John Lennon’s tooth sold

One of John Lennon’s teeth has been bought by a Canadian dentist at an auction in Stockport for £18,500. Albert-based Michael Zuk won the tooth after a phone bid. The tooth was originally given to Dot Jarlette, who was John’s housekeeper in the 60’s. Other items being sold included oil paintings from John Squire of the Stone Roses and gifts from politicians. Mr Zuk, who has written a book on celebrities’ teeth, said in a BBC report: “Once I heard it was up for sale I had to have it.” According to the report, Mr. Zuk not only plans to display the tooth in his surgery, but he plans to take it on a tour of other dental surgeries and dental schools. "Some people will think its gross, others will be fascinated by it," he added.

Teeth’s a crowd

A unique study from the Faculty of Dentistry at Malmö University has shown that the size of our jaw is decreasing with age. The study started in 1949 and has since followed several dentists throughout their adult lives. Plaster moulds were taken of the participants this procedure was repeated in 1959 and 1989. On that occasion the researchers were in touch with 18 of the original 50 participants. The study found that the jaw shrinks a few millimetres, resulting in the front teeth crowding. “We can also eliminate wisdom teeth as the cause, because even people who have no wisdom teeth have crowded front teeth”, Ron- demark said. Researchers are yet to discover why our jaws change as we get older.

“I don’t use the NHS”

NHS Commissioning Board head ‘not a patient of NHS’

According to a report in Pulse, the Government’s newly-appointed chair of the NHS Commissioning Board Prof Malcolm Grant (pictured) has admitted that he doesn’t use the NHS.

The claims came during a session with the House of Commons Health Committee last week, where Prof Grant failed to demonstrate his ‘passion’ for the NHS.

“Come on, what do you want me to say?” he reportedly asked the Committee. “I find it difficult to demonstrate because I am not a patient of the NHS.”

Prof Grant, who is currently chief of University College London, will be trusted to spend the £60 billion budget on the NHS wisely; however, after his recent outburst GP leaders have branded Prof Grant’s position as controversial and have called for the post to be filled by a GP. Even MPs are reportedly unconvinced of Prof Grant’s suitability for the role.

What comes as a further blow is that health secretary Andrew Lansley supported Prof Grant as his ‘preferred candidate’ to chair the NHS Commissioning Board.

Writing in the Sunday Mirror in response to the admission, shadow health secretary Andy Burnham said: “It really does say it all. The first choice to control your NHS doesn’t believe in it enough to use it himself.”

According to the Telegraph Prof Grant, who will be paid £63,000 a year for chairing the NHS Commissioning Board two days a week, was unwilling to give details of any private health cover.

A Department of Health spokesperson said on the issue that: “Professor Grant was selected as Chair of the NHS Commissioning Board because he was the best candidate for the job. His choice of healthcare is a personal matter.”

However, the feeling of uncertainty continues through the health profession. Neil Kohari, a practice owner in Cambridge, commented: “Given the vast funding and extensive recent reform to NHS dentistry it’s a shame that Prof Grant feels he has to go outside of the NHS to meet his dental needs.

“Perhaps it is now time to question what the NHS needs to do to attract patients like Prof Grant to use its services, or alternatively focus on a core budgeted service where every patient has a clear idea of what they can expect. After all let’s not forget the high street chain Woolworth’s tried to offer something for everyone but ultimately failed as the world moved on.”

www.dental-tribune.co.uk
A look at the state of men’s health

Don’t sell yourself short

The Dental Defence Union (DDU) is warning dental professionals to be wary of promoting their practice by offering discount vouchers on particular treatments as they may be inadvertently making themselves vulnerable to a complaint or even a GDC investigation.

Rupert Hoppenbrouwers, head of the DDU commented: "While in these straitened times, it may make business sense to tempt new patients through your door with a bargain, dentists need to put their professional obligations first. We have received a number of calls to our advice line from members seeking advice about whether to take part in discount voucher schemes.

"Our view is that by accepting discount vouchers for a particular procedure such as tooth-coloured restorations or veneers, dental profession- als are effectively committing themselves to providing inva- sive treatment which may not prove clinically necessary, ap- propriate or in the patient’s best interest on examination. If the patient has paid for and expects a particular treatment which is not in their best interest, and you are obliged to disappoint them, they may well feel justi- fied in making a complaint or even reporting you to the GDC.

"The fact that the GDC was prompted to advise den- tal professionals about discount deals earlier this month suggests that this is a problem area, which is generat-

ing complaints to the regulator."

The DDU reminds dental professionals that in promoting their practice they must meet the standards set by the GDC by avoiding any offer or claim which could be seen to be misleading and putting the interests of patients above their own or their business. In addition, market- ing material must conform to the Code published by the Com- mittee of Advertising Practice (CAP). The Advertising Stand- ards Authority (ASA), which enforces the Code, can demand the withdrawal of adverts and offenders can also be referred to the Office of Fair Trading.

The DDU is happy to advise members with specific den- tal concerns about advertising or promotions.

Inmates sue NHS

A ccording to a report in the Yorkshire Post, in- mates who are suffering from toothache at a Yorkshire high security prison have sued the NHS more than poor dental care; taxpayers are expected to foot the £350,000 bill.

Prisoners at HM Prison Wake- field, which houses noto- rious criminals including Charles Bronson, Crossbow Cannibal Stephen Griffiths, child killer Robert Black and Sarah Payne’s killer Roy Whiting, received a staggering £47,500 in total for “damages”.

The figures, which were re- leased under the Freedom of Information Act, revealed that pay-outs were decided depend- ing on the level of pain the in- mates had in relation to how long they had to wait for an ap- pointment; individual pay-outs ranged from £1,200 to £5,000.

What is causing further out- rage is that legal cost came to £50,000 after NHS chiefs were forced to pay prisoners’ sol- licitors fees; the total cost has come to £55,500, and three claims remain outstanding.

Quoted in the Yorkshire Post, Gill Galdins, chief operat- ing officer for Wakefield Dis- trict Primary Care Trust, said the NHS inherited a long wait- ing list for complex and expen- sive treatment when it took over prison healthcare in 2005.

She said: “The figures paid to claimants were all relatively low. When this happens it’s of- ten the case that the claimant’s solicitor’s costs are disproporti- onate.

“Where a patient experi- ences a breach of duty care and injury follows that they are enti- tled to compensation.”

A prison service spokeswom- an said: “All claims are robust- ly defended, and would only be settled on the basis of strong legal advice, and in order to seek the best value for the taxpayer.”

However the assistant secretary of the Prison Offi- cers Association (POA), Glyn Travis, said that his association would not see anyone denied NHS care whenever they need- ed it.

He added: “What we do say is they get priority care that they don’t pay for and when they receive poor treatment they sue. Solicitors are hap- py to take their cases because they know they will get paid in the end.

“It is ridiculous, they are suing for treatment they didn’t pay for in the first place.”

“Clear timetable must be set” says BDA

The British Dental Associa- tion (BDA) in Northern Ire- land is calling for a clear timetable for the progression of the reform of Health Service den- tal care to be set.

The call is being made ahead of the fifth anniversary of the pub- lication of recommendations for the reform of dental services in the Department of Health, Social Security and Public Safety’s Pri- mary Dental Care Strategy. That document, which was published on 16 November 2006, set out a prevention-focused direction for dental services, the care patients receive and the system of dental practitioners.

