Handouts and Reading List

REASONS TO BE CHEERFUL

Kevin Lewis BDS FDS RCS(Eng) FFGDP(UK) **November 2017**

UK dentistry has felt somewhat under siege in recent years, with a number of factors conspiring to make it seem increasingly difficult to make headway. The well-recognised problems in relation to the GDC and the litigation environment, the frustrating delays in finding an alternative to the flawed UDA system in England and Wales, the economic climate generally and the continuing uncertainties created by the Brexit vote and the current political environment, all play a part.

But these and other less obvious underlying factors are precisely the circumstances which create real opportunities for those who are prepared to seek them out and grasp them. A typical working day inside general dental practice here in the UK has been rendered hopelessly over-full with layer upon layer of additional demands from all directions and a relentless focus on productivity (whether UDAs or private earnings), compliance and accountability. This leaves little time and energy to think constructively about the bigger picture and how we can influence our career for the better.

Thinking and working outside the box needs to start with a willingness to challenge popular myths and to venture outside the box. This presentation encourages us to look outside dentistry at other fields and the world of business, and to start to appreciate how many solutions, lessons, skills and strategies we can discover and directly apply to dentistry - including clinical dentistry – whether working in private practice or in other areas of dentistry. It will also look under the surface of dentistry at some flawed assumptions and things we may be taking for granted.

This presentation aims to give us an appetite to discover more of what lies outside the box, and help us to appreciate that we probably have a lot of the skills we need already. We just need to realise that they are there, and be able to reach for them and remember how to apply them when it matters.

Topics covered in this thought-provoking day will include an analysis of the internal and external factors impacting upon dentistry internationally and here in the UK; proven tools for managing patient expectations, generating patient satisfaction and dealing with dissatisfaction; demystifying price, cost, value and profitability; the benefits and risks of practice development and promotion in the digital era; and an exploration of the possible future direction of professional regulation and accountability including professional standards/postgraduate training/ competency/ CPD.

THINKING

Vertical Thinking - Lateral Thinking - Parallel thinking

Thinking tools

Opportunities Train Driver - Doctor – Fisherman – Farmer

Edward de Bono was born in Malta (in 1933), graduated initially in medicine at the age of 21yrs then as a Rhodes scholar moved to Oxford University in UK, where he undertook the first of four postgraduate degrees. His approach to thinking and problem solving have had a profound effect upon my own career, and later in the seminar it will become clear why there is such a strong synergy with some of the other ideas that we will be considering. De Bono's great legacy is to recognise that traditional education instils in us an unhealthy reliance upon predictable, straight-line thinking. Unless solutions and opportunities are obvious, when applying traditional "rules", we will not see them. If they are obvious to anyone who is using conventional thinking then everyone will be able to see them and they won't present much of an opportunity anyway. Lateral thinking (and an application of it known as parallel thinking) provides us with a selection of useful alternative approaches to thinking, problem solving and looking for opportunities, that can applied to many different kinds of situation.

In addition to being able to manage everyday situations as they arise, it takes a particular kind of skill to be able to identify

- the need to challenge existing ways of doing and looking at things, when everything might appear to be going well enough
- the need to develop and explore new options rather than assuming that if the status quo is working well enough, then such activities are not a sensible and efficient use of time and effort
- area(s) in which such development is needed
- the possibility that there might be a better way to do something
- opportunities, especially those that others have not spotted
- potential problems, risks and threats

When faced with a problem, many people are content once they have found what appears to be a solution to the problem. Once this stage has been reached, very few people keep looking for alternative solutions that might be better, or simpler, or more cost effective. Many businesses continue to do things in a particular way for no reason other than the fact that nothing has happened to persuade them to do otherwise. But there may be an inherent weakness in that system or process that could eventually create a significant problem, unless it is identified and eliminated. That moment may not yet have arrived.

Actively looking for weaknesses of this kind ("problem finding") will not always be an efficient use of a manager's time, because much of the work done and time spent will yield no meaningful or useful results. In any event, there is usually too much else to do, and too many other problems that need to be solved. But there will be other occasions when such efforts will be richly rewarded. Problem finding needs to be a deliberate activity, with appropriate blocks of quality time attributed to it.

In the same way, it will not always be an effective use of time to look for opportunities, but if you make this a conscious habit, every so often you are likely to see something that very few others have seen, or to realise the synergy between two or more things that everyone has probably seen, but nobody has linked. In order to be able to do this you must have an exceptionally good understanding of the business that you are in, and what is happening in and around it ("the big picture"). It is also necessary to be aware of, and to understand, what is likely to be happening in the next few years and any new issues that might arise and impact upon your business ("horizon scanning").

Busy people with responsible jobs rarely have the luxury of unlimited time, so they must be able to prioritise and make the best possible use of the limited time they do have at their disposal. Introducing some structure into one's natural way of thinking is one way of achieving this, because thinking without structure can be very wasteful and unproductive.

There are times in most walks of life when the going seems to be particularly tough, and when every colleague you speak to is sharing and repeating the same 'gloom and doom' stories. Vertical thinking throughout our education at school and university, 'hard wires' us into viewing the same challenges in similar ways. Anyone who can think differently can view these same challenges differently too – and will be able to see opportunities that most other people are missing.

Thinking styles

One of the problems inherent in traditional thinking styles is that situations are usually addressed from a fixed perspective – usually that of "where we are now". Creative thinking is often limited by the imagination of the individual and by the constraints and pressures of the situation in which that individual finds himself (or herself). Too much pressure from things that need to be done now, or today, is the greatest enemy of creativity and constructive, innovative thinking. But, irrespective of how busy we are, we need not accept that we are always limited and constrained in this way. Edward de Bono's book "*The Use of Lateral Thinking*" was published in 1967 when he was aged just 34yrs. He wrote "*Lateral Thinking for Management*" four years later and a huge body of related work has followed.

Vertical thinking is logical, linear thinking. It is continuous, 'stepwise' and progressive in nature, each stage building logically upon the previous stage. It makes the most effect use of time and effort because it is rules-based. For this reason, conventional education concerns itself almost exclusively with vertical thinking.

Lateral thinking, on the other hand, is illogical, exploratory and speculative, and it often makes very ineffective use of time because many of the lines of thinking produce no useful or identifiable outcome. It deliberately transports a line of thinking away from the direction that has been taken to date.

Vertical thinking accepts an existing, adequate solution or approach; lateral thinking challenges the status quo and asks whether an even better solution or approach might just be possible. Vertical thinking looks for demonstrable, stable and robust answers that are so obviously satisfactory that one can immediately be content with them (the parallel with evidence-based medicine and dentistry should be obvious). On the other hand, lateral thinking asks new questions, and new ways of answering old questions.

Vertical thinking works on the basis that being right at each stage ("YES"), and rejecting wrong options at each stage ("NO") automatically means that the final outcome will always be correct. Lateral thinking suggests a third way, the provocation option ("PO") which does not tolerate the complacency and arrogance of assuming that the answer to all life's decisions can be comfortably labelled "YES" or "NO". Lateral thinking does not allow yesterday's decisions to be repeated indefinitely, without questioning them.

Vertical thinking is logical and analytical, and the nature of this analysis is conventional. If certain premises and assumptions have been made on previous occasions, they are likely to be made again. If an option has been rejected previously in a process of vertical thinking, it is likely to be rejected again. Lateral thinking is provocative, it does not allow itself to be blocked by habit or assumption, and the nature of any analysis will always be unconventional. Lateral thinking would look at an idea or possibility that was previously discarded, and ask whether the reasons for the previous decision are still valid.

Vertical thinking works in stepwise fashion, one thought or one conclusion leading from another. In lateral thinking the whole purpose is to avoid this happening. This often results in deliberate jumps being made in random directions – sometimes logically, but quite often illogically.

Vertical thinking relies on the view from where we are at the present moment in time. Lateral thinking allows us the luxury of transporting ourselves to somewhere else to see if the view might just be different. It often is. By deliberately shifting our perspective to a hypothetical alternative position, we are given the freedom to think in different ways without being constrained by the present situation and all the pressures and challenges that it might present for us. Vertical thinking has identifiable end points; it is therefore a closed procedure. Lateral thinking has no such predetermined end points and is therefore open ended and unconstrained in its scope. One cannot know at the outset where one will finish up.

Distractions disturb vertical thinking and are unwelcome because they throw the thinking process off balance. Because vertical thinking is rules-based it is often necessary to go back to the stage you were at when distracted, and re-trace your steps. Vertical thinking restricts itself to what is relevant and most likely to lead us to a predictable and reliable outcome. Vertical thinking likes the security of familiar and well-worn stepping stones, but the potential achilles heel of vertical thinking is the sin of assumption. On the other hand, lateral thinking actively welcomes unexpected distractions and detours in the thought process; it deliberately challenges and often rejects assumptions and encourages the exploration of the least likely avenues.

It is perfectly acceptable and understandable that we will tend to use vertical thinking 90% or more of the time. Lateral thinking comes into its own when vertical thinking has ground to a halt. Lateral thinking comes up with a high-carat idea, while vertical thinking may still be necessary to develop it into something with practical application. De Bono describes vertical thinking as digging the same hole deeper, in contrast with lateral thinking where you start digging a new hole somewhere else.

Parallel thinking is an alternative form of structured thinking. It involves introducing a discipline to focus your thinking in one particular way at a time, before moving on to an (enforced) different perspective. It combines elements of both vertical and lateral thinking. A "SWOT" analysis is a simple and familiar example of parallel thinking, involving four separate assessments of the same situation

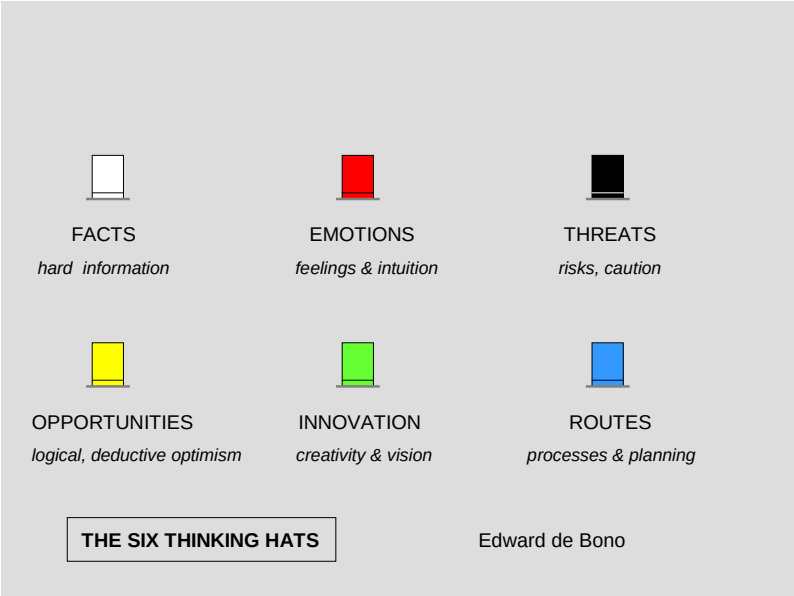
- **S**trengths
- **W**eaknesses
- **O**pportunities
- **T**hreats

Instead of asking the somewhat simplistic question "*Is this position good or bad ?"* or the more open question *"What do we think about our present position?",* parallel thinking forces us down narrower and more objective channels, asking one question at a time, such as "*What are the strengths of our present position ?",* or "*Are there any threats to our present position, and if so what form might they take?"*

Only when one has exhausted the analysis and consideration of one question, does one move on to the next question. This makes the thinking process, and the ideas that are generated from it, less random and more effective. It harnesses thought by providing both focus and a concentration of effort. It also provides structure to the thinking process without constraining it in any way.

In his book, **The Six Thinking Hats (2003), Edward de Bono** encourages us to metaphorically wear one of six coloured "hats" in order to adopt six very different thinking perspectives in considering a single situation. Symbolism and analogy are common themes of De Bono's approach, which recur throughout much of his published work. The different colours he has chosen for particular hats, to act as a metaphor for their meaning and purpose, is therefore quite deliberate and it is worth a moment's pause to reflect upon why he might have chosen them. WHITE-facts, RED-feelings, BLACK-threats(negative), YELLOW-opportunities (positive), GREEN-innovation, BLUE- planning the route ahead.

