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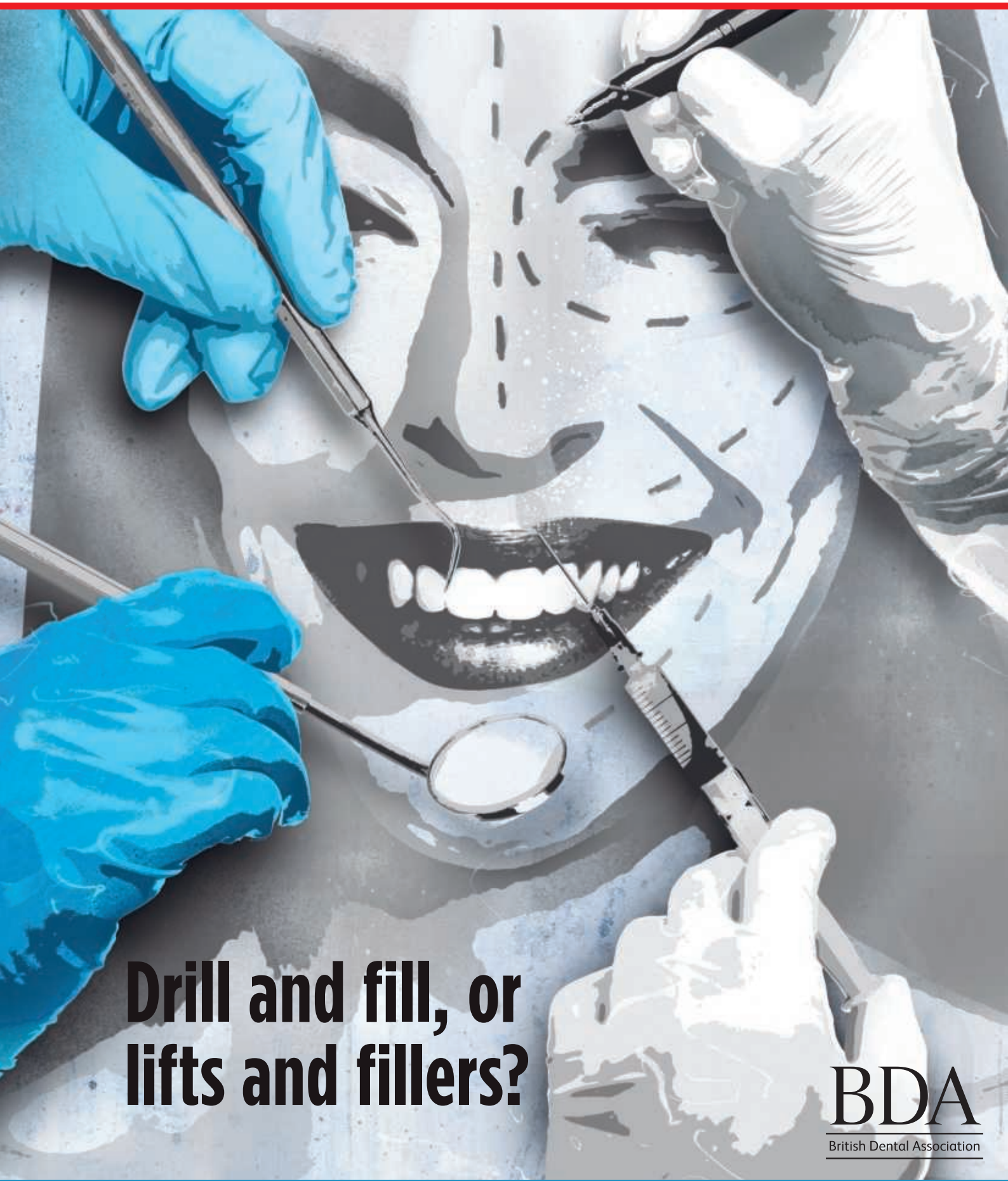

Drill and fill, or lifts and fillers?

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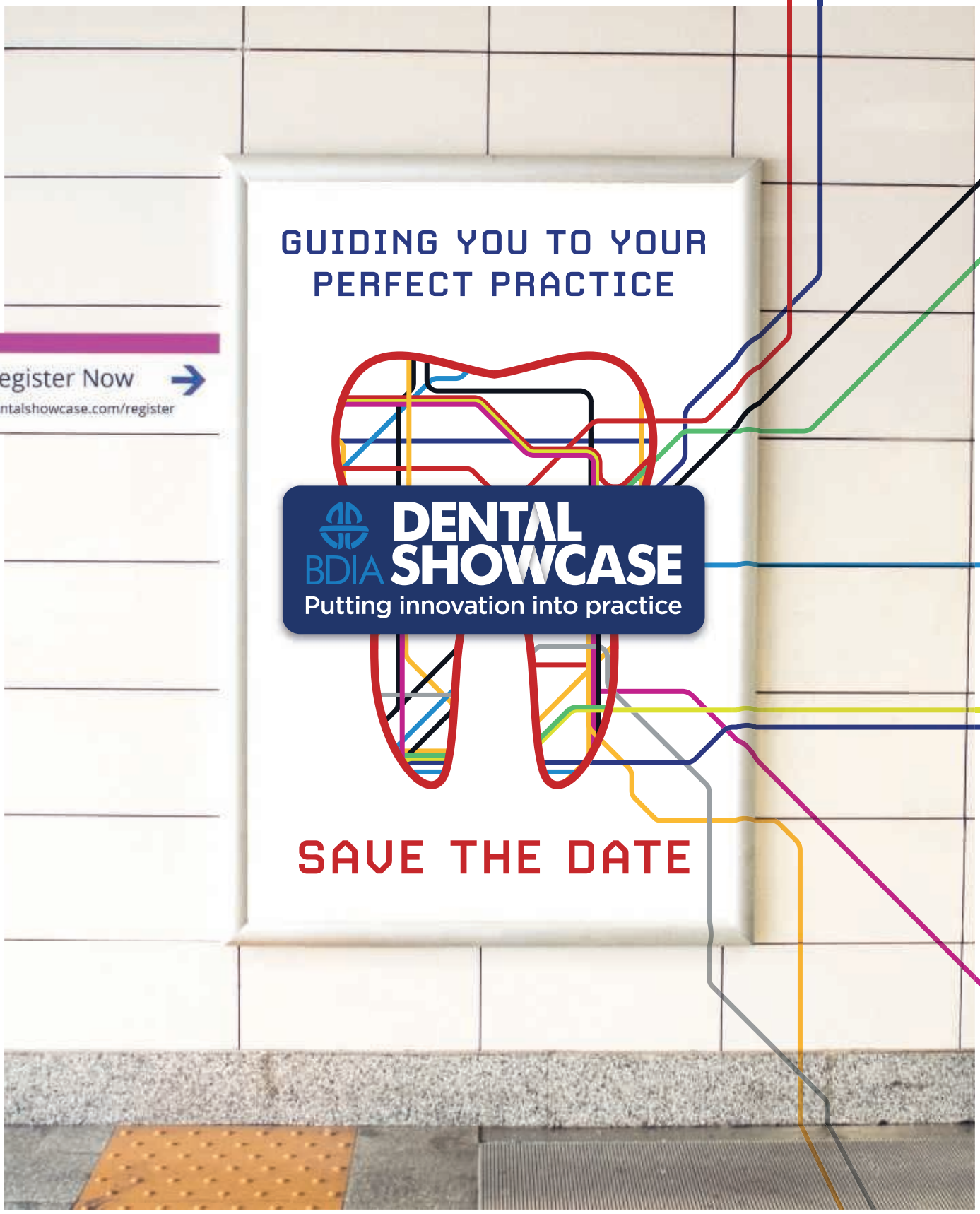
Going through the motions ■ Be careful what you wish for pt 2 ■ OSA ■ Female role models



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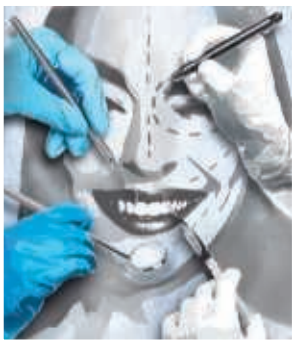

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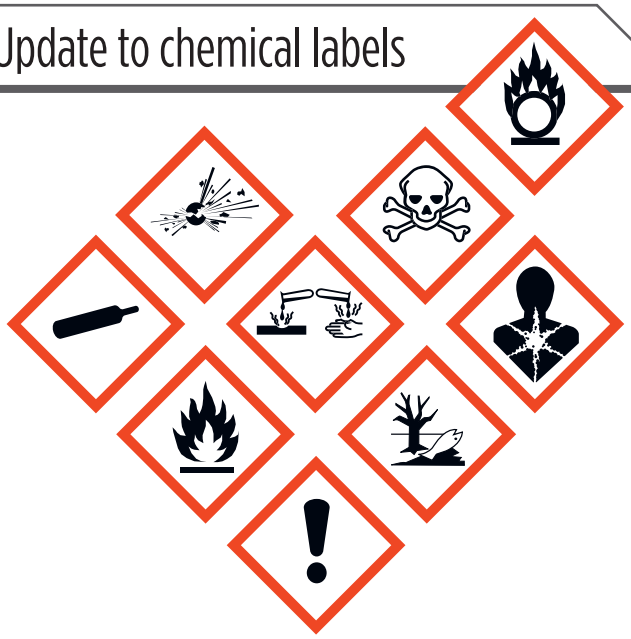
Update to chemical labels



The gradual replacement of danger symbols on hazardous chemical products has been completed. As part of this update some of the classification criteria and methods are different which may lead to some chemical products being classified more or less severely.

The seven old danger symbols have been updated to pictograms, with three new pictograms added. They have also added new wording in the hazard and precautionary statements which replaces the old risk and safety phrases. The classifications have been moved on the safety data sheets from Section 15 to Section 2 to help make them more accessible.

You should look out for the new labels and safety data sheets, check whether the classification has changed and follow the advice provided on them. Evaluate the risks to your workers and update the workplace risk assessments if necessary, check that your use of the substance is covered on the SDS and is not advised against. You should also update your COSHH folder. ◆

The three new pictograms have the following meaning:

Type of hazard	Old symbol	New pictogram
May cause serious long-term health effects, such as carcinogenicity, mutagenicity, reproductive toxicity, respiratory sensitisation, specific target organ toxicity and aspiration hazard	 or 	
Less serious health hazards such as irritants, skin sensitisers and less severe toxicity (harmful)		
Contains gases under pressure	No symbol	

New electronic referral system for dentistry in Wales

Patients in Wales referred for specialist dentistry care will be able to track the status of their referral online, it has been announced.

