for $750. The money raised will be given to McGill University’s head and neck cancer fund.

Mixing with guests and having photos taken, Douglas was reported to appear energised.

According to reports, both Douglas and his wife, Catherine Zeta-Jones, put themselves up for auction: one such live auction was a golf outing, which was auctioned for $180,000. By the end of the night the charity event had raised more than $1 million.

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To make a donation, or for further information, individuals should contact Jason Finch by phone on 0207 555 5852, or by email at jason.finch@bda.org.uk.
A-dec goes the extra mile for B2A

Thirteen representatives from dental equipment manufacturer A-dec recently took on the challenge of the infamous Coast2Coast bike ride, and fighting arduous headwinds all the way, completed the 151 mile bike ride in three days!

Cycling from Whitehaven on the west coast to Tynemouth on the east coast, across the very hilly Lake District, the Pennines the northumberland moors, and despite the at-times daunting terrain, falls, bruises, punctures, sunburn, headwinds, and facing early retirement with a snapped derailleur, the team finished together in high spirits on the afternoon of Monday 2nd May.

Fuelled by energy drinks, flapjacks, oh-so-many bananas, pain relief and deep heat, not to mention the key ingredient (TEAMWORK), all 11 riders completed the challenge with an immense sense of achievement and pride.

The group is raising funds for Bridge2Aid, their partner charity who carry out amazing work in the Mwanza region of Tanzania and across the area, plus other UK charities which are close to the fund-raisers hearts.

Charlotte Cligg and her partner Ben, Jo Gamble, Stacey Roberts, Tracy McNicoll and her husband David, Brian Anderson and his wife Sarah, Ashley Woodruff, Garan Hynes and Charlie Cope – supported by Sarah Treble and Eugene O’Malley, aim to raise more than £7,000 for Bridge2Aid, NSPCC, MS Society, Breast Cancer Campaign and Leukaemia & Lymphoma Research.

To make a donation, please visit uk.virginmoneygiving.com/team/A-dec.

BDA President

Dr Janet Clarke, Clinical Director of Birmingham Community Healthcare Trust Community Dental Service (CDS) and Honorary Clinical Lecturer at Birmingham Dental School, will become the 125th President of the British Dental Association (BDA) on Thursday, 19 May. She will be presented with her chain of office and make her inaugural speech as BDA President at the opening of the 2011 British Dental Conference and Exhibition at Manchester Central Convention Complex, Manchester.

Dr Clarke was awarded her Bachelor of Dental Surgery Degree by the School of Dentistry, University of Birmingham, in 1981, and a Master of Community Dental Health in 1989. As clinical director at Birmingham Community Healthcare Trust CDS, Dr Clarke manages an NHS dental budget of over £6 million. She oversees the provision of the community dental service for vulnerable patients in Birmingham, Sandwell, Dudley and Walsall.

Dr Clarke has significant experience of representing the dental profession. Locally, she has served as Chair of the BDA’s West Midlands Division of the CDS Group, and as president of the BDA’s Central Counties Branch. On the national stage, she chaired the BDA’s Central Committee for Community and Public Health Dentistry (the forerunner of the current Salaried Dentists Committee) and successfully led the negotiations to introduce a new contract for salaried primary care dentists in 2005. Her contribution to dentistry is widely recognised. She was awarded an MBE in 2010 for services to dentistry, and two years earlier she was appointed by the Secretary of State to work alongside Professor Jimmy Steele in his Independent Review of NHS Dentistry.

FEWER THAN ONE IN THREE PEOPLE HAVE MENTIONED BLEEDING GUMS TO THEIR DENTIST OR HYGIENIST.

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Can volunteers make a difference?  

B ridge2Aid are delighted to be hosting a number of events at this years' BDA in Manchester, on the growing issue of corporate social responsibility and the long term value in volunteering.

Posing the question whether short term volunteers can make a long term difference, Friday’s 2pm seminar will see Bridge2Aid’s (B2A) CEO, Professor Andrew Eder, and Clinical Periodontology Fellow at the UCL Eastman Dental Institute and a Past President of the British Society of Periodontology and start and aims, methods, relevance to clinical periodontology have significantly advanced the field.

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Can volunteers make a difference?
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A photo says a thousand words
Elaine Halley speaks about early mornings, comments, and those all-important clinical cases

Well - I guess this is the beauty of a distance learning course - I was planning a well needed trip to stay with friends in Malaysia over Easter when the deadline came in for the end of unit 4 assessment – right when the deadline came in for all-important clinical cases.

Elaine Halley speaks about early mornings, comments, and those all-important clinical cases

managed to do some early morning stints and get the assignment in two weeks early. The assignment involved treatment planning for a restored dentition, including discussing the rationale for direct composites versus the alternatives. This was a very apt assignment as of course, these are the subjects that we encounter on a day-to-day basis in practice.

Meanwhile, while I have been away, email alerts to tell me the remaining clinical cases from Unit 3 (Anterior aesthetics) have been marked have been coming in thick and fast. This has been driving me mad as it costs me considerably in roaming charges to access the internet on my iPhone to log in and get the results. However, patience has never been my strong point and so I have succumbed to finding out. Luckily, all good so far. The examiners comments have been interesting and it again is probably a sign of my personality (control freak, used to being the boss etc) that it is just as well the examiners are anonymous, as I disagree with a few comments and if I knew who it was I would be on the phone! I have also ‘tested’ the system somewhat by sending in different case outcomes - some I would be proud to present in a lecture, others that were a compromise in some form or another.

Notably, my Class III composite case I sent in a phobic patient with a high caries rate where the result was not aesthetically perfect in the first attempt. My justification in the write-up was noted and I gained a good mark. The key, as in so many exam processes, is in the photography. Good photography seems to allow the examiners to see every detail of the case.

The other thing I have missed since being away is all of unit 5 (Complex Treatment) – and it seems that the level of lectures has increased dramatically. Again, a criticism is the short notice of the exact dates and times of the lectures. I am sure that Smile-on will be on the phone! I have also ‘tested’ the system somewhat by sending in different case outcomes – some I would be proud to present in a lecture, others that were a compromise in some form or another.

Discover stints to catch up on hours of misses. I would be proud to present in a lecture, others that were a compromise in some form or another. So I am looking forward on my return to some more early morning stints to catch up on hours of lectures on how to assess the complexity of a case, biological aspects of tooth loss, oral medicine update, diagnosis, treatment planning and letter writing plus consent, and decision making. I am sure that Smile-on will be on the phone! I have also ‘tested’ the system somewhat by sending in different case outcomes – some I would be proud to present in a lecture, others that were a compromise in some form or another.

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The lead up to the 2011 Dental Awards reached its grand finale on Friday 6th May at a glittering black-tie ceremony held at the exclusive Lancaster London Hotel. Dental Tribune was there and being accompanied by some of our contributors at our table it was, without doubt, a fantastic night!

