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In 1986 yet another young and enthusiastic graduate left University with a BDS. There were few house jobs and for most of my generation, as had been the case before and since, gainful employment was to be found in general practice.

Looking back, qualifying as a dentist was the easy bit. As undergraduates we had received only tacit training in General Dental Practice and this was limited to running an ‘intercalated clinic’ rather than any aspect of business. Never was business or money discussed. Training was purely clinical. We were after all clinicians?

During the course of my career more and more emphasis has come to be placed on the ‘business of dentistry’. Yet it cannot be said that training has evolved to complement this considerable skill required of practitioners. To add further pressure consumer organisations have become ever more vocal when criticising dentists for their financial activities and regulators have taken an ever more stringent position, often increasing practice costs with a level of compliance now required in the UK almost unsurpassed in any other profession.

It is often quoted that 95% plus of dentistry is delivered in the High Street. Clinicians who own a dental practice are small business owners. However, many are poorly trained for this critical aspect of their professional career. A number remain reluctant business people and some find it extremely difficult to blend clinical practice and ethical standards with business. They may sell their practice prematurely whilst others allow the practice to become an overbearing and occasionally debilitating influence on their professional and personal lives.

Against this backdrop it might seem that the situation is hopeless? My own experience (and of others) has been far from that. It is from my nearly 30 years as a dental businessman and clinician my belief has formed that dentists can run ethical profitable practices. So it is for this reason I am very pleased to be able to write the Foreword to this second edition of Profitable Dental Practice.

So how can it be done? Where is this Utopia to be found?

In the clinical arena the clinician must be confident and proficient in their clinical skills and patient management. Clinical teaching emphasises technically perfect dentistry, which is required at all times. However, indiscriminate
use of technical skills may only lead to short-term outcomes with dentists trying to save teeth rather than manage long-term viable dentitions. In a consumer-driven society patients (or customers) expect value for money and that treatment delivered will have a reasonable lifetime. The successful clinician will realise this and manage patient expectations and only deliver treatment which they are competent to do. Additional clinical skills can be learnt over time but a reflective, honest and open approach to personal and professional development is essential. So-called ‘soft’ or communication skills are also necessary tools when discussing difficult and sometimes complicated treatment plans, especially when it is so important to gain valid consent. An empathy and understanding of patients’ needs and wants with an ability to blend these with that which will deliver predictable clinical outcomes is vital.

Then of course dentists need to develop the business skills which they will require to run a successful profitable business. It is only through this they can hope to provide the basis from which they can deliver the high-quality clinical services which so many yearn to do. It is worth reflecting on that many disciplinary cases brought before regulators have their origins in the financial pressures clinicians have found themselves wrestling with in practice.

The business of dentistry requires skills not only in finance and law, but human resources, business planning and development, organisation, communication and leadership, marketing and IT, to name but a few. Interestingly, as with clinical skills the dentist may not possess all necessary business attributes in depth but needs to know when to delegate and refer these to others. Whether running a single or group of practices the ability to build a team, to lead and drive a business forward is essential. It cannot simply be assumed that every graduate possesses these skills or that they will acquire them ad hoc as their career progresses. With the rise of corporate dentistry it is my view that if the profession wishes to remain financially autonomous then more young practitioners will have to recognise the need for these skills much earlier in their careers than hitherto, and become as proficient in them as clinical dentistry.

So it is essential that clinical and business skills are not seen as mutually exclusive and that a profitable dental practice lies in a combination of both. This book also provides a combination. Phil Newsome, an undergraduate teacher and international speaker not only on clinical dentistry, but how that needs to integrate with the business of dentistry (almost uniquely for a university-based clinician) and Chris Barrow, who has over 20 years cajoled and encouraged many UK dental business owners to learn to not only sell themselves and their practice but to reflect and develop themselves personally.

Whilst no single book or educational event can provide ‘The’ solution I would however commend this book both to the young graduate aspiring to
buy their first practice as well as the older practitioner who might wish to build on an already successful business.

Trevor W Ferguson
Dean of The Faculty of General Dental Practitioners (UK)
The Royal College of Surgeons of England
January 2014
Foreword to first edition

Some would say that the dental practitioner faces an unenviable challenge in having to be a healthcare professional at the same time as trying to run a business. There can be conflicts between the two from time to time, when the need of any business to create profits can get in the way of the ethical imperative for any healthcare professional to keep the best interests of the patient paramount at all times.

At first sight this seems to be an uneasy partnership, but it is one that is mirrored by the partnership between Phil Newsome and Chris Barrow – two unusual people with different professional careers that were themselves unusual in their own way. This book is the result of a fascinating synergy between an academically-based dentist who has always been fascinated by the world of business and marketing, and a former insurance salesman and independent financial adviser who has been fascinated by the untapped business opportunities in the professions generally, but dentistry in particular.

It is also a fusion between two people who have spent their lives in communication – one in teaching undergraduate dental students in the day job (and anyone else that would listen the rest of the time), and the other whose speciality has become coaching, and teaching people to bring out the best in themselves and others.

We should not be too surprised, therefore, to find ourselves enjoying the fruit of this fortunate union. The book is written unashamedly for dentists who have been too busy to listen to their inner voices, too busy providing dentistry to think about the benefits that patients might want from it, and too busy to step back from the day-to-day pressures of dental practice to recognise the rich vein of opportunity that has been coursing, unnoticed, through every day of their professional lives. The messages are powerfully and effectively conveyed. You won’t agree with them all – at least, not today – but few of us are comfortable when our views are challenged. Professional people tend to be particularly sensitive, especially when their ethics, skills and standards of patient care are being questioned.

But, I would invite you to accept that the book stops you in your tracks only to facilitate the process of making tomorrow better than yesterday. The work
of the dental profession is changing at a remarkable rate, and the skills we all learned at dental school – whenever that was – are no longer enough to provide the platform for a successful career in dental practice.

The irony is that technical, clinical skills are only a very small part of the toolkit that one needs in order to be successful in the real world of dental practice. This realisation comes quicker to some than to others. Yet the soft skills of communication and patient care in the broad, holistic sense, will make a much greater difference to our professional lives than the next piece of fancy dental equipment, or ‘wonder material’ or new technique. These shooting stars in the dental firmament fade surprisingly quickly, but the core skills outlined in this book will last a lifetime.

Despite its title – and I suppose even books need to sell themselves – the book is about a lot more than profit in the traditional sense. Paradoxically, a lot of this book is actually about loss – lost profits, yes, but also loss of balance in one’s personal life, wasted time, lost staff, lost patients, lost potential patients, and lost opportunities in patients you have been treating for years. Above all else, one is forced to realise how much fun and personal satisfaction there is in finding that elusive formula that allows you to be a successful businessman or businesswoman who happens to be a dentist.

