Call to ban non-medics performing cosmetic surgery

Royal College of Surgeons calls for new professional standards

Only surgeons should provide cosmetic surgery and only doctors, dentists and nurses who have undertaken appropriate training should provide non-surgical cosmetic treatments such as Botox, recommends new professional standards for cosmetic practice. Currently certain cosmetic treatments can be administered by anyone, anywhere with no medical training.

The guidelines state that as standard practice, practitioners should discuss relevant psychological issues (including any psychiatric history) with the patient to establish the nature of their body image concerns and their reasons for seeking treatment. They should not at any point imply that treatment will improve a patient’s psychological wellbeing.

Aimed at all doctors, dentists and nurses involved in cosmetic practice, the document entitled Professional Standards for Cosmetic Practice focuses on the behaviour and competences of medical professionals should be expected to demonstrate when providing cosmetic procedures.

The standards, issued by the Royal College of Surgeons (RCS), state that financial deals such as time limited discounts should be banned and stringent psychological assessment promoted. They lay out the professional duty practitioners have to their patients, including the need to ensure they have a clear understanding of the risks of the procedure, outlining consequent aftercare and being transparent about costs from the outset.

Developed by a working group of key professionals including surgeons, psychiatrists, psychologists and dermatologists, key points in the professional standards include:

- Practitioners should not imply that patients will feel ‘better’ or ‘look nicer’, and should instead use unambiguous language like ‘bigger’ or ‘smaller’ to describe what that patient is trying to change.
- All practitioners should consider whether they should refer a patient to a clinical psychologist before proceeding with further consultations or treatments. Pre-procedure discussions should include the disclosure of relevant psychiatric history such as eating disorders and the practitioner should document any signs or symptoms of Body Dysmorphic Disorder. Psychological factors contributing to the motivation to undergo the procedure and expectations of outcome should also be assessed.
- Marketing and advertising must be honest and responsible, using only real patient photographs that have not been air brushed or digitally enhanced.
- The RCS recommends that only licensed doctors, registered dentists and registered nurses who have undertaken appropriate training should provide any cosmetic treatment.
- Only those who have qualified as a medical doctor and undertaken post-graduate surgical training should carry out invasive procedures such as breast surgery or liposuction.
First Green Dentistry Conference™ held

The Eco-Dentistry Association® has announced that it will hold the industry’s first dental conference devoted exclusively to high-tech, environmentally sound dental practices. The event will take place May 5 and 4, 2013, at the eco-friendly Robert Redford Conference Center in Sundance, Utah, part of the Sundance Resort. Attendance is limited to the first 100 registrants.

The 2013 Green Dentistry Conference™ will showcase the information and products dental professionals need to create and maintain state-of-the-art green practices. “A” List dental speakers include Gary Takacs of Takaes Learning Center, who will share the essentials of branding and marketing a green dental practice. The event’s keynote speaker is dental technology guru Marty Roth, noted sustainability author and speaker, who will lead a break out group called “Green Builds Business.”

The conference will offer panel discussions on everything from building and financing a high-tech, green dental practice to creating a successful green hygiene program. Unique, small group, hands-on opportunities with dental technology such as lasers and CAD/CAM systems will also be available.

The 2013 Green Dentistry Conference™ will offer attendees something rarely found at dental conferences: promoting the overall health and wellbeing of the dental team. There will be panel discussions on self-care and meditation will be available for all attendees and there will be presentations focusing on the importance of work-life balance to support personal and professional success.

On Sunday, May 5, attendees will have the option of hiking in the 6000 acres of pristine wilderness adjacent to the Sundance Resort, enjoying fly-fishing, golf or the spa.

Customisable sponsorship opportunities are available for companies offering green dental, green building, or wellness products and services.

Discounted early bird registrations open on Tuesday, January 22nd, 2013 at www.ecodentistry.org/conference. Contact info@ecodentistry.org

Soft drinks should have tooth decay warning

Researchers from the University of Adelaide say any health warnings about soft drinks should include the risk of tooth decay, following a new study that looks at the consumption of sweet drinks and fluoridated water by Australian children.

“There is growing scrutiny on sweet drinks, especially soft drinks, because of a range of detrimental health effects on adults and children,” says Dr Jason Armfield from the Australian Research Centre for Population Oral Health at the University of Adelaide’s School of Dentistry.

“ Tooth decay carries with it significant physical, social and health implications, and we believe the risk of tooth decay should be included in any warnings relating to sweet drinks,” he says.

Dr Armfield is the lead author of a new study published this month in the American Journal of Public Health, which looks at the consumption of sweet drinks and fluoridated water by more than 16,800 Australian children.

The study found that the number of decayed, missing and filled deciduous (or baby) teeth was 46 per cent higher among children who consumed three or more sweet drinks per day, compared with children who did not consume sweet drinks.

“Consistent evidence has shown that the high activity of many sweetened drinks, particularly soft drinks and sports drinks, can be a factor in dental erosion, as well as the sugar itself contributing to tooth decay,” Dr Armfield says.

“Our study also showed that greater exposure to fluoridated water significantly reduces the association between children’s sweet drink consumption and tooth decay. This reconfirms the benefits of community water fluoridation for oral health.

“Essentially, we need to ensure that children are exposed less to sweet drinks, and have greater access to drink fluoridated water, which will result in significantly improved dental outcomes for children,” he says.

“If health authorities decide that warnings are needed for sweet drinks, the risk to dental health should be included.”

Charity raises £40k

The Mouth Cancer Foundation, which has been providing information, support, and advice to mouth cancer patients and their families for nearly 20 years, launched its annual Mouth Cancer Awareness Walk in London’s Hyde Park on Saturday 22nd September 2012.

The Mouth Cancer 10 KM Awareness Walk has been designed to increase awareness and generate much needed funds to allow the charity to provide support for mouth cancer patients and carers.

Last September almost 800 people travelled to the capital to walk 15,000 steps it took to complete a 10 KM course. Together they celebrated survival, remembered lost dear ones and had fun. There were medals, T-shirts and goodie bags for everyone who took part.

The Mouth Cancer Foundation raised £40,000 from its 7th annual Mouth Cancer 10K Walk, which took place in London’s Hyde Park on Saturday 22nd September 2012.

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A study published in Annals of Oncology has revealed that acupuncture can relieve symptoms of xerostomia. Dry mouth is a common side effect of radiotherapy, and as many as 41 per cent can still be suffering from it five years after treatment.

Doctors at seven cancer centres in the UK recruited 145 people suffering from radiation-induced xerostomia. The researchers found there were no significant changes in saliva production; however individual symptoms were significantly improved among the group receiving acupuncture.

Dr Richard Simcock, one of the authors of the study, said: “The amount of saliva produced does not necessarily influence the experience of a dry mouth. Xerostomia is therefore an entirely subjective symptom – it is what the patient says it is, regardless of salivary measurement.”

The researchers say that further studies are needed to refine the acupuncture technique, but they believe that it could be easily incorporated into the care of patients with xerostomia.

So, if you’ve never experienced a webinar, take a look at www.dentalwebinars.co.uk register and take a look at the archive. Here you will be able to watch the format and get a feel for how they work before embarking on your first live experience!

Upcoming webinars include: Feb 21 Anthony Roberts The clinician’s role and patient’s responsibilities in the management of periodontal disease; Feb 26 Anoop Maini Short Term Orthodontics for the GDP; March 5 Colin Campbell Getting Serious about Implantology with the ITI See you at the webinar!
Antibacterial agent found in freshwater lakes

New study conducted by researchers at the University of Minnesota, has shown that the common antibacterial agent triclosan, used in soaps and many other products is found in increasing amounts in several Minnesota freshwater lakes.

In addition, the researchers found an increasing amount of another chemical compound called chlorinated triclosan derivatives that form when triclosan is exposed to chlorine during the wastewater disinfection process. When exposed to sunlight, triclosan and its chlorinated derivatives form dioxins that have potential toxic effects in the environment. These dioxins were also found in the lakes.

Triclosan was patented in 1964 and introduced into the market in the early 1970s. Since then it has been added to many consumer products including soaps and body washes, toothpastes, cosmetics, clothing, washing up liquid, and kitchenware. Beyond its use in toothpaste to prevent gingivitis, the U.S. Food and Drug Administration has found no evidence that triclosan in antibacterial soaps and body washes provide any benefit over washing with regular soap and water.