The evening, which was organised by Purple Media Solutions Ltd and sponsored by The Dental Web, Dentsply, Software of Excellence, Waterpik and Wrigley, was a fantastic night full of laughter, great company and excellent food!

Teams and individuals from dental practices across the UK came together to celebrate the outstanding level of clinical care and patient service they provide at the 13th annual Awards. The ceremony was attended by many industry key opinion leaders and having been presented by celebrity compere, Hal Cruttenden, the evening was a fabulous and entertaining event. Guests and finalists from across the UK, including Liverpool, North Wales, London, Bristol and Manchester, enjoyed a gala dinner, with a champagne reception, four-course meal and awards ceremony.

For those of you who weren’t there, the winners were as follows:

**Dental Laboratory of the Year**
- Winner: Casterbridge Dental Studio – Dorset
- Highly commended: Egan Dental Laboratory – North Yorkshire

**Dental Therapist of the Year**
- Winner: Charlotte Wake – Southampton
- Highly commended: Kevin Lawlor – Cambrria

**Dental Nurse of the Year**
- Winner: Kerry Hensley – Apollonia Dental & Cosmetic Centre, Liverpool
- Highly commended: Michelle Whithy – Sweetcroft Dental Practice, Middlesex

**Dental Receptionist of the Year**
- Winner: Barbara Whittaker – Cahill Dental Centre, Bolton
- Highly commended: Carly Frank – Thompson & Thomas, Sheffield

**Clinical Dental Technician of the Year**
- Winner: Andrew Barrs – Middlesex
- Highly commended: Roderick Patterson – Nottingham

**Practice Manager of the Year**
- Winner: Sharon Sweet – The River Practice Specialist Centre, Truro

**Dental Hygienist of the Year**
- Winner: Monika Patel – Harrow Middlesex
- Highly commended: John Stanfield – Cheshire

**Best National Smile Month Event**
- Winner: Thompson & Thomas – Sheffield

**Outstanding achievement**
- Winner: David Phillips

**Team of the Year (North)**
- Winner: Dental Mavericks – Sunderland
- Highly commended: Thompson & Thomas – Sheffield

**Team of the Year (South)**
- Winner: Sweetcroft Dental Practice – Middlesex
- Highly commended: Maple Orthodontics – Berkshire

**Practice Design and Interior**
- Winner: The River Practice Specialist Centre – Truro
- Highly commended: Maple Orthodontics – Berkshire

**Best National Smile Month Event**
- Winner: Thompson & Thomas – Sheffield
- Highly commended: Guidepost Dental Practice – Northumberland

**Dentist of the Year**
- Winner: Donald Sloss – Clock Tower Dental Care, North Yorkshire

**Clinical Dental Technician of the Year**
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- Highly commended: Roderick Patterson – Nottingham

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Luke Moore discusses understanding the value of your practice

Like it or not, the dental sector is consolidating and fast. A sector formerly run by clinicians is increasingly now a sector run by entrepreneurs and accountants with a stronger emphasis on underlying profitability.

As a result of these changes the business of dental practice valuation is becoming less of an art and more of science and the banks, burnt by overly ambitious practitioners, look for lending opportunities with good profits or business plans with substantial marketing budgets.

I first joined the sector when dental practices changed hands for as little as 20-50 per cent of Gross Fees, a figure that would see a buyer laughed out of town these days with the latest NASDA statistics stating averages of 84 per cent of gross fees.

However, I am not alone in finding this expression of valuation a complete lunacy. As someone with an accountancy background I simply cannot comprehend how businesses with identical turnovers can be regarded as the same when the rent and utility bills are frequently £15,000 different. Similarly, EBITDA (Earnings before Interest, Tax, Depreciation & Amortisation) is often used as the more mathematical method of valuing dental practices but business risk and likely cost savings are often ignored.

It is worthwhile remembering that whilst all of the dental corporates use EBITDA as a method of valuing what the business is worth to them, their EBITDA calculation will often be substantially different. As with any investor they will look at cost savings within the business; the most obvious and potentially largest saving being associate fees.

However, they will also consider whether your practice awards them any ‘marriage value’ ie not only can they save £10,000 on your staff costs by asking the practice manager to look after another site down the road, but this could also increase the EBITDA of the practice down the road they already own. Similarly, each group buyer will have different ideas on average associate fees, lab fees and staff costs in any given area. Whilst as standalone figures, these numbers may be fractions of percentages and collectively they can equate up to £5,000 of EBITDA, which could be a purchase price differential of £50,000. It sounds obvious but many forget they also have to compensate for other local branches.

It is worthwhile remembering that the bigger the risk the lower the multiple. You can look to mitigate against this risk before sale in order to increase your multiple. Therefore the actual multiple at which practices change hands is largely irrelevant as one buyer’s 4.6 is more than another’s 5.4. In a recent case I had £182,500 different! It is important to work out which group buyer assumes which risks and who can benefit from other local branches.

However, this is not the be all end all as some buyers have different strategies than others and you never know what other local practices are currently up for sale. Therefore the actual multiple at which practices change hands is largely irrelevant as one buyer’s 4.6 is more than another’s 5.4. In a recent case I had £182,500 different!

Remember that group buyers will always be dictated by their multiple of EBITDA and not a percentage of turnover calculation. In my experience, when group buyers start talking in terms of percentages of gross it is normally because they see a good deal coming their way! It is important to work out which group buyer assumes which risks and who can benefit from other local branches.

For instance, a principal performing more than £250,000 per annum worth of treatment, be that private or NHS, would instantly be deemed high risk and the outgoing vendor will have three options:

1. Stay on for a period beyond completion, in an ideal world this would cover the purchaser’s payback period of five years.
2 Make changes within the practice in the years leading up to sale so that the outgoing principals’ personal gross is less
3 Accept that you are going to have to accept a slightly lower price for the practice to find a very confident purchaser

To counteract this principals are advised to consider when they are going to sell the practice well ahead of the time they intend to hang up their hand-piece. Principals often make the mistake of running down the practice before they sell it on which makes it less desirable and less valuable to any future purchaser. So:

1 Don’t reduce your NHS contract value unless you are replacing this turnover elsewhere; get an associate!
2 If you drop a session, don’t let the overall practice gross drop. There are options such as a dental therapist and associates who can do remedial work
3 Don’t re-equip all the surgeries with brand new state-of-the-art equipment in the three years leading up to sale. You will not get your money back
4 Do move the practice goodwill away from your name, ie if you are Dr Gregory & Associates become Cornwall Dental Centre
5 Lock in your patients somehow. If you are not a plan or NHS practice consider looking at membership clubs and encourage some loyalty to the practice and associated brand

The key is always in planning; the better an exit is planned the more fruitful it is likely to be. Similarly it is worthwhile considering the value of additional funding and additional turnover in the practice as your approach sale.