It's part of a new digital dental referral system, funded by Welsh Government, to be rolled out from this autumn. Benefits include a faster referral process, it is anticipated that this will shorten waiting times for patients.

The new system will replace the current paper based process used by dentists to send referrals, which can take up to four days to be delivered by post.

It will allow dentists to refer patients needing specialist dental treatment, such as oral surgery and orthodontics, using an electronic referral process. Higher quality information will be used to inform clinical decisions. For example, the new orthodontic referral template will support the referring dentist to calculate the need, timeliness and suitability of patients for orthodontic assessment and treatment.

Chief Dental Officer at Welsh Government, Dr Colette Bridgman said: 'We are delighted to announce the award of this contract. This innovation is the culmination of considerable work and effort from a number of organisations and clinicians. Once operational Wales will be the first country in the UK to implement a fully electronic system for dental referrals. We anticipate this will contribute towards realising our vision of accessible specialist dental care for those who need it in the most appropriate setting.'

Radiograph scanners will be offered to dental practices in Wales to ensure high-resolution images are attached to referrals and standardised referral templates will ensure consistent information is provided to NHS specialist services.

The initial three-year contract to supply the service was awarded to FDS Consultants following a robust procurement process led by the NHS Wales Informatics Service, in collaboration with Welsh Government, dental professionals, Public Health Wales and health boards.

FDS Consultants provide a similar service to a number of trusts in NHS England.

The new service becomes available from September 2018, with planned early-adopter health boards Abertawe Bro-Morgannwg University (ABMU) and Hywel Dda. The service is due to be available across Wales by January 2019. ◆

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Make your voice heard

The BDA is calling on general dental and specialist practitioners to share their experience of working in a dental practice across the UK.

Your responses will shape the vital work we undertake on your behalf. They provide us with a unique insight into the pressures facing the workforce in 2018. They also provide the evidence we submit to the Doctors' and Dentists' Review Body that makes recommendations on dentists' pay.

Please tell us about your motivation, job satisfaction, morale, well-being as well as your working patterns and hours, future career intentions and issues you may encounter retaining or recruiting dentists, if this applies to you.

It just takes 10-15 min to complete the survey and you could win a £100 voucher or a gift card.

A random sample of eligible BDA members have been selected, so if you have received an email from The British Dental Association inviting you to take part, please complete the survey today by clicking on the personalised link shown in the email entitled *Share your views: major survey of UK GDPs*.

Your information will remain anonymous and we will not pass your details on to any third parties.

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BOOK REVIEW

The business of excellence

The Business of Excellence
Justin Hughes
Bloomsbury, 2018
ISBN: 978-1-4729-5359-9
£10.99

In a nutshell

Former RAF fighter pilot and Red Arrows team member Justin Hughes now runs his own management consultancy Mission Excellence, working with some of the world's most successful companies. In his book The Business of Excellence, he discusses the drivers to success in business, both from the perspective of team membership and the organisations themselves. In the introduction, Hughes describes how, whilst flying with the Red Arrows, a potentially disastrous incident was averted by what he called mission execution rather than task execution. The team survived by complying with the overarching collective plan rather than deploying individual initiatives. This description underpins Hughes's credo that in order to provide an excellent outcome it's essential for the team, big or small, to work cohesively and, importantly, have a clear understanding of their desired outcome. This effectively, he maintains, is the imperative to inculcate a high-performance culture within an organisation.

Who is ideal for?

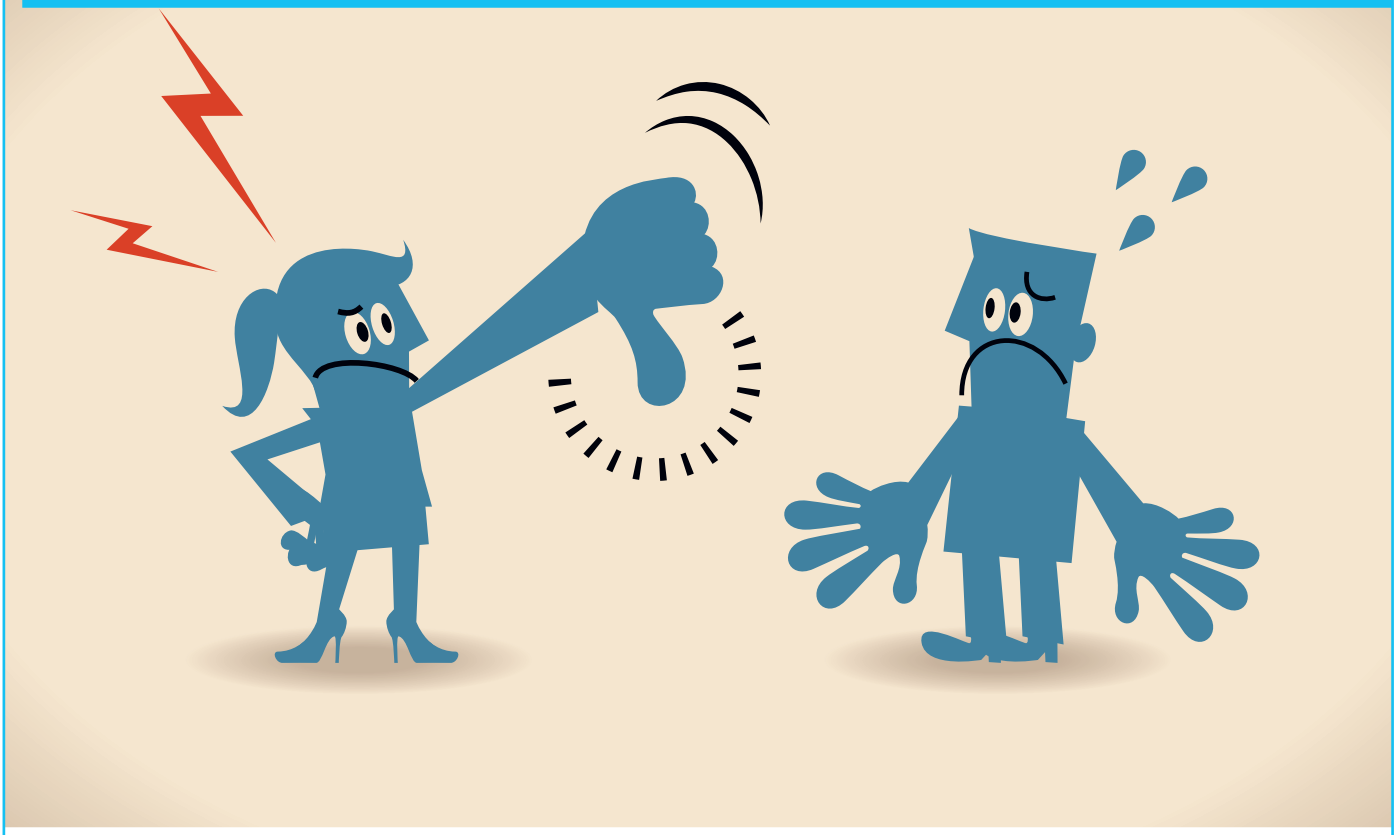
All the methodology and practical philosophy behind Hughes's book is relevant to everyone in an organisational team. Although ostensibly aimed at the leaders or managers of teams or organisations, he takes pains to explain how and why these ideas work. So it's not necessary to be a leader or manager to take away concepts which will enhance working practices in all contexts. Although the anecdotes given in Hughes's book are, for fairly obvious reasons, predominantly military in nature and invariably related to flying fighter jets, these are still very pertinent to teamwork in any context. The penultimate chapter, however, focuses on leadership and is appropriately subtitled 'bringing others on the journey'. This is a crucial chapter which offers both definitions of leadership and additionally explains the paradox of leadership, where Hughes contends that those in top positions can be good at (task) execution skills but possess weak leadership skills.

Why you should read it?

Hughes has done his homework and knows his subject well. He quotes leadership guru Stephen Bungay, who in his book The Art Of Action, also based on military operations, posited the theory of the hierarchy of organisational performance, which Hughes graphically depicts as a triangle showing leadership and direction underpinning execution. The latter term, which he favours, arguably stems from his time in the military, but also serves to represent the action of delivering results. He cites some actual examples of leadership behaviour which emphasise the ethos of the book: 'If you're the team leader, the chairperson or the boss, what you project will get reflected back at you' and he continues 'it's all about the standard you set'. High-performance team processes will include task clarity, role clarity and clarity in common purpose, which means that everyone is pointing towards the same collective goal. The team is aligned through a commitment to a common approach and empowering the team motivates the members in owning their own part of the task and facilitates both agility and flexibility to respond to the desired actions. ◆

For more about these books: www.bda.org/booknews

Effective in-house systems can nip complaints in the bud



New evidence shows that having an effective, in-house complaints process in place and displayed in the practice can help to avoid complaints from escalating into claims and prevent a complaint being made directly to the General Dental Council (GDC), say Dental Protection.

In a YouGov survey, conducted on behalf of Dental Protection, 65% of the public said they are not aware that dentists are required to provide a formal process for managing complaints from their patients. 16% of the public surveyed also said they would consider complaining to the GDC about the treatment they received.

Dental Protection said it recognised that some dentists may be reluctant to display their complaints procedure, for fear of encouraging a complaint, but stressed that timely and effective management of a complaint within the practice can often nip complaints in the bud, and avoid them becoming more serious.

Dr Raj Rattan, Dental Director at Dental Protection said: 'There is often a very small window of opportunity to nip complaints in the bud and dealing with them promptly, within the practice, is often the most effective way of doing this. Dentists have an obligation to provide a formal written process for resolving complaints, so every team member knows what to do, and they should ensure patients are also aware of the process.

'This will help to prevent a patient taking a complaint into another forum such as formal complaints handling scheme, the GDC, or into the hands of a 'no win no fee' lawyer.

'While understanding and managing patients' expectations before commencing treatment is key to avoiding complaints from occurring in the first place, it is just as important that dentists know how to manage a complaint effectively when one is received. This again will help to prevent it escalating.

'In the YouGov survey, when the public were asked what they would expect to happen if their treatment didn't go as expected, 74% said they would expect the dentist to offer further treatment to fix the problem at no additional charge, 36% said they would expect the dentist to refer them to someone else to fix the problem, and 31% said they would expect a refund. 50% said they would expect an apology.

'Interestingly when Dental Protection asked over 1000 of its members the same question, only 27% thought patients would expect an apology.

'We would always encourage dentists to apologise if treatment does not go as expected. This is not the same as an admission of fault or liability, and should be offered at the earliest opportunity. Dentists should then discuss further treatment options with the patient to ensure that any issues can be resolved in the practice. Dental Protection can assist with formulating a response to a complaint and assist and support you through to its satisfactory resolution. We can also work with you to look at why complaints arise and how to minimise the risks of recurrence.