The researchers studied the presence of triclosan in antibacterial soaps and other products and its chlorinated derivatives in various sizes throughout Minnesota with varying amounts of treated wastewater input. Sediment collected from large lakes with many wastewater sources had increased concentrations of triclosan, chlorinated triclosan derivatives, and triclosan-derived dioxins since the patent of triclosan in 1964. In small-scale lakes with a single wastewater source, the trends were directly attributed to increased triclosan use, local improvements in wastewater disinfection since the 1960s. When UV disinfection technology replaced chlorine in one of the wastewater treatment plants, the presence of chlorinated triclosan derivatives in the sediments decreased.

In the lake with no wastewater input, no triclosan or chlorinated triclosan derivatives were detected. Overall, concentrations of triclosan, chlorinated triclosan derivates, and triclosan-derived dioxins were found to be low, indicating that triclosan use in Minnesota is currently limited.

Denplan Launch NHS Viewpoint Seminars

Denplan has launched the UK’s biggest debate to discuss the new NHS contract with both UK-wide seminars and a discussion forum to encourage dental professionals to have their say.

Denplan’s Viewpoint Seminars have been arranged around the country so that dental professionals can receive some much needed clarity on how the new contract will mean for them and their practices and have their say in the matter, so I would urge everyone to get involved.

Dates for the Seminars are as follows:
- Wednesday 20th March - Hilton Dartford Bridge, Dartford
- Monday 25th March - Thorpe Park Hotel, Leeds
- Tuesday 26th March - Kilworth House Hotel, Leicestershire
- Tuesday 16th April - Village Hotel, Cardiff
- Wednesday 17th April - Holiday Inn (Grove Road), Basingstoke
- Tuesday 30th April - Copthorne Hotel, Manchester
- Wednesday 15th May - Newcastle Marriott Metrocentre, Gateshead

For more information about the Denplan Viewpoint Seminars, please call 0800 889 5987 or email events@denplanviewpoint.co.uk, or to join in the debate, please visit www.denplanviewpoint.co.uk.

VLA Healthcare withdraws Sharps Terminator®

Sharps Terminator® has been removed by the General Dental Council (GDC) following a public hearing into allegations he made false claims to the NHS about treatment he had given to 45 different patients.

The allegations heard by the GDC's Professional Conduct Committee are in connection with incidents that happened between 2000 and 2011 when Edward Mills (Registration No.69243) was working at Truro Dental Care, 57 Lemon Street, Truro, TR1 2NR.

The Committee found that Mr Mills made a number of dishonest claims to the NHS for remuneration. He claimed for posting out oral hygiene leaflets to patients, along with oral health “passports” and prescriptions for fluoride products. The Committee found that Mr Mills had known that he was not entitled to make claims to the NHS for these activities.

In considering this case, the Committee noted: “Mr Mills’ dishonesty was not an isolated incident. He made a series of dishonest claims over a period of many months. Although the amount of money he gained was relatively small (£4,000), that money was wrongly diverted from the public purse and was not used to provide NHS treatment to patients as it should have been, thus depriving patients of NHS dental care.”

In the circumstances the Committee determined that the only appropriate and proportionate sanction, to maintain the standards of the dental profession and public confidence in it, was that of erasure. Unless Mr Mills exercises his right of appeal, his name will be erased from the register in 28 days’ time.

More details can be found on the GDC's website.
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Free to attend
www.thedentistryshow.co.uk/leaders

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Hosted by Raj Rattan with presentations from Nilesh Parmar & Prem-Pal Sehmi, Kevin Lewis, Elaine Halley and Daz Singh
Drill-less technique a hit in New Zealand

New Zealand dentist has found that children prefer the ‘Hall technique’.

Dr Lyndie Foster Page, head of preventive and restorative dentistry at the University of Otago Dental School, and colleague Ms Dorothy Boyd, a specialist paediatric dentist, trained 10 Hawke’s Bay dental therapists to use the new Hall technique as part of a feasibility study funded by the Health Research Council of New Zealand.

The Hall technique, developed by Scottish dentist Dr Nor- na Hall, involves placing a stainless steel crown over a baby molar tooth to treat tooth decay in, rather than the conventional method of removing the decay with a drill and then placing a filling. Starved of nutrients, the decay then stops or slows down. The crown stays in place until it falls out naturally with the tooth at about age 10.

Of the nearly 190 children between five and eight years old who took part in the Hawke’s Bay study, just over half were Māori. Nearly 100 children received treatment for their decayed teeth using the Hall technique, while the remainder were treated using conventional methods. Many of the children already had six or seven fillings in their mouth, and two-thirds came from low socio-economic status areas.

Dr Foster Page said the study showed that children treated in the new way (which doesn’t require anaesthetic) reported less dental anxiety than those who had received conventional care. Interestingly, almost all (90 per cent) of those treated with the Hall technique reported enjoying their clinic visit, among those conventionally treated, the figure was 52 per cent.

“A first, some parents were concerned that people might judge children who had these crowns because of the way the crowns look. Many people today want white fillings. However, after the treatment, we found that the overall positive response of the parents and children was overwhelming. This was a way to diagnose Parkinson’s disease. Making a diagnosis in living patients is a big step forward in our efforts to understand and better treat Parkinson’s disease. This finding may be of great importance if we can use this test to rule out other conditions. Up to 50 per cent of patients may be misdiagnosed early in the disease.”

Banking group launches online banking technology

Lloyds Banking Group has launched a new online internet banking facility for business customers. The service allows companies such as healthcare practices that were previously unable to bank online because they needed two signatories, to process payments using internet banking.

The technology gives organisations greater control of their banking as two or three users can now authorise payments. Businesses can apply payment limits to delegated users and the system provides easier management of their finances. The reduction of paper-based transactions also makes it easier to keep track of a payments’ status.

The facility is available through a simple online registration process once internet banking has been established for the company, and is ideally suited to GPs, dentists and pharmacists.

Study identifies vital protein

Fibrocartin is required for root formation, a new study has found. The paper, titled “Fibrocartin is Required in Odontoblasts for Tooth Root Formation”, was written by lead authors Tak-Heon Kim and Cheol-Hyun Bar, Chonbuk National University Korea School of Dentistry, Laboratory for Craniofacial Biology, is published in the IADRAADIR Journal of Dental Research.

The tooth root, together with the surrounding periodontium, maintains the tooth in the jaw. The root develops after the crown forms, a process called morphogenesis. While the molecular and cellular mechanisms of early tooth development and crown morphogenesis have been extensively studied, little is known about the molecular mechanisms controlling tooth root formation.

In this study, Kim and Bae et al show that a protein called β-fibrocartin is strongly expressed in odontoblasts - the cells that develop the tooth dentin, and is required for root formation. Tissue-specific inactivation of β-fibrocartin in developing odontoblasts produced molars lacking roots and aberrantly thin incisors. At the beginning of root formation in the mutant molars, the cervical loop epithelium extended apically to form Hertwig’s epithelial root sheath (HERS), but root odontoblast differentiation was disrupted and followed by the loss of a subset of HERS inner layer cells. However, outer layer of HERS extended without the root, and the mutant molars finally erupted. The periodontal tissues invaded extensively into the dental pulp. These results indicate that there is a cell-autonomous requirement for Wnt/β-fibrocartin signaling in the dental mesenchyme for root formation.

“At first, some parents were concerned that people might judge children who had these crowns because of the way the crowns look. Many people today want white fillings. However, after the treatment, we found that the overall positive response of the parents and children was overwhelming. This was a way to diagnose Parkinson’s disease. Making a diagnosis in living patients is a big step forward in our efforts to understand and better treat Parkinson’s disease. This finding may be of great importance if we can use this test to rule out other conditions. Up to 50 per cent of patients may be misdiagnosed early in the disease.”

Research shows promise for Parkinson’s disease

New research from Mayo Clinic in Arizona and Banner Sun Health Research Institute suggests that testing a portion of a person’s saliva gland may be a way to diagnose Parkinson’s disease.

“There is currently no diagnostic test for Parkinson’s disease,” says study author Charles Adler, M.D., Ph.D., a neurologist with Mayo Clinic in Arizona. “We have previously shown in autopsies of Parkinson’s patients that the abnormal proteins associated with Parkinson’s are consistently found in the subman- dibular saliva glands, found under the lower jaw. This is the first study demonstrating the value of testing a portion of the saliva gland to diagnose a living person with Parkinson’s disease. Making a diagnosis in living patients is a big step forward in our effort to understand and better treat patients.”

The study involved 15 people with an average age of 68 who had Parkinson’s disease for an average of 12 years, re- sponsive to Parkinson’s medication and did not have known salivary gland disorders. Biopsies were taken of two different saliva glands: the subman- dibular gland and the minor salivary glands in the lower lip.