If your fixed cost base is covered (rent, nurses, light & heat etc) your typical gross margin as a dentist is 40.5 per cent, hygienists’ typical gross margin is 59 per cent. For every £1 in increased turnover from a dentist you will add 40.5p to the profit of the practice. If you later sell for a multiple of 4.8x EBITDA this would equate to an increase in value of £1.96 per pound of turnover generated. In an NHS environment if the increased capacity can be met by existing associates at £10 per UDA an additional 1,000 recurrent UDAs at £22 equates to an increase in value of £47,568 when based on multiples of EBITDA. This turnover is commonly referred to as exponential turnover.

Naturally, geography and the type of treatments you are performing does have an impact on this multiple and also the volume of marketing activity required to achieve this turnover. Put simply, routine family dentistry is valued at a higher multiple than that of dentistry, which relies heavily on referrals and big-ticket treatments; eg implants and full smile makeovers.

Of course some practices do not generate enough EBITDA to come to a value sensible for an acquisition by a group buyer and naturally fall into the area of a practice suitable only for an owner occupier and are better valued using an alternative method practiced for owner-occupier sales. There are some practices, normally with turnovers between £300,000 and £500,000 who depend on their cost bases sit between these two models and it is worthwhile considering both buyer markets. This is especially relevant for principals with NHS contracts within these two boundaries who believe they will get the best deal from a dental corporate when often they will not.

About the author

Luke Moore Director – Dental Elite Dental Elite are a Practice Sales & Recruitment Agency with a nationwide remit. We offer all principal dentists a complimentary on-site practice health-check with no strings. The healthcheck includes a valuation of the practice and a report detailing the basis for this valuation and some suggestions how this could be improved. luke.moore@dentalelite.co.uk

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Which comes first - house or practice purchase?

David Brewer discusses savings, deposits and mortgages.

Unlike the chicken and egg conundrum, there is a clearer answer to this question.

In the heady days of easy credit in the early to late 2000s, raising finance for practice purchase was relatively straightforward. As long as you had a GDC number and a pulse, the banks would probably lend to you - often the full 100% of asking price and at rock bottom rates. As we all know, the banks then experienced a few financial difficulties (and that's putting it mildly) and almost overnight sizably changed their lending stance to any new lending proposal (be it for house or any type of business including dental practice purchase).

The banks now take a much more critical approach to any financial request and will review in great detail all aspects of any proposal with particular focus on the purchaser's experience, client commitment and overall ability to repay.

A prospective new purchaser should actually take comfort from the fact such a detailed analysis is now being undertaken by the bank to ensure the proposal actually 'works' - and it is staggering that in the past these questions were not being asked.

Thankfully, the dental profession remains one of the so-called 'Green Light' sectors for most of the banks - dentists are considered relatively low risk; the banks have very few dental loan defaults on their books and a positive appetite to lend - but to the right applicants.

One of the biggest changes in banks' lending requirements is the need for the purchaser to commit 'something' towards the purchase - ideally a cash contribution. As a rule of thumb, a contribution of between 10 per cent and 20 per cent of goodwill purchased is often sought by the banks. The same goes for house purchase as well - the days of being able to raise 100 per cent mortgage on your house are a distant memory. Nowadays if you want a decent house mortgage you need to put down a sizable cash contribution.

Most associates do normally have a reasonable level of savings (or possibly Bank of Mum and Dad) behind them, which could be used. However this is where we have the dilemma - do you put your deposit towards your first house or do you buy your first practice??

Past evidence has shown that practice purchase FIRST is the most effective way forward.

If you buy your house first, you will have used your own/family savings towards the sizeable deposit required by the mortgage lender leaving nothing left over to put down towards practice purchase. Gradually your savings will slowly build up again - however as an associate your earning potential may be restricted by your current principal or practice partner base so it could be a while before your deposit has built up again.

Also... it may well be that you buy your house first and later find the ideal practice many miles away - so you will end up having to go through the whole house sell/buy process again.

By utilising your/family savings of say 10 per cent toward the purchase of a dental practice, you will of course be the proud owner of the practice which in turn should enable you to earn considerably more than you would have done as an associate - leading to your savings accumulating at a much faster rate thus putting a deposit down for a much larger house closer to where the practice is.

The same analogy can be applied to purchase of investment properties (normally referred to as residential buy to lets). If your wish is for practice ownership, in the vast majority of cases you would earn more £ for £ putting a dental practice compared with investing in property.

Equity in your house or own/family investment property can be considered by the bank as quasi contribution - however at present with property prices static at best, any deposit/equity within the property may not be as high as you think. The banks tend to place a 'security' value of between 70 per cent to 80 per cent of the value of the property LESS any existing mortgage. Eg House value £500k with £300k mortgage. The banks value at say 70 per cent would be £50k (ie 70 per cent of £500k less £300k) much less than the 'true' equity of £200k.

I would stress again that the banks ARE still lending for practice purchase and the dental sector is viewed by them as relatively low risk. - the fact the banks will still lend up to lend 90 per cent of Goodwill is great testament to the dental profession. Indeed there are very few other sectors in which this would happen.

If you are seeking to raise funding for practice purchase it remains essential your application is presented in the right manner.

ALWAYS engage the services of an independent specialist to work on your behalf. They should present your proposal in a manner which will satisfy the bank's lending criteria (which will vary from bank to bank) and ensure you are personally introduced to a number of the specialist dental divisions of the banks. By speaking with more than one bank, a degree of competition can also be generated to ensure more competitive terms are secured.

About the author

David Brewer has worked with the dental profession for over 15 years helping over 1000 clients secure funding for practice purchase and start up. With his banking background and friendly pro-active approach, he is ideally placed to provide advice and guidance to clients who are looking to purchase a practice or simply review their existing arrangements. David works with Frank Taylor and Associates and can be contacted on 0845 1254514 or david.brewer@fta-associates.com

Manchester May 2011 – January 2012

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A good night’s sleep
Matt Everatt discusses some solutions to snoring and bruxism

Snoring and bruxism are common problems frequently experienced during the night by most people in the UK, yet they not only result in problems for the individual, they can also cause those who share a bed or a house with them to have their sleep disrupted frequently.

Snoring is mainly caused by the partial closure of the airway during sleep. As the neck muscles relax, the soft tissue in the upper throat vibrates creating the harsh sound known as snoring.

Those who are overweight are more vulnerable to snoring, as are those who are older as the throat muscles become weaker with age. In some people, drinking alcohol can cause further relaxation in the neck and throat, resulting in snoring, and in others it is merely a result of the shape of their airways. However, no matter the reason, snoring is more harmful than it otherwise appears. Hypertension, cardiovascular disease, diabetes and high cholesterol are all more common in snorers, but it is the sleeping issues that can be most detrimental.

Many snorers suffer daytime sleepiness as a result of Obstructive Sleep Apnoea (OSA), in extreme situations this sleep deprivation can result in the sufferer inadvertently falling asleep with little warning, which can of course be incredibly dangerous. OSA occurs when breathing briefly ceases during sleep. These interruptions occur when the airway narrows so much that it closes, reducing the oxygen level in the blood. Adrenaline is then released into the body, sometimes partially waking the sufferer without their knowledge. In severe cases of OSA, Continuous Positive Air Pressure (CPAP) is used to pump filtered humidified air into the nose to prevent the upper airway from collapsing.