The BDA has long campaigned for new arrangements that will bring a new preventive emphasis to Health Service dentistry and supported the recommendations outlined in 2006. Such arrangements, the BDA believes, will help tackle the unacceptable oral health in- equalities that continue to plague Northern Ireland’s communities.

Dr Peter Crooks, Chair of BDA’s Northern Ireland Dental Practice Committee, said: “It is now nearly five years since Gov- ernment set out a vision for bet- ter dental care for our citizens. We should, by now, be seeing the implementation of new arrange- ments. Dentists know that con- tinuing with the present arrange- ments simply isn’t an option if Northern Ireland is serious about tackling the poor oral health and inequalities that plague its com- munities. We have been positive about the proposed changes, re- peatedly stressing our commit- ment to constructive engagement in taking reform forward. Now is the time for action.

“We call on the Department of Health, Social Services and Public Safety to mark the fifth anniver- sary of its proposals by re-affirming its commitment to reform and set- ting out a clear and realistic time- table for it. That timetable must include a date by which pilots for a more prevention-focused con- tract are expected to begin.”
Immerse the scene – you work one day to find out you have been put in charge of the company’s football team (ok I know you’re dental professionals and don’t have company football teams but work with me here). The thing is, you’re keen on rugby and have no interest in football – in fact you’ve never been to a game!

Sound a bit silly? Well, let’s broaden this out to something a little more close to home – you are the man in charge of commissioning healthcare services for the nation. Thing is, you don’t use this service.

Much as the medical and dental professions like to think they are different, I think one thing they may agree on is that someone who is in charge of a body such as the National Commissioning Board should really be experiencing firsthand the service that he is ‘in charge’ of.

Prof Grant has been called ‘the right man for the job’, and I am sure that a man of his experience – barrister, environmental lawyer, academic public servant and since 2003 UCL’s President and Provost – will no doubt prove himself to be so. Still, I am of the opinion that when you are heading up a service that is supposed to react to the needs of ‘customers’, what better way to gauge these needs but as a user yourself?

Let me know what you think – email lisa@dentaltribuneuk.com.

Correction

In Denta Tribune Vol 5 No 21 pages 42-44 the contact details for Jacques Gans were incorrect. Her contact number is 08450 449466. We apologize for any confusion caused.
Normal bacteria which live in our mouths provide the catalyst for the development of gum disease, a debilitating condition which leads to painful gums and the loosening of teeth, new research from Queen Mary, University of London has found.

The unexpected finding could pave the way for the development of preventative measures in tackling gum, or periodontal disease, by manipulating the normal bacteria in the same way that probiotic yoghurt works to protect the intestine.

Researchers at Queen Mary’s Blizard Institute, including Medical Research Council Clinical Research Training Fellow Mark Payne, worked with scientists in the US; they published their findings in the journal Cell Host and Microbe today (27 October).

The scientists introduced the oral bacterium Porphyromonas gingivalis to mice living in two different test conditions. The mice with normal bacteria in their mouths developed periodontal bone loss but the mice raised under germ-free conditions, in the absence of any normal bacteria, remained disease-free.

Professor Mike Curtis, Director of the Blizard Institute and co-author on the paper, said when the oral bacterium P. gingivalis was introduced under normal conditions “it stimulated the growth of normal bugs leading to a large increase in the number of those organisms already there”.

“The P. gingivalis was introduced at very low levels yet it had a major effect on both the immune system and the inflammatory system,” he said.

“This oral bacterium only affects those who really have to understand the role played by our normal bacteria in both the development of disease and prevention from it,” he said.

“This may then provide the means to develop preventative measures for the disease.”

Professor Farida Fortune, Dean for Dentistry at Queen Mary said the research was encouraging in terms of understanding the way gum disease develops, there was still “some way to go” before there was a similar product on the market for gum disease as a probiotic yoghurt is available for the intestine.

“Now we know that periodontal disease only develops through P. gingivalis interacting with our normal bacteria in our mouths, we need to understand the role played by our normal bacteria: it’s a complex system, and for more than ten years, the theory ignited a heated debate; apart from the tools, there was no consensus on the overall ecology. It has a keystone effect in a community – working in the same way that starfish, which have a major effect on both the ocean and communities in the sea.

Professor Curtis said although the findings were encouraging in terms of understanding the way gum disease develops, there was still “some way to go” before there was a similar product on the market for gum disease as a probiotic yoghurt is available for the intestine.

“We’ve done a new reconstruction, and we’ve actually found that one of the teeth was in the wrong place. That’s for start-ers,” said co-author Prof Chris Stringer, from London’s Natural History Museum, in a BBC report.

“But we’ve also done a really detailed comparison, right down to the shape of the roots and internal pulp cavities. We’ve gone to microscopic details to show this really is a modern human. You wouldn’t find a Neanderthal fossil that had this many modern human features.”

The findings confirm that Homo sapiens shared the land with Neanderthals. Although this recent discovery will answer some burning questions, it simultaneously raises others such as how, and why, the Neanderthals became extinct. Could the Homo sapiens he blamed for their evolutionary cousins’ demise?

“What’s significant about this work is that it increases the overlap and contemporaneity with Neanderthals,” explained Dr Tim Higham, from Oxford University, who led the study on the British specimen found at Kents Cavern, Devon. The teeth and jaw fragment have been known about for decades, yet, it is now, thanks to modern technology and the team re-examining the shape of the teeth, including their internal structure, that scientists can reveal they are the earliest remains of Homo sapiens in Europe, and are 41,000 and 45,000 years old.

The findings confirm that modern humans were not alone when they conquered Europe and confirm that Homo sapiens shared the land with Nean- derthals. Although this recent discovery will answer some burning questions, it simultaneously raises others such as how, and why, the Neanderthals became extinct. Could the Homo sapiens he blamed for their evolutionary cousins’ demise?

“Those questions are likely to become even more difficult at a time when the NHS faces an unprecedented financial challenge,” he warned.

According to a report in Net Doctor, David Buck, senior fellow in public health and inequalities at the King’s Fund think-tank, welcomed the report and described the current lack of progress as “the most significant health policy failure of the last decade.” He has since urged MPs to act on the committee’s recommenda-

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The issue of health inequalities in today’s society has been causing a stir for some time, and now MPs have called for focus on the matter, and have claimed that greater efforts are needed to tackle the problem.

In a new report, which examines the government’s proposals for public health, MPs on the Health Select Commit- tee explained that the importance of improving health pro-

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BADN AGM votes to abolish post of chairman

BADN members voted to abolish the post of Chairman of Council, expanding the role of President to encompass the duties of Chairman. The Motion to abolish the post of Chairman, which was proposed by a BADN mem- ber and supported by several Council members, was debat- ed at BADN’s well-attended AGM – held at Dental Show- case on Saturday 22 October 2011 – and passed by a 96 per cent majority vote.

“BADN would like to thank past Chairman Tony McLean for her sterling work on behalf of the Association” said Presi- dent Nicola Docherty. “Angie has been a member of Coun- cil for more than ten years, having held the posts of Re- gional Coordinator, President, Chairman, acting Finance Of- ficer and Chair of the now-de-
Belmont’s FREE extended warranties will keep the nation’s dental surgeries working through tough economic times.
Lost in Ovid
Elaine Halley reveals the power of the username and passwords

With just over three months to go before the deadline for the final handing in of the dissertation, there is a slight sense of panic rising in me which I am struggling to keep down.