The six hats are summarised in the diagram below :-



The choice of these specific perspectives is particularly valuable because it forces people out of their natural thinking styles and attitudes. Generally negative or pessimistic people might otherwise struggle to look for positive aspects or opportunities in a given situation – this is not how they think because their default position will always be to look for (and worry about) the worst that could happen.

Similarly, perpetual optimists can be persuaded to appreciate risks and the occasional need for a more cautious approach, while those who are habitually cautious and risk averse can be helped to appreciate the opportunities that they are letting slip, and coaxed into realising that risk can be effectively managed, instead of always trying to avoid it altogether.

Inward-looking, process-orientated people can become more outward looking and creative. They can be persuaded to look up from immediate, day-to-day demands and their natural craving for shape and structure, to look for the 'big picture' and to scan the horizon. In the same way, managers whose natural style is to rely upon 'gut instinct' can be encouraged to look for hard facts to support (or challenge) these instincts, and people who always concern themselves with facts can allow themselves to take feelings and intuition into account. Out of all this a more balanced and rounded management approach can hopefully evolve.

The Six Thinking Hats can be used in group settings, where one usually finds that different members of a team have a particularly valuable contribution to make in some areas, while taking a back seat in other areas. This harnesses the different strengths of different team members, and helps to compensate for their weaknesses too. This also helps to overcome a familiar problem of group discussions where one or two individuals tend to dominate any discussion. If they are senior, influential people and they have a negative and pessimistic perspective, that tends to set the tone of the discussion and others may feel less inclined to speak up with a more positive, creative viewpoint thinking that it will not be welcome. The "six thinking hats" approach is deliberately designed to ensure that everyone's view matters and has validity and will get its chance to be heard at a time in the discussion when it cannot and must not be drowned out.

People who have excellent vision and the ability to think creatively will often lack the eye for detail, or the organisation and discipline to see things through to completion. Others who are dependable organisers, planners and "completer-finishers" will often be constrained by the need for systems, processes and structure, and sometimes this can mean that they are also less creative and imaginative in their management approach. Organisations are often defined by the personal characteristics of the people leading them and the most successful organisations seek a balance of skills in senior management posts.

Just as with any other toolbox, one or more of the tools of lateral thinking can come to our rescue whenever we find ourselves unable to find a solution to a problem.

- **Focus** Focusing upon narrow targets minimises the chance of becoming distracted by irrelevant issues. On the other hand, there are times when too narrow a focus can be unhelpful and we can think more creatively by giving ourselves much wider targets to aim at. Bigger targets are easier to hit but remember that the highest scores are achieved by aiming at the bullseye and the area immediately surrounding it. If an important task needs doing, or an important problem needs thinking through, allowing someone to focus all their energy on this, free from distraction, will usually yield the best results. You can only have one first priority at any moment in time.
- **Concentration** The more time and application you can bring to bear on a problem, the sooner it will be resolved. The principle is much the same as one of Sun Tzu's strategic principles, "*use overwhelming force*" (see reading list). This concentration of effort relates to individuals and groups ; if something is made the number one priority for every member of a group of people, it is more likely that the effort of the individuals will be synergistic rather than conflicting.
- **Re-define the problem** Sometimes the key to seeing a solution to a particular problem, is to think of the problem in a different way. "Re-framing" the problem might involve using different words to describe it, or separating the problem itself from any people or other things which are closely associated with it.
- **Work backwards** If it is difficult to visualise a clear route towards your intended objective, imagine yourself having already reached that objective, look back towards where you are now, and identify something that would need to have happened first, before arriving at your objective. Now transport your thinking to that intermediate point and repeat the process until you see where you are now. This helps you to plot the steps along the way, which you can now follow in reverse from your present position to your destination.
- **Look upstream** Instead of dealing with the manifestation of a problem – especially one of a recurring nature – it often makes more sense to trace the problem back to its root cause, and deal with it at source. A practice that uses a manual filing system for hard copy documentation may have a problem with 'lost' or mis-placed documents or files. Instead of focusing attention on the activity of <u>retrieving</u> the documents from the filing system, or the person responsible for this activity, it makes more sense to focus upon the way in which the documents or files are being <u>re-stored</u> after use. It is almost always a deficiency or weakness in this part of the process that is the 'upstream' cause of the problem that manifests itself weeks or months later as the inability to locate a

document or folder within the system. Interestingly, the GDC identifies "Moving Upstream" as one of the four pillars of its new strategic approach (see reading list)

- **Challenge and Provocation** This skill lies at the heart of lateral thinking because it is our reluctance to challenge the status quo, or to question why we are thinking or acting in a particular way, or assumptions that we are making, that inhibits our ability to find better answers and solutions than those we have found to date. Many of these challenges are outrageous, nonsensical and completely impractical. But some are not. In many cases it is more ridiculous to continue doing something in a fashion which is more complicated, more time consuming, more expensive and less effective than an alternative that we can't be bothered to consider. It is worth going through the process of finding out for sure.
- **De-aggregation** It is often easier and more convenient to lump together different things, with different attributes, but in doing so we lose the opportunity to look more closely at one or more individual components. When issues are aggregated we lose some of the detail that contains most of the solutions and opportunities. Break big and complex things down into their component parts or smaller units and they become easier to think about, analyse and understand. Don't fall into the trap of assuming that two factors that are traditionally assumed to be inseparable, cannot be treated independently. They may look very different if they are viewed one at a time.
- **De-averaging** A variation on de-aggregation, this is a deliberate process of stepping back from a piece of information that represents an "average" , to look at all the independent elements that contribute to that average. Management accounting, and absorption costing are examples of this approach. An average tells us nothing other than the fact that it is the net result of lots of things that are each very different from that average. The opportunity lies in understanding those differences and how they arise, and recognising the significance of those differences.
- **Pause** We are all familiar with the concept of "sleeping on it" when a particular problem seems impossible to resolve. When you come back to such problems after a break (or a good night's sleep) it is amazing how often the elusive solution is screaming at you**.**
- **Analogy** Try to think of a comparable situation in a setting as far removed as possible from the one you are in. Solve the problem in the analogous situation and then see of you can re-apply it back to your own situation.
- **Borrowing** It is a dangerous and short-sighted mistake, to assume that all the answers you need in dental practice management, are to be found in dentistry. In most cases the reverse is true. Look across at other professions, and at other businesses in other fields, and see how they solve similar problems Can you steal any ideas and adapt them to your own situation ? Actively stay on the lookout for ideas you can steal or borrow – whether they are helpful now, or are simply ideas that attract you that you can file away for another day. You never know when they will come in handy. Aviation learned that simple human errors were the cause of many accidents and near-misses, especially when involving seemingly mundane and repetitive tasks. By introducing 'checklists' and enforcing their use, they dramatically reduced the chances that key things were being overlooked.
- **Innovation : generating new ideas through green field thinking** Innovation in a "green field" situation is more difficult than problem solving because you have nothing specific to aim at (ie a problem that needs to be solved). Brainstorming is often a productive technique to use in search of ideas that can form the seeds of innovation. Putting shape to the ideas is a separate process, but you still need to generate the ideas in the first place.
- **Combination** There will be occasions when two (or more) separate things need to happen in combination with each other, in order that a problem can be solved or an opportunity can exist. Looking at each of these things in isolation will not seem like a solution. It is the synergy of putting them alongside each other that makes a solution possible**.**
- **Movement** Try to look at things from a different perspective by shifting your thinking position to somewhere other than where you are now. Try to imagine how things would look if viewed from somewhere else. With some kinds of blockages in thinking, the process of moving away from the blocked line of thinking, is all it takes to start moving forwards again.

- **Distortion** Sometimes a potential solution is rejected because it doesn't quite fit the current situation. But it may be possible to 'bend' the solution in some way, so that it can fit the situation in a different way. Adapting proven solutions from an entirely different situation is a commonly–used way of resolving existing problems and exploring new opportunities
- **Leapfrogging** Occasionally, a line of thinking will come to a complete halt, and the same obstacles will repeatedly get in the way. This is particularly likely to happen when using a vertical thinking approach. When this happens, try jumping – however irrationally – past the blockage and see if this makes it easier to see a solution. In many instances you will discover that the 'blockage' that you always thought was unchallengeable, is infact entirely unnecessary and dispensable.
- **Simplification** Many products and processes are unnecessarily complicated, including features that provide no practical benefit and layers of extra tasks and stages for reasons that nobody can remember the purpose of any more. We often end up compensating for complexity instead of trying to reduce it and when a system fails to work, the normal response is to introduce additional complexity.
- **Escape** Drastic situations sometimes call for drastic remedies and it may be far easier to stop doing something altogether, than to continually make adjustments or allowances for it, or to invest huge amounts of time, effort and money in order to continue doing whatever is causing the problem. Dentists who convert from NHS to private, or who take the decision to refer a particular kind of procedure to specialists, are adopting this strategy.
- **Amputation** Sometimes, it is one particular aspect of something that is causing a problem. It may be the attitudes and behaviour of one particular person that is responsible for making a team dysfunctional, or one stage in a process that is making the whole process too slow or unworkable. In each case, consider the possible impact of a selective 'amputation'. Imagine how life would be without that problem area or person, or that problematic stage in an otherwise streamlined process. Does the amputation really solve all the difficulties, or merely shift them somewhere else ?
- **Magic** Imagine yourself in possession of a magic wand that makes anything possible. What would you use it for?

THINKING WITHOUT THINKING

In his best-selling book **"Blink! – the power of thinking without thinking",** the author **Malcom Gladwell** explains the importance of intuition and being more trusting of our instincts. Healthcare professionals – like most highly trained experts in their chosen field – tend to have rigid systems and processes when making their decisions. Our many years of scientific training makes it even more likely that we will be vertical thinkers, always looking for evidence to support the decisions that we are about to make.

But there is a heavy price to pay for ignoring those 'gut feelings' that have evolved throughout evolution as a protective mechanism designed to maximise the prospects of survival. But modern life (and vertical, logical thinking') urges us to ignore such nonsense because it appears to have little or no evidence to support it. Infact, **Blink!** makes a compelling case that the evidence in support of intuition is overwhelming and irrefutable. It can be nicely summarised in the sage advice, *Listen to your gut – it knows what your head hasn't figured out yet.* And how many dentists would not recognise the quotes below, which come from actual dentists after things have gone badly wrong for them…..

" I knew this patient was going to be trouble from the moment she walked through the door. With the benefit of hindsight, I wish I had never agreed to treat her." or

"I think I just allowed myself to be bullied into carrying out this treatment. I was always uneasy about it, but he is not an easy patient to refuse. He is very persistent, and (I now realise) very manipulative. It was nothing specific but my nurse and receptionist also felt as uneasy about this patient as I did."

COMPETENCE

One of the realities of professional life that we discover as we gain in experience - probably starting from the first moments that we compare notes with our student colleagues in a 'phantom head' / 'mannequin' training environment, is that we and our colleagues do not all share the same levels of ability. Whenever we examine a new patient for the first time – other than those with an intact, healthy dentition - we get an opportunity to form a view about the clinical and technical ability of the professional colleagues who have treated the patient previously, and thereby to recalibrate any perceptions we might hold of our own skill levels.

Many procedures in clinical dentistry are technically challenging and few of us would doubt that nothing other than the experience of repeating that procedure on different patients and in different circumstances, will hone our skills and improve the quality of what we deliver in a technical sense. The difference between didactic teaching, and the hands-on learning environment is profound not only because the different approaches prepare us in different ways, by engaging our senses differently. The fact is that nothing other than going through the stages of physically carrying out the procedure can take us to a stage where it becomes familiar and natural. This is particularly true of those procedures that are most unlike anything else that we do in our professional or personal life. But the challenging process of not only improving our ability so that we can achieve the required quality of outcome, but also developing our ability to deliver it in a consistent, repeatable way in variable circumstances, is actually a lot more complicated than that.

GLADWELL and SYED

In his bestselling book **"Outliers",** Malcolm Gladwell (see above re his earlier book, *Blink!)* cites many examples, drawn from a wide range of human activity, to illustrate the premise that it takes something in the region of ten years to make the journey from novice to expert in any given field. He describes this as 'the 10,000 hour rule' on the premise that anything more than 1,000 hours per year of application to any one area of activity is about the limit that most people would find practicable in order to maintain the focus and intensity of the learning and also to have any kind of life around it. Infact, Gladwell makes a persuasive case that no amount of natural talent can ever replace the single-minded commitment and dedication required to become a world beater in any field, and sometimes that '*any kind of life around it*' element ends up being the difference between the genuinely outstanding, and those who simply end up being very good.