Where snoring is concerned, patients should be screened in order to eliminate the possibility that they could be suffering with OSA. The most effective solution for simple snoring is a mandibular advancement splint (MAS). Worn during sleep, these are designed to hold the lower jaw slightly forward to reduce the chance of the airway narrowing.

Although snoring is a main cause of sleep disruption for most people, bruxism is more damaging to the individual. Whereas snoring is the result of muscle relaxation, bruxism is the result of muscle tension.

Bruxism is a type of parafunctional hyper-activity that can cause a range of painful symptoms including poor sleep quality, migraines, tinnitus, neck ache, TMD and even depression. It can also lead to erosion of the teeth causing related dental problems, such as stress fractures, broken cusps and abrasions. A lack of motor control during sleep causes the nociceptive trigeminal inhibition (NTI) reflex to be overridden, For many people at stressful times in their lives the effects of bruxism can be exacerbated, what’s more, as this is most commonly a nocturnal issue, patients are usually unaware of the cause of their problems and it often goes undiagnosed and therefore, untreated.

The effects of bruxism can be reduced with the implementation of an occlusal splint. The most effective splints not only inhibit nociception by keeping the canines and molars separated, but also trigger the NTI reflex, forcing the muscles to relax and physically preventing the damaging clenching action, as opposed to the most commonly used full arch soft splints, which can often be uncomfortable to wear and not always effective as they can still permit and in some cases actually increase clenching.

Dates & Venue 2011/12

Introduction to Occlusal Splints - £280
book before 31st July £252 Inc VAT
- 9th Sept-London
- 4th Nov-Sheffield
Hands On Sessions - £450
book before 31st July £405 Inc VAT
- 2nd Dec-Birmingham

Snoring & Sleep Apnoea - A role for the GDP
£280
book before 31st July £252 Inc VAT
- 7th Oct-Norwich
- 16th Nov-London
- 20th Jan-London

Introduction to Occlusal Splints

Looking for a simple, reliable way to help patients who present with:
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- Cheek biting
- Tooth sensitivity
- Bruxism
- Gingival recession
- Worn teeth
- Headaches and sinus pain
- Chronic Tension

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The seminars cover areas of occlusion including:
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- TMJ function & anatomy
- principles of progressive splint therapy
- relief of pain and stabilisation
- using facebow and take occlusal records
- ‘hands-on’ element - uses, designs and fitting splints

Presented by Dr Helen Harrison
6 hours CPD - See dates below

About the author
Matt Everatt
Technical Director S4S
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www.s4sdental.com
Back pain, one of the principal causes of occupational disability in the dental industry, is often attributed to poor posture, usually occasioned by an incorrect working position. The traditional sitting position adopted by dental professionals can have an iatrogenic effect on the spine, which in turn causes vertebral problems, often in the lumbar region. Constant bending or twisting also contributes to back problems.

While it has always been accepted that the patient must be comfortable and relaxed during treatment, the comfort of the dental team has often been overlooked.

A recent industry survey of musculoskeletal (MSK) disorders among dental professionals found that between 64 and 93 per cent of the respondents suffered MSK pain. Dentists reported pain chiefly in the back (36 to 60 per cent) and neck (20 to 85 per cent), while hygienists were most affected in the wrists and hands (60 to 70 per cent).

It was once thought that the failure of dental equipment designers to fully understand ergonomic principles was a key contributor to a potentially damaging working posture. Today’s manufacturers create solutions, which adapt to the requirements of the user, offering treatment chairs, dental units, handpieces, cabinetry and dentists’ stools with safe ergonomics at the heart of their design.

Designers also take account of the dentist’s need to move freely around the patient, and that access to instruments and surgery equipment must be arranged to minimise actions which could potentially lead to muscle strain.

All dentists should be aware of the two primary considerations inherent in a safe working position: comfort and possible health risks, and the appropriate and convenient positioning of equipment and instruments.

Comfort and health
Although all dentists will naturally adopt a working position which suits their own preference, physicality and state of health, a symmetrical, upright posture that does not overload the musculoskeletal structures or put added stress on the spinal column is the recommended ideal.

Some movement around the treatment chair is inevitable, but remaining as much as possible behind the patient’s shoulder will help to avoid twisting of the upper body and neck. Making many small movements during treatment will further reduce the risk of muscle strain. It is also impor-

Ergonomic Surgery Seating Design
Gianluca Soldati discusses the essential backbone for a safe working posture

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Some movement around the treatment chair is inevitable, but remaining as much as possible behind the patient’s shoulder will help to avoid twisting of the upper body and neck. Making many small movements during treatment will further reduce the risk of muscle strain. It is also impor-
tant to vary the chair height to keep the working site at a comfortable distance.

Positioning and suitability of equipment and instruments

The dental unit, and ancillary equipment and its positioning, should complement the physical characteristics as well as the occupational requirements of the dentist; the dentist should not have to compromise posture or comfort for the sake of efficiency. Equipment options should be available so that clinicians can tailor their equipment to meet their individual needs.

The treatment chair/unit is the heart of every surgery, and the best designs satisfy the patient's comfort, functional requirements and the comfort of the dentist. Chairs should feature a thin, narrow back to avoid unnecessary leaning over the patient while allowing easy access to the working area. Leading manufacturers include design features which provide added support for the patient without compromising the dentist's access.

The latest chairs offer a wealth of extra features and may incorporate innovative concepts such as intuitive instrument replacement and built-in control panels. Hanging tube storage systems are proving popular, combining immediate access to instruments with convenient placement when not in use. More advanced options include ingenious extendable trays on articulated arms which can be positioned almost anywhere around the patient to provide maximum comfort and efficiency for the clinician.

Many models of dental unit are designed in a way that dictates the positions of the dental team, but ideally the team should be able to adapt the configuration to suit its own way of working. Dentists today should expect their chair to be an ergonomically functional treatment platform which offers all the features they need to deliver high quality care and which also provides for a balanced working posture to safeguard their own long term health.

Second only to the chair, the handpiece is probably the most frequently used item in the surgery. With its almost ubiquitous application across a wide spectrum of treatments, versatility and longevity are vital influences when making the choice.

The other fundamental tools of the dentist's trade, in constant use, including suction, pliers, forceps, mouth mirrors and scalers all need to be positioned where their accessibility will promote a better posture.

References


About the author

Gianluca Soldati is Advertising and Communications Manager at Castellini. Gianluca qualified in 1990 with a degree in Technical Graphics and Advertising and continued his studies for the following two years taking part in intensive photography and graphics courses whilst working as Art Director for an electronics manufacturer. Gianluca has been working for Castellini since 1992 and was promoted to his current role in 2000, where he is responsible for creating and coordinating the business' corporate communications.