The abnormal Parkinson’s protein was detected in nine of the 11 patients who had enough tissue to study. While still being analysed, the rate of positive findings in the biopsies of the lower lip glands appears much lower than for the lower jaw gland.

“This study provides the first direct evidence for the use of submandibular gland biopsies as a diagnostic test for living patients with Parkinson’s disease,” Dr. Adler. “This finding may be of great use when needing definitive proof of Parkinson’s disease, especially when considering performing invasive pro- cedures such as deep brain stimulation surgery or gene therapy.”

Currently, diagnosis is made based on medical his- tory, a review of signs and symptoms, a neurological and physical exam, and ruling out other conditions. Up to 50 per cent of patients may be misdiagnosed early in the disease.
The lasting impact of eating disorders

DT’s Angharad Jones looks at eating disorders and how dental professionals can help

Figures from the National Institute of Health and Clinical Excellence suggest that 1.6 million people are affected by an eating disorder in the UK. With Eating Disorders Awareness Week taking place this week (11-17 February), charity Beat are encouraging people to ‘sock it to eating disorders’, by organising ‘silly socks’ events and fundraising to help support those with these illnesses.

One of the biggest impacts eating disorders can have is on the teeth. Eating disorders cause tooth wear, which occurs when the outer tooth surface is lost as a result of chemical or mechanical activity in the mouth. All sorts of dental problems can arise as a result, such as teeth becoming short and unattractive as well as rough or sensitive. Speaking or chewing can become a problem and some people will end up with numerous restorations or having teeth removed.

Results from the Adult Psychiatric Morbidity Survey show that bulimia is the most prevalent eating disorder, making up 40 per cent of those with an eating disorder, compared to 10 per cent of sufferers having anorexia. Bulimia causes tooth erosion due to repeated acid regurgitation, and diet choices among those who are bulimic may be acidic, with sugar free and carbonated soft drinks, sports drinks and alcohol being frequently consumed, adding to erosion.

Stress

Stress is a common aspect in all eating disorders, which can also lead to other types of tooth wear. Emma Pacey, Clinical Coordinator at the London Toot Wear Centre® says: “The associated psychological complications of an eating disorder mean the patient may be susceptible to other types of tooth wear often caused by grinding or clenching habits, whilst obsessive behaviour can translate to tooth brushing, resulting in abrasion.”

Those with bulimia also become overly concerned with the prospect of bad breath, causing them to excessively brush their teeth. Terence, a bulimia sufferer for 11 years says bad breath took great importance for him during his illness. “After vomiting the first thing I did was clean my teeth, as I thought this would help keep my teeth strong and prevent bad breath. I was more bothered about bad breath [than oral health] and I didn’t realise what I was doing in my teeth.”

Unfortunately, oral care can often take a back seat when people are going through their illness. As with other psychological disorders, judgement may be affected, and one of the concerns likely to be at the bottom of the list is the impact their lifestyle is taking on their teeth.

Sam, who suffered from anorexia and bulimia for 15 years, has had tooth decay, intensive root canal treatment, numerous fillings and three missing teeth as a result, says: “[Oral health] wasn’t high on my list of priorities, being thin was. When you have such a low opinion of yourself your teeth...is just one thing in a long list of things that you hate about yourself.”

Causative factors

Although a difficult and sensitive subject to broach, tooth wear which is deemed to be the result of an eating disorder should be acknowledged. Emma says: “Denial and shame often feature and so discussion must be without judgement, with sympathy and time. Acknowledgment and rectification of the causative factors need to be realised, otherwise treatment will be compromised.

“It is important to communicate effectively and with consideration, and provide clear explanation in an open and supportive environment.”

Sam agrees: “My dentist reacted with what I perceive to be a disgust and a total lack of sympathy. She was very dismissive and offered very little support and advice...it made me feel really bad about myself and I had no one to turn to. I saw the hygienist and broke down about my problems and told her how I felt about my teeth. She was very supportive and told me there are lots of things that can be done but I would need to be referred to a private clinic.”

Advice

It is also important to note that people with eating disorders may not want to listen to any advice given. Bhian, an eating disorder sufferer for 15 years, says: “I received very little advice [from my dentist]. I didn’t seek any and I wouldn’t have been willing to accept any either.”

Allison, who has suffered from both anorexia and bulimia, reiterates this. “Any advice you give may usually fall on deaf ears.”

Nonetheless, dentists should not be disheartened when it comes to treating patients, and still need to look out for tooth wear as a result of eating disorders. Allison encourages “every dentist not to shy away from talking to their patients who present with high acid erosion on their teeth that could be attributed to an eating disorder.”

Sam’s advice to dentists is: “Don’t be judgemental, eating disorders are not a lifestyle choice, they are serious illnesses. Educate yourself about eating disorders, the effects they can have on teeth and the signs to look out for.”

Signs to look out for include increased levels of sensitivity, and sharp or chipped front teeth. Acid erosion presents on the palatal and occlusal surfaces of the teeth mostly, where acidic fluid pools in the mouth, and back teeth become rounded and lose some of their surface characteristics, while front teeth may become translucent at the biting edges. If abrasion is also present, grooves may develop in the teeth near to where they meet the gums.

Regret

One of the biggest impacts that come with dental problems attributed to eating disorders is a lack of confidence and regret that oral health was neglected during their illness.

Sara, an anorexia sufferer, says: “Following recovery, the impact my eating disorder had upon my teeth has affected my confidence. I was, and am, aware of the appearance of my dentition, my missing tooth, and am self-conscious at times when speaking.”

Bhian says: “It upsets me that this is the lasting legacy of my eating disorder that I will have to live with for the rest of my life. I get annoyed at the amount I have and will continue to have to pay out because of the damage years of an eating disorder has done to my teeth.”

While dentists may not be able to stop an eating disorder, they may be able to prevent severe tooth wear which has occurred as a result, and make a big difference to that patient’s life.

Contact information

For more information regarding eating disorders and tooth wear, visit www.b-eat.co.uk and www.toothwear.co.uk.
During 2012, 834 Dental Practices made a choice... 

With the dental profession facing ever-increasing regulatory and running costs, getting the right deal from your dental supplier has never been more important. That’s exactly what 834 dental practices did in 2012 by opening a new account with The Dental Directory.

The Dental Directory recognises this and wants to assist every dental practitioner in the country by continuing to cut the prices on everyday, essential dental products.

Despite considerable price increases from dental product manufacturers, The Dental Directory is the ONLY dental dealer who did not increase the vast majority of its prices during 2012.

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SDM compared the final selling out prices of 25 top-selling branded products from the categories shown below. These are the final prices charged to customers, after all discounts and promotions have been applied, and they found that The Dental Directory were an average of 5.4% cheaper than our competitors during 2012!

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We continuously compare our prices with our largest competitor – the American-owned, $7billion turnover, multi-national dental dealer, Henry Schein Minerva.

In a recent comparison of 100 like-for-like products featured in the Henry Schein Minerva Essentials Mini Catalogue and Dental Directory manufacturer dedicated flyers, our prices were found to be an average of 7.21% cheaper.*

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An average 5.4% cheaper on the top 25 best-selling branded products!

An average 7.2% cheaper on 100 like-for-like products on promotion during November 2012!

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Every Consultant is regularly manufacturer-trained on the latest products, but, as all our sales staff are salaried and NOT commission-based, you can be reassured that they have no personal financial motivation to sell unnecessary products to your practice.

We firmly believe that The Dental Directory offers the best combination of value and service: working with the dental profession to give every dentist the pricing and added-value services that are needed in these difficult times.

So if your current dental dealer doesn’t offer the same, join the 834 dental practices who opened a new account with The Dental Directory in the last 12 months.

To find out more about The Dental Directory, or to arrange for your local Business Consultant to visit your practice, please call us FREE on 0800 585 586

Trust…
Social media has become an integral part of daily communication for many. According to Pew Research Center, the UK has the highest proportion of global users with 52 per cent of adults using social media services such as Facebook, Twitter and YouTube (i.e. compared to the US at 50 per cent and Spain at 49 per cent). Social media also plays a large role in marketing, and in media overall. Consider how many television programmes, entertainment shows, news channels or well established publications, now use social media to extend the reach and longevity of their audience interaction. Social media is no longer new media. Whether businesses decide to use social media or not, it will impact them.

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Social media’s greatest impact on your practice
Rita Zamora looks at how social media gives a voice to customers

Is this what we’ve come to? A time where customers can tell businesses what their tagline should be? Absolutely.