Matthew Syed, in his stimulating book **"Bounce",** while acknowledging and fully supporting Gladwell's '10,000 hour rule', adds a further dimension to it by drawing a distinction between simply clocking up the hours spent on a given activity, and what he terms '*purposeful practice'*.

It is interesting that both Gladwell and Syed place great emphasis upon the role that extraneous and seemingly unrelated factors, and/or pure chance and serendipity, have to play in separating the ordinary from the good, and the good from the outstanding. On reading their books one can be persuaded that our genetic make-up and innate talent is probably little more than one of many factors that gets some of us to the starting line and – if we are lucky – positions us so that more opportunities are likely to come our way.

The reality is that doors to self-improvement are opening and closing for most of us, most of the time, but very few of us have the insight and inner drive to recognise and seize those opportunities when they present themselves. And fewer still have the commitment and ruthless focus to push them as far as they will go because 'good enough' is good enough for most people and for most of their purposes. Many of us have neither the need nor the desire to turn a modest advantage into the pursuit of genuine 24 carat excellence,

just as long as the bills get paid. Not everyone aspires to be the best in their field and other human aspirations have a value of their own – and for some, a much higher value.

As Gladwell puts it

"Success follows a predictable course. It is not the brightest who succeed……nor is success simply the sum of the decisions and efforts we make on our own behalf. It is, rather, a gift. Outliers are those who have been given opportunities – and who have had the strength and presence of mind to seize them."

Gladwell also describes another aspect of overall ability that some might find a little surprising, but has massive application in medicine and dentistry:

"The particular skill that allows you to talk your way out of a murder rap, or convince your professor to move you from the morning to the afternoon section is what the psychologist Robert Sternberg calls 'practical intelligence'. To Sternberg, practical intelligence includes things like 'knowing what to say to whom, knowing when to say it and knowing how to say it for maximum effect.' It is procedural: it is about knowing how to do something without necessarily knowing why you know it or being able to explain it. It is practical in nature: that is, it's not knowledge for its own sake. It's knowledge that helps you read situations correctly and get what you want. And, critically, it is a kind of intelligence separate from the sort of analytical ability measured by IQ. To use the technical term, general intelligence and practical intelligence are 'orthogonal': the presence of one doesn't imply the presence of the other."

There are echoes here of what is often termed 'emotional intelligence', but that is not the whole story. In healthcare there is obviously another side to this coin in that it is not our proper role always to 'get what we want' but the relevance of the rest will not be lost on most of us.

Matthew Syed is ruthlessly dismissive of the assumption that talent and ability is all about genetics. Quite early in **Bounce** he explains,

"Think about how often you have heard people dismiss their own potential with statements like 'I am not a natural linguist' or 'I don't have the brain for numbers' or 'I don't have the co-ordination for sport'. Where is the evidence for such pessimism?

Often it is based upon nothing more than a few weeks or a few months of half-hearted effort. What the science is telling us is that many thousands of hours of practice are necessary to break into the realms of excellence.

If we believe that attaining excellence hinges on talent, we are likely to give up if we show insufficient early promise."

Malcolm Gladwell picks up a parallel theme in Outliers, in describing the work of Alan Schoenfeld a Professor of Mathematics at the University of California, Berkeley who encounters a nurse in her mid-20s (Renee). She is described as "not a maths natural" but her special ability was her persistence and determination to overcome seemingly impossible problems and challenges.

Confronting her with a testing mathematical challenge, Schoenfeld reports

"If I put the average eighth grader in the same position as Renee, I'm guessing that after the first few attempts they would have said ' I don't get it. I need you to explain it' "

But as Gladwell puts it,

"Renee persists. She experiments. She goes back over the same issues time and again. She thinks out loud. She keeps going and going. She simply won't give up." He adds, *"We sometimes think of being good at mathematics as an innate ability. You either have "it" or you don't. But to Schoenfeld it's not so much ability as attitude. You master mathematics if you are willing to try."*

Clearly a prospective dentist needs to possess a pretty high level of intellectual ability and academic attainment in order to get into University in the first place - and a greater level still to gain a place on a highly competitive degree course such as dentistry. Beyond that there is a certain level of visual acuity, spatial awareness and manual dexterity (including hand-eye co-ordination), and ability to communicate, without which the particular demands of clinical dentistry would seem to be insurmountable. All of these physical abilities can – with very rare exceptions – be worked on and improved and this is reassuring to discover, given that many people over the years will have graduated with a dental degree having only the barest adequacy of skills in some or all of these respects.

Feedback

Matthew Syed was himself a successful professional sportsman so his book uses a lot of examples drawn from sporting and competitive contexts. His reference to "*purposeful practice*" makes particularly good use of sporting analogies; for example he explains that one can compress a huge amount of experience into less (but more productively spent) time by designing into each hour of training as much feedback as possible. Ideally, this should be immediate – that is, received at the time - and from as many sources as possible.

Using the example of someone learning the skills of golf, he contrasts the pleasurable but somewhat limited beneficial effect of simply playing a certain number of rounds of golf in the company of another novice, with the very different approach of someone taking a bucketful of golf balls and playing the same shot again and again from the same position, studiously noting what works and what doesn't and how the outcome changes when he plays the shot in a different way. He gradually learns what it feels like when everything is happening in the right way at the right time, and what it feels like when it isn't. Having an experienced professional coach in attendance to watch him in action, point out the good and bad aspects and suggest ways to eliminate the weaknesses and make the best bits consistently repeatable, is obviously a huge step forward and it is easy to understand why this approach would dramatically accelerate the improvement. It is also very easy to see how exactly the same approach applied to learning the fine technical skills of endodontics, for example, might pay huge dividends.

Syed quotes Jack Nicklaus, probably the most successful golfer of all time,

"Nobody - but nobody - has ever become really proficient at golf without practice, without doing a lot of thinking and then hitting a lot of shots. It isn't so much a lack of talent: it's a lack of being able to repeat good shots consistently that frustrates most players. And the only answer to that is practice."

Syed goes on to use a powerful analogy to explain why the skills of medical GPs in carrying out a specific procedure that they rarely undertake might erode over time, while those of medical specialists in that same field keep on improving as their experience grows.

"In effect, GPs are like amateur golfers encountering a tricky 'lie' and hitting only one ball; they have insufficient feedback to challenge and refine their judgment. The specialists on the other hand are like pro golfers hitting multiple balls from a different lie; they deepen and refine their knowledge over time, getting better and better."

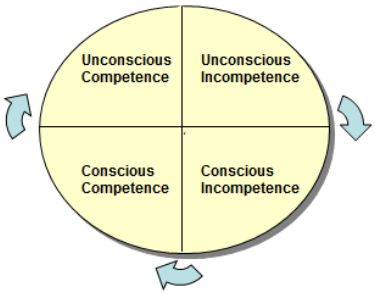
Gladwell and Syed reveal, in their different ways, another 'head start' that experts have over the rest of us. The deeper your knowledge and understanding of a field of activity, the greater your ability to sift the information before you in double-quick time and to make sense of it. Not only do you know what to look for and what is (and is not) significant, but you are able to see things that the novice does not see because you have trained yourself to pick up patterns, nuances and subtleties that the novice will almost certainly miss. In healthcare it is obvious what a crucial advantage this becomes in terms of a differentiator of ability. But yet again this has little or nothing to do with natural talent, and everything to do with application and purposeful practice. This "thin slicing", rapid processing ability is a natural extension of the phenomenon described by Gladwell in "Blink!". The experienced physician or surgeon adds intuition into his little black bag. Unfashionable to accept in the days of the evidence base perhaps – but nobody doubts its truth.

Many sports now use sophisticated video and computer technology to track and analyse every aspect of an individual's performance. This may not be immediate, but it provides another layer of feedback and a powerful tool for further improvement.

Specialists are expected to have a greater level of ability than non-specialists. And the messages from Gladwell and Syed explain why this is likely to be the case. Specialists may not all have satisfied 'the 10,000 hour rule' but they will certainly have compressed a huge amount of "purposeful practice" into their specialist training course, received regular and expert feedback throughout and will have acquired deep knowledge and understanding along the way. Specialists will have invested many hours into learning what works and what doesn't and within their field they are likely to have developed their "practical intelligence". So as a predictor of ability, the dice will always be heavily loaded in favour of the specialist.

Experts frequently make even the most difficult things look deceptively easy, and this can confuse non-experts into believing that the same standard is more accessible and attainable than is actually the case - unless they are able to fully appreciate how proficient the expert has become (and why).

MARTIN BROADWELL at the University of Michigan (in the late 1960s) should almost certainly be credited for something which was later popularised by Gordon Training group in California, and which has been applied and re-applied by many others over half a century. It has become known as the 'Conscious Competence' model of skill development.



Whenever we start doing something for the first time, we will not (yet) be competent in carrying out that task. We may not realise this initially, but we gradually start to understand our limitations and move from this position of "unconscious incompetence" to one of "conscious incompetence". We then continue around the circle clockwise until (hopefully) we end up being 'unconsciously competent' – that is, we are consistently good at what we do without thinking too much about it. At this stage it is easy to forget what effort and application it took to become that good, and how long it took.

But every new procedure, technique or activity we encounter during the course of our career, brings a new conscious competence cycle. We may have reached the dizzy heights of becoming unconsciously competent at task A, and perhaps even at tasks B, C and D too. But the danger is then that we look at a new and unfamiliar task E and ask ourselves "How difficult can it be – especially when I can already do tasks A,B, C and D so well and so easily?"

Every time we start a new task or procedure we become a student again.

DAVID DUNNING and JUSTIN KRUGER

Their work published in 1999 demonstrated that less skilled and less competent people tend to overestimate their level of competence and expertise initially, while those who are truly expert sometimes underestimate their true level of expertise. Socrates may have been quoted as saying that the one thing that he did know was that he knew nothing. Not so sure about that – but it is important to understand a few basic things about training and competence

- If an opportunity for the acquisition of knowledge and skill appears too quick and too easy to be true, it probably is.
- Be prepared to question the quality and substance of the further training that you seek.
- There are no short cuts. There is no substitute for the investment of time and money.
- Don't under-estimate the value of mentoring when you first try to apply a new skill.

NEW PERSPECTIVES ON COMPETENCE

Every practitioner owes a duty to every patient in whose treatment they become involved, to exercise a reasonable level of skill and care (the "duty of care") and to make sure that they only provide treatment that they can deliver safely and to an appropriate standard. Every registered healthcare professional has a personal duty of care which has a legal, ethical and professional/human dimension.

During the course of a professional career which might span several decades, is it inevitable that dentistry will change. New equipment, materials and techniques will replace those that were the norm during our undergraduate training. Somehow we need to add on all these extra skills, knowledge and risk awareness "on the job" – and perversely, it is left to each individual registrant to decide for themselves whether they are sufficiently competent to add the new procedure or technique to their clinical repertoire. This hands-off approach is in stark contrast to a field such as aviation, where it would be clearly absurd if pilots could jump into the cockpit of a plane that they had never flown before, and fly passengers around the world withour needing to demonstrate their training and competence. Interestingly, aviation imposes many layers of regulation firstly to get and retain a pilots license, and then in respect of flying particular planes in particular circumstances. Suddenly the GDC and GMC start to feel like the most benevolent and 'hands-off' regulators in the world.

Dentists and other non-dentist team members

From an ethical perspective you should always seek to place the best interests of your patients above your own interests, or even that of your employer. You should take all reasonable steps within your control to prevent avoidable harm to patients. You should only ever undertake procedures that you are trained and competent to carry out (and obviously, which are not prohibited by law). Being asked by a dentist with whom they work, to do something they are not happy doing can place a dental nurse or receptionist, hygienist or therapist in a very difficult position, and can cause personal as well as professional tensions. In some cases it can even be illegal (both both parties).

It is not a sufficient defence to say that you were only following the instructions of your employer. If you have a reasonable belief that you are being asked to do something illegal or beyond your scope of practice/training/competence, then you should not allow yourself to be persuaded to do it.

Similarly, even in situations where you would not be acting illegally or beyond your scope of practice, if you do not believe that you will be able to treat a patient safely and to an acceptable standard, then you should not be treating the patient at all. Declining to provide treatment is not always an easy decision, and you can come under pressure from employers and patients alike, but here again you may be better placed than the patient to realise the potential risks of proceeding with their treatment.