For further information about the comprehensive range of Castellini products call 0039 356 8219 or visit www.castellini.com
Jane Armitage discusses the BDA Good Practice Scheme and the CQC

By now all practices should be compliant with the Care Quality Commission (CQC) requirements.

I am so thankful that we had been endorsed with the British Dental Association Good Practice Scheme as this made the signposting of all the required elements so much easier.

I start every January by trawling through all manuals relevant to the running of the business ie: Clinical Governance, Health & Safety, BDA Good Practice, and the Practice Policy Folder to name a few. As we are DF1 training Practice I usually begin with the documented evidence the Regional Postgraduate Office require. Even this has increased in volume.

If you have an organised system already in place the requirements of the CQC are straightforward. I wouldn’t like to be in a position where I managed a practice without systems and procedures. It is of little use knowing you have evidence somewhere in the practice but not in any file or order; however you know you have it! Somehow I can’t see the Care Quality Commission buying that.

So if you are reading this and this sounds like you maybe it’s time to implement systems. In the long run it makes life so much easier.

The BDA Good Practice Scheme is based on quality assurance. It is a practice recognition scheme for practices committed to providing a standard of good practice to their patients. The scheme is based on legal and ethical requirements required for running a dental practice.

It is a quality system which encourages all members of the team to become involved.

In my opinion if you are part of BDA Good Practice, the information you will have in your file represents a major portion of the evidence you need for the CQC.

It is most important that all practice documentation is reviewed at regular intervals. It’s surprising what a review flags up, maybe a nurse who held extra responsibilities has left.

Identify each piece of documentary evidence.

I also created a separate employment file, where I maintain certificates for every staff member covering immuno-vaccinations, GDC certificates, liability insurance, Irmer certification, proof of citizenship, CRB checks, etc.

I then wrote the requirements for each outcome as worded in the guide for providers of primary dental care services. Ref: www.cqc.org.uk

For example: CQC Outcome 1: Respecting and involving patients.

Demonstrating Compliance:
I noted the compliance evidence I had within the practice and my cross references for where the evidence could be found:

Complaints handling policy can be found in (GP9.2) (CG9.1) (KS5) (PP30) Good Practice 9.2, Clinical Governance 9.1, Key Skills 5 and Practice Policies 50.

Interpreter Services (CG10.1) Clinical Governance 10.1

I continued this for all the relevant requirements. On the front cover I also designed an appendix showing all policies etc and which file they can be found in. This for me is a user friendly template; it will make it easier when the review date comes around without having to wade through the CQC manual.

Did I find it easy? Yes I did, but only because I already had a Clinical Governance system in place and because we have BDA Good Practice, which were both current and in line with legislation.

For further advice on meeting registration requirements for CQC please see www.cqc.org.uk

I must admit, I was glad when I had finished, and I breathed a sigh of relief. However this was short-lived as I opened my email only to find the Information Governance Toolkit sitting there. Will it ever end?

About the author

Jane Armitage is an award-winning practice manager and has almost 40 years’ industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Assessors award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit in Management. She has her own practice management consultancy, offering a practice management consultancy service, which includes on-site assistance covering all aspects of practice management with a pathway if required for managers to take their qualification in dental practice management. If you have any specific choices of topics you’d like addressed, call Jane on 01142343540 or email janearmitage@talkTalk.co.uk.

All practice documentations should be reviewed at regular intervals
When a new enquiry is received in your practice, what happens? Is the prospective patient sent a few unbranded treatment leaflets with a brief covering letter? Not only is this unprofessional, once removed from the envelope the random leaflets do not relate to your practice. Almost as bad, are your patients sent practice literature about which you feel a twinge of embarrassment because of the low quality?

Every new patient enquiry is an opportunity to promote your practice; an invitation to send an attractively designed welcome pack that will reinforce your brand, communicate all that you offer and appeal to a prospective new patient.

Giving your existing patients a tastefully designed and informative pack also makes sense – to ensure they know everything you have to offer and are less likely to be tempted to go elsewhere.

Before considering your welcome pack, do some mystery shopping. Find out what practices near you send to prospective new patients. If they have beautifully produced packs, you will need to up your game.

Essentially, the contents of a welcome pack should comprise:
- A welcoming introduction, including the philosophy of the practice
- Who you are – a brief biography of the principal dentist and an overview of the team members
- Treatment options
- Testimonials
- A map and directions
- Opening hours
- Contact details and information about emergency appointments
- A smile analysis form (as separate insert)
- Fee guide (as separate insert)
- Referral card (to hand on to friends and family)

The wording should be clear, concise and patient centred, focusing on the outcome of treatment rather than excessive technical detail. If your practice looks great inside and/or outside, flaunt it by including lots of photographs. Make sure to invest in good photography and don’t be tempted to take your own snaps, the quality (or lack of it) will show. If the practice interior is not its best feature, put in a nice team photo instead.

A good dental designer will have some stock photos of people with beautiful smiles but if you have any real patient photos you may choose to include them. The general consensus is to avoid ‘before and after’ photographs as the ‘before’ pictures will be unattractive and may reduce the instant appeal of your welcome pack. Save them for specific sections on your website.

A business card or appointment card can be inserted loosely or tucked into pre-cut slits in the pocket of the folder. The patient usually completes...
a medical history form at their first visit to the practice and you may choose to include one in the pack.

A smile analysis form is a simple list of statements for the patient to tick, those they feel to be relevant. Completed by the patient before their first visit, it is an excellent tool for opening discussion about what they may be looking for in terms of their dental health and appearance. It should support the treatment options outlined in your main brochure. If a patient has ticked a statement such as 'I feel my old silver fillings are unsightly' or 'I wish my teeth were whiter', you can readily offer the appropriate solution.

The quality of your welcome pack reflects on the quality of your practice and your treatments so when it comes to printing, make sure you go for high quality. With printing you get what you pay for and all the effort invested in design, writing and images can be ruined by a lousy print job.

For similar reasons, forget about a DIY welcome pack. Make sure it is beautifully designed; professionally printed and better than anything else your patients receive. Then all you have to do is distribute it freely, with pride and confidence.

The inventor of the Original Piezon Method has won another battle against the destruction of tissue when dental implants are performed. The magic word is dual cooling – instrument cooling from the inside and outside together with simultaneous debris evacuation and efficient surgical preparations in the maxilla.

COOLING HEALS
A unique spiral design and internal irrigation prevent the instrument’s temperature from rising during the surgical procedure. These features combine effectively to promote excellent regeneration of the bone tissue.

EMS Swiss Instruments Surgery MB4, MB5 and MB6 are diamond-coated cylindrical instruments for secondary surgical preparation (MB4, MB5) and final osteotomy (MB6). A spiral design combined with innovative dual cooling makes these instruments unique in implant dentistry.