'There will always be patients who are dissatisfied with their treatment, or whose expectations are not met. Grasping the opportunity to resolve complaints at an early stage within the practice reduces the likelihood that the patient will raise the issue outside of the practice. It contains the risk and is likely to lessen the impact a complaint can have on the confidence of the individual team member involved.' ◆

New Dean and Vice-Deans at FGDP

Ian Mills has been inaugurated as the new Dean of the Faculty of General Dental Practice (UK), and Onkar Dhanoya and Mark Richardson have been elected as its new Vice-Deans.

Ian, who works in general dental practice in North Devon, has now been sworn in following his election in February, and succeeds Dr Mick Horton as Dean. Qualifying as a dentist from Glasgow University in 1987, he spent the early part of his career working in maxillofacial surgery. After moving into general practice, he joined FGDP in 1994, completing its Diploma in Implant Dentistry, representing the South West region on the board and becoming a Vice-Dean in 2016. He has been an elected member of the BDA General Dental Practice Committee (GDPC), a member of Devon LDC, and on the Professional Executive Committee of North Devon Primary Care Trust, and is also a Fellow of FGDP(UK), the Higher Education Academy and the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow. In addition to his clinical practice, he works at Peninsula Dental School as a clinical supervisor, group facilitator and honorary lecturer.

Mr Mills commented: 'On behalf of all members of the Faculty, I congratulate Onkar and Mark on their election as Vice-Deans, and offer our wholehearted thanks and appreciation to Mick for his hard work and strong leadership over the last three years. Under his Deanship, FGDP has increased its influence, strengthened its world class education and re-vitalised its Fellowship programme, fit for the future ahead of us.

'It is a great responsibility to lead the UK's only professional body dedicated to general dental practice, and a huge privilege to be able to draw upon the immense talents, knowledge and expertise of our members as we move forward together to establish a new College of General Dentistry as the academic home of GDPs.' ◆

Going through the motions

David Westgarth
Editor, BDJ in Practice

Two days. More than 40 motions and 240 delegates. This year's Local Dental Committee Annual Conference held in Belfast has drawn many positive comments from those I have spoken to who attended – upbeat, engaging, optimistic.

Against a backdrop of unprecedented challenges facing the profession, one would think this represents a step in the right direction. Thanks to the four offices of the Chief Dental Officers in England, Wales, Scotland and Northern Ireland, we're in a more informed position about the impact of devolution on NHS services and how they are working to get prevention back at the heart of the dental contract in England.

While I do not disagree with the positive sentiments echoed, I cannot get away from being reminded of a scene from *Monty Python's Life of Brian*. In it the 'People's Front of Judea' call an emergency meeting to discuss that there be immediate action – once a vote has been taken – on how to help Brian, not moments after declaring 'it's action that counts, not words, and we need action now'.

Take any failing relationship, for example. At some point throughout that cycle before a split, one of the parties involved will identify the problem, but may find it difficult to offer a solution. As the relationship nears breaking point, continual affirmation of the problem without a solution leads to a cycle of frustration, and ultimately neither party is happy with an apparent lack of progress.

If that sounds familiar, you could substitute a relationship for contract reform. You could substitute it for negotiations with DDRB. The options are endless.

Which brings me to the motions tabled. Why, for a profession trained in the art of identifying a problem and fixing it, and preventing it from happening to begin with, are we seemingly content to merely state the problem without offering solutions, and doing little else other than metaphorically and literally going through the motions?

If you take the following three motions – and there are more to choose from – you begin to see the issue at hand.

'This conference deplores the manner in which the government, whilst publicly advocating wider dental access, is covertly reducing treatment availability by diminishing the dental budget through claw back'.

'This conference believes that the delays in implementation of the pay awards, particularly in Northern Ireland, every year are unacceptable'.

> 'Have we become so entrenched in the problems that we can no longer see solutions, and when we are presented with one we revert to the approach favoured by the People's Front of Judea?'

'This conference demands that dentists cease to be tax collectors on behalf of the government and that the Treasury find an alternative mechanism for collecting patient charges'.

Three very real, tangible problems affecting large swathes of BDA members, yet three motions that do very little other than go through the motions, which were carried unanimously. Where is the suggested solution to these problems? It is perhaps little wonder relations between NHS England, the Office of the Chief Dental Officer in England and the dental community are so fraught. The BDA has long highlighted problems and no forthcoming solutions – irrespective of the number of consultations and responses – at the GDC.

Are these motions guilty of the very accusations the profession labels at the regulator?

Clearly not all of the motions were in this vein. I firmly believe LDC Conference is a very useful and engaging event to gauge the thoughts and emotions of those in attendance. Yet it is at this point I will draw attention to two specific motions tabled.

'This Conference believes that dialogue with NHS England has produced very little benefit and calls on GDPC to investigate all forms of potential industrial action that will assist those of the profession affected by the intransigence, to support via a ballot'.

'This Conference calls for the implementation of an Interim NHS Dental Contract Proposal while GDPC continues to engage with DH in the pursuit of positive Contract Reform – providing a transitional phase aimed at reducing pressures on the NHS dental workforce and improving its morale and improving the quality of patient care – until such time as Contract Reform is ready for national roll-out'.

Two motions that present a problem, and very clear solutions. Very different to the three previously highlighted that were all carried unanimously. In the case of these two, they were carried with a very slim majority. Far from going through the motions, healthy debate on how to advance the problems the profession faces provided a fascinating insight from my chair. Have we become so entrenched in the problems that we can no longer see solutions, and when we are presented with one we revert to the approach favoured by the People's Front of Judea?

This is my problem, so what is my solution?

I call for this conference to deplore the affirmation of continuing problems and to encourage the submission of solutions about how we can collectively begin to rectify the vast number of issues this profession faces. Only then can we truly be in a place to make a difference. ◆

Drill and fill, or lifts and fillers?

By David Westgarth,
Editor, *BDJ In Practice*

If your shower starts to leak, there are a number of options available to you in order to bring about a solution. You could do it yourself, which, unless you've got detailed knowledge of how to identify the problem, probably isn't advisable. You could call out your local handyman, who you know has a bit of knowledge in fixing pipes, or you could call a plumber, a specialist in the area.

One would reasonably assume most people would go for option three – call the one expert who knows. There's probably a degree of safety in the decision too – what if you encounter problems with your local cash-in-hand handyman? Most reputable plumbers are part of a guild or association, and complaints and subsequent resolutions can be addressed.

And after all, you don't pay for a plumber to bang pipes, you pay them to know which pipe to bang.

Which leads me onto a rather curious case of symmetry in the profession. If, as a patient, you decide you want to have Botox, do you do it yourself (highly unadvisable), do you go

to a dentist, who may have the skills but isn't adequately regulated, or do you go to a fully qualified medical professional?

I use the phrase 'adequately regulated' very carefully, however the facts are clear, and pose a number of ethical dilemmas and unanswered questions; no regulatory body officially regulates dentists offering cosmetic facial treatments.

> 'If, as a patient, you decide you want to have Botox, do you do it yourself (highly unadvisable), do you go to a dentist, who may have the skills but isn't adequately regulated, or do you go to a fully qualified medical professional?'

A popularity boom

In order to understand and address some of the ethical dilemmas posed, it's worth asking the question how and why do dentists now offer treatments like Botox and fillers rather than doing what most patients would qualify as their day job.

The non-surgical facial aesthetics (NSFA) industry represents nine out of every ten cosmetic interventions and 75% of the market. In 2014 a total of 45,000 surgical procedures were undertaken: it is estimated that the cosmetic industry is worth £3.6 billion per year in the UK alone.[1] Non-surgical facial aesthetic treatments are easily accessible, affordable, relatively non-invasive and acceptable to patients.

Take that in the context of what dentists have seen. The last decade has seen income for dentists fall by 30%. Public sector pay rises have been capped at 1% while inflation has significantly outstripped that. The make-up of the dental workforce has changed – more professionals than ever before are seeking a 'portfolio career', while the corporate market in the UK has had a profound effect on the pathways into the profession for new and young dentists. The recruitment crisis that runs deeper than dentistry. Half of British employers think they will struggle to find the permanent staff they need – the biggest proportion since early 2017 – according to a survey from the Recruitment and Employment Confederation (REC), is perhaps a direct result of the previous points. With recruiters struggling to fill vacancies in non-urban areas, you begin to see why dentists feel they may need another string to their bow, simply to be employable.

It isn't always a necessity for employees to be better than the next CV. Many practice owners feeling the pinch are investing in their staff for them to be able to offer facial cosmetic treatments. In the other direction, public demand for non-surgical treatments have boomed in the last five years. Dermal fillers remained the most sought-after non-surgical procedure, and the fastest growing cosmetic trend of 2016 was non-surgical nose jobs, with an increase of 29%.[2]

With supply marrying demand, it is perhaps for this reason why in March of this year Simplyhealth Professionals launched a new Flexible Payment Plan, opening up the possibility for patients to spread the cost of anti-wrinkle treatments, Dermal fillers and Botox alongside cosmetic dental procedures. I asked Catherine Rutland, Head of Professional Support Services, Henry Clover, Chief Dental Officer, and Sandy Brown, Director of Dentists at Simplyhealth Professionals about the potential conflicts of interest dentists may face.

'The allocation of time for dental and non-dental work are two separate business objectives', Sandy suggested. 'The vast majority of funding – as it's not a claiming plan like the dental-specific offering we have – is still for general dentistry. We had presumed it may have been for the more cosmetic end of the market, which hasn't materialised.'

Henry added: 'Consumer attitudes, health trends and on a more basic level the market have all changed. Prevalence of common dental disease – caries being the prime example – has changed. We know that older people are living longer, keeping their natural teeth for longer but have very different and complex needs to address than what we have seen in the past.

'To be successful, any business, and especially a small one, needs to adjust and react to the market. As Sandy has alluded to, demand for cosmetic work is on the increase, so if that's something dentists need to offer to patients, then provided its done ethically and responsibly, this type of plan meets the needs of the current market. Dentistry is and always will be the mainstay of the business, and any further branching out will be complementary to that.'

Danielle, a patient co-ordinator for a cosmetic surgery company based in London, believes patient knowledge is there – they just choose the plumber over the handyman.

'On average, I would guess that around 8 out of 10 patients that come to see me are aware that a dentist could offer Botox, dermal fillers and other non-surgical facial aesthetics', she told *BDJ In Practice*.

'That doesn't necessarily mean that's what they choose. Medical treatments of any form require a degree of trust in the professional undertaking the work. In my opinion, there's significantly more trust in those qualified to undertake the work than a dentist.'