You should always try to raise any concerns of this nature in private with the person concerned, at an appropriate moment and without undue delay. Sometimes it is sensible to confirm your concerns in writing – perhaps after raising them verbally and in person in the first instance. This has the twin advantage not only of putting down a "marker" that you had acted professionally and in the best interests of patients, in case your actions are ever questioned subsequently, but also of making it less likely that your comments will be ignored. Once they are placed in writing, they are well and truly "on the record".

What you should never do in these situations, is to agree to do things against your better judgment, perhaps even placing patients at risk or compromising their care, simply to avoid confrontation and/or for the sake of an easy life.

Nor should you put your head in the proverbial sand and choose not to notice or react to things that in your heart you know aren't right. When things go wrong, the questions will always be asked, "who knew what and when – and what did they do about it?"

A particularly difficult situation arises when nobody that you are working with on a daily basis, or at a time when a specific problem arises, is in a position to do anything about the situation. They may not be in a position of sufficient authority to take the necessary decisions (corporate dentistry is full of moments like this). You should then contact someone of the necessary seniority by phone or email, and keep a record of what was said and who you spoke to. In the meanwhile you should act in the best interests of any patients under your care. In most situations, postponing dental procedures is a sensible and readily available option that buys you time to reassess the situation.

"Borrowing" ideas from other fields and other parts of the world helps us to see our own situation in a different light. It is, after all, one of Edward de Bono's recommended tools for lateral thinking. In Australia, for example, the so-called 'competency-based approach' is adopted, stating that "**dental practitioners must only perform those dental procedures for which they have been formally educated and trained in programs of study approved by the Board, and in which they are competent."**

Dentists and specialists

There is an expectation that a dentist will be able to recognize when a given clinical situation is beyond the limits of their expertise, training and/or physical capability, and both in law and in terms of professional standards and conduct, there is provision for a dentist to make the decision as to what to delegate, refer and/or carry out independently or with guidance/supervision. This is easy enough in theory – and also in a practical sense when considering procedures such as oral and maxillofacial surgery, or complex orthodontics.

But it gets more difficult when the procedure in question is in broad terms something that falls within a general dental practitioner's scope of practice, but in the specific situation of an individual patient, on a particular day, could be beyond their ability to carry out the treatment safely and to an acceptable standard.

On these occasions, working your way through the checklist below, asking yourself each question in turn, may be helpful :-

Should I carry out this procedure ?

1. Am I legally permitted to carry it out ?

2. Have I been adequately trained to carry out? Was this a formal course of study approved by the Dental Board ? Would I be able to satisfy the Dental Board or a court of law that this was the case ?

3. Am I sufficiently experienced in carrying out this procedure ?

4. Am I in a position to assess the complexity and potential risks of carrying out this procedure in this specific situation, taking account of

- the patient in question
- the clinical situation
- the physical aspects of my working environment (the surgery facilities, the equipment and instruments, the lighting/access)
- the human aspects of my working environment (the competence and experience of the staff available to assist me)
- how the patient feels today
- how I feel today
- what fall-back I would have if I run into difficulties
- what alternative options exist – what else could I suggest ? Is it possible that by postponing the treatment, my ability to carry it out to an appropriate standard on another occasion might be very different?
- In the light of all the above, am I confident in my ability to carry out the procedure and complete it safely and to a satisfactory standard ?

Many practitioners are reluctant to concede that they should seek assistance from a more experienced or specialist colleague, either because of a misplaced sense of pride, or because they are worried that they might never see the patient again.

Any concern that you might look foolish or inadequate, needs to be viewed alongside how you would feel if you embarked upon a procedure and got into difficulty, and then found yourself forced to call in the cavalry at a later stage.

There is a lot more to the question of competence, then, than the bare bones of whether or not you have been trained to carry out the procedure and feel confident to do it. Unfortunately, if you attempt a procedure and things don't go to plan, it might well be alleged (if a negligence claim were to be brought against you), that you could and should have been aware that the procedure was beyond your ability, and taken the appropriate steps to refer the patient elsewhere. It is also quite commonly alleged that the patient's consent was invalid because they should have been warned that there was a possibility of you not being able to complete the procedure to an reasonable standard, and had you warned them to this effect, they would never have agreed to allow you to carry out the procedure, and would have elected instead to have been referred to someone who was better able to undertake the procedure.

Is unconscious incompetence increasing?

Global mobility places dentists in environments which are dramatically different from those that they are used to – things that seemed well within their competence in one situation can suddenly become unexpectedly fraught with risks.

Young dentists leave dental school having much less experience of clinical dentistry under their belt, than was the case for previous generations of dentists. It is also well recognised that Generation Y characteristics include a desire for "convenience" and "immediacy" – mobile technology has led them to expect things to happen quickly and easily, when they want them to happen and with minimum effort needing to be invested. If there seems to be a quick and easy way to acquire a new competency, they may well find that preferable to a much slower and more complicated formal, structured training pathway. On the other hand, there is growing evidence that many young dentists are acutely aware of their clinical/technical limitations and indeed, are voicing apprehension that they are being thrown into an unforgiving 'real world' after Foundation Training, with insufficient practical hands-on experience.

But older dentists may be lulled by all their years of experience into a false sense of security, failing to approach new procedures with the same circumspection and caution that they might have adopted early in their career. Confidence (or over-confidence) is not the same as competence.

The GDC's imminent move to 'Enhanced CPD' places more responsibility on an individual registrant to identify how to choose and prioritise their CPD activity. It is human nature to gravitate towards courses that seem most relevant and interesting, so it is a familiar pattern that (apart from the recommended core CPD subjects that unfathomably have never included communication skills) dentists return again and again to lectures on similar or related topics. This makes more obvious sense for specialists, but even then it runs the risk that they will become progressively de-skilled on all aspects of dentistry beyond their narrow field of special interest and expertise. Time spent keeping your wider knowledge as broad and current as possible, is seldom wasted.

Using a De Bono analogy, it is the difference between digging the same hole even deeper, or digging a different hole somewhere else.

CHASING SUCCESS IN THE MODERN WORLD

Arianna Huffington is co-founder and editor-in-chief of *The Huffington Post*, and outwardly would be viewed as one of the world's most influential and successful women. In 2014 she wrote a candid and inspirational book *Thrive*[1] which quickly became an international bestseller, not least because it challenges each and every one of us to question what kind of success we are searching for. In the opening section of the book she shares with us a very personal moment of catharsis which could

have been disastrous in its consequences but was in fact a triumph of sorts. Initially in heavy disguise, perhaps, but a triumph nevertheless.

Her powerful opening chapter in this thought-provoking book stops us in our tracks:-

On the morning of 6 April, 2007, I was lying on the floor of my home office in a pool of blood. On my way down, my head had hit the corner of my desk, cutting my eye and breaking my cheekbone. I had collapsed from exhaustion and lack of sleep. In the wake of my collapse, I found myself going from doctor to doctor, from brain MRI to CAT scan to echocardiogram, to find out if there was any underlying medical problem beyond exhaustion. There wasn't, but doctors' waiting rooms, it turns out, were good places for me to ask myself a lot of questions about the kind of life I was living.

We founded The Huffington Post in 2005 and two years in we were growing at an incredible pace. I was on the cover of magazines and had been chosen by Time as one of the world's 100 Most Influential People. But after my fall, I had to ask myself, "Was this what success looked like?" "Was this the life I wanted?" I was working eighteen hours a day, seven days a week, trying to build a business, expand our coverage, and bring in investors. But my life, I realised, was out of control. In terms of the traditional measures of success, which focus on money and power, I was very successful. But I was not living a successful life by any sane definition of success. I knew something had to radically change. I could not go on that way.

This was a classic wake-up call. Looking back on my life, I had other times when I should have woken up but didn't.

"What is a good life?" has been a question asked by philosophers going back to the ancient Greeks. But somewhere along the line we abandoned the question and shifted our attention to how much money we can make, how big a house we can buy, and how high we can climb up the career ladder. These are legitimate questions, particularly at a time when women are still attempting to gain an equal seat at the table. But as I painfully discovered, they are far from the only questions that matter in creating a successful life.

Over time, our society's notion of success has been reduced to money and power. In fact, at this point, success, money, and power have practically become synonymous in the minds of many. This idea of success can work – or at least, appear to work – in the short term. But over the long term, money and power by themselves are like a two-legged stool – you can balance on them for a while, but eventually you're going to topple over. And more and more people – very successful people – are toppling over.

As my eyes opened, every conversation I had, seemed to eventually come around to the same dilemmas we are all facing – the stress of over-busyness, overworking, over-connecting on social media and under-connecting with ourselves and with one another. The space, the gaps, the pauses, the silence – those things that allow us to regenerate and recharge – had all but disappeared in my own life and in the lives of so many I knew.

Later in the book, the author offers us her thoughts on where all the "spaces" and "pauses" might have disappeared to. She describes our relentlessly progressive dependency upon electronic devices as "Over-connectivity: the snake in our digital Garden of Eden." She explains:

Unfortunately, the ever-increasing creep of technology – into our lives, our families, our bedrooms, our lives – makes it much harder to renew ourselves. The average smartphone user checks his or

her device every 6½ minutes. That works out at about 150 times a day. But the connection that comes from technology is often an unfulfilling, *ersatz* version of connection. Its siren call (or beep, or blinking light) can crowd out the time and energy we have for real human connection.

Our relationship with email has become increasingly one-sided. We try to empty our in-boxes, bailing like people in a leaky lifeboat, but more and more of it keeps pouring in. How we deal with our email has become a big part of our techno-stress. And it's not just the never-ending e-deluge of emails we never get to – the growing pile that just sits there, judging us all day – but even the ones we do get to, the replied-to emails that we think should be making us feel good. Linda Stone worked on emerging technologies at both Apple and Microsoft in the 1980s and 1990s. In 1997, she coined the term "**continuous partial attention**" to describe the state of always being partly tuned in to anything. Now it feels like a good three-word description of modern life.

Are we perhaps walking blindfolded into a future where an increasing proportion of the workforce – and of the healthcare professions – have become hard-wired into 'continuous partial attention'? How can they tune back into the 'here and now' instantly in order to give their undivided attention to a patient or a clinical procedure (or, in another context a family member). How can they possibly hope to achieve this re-tuning scores or hundreds of time a day, without no downside?

Perspective and Balance

A strong undercurrent that pervades the pages of *Thrive* is that success is not just about what you achieve, but how you achieve it. In terms of professional/technical (clinical) success it is worth pausing to remind ourselves that even the highest quality of clinical dentistry in a technical sense is diminished in its value if the treatment is not necessary in the first place, or if it doesn't serve the patient's needs or best interests.

Similarly, what is the real value of any apparent financial "success" that is based upon unethical or dishonest behaviour, and/or the provision of treatment that is inappropriate or of poor quality? Using Arianna Huffington's analogy of the two-legged stool, it may feel like success for a few fleeting seconds but sooner or later the painful reality will become apparent.

The book spends time discussing the issue of "work-life balance" – that elusive nirvana that so many of us were led to expect 20 or 30 years ago and the members of so-called Generation X are still looking for today. They were promised a short working life and a long leisure-rich retirement. Two recessions and a global financial crisis later, they face the prospect of an extended working life and a retirement that is more difficult than ever before to plan for and adequately resource. Whether or not it ends up being a shorter retirement may well depend on how many of the lessons of this book are taken on board.

Unsurprisingly - as a career woman herself and the mother of two daughters - the author tackles head-on the dilemma faced by all those women who are trying to combine career and family and achieve success in both. But she is quick to acknowledge that while mothers are biologically equipped to have a particular role in delivering and nurturing children, fathers are also touched by some elements of the same dilemma while children are growing up.

She recounts the memorable story told by Carl Honoré in his book *In Praise of Slowness*[2]. At a frantically busy time in his life, he was at an airport waiting for a flight home from Rome. Instead of relaxing and treasuring a short period of enforced "down time", he was filling his time making phone calls while simultaneously flicking through the pages of a newspaper or magazine.

His eye was drawn to a feature headed “The One Minute Bedtime Story” which explained that many of the classic children’s stories had been slimmed down so that they took just 60 seconds to read. His first reaction was to think what a great timesaver this could be, as he had a two-year-old son who was very fond of his bedtime stories. Instinctively making a mental note to order a copy of the book as soon as he got back home, he suddenly came to his senses, asking himself “Have I gone completely insane?”