The dinner guest shared that this repair shop had promoted itself as “the best in customer service”. Naturally when the customer had a service issue, he expected the problem to be easily resolved – after all this business was supposed to be the best in customer service...

Over time, the customer’s issue was in fact resolved. When I asked the dinner guest if he removed the poor review on Yelp, he said, “No. That business has promoted itself for years as the best in customer service. They aren’t the best, and in fact they suck at it”. Wow. The dinner guest went on to say that he wanted the public and the business to know that their “promise” of good customer service wasn’t true. This could “give other customers honest information, and also give the business a chance to rethink their customer service or their tagline all together”.

Is this what we’ve come to? A time where customers can tell businesses what their tagline should be? Absolutely. Whether we like it or not, it’s happening everywhere. Customers want the businesses they support to hear them. Not only do consumers want to be heard, they also want to know that the businesses they support are aligned with their values and what they believe in. Dan Pink, bestselling author of Drive and A Whole New Mind, describes this behaviour as a result of the abundant times we live in. In a recent interview with Oprah Winfrey, Dan and Oprah discussed how: “We no longer just want to have things; we want cool things. We want well-designed things. We want things with meaning.” This abundance mindset, combined with the
communication capabilities that social media provides, has created the perfect storm for many businesses.

So how can practices protect themselves and even thrive in this potentially turbulent environment? For answers, let’s look at those practices that are well aware of their core values. Note if you don’t know what core values are, this is a great time to learn. Know what your core values are (it helps if you know your core values personally and you can then often apply similar values to your practice). Next, align your values with your branding. Those businesses that are well aware of their core values and have aligned their branding and everything they do day to day are well positioned to thrive in the future.

Patients will not become quieter over the years - they are becoming more vocal. People will expect more, not less. Your clients want to know who you are as a business, and as a person. If you can show your clients that you have similarly aligned values, then you will attract like-minded, high quality patients. Examples of similarly aligned values may be your belief in philanthropy - be specific, whether it’s your support of local schools or your passion for animals and the local humane society. Those patients you attract via similar values will remain loyal, refer, and easily accept treatment from you.

It’s a win-win, if you choose to embrace the fact that people want to spend their dollars with businesses that have meaning. Allow others to learn who you and your team are as people. Analyse your Facebook page and your Twitter account, and determine if they honestly represent you and your practice - in other words, do you like what you see? Social media accelerates and amplifies the truth about us as individuals. Be sure the “truth” being published about you in social media is aligned with your authentic truth and your core values, and you will be well-positioned to succeed in the future.

Customers are using their voice through social media.

‘If you can show your clients that you have similarly aligned values, then you will attract like-minded, high quality patients’

About the author
Rita Zamora is an international social media marketing consultant and speaker. She and her team actively co-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the British Dental Practice Managers Association. Learn more at www.DentalRelationshipMarketing.com or email rita@ritazamora.com.
A life-changing experience: UK students provide dental care in Nepal

DTI’s Yvonne Bachmann looks at the Work the World initiative

Nowadays, health-care electives are part of many medical degree courses. Not only does the experience help students gain practical knowledge, but it also gives them the chance to expand their horizons and in some cases go abroad and learn how health systems work there. UK dental students Anisha Sangha, Catie Michaela Sherlock and Emily Hooper signed up for a dental outreach placement arranged by British organisation Work the World. In summer 2012, the young women travelled to Nepal to provide dental care to people in need.

Brighton-based Work the World offers placements abroad to those looking for experience in medicine, dentistry, nursing, midwifery, physiotherapy and radiography. Participants can go to Asia, Africa and South America. Dental students wishing to expand their knowledge can choose between a hospital placement and an outreach placement.

Anisha (22), Catie (22) and Emily (21) all chose the outreach placement, which led them to Nepal. The country is one of the poorest in Asia and the fifteenth poorest in the world, with over half the population surviving on less than US$1.25 a day, according to the British Foreign and Commonwealth Office.

“Nepal is a Third World country, one of the poorest countries in the world, and, on research, I found that there is a severe shortage of dentists. I therefore felt that our visit would be very beneficial to the communities there,” Catie told Dental Tribune International.

The senior dental student at the University of Leeds mainly aimed at gaining more hands-on experience when entering the programme. Just like fellow student Anisha, she was sent to Pundi Bhumdi, a village in the centre of Nepal. “We set up our dental camp in a local school in the village. Work the World provided us with portable dental chairs and units, including drills, which completely exceeded our expectations, and allowed us to provide more conservative treatment than we thought. We were able to fill many teeth that were decayed rather than simply extract them,” said Catie.

Emily, enrolled at the University of Bristol, was sent to a temporary clinic set up in a mountainous farming community overlooking the Annapurna mountain range, near the city of Pokhara. “There was a lot of interest within the local community to see who we were. We saw patients of all ages, anything from babies to the elderly, some of the latter had never seen a dentist before’

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For the English students, the placement turned out to be a very helpful opportunity to gain a great deal of hands-on experience. “We were supervised by a Nepalese dentist. There was a dental hygienist there to assist us, and also a member of Work the World staff every day,” said Anisha.

“Together, they made sure that we were carrying out dental treatment to the highest standard and that any treatment we undertook was effective and provided a long-lasting result for the patients,” Catie added.

Not only did the young women provide dental treatment, but they also educated patients about dental health. According to Catie, one of the most important aspects of the volunteers’ trip was to promote oral hygiene to allow the local population to improve their dental health themselves and reduce future dental disease. “After each patient we screened, we reinforced how best to brush their teeth, providing toothbrushes and toothpaste to those who required them.”

Before they left for Nepal,
Emily, Anisha and Catie were concerned about the language barrier and thus a problem connecting with their patients. “As a dental professional you gain a rapport with your patients primarily by talking to them, and such a rapport I felt would be difficult to gain owing to the language barrier. This did happen to an extent, but the local translators were very good and you could see that they eased the patients when apprehensive,” Emily told DTI. Anisha added: “It is definitely surprising how far you can still communicate your message using body language alone.” For Catie, it was not always easy to bond. “Time spent with patients was very short and communication very difficult, meaning that rapport was largely impossible.”

The students benefitted from the placement with regard to professional and personal experience. They pointed out that treating patients under only the necessary supervision significantly increased their self-confidence. “In terms of practical skills, the experience I gained from my elective was invaluable. I feel that I have increased in confidence in treating patients, in particular children,” said Catie. Anisha too stated that she had increased her confidence in making independent clinical decisions and had improved her efficiency. For Emily, the surgical experience she gained was invaluable, she said. She was able to extract many more teeth in Nepal than she could in the same period in the U.K. “I also feel a lot more confident when faced with restorative procedures, especially treating very large carious lesions,” she explained.

Additionally, the dental students had a chance to meet and work with the local people and get to know a new culture and lifestyle. “I would definitely say that I have had an eye-opening experience, in terms of not only the dentistry but also the culture, people and religion,” said Emily. “The Nepali people have a lovely nature and they welcome you into their community with open arms. They were so grateful for the dental treatment that we were able to provide.”

All three students stated they would volunteer for a charity project again. “I would have no hesitation in doing something similar in the future. I wholeheartedly recommend the Work the World project to other people,” Catie said. Anisha has caught the bug for dental volunteering abroad: “It is a life-changing experience, but I hope it is not a once-in-a-lifetime experience as the cliché goes, as I would love to repeat it!”

The facilities were basic but serviceable

Contact information

Work the World was created in 2005 with the aim of providing healthcare students with safe, affordable overseas elective experiences.

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NLP – a practical philosophy of being
Joanna Taylor discusses Neuro-Linguistic programming

N

eurolinguistic Programming, or NLP, has been described as “the handbook of how to achieve what we want out of life”. It is a model that helps us understand how we think, how our use of language affects how we think and how others understand us, and how all of this affects our behaviours. It was developed in the 1970s by Richard Bandler and John Grinder, who were very curious to discover how certain therapists were achieving consistently good results with their clients.

It draws on many established areas of psychology, bringing together all the elements that work and putting them into a framework that is comprehensive, accessible and ethical. From understanding yourself, your personal relationships and your professional relationships, NLP will challenge the way you think about your world, and have a positive impact that is empowering for you and those around you.

The name is derived from: Neurology (the study of the mind and nervous system; how we think), Linguistics (the study of language and how we use it) and Programming (the sequence of our actions; how we motivate ourselves to achieve our goals). NLP is therefore the study of the structure of subjective experience or, in other words, how we use the language of the mind to consistently achieve our specific and desired outcomes. It is a practical philosophy of being.