If it does nothing else other than persuade you that you are selling yourself (and your patients) short if you continue to squander the time you spend with those with whom you share your life – at home and at work – then I suspect the authors will reflect upon a job well done.

Kevin Lewis
Dental Director
Dental Protection Ltd
Medical Protection Society
June 2004
Preface to second edition

What is success? One thing that may be said with some certainty is that it can and does mean different things to different people. Financial gain probably springs to mind first, but your career isn’t entirely about money is it? For most people it is something deeper, something central to your core, having your say, making things happen, personal fulfilment, the recognition of others . . . all of these and more contribute to the much-desired but often elusive condition that we call success. While there may be many ways to achieve success it does seem that those organisations that are considered to be successful do share a number of common characteristics. This book looks at how those characteristics apply to the profession of dentistry, at what it takes to create and sustain a successful dental practice. There exist literally hundreds of dental practices, and while most of them provide their owners with a reasonable living, only a small number could be described as being truly successful, flourishing organisations. The eight strategies described in this book mesh together to provide a blueprint for anyone wishing to develop a thriving dental practice, one that enhances the lives of everyone involved with it – patients, support staff and of course the dentist. A brief explanation of each chapter follows.

Introduction: The changing face of dental practice
This chapter looks at how dental practice has changed in recent times and, indeed, since the first edition of this book was published in 2004. It examines what impact factors such as improved treatment modalities, deregulation, the rise of corporate dentistry, direct access and the growth in consumerism have had upon the profession. The case will be made that in such a rapidly changing business environment the strong will get stronger and the weak will struggle to survive.

Strategy 1: Construct a powerful three-year vision
Dreams don’t usually come true by accident. Success in any walk of life is more likely to happen if you can envisage that success and then plan for it to happen. Key features of this planning process include a clearly articulated personal and professional mission statement coupled with specific goals covering every
aspect of one’s life – financial, business, family, social, physical, intellectual and spiritual.

Strategy 2: Plan the time to plan
One of the biggest obstacles in the process of making transformational change is a perceived ‘lack of time’. There is no such thing as ‘lack of time’ – there is only an inability to prioritise time effectively. Failing to plan is planning to fail – allocating time, well in advance, for strategic thinking, strategic planning and strategic action is one of the most important habits of the successful dental team leader.

Strategy 3: Control your finances
No practice, whatever its size or nature, can be considered to be truly successful without a firm commitment to maintaining its financial health. This means living within your means, preparing budgets for both business and personal expenditure a year in advance, preparing management accounts at the end of each month, comparing actual versus budget accounts and taking corrective action on a monthly basis. Pricing strategy should be carefully calculated to cover the fixed costs and overheads of running the business, to provide the owner’s desired income and to allow for the setting aside of monies for the future.

Strategy 4: Lead a championship support team
Successful dental practices show clear evidence of effective leadership and the creation of a practice culture that is compatible with the practice owner’s core vision. Our belief is that you should spend 80% of your time focusing on your unique ability of building relationships with the right type of patients, to help them identify and solve their current and future problems and aspirations. The remaining 20% of your time should be spent leading the support staff who then have responsibility for carrying out everything else – namely, financial control, sales strategy, marketing and day-to-day operational control. Without exception, all successful dental practices possess a keen, motivated, highly trained, well-rewarded, empowered and harmonious team.

Strategy 5: Deliver world-class customer service
The traditional ‘doctor knows best’ approach to dental practice has no place nowadays – patients expect to be involved in any decisions that affect them. Successful practices recognise this and therefore do all they can to understand more about their patients, their likes, dislikes and motivation, and in so doing maximise the practice’s ability to attract and retain the best patients. Patients are no longer going to tolerate the conditions that exist in many practices.
Poor location, difficult access, substandard décor, low staff morale, out-of-date equipment and lousy literature will simply drive patients into the arms of those who are willing to invest in success.

**Strategy 6: Refine your selling skills**

Like it or not, a practice is a sales operation and everybody who works in it works in sales. Not hard, pushy, aggressive sales but soft, ethical sales – creating an environment in which patients want to buy. The majority of dentists have very little idea about the psychology of selling and are pretty good at keeping their products and services a secret from the people who could buy them. A sales organisation should have clearly visible targets that should be communicated to the support team on a regular basis. Part of the team’s remuneration should be linked to performance against these targets so that the whole team becomes empowered by the process of achieving targets, while at the same time maintaining professional standards.

**Strategy 7: Create a low-cost marketing engine**

Many dentists say that they have tried a marketing technique at some stage, but stopped ‘because it didn’t work’. Rarely though is there a marketing plan – a systematic low-cost approach where events are scheduled up to a year in advance and delegated to the support team. Successful practices understand the need for a comprehensive and ongoing marketing strategy involving not only obvious promotional strategies but also an understanding that marketing is built around *all* the day-to-day interactions or ‘moments of truth’ that take place between the practice and its patients.

**Strategy 8: Maintain a balance between work, rest and play**

It doesn’t matter how much profit you are generating from your practice if your life is dysfunctional, if you are always stressed, if you are frequently in a state of chronic fatigue, if your family and friends don’t know who you are, if you never seem to have enough time for yourself.

Philip Newsome
Chris Barrow
*January 2014*
About the authors

Philip Newsome graduated with honours from Leeds Dental School in 1976. After a number of years in general dental practice he returned to academic life at Leeds before moving to the University of Hong Kong’s Faculty of Dentistry in 1986. His time is now divided between private practice, writing and speaking engagements. He holds an FDS and MRD from the Royal College of Surgeons of Edinburgh and is on the UK and Hong Kong specialist lists for prosthodontics. He also has an MBA from the University of Warwick Business School and a PhD from the University of Bradford Management Centre. In 2013 he was awarded an honorary Fellowship of the Faculty of General Dental Practitioners (UK) for his contribution to the profession.