It is a nice story and a thought-provoking one on many levels. Nobody tells us that every waking minute of every day needs to be packed full of “stuff”. That is a deluded conclusion that we come to when we are struggling to fit everything in – instead of pausing to ask ourselves whether we are fitting the right things in and prioritising them in a sensible and sustainable way.

Several times in her book Arianna Huffington challenges the reader to ask whether they are looking after themselves (in the holistic sense) or simply doing things that will please or impress others. This goes to the very heart of what success means, and to whom, and how much it matters. Her analogy of the pre-flight safety demonstration which exhorts parents to fit their own oxygen mask first, before attending to fitting the masks for their children, is a powerful one. In order to be truly successful, you have to invest time in yourself and be very clear about your priorities rather than picking up the crumbs after you have spent all your quality time chasing less meaningful trinkets of success. In healthcare, we cannot hope to care for others to the best of our abilities unless we ourselves are in a fit state to do so.

Thrive concludes with an uplifting Epilogue:

I wanted to share my own personal journey, how I learned the hard way to step back from being so caught up in my busy life that life’s mystery would pass me by. But it was also important for me to make it clear that this was not just one woman’s journey. There is a collective longing to stop living in the shallows, to stop hurting our health and our relationships by striving after success as the world defines it – and instead tap into the riches, joy and amazing possibilities that our lives embody.

It is up to each and every one of us to decide for ourselves what success should look and feel like for us personally. When surrounded on all sides by urban myths of what a successful dentist looks like, it is not always easy to pursue success on your own terms, and at your own pace, but ultimately it makes little sense to do otherwise.

A career in dentistry can certainly be all-consuming – whether you spend it in general practice, specialist practice, the hospital/public service, research or some other area of the profession. Working in any healthcare field brings challenges which are different but no less demanding than the commercial world of business, and we need to be mindful that there are times in everybody’s life when external pressures will conspire to drive us off course and it will be particularly difficult to square the circle.

Understanding and accepting that reality, whilst having a clear grasp of what is important to you and what you are trying to achieve, will help you to make right choices when important decisions need to be made.

[1] Thrive; Arianna Huffington. Published by W H Allen 2014. ISBN 978-0-75355-542-2

[2] In Praise of Slowness; Carl Honoré New York: Harper One, 2004. ISBN: 978-0-60750-510

DE-AGGREGATION

One of Edward de Bono's tools for lateral thinking is 'de-aggregation'. Success rates for various clinical procedures are a classic example of an output of vertical thinking. But once you de-aggregate the information, however, you can reveal a very different picture, with some instances of success and some instances of failure. This allows us to look more closely at the reasons for those failures, and by understanding them better, take steps to improve our success rates.

PARETO, ZIPF, KOCH, CARLSON Vilfredo Pareto was an Italian economist in the 19th century, George Zipf a professor of Philosophy at Harvard 50 years later and Josef Duran a Russian-born engineer who is widely credited for what is known as the quality revolution in the 1960s-1980s. From very different backgrounds they came to a similar conclusion which became known as the Pareto Principle or the 80/20 rule. Richard Koch has since popularised this and placed it in a modern context in his best-selling book **"The 80/20 Principle : Achieving more with less" ISBN: 9781857881684**

Applying it to dentistry, we might ask ourselves whether we agree in broad terms with any or all of the following statements :

- Not all patients are equally profitable
- Not all procedures are equally profitable
- A small amount of your time delivers disproportionate results
- A small number of tasks have a disproportionate impact, while a large number of tasks have minimal impact
- A small number of patients have critical significance for your practice
- Some moments in your ongoing relationship with your patients have much greater significance than others

Similarly (whether or not you agree with the actual 80/20 percentages)

- 80% of profits come from 20% of the patients
- 80% of broken appointments arise from 20% of the patients
- 20% of the procedures deliver 80% of the profits
- 20% of each procedure accounts for 80% of the total time taken
- 80% of the hassle and stress comes from 20% of the people
- 80% of the time, you are using only 20% of your equipment/instruments
- 80% of the time, you are using only 20% of the materials you stock
- 20% of your patients produce 80% of the late payments and bad debts
- 80% of complaints and claims come from 20% of the patients

- 20% of your patients create 80% of your new patient recommendations

ATTITUDES TO RISK

In his work "Risky Business", published by the Adam Smith Institute (1999, ISBN 1-902737-06-7), **Professor John Adams** suggests that one can predict risk behaviours by looking at an individual's attitude to risk. He describes the concept of "virtual risks", where in the absence of known, solid scientific evidence about given risks, individuals are at the mercy of their own judgments and attitudes, and their predispositions to view whatever evidence is available, in particular ways.

Adams puts forward what he describes as a "four-fold typology" of these predispositions :-

INDIVIDUALIST - a cheerful optimist who believes that if you can't prove it's dangerous you can assume that it's safe. He believes that science provides solutions.

EGALITARIAN - a worried pessimist who believes that unless you can prove that it's safe, then one must assume that it is dangerous. He also believes that science and technology creates new risks.

HIERARCHIST - believes that all risks can and should be quantified and managed. He doesn't like uncertainty, so he demands information, systems and processes and measurement.

FATALIST - feels powerless in the face of forces that he feels unable to control. Stuff Happens and What will be, will be and the best you can do is keep your eyes open and duck if you see something about to hit you.

Interestingly enough, the two groups to the right of the midline are essentially 'problem finders' while the two to the left are essentially 'problem solvers'. Both are important and bring something to the party.

Adams feels strongly that you should not ignore risk and simply hope for the best, but nor should you become excessively risk averse and negative. Instead he advocates an approach whereby you try to understand risks, effectively manage those that you are able to influence, and accept those that you cannot control. Your approach should be positive and pro-active, but you should not become so consumed by risk that you stop looking for solutions, because you are so busy looking for problems.

Within the world of dentistry we see individuals with all of the above characteristics. One dentist will think it sufficient to learn a new procedure at a half day course, and will book the first patient in for this procedure the following day. Another more cautious dentist will attend many courses, talk to colleagues, and plan to attend a few more courses before taking the plunge. Many of the dentists who experience multiple claims and complaints seem to have no 'risk radar' whatsoever, or perhaps suffer from an unshakeable overconfidence – or occasionally, arrogance. We can all have the occasional bad day at the office, but most of us will reflect on why it happened and take steps to prevent a recurrence. If you go through life shrugging your shoulders and adopting a "stuff happens" viewpoint you are unlikely to benefit from any reflective learning. You may even start from the premise that nothing is ever your fault.

Understanding our own 'default' predisposition to risk is an important part of developing a healthy, constructive approach to risk management.

STANDARDS

William Moyes, the current Chair of the GDC (in his now-infamous 2014 Pendlebury Lecture at the Faculty of General Dental Practice) has declared himself to be astonished by the level of complaints about UK dentistry and he drew the conclusion that there must be something seriously wrong with the quality of care and treatment provided by UK dentists. From the starting premise that no patient complaint can be wholly unjustified, he predicted that "*The exposure of failure will grow*".

In one section of his address this is what he said:-

"DEMAND FOR DENTISTRY IS GROWING…AND SO ARE COMPLAINTS

Public attitudes have also changed. The users of dental services are now much more consumerist in their attitude. Dentists and dental care professionals now have customers, not clients ……or, indeed, patients. Part of a consumerist attitude is an expectation that services will be organised around my needs and preferences, that quality will be good and the price fair. And if the service is poor or the quality unacceptable, consumers are willing to complain and to seek whatever form of redress seems appropriate to the circumstances of the case.

These consumer pressures are compounded by the increase in demand for dental treatment, and in the volume of complaints. 1.4 million more people have been seen by an NHS dentist since 2010. Not all of this is traditional oral healthcare work. Demand for cosmetic treatments continues to rise - there has been a 50% rise in cosmetic dentistry in the past 5 years

So, this increase in demand for services coupled with changing attitudes have together generated an unforeseen level of complaints. There has been a 110% increase in complaints to the GDC between 2010 and 2014. Well over half of our budget is spent on fitness to practise.

And it's not just the GDC that is getting more complaints about dentists and dental care professionals.

It is extremely difficult to get a completely accurate picture of dental complaints across the UK as it isn't centrally recorded. But in 2012-13:-

NHS England received 7637 complaints about primary and secondary dental care

The Dental Complaints Service dealt with 1876 cases

The CQC received 1043 complaints

The Ombudsman investigated 3770 NHS health complaints, some of which would have included dentistry (but there's no breakdown of the figure to help us)

Add to these figures the 2972 complaints made direct to the GDC.

In 2013 there were just over 38500 dentists and 62500 dental care professionals on the GDC's register. So very crudely – and I stress that caveat - these very rough figures could mean that 17 per cent of the profession were the subject of some form of complaint. Even allowing for some overlap between the referrals to different agencies, this is staggeringly high.

It also undermines somewhat the proposition that there is a high level of patient satisfaction with dentistry.

Bear in mind that the GDC doesn't aggressively market its disciplinary role……we don't behave like a claims management company! However, the Francis report said regulators should raise their profile with patients and engage in more pro-active regulation. The GDC can't ignore that."

This section of his address was also interesting for other reasons:-

- These words were being delivered around the same as the GDC was advertising in the national media, encouraging patients to complain to the Dental Complaints Service and the GDC (and failing to mention that they should first be raising their concerns informally using the dentist's in-house complaints procedures)
- The numbers of complaints quoted do not include complaints made informally and managed in-house, nor complaints made to organisations such as Denplan (so the actual total numbers are even higher than he quotes)
- The fact that no mention was made of in-house complaints procedures either in this address, or in the GDC's advertising campaign, was revealing in that it suggests that the GDC sees the public "exposure of failure" and third party investigation and sanction, as being more important and more valuable than resolving any concerns informally between dentist and patient – ie it is all about that "exposure" and "regulation" rather than patient satisfaction.
- *(note the underlined section towards the end)* The GDC starts from the premise that all the research suggesting that the majority of patients are happy with their dentist, has got it wrong. Ironically some of this research was commissioned by the GDC itself.

Expectations

Most complaints and litigation can be traced back to some kind of unmet expectation on the part of the patient. Sometimes it is simply an adverse clinical outcome – perhaps through no fault of the dentist – but sometimes we might allow patient expectations to become unrealistic and/or not do enough to stop this happening.

Third parties (like the NHS) don't always help when they promise or lead patients to expect more than dentists are likely to be able to deliver, all of the time. The **NHS Choices** description of what treatment is available under the NHS (and what patients therefore have a right to expect) is dangerously – and no doubt, deliberately – ambiguous (refer to **Appendix section below** for precise wording). It is setting dentists up for confrontation with patients, and complaints.

But after years of economic downturn and a desperately protracted recovery, dentists have often fallen into the trap of "overpromising and under-delivering". Some of the statements made and images used on practice websites and in marketing material is an accident waiting to happen and this provides rich pickings for the GDC and the "no win- no fee" law firms.

Standards

But right at the heart of the relentless increase in complaints, litigation and regulatory challenges by the GDC, is something that becomes blindingly obvious once we know where to look. It has been happening right under our noses, gradually and silently, and it is still happening even today. Dentists in the UK have for many years been judged against wholly inappropriate standards and facing criticism and challenge for providing care and treatment that in most other countries in the

world would be considered perfectly acceptable. This has been getting progressively worse, year after year, because each new set of guidelines and each new standards document seems to move the "bar" further and further away from the Bolam standard. Try to think of the last time a new set of guidelines moved the goalposts back in the other direction.

This realisation prompted a campaign to raise awareness of this incremental shifting of the "standards" goalposts in the UK, and while recognising the importance and value of many guidance documents, education or other interventions designed to improve or enhance the standard of care, it also called for a fairer and more appropriate review of what should represent a minimum, "reasonable" standard so that busy practitioners know where they stand.

The tsunami of complaints, litigation and regulatory (GDC) challenge faced by UK dentists in recent years is suggestive of misplaced and unrealistic expectations coupled with an unnecessarily hostile professional environment. Contrary to the views expressed in some quarters, it does not provide evidence of falling standards in UK dentistry.

Indeed, this relentless criticism of UK dentists and the ease with which they can find themselves challenged for the care and treatment they provide, even when it is of a perfectly reasonable quality, is unwarranted and demoralising. Furthermore it is ultimately counter-productive because it leads to a defensive, fearful climate in which the profession's focus is on avoiding criticism and deflecting blame, rather than genuinely seeking to improve standards and offer patients the widest possible range of dental care to meet their needs.