I fitted my complex case yesterday and remembered to photograph the laboratory work on the models before I bonded the case – thank goodness. I’ll be reviewing the case today so then all that’s left to do is upload the photographs and finish the write-up and reflection. My dental nurses asked me yesterday what I needed to do with this case for my MSc so I started to explain that I needed to provide a justification from the literature for every step of the treatment. Yes, you guessed it – I was still talking ten minutes later and their eyes had completely glazed over.

The deadline for the complex case write up has been extended to the beginning of December. So far, we have had feedback on our research question, our aims and objectives and 2,500 words of a literature review. It would have helped if I had actually read the guidance on the Harvard system for referencing as I got that wrong. I found the literature review to be a challenge which may be related to my choice of question and there being so many papers and tangents to explore.

The term ‘lost in Ovid’ has meaning to my fellow students. Ovid is the search tool used through the Manchester University Library that searches Pubmed and other databases. What tends to happen is that you find a paper of relevance, and then you find the references of that paper. Then you go down a trail of institutional log-ins trying to source the article in free-text. Whilst doing that, you come across other relevant articles and references which distract you from the original quest and before you know it three hours have gone by and you have a stack of references that may be marginally relevant to your research question. It does feel akin to a labyrinth and maybe a trail of white pebbles would be appropriate.

However, I must give some credit here to the system. I am absolutely in awe of the fact that armed with my University of Manchester username and password I can access all sorts of academic sites across the globe and full text articles from worldwide at the touch of a button and from the comfort of my sitting room.

Meanwhile, the current topics are 3,500 words on Methodology and 1,000 on data handling and STATISTICS. The hot topic of conversation is how on earth does anyone figure out how to calculate the sample size?! We have hand-outs and web links and examples but I still am none the wiser.

About the author
Elaine Halley BDS (Dip GP) (UK) is the BACD Immediate Past President and the principal of Cherrybank Dental Spa, a private practice in Perth. She is an active member of the ACD and her main interest is cosmetic and advanced restorative dentistry and she has studied extensively in the United States, Europe and the UK.
A royal encounter

In the second part of our look at Sir Harry Baldwin Laura Hatton uncovers his role as the Royal Family's dentist

I n last month's article I ventured into the history of World War I and revealed the incredible story of Sir Harry Baldwin and his involvement with the maxilla facial hospitals in France and Britain. However, this was only a fraction of Harry's life; the other part of Harry's career was intertwined with royalty.

A royal way

The path which led Harry to the halls of Buckingham Palace began early during his training and undoubtedly through his hard working and accomplished character. By day Harry would train and refine his skills in dentistry at the Royal Dental Hospital and Schools but by night he would fall into the role of doctor, expanding his wealth of medical knowledge at the Middlesex Hospital. During these schooling years, Harry surpassed his peers and excelled in the classroom. His focus and classroom excellence earned him the Saunders Scholar, a scholarship that was an honour for any student. Funded by Sir Edwin Saunders, who was at the time dentist to Queen Victoria and Prince Albert, the Saunders Scholarship was a lifeline into the dental profession, and for Harry it most certainly became a helping hand in getting his ‘foot in the door’.

With the Saunders Scholar under his belt and a great understanding of dentistry fast developing, (and not to mention a prize for practical surgery) Harry was an employer's dream. After qualifying in 1884 he was employed to work in the famous dental practice of Sir John Tomes in Cavendish Square (the gentleman who was referred to by Sir D'Arcy Power, in the Dictionary of National Biography, as the gentleman who “began to practise dentistry when it was a trade, and... left it a well-equipped profession.”). During these years Harry not only completed his medical training, but he also met his future wife, a dental nurse named Lucy White, whom he married in March 1914 just before the outbreak of World War I.

Working alongside Sir John's son, Charles, (an exceptional dentist who was later awarded the John Tomes Prize) Harry's career was progressing into a prosperous profession. From 1891 to 1899 Harry shared his expertise and knowledge with the Royal Dental Hospital as assistant dental surgeon where he was “vividly remembered” as the man whose “self-reliance and keen analytical acumen” helped several junior surgeons through “many a difficult case.”

Harry's career was thriving, and it was with much esteem that within a decade Harry found himself embarking on a Royal mission which led him into the halls of the Royal household.

Making impressions

And so it was that Harry was appointed to attend to Queen Victoria's dental needs in her final years. And although this information was not well known, he also held a similar post in the household of King Edward VII.

There were, however, other remarkable stories regarding Harry's royal post. During my research I interviewed Richard Fowler, who is the godson of Harry's only child. As Richard divulged on the past and the incredible history of Harry, he narrated to me of one of his childhood memories:

“Our two families knew each other since 1909. I knew Sir Harry's wife, Lady Lucy Baldwin and I recall holding the mouth impressions of Queen Victoria. When Lucy died, my godmother Mary gave a lot of Harry's equipment and mouth impressions to Dental College London – I believe that the impression of Queen Victoria's mouth went there.”

The story was intriguing and encouraged me to find out more regarding this particular encounter between Queen Victoria and Harry. Although the research got off to a shaky start, with the impression of Queen Victoria's mouth misplaced somewhere amongst a pile of archive material (or left to the services of Harry, who was personally called upon by Queen Victoria. With little hesitation in granting her consent for Harry to take an impression of her lower jaw, Harry used his skills and professional know-how, and unlike no one else of that time, fitted the Queen with a lower denture.

A presidential career

Harry's career continued to excel in every direction; in 1912 he was elected president of the British Society for the Study of Orthodontics, and for many years was treasurer of the British Dental Association. In 1915 he was appointed president of the Metropolitan Branch of the British Dental Association, and in 1915 of the appointed president of the Odontological Section of the Royal Society of Medicine.

Alongside his growing collection of titles, Harry's familiarity and trust with the Royal Family continued to develop, and as Richard explained during our interview, Harry not only had a growing passion for art, but he had also become a personal favourite of Queen Mary and quite a hero (in relation to her teeth) too.

The letters

It would seem that Harry's charming manner had a way of instilling a level of trust in his Royal patients and for a number of years Harry attended the King and Queen regularly at both Buckingham Palace and Balmoral. His accomplished manner and charm meant that Harry was often invited to social court events and after finding that Queen Mary had a love for antiques, Harry struck up a friendship with the Queen, where their correspondence led to a number of exchanges and notes.

Throughout my research I was granted access to a number of letters of correspondence between Queen Mary and Harry's wife, Lady Lucy.
It seems that these days the old adage ‘the customer is always right’ is becoming obsolete, as many businesses sacrifice customer service for the sake of budget cuts. However, at The Dental Directory customer service is still the number one priority and it is this attitude to personalised care that has earned the company a reputation for excellence and over 50% of the current market share in Dental Supplies.

It is not just this area that the company excels in, for The Dental Directory also provides a first class equipment service for surgery planning and supply. Here Shilpa Chitnis, of Dental Concepts in Hampshire tells us about her experiences of working with The Dental Directory on their recent surgery project.