To me to you

It's at this point I will draw your attention to two of the main regulatory bodies in the medical field – the GDC and the GMC. Responding to a question about the GDC's role in relation to dental professionals undertaking cosmetic treatments such as Botox or fillers, Matthew Hill, Executive Director, Strategy of the General Dental Council, said: 'The provision of cosmetic services such as Botox or fillers falls outside of the practice of dentistry, and the GDC has no immediate remit regulating this activity.

> 'I know of people hosting Botox parties in their friend's living room. They make a social event out of it. Would I choose a dentist over one of those? Without question I would – but that doesn't mean I'd choose a dentist over an aesthetic practitioner.'

However, we are conscious of increasing public concern about dental patients potentially being 'ported' into unnecessary and possibly unwanted cosmetic treatment by dental professionals who are effectively trading on their title, and we are considering the regulatory implications of this issue. And of course, where a dental professional's conduct might have an impact on public confidence, whatever they are doing, it might raise questions about their fitness to practise.'

In answer to the same question posed to the GMC, a spokesperson said they regulate their members, rather than any specific criteria of procedures offered.

An entirely sensible suggestion, one would surmise. However, on closer inspection of the GDC's statement, two things should cause great alarm for professionals offering these treatments. The first is that essentially, they regulate the practice of dentistry, rather than their registrants, and secondly – and perhaps more shockingly – even though they do not see it as their job to regulate, they are still willing to suggest it 'might raise questions about their fitness to practise'. We don't see it as our job to regulate, but we'll certainly listen if you have a problem with the dentist offering it. Is that acceptable? Is it acceptable that the GDC, whose motto is '*regulates dental professionals in the UK, maintaining standards for the benefit of patients*', can directly contradict that statement?

Danielle believes the onus on regulation lies with those qualified to understand the procedures involved.

'I would think it would be up to the GMC to regulate it, as it isn't a dentistry problem as such. Although it is a dentist carrying out the procedure, that doesn't mean that it is dentistry work.

'Like the plumbing analogy, there are safe ways of doing this and there aren't. Anyone can do a Botox course. I know of people hosting Botox parties in their friend's living room. They make a social event out of it. Would I choose a dentist over one of those? Without question I would – but that doesn't mean I'd choose a dentist over an aesthetic practitioner.'

Sandy took a different stance.

'It's entirely proper for dentists to augment their business earning capabilities, in particular where relevant to the fixed or declining NHS earnings, and while I agree that lack of regulation is mystifying what better place for patients to receive these treatments than from the highly regulated practice environment of dentistry.

'Sir Bruce Keogh's report in 2013 highlighted there was no regulation in this area, and four years on there is still no compulsory regulation. There are avenues of voluntary regulation, but there aren't enough practitioners aware of their existence.

'Dentists have been urged post-Keogh to check with their indemnity union. Defence organisations have been more reactive and alive than the dental regulator by tightening up their regulations to ensure their members have the right cover for the situation.'

Reactive or proactive

It isn't a stretch of the imagination to think dentists are providing non-surgical facial treatments to improve their bottom line. Stories of employers struggling to recruit in non-urban areas and associates in urban areas being offered low UDA rates create a perfect storm. Does that mean we have seen a rise in dental professionals having to turn to non-dental items to be more employable than the next? Catherine believes it may be the other way around.

'A lot of dentists who train to do facial aesthetic treatments do it secondary to having been on courses to widen their dental scope of practice', she said. 'I have heard of and seen a number of people doing a Masters quite soon after qualifying, and there may be an element of that thought process which feels rushed through.'

'In my experience practitioners seek to build their CVs and portfolios by doing clinical, academic additions ahead of cosmetic treatments like we're discussing here. Nothing will ever replace getting on and doing what you've done at university, so personally I think it's about being able to increase your practice experience once you're in the surgery rather than increasing your qualifications before you can get a job. That's not to say it won't harm your chances, but the majority of employers will assess their dental portfolio rather than additional training they may have.'

Henry added: 'The gradual increase in population with complex needs means the training Catherine refers to will be invaluable in the short term for employability purposes to give the workforce the skills to meet these challenges.

'On the opposite side of the fence you have patients who haven't experienced high levels of caries who may have a good relationship with their practitioner, and if the 'sales pitch' process is done in the right way and any treatment is consented to after a full and frank discussion, I see no reason for dentists not to adapt and promote services they have available for the patient.

'There is a lot to be said about the balance between practitioners offering treatment to be more employable, offering it to get ahead of the curve, and on a more basic level the patient expectations that are driving those factors. The cosmetic market has been moving in an upward trajectory, and dentistry has always been slightly ahead of the curve when it comes to understanding the balance between what a patient wants rather than needs – tooth whitening, for example – I would argue we are better placed ethically and medically to provide non-surgical facial treatments.'

So, what is the main difference between the dentist and the aesthetic practitioner?

'I think the main difference between a dentist and an aesthetic nurse/doctor/practitioner carrying out these treatments is experience', Danielle added. 'I would imagine that a dentist has fewer Botox patients than someone who specialises in that area.

'This may not always be a negative. This could mean that due to their lack of experience the dentist would not rush the procedure, and would be more careful to ensure they did it correctly, *versus* someone who does it regularly who may become complacent. On the other hand, they may do it so rarely that they would (naturally) forget the best practice, ending with terrible results Experience does not always equal skill. It is a fine balance both ethically and practically that patients should be made aware of.'

Ethics and regulation

Dentists – and all other healthcare professionals for that matter – have a code of conduct and an ethical commitment to treat all patients in their best interests. That is indisputable. If you're seeing a patient within your surgery, even if the treatment itself may not be regulated, the fact of the matter remains you're still a better, safer option for that patient than if they went elsewhere.

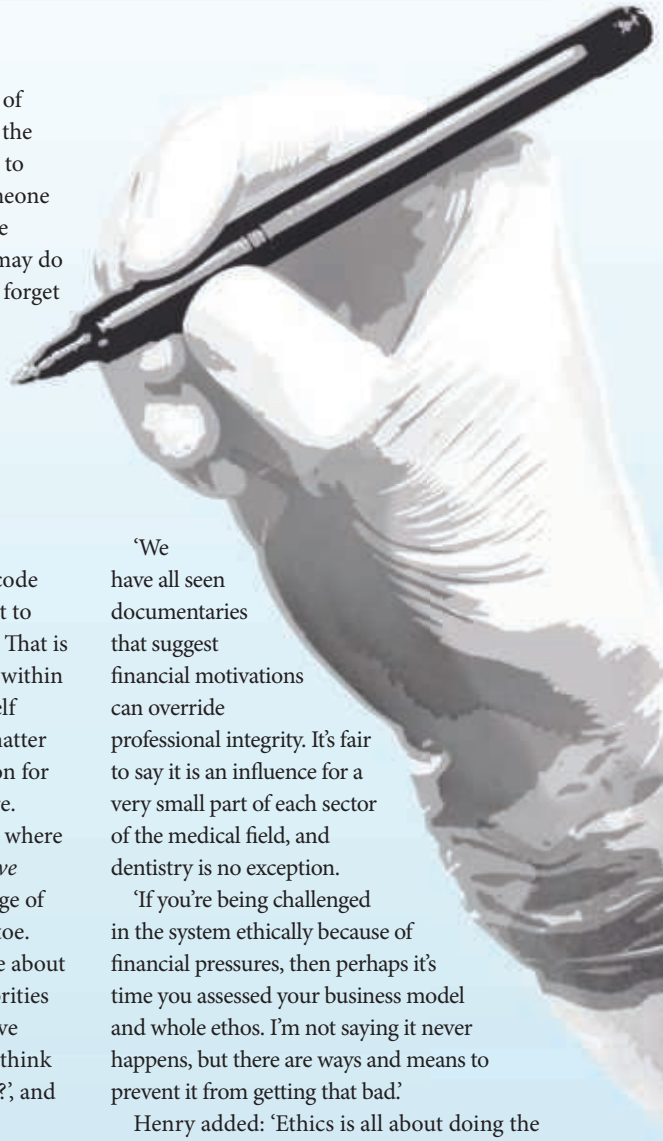
On the flip side, without regulation, where does one draw the line? Take ITV's *Love Island*, for example. There is no shortage of cosmetic work on show from head to toe. Tabloid newspapers do not think twice about highlighting the amount of work celebrities have done, for better for worse. We have probably all seen examples where you think 'who has thought this was a good idea?', and that's in a regulated industry.

And that begs the question, if patient autonomy can override professional integrity in a regulated industry, what's to stop it from happening in an un-regulated industry, and how is that providing safety for patients?

'I imagine that patients would approach the dentist themselves if there was a complaint about the results or the treatment process', Danielle suggested. 'I don't think that people would take the time to research whether or not someone was regulated, or even to look in to a complaints process before their procedure. I would question whether someone with an untrained eye would necessarily know they had a bad result unless it was drastic thanks to social media/celebrity culture – like you have previously mentioned.

'That's not to say they shouldn't research the treatment and the provider beforehand. You're having a procedure carried out after all. Patient prudency wouldn't go amiss here.'

'The profession has to sit within integrity', Catherine added. 'It can be a hard line to draw and be a hard message to a patient, but as professionals there is no other choice.



'We have all seen documentaries that suggest financial motivations can override professional integrity. It's fair to say it is an influence for a very small part of each sector of the medical field, and dentistry is no exception.

'If you're being challenged in the system ethically because of financial pressures, then perhaps it's time you assessed your business model and whole ethos. I'm not saying it never happens, but there are ways and means to prevent it from getting that bad.'

Henry added: 'Ethics is all about doing the right thing whether anybody finds out or not. Healthcare professionals have a huge degree of ethical awareness and understanding. A very small minority will perhaps succumb to some outside influences – like the bottom line – but it remains a very small minority.

'If a patient challenged me on how their treatment was handled, I would deal with it in exactly the same way I would if the GDC were involved in the regulation of it. There should not be any differentiation between ethics and standards.'

A window of opportunity

Sami Stagnell is a specialist oral surgeon working on the south coast. He has been practising aesthetic medicine for six years and is currently completing a Masters in Skin Ageing and Aesthetic Medicine with the University of Manchester. In March, he wrote an account describing a way dentists can, albeit voluntarily, gain regulation and increased credibility in the non-surgical facial aesthetics area[3] – by joining the British College of Aesthetic Medicine (BCAM).

In it he wrote: '*Within dentistry we have begun to see improving frameworks for postgraduate education but non-surgical facial aesthetics pose a barrier where many dentists may struggle to understand how to plan and evolve their theoretical and practical skills. This is especially prudent when we consider the recently changed framework for CPD and PDP implemented by the GDC.*

With so many changes afoot surrounding the cosmetic sector and the profession, there is a feeling that dentistry needs to find a home within non-surgical facial aesthetics, especially to ensure we continue to provide high levels of care to our patients.'[3]

From 2018, BCAM formally began to consider dentists eligible to join as members, a point BCAM president, Dr Paul Charlson, believes will only serve to provide patients with better treatment.