Lewis K. Professional Standards and their Escalating Impact upon the dental profession. BDJ April 2015

APPENDIX to this section

Clinical Negligence and The "Bolam" Standard

"Bolam" refers to the landmark case of **Bolam v Friern Hospital Management Committee (1957),** in which principles of clinical negligence were established in British law that would endure for over half a century and still apply today. Scotland, Ireland and many other jurisdictions around the world that are based on British law, have their own equivalent cases, but the time-honoured *Bolam* principle still applies in that a practitioner is not negligent if s/he has acted in a manner which is **considered to be appropriate by a responsible body of opinion amongst people working in the same field** and professing to have the same skills as the practitioner in question.

Furthermore, the *Bolam* judgment made it clear that a clinician's failure to follow a practice which one particular 'reasonable body of opinion' might consider appropriate, does not necessarily mean that the clinician has acted negligently. The practitioner's defence in law, in such a situation, is that s/he has followed an alternative body of 'responsible opinion' that happens to hold a contrary view.

The challenge, of course, is to persuade a Court of Law that the body of opinion that you are following is not only responsible, but also respectable, reasonable, logical and (when the context demands) seeks an appropriate balance between potential risks and benefits. This facet of the

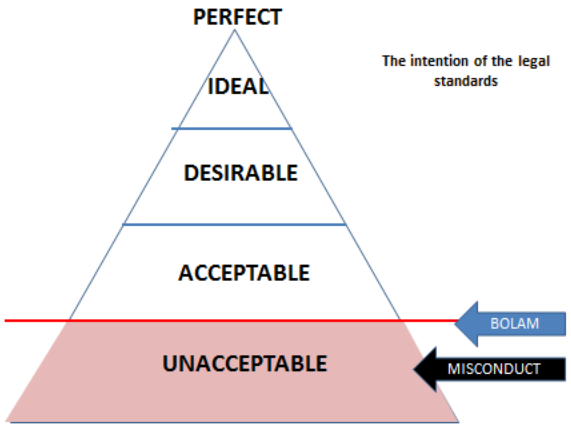
professional opinion that the clinician has chosen to follow, was described in the later case of ***Maynard v West Midlands Regional Health Authority (1984),*** (finally determined on appeal in the House of Lords) and subsequently confirmed in several other cases.

In the arena of clinical negligence in the UK indemnity organisations like Dental Protection currently face many challenges. Not least amongst them is that of ensuring that our members are genuinely being measured against a reasonable peer group, rather than against the standard of a specialist carrying out the same procedure(s). Our own choice of expert is crucial, and we do take great care to use credible "GDP experts" where a claim involves a general dental practitioner and similarly, a specialist in the relevant field of expertise where that is felt to be appropriate.

The GDC

For many years the threshold standard for fitness to practise cases coming before the GDC was that of "serious professional misconduct", flowing from the case of Doughty (determined on Appeal)
Doughty v GDC [1988] AC 164 PC

Expressed simply, this meant that the GDC must have made one or more findings of fact, which individually or collectively must not only have shown the registrant to have fallen short of an acceptable professional standard (this amounting to a peer standard of reasonableness not unlike that expressed in Bolam), but such 'falling short' must have been to a serious degree. In summary, simply falling short of a reasonable professional standard was not sufficient to justify a finding of serious professional misconduct (SPM). Simply falling short of what a single body of professional opinion might consider to be reasonable, was even further from satisfying the test of SPM.



Since 2005 a number of things have happened to change the fitness to practise landscape.

- The concept of "SPM" has been overtaken by a two-stage test.
    - Misconduct
    - Impairment of the registrant's fitness to practise

  (A further important practical effect of this separation of these two issues will be discussed below)

- The evidential burden has been reduced by the move from the previous 'criminal standard' of proof (the requirement to find the facts proved "beyond reasonable doubt") to the much lower civil standard of proof (the "balance of probability").
- The removal of the requirement for a statutory declaration (sworn and witnessed affidavit) when reporting information to the GDC for consideration. Such information and notifications can now be made anonymously.
- Erasures are now for a minimum of five years (previously 10 months)

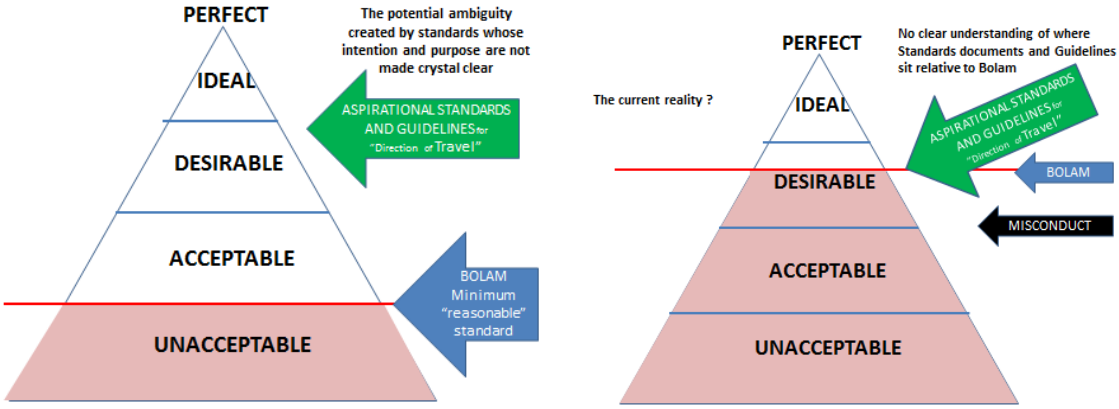
The term **"Misconduct"** appears at first sight to suggest a standard that is different (and perhaps better) than "serious professional misconduct" but this point has since been clarified by a Judicial Review of a GMC decision, which ruled that "misconduct" must mean a standard no less deficient than the previous "SPM". As depicted in the diagram above, it is a standard that is a serious departure from the "Bolam" standard.

Once a finding of "misconduct" has been made, using this test, the Professional Conduct Committee (PCC) must move to the final stage of its determination, which is to decide whether or not the registrant's fitness to practise is impaired on the day that it considers this question (as opposed to whether or not this was the case at the time when the misconduct occurred). No case should be referred to the PCC unless there is a realistic prospect that a finding of misconduct and current impairment could properly be made.

Guidelines

The majority of Standards and Guideline documents produced in the UK – of which there are many - fail to make it sufficiently clear whether the standard(s) described purport to represent the minimum acceptable (Bolam) standard, or something much more aspirational than this. As a result, experts of all kinds in many different kinds of forum, are quoting standards and guidelines and assessing treatment with reference to them, without ever questioning the provenance or intention of the guidelines they are quoting.

The consequence of this is that, by default, these asprational standards are confused with and interpreted as being the Bolam standard. The knock on effect is that findings of misconduct can be made at the GDC in situations where most dentists would consider the quality of care to be well above an acceptable standard, or perhaps view it even more favourably than that.



Infact matters can be made worse by bodies such as the NHS which use descriptions such as “high standards” and “the highest standards” etc when descibing what patients can expect from the NHS – when the law itself does not expect anything more than the Bolam standard. By way of illustrating this point, dramatic reductions in the level of funding available to provide that care, as has occurred in England and Wales since the introduction of the UDA system (especially in Band Two) creates a mismatch between what the State expects – and leads patients to expect - in quality terms, and what it is prepared to pay for. For example,

NHS England publishes information on the NHS Choices website (and elsewhere), couched in the following terms :-

If your dentist says you need a particular type of treatment, you should not be asked to pay for it privately. Your dentist **is not allowed** to refuse you any treatment available on the NHS but then offer the same treatment privately. Also, any treatment provided on the NHS has to be of the same high quality as treatments provided privately.

Note the reference here to “high quality”, as opposed to “reasonable quality” or even “satisfactory quality”.

NHS Scotland goes even further than this. referring not only to “high quality services” but also - within the same paragraph - the “highest standards” of care :-

Setting Standards - Quality Monitoring and Quality Assurance

Patients have the right to expect high quality services delivered by a range of well-trained health professionals in premises suitable for the delivery of that care. We will support professionals in delivering the highest standards of oral health care, based on the primary care dental standards developed jointly by NHS Quality Improvement Scotland and the National Care Standards Committee.

How practitioners (or patients) are expected to make sense of this is something of a mystery.

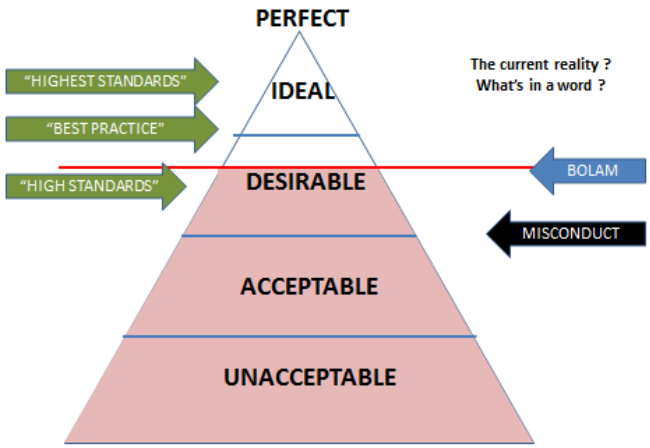
The private capitation scheme **Denplan** includes the following statement in the Rules of Dental Care :-

9. Quality Assurance

Members shall participate in the Denplan Quality Programme and other programmes with the objective of promoting the provision of preventive dental care and dental treatment of the highest standard.

This is at least private dental care, and a private contractual arrangement between dentist and patient, so it is up to the parties what terms and requirements they choose to agree. Yet that same desciption “highest standard” does sit at odds with the intentions and expectations of Bolam. It would be perverse indeed if a respected private capitation scheme such as Denplan had lower expectations of Denplan member dentists than NHS Choices was effectively promising patients for NHS treatment.

Finally, several sets of guidelines from specialist societies make reference to “best practice” which again is different from the “reasonable” standard inherent in Bolam.



A reason to be cheerful

At the heart of recent problems for UK dentists had been the baseline standards against which the registrants are being measured, because it is easier to fall seriously short of a standard, if that standard is being placed at an unreasonably high level in the first place.

Much to its credit, the FGDP recognised the arguments set out in the above BDJ article and joined the campaign to re-set the bar in terms of the standards against which UK practitioners have latterly been measured. In May 2016 they launched an updated version of their standards guidance

on Clinical Examination and Record Keeping, in which they clearly identified whether each cited standard was intended to represent the basic expected standard (B), or something more aspirational than that (A). They also identified standards (C) which may not apply in every clinical situation. When introducing these standards they explained :-

"In recent years the Faculty has heard complaints from practitioners that our previous editions of these guidelines have been misinterpreted."

"No practitioner should be censured for failing to meet A grade recommendations. Nor does a failure to meet B or C grade recommendations necessarily imply negligence on the part of the clinician. A clinician must assess each patient on their merits, in the circumstances in which they find themselves, and with the evidence available to them they must use their clinical judgement."

This clear and admirable leadership from FGDP was underpinned by its decision to make all its standards documents and guidelines 'open access', ie available at no cost to allcomers in both the UK and internationally. It is no longer possible for those giving expert evidence to claim that they were unaware how FGDP standards were intended to be interpreted.

EVIDENCE BASED DENTISTRY – a note of caution

One of the most valuable tools in the clinician's armamentarium is the existence of a meaningful evidence base and its ease of access. In theory this should make life and treatment outcomes more predictable, unwelcome surprises less frequent and our ability to share meaningful information with patients as part of the consent process, much easier.

Some would even argue that patients must be provided with every last detail of the evidence base, in order to enable them to assess the information objectively and to compare alternative treatment options. Not only is this another onerous prospect for the clinician, it also fails to recognise two important aspects of the consent process.

Firstly, it is not sufficient for the clinician to present the patient with information in terms that would be meaningful to another clinician. The evidence base is invaluable for the purpose of informing a clinician, but this is usually very different from what an individual patient needs to know, and how this information needs to be presented to each specific patient in the context of their personal situation.

Secondly, while the evidence base provides information regarding what treatment is most likely to succeed, or fail, it takes no account of the particular situation and circumstances of an individual patient. Take, for example, a clinician who gives a standard explanation to every patient who is considering the provision of dental implants that (for example) the "success rate" of implants is known to be x%.