Chris Barrow has been active as a consultant, trainer and coach to the UK dental profession for over 20 years. Naturally direct, assertive and determined, he has the ability to reach conclusions quickly, as well as the sharp reflexes and lightness of touch to innovate, change tack and push boundaries. As a speaker he is dynamic, energetic and charismatic. Chris spent the first 17 years of his working life in the corporate sector and followed this with 26 years of self-employment. The different dynamics of both worlds have given him the valuable gift of knowing how to operate – and communicate – in both. In 1987 Chris was active in the establishment of the Institute for Financial Planning, an organisation representing the first fee-based financial planners; Chris specialised in working with small businesses. In 1993 Chris decided to make the transition to business coaching and became one of the first UK students at Coach University, from where he graduated as a certified coach. Recognising the opportunity in the dental profession, 1997 saw the creation of The Dental Business School and the development of a 12-month business coaching programme for dental practice owners and their teams, delivered to over 400 UK dental practices in the following 10 years. In October 2008, Chris became Director of Private Sector Development at Integrated Dental Holdings Ltd and now acts as an occasional Non-Executive Director for dental corporates as well as continuing his freelance consultancy work for corporates, primary care trusts and independent practices. His main focus now is on 7connections, a privately
owned company that specialises in training, consultancy, coaching and mentorship in independent dentistry and also takes minority equity positions in private practices.
Acknowledgements

My contribution to this book is based on all the things I have learnt and on all the mistakes I have made over the many years since I entered dental school. I have been so fortunate to have worked with some of the wisest, most knowledgeable and downright funny people you could ever wish to meet. My first years in dental practice with Peter Hamlyn were wonderful times, as was the period I spent with John Dyson. Those years in practice taught me that as dentists we care for people first, mouths second. During my academic career, Professor Richard Walker stands out as a mentor, friend and critic who taught me that you can do almost anything – as long as you do it with a smile, charm and wit. Equally, Professor Ted Renson and Professor Fred Smales have been tremendously supportive, as has Professor Gillian Wright.

Philip Newsome

In his book True Success, philosopher Tom Morris defined success as ‘doing what you want to do, when you want to do it and with the people you want to do it with.’ Not exactly Shakespeare but it makes the point. In considering my own definition of success, I would replace the word ‘want’ with the word ‘love’ – because I truly love the work I do, the times when I do work and the people I work with. Which allows me to acknowledge all the fantastic clients I have worked with over the years and who have been my priceless R & D team, telling me when my ideas were awesome, OK or just crazy and impossible. Then there are the giants whose shoulders I have stood on – the authors of the many books and speakers at conferences who have inspired and enlightened. The friends, both professional and personal, who have cared enough to listen. The team who have supported me from backstage over the years, tolerating and compensating for my weaknesses. The family who have always been there and always will be. I dedicate my contribution to this work to those I love.

Chris Barrow
CHAPTER ONE

Introduction: The changing face of dental practice

Whoever desires constant success must change his conduct with the times.
Niccolò Machiavelli

The latter part of the twentieth century saw far-reaching changes in the economies of most westernised countries. Such modern economies are based more and more on the production and consumption of increasingly differentiated goods and services. Few sectors have escaped this shift in emphasis and that includes the practice of dentistry. For many years the vast majority of dental procedures performed in the UK were done so under the National Health Service (NHS) umbrella, with treatment costs heavily subsidised by the government. There wasn’t too much choice in the kind of treatments being offered to patients, and even less choice in the way that this treatment was provided. Most patients received their dental care in converted residential properties and the treatment itself, if we are honest with ourselves, usually centred on a mixture of amalgams in posterior teeth, composites (or more likely silicate cements) in anteriors, extractions, a quick scale and polish (with little thought to any long-term management of the patient’s periodontal condition), metal-based full crowns, partial dentures, perhaps conventional bridgework and at the end of the road . . . traditional full dentures. The relationship between dentist and patient was paternalistic at best, with patients usually having little say in what treatment was provided – ‘they aren’t really paying for it so why should they have a say?’ was an attitude prevalent at the time. Going ‘private’ was an option taken up by a very small percentage of the public and usually only by those people living in the most affluent regions of the country.
While some cynics might argue that in many practices up and down the country this scenario has hardly altered, there is no doubt that times are changing. Treatment options have increased dramatically and the approach to care is now aimed more towards prevention than mere repair and is increasingly patient-driven rather than entirely dentist-directed, with a greater emphasis on elective dentistry in the form of whitening, tooth-coloured fillings, laminate veneers, implants, and so on. Since the events of the 1980s and early 1990s many dentists have opted out of the NHS and are now providing dental care that is financed independently. New corporate players, with a more retail-oriented outlook, have sensed an opportunity and have entered the market with considerable financial backing from a variety of financial backers. This introductory chapter looks at these various trends and explores how they have shaped, and continue to shape, the profession. The concurrence of these trends has created an environment in which an ever-increasing number of ‘savvy’ dentists are able to run extremely successful practices while at the same time providing the sort of care and work environment that could only have been dreamt of even a short while back.

THE CHANGING ROLE OF THE DENTIST

Fundamental advances in oral healthcare have resulted in a far greater emphasis on scientific, evidence-based treatments. Take, for example, the recently adopted National Institute for Health and Care Excellence guidelines on the use of antibiotic cover in dentistry. These turned conventional wisdom on its head and have seen the almost total elimination of the once ubiquitous prophylactic antibiotic cover in UK dental practice.¹ Research has done much to clarify the biological and behavioural mechanisms involved in oral health and the prevention of disease – primarily dental caries and periodontal disease. Successive Adult Dental Health Surveys have shown that the oral health of UK adults has improved significantly over recent decades. For example, the proportion of adults in England with visible coronal caries has fallen from 46% in 1998 to 28% in 2009 while the proportion of edentulous adults in England has fallen from 28% in 1978 to 6% in 2009.² Nowadays, people are rendered edentulous at a rate that is almost too small to measure. Many millions have been converted from recurring emergency extractions to regular check-ups. In short, a massive number of people now enjoy the benefits of good dental health.

With this reduction in gross disease, in a more dentally aware population, a larger proportion of a dentist’s work is now elective in nature, dealing with matters of poor appearance and impaired function rather than the simple alleviation of pain. Greater emphasis is also being placed upon evidence-based
dentistry. In tandem with these changes, technological developments in areas such as dental materials, pharmacology and treatment modalities have resulted in a much wider range of treatment options. Most of these procedures are much more technique-sensitive than their predecessors – for example, consider placing an implant compared with providing a partial denture, or inserting a posterior composite as opposed to an amalgam. Because of this added complexity these techniques demand a coordinated team approach if they are to be successful – ‘team’ meaning not only the dentist and his or her chair-side assistant but also hygienists and technical support, even front-desk staff have an important role to play by helping us to communicate better with patients as well understanding and even modifying their expectations.

All of these changes have a number of important implications for the way we work. While ever higher standards of clinical practice are required of the dentist and other members of the dental team, clinical practice will increasingly centre on prevention, control and self-care strategies based on knowledge of general health and the lifestyle of individual patients – for example, counselling patients to wear mouthguards while playing sports. Such preventive-oriented approaches towards care usually require a fundamental shift in the patient’s behaviour and the modern dentist (together with his or her staff) is therefore called upon to be more aware of, and more sensitive to, issues concerning patient compliance and motivation.