> 'Dentists are specialists in their area, and if additional treatments are being carried out that would fall under their expertise, I wouldn't be against the evolution of the curriculum to meet patient needs and expectations.'

Dr Charlson said: 'I am absolutely delighted that BCAM is now an organisation for doctors and dentists. I think it's important to include dentists because they currently don't have a body to represent them in aesthetics. Also, there is a huge number of dentists practising out there so it's a good opportunity for them to really work with us and increase their skills and knowledge.'

Futureproofing

In January 2016, Health Education England (HEE) published guidance for dental practitioners on who can do what and the level of educational qualification required to offer Botox, dermal fillers and other non-surgical facial aesthetics. That guidance suggested a level 7 qualification should be obtained by those wishing to practice NSFA in the UK.[4]

Given that dentists already offer Botox, and hold a Level 7 clinical qualification, could UK undergraduate courses provide training for dentists to be able to be trained in this field?

This was a question research published in 2017 addressed.[5] They concluded dentists were well-placed to offer these treatments, given their knowledge of relevant subjects and surgical training. They concluded that it would be '*prudent to consider that training standards around NSFA are reflected in both undergraduate curricula and appropriate post-graduate clinical training for dentistry.*'

If it was offered as part of the dental syllabus or as an add on, would it truly be a prudent move?

'Parking the practicalities aside, if you look at how the curriculum has changed – implants and amalgam, for example, were taught in a very different way when I was at dental school compared to now – you have to seriously consider the future needs of the population those students will be treating', Henry explained.

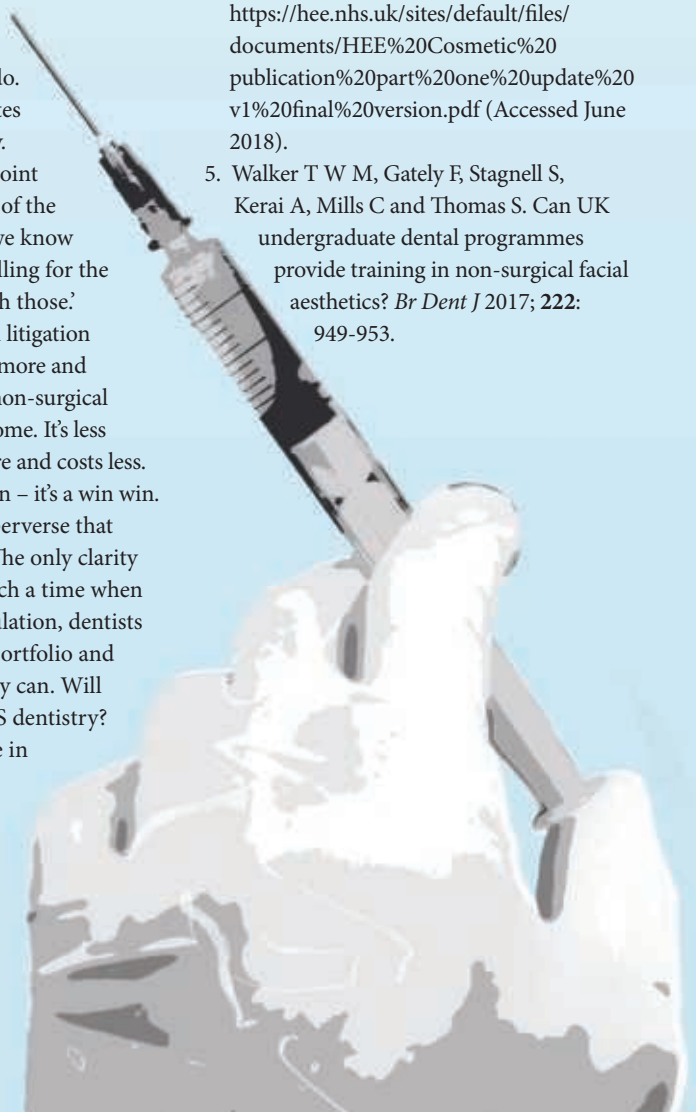
'I believe we will see more undergraduates spending time developing their knowledge on the links between oral health and general health. Dentists are specialists in their area, and if additional treatments are being carried out that would fall under their expertise, I wouldn't be against the evolution of the curriculum to meet patient needs and expectations.'

'It's very tough fitting it into the syllabus', Catherine suggested. 'It used to be 4 years and a term, which was expanded to 5 years simply because there is so much to do. Even then many new graduates still feel like they're not ready. However, I do take Henry's point about evolution. If the needs of the population change – which we know they are – we would all be calling for the syllabus to change in line with those.'

In a profession shrouded in litigation fear, maybe it is little wonder more and more dentists are looking to non-surgical procedures to boost their income. It's less hassle, it's quicker, it pays more and costs less. And there's no fear of litigation – it's a win win.

Yet – as Sandy said – it is perverse that there is no clear regulation. The only clarity is that there is none. Until such a time when we see clear and defined regulation, dentists will continue to boost their portfolio and income in whatever ways they can. Will that be at the expense of NHS dentistry? Will that continue to be done in a safe and ethical way? Will a widened scope of practise ultimately allow dental care professionals to penetrate this market?

Whatever your views, one thing is for certain. I'll continue to pay the plumber to bang on the right pipe. ◆



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Be careful what you wish for

Part two

Mike Young on the hard work starting now

Mike Young
Author of *Managing a Dental Practice the Genghis Khan Way*

Your newly appointed specialist probably will have never had to market their skills, but for both the practice and the specialist setting up an in-house specialist practice (that is what it is, after all) is not just about setting up a practice, it is also a long-term exercise in marketing, not only marketing clinical expertise, but also the specialist as someone in whom your colleagues are prepared to put their trust.

At some point either you as the practice, or the specialist, or even better, together, are going to have to bring in additional work by building up your sources of referrals from colleagues. You can do this by writing to all the dentists in your area telling them:

- About the specialist
- That they will be working at your practice
- They will be accepting referrals and for what treatment(s)
- The terms under which their patients will be treated i.e. privately
- How they should refer patients.

By now you and the specialist should simultaneously be working hard on your joint-marketing plan.

Other practices often worry that if they refer a patient to what is in essence a general practice, they will never see the patient again. One way of allaying such fears is to invite practitioners to an open evening so they can look around your new specialist facility: possibly meet and talk to the specialist; letting your employees talk to them so that the dentists see that the whole practice is a very well run and highly professional, ethical operation, which should help to reassure them that every referred patient will be sent back to them. You can do no more.

The specialist has to invest time to get themselves known among dental colleagues. They can do this by offering to talk at local dental meetings, starting a study group, and writing articles in the dental press, for example. The specialist has to be aware that it is not solely their clinical skills that

are going to make them a success, it is this plus customer care that really makes the difference. Making themselves well known in the dental world might not at first sight seem a likely way of attracting patients, however, it can be an effective strategy.

Being on the speakers' circuit and/or writing articles etc. imparts a certain authority and status upon a person. That person then becomes someone with whom other dentists want to be associated, ideally by referring patients. The specialist can advertise what they've been getting up to outside of the practice in their promotional material within the practice, which is seen by patients, who in turn think it is nice to be treated by someone who must be very well respected within the profession. It is a circular and self-feeding process.

I have deliberately not gone into a great deal of detail about how to run the specialist side of your practice, however, there is one aspect that warrants a great deal of thought, and that is the referral process. Decide between yourselves how you want your colleagues to refer patients to the specialist? There are obviously a number of options: telephone, email, online, letter. You should always insist on having a paper record of any referral, so if the initial referral is made over the telephone (to expedite the process) always ask the referring practitioner to follow this up with a written request. A letter is always the best way to refer: it provides a permanent record (important for medico-legal reasons) and leaves the writer free to say as much as they want about the patient and their problems.

The second stage of the referral process is when the practice contacts the patients to arrange their first appointment. As this is the first contact a new referral has with your practice, the practice needs to be geared up to handling this as smoothly as possible. You only get one chance to make a great first impression. One way of handling this, if it is agreed with the specialist, is:

- Your receptionist should contact the patient within a day or two of receipt of the referral. (The specialist may choose to contact the patient themselves, which is a more personal touch.)
- It should always be made very clear who is contacting the patient and why
- The initial appointment is made, and if this is done over the telephone, written confirmation should be sent by first-class post by way of confirmation. Email is faster and more convenient but is not secure
- The receptionist should ask the patient if they have any questions and should answer these as fully as possible
- The patient should be given information about directions to the practice, parking facilities etc. Nothing should be left to chance.

> 'I am not sure if this is the rule or the exception, but I have come across specialists who give their patients their personal mobile number, their email address, and who will bend over backwards to deal promptly with all clinical problems, no matter how small.'

Practices can sometimes have problems with specialists. Practitioners have often had to make substantial investments in terms of both cash and time; sometimes these specialists can be difficult to manage, for example, because they only work one day per week and are leaving clinical problems for the practice to resolve in the interim. Any dentist working in several places always has the risk of mid- or post-treatment problems arising with their patients when they are not in attendance; this is more of a problem with specialist treatment and the practice not being able to adequately deal with the more serious problems. This is something a practice would have to work through with the specialist from the outset because patient care could potentially suffer. I am not sure if this is the rule or the exception, but I have come across specialists who give their patients their personal mobile number, their email address, and who will bend over backwards to deal promptly with all clinical problems, no matter how small. To me, this is customer care par excellence. Implants, for example, have their own unique set of problems and, if not managed correctly, can become major issues with the risk of litigation.

Practices quickly realise that there is also a lot of compliance to organise for the small amount of time the specialist is actually working. There is no way around this, but the practice has to balance this against the benefits of having a specialist on board.

A not uncommon problem apparently is specialists playing one practice off against another to secure a better deal. This could work in a practice's favour if that practice happens to have excellent facilities, superb staff and a proactive marketing strategy. There's also the question of who owns the goodwill, is it the practice or the specialist? Practices have sometimes found that their specialist(s) are not really team players, that they tend to focus on their own interest, and are reluctant to work with other disciplines. Co-ordinating an overall treatment plan can therefore be problematic, resulting in patients being left feeling as if nothing is being done, or it's being done slower than when they were under the care of just one dentist.

So what about the specialist's point of view? Let's invent a specialist, one who works in one practice 3-4 days per week and who works, say, in 4 other practices for 1-2 days per month. What are the benefits for them? The most obvious ones are variety and flexibility. Working in different practices with different staff and a variety of patients appeals to some. Some specialists cite not being reliant on one practice for their income, with the possibility of being able to switch sessions if one practice isn't busy, as the main reason for their peripatetic life style. Obviously the flexibility aspect might suit the specialist, but might not be so good for the practices. The specialist might not want to get tied up with practice politics as they might do if only working in one place. However, does this call into question their loyalty to a practice? Advantages for the specialist often translate into disadvantages for the practice.