Patient (A) is a young, healthy patient with no relevant risk factors, considering the provision of a single implant-supported crown placed in the lower molar region. Patient (B), on the other hand, is an elderly patient with a long history of periodontal disease, having an eight-unit implant-supported fixed bridge placed in the anterior maxilla. The patient is a heavy smoker, an alcoholic with patchily controlled diabetes, extensive loss of alveolar bone in the area in question, and a high lip line. The clinician's standard

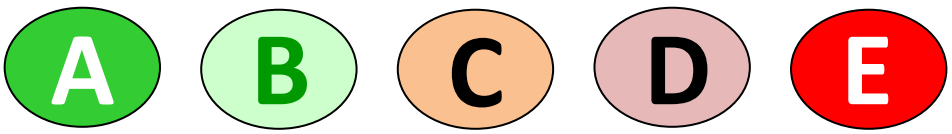
commentary on the “success rate” of implants is clearly irrelevant and inappropriate to both of these patients.

This illustrates the danger of giving the same information in the same way to every patient, and the importance of personalising any information provided, for each individual patient. One patient could be extremely risk averse and another patient much more willing to take risks if they see a perceived benefit as being sufficiently attractive. All of this has of course been enshrined in the legal precedent created by the 2015 Supreme Court decision in the case of Montgomery-v- Lanarkshire Health Board.

Similarly one might be describing the risk of temporary or permanent lingual nerve injury resulting from the surgical removal of a lower molar. Quoting the risk in generic percentage terms is meaningless without also helping the patient to understand what the practical consequences might be for them personally – this might depend upon their occupation. Quoting the risk of an adverse outcome in terms of a generic percentage of likelihood across all cases, is not even meeting the “reasonable patient” level. Patients aren’t interested in what might happen to other patients, but what is likely to happen to them personally, in the circumstances of their own individual case. Satisfying the “specific patient” requirement where material risks are concerned, is not likely to be achieved using generic success rates routinely quoted to every patient, or printed on the consent form for every patient.

Another way of looking at this issue is to consider, for example, five possible ways to deal with a given clinical situation. Option A is the one most strongly supported by the evidence base but B is also supported by a reasonably good base of evidence. At the other extreme, option E has no evidence to support it at all. In between, options C and D are possible but less likely to be successful than A or B.

A specialist (or anyone else) who is very familiar with the evidence base, may well feel that they would only be prepared to offer A and B (or even A alone) for the patient’s consideration. This is a perfectly reasonable position to adopt, but should not be confused with a situation where the patient is never given the other options. Patients have a right to make irrational decisions or to proceed in ways that are contrary to their best interests and therefore to choose even E if that is their choice.



The clinician has every right to decline the provision of E, giving their reasons, but somewhere between B and E a line is crossed which is different for each clinician. No clinician should be persuaded to carry out treatment which is likely to leave the patient worse off, but patients to have a right to choose C or D because that is a cheaper, quicker, simpler or more attractive alternative to A or B in some respect or another that matters to them. The patient has a right to know that these options may be available elsewhere as well as the fact that the clinician considers them less likely to succeed (or more likely to fail or cause other problems) and is therefore not prepared to provide them.

In short, the clinicians who are most familiar with the evidence base tend to be vulnerable to claims which allege that they denied the patient the option of considering C, D or E, particularly if they chose not to mention them at all. On the other hand clinicians who are less experienced or less

familiar with the evidence base may not themselves provide options A and B and consequently might advocate C,D or E in ways which fail to present the risks and limitations in a balanced way (or at all). If the treatment then fails or complications arise, the allegation that they expose themselves to is that they could and should have acted in the patient's best interests by offering the patient a second opinion or perhaps a referral to a colleague who could provide A or B.

Clinical Pathways are a natural extension of the evidence base and have the potential to compound the above problem if (for example) the NHS will only fund treatment provided in line with prescribed/recommended pathways. This does not relieve a clinician of the responsibility to take into account the patient's own value systems and preferences – they have a right to at least know about, and the option to choose, a treatment approach which may differ from a clinical pathway. The clinician has no obligation to provide treatment which they are not comfortable to provide and/or which they do not believe to be in the best interests of the patient: but this does not give the clinician a right to run roughshod over the patient's autonomy. Especially not in the new world of consent that has existed since the Montgomery decision.

PRICE, COSTS, VALUE and PROFITABILITY - exploding the myths

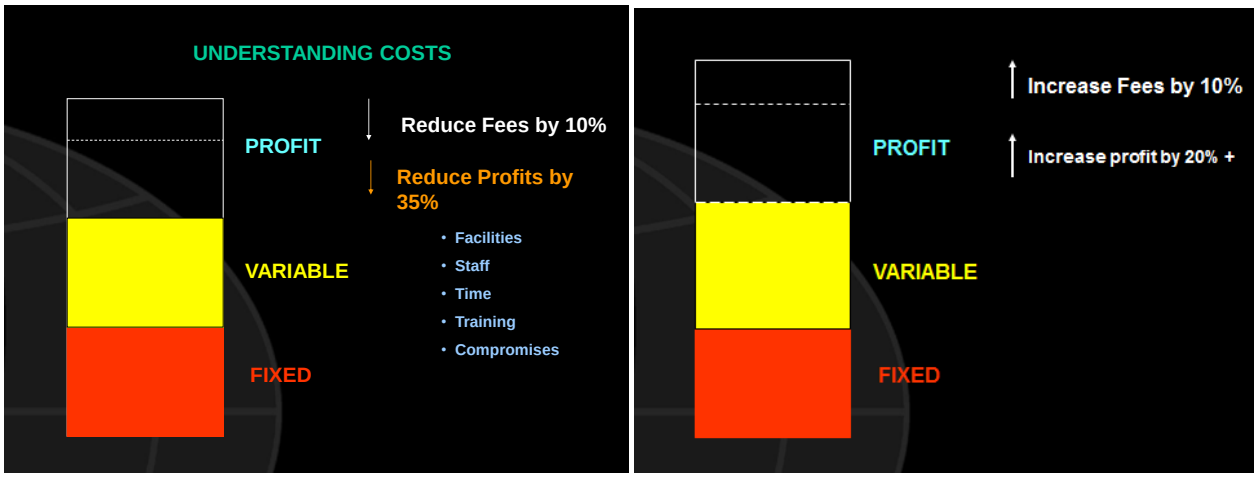
KODAK The Kodak Study in the late 1970s and early 1980s asked groups of eminent business people what they thought were the key drivers of profitability. Was it (for example) any of those listed below ?

- Throughput (numbers of customers) ?
- Success in attracting new customers ?
- Customer loyalty (% of repeat business) ?
- GrossTurnover ?
- Return on invested capital ?
- Price at which you sold your goods or services ?
- Expenditure levels (ie your direct and indirect costs) ?
- Level of fixed costs ?
- Staff costs ?
- Cost ratios ?
- Utilisation of plant / assets ?

Each of the above might seem the most important either at a particular moment in a business's life, or to businesses of a certain kind. But the conclusion the Kodak Study came to was that nothing matters as much as the price you charge. This could be the UDA value that you negotiate and accept. It could be your private hourly rate or fee per item level, or the structure and levels of any private capitation arrangement that you enter into. But it adds up to the price at which you sell your services.

Many businesses discount their price, sometimes to stimulate extra demand and/or cashflow. But if the selling price is the only thing that changes (ie the fixed and variable costs are unaffected), then every cent

you take off the price has to come out of your profit margin. It may only be 10% off the total price but it could amount to 30-35% off the profit and this enforces compromises on your investment in facilities and infrastructure, staff wages, training, etc. The same applies in reverse if you are able to increase your price without impacting upon your fixed or variable costs – a 10% increase in price adds 25-35% to your profit. The diagram below is drawn to scale, using an approximation of the level of fixed and variable costs for an average dental practice.



UDAs –exploding the myths

The three-band UDA system in operation in England and Wales for the past decade appears deceptively simple but from a business perspective it is widely misunderstood and its dangers in a business sense under-appreciated.

In theory all of your time is contributing to courses of treatment which achieve 1, 3 or 12 UDAs. In reality,

- Not all the hours you spend in delivering those courses of treatment are productive
- Not all the hours are equally productive
- A lot of the time you are very busy - but not productive.
- You can be not busy enough to generate enough UDAs
- You can even be too busy to generate UDAs – because you are spending far too much time generating no UDAs.

There are numerous ways to achieve zero UDAs from the clinical/surgery time you are investing

- Carrying out multiple procedures within the same Band. Dentists who take on a lot of new patients in areas of high dental need, will spend a disproportionate amount of their working day in Band two, achieving zero additional UDAs.
- Time bars, restrictions and exclusions
- Short notice cancellations

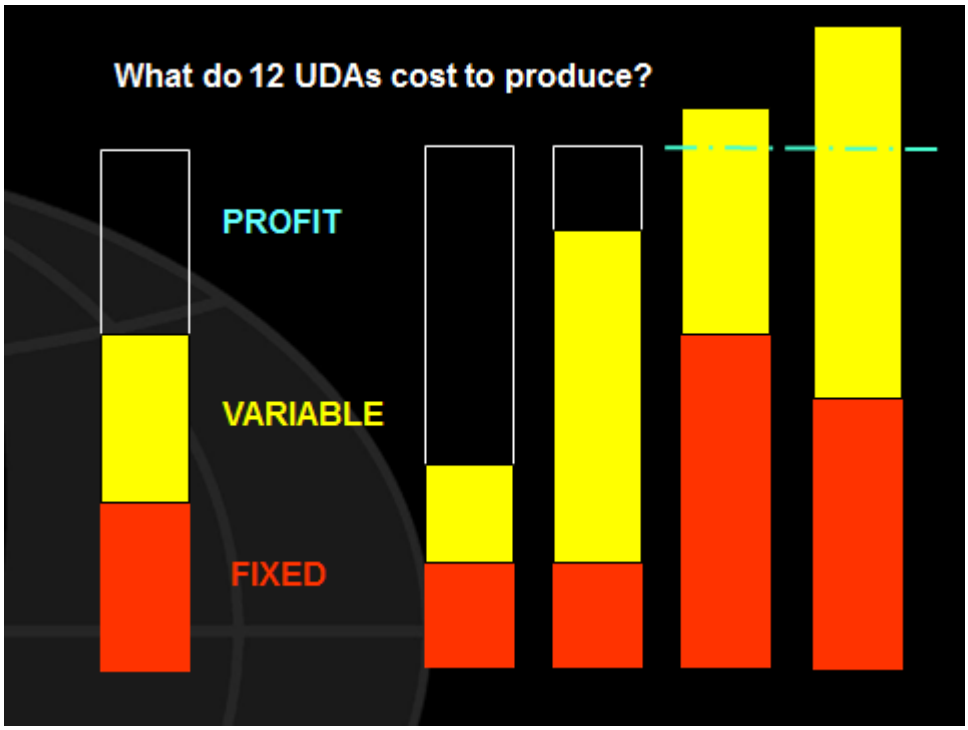
- FTAs
- Treating patients when you have already completed all of your contracted UDAs for the year

But every minute or hour that you spend achieving zero UDAs still has an unseen burden of fixed costs that need to be covered. So that fixed cost element cannot simply 'disappear' or be ignored – it needs to be covered elsewhere and this effectively means that any profit you make on your next productive hour, may well be reduced or subsumed by the additional fixed costs that were deflected from that unproductive time. This happens far more often than most practitioners realise.

UDAs are not a unitary currency either, because achieving the same number of UDAs may incur very different levels of overhead, depending on the procedure(s).

- The more surgery time it takes, the greater the burden of fixed costs that must be covered out of the same number of UDAs and hence, UDA revenue depending upon your UDA value.
- Variable (direct) costs are highest for procedures incurring laboratory items, high for some procedures like endo, and lowest for non-interventive work.

In the diagram below, the column on the left represents the "average" costs and profit from achieving 12 UDAs. But this is very misleading because if we de-aggregate the component parts of that average, as shown in the columns to the right, we discover that some activities with low overheads (many Band 1 courses of treatment and some simpler Band 2 courses) are very profitable and others relatively profitable. But extensive multi-visit courses of treatment in Bands 2 and 3 are loss making (and some of them heavily loss-making) either because of the surgery time they consume or because of the direct costs they incur (eg lab, endo consumables etc) or a combination of both.



So when you are nearing the end of a contract year, and are concerned about looming clawbacks, it may make more sense to forego some of the UDAs and accept the clawback, than to go searching for additional UDAs that may preserve your income and cashflow but which will actually incur a financial loss and reduce your profitability. On the other hand, it is possible to identify an realistic and workable strategy to achieve some of the missing UDAs, from courses of treatment that are also likely to be more profitable.