“During the time I was an associate, the practice I was at used The Dental Directory so I have been dealing with the company for over six years. I now own Dental Concepts and, after my previous experiences, was only too pleased to continue the association. I have worked with The Dental Directory as a practice owner for around ten months now.”

Shilpa recently undertook a refurbishment of the practice after taking over as owner and utilised the services of The Dental Directory in both an advisory and supply capacity. After extensive consultation, The Dental Directory supplied Shilpa with a new state-of-the-art Anthos surgery and the latest equipment and Modwood cabinetry for her decontamination room. When making such large purchases, it was important to Shilpa that she dealt with a reputable and efficient company.

“I was dealing with three or four companies at once during the refurbishment so the whole thing was rather complicated, but throughout it all my Dental Directory Equipment Consultant, Martin Gregory, was fantastic and made the process so much easier. The Dental Directory offered good prices on all the items I needed but to be perfectly honest I have stayed with this company not for the prices, but for the service. The customer care I receive is outstanding and that alone is worth its weight in gold! If ever I need something or have a question, my phone calls are answered within three rings, my messages receive an immediate response and any information or brochures requested are received within 24 hours by email, fax or post. The response time is exemplary, which is of particular benefit to me as a practice owner as I have dealt with companies in the past that take three days to get back on my queries and often don’t have any answers when they do. The Dental Directory has obviously realised that going the extra mile for its clients makes good business sense as it ensures customer loyalty.”

Even if Shilpa requires something outside of The Dental Directory’s remit, she can still rely on her Equipment Consultant to help her with this and any other queries.
“Martin liaises with other companies and arranges for their representatives to call me, which really takes the hassle out of dealing with a new business. The refurbishment was a big job and the equipment was a massive investment but I really came to trust Martin as he was always honest and always on the end of the phone when I needed him.”

The Dental Directory offers a full equipment service from installation to aftercare with in house specialists on hand to answer any questions. Mohammed Latif, is the resident digital imaging expert with over 15 years in this field. Shilpa was extremely happy with every aspect of the service she received and to know expert help was always on hand.

“When I was choosing equipment for the surgery the most important thing The Dental Directory did for me was listen. Martin really listened to everything I had to say and took note of all my requirements. He even spent two hours discussing the project with me one evening after practice hours, when many of the companies I had previously spoken to refused to come out after 5pm. It was a great relief knowing the The Dental Directory was willing to work to my schedule and that there was someone there to guide me every step of the way.”

The Dental Directory as a whole, and by Martin Gregory in particular, has been outstanding. The refurbishment was very recent but already the aftercare I’ve received has been excellent. Ask me again in six months time and I’m certain the answer will be the same. I spoke to Martin over thirty times before making any decisions about the equipment I wanted and he was endlessly patient! He never pushed me to buy anything and he never had any guarantee that I would even go through with the purchase, yet was still there for me at every turn. I will continue to work with The Dental Directory on both large and small orders because I firmly believe that they will endeavour to do their best for me and my practice.”
and Harry; some regarded visits to Buckingham Palace to treat irritated teeth, and in others Queen Mary discussed with Harry oral health products.

One of these letters, dated Feb 4th 1915, was an apologetic request from Queen Mary for Harry to come and visit her. The letter read:

“I am so sorry to trouble you but will you please come to see me tomorrow. The other tooth with its cement has given way, and you must please mend it! It is so unsightly!”

Splendid job
And so it was that Harry did a rather splendid job and was gracefully thanked for the “trouble [he had] taken.” Soon his involvement with the Royal Family comprised of assisting with the choice and supply of tooth cleaning powders and toothbrushes and as the letters illustrate, Harry offered Queen Mary advice and various cleaning equipment in which to look after her teeth.

Harry continued to treat the royal family with great honour and skill, and what is most valuable in understanding the workings of a royal dentist is that Harry recorded some of his more memorable visits in a day-book. How- ever, the enjoyment of this discovery has been somewhat short-lived, as the book itself has proven difficult to find, although there remains an account from a previous researcher, Jane McBretney. In her article, Jane described how the day-book was always kept at Harry’s side, ready to “jot down all manner of amusing incidents, observations and limericks which appealed particularly to his sense of humour.”

Surgeon dentist
After many years of service, Harry was appointed as Surgeon Dentist to King George V in 1918 and on his retirement in 1926, Sir Harry (as he was called after his knighthood following his work during the war) was given the title Honorary Surgeon to the king.

A dental pioneer
And so it was that Harry became not only a famous face, but a loyal and trusted one too. As Richard proudly explained, Harry was a pioneer in dentistry; not only was he one of the first pioneers to take part in the innovation of Paris impressions, but he also initiated the development of crowns. What’s more, he also invented a new amalgam for his time, which was universal- ly used and resulted in saving large numbers of apparently hopelessly decayed teeth.

And yet his passion didn’t stop there.

Next month is the final instalment of Sir Harry Baldwin’s history and I will be bringing back to life Harry’s messages on the relationship between diet and oral health. Although Harry uncovered the relationship almost 100 years ago, his ideas and beliefs are still being widely discussed today and most importantly, they are being proven.

Acknowledgements
I would like to thank Richard Fowler for giving me the opportunity to write this article and for the resources that he donated to King’s College London.

I would also like to thank the staff at the Archive Department at King’s College London for their help and guidance whilst completing my research.

Quotations courtesy of King’s College London
Images courtesy of Richard Fowler
Association of Dental Implantology
UK welcomes new President

The surgical microscope
John Woods on improved precision

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EAO 20th annual meeting in Athens a success story

The European Association for Osseointegration (EAO) held its 20th annual scientific meeting in Athens on October 14, 2011. At the congress, the EAO Junior Committee elected a new Chairman, Dr Theodoros Kapos, and despite announcements of Greek strikes, the EAO congress was attended by approximately 3,000 clinicians and researchers from all over the world.

Dr Kapos is very proud to have been elected as the new Chairman. “I am very much looking forward to my new role in the Junior Committee,” says Dr Kapos. “Isabella Rucchieta has done a terrific job. I look forward to continuing her initiatives.”

The overall theme of the ADI’s mentor training course at Salford University. He has authored the Foundation Course for Arts, the ADI’s online education resource, and is Chairman of its Editorial Board. Prof Ucer, a specialist oral surgeon, is the Clinical Lead of the Diploma/MSc Programme in Implant Dentistry at the School of Health Care Professions of University of Salford and a member of the Faculty of Examiners for the Diploma in Implant Dentistry of the RCS Eng.

His current clinical research interests include immediate implant placement and the effect of bone density on success of implant treatment. He is a member of a research team at University of Salford, which received a substantial MRC grant for the investigation of use of laser technology for the assessment of bone density. Academically, he has gained European recognition for his work in the development of a new framework for teaching and assessment of clinical competences in implantology. He is a co-author of the consensus paper produced by the Association for Dental Education in Europe (ADEE) as part of the first Pan-European collaboration between EU Universities to establish common training and assessment standards in dental implantology.

Prof Ucer is looking forward to working with the newly elected Board over the next two years to steer the ADI through many challenges and exciting new projects. He is also looking forward to working with the members and younger colleagues whose participation on a local and national level will be crucial for the future of the ADI and implantology in the UK.

The top countries represented are host country Greece, Switzerland, Italy and Sweden, followed by Japan, the Republic of Korea and China.