The downsides for our specialist include frustration when a practice is not very well run, the amount of travelling they might have to do, and the need to meticulously plan and manage their diary and patients. This problem of working in a not-very-well managed practice is a common thread among specialists' complaints. I think it is fair to assume, and not unreasonably, that the specialist simply wants to go to work, do their job, and go home. It is probably the case that the best treatment is carried out when everything from a practice management point of view runs like clockwork. ◆

In the final instalment, Mike discusses what can go wrong – and how to put it right.

The role of GDP in the diagnosis and treatment of Obstructive Sleep Apnoea

Dr Badr-Amin Mihramane discusses why we're in a prime position to identify an under-diagnosed problem…

Dr Badr-Amin Mihramane
Maxillofacial DCT 2

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Obstructive Sleep Apnoea (OSA) is recognised by the medical community and the general public as an important chronic medical condition which can have serious medical consequences. The condition can not only impair ones quality of life, through the disturbance of sleep which plays an important role in one's physical health but it can also reduce lifespans. A staggering 250,000 men in the UK have sleep apnoea[1] with 5% of the UK adult population thought to have undiagnosed OSA.[2]

The NHS is at the forefront of nationwide screening. Intra-oral examination of oral lesions has shown a significant increase in early diagnosis of oral cancer[2], which begs the question if a similar approach would yield similar results with the early diagnosis of OSA. The aim of this article is to discuss the dual role GDPs have in identifying patients with OSA and referring to secondary care (specialist) when primary care is not appropriate. Secondly, they can provide effective devices for the control of OSA as second line therapy. This article will also discuss the overall implications clinicians face in the diagnosis and treatment of OSA which stems from the fact that to date the dental profession has not been given much guidance as to which cases should be treated in the first instance and those who should be referred for specialist assessment; such a service therefore needs adequate prior training and a general strategy which encourages a multidisciplinary approach to the management of those suspected of having OSA.

What is meant by the term OSA?

OSA is a common condition in which the walls of the throat relax and narrow during sleep.[2] The risks associated with OSA are not limited to interrupted sleep, there has been growing evidence to suggest that it increases the risk of developing certain conditions such as type 2 diabetes and heart problems.[3] Symptoms which often present themselves can be loud breathing, snoring at night and sporadic episodes of interrupted breathing.[3] There are two types of breathing characteristics which are defined as:

- Sleep **apnoea**: where the muscles and soft tissue collapse in which there is complete blockage of the airways (10 seconds or more)
- Sleep **hypopnoea**: a partial blockage of the airway that results in airflow reduction of greater than 50% for less than 10 seconds.

The role of GDPs in the diagnosis of OSA

There is strong evidence to suggest that there is an average of seven years between first symptoms and OSA diagnosis.[4] In view of this, can GDPs do more in respect to diagnosing and preventing the condition to develop? On average, a GDP will see up to 80 adult and child patients a week. Given that the profession comes into regular contact with the general public, GDPs have an important role in identifying patients with OSA.

As part of routine dental check-ups, GDPs can use their medical training to recognise a small upper airway and other anatomic risk factors associated with OSA. Notwithstanding that most patients will present obvious symptoms, simple screening questions and looking out for possible risk factors such as obesity, specific skeletal patterns, chronic fatigue and commercial driving can address the issue of under-diagnosis of OSA. With reference to undergraduate training, more provisional learning time given to the topic together with exposure to OSA patients is required. At the other end of the spectrum,

the diagnosis of OSA in more severe cases, however, should be referred to the OMFS/ Respiratory unit, whose training prepares them to explore the interaction of OSA with other medical diagnoses.

OSA is not limited to adults but also effects children as young as 4 years old.[4] The British lung foundation has taken action in providing greater awareness about OSA among children.[5] The associated night-time symptoms of gasping, snorting and choking sounds can cause early morning headaches, tiredness, poor concentration which will undoubtedly affect their formative years in education. A simple form or questionnaire similar to a diet sheet would provide more information to form a diagnosis and potentially detect OSA at an earlier stage. If studies show that an expansion in the role of the GDP results in better diagnosis and treatment of OSA, this may potentially prevent maladies such as type 2 diabetes, heart disease, stroke and obesity which can be co-morbid with OSA.

What treatment is available?

Conservative management in the form of advice regarding weight loss, sleep positions and cognitive behaviour therapy is often provided in the first instance by GPs before more invasive measures are looked into. However, for some, referrals are often directed to OMFS units who, for example, can construct Maxillary-mandibular advancement (MMA) prosthesis, although this treatment option is not always readily available on the NHS. Nasal inhaled corticosteroids can aid younger adults who have OSA, this is often coupled with surgical intervention if deemed necessary (Adenotonsillectomy). The more common approach is providing the patient with a continuous or bi-level positive airways pressure (CPAP) device. This can help the patient by providing a constant airflow through a face mask to aid breathing; this treatment is usually overseen with follow ups with a respiratory speciality team.

The more invasive measures will be overseen by the maxillofacial department who will undertake orthognathic surgery if the patient has an unfavourable malocclusion in relation to their OSA symptoms. New interventions and techniques are still developing worldwide but comprehensive evidence has yet to be

produced to suggest such measures are more efficient in tackling OSA. The management of OSA is a case-by-case consideration which is heavily reliant dependent on the clinician's experience, advanced knowledge and technical ability when diagnosing and confirming treatment planning.

> 'Given that the profession comes into regular contact with the general public, GDPs have an important role in identifying patients with OSA'

Can the introduction of OSA intervention be feasible under the current NHS climate?

As ever it is critical to assess the feasibility of treatment for those patients that receive dental/medical treatment through the NHS. The way in which GDPs will be reimbursed in relation to OSA intervention may be similar to the way in which they are reimbursed for administering periodontal intervention. In other words, there would be limited financial incentive to carry out this type of work.

However, encouragingly in a survey answered by 50 dentists – including consultants, restorative registrars and GDPs – 82% strongly agreed that OSA intervention should be within the scope of dental practice and agreed that more can be done in tackling this condition.[5] This stance would be more widespread amongst the medical community if future studies show a strong positive correlation between the active participation of GDPs and diagnosis of OSA.

The NHS can provide a clear communication pathway between medical establishments and specialities and, as an example, the use of MMA prosthesis can be undertaken by the Banding system under the NHS Band 3.

Generally, whether treatment is provided within the NHS framework or otherwise, more guidance should be provided to GDPs if OSA screening is to be implemented by clinicians nationwide, for example, GDPs assessment on patients' blood pressure, heart rate and oxygen saturation; the results of which may establish an early diagnosis for widespread medical conditions.

In summary

GDPs can play an important role in identifying patients with OSA. A clear understanding of the symptoms coupled with clear guidance from the specialities involved is paramount to the diagnosis and treatment of OSA. Treatment for OSA is a multi-faceted task requiring substantial knowledge, technical ability and good communication within the healthcare network. Recent studies have emphasised the need for more GDP/ GP involvement when referring to specialist care in the UK, especially for those who are placed in lower socio-economic background under the NHS contract. Both GDPs and GPs have essential roles in the treatment of OSA each contributing their special expertise. It is important that a collaborative relationship be established so that patients will receive the most effective care for OSA. Dentists have the opportunity to have an effective and significant role in OSA. It is clear more exposure and teaching is required for this to come to fruition but evidence has shown[2] that when clear guidance is given to the profession, significant targets and nationwide improvements can be anticipated. ◆

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More than just a dental practice

Mark Topley on the value of Corporate Social Responsibility

Good family dentists are often held in high regard, appreciated for the work they deliver with dedication and care. And, although as prevalent as other essential health services, the dentist isn't often the first institution people think of when they describe the fabric of their local community.

Many family dentists work for most of their careers in the same area, and, at least until recently, treat multiple generations of the families they serve. During my time as CEO of Bridge2Aid, I met several volunteer dentists, recently retired, who had been in practice in the same town for over 30 years, often treating more than three generations of the same family during their tenure.

However, with the rise of the corporate dentistry and the changes in NHS and private dentistry, the dental landscape is changing.

Against a backdrop of the dental practice as part of the community, this presents a challenge for dental practices. How can a practice attract patients and keep them for the long term? How can they stand above other practices in the eyes of the consumer? And how can they find and retain a strong team of staff?

But it also creates an opportunity.

Corporate dental practices must demonstrate that they have a vision beyond mere profit and an identity beyond their national brand. In order to connect with current and prospective patients, they must build brand affinity with the communities they are a part of.

Independent practices have the opportunity to differentiate themselves strongly from their competition. Without corporate guidelines to follow, independent practices can be more flexible and choose causes close to the people in their area or causes that they connect with in the sector. This, along with the potential longevity of their relationship with the community, can bolster their standing with those they aim to serve.

Whether corporate or independent, NHS, private, or mixed, all practices will need to exhibit the hallmarks of a respected practice:

- a reputation as a capable and caring institution that excels in patient care and customer service
- meaningful investment in staff, and a commitment to good leadership
- environmental responsibility including reducing waste, maximising recycling, sourcing recycled and fairly traded products, and committing to green energy
- a positive contribution to good causes and the community.

In fact, not only are these the hallmarks of a respected practice, they are the core components of Corporate Social Responsibility, or CSR.

But what is CSR – really?

CSR speaks to who your company is, what it believes, and how it does business. What you 'do' as part of your CSR flows from your values as a business and how you see your role, your influence, and your responsibility as part of your community and society. It flows into how you engage with your local and wider community, basically, how you play your role as a good corporate citizen. It flows into acting honestly and with integrity as a business, going beyond mere compliance. And it flows into how you treat your team. If CSR is done well, and with commitment, it creates heart and energy at the centre of your business.

Your business needs CSR

CSR is increasingly important for two reasons.

Firstly, ignoring CSR is no longer an option in the opinions of both consumers and staff. In recent years, society's values and expectations have shifted, and continue to move at pace towards judging businesses of every level at a standard beyond profit. Nearly 9 out of 10 people now expect the businesses they buy from to create social and environmental benefits as an integral part of their business strategy. In people below the age of 30, this number is even higher. Consumers

and staff will reject companies they perceive to be doing harm or acting in a socially irresponsible way.

Secondly, there are huge gains available for companies that have a strong CSR strategy in place. It has a strong impact on your team, your patients, and your reputation. It creates staff that are happier and more engaged. Consider that 76% of millennials weigh social and environmental factors when seeking employment and 83% will be more loyal to a company that helps them contribute to society through their work. Also consider that millennials will make up 46% of the workforce in just two years, and a full 75% by 2025. Having a strong CSR strategy in place will help your business find and retain strong staff which, in and of itself, is good for business.