Keeping ‘up to date’ with all these changes makes dental education a vital and continuing process, demanding more commitment from the dental practitioner than in the past, when the pace of change was much slower and when many a dentist would seemingly pass from graduation to retirement virtually without ever learning anything new. In 2002, in recognition of this need for dentists to stay up to date, the General Dental Council (GDC) implemented its programme of compulsory continuing professional development (CPD), with CPD defined as:

> study, training, courses, seminars, reading and other activities undertaken by a dentist, which could reasonably be expected to advance his or her professional development as a dentist.\(^3\)

The advent of compulsory core subjects in 2007 further strengthened this approach. Successful dentists know all too well that keeping meaningfully up to date is a must, not something to which they pay mere lip-service and they will therefore devote time, energy and resources to do so. They will also encourage, even insist, all their staff do the same and indeed in 2008 the GDC made CPD compulsory for all dental care professionals.
Given the rapid changes in the way dental care is being delivered, CPD should also embrace not only ‘hard’ treatment modalities, but also ‘softer’ interpersonal and behavioural aspects of dental care as well as a knowledge of business management methods which helps to blend all these disparate parts together to produce a successful dental practice. In 2008 the GDC issued *Guidance on Principles of Management Responsibility* offering direction for those dental professionals with management responsibility.\(^4\) It is widely accepted that most graduating dentists sadly do not possess the requisite knowledge and skills to become competent practice principals and little seems to have changed in this regard since the publication in 1999 of one British Dental Association (BDA) survey looking into the views of over 1000 young dentists (that is those qualifying after 1987) who, while feeling well-prepared for general practice in most clinical aspects, considered themselves ill-prepared in areas such as staff management, business and finance.\(^5\) The dentist’s role is clearly changing and the modern professional has so much more to contend with than counterparts, say, 20 or 30 years earlier. This was clearly articulated in a letter published in the *British Dental Journal* in the spring of 2013, in which the author, a retiring dentist, rather cynically observed:

> Forty years ago my job description was dental surgeon; today my job title is performer and provider of primary dental care for the local PCT [primary care trust], lead in child protection, lead for cross-infection control, radiological protection supervisor, health and safety supervisor, fire warden, lead for information governance, lead for staff training, and environmental cleaning operative.\(^6\)

Perhaps fortunate then for the writer of that letter that he is retiring, as there lurks on the horizon a further sea change in the shape of *revalidation*. The publication in 2007 of the government’s White Paper *Trust, Assurance and Safety*\(^7\) proposed that all health regulators are required to develop a system of revalidation. Accordingly, the GDC has been working for some time towards a system in which a dentist is obligated to prove that he or she is fit to stay on the *Dentists Register*.\(^8\) Compulsory CPD can now be seen as a first step of a far wider process in which the onus is on the dentist to demonstrate not only that he or she has undertaken some postgraduate courses but also that he or she complies with the standards set by the GDC throughout his or her professional life. It is proposed that revalidation will encompass four domains: (1) clinical, (2) professionalism, (3) management or leadership and (4) communication. At the time of writing it is not clear how dentists in different sectors, such as academia, will be assessed. Not surprisingly, a number in the profession view this whole exercise as yet another set of disproportionate, onerous,
bureaucratic impositions, as one frustrated contributor to an online discussion group noted:9

Another idea that sounds good on paper, but in reality is not necessary. Surely revalidation shouldn’t apply to anyone with a clear record with no complaints? What big problem do we have in dentistry that revalidation will fix. Revalidation is very likely to degenerate into yet another box ticking exercise, instantly increasing expenses to patients and dentistry providers, and reducing access to dental care. We’re already being revalidated and regulated and nickel and dimed to death.

The difficulty is that revalidation will happen. Forward-thinking dentists will not wait to be told to keep up to date and abreast of all relevant developments in their profession. Unfortunately, such developments and shifts in philosophy are often slow to be adopted by the majority of dentists, but those who have embraced this new paradigm of care are reaping the rewards in terms of increased satisfaction – not only their own but also that of their staff and, crucially, their patients. A number of dentists have seized upon the opportunities presented by entering specific niches within the profession – for example, in areas such as orthodontics and implants. This, unsurprisingly, has created a backlash from specialists in these fields who feel undermined and fear a lowering of clinical standards.

Patient satisfaction is, as we will see, one of the ultimate goals for any successful practice. For it to happen, the practice principal must see himself as more than just a dentist, he must also be a visionary. Dreams don’t usually come true by accident. Success in any walk of life is more likely to happen if you can envisage that success and then plan for it to happen. Key features of this planning process include a clearly articulated personal and professional mission statement coupled with specific goals covering every aspect of one’s life – financial, business, family, social, physical, intellectual and spiritual.

GREATER EMPHASIS ON A TEAM APPROACH TO PROVISION OF DENTAL CARE

Successful dental practices show clear evidence of effective leadership and the creation of a working culture that is compatible with the practice owner’s core vision. Almost without exception, all successful dental practices possess a keen, motivated, highly-trained, well-rewarded, empowered and harmonious staff, which has traditionally comprised receptionists, back-room staff, dental nurses, hygienists and, of course, dentists, but which increasingly includes practice
managers and treatment coordinators, among others. It is a key management task to see that such a team is established.

The need for a team approach to dentistry received considerable attention throughout the 1990s, primarily in the various reports published by the likes of the Nuffield Foundation and the GDC. Generally speaking, there has been a move away from small, often single-handed, practices with minimal support staff, in favour of larger group practices with a corresponding emphasis on the ‘team’ approach to care. In addition to the advantages a larger team can bring in terms of the range and flexibility of services that can be offered to patients, expanded practices are better placed to take advantage of economies of scale, as both fixed and non-fixed costs can be spread over more dentists and surgeries. From the description we have given here thus far, it may seem that this trend is entirely one-way, an assumption that would, however, be misleading. A number of dentists have ‘downsized’ from larger practices (with one or more associates) back to single-handed practices, albeit with a strong emphasis on quality of care provided by a small team of dedicated staff. It appears that for some dentists the task of finding associates who share the same vision of dental practice proves to be just too difficult in a climate characterised by a shortage of dentists, or more pertinently a shortage of dentists they would want to have working in their practice. One dentist expressed this view thus:

\[ The \textit{second best day in your working life is when you take on an associate \ldots the best day is when they leave.} \]

Ten years ago, when the first edition of this book was published, we discussed the perceived and actual shortage of dentists in the UK. This is less of an issue now and as a result there is a significant and continued reduction in associate remuneration. This is partly a result of there being more dentists in the marketplace and partly because, from a business standpoint, practice owners simply cannot justify the high percentages previously being paid.