Did they hear what you said, or what they think you meant? We’ve all had the experience of having someone take something we said the wrong way. The meaning of communication is the response you get from the other person; people will respond to what they think you said – which is sometimes not what you actually meant! Because we all think differently, we will perceive others’ communications in different ways. The NLP Communication Model can help us appreciate how our unconscious mind filters our experiences through our personal internal values, beliefs and memories; so that effectively we all construct our own idea of what reality means to us.

As we listen to others, noticing language patterns, body language and voice tonality, we can gain insights into how they are processing their own experiences, which can help us discover how best to make ourselves understood. If a patient is nervous, for example, they will be filtering your conversation through their belief that your practice is a scary place to be, so that any words they don’t understand may cause added anxiety (“I’ve never heard of it, therefore it’s something I need to be afraid of!”). The more choices and behavioural flexibility we can have in our communication style, the more likely it is that the other person will understand what we really mean.

Understand how you can use body language to help your patients feel comfortable. We all instinctively “do” rapport with people we like, and NLP teaches us how these unconscious processes work. Through techniques such as matching and mirroring we can gain rapport with people very quickly in order to increase their feelings of comfort and security in the surgery. Using our sensory acuity, we can pay attention to our patient’s unconscious responses in their body language and physiology so that if our communication is not working, we can change our approach.

Respect for others’ own opinions. An underlying part of the philosophy of NLP is respect for another person’s “model of the world”. Our perception of reality is not necessarily reality, because we all construct our own view of it – however, it is our reality. Everybody has a different way of perceiving their world; their opinions, beliefs and values are individual to them and NLP teaches us that it is not our responsibility to change somebody else’s model. Accepting this idea can have an enormous positive impact on any relationship; as the author Wayne Dyer says: “Practice being kind, not right.”

Sometimes another person’s ideas might be radically different from yours because we all have our own opinion as to what is important to us. How useful would it be if you could discover what your patient’s values just through conversation? When you understand what is important to your patient, it means that you know exactly how to satisfy their needs, and your patient knows you are really listening to them. You may consider that a patient with discoloured teeth would certainly be interested in a whitening treatment, but is that their value, or your own?

You once understand a patient’s values, it’s possible to use that knowledge to increase their motivation; for example in oral hygiene compliance. A teenager might be thinking of oral hygiene as an unwanted interruption in their Facebook time, but if you can discover something else that is important to them (for example a forthcoming job or university interview) then you can use this information to “reframe” their approach to oral hygiene. This is another example of respecting someone’s “model of the world”, however – it won’t work if you are using your own values of what you believe they should think is important!

As we listen, respect the patient’s “model of the world”, paying attention to what is important to them and how they are constructing their reality, we can make a real difference to the quality of our communication and develop a solid, long-term relationship which is based on respect and understanding.

We already have all the resources we need
NLP has been described as “a practical philosophy of being” – hence the title of this article. We operate most effectively when we are in a resourceful state; utilising the philosophy of NLP can help us access our inner positive resources and operate from a “physiology and psychology of excellence”.

As human beings, we have a tendency to believe what we see, and see what we believe; consider – how many times in the past have you “known” something would go wrong with a particular patient, and proved yourself right? What if, instead, you “know”...
Every behaviour has a positive intention. All our actions and behaviours have at least one purpose – to achieve something that we value and that benefits us in some way. Even a behaviour which others perceive to be manifestly antisocial, such as bullying another staff member, will have a positive intention of some sort for the person doing the behaviour. It is a way. Even a behaviour which we cannot achieve something that we value, we have at least one purpose – to behave in a particular way, it will do the best we can at that time with what resources we had at the time back then. We carry a map in our minds of what we believe reality to be, but the real territory of our world is always richer than our perception. Our map depends on our own internal “filters” of values, beliefs and memories, and is not necessarily personal to us. An anxious patient, a retired dental hygienist and a CQC inspector visiting your practice will all have a completely different internal map, or perception, of your surgery as they will notice and pay attention to, very different things. These ideas are some of the central principles and guiding philosophies of NLP, known as the operating beliefs, or “presuppositions”. They are called ‘presuppositions’ because, as practitioners of the art and science of NLP, we pre-suppose them to be true and then act as if they are; effectively, they are ethical and ecological principles for life. Understanding NLP, and employing these principles, will improve your communication skills and increase your success in every area of your life.

People are doing the best they can. In any given situation, we will do the best we can at the time with what resources we have available to us. How often have you said to yourself, “If I’d known back then what I know now...”? The resource of that knowledge was not available to you at that time, so whatever you did back then was done from a positive intention, with the expectation of a particular outcome, and with what resources you had at the time. A nervous patient reacts angrily to a suggestion for treatment may actually be afraid, but unable to verbalise that feeling. If we can understand how and for what purpose someone is behaving in a particular way, it is possible to work with them to assist them to change their behaviour into something more useful or desirable. We are not our behaviours; when we have a better choice of behaviour that also achieves that same overall positive intention, we will take it. People are doing the best they can. In any given situation, we will do the best we can at the time with what resources we have available to us. How often have you said to yourself, “If I’d known back then what I know now...”? The resource of that knowledge was not available to you at that time, so whatever you did back then was done from a positive intention, with the expectation of a particular outcome, and with what resources you had at the time. A nervous patient reacts angrily to a suggestion for treatment may actually be afraid, but unable to verbalise that feeling. If we can understand how and for what purpose someone is behaving in a particular way, it is possible to work with them to assist them to change their behaviour into something more useful or desirable. We are not our behaviours; when we have a better choice of behaviour that also achieves that same overall positive intention, we will take it.

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Get your patients smiling by referring certain aspects of treatment
Tim Bradstock-Smith talks referrals...

With millions of people tuning in to TV programmes like Embarrassing Bodies, 10 Years Younger and Extreme Makeover, the public has never been more aware of the possibilities for changing their looks. These reality shows have provided exposure to the cosmetic dentistry industry, and, together with increasingly cost-effective treatments, have shown that procedures are now available to almost anyone, rather than restricted only to the rich and famous. Now more than ever, the British public are keen to have straight, white teeth like their favourite celebrities and there is no question that demand for cosmetic dentistry is on the rise. Orthodontic treatment in particular has benefited from countless pages of publicity thanks to famous brace wearers such as Tom Cruise or Kate Middleton.

Assumption
In the past, people have generally assumed that only the teeth of the young can be moved into a more attractive, even position, but the fact is that orthodontics can work at any age. Patients are now becoming increasingly aware that good teeth can not only boost their self-confidence but also improve their general health.

Patient Knowledge
In fact, the once unfashionable view of wearing braces is now acceptable even for adults. This is helped enormously by the sheer range of modern treatments available, which are far less obtrusive than the traditional ‘train tracks’ and are often more effective, more quickly.

With this increased interest in cosmetic dentistry and the ability to search the Internet for the various options available, patients are more knowledgeable now than ever before and they expect to have all of these choices available to them. This awareness and level of expectation puts general dental practitioners under considerable pressure to provide their patients with the desired specialised treatments.

For all dentists, their patients’ wellbeing is paramount
Particular treatments sometimes need special expertise and often expensive, specialized treatments, such as orthodontics and implant work, can require particular expertise, and often expensive, specialized equipment. In order to provide this service, which is tailored to the unique requirements of their patient, there is the option for dentists to refer some or all of the work to a more suitably trained and equipped practice. This not only provides the ideal outcome for patients, it also expands the range of services the dentist can offer.

Offering alternatives
These referral practices are able to break down quite difficult or complex cases, provide second opinions or further advice, and often offer alternative or simpler treatments the referring dentist may not have even been aware of. Dentists new to this course of action should not consider this step an admission of defeat; rather it should be viewed as a positive move. Patients will see the referral as a demonstration, by their practitioner, that their best interests are being served, and show more trust and appreciation.

This enhanced loyalty to the practice is likely to encourage some referral patients to agree to subsequent work by their own dentist. Treatments such as teeth whitening would not have been especially appealing to patients with severely crooked teeth. However, having been referred to a specialist orthodontist, they may be more than happy to draw attention to their newly straightened teeth.

Choose carefully
Referring a patient to another practice, however, is not to be taken lightly; it is important to choose the right clinic to care for your patient and this means contacting the practice, asking to see the premises and establishing whether or not you will all work well together. The referral practice you choose needs to behave as if it were an extension of your own practice, and work as part of your team.

Leading referral practices understand the importance of your decision to refer and will be happy to provide more information or dispel any concerns you may have. They will seek to understand all your requirements for your patient and any future work you may be performing. You will also be kept informed throughout the treatment, and your approval and consent sought at every stage. In fact, the very best referral practices even provide models that you can send to your own ceramicist.