EAO 20th EAO congress was treat- ment planning in implant den- tistry. As dental implants are now considered a widely ac- cepted form of treatment, it is crucial that the state-of-the- art solutions they offer meet patients’ expectations. Accord- ing to Professor Soren Schou, President of the EAO, good treatment planning should en- able dental professionals to cre- ate appropriate treatment plans for every patient.

At the congress, a world- class faculty of more than 80 speakers and chairs shared their scientific and clinical knowl- edge, providing evidence-based guidelines and practical advice. “The EAO is very pleased with the high-level presentations and scientific work showcased. Yet, we face many more challeng- es in clinical research. Many speakers’ conclusions are that even more research is needed to be able to generate consen- sus statements,” state Professor Friedrich Neukam and Professor Asterios Doukoudakis, Chairmen of the Scientific Com- mittee, said.

“We are very happy to wel- come this large number of pro- fessionals, many of whom are nationally or internationally renowned scientists and clini- cians,” added Professor Neu- kam and Professor Doukouda- kis. The EAO has registered up to 5,000 attendees from more than 70 countries around the world. The top countries repre- sented are host country Greece, Switzerland, Italy and Sweden, followed by Japan, the Republic of Korea and China.

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At The Dental Directory, we have always understood the need to offer the very best price to our customers. The need to keep costs as low as possible is an intrinsic part of our business philosophy – and never more so than in the current economic climate.

Our new Value PLUS promotion is a further example of this philosophy in action. Value PLUS is the largest promotion we have ever run – offering unbeatable prices on thousands of essential everyday products. Our new Value PLUS flyer shows massive savings of up to 51% compared to Henry Shein Minerva catalogue prices*.

Plus, for added peace-of-mind we have our Price Match policy. Price Match ensures that we will match any nationally advertised price on all like-for-like consumables, sundries and materials products.

How do you measure Value?

Savings of up to 51%*

Our new Value PLUS promotion is a further example of this philosophy in action. Value PLUS is the largest promotion we have ever run – offering unbeatable prices on thousands of essential everyday products. Our new Value PLUS flyer shows massive savings of up to 51% compared to Henry Shein Minerva catalogue prices*.

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1000’s of Products on Promotion!

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We will match any nationally advertised publisher price.
A key indicator of overall value is the level of customer service provided. The Dental Directory prides itself in giving the very best sales and after-sales service. Each of our highly trained sales teams cover a particular region of the UK and consist of both office-based and field-based personnel who work closely together.

This continuity enables us to provide a more personal service, gives us a better understanding of your requirements and ultimately builds a much stronger business relationship. We have over 50 field-based Business Consultants, Equipment Engineers and Product Specialists on-hand to offer advice, support and access to a variety of cost saving programmes.

In the last 4 years alone, The Dental Directory has invested over £4.5million in stock control and warehousing systems that have virtually eliminated back orders and picking errors – meaning that 99.6% of all orders are picked and dispatched same day for free next day delivery. This on-going re-investment ensures that we can deliver the very best service to all our customers.

In keeping with our policy of investing back into the dental profession, and to mark our 40th anniversary, we have just funded The Dental Directory Chair in Primary Dental Care at Warwick Medical School. This is just one example of The Dental Directory’s commitment to supporting the aims and objectives of British Dentistry – a commitment that has seen an investment of over £1million in the last 2 years alone.

How about all three!

Combine Price, Choice and Service and we believe you have the best overall value of any dental dealer in the UK. Whether it be prices and promotions, product choice, or levels of service; through cost-control, investment in new technologies and the belief in putting customers ahead of shareholders, The Dental Directory offers unbeatable value.

For further information on how The Dental Directory can help your practice, speak to your local Business Consultant or call FREE on 0800 585 586

Trust...
Great hospitality - nine hours CPD, two flights and a pigs head...

Adrian Binney describes the great hospitality he received when attending a two-day CAMLOG Soft-tissue Course in Wimsheim, Germany

On Thursday evening our flight, arranged by Cambridge Innovation, arrived at Stuttgart from where we were transferred to Wimsheim, manufacturing home of CAMLOG, located on the northern edge of the Black Forest. After a short transfer we checked into the 18th Century hunting lodge that was to be our base for the next couple of days. In this rustic atmosphere we sampled a late dinner of regional cuisine from the Swabian region. And so to bed, for we were transferred to Wimsheim from where we arrived at Stuttgart from where we were to practice the next morning.

The session ended when Professor Hildebrand summarised events and wrapped up a busy day, promising that questions could be answered in more convivial surroundings as he was joining us for dinner.

The following morning more ‘patients’ were waiting for us. This time pig’s jaws were provided, as we were to learn and practice soft tissue techniques around teeth: graft harvesting and management of several flap techniques, and careful soft tissue management.

Following lunch on this second day, we had the opportunity to take a look at one of the largest and most successful implant systems in Europe. CAMLOG, a name not so widely known in the UK, is one of the most modern implant manufacturing facilities in Europe. CAMLOG, a name not so widely known in the UK, is one of the largest and most successful implant systems in Europe. Currently number one in Germany, CAMLOG doubled the size of their manufacturing area last year and, frankly, the factory tour was impressive. Many dentists believe that it is a simple process to turn a titanium rod into an implant, but we got to see just what was involved and I can tell you it takes nearly three months to turn that piece of titanium into a surgically sterile implant. The level of careful product assessment at each stage of manufacture and the care with which the products were packed and sterilised was excellent.

By this time we had gathered as a group and the transfer to the airport passed in no time. However, our hosts had one last treat for us on the journey back to the airport – a guided tour of the fascinating Porsche museum.

In the monolithic, virtually floating exhibition hall we saw more than 80 vehicles. In addition to world-famous, iconic vehicles such as the 356, 550, 911, and 917, we saw exhibits explaining some of the outstanding technical achievements of Professor Ferdinand Porsche.

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The surgical microscope in implant dentistry

John Woods on improved clarity and improved precision

Whilst the value of the dental microscope is widely acknowledged across the treatment spectrum, its impact has been most keenly felt in the field of implants.

Implant dentistry is one particular application where the introduction of the microscope has brought significant benefits to every phase of the treatment protocol. Implant treatment may take place over several weeks and involve delicate and complex surgery where absolute clarity of view is vital to achieve the optimum outcome with minimal peripheral tissue damage or invasion. Studies have demonstrated that the accuracy of such procedures is almost always improved when surgeons enlist the aid of a microscope, a clear indication that employing microsurgical techniques in implantology offers advantages over more traditional methods. The surgeon is able to place the implant through a relatively minute incision in the gingiva, thus minimising tissue trauma and significantly reducing the pain experienced by the patient; healing and osseointegration are both expedited, and overall aesthetic results enhanced.

A high specification, high magnification microscope is especially valuable in more challenging cases involving, for example, sinus elevations or the need to place implants proximal to other sensitive anatomic structures. The current generation of advanced microscopes allows unimpeded stereoscopic vision whilst dedicated illumination enables the delivery of high-contrast, true-colour images of even the most inaccessible areas to be viewed with clarity and in comfort. These state-of-the-art microscopes feature lenses of supreme precision which incorporate apochromatic technology to eliminate chromatic aberration, and filters which not only prevent premature curing but can enhance the visibility of specific tissue types.