It's a win-win scenario.

The word 'strategy' is key though. It's not that people aren't doing CSR type activities, but good planning and intention are fundamental to having CSR make a difference for your business. I often see CSR fail to make an impact when businesses have one-off, or sporadic ideas with no over-arching purpose to tie everything together. Without a thought-out strategy, a bit of engagement here and there doesn't necessarily differentiate your business. It's the consistent, themed approach that garners attention and respect and signals that you are committed to the causes and the community that you serve.

When done well, good CSR can help increase turnover, keep staff happy (and less likely to leave) and improve your standing within the community around you.

As a case in point, Phil and Shaenna Loughnane ran two highly-successful practices as part of the Chipping Manor Dental Practices in Gloucestershire.

Having sold Chipping Manor two years ago, today Shaenna runs the dental charity, Bridge2Aid, while Phil continues in practice.

They built a strong business, always making clear they wanted to do something 'extra', to create a 'culture of trust', between themselves, their local community, and their patients.

Chipping Manor decided to support Bridge2Aid, the charity where I was, until recently, CEO. They helped 19 staff members to travel to Africa as part of Bridge2Aid's work in Tanzania. Staff volunteered, usually in rural areas, facing very challenging circumstances.

'Those who volunteered definitely came back changed people, and grew as individuals and practitioners,' says Shaenna.

When hiring new staff, there were regularly applications that specifically mentioned the practice's charitable work. And staff turnover ended up lower than the average for the dental sector, too.

In fact, research suggests that a good CSR programme can help create a more effective, inspired and engaged team and reduce staff turnover by up to half.

Key factors for success

It's important to consider four keys – *commit, fit, connect, and manage*. You need to commit wholeheartedly to the activity and to having a strategy. You need to find a cause or a set of causes which fit with your business. You must connect your team and your other stakeholders to what you're trying to do. And you must manage the process like any other value-creating asset in the business.

In doing CSR well, there are four key results you can expect and there are studies to back this up.

Positive PR and reputation – strong CSR helps you build your brand and gives you a reason to talk to your patients. Having a strong statement about your values and commitment to CSR on your website, which is then evidenced through the subsequent activity (at the appropriate level and frequency) is a powerful way to communicate. Photos of your team taking part in activities and engaging with the community gives you the opportunity to generate genuinely positive PR for your business and good causes, strengthening your brand.

Customer loyalty – CSR activity can demonstrate the kind of authenticity in the company that customers are looking for, particularly when, as a dentist, they are trusting you to treat them. Knowing that you are committed, not just to clinical excellence, but to being a responsible corporate citizen, and seeing that demonstrated through regular activity, cements customer loyalty. Studies suggest that you can see up to a 20% bump in revenue, and for many reasons, it is easier to engage with your patients if you demonstrate good CSR.

Staff engagement and retention – CSR is important for your team. Getting your team involved in planning and participating in activities will boost collaboration and give them a shared purpose. There are many factors that contribute to you retaining team members, but a sense of purpose at work is increasingly important. If you can demonstrate or provide a way to bridge the gap between your team's personal values, and give them an opportunity to outwork a level of this within the business through your CSR activity, evidence suggests that this creates a very strong loyalty in your team. In fact, an up to 50% reduction in turnover can be expected when you have a good CSR policy in place.

Social impact – good CSR will create maximum impact for good causes. Well planned and managed activities raise more money, and there is nothing more satisfying than seeing the benefit of your commitment to CSR changing lives in your community and beyond. Charitable organisations will also thank you for your forethought as it makes their own planning slightly easier.

It's obvious that CSR is becoming increasingly important for businesses of all sizes. With some forethought, and the integration of some simple policies, principles and activities, you will benefit your community, connect with patients, strengthen your team and raise the profile of your business to more than just a dental practice. ◆

Mark Topley is a CSR Coach, helping dental practices and businesses to maximise impact from their CSR. He writes at marktopley.co.uk, and provides free articles and advice on his Facebook page – facebook.com/toppernator, Twitter @Mark_Topley

The significance of female role models within the workplace

Dr Mahrukh Khwaja, founder of Empowering *Women in Dentistry*, talks to *BDJ In Practice* about the role – and value – of female role models

Dr Mahrukh Khwaja

Why do you feel so strongly about this?

After graduating from King's in 2010 and completing my vocational training, I decided to stay within NHS dentistry and worked in Kent, Essex and Birmingham. My first years after university were the worst in my career. I was unfortunate enough to have two extremely narcissistic bosses – a woman and man – who were much more invested in tearing down rather than nurturing. It was when I finally moved back to London after my divorce that I decided it was long overdue for me to invest in myself and career. I wanted to have more meaningful connections with patients. I wanted to make a difference.

I signed up to all the courses that would help me upskill and provide high quality dentistry that could change a smile and life. It was exhilarating to finally meet other female dentists that were passionate about their career. Only one of the courses was led by a female. It wasn't until I met Dr Mali Aghelnejad, and felt an instant euphoria that I could also be as successful as her, did I truly value the significance of positive female role models within dentistry and the wider business world.

In your mind how significant are role models?

We only need to look at our own childhood experiences to appreciate the significance of

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our attachments and the value of role models in inspiring, motivating and encouraging us to be the best versions of ourselves. Despite throughout the UK and across all forms of society. Successful women are simply not portrayed within the workplace as their male counterparts are, and in 2018, that cannot happen.

From the moment I met Dr Aghelnejad, I noted that at every course or conference, despite finding them inspiring and educational, it was painfully clear how under represented women were.

What changed?

In March, I was on a train to another course, and I distinctly remember saying to myself it really is time for change. I wanted to be part of a group that helped empower women, to help them connect rather than compete against each other, and to collectively challenge inequalities within the workplace. Strength in numbers is a strong way to create momentum. Maybe the Harvey Weinstein scandal as a backdrop provided the impetus for us to begin to build that momentum – momentum that propelled me to develop this concept and direction. I just knew from then on, I couldn't shake my desire for change.

I searched online and social media to see if there were similar groups. I reached out to male course leaders. I spoke to other women. There just didn't appear to be a group that represented women in a way that I personally connected with and that reflected what I wanted to achieve. I initially envisaged interviewing women in dentistry to showcase positive role models. I thought about approaching journals and other blogs to publicise my cause. It wasn't until one individual gave me some excellent advice; to stop asking for permission from others and just do it. From then that I took the plunge to make the group a reality.

How has it been received?

It's been a short but amazing ride so far, and it is my aim to take the group further. Our first social was held on 30 June, and I believe it will be the first of many. I have paired up with a life coach to discuss turning our vision into results. I also plan to start workshops on mindfulness and meditation so that holistic living can be practised.

I opened an Instagram account for the group, set up my own blog and bought my domain. I initially approached women via social media to initially gain some traction, but then women started approaching me to be involved, which was amazing from my point of view.

Throughout every interview one common theme emerged – they have had to fight against adversity and been bullied at school level or university level, some also undermined in the workplace.

What strands have you discovered about barriers to senior roles?

While they do exist, the reasons and the barriers are complex. Men do not appear to be giving women the same opportunities as other men. This is clear when I look at the lack of female representation at conferences or courses. There are certainly women that are successful and excellent teachers, but they are not given the same platform to speak. There does seem to be an 'old boys club' that still exists and yet is archaic in today's progressive climate.

> 'Throughout every interview one common theme emerged – they have had to fight against adversity and been bullied at school level or university level, some also undermined in the workplace.'

Fear is another barrier encountered, both in life and the workplace. From the fear of taking a risk and moving to a better job to the fear of standing out or being heard, the fear of feeling vulnerable does seem to hold them back. That isn't to say the fear of not being good enough or the fear of not being successful doesn't affect men too – of course it does. It is simply a common theme that courses through the discussions I have had, and when you take into account the issues we have already spoken about here, perhaps it is unsurprising.

Society has a lot to do with that. From an early age, depicting women in a certain light – the pretty girl and the nurturing woman. Women that are beautiful, ambitious and strong are still not readily celebrated in mainstream culture. To change a culture and achieve equality in the workplace, some difficult conversations need to be had. It is through discussion, identifying inequalities, I hope there will be greater appreciation of the challenges women face.

How do you begin to improve on something like fear? As you point out it can be deep-rooted from childhood

Women need to learn to reframe fear. By taking risks, women can begin to conquer new territories and lead. Instead of remaining hostage to fear, we may say to ourselves, wonderful things are going to happen to me. It's a bold affirmation. It's our vision for an empowered, liberated future.

I firmly believe women also need to take risks and explore the possibility of leadership. Women need to dream big and be proud. It's a change in mindset, but one that we ultimately have control over.

How do you aim to build on this for the future?

I believe that we can create more female role models within the workplace by celebrating women more. We need to be invited to the table. Women need to take the risk to put their hand up more. Women need to lead conferences and courses.

Teaching the next generation of young, ambitious women – even as old as new dental students – is also vital. Self-love, creating healthy boundaries, leadership and creativity are skills that can be fostered at school level. Why not invite therapists, councillors and life coaches to discuss these relevant topics and create a more holistic curriculum?

As cheesy as it may sound, as the Empowering Women in Dentistry group has developed, I really do see them as my role models. Part of the problem was that I just did not know female role models in dentistry. Three of the four Chief Dental Officers are female, but representation further downstream is lacking. That is why I hope to continue promoting positive role models and build a community where comradery is strong. Let's make it an exciting time to be a woman in dentistry. ◆

Dr Mahrukh Khwaja is a dentist practising in Kent and founder of the women's group Empowering Women in Dentistry. She is passionate about changing the makeup of the profession and to challenge inequalities. She is a huge advocate for therapy and openness around mental health.

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Dental amalgam: change in the law for usage

From 1 July 2018, UK law states that dental amalgam should not be used in the treatment of deciduous teeth, in children under 15 years-old, and in pregnant or breastfeeding women, except when deemed strictly necessary by a dentist based on the specific medical needs of the patient.

The law has been passed on the basis of environmental concerns about mercury pollution, and does not reflect any evidence-based concerns about adverse effects of amalgam on human health.

What you need to do

- Follow the UK-wide guidance from the SDCEP on putting the new regulations into practice
- Print out the leaflets for Patients Under 15 Years Old, Parents or Carers of Patients Under 15 Years Old and Pregnant or Breastfeeding Patients

What is the BDA doing on this issue?

We have been lobbying at the European Union level and globally for over 10 years regarding the move towards phasing down the use of dental amalgam. We strongly argued the case that it should be up to dental practitioners to recommend the best restorative option for their patients on a case by case basis. The wording of the new regulation leaves scope for dentists to exercise clinical judgement and we are pleased that the concerns of UK dentists were taken into account.