CONTROL SAVES
Effective instrument control fostersatraumatic implant preparation and minimizes any potential damage to the bone tissue.

PRECISION REASSURES
Selective cutting represents virtually no risk of damage to soft tissue (membranes, nerves, blood vessels, etc.). An optimum view of the operative site and minimal bleeding thanks to cavitation (hemostatic effect) further enhance efficacy.

The new EMS Swiss Instruments Surgery MB6 with unique spiral design and internal instrument irrigation for ultralow temperature at the operative site.

EMS Swiss Instrument Surgery MB6 with unique spiral design and internal instrument irrigation for ultralow temperature at the operative site.
The creation of a functional occlusion is the goal of any prosthetic treatment and can be very difficult to achieve in cases of full-mouth rehabilitation, especially in the case of temporomandibular joint (TMJ) dysfunction. In these clinical situations, provisional restorations are an excellent diagnostic instrument. Aesthetics, phonetics and function, after evaluation and acceptance by the patient after try-in of the provisional restorations, should be accurately transferred to the final restorations to ensure the same clinical success.

The aim of this study is to demonstrate the manner in which individual movement characteristics of a patient's TMJ can be included in traditional CEREC temporary crown fabrication. New occlusal relations need to be created with respect to the individual characteristics, such as mandibular and hinge axis positions, Bennett and sagittal angles. The incorporation of occlusal plane formation principles is essential to improve a patient's adaptation to new occlusal relations, as well as to reduce the probability of TMJ dysfunction. However, CEREC software does not enable the inclusion of TMJ parameters.

Following, we describe a technique that enables the fabrication of temporary CEREC restorations with respect to a patient's TMJ parameters.

Step I: Electronic axiography and lateral X-rays
Computer analysis of jaw movements with electronic axiography is useful for determining the joint parameters (Fig 1). Using mechanical tracing, axiography enables the collection of data on a patient's TMJ, such as curve and inclination of the condylar path, mouth opening, Bennett and sagittal angles, mandibular protrusion and course of the mediotrusive tracks. Lateral X-rays provide data on movement by including the condylar tracks (Figs 2a & b).

Step II: Slavicek analysis
We used CADIAx (Gamma Dental) to analyse the X-rays in detail (Fig 3). Here, the distances, spaces and tooth relations are of considerable importance. The vertical dimension and the special position of the occlusal plane, the Spee's curve and the various occlusal tables of the laterals were determined. In the lateral X-ray, we paid particular attention to the occlusion tables of the molars, especially tooth #6.

Step III: Partial wax-up
A partial wax-up of the individual occlusal surface was modelled on the master casts with respect to the TMJ angles and occlusal pattern of sequential functional guidance occlusion with canine dominance (Figs 4 & 5).

Step IV: Scanning
The partial wax-up was scanned and combined with the virtual images of the teeth stumps and virtual restorations from the CEREC software database. Thus, we were able to easily control the form, cusp position and inclination of the teeth with respect to individual

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Lifelike Dental Laboratory is a small private dental laboratory in Buckinghamshire. We like to think the products we offer are as good as our service, but that's up to you to decide. We work with you in partnership to ensure that you are able to offer your patient the best solution at a competitive price.
TMJ movement characteristics and peculiarities of the facial skeleton. We used the diagnostic display with display options for virtual modelling using CEREC software (Fig 6).

**Step V: Milling**

The temporary restorations were traditionally milled (Fig 7).

**Conclusion**

The method of real-virtual modelling described in this article enables us to guide the anatomical form of restorations using wax reference points with respect to the dynamic TMJ parameters of the patient. The method is a combination of a partial wax-up in the articulator and virtual computer modelling. With CEREC software, we are able to create temporary restorations with respect to individual jaw movements.

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**About the author**

Dr Mikhail Antonik, Dr Mikhail Murashov and Dr Natalya Muraviova from the Moscow State University of Medicine and Dentistry in Russia can be contacted at mmurashov@yahoo.com. This article was first published in Cad/Cam Issue 2/2010.
The Endodontosaurus – A dying breed?
Michael Sultan discusses attitudes towards alternative methods of restoring teeth

When I admit to being an endodontist I receive a look of pity from my peers. Unfortunately, with dental implants growing in popularity, this field of dentistry is often regarded as outdated - a dying art.

If a tooth is deemed unrestorable, or retaining the tooth could make future implant placement more difficult due to infection and further bone loss, then of course extraction and appropriate replacement should be considered. However, with an ageing population, implant surgery may increasingly be contraindicated.

It is the role of the clinician to weigh up their options and select the appropriate solution for each patient on a case-by-case basis. Implants are not the ‘be all and end all’ of restorative treatment. Rather than instinctively reaching for the forceps, some clinicians need to reconsider their attitude towards alternative methods of saving a tooth. I have heard post crowns being referred to as ‘PRPI’ or provisional restoration pre-implants. Given there is sufficient tooth structure and sufficiently long roots, post crowns can actually have a very good prognosis and shouldn’t necessarily be automatically considered as a temporary solution.

What’s more, implants are not necessarily as atraumatic as they are sometimes perceived to be. They necessitate a CT scan, a surgical procedure and a long period of temporisation while waiting for integration. For a suitable patient, good endodontics on the right tooth avoids the need for this trauma and expense. It will also mean the patient can retain their natural tooth, heightening proprioception.

‘Success’ in endodontics is not easy to define and is the subject of much debate amongst endodontists themselves. A successful implant treatment can be defined by whether or not the implant has integrated or ‘survived’. The success rates lie somewhere between 85-95 per cent; however to decide whether treatment can be deemed a success in endodontics, consideration needs to be given to the desired final outcome. Is endodontic treatment a success when the patient is free from pain and swelling? Or can the treatment be considered a success when no lesions are present? As a result, success rates for endodontic treatment can vary from 45 per cent to 95 per cent.

Dentists need to be able to make an objective decision based on the most favourable outcome for the patient. A growing trend in endodontics courses in the US is for students to learn to treat implants too, enabling a fractured tooth with plenty of bone to be suitable for immediate implant treatment. This trend looks set to catch on in the UK, with the result that endodontists will be able to undertake the best treatment.

In short, we have to ask ourselves, ‘what’s the worst that could happen?’. Do we really want a long bridge with a short root filled tooth with a post as an abutment, or should every compromised tooth be replaced with an implant? If both treatments have the same longevity and no adverse factors then ultimately it comes down to operator experience and confidence as well as informed patient consent.

Dr Michael Sultan BDS MSc DFO FICD is a specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for five years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in Harley St, London in 2000. For further information please call EndoCare on 020 7400 8989 or visit www.endocare.co.uk.
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CADCAM at Christmas

Phil Horn from the Precision Coping Company reports on a recent course that illustrated how CADCAM in dentistry keeps evolving...

At the PCC we like to think we are at the cutting edge of technology. Hence why we attended a Nobel Procera ‘Training Camp’ so that we could learn how to get the most out of our new scanner.