A modern dental microscope offers more than simply a hugely magnified image of the treatment site. The combination of magnification with intense, shadowless, panoramic illumination from an integrated co-axial light source brings into view features previously imperceptible, even through the use of dental loupes. Typical benefits include enabling more accurate drilling of the lateral socket wall to achieve greater stability for the implant, leading in turn to more accurate alignment and the promotion of op.

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‘Advanced instruments and equipment are vital to ensure a practice’s continuing success’

Surgical microscope

‘Advanced instruments and equipment are vital to ensure a practice’s continuing success’

dental microscopes are easy to control and react intuitively to minimise procedural disruption. Complex surgery demands intense concentration, and the more sophisticated microscopes offer versatile mobility and superb operational convenience through the incorporation of a MORA (Mechanical Optical Rotating Assembly) interface. MORA enables the practitioner to reposition the microscope with one hand, whilst still remaining comfortable, regardless of any change in the viewing angle. Motorised adjustments of the focal length and a range of focal distances allow practitioners to work at their own ideal working distance and with magnification options such as a five-step magnification changer a detailed, close-up view can easily be alternated with a complete site overview.

The acquisition of a surgical microscope with its provision of vastly enhanced visual acuity instantly increases the practitioner’s range of treatment options, and many dentists have found that microscopic examination methods have transformed both the accuracy of their diagnoses and their working methodology. It’s also true that in a competitive environment, and with a technologically aware public, advanced instruments and equipment are vital to ensure a practice’s continuing success. However, the purchase of a microscope, with all the potential it offers to exploit the latest treatment techniques, is usually a one-off occasion, and both the unit itself and the supplier should be chosen with care.

Progressive practitioners in every dental discipline owe it to themselves, their practices and their patients to investigate the benefits of investing in a quality dental microscope.

About the author

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Chief Executive Officer of Nuview Ltd. For more information call Nuview on 01453 872266 or email info@nuview-ltd.com

www.voroscopes.co.uk
Laser ridge preservation

Dr Darius Moghtader describes an alternative treatment option

The following article describes an alternative treatment option to reduce bone resorption post-tooth extraction with the help of laser technology and autologous materials, thereby creating the optimal conditions for implantation.

Many prosthodontic dentists are familiar with the problem of the crucial buccal lamella being partially or completely resorbed within six weeks post-tooth extraction. This resorption then leads to subsequent implantation problems. Treatment of insufficient bone is attempted via expensive and cumbersome bone augmentation procedures either during or before implantation.

Numerous procedures have already been introduced to prevent this bone resorption: from direct implantation to filling the alveole with materials of different origins and frequently additional membranes to cover the introduced material.

This costly bone graft procedure, usually using foreign materials, can unfortunately lead to unforeseeable results, ranging from very good to very poor. Aside from the often-mentioned risks related to bone substitutes of human or animal origin, it is very disagreeable to find non-osseointegrated bone replacement material instead of the desired newly formed bone during implantation and being worse off than without the procedure.

Amongst some surgical colleagues, the phrase ‘party crasher’ is used, ie the bone formation party fails to happen. Unfortunately, even immediate implantation, which would help in most cases, is often no solution, because infection, insufficient treatment time, unsuited implant systems, and especially the legally uninformed patient are obstacles to an immediate implantation.

Even if immediate implantation is a success, the results are not reliably predictable, especially with regard to aesthetics. For these reasons, I searched for an alternative, affordable, fast and non-cumbersome procedure using autologous materials to reduce bone resorption and create optimal conditions for subsequent implantation.

This procedure, elap-rp (elixion laser-assisted protocol-ridge preservation), will be presented in this article.

Theoretical reflections

Romanos demonstrated in his study with a high-performance Nd:YAG laser that a laser cut heals distinctly slower than a

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silicone membrane and therefore scar free. After three weeks, at the earliest, the laser cut is completely healed. It is assumed that thermal damage to the external epithelial layer slows the healing process. This undesired result occurs with every thermal laser and therefore with an undesired, related tissue carbonation.

**Effectively slowing healing**
The effect described is of use to the experienced laser operator during de-epithelialisation of movable mucoperiosteal membranes for controlled reproduction of attached gingiva. The de-epithelialisation area acts as the barrier that slows the healing process. In brief, the area treated with the high-performance laser acts as a natural, resorbable, highly effective membrane with all known advantages.

Fig 1 Membranisation

![Membrane](image1)

Fig 2 Condition after extraction

![Extraction Site](image2)

Fig 3 Launch of glass rod from laser

![Laser Treatment](image3)

Fig 4 Elap-rp membrane

![Membrane](image4)

Fig 5 Situation after three days

![Temporal Healing](image5)

Fig 6 Recall after four weeks

![Follow-up](image6)

Fig 7 Four weeks after elap-rp

![Healing Process](image7)

Fig 8 Six weeks after elap-rp

![Long-term Healing](image8)

Fig 9 Directly after x and elap-rp

![Immediate Healing](image9)

Fig 10 Situation after twelve weeks

![Final Healing](image10)

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ond important factor for optimal bone regeneration is blood, as already conclusively presented and practised by Schulte with autologous blood coagulum of cysts. If the vestibular lamella can be retained during tooth removal, when compared to a hexagonal cube, it is about a defect in five of the sides and a missing “lid”. This can be compared to a cyst defect; the sole difference being that no primary wound closure can be achieved without otherwise unnecessary addi-

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Fig 4 Elap-rp membrane

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Dr Max Cohen presents a clinical case

Immediate restoration in the fully edentulous maxilla region

This clinical case required optimal implant placement based upon a restoratively driven treatment plan and guided surgery. To achieve this goal, we made use of CT scans, SimPlant planning software, the new Zimmer Guided Surgery Instrumentation and the new Immediate Smile model. The patient was a 49-year-old white female in good health, completely edentulous in the maxilla and wore a complete upper denture. On the lower jaw, she wore an implant-retained over-denture.

The planning phase for the case began with a CT scan utilising the i-Cat and the Dual Scan protocol. The patient’s existing denture was transformed into a scan prosthesis by gluing eight Dual Scan Markers onto the surface. A radiolucent bite index was made to secure the prosthesis in the correct position.

The patient was first scanned in the i-Cat 17–19 while wearing the conversion prosthesis and the bite index. In a second scan, the conversion prosthesis was scanned alone. The resulting CT data was loaded into SimPlant, and the scan prosthesis was superimposed upon the study using the SimPlant Dual Scan wizard (Fig 1).

Using SimPlant, the optimum implant positions were determined, based upon available bone with a minimum of 3mm between implants, and the design of the final restoration (Fig 2). The resulting treatment plan was submitted for fabrication of a SurgiGuide and an Immediate Smile model.

I received the Immediate Smile model, which contained a duplicate of the scan prosthesis, a bone model with a silicone soft tissue, and a mucosa-supported SurgiGuide. The bone model came with eight openings corresponding to each of the eight implant positions as designed in the SimPlant plan and corresponding exactly in size to the dimensions of Zimmer analogues.

The bone model came with a screw fixation system, which...

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allowed me to recover the analogues. The silicone soft tissue on the model also corresponded to realistic soft tissue. I also received written drilling instructions and a prolongation report detailing the depth and size of each osteotomy. Zimmer analogues were placed in the Immediate Smile model (Fig. 5). The duplicate of the scan prosthesis was used to mount the bone model with the soft tissue on an articulator (Fig. 4), giving correct orientation and vertical dimension.