While the rate of change towards a more integrated team approach is first and foremost a commercial response to the need for higher levels of care and service being demanded by the public, it is also widely appreciated in the profession that there is a need to clarify and enhance the roles played by all types of dental ancillary staff. The Dental Auxiliaries Review Group, which was set up by the GDC to explore the future role of ancillary dental staff, published its report in May 1998 and concluded that ‘dental care in the next century will be provided by a multi-skilled team comprising members of the dental profession

* Anonymous. Personal communication.
and professions complementary to dentistry, all led by a dentist. It was anticipated there would be new classes of operating auxiliaries who would carry out the more routine aspects of dentistry as part of teams directed by a dentist, probably one per team, whose role it would be to do the treatment planning and the more sophisticated aspects of dentistry. This gained further momentum in 2008 when the GDC introduced mandatory registration for all dental care professionals, dental nurses, dental technicians, clinical dental technicians, hygienists, therapists and orthodontic therapists. At the time of writing, over 63,000 dental care professionals are registered with the GDC. There is, however, one potential fly in the proverbial ointment with the announcement by the GDC in March of 2013 that it would remove its barrier to direct access for some dental care professionals. In the past, every member of the dental team had to work on the prescription of a dentist. This meant that patients had to be seen by a dentist before being treated by any other member of the dental team. This latest move represents a complete volte-face by the GDC and clearly contradicts earlier GDC initiatives (as discussed earlier). It appears to have arisen through pressure from the Office of Fair Trading and is being vehemently opposed by the BDA, whose view was very clearly stated in a statement released on the date the decision was announced:

This is a misguided decision that fails to consider best practice in essential continuity of care, patient choice and cost-effectiveness, and weakens teamworking in dentistry which is demonstrated to be in patients’ best interests. Dental hygienists and therapists are highly-valued and competent members of the dental team, but they do not undertake the full training that dentists do and on their own are not able to provide the holistic, comprehensive care that patients need and expect. Our fear is that this could lead to health problems being missed in patients who choose to access hygiene and therapy appointments directly.

It remains to be seen exactly what effect this move will have on the dental marketplace, but at first sight it does appear to undo all the effort put into promoting the concept of the dentist-led team, which focuses on the need for patients to see a dentist first for a comprehensive oral health assessment and treatment plan.

**CONSUMER DEMAND**

Thinking of patients as consumers is something of a double-edged sword. On the one hand, dentistry, along with all the other healthcare services, is finding its clientele to be more demanding in terms of the expected range and
quality of services, as well as the availability of information about those services. Increasingly, people want more say about their health and health services and are demanding the best care for themselves and their families, together with greater choice in that care. The profession should not see this as being a negative development. On the contrary, it is a plus for the profession to have patients who don’t look on themselves as passive recipients of care and who instead demand a greater involvement in the process of care. The fact too that patients are paying a much larger percentage of the total treatment cost than in the past has clearly had an effect, in that they expect to know much more about what exactly they are receiving for their money. Patients are also more likely to express their dissatisfaction whenever they are unhappy with any aspect of the service provided and this has led to a far more litigious environment than at any time in the past. Indeed, one of the most noticeable trends over the past two decades has been a dramatic increase in the number of patient complaints against dentists. It is debatable whether this is because of a moral decline in the profession, or because modern dentistry is so much more complicated nowadays that more things can go wrong or possibly because the public are more inclined to complain in these modern times. The truth is likely to contain elements of all three of these. What is undeniable is that in recent years there has been a staggering growth in the number of disciplinary cases being heard by the GDC. In response, in 2005, the GDC published Standards for Practice\textsuperscript{14} effectively a road-map detailing the responsibilities of a dental profession. This was updated in 2013 and appeared as the subtly re-named Standards for the Dental Team\textsuperscript{15} featuring the following nine key principles.

1. Put patients’ interests first.
2. Communicate effectively with patients.
3. Obtain valid consent.
4. Maintain and protect patients’ information.
5. Have a clear and effective complaints procedure.
6. Work with colleagues in a way that serves the interests of patients.
7. Maintain, develop and work within your professional knowledge and skills.
8. Raise concerns if patients are at risk.
9. Make sure your personal behaviour maintains patients’ confidence in you and the dental profession.

The emphasis in this document on ‘softer skills’ and a patient orientation is clear, and on its launch GDC Chief Executive Evlynne Gilvarry observed:

*Patients have told us clearly what they expect when they seek dental treatment. The new standards reflect those expectations and guide the dental profession in meeting them.*
The GDC clearly hope that this initiative will go some way to quelling the ris-
ing number of disciplinary cases being heard. The figures speak for themselves. For example, in 1987 the total number of hearing days scheduled by the GDC amounted to around 20. By 2012 this had mushroomed to more than 1019.16

Proactive companies in other industries do not see such consumerism as a threat but, rather, an opportunity to improve on their offer to consumers. As one Dell computer advertisement put it:17

To all our nit-picky, over-demanding, ask-awkward-questions customers. Thank you and keep up the good work.

PUBLIC TRUST AND CONFIDENCE
Dentists need to embrace this new order and should not be defensive or feel threatened by it, even in the face of negative media coverage – especially when it comes to dentists who are seen to be abusing patient trust. Trust and confidence is a huge issue for most patients. Back in 1998 the Reader’s Digest ran a story titled:

Can you trust your dentist? After all, the more treatment he recommends, the more money he makes. Our special investigation exposes some alarming practices.18

Such media coverage upsets many in the profession and yet it is symptomatic of the fact that patients recognise all too well that they don’t really understand what is ‘good practice’ in terms of much of the treatment provided. A variety of scandals down the years only reinforces the public view that some members of the profession are highly dubious charlatans and fraudsters, interested only in money. Successful practices are those that address the fundamental issue of trust by placing great emphasis on genuinely caring for patients in the widest sense of the word, by treating patients with respect, by going to the greatest lengths to communicate with them, and so on.

The other side of the ‘consumer’ coin is that the growing number of treatment options has led to an increase in demand for dental care. Paradoxically, much of this has been driven by the popular media, which has helped raise public awareness by emphasising the benefits of good oral health. Indeed, three out of four people in the UK now believe the health of their teeth and gums has a significant impact on their quality of life, according to the results of one survey.19 The majority of people questioned (around two-thirds) felt that oral health had a major bearing on their appearance, comfort and how they ate, while just under half said they believed it was an important factor in terms of
their self-confidence, social life and romantic relationships. The survey results confirmed that the mouth and teeth have a strong influence on the way people feel about themselves.

This growth in awareness of the positive aspects of good dental health has also been aided by the growth of private dentistry, which has provided patients with a wider range of choice, and dentists with more time to explain to the patient the pros and cons of these various treatment options. Patients nowadays have higher expectations, such as the possibility of avoiding extractions, and keeping teeth for life. They expect to be seen promptly and for treatment interventions to be successful. Overall they expect, and are demanding, a better quality of service.

Successful practices avoid the elitist and patronising approach characterised by ‘doctor always knows best’ – a style of dental practice that really has no place nowadays. Great practices emphasise how modern dentistry can benefit the individual and so involve the patient in any decision that might affect the patient’s health, appearance, comfort and finances. Such practices do all they can to understand more about their patients, their likes, dislikes and motivation and in so doing maximise their own ability to attract and retain patients.