The Nobel Procera scanner is an optical rather than point of contact scanner, but the really new thing that excited us was the new software that we hoped would allow PCC to:

• Create custom implant abutments on screen
• Create implant bars for overdentures
• Produce items using five axis milling.
• Save time by carrying out more design work on screen

And so it was that I found myself in Zurich on a Monday night just before Christmas – a great time of the year to be there! A number of other UK dental professionals also took the trip including staff from Sheffield University and army technicians. A light dusting of snow was on the ground as we arrived and it was literally freezing! We were ably looked after by Olga Chamoun and her colleagues at Nobel Biocare and made to feel very welcome.

The course took place over two days. The majority of the training was hands-on and this was one of the reasons that the course particularly appealed. We spent Tuesday morning using the new software on standard coping design, anatomical copings and wax-ups. After lunch we then moved on to bridge scans and design before finishing off day one with custom abutment scan and design on screen. Our hosts were then good enough to give us a walking tour of Zurich followed by dinner at La Terrasse, which if you are ever in Zurich, I can heartily recommend.

The Wednesday started early and we continued using the new software for abutment scanning and design. We then spent a large amount of time on overdenture bars – this was a particular area of interest for me and I have to say that the results we have achieved at PCC have been spectacularly good. The on screen design offers complete flexibility on more complex cases.

The day finished with a summary and overview of the training before we headed through the snow to the airport and back to our day jobs. The course was incredibly useful and I think that the new scanner and the course illustrates how CADCAM keeps evolving and moving forward. PCC obviously still produce our traditional ranges but we can now offer more products using the latest technology.

To purchase please visit www.kelocote.co.uk
or simply call 08445 447450
The British Dental Conference and Exhibition opens its doors to the dental profession on Thursday 19th May. The event, which is being held at the Manchester Central Convention Complex, will run over three days, Thursday 19th, Friday 20th and Saturday 21st May.

The event will bring together a fantastic exhibition and an extensive line-up of esteemed international and local speakers, incorporating a broad range of sessions covering clinical and business innovations within the profession. Highlights of the speaker programme include keynote speaker Tanni Grey-Thompson, who will be talking about how to achieve success where others fail; John Tierman, will be discussing complaints – are you susceptible and how can you avoid them?; Raymond Bertolotti, who will be presenting their products at the conference.

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Takara Belmont

Takara Belmont will this year be displaying its range of treatment centres, the Cleo II, Clesta II and Voyager II. All facilitate multiple working methods and dental procedures whilst offering optimum patient comfort at all times, making each a flexible and versatile addition to any surgery.

With ease of access and consultation in mind each Treatment Centre has foldaway or removable armrests whilst the Cleo II has its unique and valuable folding leg rest. A diverse range of delivery systems are also available, the Cleo II for example can be supplied with traditional Over-Patient Holder or continental Rod type, Cabinet or Mobile Cart options.

Total flexibility of use is made possible by the Voyager II which has the advantage of being ambidextrous whilst the Cleo II can be factory modified for either left or right handed use. Functionality can be further increased by the addition of factory built-in features such as micro motors, fibre optics, scalers and LED curing lights. All models are available in both air and electric versions. Each model boasts durable, easy to clean upholstery in a vast array of colours, ensuring good looks and best hygiene standards.

Takara Belmont prides itself on its reputation for reliability ensuring good looks and best hygiene standards.

With its predecessors the Ultra- and Cordless Plus Water Flossers, the Nano™ is clinically proven to be twice as effective as traditional string floss in removing plaque biofilm. Normally retailing at £49.99, BDA conference attendees will be able to purchase the Nano™ at a special conference discount. Alternatively, they can pick up their free sample Nano™ by attending the Waterpik® seminar. Details and vouchers will be available from the Waterpik® stand (A43).

Committed to patient oral health, Water Pik, Inc. is proud to be launching the Nano™ Water Flosser exclusively to BDA delegates.

For more information on the range of Waterpik® Water Flossers speak to your wholesaler or visit www.waterpik.co.uk. Waterpik® products are widely available in Boots stores and selected Loyds/Pharmacies.

For the BDA Conference and Exhibition has something for every dental professional, and every dental professional can gain something from Smile-on’s e-learning packages, interactive webinars, and in-practice training sessions and includes topics such as:

- Oral Cancer Prevention, Examination and Referral
- Oral Surgery - Bone Grafting
- Orthodontics
- Endodontics
- Periodontology
- Restorative Dentistry
- Preventative Dentistry
- Oral Hygiene
- Infection Control
- Etc.

Learn about learning with Smile-on at the BDA Conference 2011

The past decade has seen Smile-on go from strength to strength, building a solid reputation as a leading provider of learning solutions in the dental industry and you can find out why at the BDA Conference and Exhibition from the 19th to the 21st May at the Manchester Central Convention Centre.

Situated at stand A18, the Smile-on team will be on hand to help you explore the options available to you should you wish to gain new skills and qualifications. With e-learning packages for undergraduate and postgraduate qualifications, revision and CPD requirements for the whole dental team, Smile-on are sure to have what you need to enhance your knowledge on a variety of subjects from radiography to legal and ethical issues.

Each of Smile-on’s popular courses is presented with specifically designed e-learning programmes, interactive webinars, and in-practice training sessions and includes topics such as:

- Oral Cancer Prevention, Examination and Referral
- Oral Surgery - Bone Grafting
- Orthodontics
- Endodontics
- Periodontology
- Restorative Dentistry
- Preventative Dentistry
- Oral Hygiene
- Infection Control
- Etc.

For more information call 020 7400 8969, visit www.smile-on.com or email info@smile-on.com.
Smile-on and The Dental Directory Award £1000

Smile-on and The Dental Directory have announced four lucky dentists a £1000 bursary to be spent on their favourite Dental Directory products while they study for an MSc in Restorative and Aesthetic Dentistry. Not only will the MSc recipient receive an MSc in Restorative and Aesthetic Dentistry on completion of the course, they will also make valuable savings on the equipment they will need throughout the programme.

The innovative post-graduate qualification which is the UK’s first online programme for dentists on the subject. Modules include:

• Patient consultation
• Treatment planning of the complex case
• Direct composite restorations
• Restoration of endodontically treated teeth

The course allows busy dentists to attend at times and locations convenient to them, enabling them to continue treating patients throughout. The majority of the modules can be accessed online, but also includes three residential ‘hands-on’ courses.

For more information about the MSc in Restorative and Aesthetic Dentistry, call 0207 400 9999 or visit www.smile-on.co.uk

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The furnishing of a workspace within a practice must be fit for purpose and safe for use. In your workspace design, think about how the task on the floor, or hand, has or has not been adapted over time as a result of circumstances. As additional help has to be spent on reducing costs, it will be of the greatest importance to define the layout of the practice. Ray Goodman, Senior Partner at Goodman Legal, has often been seen to make an efficient and safe environment for dental practices. Ray Goodman states his opinion about the dental practice. Ray Goodman: The tailor-made, practical guidance covers a wide variety of aspects. It is the dental profession’s responsibility to ensure that patients are treated with care and respect. The challenge of providing dental care in an efficient and safe manner is what Goodman Legal is passionate about. Goodman Legal is passionately committed to help dental practices provide the highest standard of care to their patients.

