Social media influence

Sir, the use of social media for self-promotion has resulted in a proliferation of so-called 'influencers' within various professions, including dentistry. It is debatable, however, whether or not these so-called 'influencers' are contributing to effective knowledge exchange. Therefore, we invite discussion about the potential impact this may be having on the profession and patient expectations.

Patients are increasingly seeking dental services through social media platforms such as Instagram and Facebook. The BDA itself has a Social Media Officer who encourages and supports dentists to self-promote and share their services online.¹ The GDC also clearly outlines that with informed consent and anonymity, social media can provide an effective way of gaining opinions from a large community of professionals.² Some 'influencers' are purely using Instagram as a marketing tool, seeking further business and developing their entrepreneurial skills. Whilst there is no issue with self-promotion and no obligation for dentists to teach, the current trend of 'influencers' is perhaps encouraging even novice dentists to advertise their own interests.

Quick fix, immediate, cosmetic dentistry is increasingly sought after, with celebrities and influencers alike promoting the 'perfect smile'. Advertisement through the use of before and after photos often shows favoured cases, and the 'highlight reel' of reality. However, what effect must this have on patient expectations? Are these photos truly authentic or filtered and

photo-shopped like many other posts on Instagram? Finally, are we encouraging patients to focus on aesthetics, neglecting the importance of everyday general dentistry?

A quick Instagram search shows that such dental influencers appear to focus their content on advertising themselves, their services to patients and to showcase their skills to others. Such influencers include experienced clinicians, newly qualified dentists and even undergraduates. With respect to students, we question whether it is appropriate without any qualification to make claims on their abilities and professional advice. The age of the 'influencer' is perhaps giving people an overinflated sense of competency and ability. Is it appropriate for under qualified and/or inexperienced individuals to self-promote highly cosmetic services to patients? Although social media may be the modern marketing platform, clinicians who self-promote in this way should take care in maintaining their professional integrity and ensure they maintain patients' confidence in the dental profession.²

It is undeniable that online teaching platforms and dental blogs offer a fantastic space for dentists to network, learn and develop clinical and professional skills. However, with many clinicians failing to demonstrate their case selection or step-by-step procedures, learning opportunities are missed. Posts are often un-referenced, with no evidence base shown.³ We must consider – what are these 'cosmetic transformation'

cases teaching our junior dentists and students? Though viewing high-quality treatments may provide inspiration for young colleagues, they can often cause dentists to question their self-worth and the quality of their work. Upward social comparison via social media is known to lower a person's self-esteem.⁴ One must remember, these posts may be unrealistic and are not representative of day to day dentistry achieved by the majority of practitioners.

Inappropriate use of social media could place dental professionals at increased risk of litigation. Scrutiny of clinical work and issues surrounding consent on social media could lead to disciplinary action for more and more dentists. Are the 'likes' worth this risk? Furthermore, where does the dentist-patient boundary lie? We wouldn't accept a patient as a Facebook friend so we question why it is acceptable to 'DM' your dentist to organise appointments and discuss potential treatment plans through Instagram?

K. Smorthit, Manchester, UK
J. Cooper, Manchester, UK.

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An unfathomable conception

Sir, I struggle to understand the mind of the person who conceived the present dental contract.

I became a member of the Executive Council in 1960. There I was reminded that 'dentists write their own prescriptions and fulfil them', which was the basis of their earnings.

I joined the Dental Rates Study Group in 1974. That required some little understanding of economics and statistics. The NHS Dental Fee Scale had been developed from that used

by insurance companies in the 1920s, which provided 'dental benefits'. It paid for items of treatment on the basis that the time required to carry out each item of treatment was different. This fee scale was adopted, largely unchanged, on the inception of the NHS in 1948.

In the early 1980s, a re-assessment of timings of the 30 'items of service' was made by a consultative study, for which the base unit would be the time taken to carry out 'Examination and Report'.

Over the years while I was a member the group, we speculated often about alternative systems of remuneration. There are several with some attraction. Our BDA Dental Secretary always recalled to us that 'apples and oranges are different prices'.

And still dentists do things. Perhaps this period of enforced quiet, could allow the Association and the Department of Health and Social Care to find a better and effective remuneration system than the present contract.

B. Murray, Glasgow, UK