CLINICAL GOVERNANCE

While patients may not fully understand the technical aspects of the care they receive, they nevertheless do expect dentists to provide quality dental care, and rightly so. Clinical governance can be defined as a systematic method for ensuring that the patient’s needs for quality of care are met. Proving you are as good as you think you are is not about demonstrating that you or your practice is perfect but that you organise and run your practice in a manner that encourages the pursuit of excellence in terms of meeting your patients’ needs as well as their reasonable expectations. Successful practices appreciate the crucial importance of a practice-wide devotion to quality, not only in technical and clinical matters (e.g. formalising treatment plans and gaining effective consent) but also in the softer, non-technical aspects of care (such as effective communication). Increasingly, they also appreciate that the use of an independently verified system helps to identify areas in need of improvement and encourages the pursuit of excellence. Independent verification also goes a long way to reassuring patients who may have lost confidence in the profession.

All the major bodies connected to the practice of dentistry in the UK, from the GDC through to the major defence unions, agree that while such governance and related risk assessment is desirable, it is debatable how many practices would participate in such activities unless forced to do so by law. With all these
concerns providing the backdrop, an independent regulator of health and adult social care services in England, the Care Quality Commission (CQC), was established in April 2009, and from April 2011 all primary dental services have had to register with the Commission. Registration is a legal licence to operate and, put simply, if dental practices are not registered then they will not be able to provide services. In order to become registered the provider must be deemed to be ‘compliant’ – that is, the provider must show that the service offered does indeed meet essential standards of safety and quality. The seemingly logical rationale behind the CQC is that when a practice has been assessed as compliant, then patients can expect the following:
- to be respected, involved and told what’s happening at every stage
- care, treatment and support that meets your needs
- to be safe
- to be cared for by staff with the right skills to do their jobs properly
- your dental practice to routinely check the quality of its services.

However, the introduction of the CQC has been far from smooth and certainly has not been welcomed with any great enthusiasm by the profession, many of whose members view it as yet another unnecessary, centrally-imposed, ill-conceived, burden. Dentistry magazine reported that ‘The introduction of compulsory registration with the CQC . . . triggered howls of protest from many dentists’, and going on to report that ‘The organisation was accused of inflicting chaos during a “farcical registration process” – with the threat of suspension for any dentists that failed to comply.’ Critics, including two parliamentary committees, have slammed the health watchdog as poorly led – and have questioned the decision to put dentists on the same footing as care homes. These views were mirrored by the BDA in a recent press release in which John Milne, Chair of the BDA’s General Dental Practice Committee, observed:

The BDA has campaigned throughout this process for the myriad flaws inherent in the system to be addressed and for Government to apologise to dentists for the stress and difficulties that have been suffered. It’s time for that long-overdue apology to be made. The magnitude of the problems . . . and the effect they have had on dentists should not be underestimated. Dentists have told us that the experience of CQC registration has led many of them to seriously consider their futures in dentistry. That is a sad reflection on an ill-conceived and woefully-flawed process.

Clearly this story has not yet reached its conclusion and only time will tell how it will end.
CHANGING APPROACHES TO DELIVERING DENTAL CARE

The most apparent change in the way dental care is delivered in the UK has been the move towards private dentistry, which had its roots in the dental profession’s widespread dissatisfaction with the NHS fee structure of the early 1990s and in the changes introduced by the government at that time – ironically in an attempt to increase the number of patients seeking NHS dental care. The NHS was introduced in 1948 at a time when the oral health of the UK population was extremely poor. Many people had no teeth, dental decay was almost universal and infection was widespread. The basics of the system remained relatively unchanged well into the late 1980s, with dentists being rewarded according to how much they ‘drilled and filled’, not how well they did it or how appropriately they made their treatment decisions. There was growing concern that financial incentives were leading to over-treatment and following a review of these risks a new contract was introduced in 1990 with an element of capitation (around 20%) that aimed at encouraging the registration of patients into continuing care. Initially the new arrangement was very successful in encouraging patients to register, perhaps too successful as it turned out. The amount of work carried out on these new patients was far greater than anticipated by the government, who sought to recoup the extra expenditure by imposing a drastic 7% cut in the fees payable to dentists. This was a pivotal moment for the UK dental profession. Given the changes already described – namely, the growing complexity and cost of treatment options, the need to employ more staff in order to create the all-important dental team, and, finally, a more demanding and knowledgeable public – many dentists decided the time had come to turn their back on the NHS if they were to maintain, and in most cases dramatically improve, the quality of care and range of services offered to patients. The work of Professor Cary Cooper around this time showed the degree of discontent felt by many dentists who agreed strongly with statements such as:

\[\text{The piecework system of remuneration should be refined so that dentists are not only paid for operative work but also for preventive work.}\]

\[\text{Since dentists have to see as many patients as possible to earn a decent living, the quality of their work can suffer.}\]

Quoting a study conducted in the mid 1990s at the University of Manchester, Teresa Waddington reported that the chief concern for dental practitioners was the uncertainty felt about possible further changes to the dental ‘system’, a concern voiced by virtually every dentist in the study.
The future of dentistry is so uncertain at the moment, you don’t know where you’re going to be in a couple of years’ time.

I suppose with most things it’s the fear of the unknown. We’re not really quite in control of what’s going to happen next.24

By the mid 1990s and with more dentists reducing their commitment to the NHS, access (or, more correctly, lack of access) to NHS dentists was becoming an increasingly important political issue. Against this backdrop of restlessness within the profession, a number of review bodies were established in an attempt to find solutions to the various problems plaguing general dental practice.10,25,26 One of these, *NHS Dentistry: Options for Change*,27 set out a vision for NHS dentistry with prevention at its heart and was widely supported by the profession. A variety of pilot schemes were tested, and in 2005 a new contract was launched that was based on a methodology for measuring dentists’ activity and which, critically, had not previously been piloted.28 The 2006 reforms featured three key issues.

1. Responsibility for planning and securing NHS dental services was now devolved to local primary care trusts.
2. The system of patient charges was changed, resulting in a reduction in the possible number of charges from around 400 to just three.
3. The mechanism by which dentists were to be paid to deliver NHS services was changed from one based on fees per items of service to one where providers would be paid an annual sum in return for delivering an agreed number of ‘courses of treatment’ or ‘Units of Dental Activity’ weighted by complexity.

A number of dentists were uncomfortable with the new arrangements and elected to convert to private practice. While the lost capacity was relatively small (4%), it served to exacerbate the already problematic access issues that had been growing since the early 1990s. It soon became clear that, rather than improving the situation, the new contract was making things worse. A *Daily Telegraph* headline from March 2007 said it all: ‘Thousands Left Without Access to NHS Dentists’. The article noted:

The contract was intended to move dentists away from the ‘drill and fill’ image and give them more time for preventative work and taking on more NHS patients. But miscalculations on the amount of money that fee-paying patients would bring meant that primary care trusts have told dentists to slow down because there was not enough money to pay for taking on new NHS patients.29
The article also cited a BDA poll of 394 dentists, conducted one year after the new contracts started, showing clear dissatisfaction with the system. Eighty-five per cent of dentists surveyed did not think that the new contracts had improved patient access, and 95% did not think that the new contracts allowed them to spend more time with patients.