This made it possible to fabricate a provisional that would be used for immediate loading following implant placement. The mounted model was then used to create an orientation jig for the SurgiGuide (Fig. 5). The jig assured that the SurgiGuide was positioned in the mouth exactly the same way as the scan prosthesis had been positioned in the mouth. This is a very important step for a mucosa-supported SurgiGuide because of the flexibility of the soft tissue (mucosa). Both the duplicate of the prosthesis and SurgiGuide fit perfectly onto the Immediate Smile model, allowing for fabrication of an accurate orientation jig on an articulator.

The surgical guide was placed in the patient’s mouth, and the tissue was punched utilizing a tissue punch (Figs 6–8). Then, the surgical guide was again oriented in the patient’s mouth with the orientation jig created on the articulator and stabilised with three SurgiGuide fixation screws (Fig. 9). Utilising the Zimmer Guided Surgery Instrumentation and Guided Surgery drills (Fig 10), all eight osteotomies were created and completed using minimally invasive flapless surgery (Figs 11 & 12).

The Zimmer guide is a SAFE system, accurately providing for depth and size. The right and left molar (teeth #5 and 14) osteotomies were created short posteriorly, using the new Sinus Crestal Approach Kit (Zimmer), I extended these two osteotomies into the left and right maxillary sinuses. Alloplastic bone (Puros, Zimmer) was placed into the sinus cavity through the osteotomies that did not involve the sinus cavity. Therefore, healing heads were placed on implants #3 and 14, and non-engaging titanium temporary cylinders were placed on #5, 6, 8, 9, 11 and 12 (Fig. 13). The provisional, which the laboratory fabricated, was attached to the titanium cylinders using cold cure acrylic, thus creating a screw-retained provisional (Figs 14 & 15). A post-operative CT scan showed how accurately the eight implants had been placed in the bone using a mucosa-supported SurgiGuide with orientation jig (made on the Immediate Smile model; Figs 16–18). The accuracy and success of this case was achieved through CT scanning, SimPlant planning with restorative model overlay, the Zimmer Guided Surgery Instrumentation and the Immediate Smile model. The surgical guide allowed for minimally invasive surgery and greatly reduced surgery time. The Immediate Smile model also reduced chair time by allowing for fabrication of the temporaries well in advance of surgery.

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Stop the world, I want to get off

Part I: Michael Young examines why so many dentists are leaving the profession

This is the first of two articles in which I aim to examine why so many dentists are considering leaving the profession. This notion is not based on any hard-and-fast ‘evidence’ or research, but on anecdotal evidence and hearsay. My assumption is therefore that there are a great many dentists who are disheartened, disillusioned, disappointed, or just downright unhappy with the profession. I want to explore ‘why?’ and then suggest ways in which you might overcome these feelings and perhaps begin to regain your enthusiasm.

At some point in your life you made a conscious decision to become a dentist, so the first question to ask yourself is: ‘What was my motivation?’ I was talking recently to someone closely connected with the dental school selection process, who told me that 20 or so years ago, when you asked someone why they wanted to be a dentist, the reply was nearly always because they wanted to care for people. Nowadays, they said, the answer is more likely to be that they want to own five practices, a big house and an expensive car! Avarice is never a good reason for entering a caring profession. To me, one thing should be common to all professions, and that is a desire to help people; the financial rewards are a consequence of that care and should never be the prime motivator.

Dentistry has undoubtedly changed in the last 20 years, but it will always be a caring profession, hopefully one that is populated by caring people. When you first decided that you wanted to be a dentist, were you doing it for the right reasons?

Ironically, many ‘caring’ dentists end up, almost by default, as business people, whether it is as principals or associates. Slowly the caring element that was initially so strong is forced to give way to a harsher financial reality. Some dentists struggle to come to terms with what they regard as two diametrically opposed concepts, that of caring for people and of having to make money. It has always struck me as odd that solicitors never seem to have any trouble talking about their fees (sometimes very large fees!) with their clients, whilst many dentists appear to have a sense of guilt about theirs. For dentists, this lack of confidence in one area can seriously undermine their confidence in others. Do the dental schools do enough to turn out well rounded dentists equipped for the ‘real’ world of dentistry? Of course not all dental graduates end up in practice, or even as clinicians, however, I suspect that most of the unhappy ones are in practice.
If you have lost your motivation, then ask yourself how, why and when did this happen. What happened to change the way you feel about being a dentist? Associates may be one step removed from the financial pressure of practice ownership, but the price they pay for this is a certain lack of control over their working life. It is often this lack of control that makes people unhappy in their work.

Associates become principals in the belief that they can regain some control over their destiny. Whilst to some extent this might be the case, there are still outside agencies and organisations to whom practice owners will always be accountable. The days when a dental practice and the people working in them are relatively free from outside ‘interference’ are long gone. Dentistry is now more highly regulated than it has ever been. There are inevitably those within the profession who resent this ‘outside interference’, but fight against it, accept it as part of what being a professional is all about.

For NHS practices, one of the biggest sources of dissatisfaction is the fee structure and the way the government keeps moving the goalposts. If you are someone who just wants to care for your patients, then you at least need to know that your bills can be paid and that at the end of each month there is enough money left for you to have not an extravagant lifestyle, then at least one that is comfortable and free of money worries. Whereas private practices don’t suffer government interference, they probably do share some degree of financial anxiety with their NHS colleagues.

I have thought on what I consider to be two key reasons why dentists become disillusioned with their job: a lack of confidence and a lack of control. I remember as a young dentist sometimes feeling intimidated by older, sometimes more highly educated patients, and thinking about how to explain the treatment I was planning to do for them.

The explosion of ‘internet knowledge’ means that nowadays everyone is a self-taught dentist! Increasing confidence comes with the experience and also with a lack of control, then at least one that is comfortable and free of money worries. Whereas private practices don’t suffer government interference, they probably do share some degree of financial anxiety with their NHS colleagues.

For the early part of my life as a practice owner I felt as if I had little or no control over my business. Realising this and doing something about it transformed not only the business, but also me. However, a more subtle change had taken place; I began to change the way I looked at things, and believe it or not, the things I was doing, they’ll feel the same thing. If you periodically take time to talk to your employees and praise them for the work they are doing, they’ll feel more valued and are more likely to work harder for you. I took control of my business because I learnt how to be an excellent manager, a people person, and a confident clinician.

My motivation for wanting to be a dentist had always been a desire to care for people; I very nearly lost this, and only fully returned when I controlled my business. My desire to now help dentists and to share with them the experiences of managing a practice was my motivation for writing a Genghis Khan way.

As an associate you may feel that you can never have any control over what happens in the practice in which you work. However, working with those who support the owner, and trying to understand their motivation and the day-to-day problems they face, is going to make your working life much easier. Change how you look at things and the things change.

There are inevitably many reasons why you might be thinking about giving dentistry up, out of necessity, very briefly. It was never meant to be an exhaustive list. Having made the case for reinvigorating your dental career, the next article will look at the options that might be available for those who for various reasons decide to leave the profession.