Is it going to cost me more?

We know that many practitioners are concerned about the increased time required and extra costs of using other restorative materials, particularly those who are working under a NHS or Health Service contracts.

We are pressing the devolved Government departments to address these concerns, and we are arguing for a workable solution to ensure practitioners are not left out of pocket.

In England, we have asked for a meeting with NHS England and are awaiting a response, and we are doing similar lobbying work in Wales.

In Northern Ireland four new fees for the provision of non-amalgam fillings for under 15-year- olds and pregnant/breastfeeding women have been agreed. GDS activity in relation to these new fees will be monitored and BDA Northern Ireland will continue to engage with the Department of Health as these are reviewed.

The Scottish Government has introduced relevant fees for children under 15-years old with a review of the fees in 12 months-time, and BDA Scotland will continue to monitor the situation.

What will happen next?

From 1 January 2019, dental amalgam must be used only in pre-dosed encapsulated form and amalgam separators will be mandatory. We believe most, if not all, dental practices in the UK already conform to this under existing compliance requirements, so no action will be needed.

By 1 July 2019, the UK must have a national plan in place to outline their intended measures to reduce dental amalgam use. We have asked the Chief Dental Officers to keep us updated on how they intend to move forward with this, and we will continue to make the case that dentists need a dental contract that rewards prevention, and ensures both patients get the treatment they need and dentists are fairly remunerated.

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For further advice visit: https://www.bda.org/dentists/advice/ba/Documents/Health%20and%20safety%20-%20Nov%2015.pdf

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What has aviation got to do with dentistry?

Dental Showcase is challenging visitors to learn not only from their peers, but also that outside of the industry. In a captivating lecture, entitled 'Lessons from the Cockpit', Steve Hawkins, BA's Chief Training Pilot, will compare aviation and dentistry.

Surprisingly there are a lot of similarities between the two. Risk is inherent in both – for the provider (pilot/dental professional) and the customer (passenger/patient). Similarly, dentistry and aviation are overseen by regulatory bodies, who set the standards, risk management, training and ongoing assessment of competence. Safety is key to both industries, however Steve will explore how attitudes to the reporting cultures of the two industries may differ.

The aviation industry actively encourages mistakes to be reported, without fear of recrimination. It needs to do this to make flying safer and sees such a culture as intrinsic to 'proactive safety management' – an open feedback loop must be created to enable changes to be implemented. Readers will be all too familiar with the growing number of cases brought against dentists by the General Dental Council. Clearly there is some disparity between the open reporting culture of the airline industry and the sometimes 'closed loop logic' of healthcare.

Steve will be just one of the captivating speakers assembled as part of the Dental Update Study day on Thursday 4 October, hosted by Professor Trevor Burke, who will be giving a lecture entitled 'Minimising Failure with Direct Restorations and Crowns'. John Milne, Head of the CQC, will also present an engaging and potentially contentious session on regulatory matters whilst Tara Renton, will look at specific risks associated with oral surgery

A full programme of lectures continues Friday and Saturday, with presentations by Louis MacKenzie on anterior composites. Paul Bachelor will explore the topic of dementia-friendly dentistry and Bob Cummings will explain some of the HMRC challenges associates face.

To register, or for more information, visit www.dentalshowcase.com.

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When patients use CB12 White twice a day for two weeks, they can enjoy sparkling, natural tooth whitening effects. For more information about CB12 and how it could benefit your patients, please visit www.cb12.com

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Innovative patient communication

Providing the best patient care takes good communication.

In light of this, make sure you communicate with your patients in an innovative and appealing way by implementing an advanced system like the CS R4+ practice management software from Carestream Dental.

The CS R4+ software contains over 100 cutting-edge, high-definition animations that present information about treatments and procedures in a way that patients can easily understand. This will help patients feel comfortable and informed during their time in the surgery, and will allow you to help them engage in the procedure to provide the best patient care possible.

Furthermore, the Appointmentor Online Booking System gives patients a straightforward way to book appointments 24/7 for a time that suits them best, making it far less likely they'll miss their scheduled time with you. This will save you time, streamline your patient care, and ultimately improve the experience for the patient.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk.

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Imagine how easy it would be if you could change the instrument set-up on your treatment unit from right to left quickly and easily. Well thanks to Castellini's ingenuity and innovation this function is now a reality. It's called the Puma ELI Ambidextrous.

A multipurpose dental unit designed to suit a wide range of operating styles the Puma ELI Ambidextrous is ideal for any practice with multiple working styles and left- and right-handed dentists. Instead of adopting an awkward working position to suit the dental chair, dentists can now alter the dental chair to accommodate their personal and clinical preferences. This will not only help to reduce the risk of musculoskeletal pain for practitioners but increase efficiency and improve workflow too.

The Puma ELI Ambidextrous can be purchased from leading equipment dental supplier, RPA Dental, who will work with you from beginning to end to source, install and service the chair.

Visit www.rpadental.net or call the London and Manchester Sales and Service Centres on 08000 933 975.

Add value to your practice

One of the three most important factors that patients value when choosing a dental practice is the use of advanced technology.[1] Practices need to make patients aware of the modern equipment, technology and materials that is available to them, not just within the practice but also from the dental laboratory.

A custom developed, high performance polymer called Ultaire AKP is now available in the UK. Created by Solvay Dental 360 this innovative material is ideal for the fabrication of removable partial denture (RPD) frames and offers patients a lightweight, comfortable and biocompatible alternative to metal.

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By presenting the high-tech option of Ultaire AKP, practices can add a valuable

distinction to treatment recommendations and patient satisfaction.

For more information about Solvay Dental 360, Ultaire AKP and Dentivera milling discs, please visit www.solvaydental360.com.

References
1. What dental patients want. 2016 Futuredontics white paper. Available online nat: www.dds1800.com/whitepapers/What_Dental_Patients_Want/ (Accessed June 2018).

Key advocate for the profession

When it comes to support and dedication, dental corporates and groups can rely on the Association of Dental Groups (ADG) to deliver.

That is because the ADG is a trade association that provides a nationwide support system for dental providers and employers (NHS and private) using a corporate or group model. The Association works in close collaboration with leading figures in the government and NHS as well as independent regulators and commissioners on a variety of issues, to ensure that members have the best chance of delivering a high standard of care.

Along with its active campaigning and ongoing commitment to awarding dental students' hard work and ingenuity through its Bursary Awards, the ADG is a key advocate for the profession.

Moving forward, the ADG will continue to work hard to overcome barriers in dental care and ensure that dental corporates and groups can provide services to an even higher standard.

For more information about the ADG visit www.dentalgroups.co.uk

Stop sepsis in its tracks

Sepsis is a life-threatening infection that affects more than 30 million people around the globe each year. It can develop from the common infections picked up by patients in dental environments and can cause organ failure, septic shock and death.

On 5 May 2018 the World Health Organisation (WHO) hosted World Hand Hygiene Day – an initiative created to raise awareness of the infection in multiple countries across the world and made it clear that prevention should be a primary concern in dental practices.

The Steri-7 Xtra range of products from Initial Medical is a versatile and effective solution that will help ensure that your practice remains sepsis free. Usable as both biocidal cleaners and high-level disinfectants, these products effectively eradicate pathogens such as bacteria, spores, fungi, yeasts and viruses.

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Natasha Wright	Consultant and Specialist in Orthodontics
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Robert Crawford	Consultant in Restorative Dentistry, Specialist in Prosthodontics, Endodontics & Periodontics

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MSc (Distinction) in Dental Implantology (University of Bristol)
Specialist in Periodontics
Interests: Periodontics and Dental Implants
On Specialist List: Yes - Periodontics

293125

DENTAL SPECIALISTS MK

www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
Tel: 01908 630169 **Email:** admin@dentalspecialistmk.com
Interests: Orthodontics, Periodontics, Implants, Peri-implantitis, Full Mouth Rehabilitation, Prosthodontics, Endodontics, Oral Surgery including TMJ , Restorative Surgery, Sedation and Snoring.
CT scanner and Zeiss microscope on site
On Specialist List: Yes, Orthodontics Dr Ayodele Soyombo, Dr Patel
Special Interest in Orthodontics: Dr Juanita Levenstein
Specialists in Periodontics: Dr Adetoun Soyombo, Dr Carol Subadan and Dr Olanrewaju Onabolu
Specialist in Prosthodontics: Dr Peter Yerbury and Dr Ulpee Darbar,
Specialist in Restorative Dentistry: Dr Ulpee Darbar
Specialist in Endodontics: Dr Neil Kramer
Specialist in Oral Surgery: Dr Tamer Theodossey, Dr Wale Towolawi and Dr Yinka Lesi

209440

ROOT CANAL DENTAL REFERRAL CENTRE

www.rootcanalcentre.co.uk

351 Richmond Road, Upper Ground Floor, East Twickenham TW1 2ER
Tel: 020 8050 0351 **Email:** info@rootcanalcentre.co.uk
Dr Nicolai Orsteen
DDS Oslo 2002
Specialist in Endodontics
GDC No. 175404
Interests: Endodontics
On Specialist List: Yes

293124

East Anglia

DEVONSHIRE HOUSE

www.devonshirehousedental.co.uk

2 Queen Edith's Way, Cambridge CB1 7PN
Tel: 01223 245266
Email: enquiries@devonshirehousedental.co.uk

Specialist Referral and Education Centre

Interests: Prosthodontics, Implants, Endodontics, Periodontics and Orthodontics, Dental Education and Mentoring.

Specialist Prosthodontists:
Julian Martin
Kevin Esplin
Ian Pearson
Wail Girgis
Cyrus Nikkhah
Nick Williams
Philip Taylor
Assad Khan

Interests: Restorative Dentistry, Dental Implants, All-on-4®, Aesthetic Dentistry, CT Scanner, OPG Service and Dental Education

Specialist Endodontists:
Elisabeth Smallwood and **Julian Martin**

Specialist Periodontists:
Trisha Whitehead and **Puneet Patel**

Specialist Orthodontist:
Dirk Bister

296176

In Practice CPD

Q1: For how long are the airways restricted in sleep apnoea?

A Less than 5 seconds
B Less than 10 seconds
C 10 seconds or more
D 15 seconds or more

Q2: For how long are the airways restricted in sleep hypopnoea?

A Less than 5 seconds
B Less than 10 seconds
C 10 seconds or more
D 15 seconds or more

Q3: What level qualification is required to practice non-surgical facial aesthetic treatments?

A 4
B 5
C 6
D 7

Q4: By which date will amalgam separators become mandatory?

A They already are
B 1 July 2018
C 1 January 2019
D 1 July 2019

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