For orthodontic procedures, the referral practice should work with you to your restorative plan and you would be required to sign off the treatment before the braces are removed. In the case of implants, you would expect the referral practice to be adaptable, either providing the whole restorative implant treatment or making sure communication is open with you to provide the restoration.

The referral process is undoubtedly a win-win scenario for all involved. The patient receives the best possible treatment from highly qualified and experienced professionalsthe referring dentist has a delighted patient who takes a greater interest in their smile and greater care to preserve it.

Paul A. Tipton B.D.S., M.Sc., D.G.D.P., U.K.
Specialist in Prosthodontics; President, British Academy of Restorative Dentistry.

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About the author
Dr Tim Bradstock-Smith is principal of the London Smile Clinic, an award-winning centre of excellence in dentistry that is based in Central London. The Clinic offers an extensive range of services, which include specialist orthodontics, implant dentistry and dentures.

For more information, please contact 020 7235 2559 or visit www.londonsmile.co.uk/refer.
A return to old-fashioned values

Managing patient expectations is crucial, says Michael Sultan

It has recently been reported in the press that private dental treatment complaints received by the Dental Complaints Service (DCS) for the year May 2011 to April 2012 have risen by 17 per cent. Of these complaints, the most frequent concerns raised by patients were unclear information, not being made aware of the treatment prognosis or alternatives, and being ignored when concerns were raised.

Though the DCS figures are of course shocking, I must say they are not really surprising, especially when we consider the changing nature of our profession, the way we are perceived by the public, and of course, the current economic climate.

Like it or loathe it, times have changed in dentistry, and we work in a profession now that is no longer solely occupied with the treatment of pain. With a broader range of treatments now available to patients than ever before, so our range of fees is equally broad. While a simple hygiene visit may cost a patient less than £40, some of the treatments at the very highest end of the spectrum can cost in excess of £100,000!

While I do not doubt for one moment that we should be able to offer these kinds of high end treatments to patients should they so choose (and should they be able to afford it!), when one considers the nature of our modern consumer-driven society, the expectations of the patient, even for a treatment that costs only a few hundred pounds, need to be carefully managed in order to avoid complaint or litigation.

And it is here I fear we find the problem. In the case of private dentistry in particular, patients are far less “patients” these days, than they are consumers. They have rights as consumers, and they are often keen to express their rights. When the cost of treatment starts to soar, so too do patient expectations, to the point where if a treatment costs £20,000, a patient will (with some justification), expect the world.

For the young or inexperienced dentist, this whole area is a minefield, and even the more experienced dentist can easily be caught out. Ethical consent has, and always will be a point of much debate in dentistry as it is in all areas of the medical profession.

‘Ethical consent has, and always will be a point of much debate in dentistry as it is in all areas of the medical profession’
Tied in closely with this notion of patient expectations is the way practices market themselves to the world. As we have seen, the range of treatments now available to the modern dentist is far beyond anything that could have been imagined half a century ago, and our society has also changed dramatically in that time.

There are just so many dentists out there now, all competing for patients and offering different things, that marketing has become an increasingly important element to any dental practice’s activities. In the last few years especially we’ve seen a massive rise in the number of spa practices filling the high streets, offering “smile makeovers” or “life changing” treatments, but I fear very often the core messages we need to be delivering to patients get lost in translation.

From my (perhaps old-fashioned) perspective, dentistry should always be about delivering exceptional quality of care. This isn’t necessarily just about delivering the most dazzling smile, but is about how well you deal with the patient in your chair, and how you make their journey with you as comfortable as possible. After all, most people don’t like visiting the dentist, and so a visit is nearly always a stressful occasion.

Sometimes in the rush for beauty, as a profession we forget about the “essentials” such as good old-fashioned empathy. Sometimes in the rush for beauty, as a profession we forget about the “essentials” such as good old-fashioned empathy, and sometimes we forget that our patients just don’t understand dentistry like we do. They haven’t done the years of study; they haven’t read the papers; they don’t spend each working day dealing with teeth. As such we need to be completely open and honest with them through every step of the way. We need to be careful and considered in our approach, and we should make sure patients don’t get too caught up in the marketing.

There can be no doubting that modern dentistry is a fine balancing act. On the one hand we all need to attract patients and pay the bills, but we also need to be responsible with how we sell our treatments to patients, and we also need to have the courage to be able to take a step back when work falls outside our comfort zone, and refer to a colleague if so needed.

Though marketing is unquestionably an essential part of modern dentistry, there can be no beating a warm and honest approach. While honesty may well lose you the odd patient keen for perfection, an open and honest approach will ensure you don’t become another DCS statistic.

‘Sometimes in the rush for beauty, as a profession we forget about the “essentials” such as good old-fashioned empathy’
Do we make it easy to do business with us?
You only get one chance to make a first impression, says Alun Rees

Dealing with people is probably the biggest problem you face, especially if you are in business. Dale Carnegie

I wonder why so many dentists make it hard to do business with them? I have received the results of a survey compiled by Exela & Red Virtual Office and they make interesting reading. The purpose of the study was to determine the speed and quality of response to patient enquiries from a random sample of dental businesses in the UK. They used both telephone and web-based enquiries in a “Mystery Shopper” exercise. The enquiry focused on the provision of general dental services for a family relocating to the area served by the practice. If the call went to voicemail, a number was left and a call back requested.

The old saying is that you only get one chance to make a first impression and many practices ensure that their front desk people are trained to “smile” when they answer the telephone, to always give the caller their name and have a script to follow when they get into a conversational with a potential new patient. All fine and dandy but what if the first impression is of a slowly answered telephone or even worse no answer at all? Do we apply to our businesses the standards that we expect of others?

Research
There has been lots of research into what consumers perceive as high standard of care and courtesy – dentistry isn’t unique. An acceptable Average Speed to Answer (ASA) is deemed to be 50 seconds - equating to four rings. More than 50 seconds and a number of callers hang up - 65 per cent hang up after four rings.

First the good news, the calls that were answered were done so in a pleasant and friendly manner with helpful and informative receptionists.

- 39 per cent of the practices called answered the call promptly and efficiently.
- 18 per cent were middle of the road answering within four to six rings.
- Nine per cent were very slow to answer.
- 34 per cent of all calls were not answered at all.

Of the unanswered calls 62 per cent were handled by answering machines. In spite of the ubiquity of voicemail, studies by Henley Business centre have shown that 80 per cent of callers do not leave messages.

Some more statistics:
- 64 per cent of dental patients call during “peak” times (start, lunch, and end of day).
- 67 per cent of dental practices close during the lunch period and hope that their patients will leave a message.
- Of those callers who do leave a voicemail 60 per cent received a call-back during their working hours meaning that they had to make a second call attempt in order to contact the practice.
- 85 per cent of callers don’t hold the line for more than four rings.
- 95 per cent of new enquirers
don't leave a voicemail.
• 26 per cent of new enquirers don't call back if the line is busy.
• 85 per cent of new enquirers don't call back if the call isn’t picked up at all.

During lunch times and school holidays practices can expect to receive 50 per cent higher call volumes. This needs additional capacity to manage the over-flow calls but in reality:

• 55 per cent of practices rely on answering machines to cope with over-flow calls.
• 24 per cent have no over-flow facility. Therefore the line is engaged or rings out.

Patient Frustration
The result of this is patient frustration, a poor impression given of practice efficiency and a potential loss of business. If nearly half of all enquiries are lost due to the patient having difficulty reaching the reception what message does it send?

Even if there is a system to book next appointments in person 45 per cent find they need to re-arrange these due to other commitments.

Of the 100 practices surveyed, 90 had websites, three of which had technical errors so were not functioning correctly. Eighty one of the sites had a “contact us” web form. Of those sites with contact forms, only eight generated any sort of auto-response acknowledging the enquiry. Worse still more than half (52 per cent) of practices did not follow up on the enquiry.

What this excellent little report tells me is that large numbers of practices don’t appreciate what their existing and potential patients want and need from them. Ask yourself the question; do you expect better service from others than you provide yourself? What really happened to those patients who you saw regularly for several years but then just disappeared? The area of lunchtime cover has always been and remains a thorny subject in many minds, yet those practices that appreciate that their patients have limited access to use a telephone during the working day, and take steps to cater for that, are rewarded for their efforts.

Perhaps you don’t think that this is important. For those looking to provide a high quality of care to discerning patients who you want to expect the best that you can offer, then high standards in those areas that they encounter first will encourage them to use your services.