About the author

Michael Young is the author of the Diagram Prize winning Managing a Dental Practice the Genghis Khan way. He has over 20-years’ experience of managing a dental practice. He taught clinical dentistry at two dental hospitals. He was forced to retire from clinical dentistry because of ill health. He is now a writer and business consultant. During his dental career he was a member of the Chartered Institute of Management, the Chartered Institute of Marketing, and was the Secretary of the North East Region Committee of the Institute of Management Consultancy. Michael is a former Young Enterprise Business Adviser. He was also a member of the Export Winess Institute. His practice was one of the first to in the UK to be awarded the British Dental Association’s (BDA) Good Practice. He was also an Assessor for the Good Practice Scheme. Over the years he has published a large number of articles on various aspects of practice management and marketing in the dental press, and an article on report writing in the legal press. He is the author of How to be an effective expert witness, which is available on Amazon Kindle. Away from dentistry, Michael’s interests include archaeology, history and the arts. Apart from his undergraduate and postgraduate dental degrees, he also holds a BA from the Open University. Visit Michael’s web page at www.thegengishskhanway.com.
High Street mortgage trap for young dentists

A brief survey of five of the UK’s best known high street banks reveals that self-employed dentists who qualified in the last three years are likely to be refused a mortgage.

The fundamental problem we discovered is that these bank’s mortgage application criteria demands at least two years accounts and in some cases three years’ accounts. It appears that high street banks don’t appreciate that dentistry can be a financially rewarding career. Unfortunately most banks operate a rigid mortgage application process often resulting in rejection part way through.

Once your application has been submitted, or if you have applied for a ‘decision in principle,’ a credit check will often be performed. If you are later rejected because of a lack of accounts the credit check will remain on your record for other lenders to view.

A solution…

Persuading a high street bank to change their lending criteria is a non-starter. The most effective way to resolve this problem is to start with a lender who is sympathetic to your cause. Thankfully there are several lenders who appreciate the unique career path of a dentist and will accept this as a valid reason for your lack of accounting history. However, only a handful of lenders offer this flexible approach. A dental specific independent financial adviser will be able to select these ‘flexible lenders’.

In many cases we will have a hotline to the mortgage underwriter to enable an application to be sent with a pre-agreed ‘stamp’ of approval. This pre-agreement is vital to ensure the application can progress. Often we will aim to back your application with a letter from the practice principal confirming your anticipated income. There may also be a requirement to produce a letter from an accountant confirming your anticipated profits.

What can I borrow?

Broadly speaking a self-employed dentist will be able to borrow up to 4.5x joint incomes or 4x your single income. However the deposit required usually restricts the mortgage to less than this. You should work on providing at least a 10 per cent deposit.

Make sure you have considered the other things that will affect your application such as your credit profile and other financial commitments. For example taking out a large car loan prior to applying for a mortgage is likely to limit your ability to borrow. Make sure you are on the electoral role and have the ability to produce bank statements showing your regular income and financial commitments. Whilst student loans may be taken into account, from experience you won’t be penalised for having one.

So in summary approach the high street mortgage lenders with caution and seek specialist advice where possible.

About the author

Jon Drysdale is a director and independent financial adviser with Practice Financial Management Ltd (PFM). PFM present a financial planning and ‘business of dentistry’ sessions for a number of Foundation dental courses across the UK. PFM offer financial advice exclusively for dentists and also offer a dental accountancy service: www.pfmdental.co.uk and www.pfmtownends.co.uk.
Practice sale No-No’s!

Andy Acton from Frank Taylor and Associates takes a look at some of the many pitfalls to avoid when selling your practice...

I never fails to amaze me, but so many sellers still fail to take care of some of the most basic items before they try and bring their practice to market. I thought that I would take you through some of the biggest ‘no-no’s’ so that you won’t make the same mistakes.

1. DON’T discuss the potential sale with the PCT. Of course when you do this the PCT will be as nice as pie and full of good intentions. However, this may come back to bite you further down the line – do not do it.

2. DON’T sell to anyone who gives you a call! If you were selling your house, would you sell it to someone who phoned up and claimed they were the only people looking? I suspect not. In which case, don’t do it with your business. Corporates will call and try and offer a knock down price – make sure you promote to the entire market.

3. DON’T spend a small fortune on the internal decor. Interesting one this. I think with the plethora of property programmes on television offering good advice on house sales eg neutral colours, new paint, new carpet etc., many feel that the same is true of a practice. In our experience this isn’t the case. It must be presentable but it is less of an issue when buying a business rather than a residence.

4. DON’T be concerned about a slightly below average level of profit. In our experience, buyers often believe they can do better than the current owner and like to feel that there is room for improvement when they place their ‘stamp’ on the practice.

5. DON’T try and inflate the figures! Many purchasers will be wary about big changes in income and profit – especially big increases in income and profit the year before sale without good reason.

6. DON’T leave equipment that doesn’t work or redundant on display. Pretty straightforward – if it isn’t of any use, pack it away or get rid of it.

7. DON’T fail to plan in advance. A typical sale will currently take around 9-12 months. If you plan ahead and have two-three years you can make any relevant changes to the practice. Any less than this is unrealistic.

8. DON’T ignore contracts. Perhaps when you took your associate on it was done with a friendly chat in the lounge bar of the Dog & Duck! When it comes to selling a business, this will no longer do. A full legal document needs to be in place – they are an ‘asset’ of the business.

9. DON’T talk to the world and his wife. Whilst it is often useful to case opinion far and wide, the sale of a dental practice is generally not in this category. You tend to find that you will get five different opinions, many of which will be misinformed.

10. DON’T be uncooperative with potential buyers. As long as you have used an independent agent to ‘weed out’ time wasters anonymously, you should be as open as possible with serious potential buyers and communicate with them fully.

11. DON’T try and keep back certain items eg practice website. This can come up quite a lot and the simple answer is that the sale of a business includes everything. It doesn’t matter that your friend designed the website and you really like it; it is an asset of the business and included in the sale.

12. ALWAYS use specialists. Whether you’re talking about finance, solicitors or the agents who sell the practice, it is absolutely vital that you work with people who understand the potential pitfalls and how to avoid them.

Selling a business is a big undertaking and as the vendor you need to maximise your return on investment. Make sure that you don’t make any of these mistakes!
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**The Dentistry Show**

The Dentistry Show – two days for the entire dental team – is back in March at the NEC in Birmingham. Providing a stimulating range of debates, presentations, hand on theatre, debates, debate theatre, debates theatre and debates! The Dentistry Show is aimed at all dental professionals. It covers the business and management side of dentistry, it is an invaluable chance to focus on the future and prepare for the exciting and challenging times ahead.

Panel sessions and keynote presentations have been specifically designed for dentists, nurses, hygienists and therapists. The exhibition provides an excellent opportunity to network with key opinion leaders. Dr Michael Cahill, Director of the award winning Cahill Dental Care Centre in Bournemouth, Laban, London, will be chairing one of the debates.

“Everyone in the team forms key relationships with patients and has a role to play in the health of those patients. The opportunity to manage that relationship and to treat or running the practice smoothly.”

Despite the raft of expectations and advances, the Dental Show is no more taking place and is one of the most exciting dates on the dental profession’s calendar.

The Dentistry Show is at the NEC, Birmingham March 2nd and 3rd 2012.
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