Clearly, many problems still existed and these lead to a further investigation into NHS dentistry conducted by the House of Commons Health Select Committee in 2008, which in turn led to an extensive independent review, *NHS Dental Services in England*, led by Professor Jimmy Steele. Subsequently, the government announced in 2010 that it would pilot three different models to help develop yet another NHS dental contract. This led to the development of a new body, the NHS Commissioning Board (NHSCB), which from April 2013 took over commissioning responsibility from primary care trusts for all NHS dental services – primary, community and secondary, including dental out-of-hours and urgent care. This will include commissioning dental services provided in high-street dental practices, community dental services, and dental services at general hospitals and dental hospitals. The stated aim of the NHSCB is to commission NHS dental services based on the local oral health needs assessment, which will be developed by public health teams in local authorities and will help determine the needs of local populations. It is hoped that the benefit of the NHSCB becoming a single commissioner for all dental services will be the ability to plan for and deliver more consistent standards, high-quality services and better health outcomes for patients across the whole of England. A more consistent approach to commissioning and contract management will be implemented in order to deliver these improvements.

Over two decades on from the events that precipitated all these changes, the dental landscape has clearly changed dramatically in the UK, and yet, according to a comprehensive study carried out by the Office of Fair Trading in 2012, the majority of dental patients still receive NHS dental treatment. Another study of the UK dental market noted that in 2011 there were approximately 29,500 dentists practising in primary care settings, with the vast majority offering NHS dental treatment or a combination of NHS and private dental treatment. Less than 10% of dentists (2,500) were thought to carry out private treatment only. The Office of Fair Trading study found that 66% of patients in England and Wales who had a regular dentist and had been to the dentist in the last two years reported that they received NHS dental treatment on their last visit. Twenty-three per cent reported that they had received private treatment and 10% reported that they received a mix of private and NHS dental treatment. More patients in Scotland reported receiving NHS dental treatment (75%), while fewer reported doing so in Northern Ireland (54%). Overall, the
dentistry market in the UK has seen significant growth over recent years, its value rising by around 90% between the periods of 1999–2000 and 2009–10 and currently standing at an estimated £5.73 billion a year, with spending on NHS dental treatment accounting for approximately 58% of the market value and spending on private dental treatment accounting for the remaining 42%.33

Compare these figures with 1996–97 when NHS fees stood at £1.6 billion (71%) and private fees at £0.6 billion (29%) and it can be seen that the size of the whole market has grown massively. However, while the cash value of the NHS has almost exactly doubled in that time, the private sector has quadrupled during the same period. These results clearly show that NHS dentistry is still alive and kicking, despite reports of its imminent demise, but equally there seems to be little doubt that the trend towards higher-priced and, one hopes, higher-quality care will also continue. That said, the recent economic downturn has undoubtedly had an impact on dentistry. While growth in the market was running at around 4% per annum from 2000 onwards, it slowed to 1% in 2008–09 and 2% in 2009–10.33

The move away from NHS-funded dental care has seen many dentists finding it convenient for both themselves and their patients to make use of the funding framework offered by one of a number of third-party schemes, with capitation plans by far the largest source of such funding for dentistry in the UK. Such capitation plans are based on a contract between the patient and the dentist to provide continuing routine care in exchange for a regular monthly payment or premium. Denplan, the largest of these schemes, offers a private capitation plan with, at the time of writing, approximately 1.8 million subscribers and over 6500 UK dentists enrolled in the Denplan care scheme. Virtually all of these patients pay their subscriptions individually without assistance from their employees. The availability of third-party funding schemes has been important in facilitating conversion from NHS to private dentistry during the 1990s and continues to be so. It is important to note, however, that third-party schemes are a relatively small source of funding. Capitation, full indemnity insurance and cash plans combined account for around 10% of general dental practitioners’ gross income. Cash paid out of patients’ own pockets, in contrast, accounts for approximately 30% and therefore remains by far the dominant mode of private payment. Future growth in the private market would therefore seem to be heavily reliant upon patients being able and willing to pay private prices.

Going hand-in-hand with increased third-party participation in dentistry is the growing involvement of corporate bodies. In July 2005, largely as a result of pressure to comply with European Union competition law, an amendment to the Dentists Act 1984 removed all restrictions on the number of 'bodies
corporate’, which had previously been held at a steady 28. Since then the corporate dental sector has expanded and in October 2010 it was estimated to account for around 10% of the dentistry market. Any corporate body can now carry out the business of dentistry, provided that it can satisfy the conditions of board membership set out in the amended Act – namely, that the majority of directors of any body corporate must be registered dentists or registered dental care professionals. It is clear that the whole issue of corporate bodies in dentistry is an emotive one, with strong voices both in favour and against. Some dentists feel threatened, raising concerns about the poaching of patients and ancillary staff. While the corporates undoubtedly have the ability to raise considerable capital to establish large new practices, a long-held concern among some members of the profession is that if profits do not accrue, then corners may be cut on materials used and on treatment quality or the range of treatments provided.

The BDA’s view on corporate bodies is essentially open-minded – provided that high ethical and clinical standards are maintained and that individual dentists can act at all times in the interest of the patient. This more positive view of corporate bodies currently seems to be carrying the most weight and as such is in favour of the move to abolish present legal restrictions, thus removing at least one obstacle to individuals or groups of dentists gaining the advantages of corporate body status.

It is certainly the proclaimed wish of many of these corporate dental groups to emphasise the personal, continuing relationship of the dentist and patient and so an important task is seen to be the recruitment of dentists with both good clinical skills and good communication skills. The corporates have expanded rapidly from a small base and are expected to continue to expand rapidly in the future and continue to influence the rest of the dental profession. In recent times there has been a proliferation of newer, smaller corporates aimed mainly at the NHS market. Some of the larger supermarket chains have also entered the fray, opening up clinics in key locations across the UK. It seems likely that these trends will continue in the future. In some cases they have raised the ante by adopting carefully thought-out strategies in a host of areas already alluded to: visionary leadership; a commitment to quality; a patient-led approach; staff selection, training and motivation; and not least financial control.