What are the solutions? If your practice is large enough, ensure that you have one person dedicated to dealing with incoming calls. This removes the need of a receptionist “multi-tasking” to dealing with patients in person and trying to cope with the telephone. This alone doesn’t remove the problem of blocked lines at busy times of the day, so consider the services of a virtual office with a dedicated and well trained staff that can contact you by email within seconds of dealing with your call. Those practices that use this or similar backup services have appreciated that the cost of the service is more than covered by the income gained by giving exceptional service.

“It is not the strongest of the species that survives, nor the most intelligent, but the one that is most responsive to change.” Charles Darwin.

My thanks to Exela and RED Virtual Office Ltd.

If you would like to commission a Free mini-Mystery Shopper for your practice contact 0844 740 1469 or email dental@excela.co.uk.

About the author

Dr Alan Rees trained in Newcastle and started his career as an oral surgery resident, before working as an associate in a range of different practices. With this solid foundation, Alan went on to launch two practices in the space of just 15 months, a challenge in the toughest economic conditions. After years of hard work, Alan finally sold his award-winning business in 2005. Alan’s background and experience give him a strong understanding of what others go through to build a successful practice. He has seen many different approaches and learned his own lesson in the real world. Alan now runs Dental Business Partners with the declared aim of helping dentists build their perfect practice and offers specific and specialised support for dentists and their teams. Raised in South Wales, Alan has family roots in West Cork where he spends as much time as work allows. In other spare moments he has run three London marathons and love rugby, real ale and music as relaxation.
The consequences of non-compliance

Forget just standing on the naughty step, there can be harsh penalties for not complying with rules and regulations as Amanda Atkin explains.

That dentists are as human as the rest of us and that some of them sometimes do bad things is evidenced by the regular notices of erasure issued by the GDC. In recent weeks a dentist was struck off because he ‘failed to keep adequate records’. Another was sentenced to seven weeks in prison for continuing to work after being struck off. Another was struck off for poor treatment and yet another for serious breaches of conduct.

Of course, dentists not only have the GDC looking over their shoulders but now also the Care Quality Commission. The CQC has the power to close down a service. It has closed a number of care homes and several more have closed voluntarily following a critical report by a CQC inspector. It cancelled the registration of a practice in Dudley in May last year and there was an (unnamed) practice in the north west of England that closed after the PCT withdrew its NHS contract following a critical CQC inspection.

In a statement made in June 2011 following rumours that the CQC had closed some dental practices, it said: ‘We do have the power to close down a service; however this would only be required in the most serious of cases, and would need to take into account the effect of not having these services available for the people who use them. It would be unlikely we would need to do this in a dental setting.’

Something to worry about? While I’ll be using this article to highlight some of the consequences of non-compliance on the basis that it’s good to understand the seriousness attached to the rules and regulations we have to deal with, my intention is not to be alarmist.

Let’s deal with the GDC first. Registered dental professionals are expected to follow the GDC standards, pay the annual retention fee on time, maintain their CPD, have professional indemnity cover and report breaches of standards. The GDC will investigate if it is told by the police that you have been cautioned about or convicted of a criminal offence, if your professional conduct is called into question and if health problems or poor performance may put patients at risk.

The GDC has different committees to deal with these matters. A Professional Conduct Committee, a Health Committee and an Interim Orders Committee. Most hearings of these committees are held in public and in the case of a Professional Conduct Committee hearing only, information about the dental professional and allegations are issued in advance. The committees’ decisions and any sanctions imposed are made public. Details of hearings for the past five years are shown on the GDC website and at the time of writing there have been 185 Professional Conduct Committee hearings, just more than 100 dentists were struck off (erased in GDC terminology). Other outcomes included suspensions and reprimands or, quite often in the case of Health Committee hear-
dings, conditions were imposed on the dental professional.

To my mind, having such information in the public domain should be a strong incentive to steer clear of any ‘trouble’ with the GDC. Do you really want savvy patients checking out if you have a ‘record’ with the GDC?

CQC – scary or not?

At first glance it seems more likely that you’ll fail to comply with CQC requirements. Not only are there many steps elements within the essential requirements but it is essentially the practice that must comply and this means all the staff members need to meet their responsibilities. However, as I illustrated above, the CQC is not ‘out to get you’ but wishes to raise standards across the whole healthcare sector.

I mentioned above that the CQC effectively closed a practice in Dudley. Are you surprised when the inspector found used instruments in a sink which had apparently been there since the last patient was seen two to three weeks previously, an inoperative autoclave, medicines that were out of date and patients’ records that were missing?

If, following a CQC inspection, your practice does not meet the ‘essential standards of quality and safety’, the extent of non-compliance is categorised as having minor, moderate or major impact on your patients. For all minor impact non-compliance occurrences and some moderate impact ones, you will be required to produce an action plan for how, and by when, the standards will be met. If at a follow up visit your practice has now met all the standards, the CQC takes no further action.

Where you’ve failed to carry out the action plan, you will get a written warning notice with a timescale to comply. You will also get a warning notice and timescale for multiple moderate impact non-compliance occurrences and some moderate impact ones, you will be required to produce an action plan for how, and by when, the standards will be met. If at a follow up visit your practice meets all the standards, the CQC again takes no further action.

Things take a different turn if you do not heed the warning notice. The CQC can decide to pursue criminal law or civil enforcement action. Remembering the CQC is categorised as having minor, moderate or major impact non-compliance.

The fines range from £500 (eg a failure to provide documents or information) to £4,000 (eg a failure to comply with conditions of registration).

If things proceed to prosecution, the fines ramp up considerably. For the two examples above the fines are £50,000 and £2,500 respectively.

The CQC may use its civil enforcement powers in cases requiring, for example, urgent suspension or cancellation of registration – when it believes that a person will or may be exposed to the risk of harm.

The CQC publishes lists of its recent inspection reports each Wednesday and these are available as monthly lists on the CQC website. People can also track down dental practices by geographical location or postcode. Once you’ve found the practice that interests you, a table summarises the results of the most recent inspection (if there has been one).

A green tick means standards were met, a black cross means improvements required and a red cross means enforcement action has been taken. The CQC offers a widget so practices can include this information on their websites – a potentially positive piece of marketing if you received all green ticks.

Keeping out of trouble

To avoid falling foul of the penalties I’ve highlighted above, I offer straightforward advice – follow authoritative guidance closely, keep up to date with changes in regulations, take expert advice when necessary and make sure your team members know their duties and responsibilities.

About the author

Amanda Atkin runs dislikes Ltd and offers practices support, training and consultancy on information governance, CQC compliance, National Minimum Standards and RTT. Her bespoke service supports practices as they embed the required standards within their daily routines – to ensure a high quality service and patient safety at all times.

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Being a practice manager

First and foremost how do you appoint a practice manager? For many practice managers they have fallen into this role having been in a practice for a lengthy period of time, some do the work but are not named practice manager and for others it is the total opposite – they do have the title, but only do a small part of this role.

What is the role? This is a question that I am often asked by dentists considering appointing a practice manager. I describe it to them as being “a practice manager takes all the administration away from you allowing you to focus simply on the clinical aspect”. For almost all dentists the prospect of no administration is highly appealing, but to some it can be a daunting prospect. Some dentists actually enjoy doing the clinical all day and the administration in the evening...

Release control
Some dentists are not ready to release control to another member of the team. A small minority will have a member of their family doing administration for them e.g. wife/husband.

I was a practice manager for several years in a small private practice in Glasgow. I managed a very small team of just four, with a patient list of approximately 600 patients; a large number of which were on a dental plan. This was a fairly easy team, but there were very limited prospects for both me and the team.

I completed payroll, hiring and disciplining of all staff, the writing and implementing of procedures, the training of staff, reconciling the income and expenditure, chairing all team meetings and appraising all dental nurses and hygienists.

In comparison I have just completed several months of secondment to one of our practices in Thurso. A fully NIS practice with four dentists and a therapist, we have more than 4000 patients (this practice opened in January 2012) and more than 1000 still on the waiting list. I managed a team of 22 and because I had a business manager to support me I found that the workload was halved. I didn’t do payroll, or reconciling of bank statements, or chair team meetings. I did however complete appraisals and for such a large team it is hard work.

For anyone considering going into practice management here are my top ten tips:

1. Remain positive – even when things are tough
2. Reassure your team regularly
3. Praise them – I used to write articles about how great my team was
4. Be open and honest with them and encourage feedback
5. Have and instil into them a open door policy
6. Be ready to accept that not everyone will be on-board with any changes or the way that you do things
7. When embarking on change ask them for input you never know they may have a unique suggestion
8. Never say no to something without explaining your reasoning – this gains respect
9. Be sure to recruit the right team – it’s much better to spend time on the recruitment process rather than sorting a problem member of staff
10. Never panic or flap in front of them – keep this for behind a closed door!