For more information please contact Ray Goodman, Goodman Legal, Lawyers for Dentists on 0151 707 0000, or email info@goodmanlegal.co.uk or visit www.goodmanlegal.co.uk

Nuview Astonishes Practitioners at The Clinical Innovations Conference

Novi - Nuview, the leading mouthwear which is part of NASDA and who discussed included lending and the increasing use of inhalation sedation in dentistry. The use of Novi - Nuview products are the first clinically proven anti-caries fluoride toothpastes that are available in the UK. The Dental Directory team demonstrated the service that has far exceeded the competition through the Clinical Innovations Conference 2011. Delegates were encouraged to speak to the Dental Directory representatives about all of their supply needs, and some even offered help, advice and details of the company’s support payment programmes, which are designed to save practices both time and money.

Ray Goodman, Senior Partner at Goodman Legal, Lawyers for Dentists said: “The UK Dental Directory team has access to all the latest products and innovations and can offer competitive pricing and a quality service. There is no doubt that the range of over 27,000 dental products across the country, and with a 59% credit repect for order accuracy, offers an easy way to use ordering and next day delivery. So for an all-round service on one convenient website, be sure to contact Admor, the office essentials company for dentists on the subject. Modules include:

• Patient communication
• Patient care and retention
• Patient treatment

In a combination of polyphosphate and stabilised stannous fluoride. In a remarkable synergy, this latter ingredient delivers long-lasting anti-bacterial benefits and as such is recognised as a broad-spectrum antibacterial agent. Its ability to inhibit bacterial growth, reduce bacterial adhesion and to affect microbial metabolic processes adds the double advantage of anti-plaque to the anti-caries defence against gum problems.

For further information please call michelle@ada-communications.com, 07920 178719

The Dental Directory at the 2011 Clinical Innovations Conference

The Dental Directory team demonstrated the service that has far exceeded the 50 % per cent share of the current dental supplies market at the Clinical Innovations Conference 2011. Delegates were encouraged to speak to the Dental Directory representatives about all of their supply needs, and some even offered help, advice and details of the company’s support payment programmes, which are designed to save practices both time and money.

As the largest private supplier of dental products in the UK, The Dental Directory team has access to all the latest products and innovations and can offer competitive pricing and a quality service. The company’s support payment programmes are designed to save practices both time and money. With high standards of customer care matched by low price, The Dental Directory deserve their reputation for excellence, and to retain the 2011 CTM get a glimpse of the experts in action.

For more information simply contact your local Dental Directory Representative, call 0800 585 586, or alternatively visit: www.admordirect.co.uk

Components of a successful design and the importance of minimising costs

Dr Qureshi will be explaining how he uses the Dahl principle day to day in restorative dentistry and how it can be used in the education of dental students combined with traditional occlusal theory. The lecture will consider how the Dahl principle can be used to prevent the need for more aggressive tooth preparation in your patients and will be delivered on Thursday 14th July, 9.30am to 10.am.

BACD London Study Club

The BACD London Study Club will be hosting a talk by Dr Qureshi, President Elect of the BACD, on Thursday 14th July at 9.30am. The talk will take place at the British Dental Association, with light refreshments served from 10.15 - 10.45 and the lecture itself commencing at 10.30.

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BACD London Study Club

On Thursday 14th July, the BACD London Study Club will be hosting a talk by Dr Qureshi, President Elect of the BACD, on the topic of ‘Bonding As An Alternative To Traditional Adhesive Bonding’. The talk will take place at the British Dental Association, with light refreshments served from 10.15 - 10.45 and the lecture itself commencing at 10.30.

For more information please contact Nita Suzy Rowden on 020 8241 8536 or email: suzy@bacd.com

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For more information please call 0800 585 586, or alternatively visit:

For more information please contact Ray Goodman, Goodman Legal, Lawyers for Dentists on 0151 707 0000, or email info@goodmanlegal.co.uk or visit www.goodmanlegal.co.uk
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Speaker: Dr Amit Patel
Date: 31st May 2011

Webinar 3: Dental Implant treatment planning and implant maintenance for the general practitioner
Speaker: Dr Amit Patel
Date: 7th June 2011

Webinar 4: Restoring Dental Implants made easy
Speaker: Dr Stuart Jacobs
Date: 16th June 2011

To book your free place go to:
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A no-nonsense approach

E veryone talks about meeting and exceeding customers’ expectations yet it is rarely achieved. Despite it being inexpensive to implement and requiring only the most basic of approaches, it is rarely well executed in practice in this country. However, achieving true customer satisfaction probably generates the greatest return of any sales or marketing activity a practice can undertake.

To address this yawning gap, Lina Craven of Dynamic Perceptions is staging a series of two-day workshops this autumn aimed at the entire team. During the course, participants will learn how to create and deliver the kind of culture, processes and practices that underpin an effective new patient process and truly utilise the role of treatment coordinators.

Lina set up Dynamic Perceptions after arriving from the USA, where the role of treatment coordinator is highly valued, to find that no such function existed in UK practices. She set about educating dental professionals about the benefits of improving the efficiency and profitability of the practice by training members of the team to become treatment coordinators. As a result the practices saw an upswing in case acceptance ratios and a marked improvement in patient satisfaction and recommendations.

The two-day workshops Lina is running are designed for practices looking for ways to maximise the effectiveness of their team and keen to introduce the role of treatment coordinator. They are equally applicable for anyone new to the role looking for ways to fully embrace their new function.

There are three parts to the workshop and in the first, delegates will learn about the function and benefits of a treatment coordinator; those best suited to the job and their roles and responsibilities. Phase two addresses the customer and sets out to explore what the ‘new’ dental patients of today expect; how to meet and exceed their expectations; to understand the true nature of the products and services practices provide and the role of the entire team in the new patient process.

Stage three tackles the business approach needed by the dental practitioner and treatment coordinator from the verbal skills needed to provide a powerful case presentation; the techniques that break down barriers before and after case presentations; how to create a winning patient journey; how to utilise technology for enhanced case presentations and finally how to schedule the treatment coordinator into the practice appointment diary for maximum benefit.

Delegates will be able to earn 10 hours of verifiable CPD over the two days of the workshop which are taking place in the autumn:

- Orthodontic practices: September 24th and 25th - Henley on Thames - Hotel Du Vin
- Dental practices: October 14th and 15th - Henley on Thames - Hotel Du Vin

As places are limited and with entire teams attending, reserving a place early, before the summer break, is strongly recommended.

For more information Dynamic Perceptions can be contacted on 01296 748692 or cra ven@dynamic.fsifile.co.uk
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