Whenever a practice makes the decision to close its doors to NHS patients, it is faced with so many new challenges – deciding on the range of services and treatment options to be provided, managing and motivating staff members, and not least re-evaluating the financial basis of the practice, particularly in terms of pricing and collection policy. Any practice, whatever its size or nature
of its funding, and no matter how excellent the treatment provided or how motivated and well-trained the staff, cannot be considered to be genuinely successful unless the management is firmly committed to maintaining its financial health. Excellent practices put in place a carefully considered pricing strategy, as well as establishing comprehensive guidelines in areas such as collection policies and payment methods.

**REMOVAL OF ADVERTISING RESTRICTIONS**

Until the mid 1970s, virtually all professional service providers such as doctors, dentists, lawyers and accountants were prevented from advertising by restrictions imposed upon them by the various professions’ own regulatory bodies. This was a worldwide phenomenon and the primary reasoning behind these restrictions was equally universal and consistent – namely, that such advertising was deemed to be unprofessional and would lower the status of the professions in the eyes of the public. However, by the late 1970s it was clear that, in the United States at least, the professions were coming under increasing pressure to deregulate, paradoxically through public as well as governmental pressure. This move towards deregulation can be traced to the seminal judicial interpretations concerning commercial free speech and restraint of trade by professional organisations. These effectively removed any constraints on marketing imposed by a whole range of professional associations and as a result, by 1983, American dentists were allowed to advertise their services freely to the public.

Following the precedent set by the US authorities, a number of other countries have also embraced dental advertising, including the UK, where the earliest discussions in this area stemmed from a Monopolies Commission report looking into the restrictive practices adopted by a variety of professions. The commission found numerous examples that they concluded were against the public interest. Among these were the constraints relating to marketing that, by denial of information concerning individual practitioners and practices, limited consumer choice or made the optimum selection difficult or impossible. The main wave of deregulation began when the British Medical Association declared:

*Patients are entitled to be given comprehensive, detailed and accurate information about medical services available to them. Doctors working within the National Health Service as opposed to private practice have particular obligations imposed on them by their terms of service by which they must provide both personal, professional and practice information.*

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The dental profession quickly followed suit and, by 1988, the only restrictions applied to advertising were those applicable to all advertising – namely, that it be ‘truthful, decent and honest’.

The 2012 Office of Fair Trading report\textsuperscript{32} drew attention to the fact that many patients were put under pressure by their dentist to sign up to advertised payment plans, commenting that, as a result, these patients are denied the opportunity to make active, informed decisions regarding how they pay for their dental treatment and even what treatment is actually required. The study found that a staggering 82\% of dental patients who received a course of dental treatment that incurred a charge did not receive a written treatment plan. Among a raft of suggestions made in the Department of Health’s \textit{Review of the Regulation of Cosmetic Interventions}\textsuperscript{39} published in 2013 were the following:

- banning free consultations for cosmetic surgery so that people don’t feel obliged to go through with surgical procedure
- ensuring consultations are with a medical practitioner and not a sales adviser
- imposing tighter restrictions on advertising including banning two-for-one, time-limited deals and cosmetic surgery as competition prizes.

This report did not target dentistry specifically, but the parallels are obvious.

All this does not mean that advertising is unprofessional but, rather, that the nature and tone is critical and to repeat it should be ‘truthful, decent and honest’. Whether or not it is effective is an entirely different matter, since little research has been done to determine if advertising does actually result in greater consumer awareness of dental issues and services and does subsequently lead to increased attendance. You have probably heard the quote about half the money spent on advertising being wasted, you just don’t know which half. It has been attributed to everyone from Lord Leverhulme (1851–1925) to John Wanamaker (1838–1922) to Leo Burnett (1891–1971) to David Ogilvy (1911–99). It does not matter who said it or when, because the way advertising money is spent has not changed enough to alter the significance of that statement. It is probably still true. As far as dentistry is concerned, most studies in this area come to the same conclusion; namely, that word of mouth is a far more persuasive influence – primarily for the reason that patients tend to give more credence to the opinions of friends and family than to promotional material put out by the service provider. It has to be remembered that advertising is just one piece of the overall marketing jigsaw and, given that word of mouth is likely to be more effective in persuading consumers, effort and resources would perhaps be better employed in hiring and training staff who possess positive attitudes towards dentistry in general, the practice in particular and, without question, an interest
in people as human beings, not just mouths to be fixed. Nevertheless, there is always scope for innovative approaches to marketing and the most effective strategies are by no means always the most expensive. A focused marketing plan comprises a comprehensive and ongoing marketing strategy involving not only obvious promotional strategies but also an understanding that marketing is built around the day-to-day interactions or ‘moments of truth’ that take place between the practice and its patients.

GLOBALISATION
UK dentists are no longer practising in a vacuum. As far as our profession is concerned, we are no longer an island. Many European Union dentists are now working here and, conversely, many patients are travelling abroad for the perceived cost benefits of having treatment done in places such as eastern Europe and even as far afield as Thailand and the Philippines. Dental laboratories are a major example of this ever-shrinking world. While at one time UK dentists would send their work to the local laboratory, these days they are just as likely to see their work going to set-ups in the Far East or even Africa. The same applies to dental supplies, traditionally provided by large companies in North America and Europe. These businesses are now having to face stiff competition from manufacturers around the world with lower cost structures. Such competition in all these fields is a good thing, provided that high standards are maintained. One thing is for sure and that is such global influence upon the UK market is not going to go away any time soon – rather, it is set to intensify in the years to come.

SUMMARY
It is clear that dentistry in the UK is undergoing the same metamorphosis that has taken place in many other Western cultures. The reaction of entrepreneurs to these changes falls into three groups:
1. those who bury their heads in the sand and refuse to recognise that change is taking place
2. those who allow the changes to happen to them and are tossed and turned by the tide
3. those who recognise that these changes represent a springboard loaded with opportunity for the future.

The rest of this book explores how to treat the current situation not as a threat but as an opportunity. While corporate dentistry probably isn’t going to go
away, we firmly believe that the successful small business of the future will need to be bespoke and five-star in its outlook – providing a high-quality service to a relatively select group. Of a UK adult population of around 51.4 million, it is estimated that there will be 29.7 million taxpayers in 2012–13. Around 3.8 million of these will pay tax at the higher rate, providing 36.5% of total income tax revenue, and 307 000 taxpayers will pay tax at the additional rate, providing 24.6% of total income tax revenue. As Willie Sutton, the American gangster, said when asked why he robbed banks, ‘because that’s where the money is’, it seems to make sense in business for you to leverage your time and efforts to those people with the greatest disposable income. The trends described in these last few pages interplay with one another to create the modern dental profession and point to the need for practitioners to balance clinical and managerial aspects of their practice. It is apparent that the modern dental practitioner must be able to provide an ethical, appropriate, high-quality service to increasingly sophisticated, knowledgeable and demanding patients, often being held accountable to outside bodies, while at the same time managing an organisation within an increasingly hostile and competitive business environment.

It is against this background that we ask you to consider the first of our eight strategies . . .
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