Try to enjoy your role
Having a dental nurse background is a huge advantage. Every practice manager should be able to explain what is required of their staff, if you don’t have the dental background you can often struggle to get “buy-in” from the team. I have seen teams run rings around practice managers who do not have dental background.

A lot of practice managers suffer from stress as this can be a stressful role. It is crucial to be able to identify this early on and not become a victim.

As someone I know says “you can be smiling on the outside and screaming on the inside”.

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‘After 20 years, everything finally makes sense’

Steve Lomas discusses his experiences of the Dawson Academy UK

T his year has been my 20th in dental practice, and without a shadow of doubt it has been the most professionally rewarding, having spent most of it learning the concept of Complete Dentistry with the Dawson Academy.

Over the last twenty years I have dedicated myself to learning the most up-to-date restorative and cosmetic techniques. Despite being able to provide beautiful looking fillings, crowns etc. there was still something missing, a burning set of questions to which I needed answers.

Why am I seeing so many patients from their thirties onwards with short-ened, worn front teeth? How can I provide some early intervention to stop this wear and restore the smile before the problem and the solution become complicated and expensive?

Why do so many patients have repeatedly breaking teeth, fillings, crowns and bridges? Is it just wear and tear? Or is it the result of teeth being filled one by one over the years, making small alterations to the bite without ever really looking at teeth and jaws as a whole?

Why do I see so many patients with clicking or locking jaws, headaches, migraines, sensitive teeth? Why is this? How can I help? Why do I clench my own teeth every night?

How do I make sure the complex work lasts as long as possible?

The answer became increasingly clear. I needed to go and solve the mysteries of the dental occlusion or “The Bite”.

Occlusion is an area of dentistry largely ignored in undergraduate dental teaching, not just in the UK, but worldwide. Generally dental graduates come out of dental schools without any real comprehension of occlusion beyond it being difficult and that it doesn’t really matter. However, providing a correct occlusion not only provides the solution to my questions, but provides long lasting protection to the teeth.

After a lot of research it became clear that the further education lay in the USA, either with the world famous Dawson Academy in Florida or the Kois Centre in Seattle. I could not believe my luck when I discovered that one of the Dawson Academy’s Faculty members, Dr Ian Buckle, had helped set up a European branch of the Academy here in the North West. I enrolled immediately for the full year long course.

After three months of almost melting my brain with reading about and learning the concepts of Complete Dentistry, I attended the first module of the course in May. It was amazing to find just how global the programme was, with UK dentists being very much the minority. The majority of delegates throughout the year came from Scandinavia, but you have to be impressed with the guys who commuted from Brazil and Australia to undertake the course. Over the next six months and three more intensive courses, Ian, along with his amazing team of mentors and staff, delivered the most beautifully constructed educational programme I have ever been involved with. Each module lead smartly into the next, with continual reinforcement of the concepts and methods along the way.

So what have I learnt? Well that the answers to all of my questions can be met by having a through understanding of the whole masticatory system, the teeth, jaws and muscles, and that just about every problem can be solved by following a disciplined, structured method for diagnosis and treatment plan in every appropriate case.

The aim is to provide a healthy, comfortable, stable and beautiful smile with the least amount of dentistry possible. The key is to be thorough and never skip a step or move on to the next step until you have completed the one you are on. After a comprehensive assessment of the jaw joints, facial muscles and teeth has taken place, I sit down with specially mounted models of the mouth, full x-rays and clinical photographs, and work through twenty six stages of treatment planning, and at the end of the process there is a solution to whatever the problem may be, there is actually an answer just like 2^2 = 4.

Now at the end of the course I can reflect on what I have learnt and realise that the Dawson Academy has helped me to make a quantum leap with my dentistry, moved it to a totally different level. After twenty years everything finally makes sense, and I have a systematic approach that will allow me to solve just about any dental problem I am faced with.

Richard has followed my progress closely this year and has been equally amazed at the changes Dawson has bought to diagnosis and treatment planning. So much so, that he has enrolled for next year’s course, and has some other friends who have visited The Old Surgery.

Many many thanks to Ian Buckle and his team. If you have any questions on specific aspects of each course, or for a customised curriculum, please email info@bdseminars.com or call +44(0)151 342 0410

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About the author

Steve Lomas BDS Day Best Dent Partner Old Surgery Dental Practice Chester. Root canal and surgery restorative and referral practice. Full Member RAGS Runs a South Cheshire Study Group for BACD (British Academy of Restorative Dentistry) Dawson Academy Alumni Member. Recognised provider Six Month Smiles and Inman Aligners.
One step backwards, two steps forwards
The use of microscopy to enhance general dentistry by Mark Howe

Dentistry used to be simple; treatment choices were limited and prior to the “celebrity smile” cosmetic dentistry did not exist. Over the past decade there have been massive technological advances in dentistry and medicine that have forever changed the treatment options for our patients. Included in these advances are implants, guided bone regeneration, milled ceramics and advanced radiographic imaging. Furthermore the public’s expectations have increased dramatically in this time, with many patients now seeking a brighter, whiter more youthful smile.

Personally I think the biggest advancement in recent years has been in visualisation: the better I can see what I am doing the better the clinical results achievable for the patient. The arrival of the operating microscope into dentistry has launched a new era in dental care by improving magnification and illumination. The dentist can now see every detail of the teeth from micro-cracks to hidden decay and infection. In the past these factors may have possibly meant having to lose the tooth, but no more. With the dental operating microscope we can dramatically reduce the “guesswork” involved when trying to save teeth.

The operating microscope has now moved from the ophthalmic and vascular surgeon to the dentist, bringing all the techniques and advantages of microsurgery into the dental practice. We are now able to magnify the tooth by up to 20 times, and using special lighting can eliminate the shadows where decay and infection previously lurked.

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- Cleaner root surfaces when treating gum disease.

I and many in the profession strongly believe that if we can go back and improve some of our older restorative techniques we can not only reduce the need for more costly and complicated treatments. The ten-year success rate on a root-filled front tooth and a similar front tooth restored with an implant are both around the 90 per cent mark. It is interesting to note the root-filling can be completed in a few hours while the implant may take up to a year before it is finally completed at three times the cost. This is not an ‘anti-implant’ stance but it makes sense to exhaust all practical restorative options and try and preserve the implant option as our ‘ace in the pack’ to be pulled out when there is no better choice. In addition where possible the use of a surgical microscope, microsurgical techniques and conventional dental techniques we can get the best possible success rates out of our own teeth before we need to resort to more complicated, expensive and protracted treatments. As a footnote if you keep on top of your check-ups and keep the idea that “prevention is better than cure” you won’t have to worry too much about advanced surgery, implants, bone grafts etc, etc.

By combining the improved magnification and precision of the surgical microscope and conventional dental techniques we can get the best possible success rates.

The ability to have high quality video and images of the teeth. This is extremely useful when explaining treatment options to patients and colleagues.

The delicacy of microsurgery improves patient comfort and speeds up healing.

Most importantly we are now able to save teeth that previously had to be extracted and I think I am right in saying that patients generally would like to keep their own teeth rather than have extractions. If we can keep hold of our teeth longer and improve their looks by enhancing the precision of our restorative and conservative treatments the patient can avoid or at least defer the more expensive and complicated treatments such as implants.

About the author
Mark Howe qualified from Birmingham University in 1988. After four years in general practice he joined the Royal Air Force Dental Branch on a Short Service Commission. He served both in the UK and overseas and gained experience in oral surgery and advanced dental treatments. Additionally he gained his Diploma and Membership exams in general dental surgery. On leaving the RAF, Mark completed his Fellowship in the Faculty of General Dental Practice (FGDP) in their highest qualification. To keep up-to-date he attends many conferences both in the UK and abroad. Mark also lectures on restorative dentistry and provides a referral service for other dentists. Mark is an Assessor for the Royal College of Surgeons (RCS) for fellowship and is a member of the British Society for General Dental Surgery (BSSGdS), the British Society of Prosthodontics (BSSPD), and the European Association for Osseointegration (EAO).
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and Exhibition in Liverpool.

the recent British Society of Dental Hygiene & Therapy (BSDHT) Conference

impact” in a lecture sponsored by GlaxoSmithKline Consumer Healthcare at

that taking three or more drugs means there is around a 50 per cent chance of

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