It's not rocket science – it is just some of the elementary essentials of any business. Unfortunately, they are essentials that (even after 10 years of using the system) are still a mystery to many practitioners.

SETH GODIN Another best-selling author, Godin is widely regarded as amongst the best and most innovative of modern business writers. His book "**The Dip**" talks about the cycles of success and challenge/failure experienced by many businesses. He explains the importance of knowing when to stick with your convictions, and when to change course or "quit". His book may have been written before the global financial crisis, but it is hugely relevant in the context of an economic slow-down or downturn. Moments when everyone else is feeling the strain and taking a breather are a fantastic opportunity for those who are willing to make the extra effort, to pull away from the pack. See also another of his books (below), "Purple Cow".

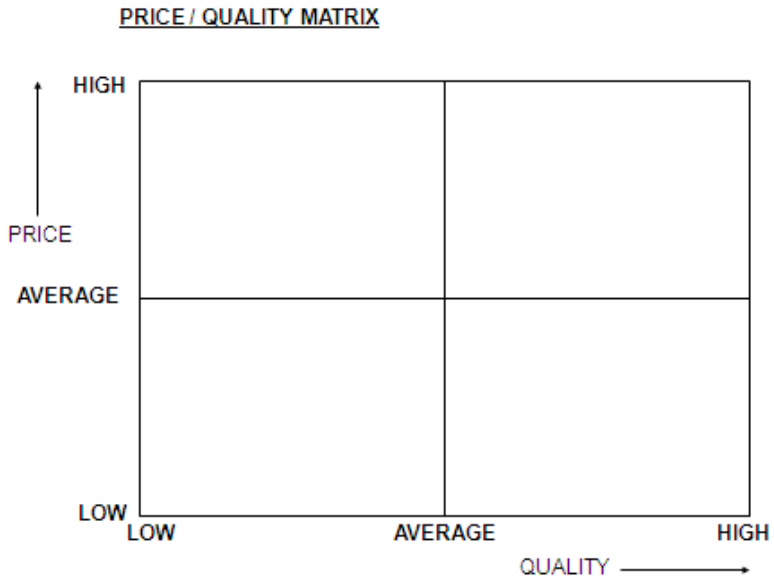
LEVITT Theodore ("Ted") Levitt was one of the architects and godfathers of marketing as it is understood and practised today. He argued that many businesses fail to see their product through the eyes of the customer because they are too internally focused. The more specialised and technical the business, the greater the danger that this will be so, and he advocated understanding the business that you are (really) in rather than the one you think you are in. He famously observed, at the time when the US railroad giants were forced to give way to the airlines – not just in terms of passenger traffic but freight traffic also - that

"The railroads collapsed because they thought they were in the railroad business, when infact they were in the transportation business."

There is a massive lesson for dentists in this statement. Many dentists and dental practices seem to believe that they are in the dentistry business, or the tooth business, or the implant or veneer business. Infact they are in the people business, and people buy people, long before they buy veneers from them. The most successful dentists treat people, not teeth.

Use the grid below to position your practice in terms of the price you charge relative to your competitors and the overall quality of the dental care and treatment you provide (horizontal axis). Place an 'x' on the grid where you think you are at the present time.

For a moment, you can define "quality" in any way you want, but we will be returning to consider this again shortly.



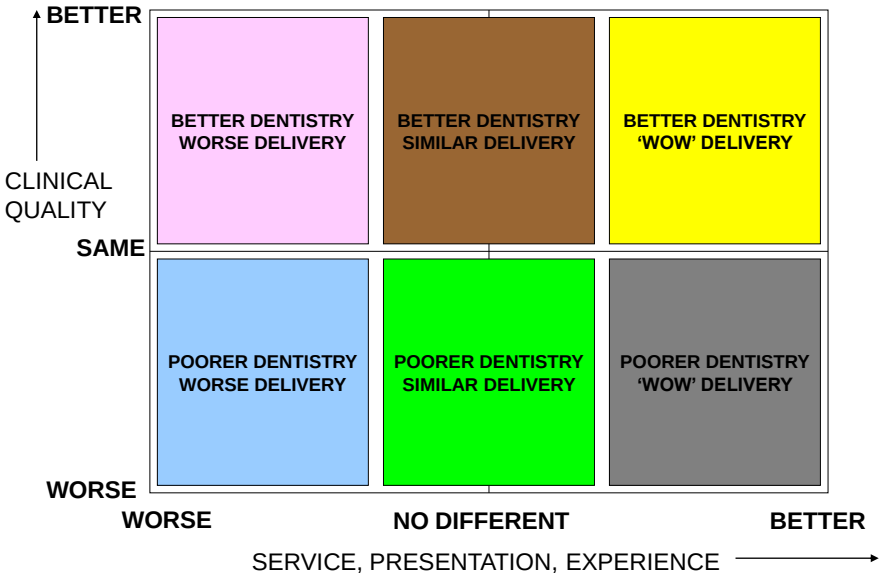
It is often revealing to ask every member of your team to carry out this exercise independently, firstly in respect of your own practice and then in respect of any local competitors. In an ideal situation, there would be a broad level of agreement within the same team about where the practice is positioned, and where other practices sit in relation to that. If there is no such agreement it is worth discussing these perceptions in order to understand the basis for them.

The subject of "Quality" is both interesting and complex. **PHILIP CROSBY** was an internationally respected authority in this field, and his message echoes that of Ted Levitt in that he believed that quality is determined not by the person providing the product, but by the end customer. Too many businesses, he argued, have a self-indulgent, inward-facing perception of quality in a technical sense, and too few measure quality in terms of how well the product or service meets the needs, expectations and demands of the customer. They are preoccupied with their own parameters of quality and they will place the highest value on whatever they think they are best at. This has a strong resonance for dentistry and most other scientific fields – in our case, the profession seems to believe that quality is something that only the profession (and the evidence base) can determine. But do we seriously believe that the quality of an endodontic outcome can be assessed from an xray alone?

In dentistry, the end-customer (patient) often has a limited ability to measure the technical / clinical excellence of the dentistry itself, so they use other things that they can measure as a "proxy" for quality – things like the service they receive, the customer care and human interaction, the way the treatment is delivered, how efficiently the administrative aspects are handled and how their overall experience stacks up against their expectations at the outset.

We could bundle all these attributes together under the heading "delivery" and ask ourselves whether it is the clinical dentistry itself, or its "delivery" that has the greater impact upon the overall levels of patient satisfaction, and the ultimate success of the practice. Where on the grid below would you position your practice ?

COMPETITIVE ADVANTAGE



It would be difficult for anyone not to have noticed the growing emphasis on customer "loyalty" in every corner of our lives. In dentistry, the general practitioner has a huge advantage over the specialist because it is possible in many cases to build up strong relationships over time with patients and families. Specialists may be more likely to treat a patient for a brief episode of treatment, perhaps on referral from another dentist.

Some businesses rely on single–sale transactions with customers that they may only ever come into contact with on that one occasion. Healthcare in general (and general dental practice in particular) is not like that. **Relationship marketing** is such an important concept for the general dental practitioner and his/her staff to understand, and yet most dental practices fall into the trap of carrying out their advertising and practice promotion as if they were looking for single-sale business. They are treating teeth, not people.

Most successful businesses will have much of their promotion done for them, at no cost, by existing, satisfied customers instead of relying upon costly external advertising to total strangers (although in the case of a new practice this may be both necessary and desirable). **VICTOR KIAM** spoke of businesses needing a "Unique Selling Proposition" (USP) – something that leads the customer to buy your product, from you, rather than buying something else from someone else. In dentistry you are the USP (at least, you should be). If you sell dentistry and dental procedures like a commodity, as many practices are short sighted enough to do, you are inviting patients to shop around for the cheapest price.

If instead you make yourself, your skill and the quality of your engagement with the patient the product, there is nowhere else for them to go because they can't buy you anywhere else.

Do this outstandingly well, consistently, patient after patient, visit after visit and you have no need to fear competitors because your patients won't be looking for other options.

SETH GODIN in his stimulating short book "**Purple Cow**" (which condemns mediocrity and exhorts us to make our businesses 'remarkable'), and **EMANUEL ("Manny") ROSEN** in his book "**The Anatomy of Buzz**" (explaining word-of-mouth marketing) have a lot to teach us in these areas. Rosen wrote his original book

before social media arrived on the scene so it is apposite that he has recently published an updated reflection on that, "**The Anatomy of Buzz revisited**" which is every bit as good as the original and brings the principles into the 21st century.

LEONARD BERRY coined the term "relationship marketing" in the 1980s, as a means of differentiating it from "transactional" marketing.

THE CHANGING FOCUS OF MARKETING

TRANSACTION		RELATIONSHIP
Single Sale	FOCUS	Customer retention
Feature-centred	ORIENTATION	Benefit – centred
Short	TIMESCALE	Long
Low	EMPHASIS ON CUSTOMER CARE	High
Low	CUSTOMER COMMITMENT	High
Moderate	CUSTOMER CONTACT	High
Low	EMPHASIS ON ETHICS	High

THE TWO GORDONS – HARRY GORDON SELFRIDGE, GORDON BETHUNE

It was **H.G. Selfridge**, the creator of the famous store in London's West End that bears his name, who coined the phrase "The customer is always right", implying that it is the saleperson's role to serve and sell, not to question and judge.

Gordon Bethune, who for many years headed up Continental Airlines, and is credited for an astonishing upward reversal in its fortunes, takes an opposing view. "The customer is always right", he says, "is wrong." He advocates a zero-tolerance approach to rude, unreasonable and abusive customers and says that he is not prepared to force his employees to indulge them. He rejects Selfridge's concept on the grounds that

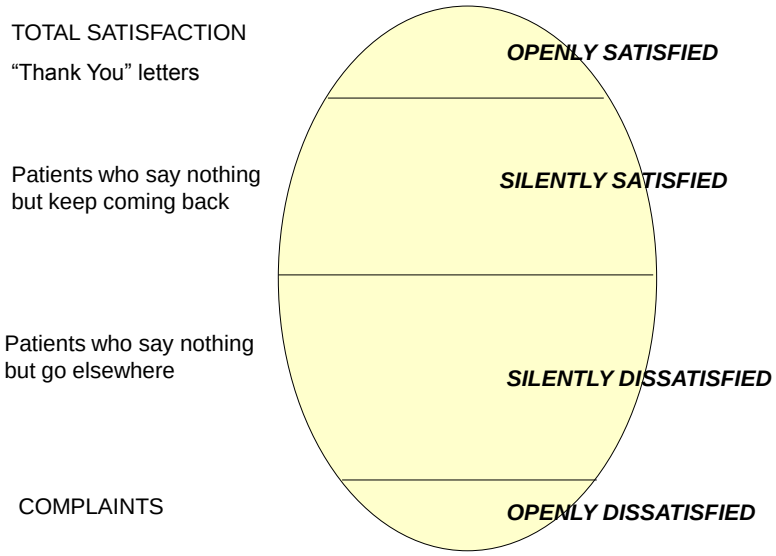
- It makes employees unhappy
- It empowers rude and unreasonable customers
- Some customers are bad for business
- It results in worse customer service
- Some customers are just plain wrong
- Some customers want us to do things or sell them things that are not in their best interests and in many cases might actually be harmful to them

Do you really want to leave patients worse off than when they came to see you, just because they are willing to pay you for it? Do you really want every patient? Even those who are rude to your staff, wholly unreasonable in their expectations, insufferably demanding, unwilling to follow your advice, reluctant to pay your fees, disrespectful of your time ? If you encourage and reward bad attitudes and bad behaviour on the part of your patients, will you get less (or more) of it ?

Bethune's sometimes controversial but always though-provoking story is chronicled in the book "From Worst to First" – see reading list.

CUSTOMER CARE and dealing with feedback and complaints

There is a spectrum of dissatisfaction between patients who are satisfied enough to tell you (eg a "thank you" letter or gift), and those who are dissatisfied enough to complain or sue you. In practice, there are usually not many of either, and at least because they tell us, we know who they are and what we have done well or not so well. A much larger number of people (see diagram below) are either silently satisfied, or silently dissatisfied, and the problem with both is that we don't know what we are doing well (or badly) – a patient that simply decides to go elsewhere has left us none the wiser as to why they took the decision, and we have lost the opportunity to put something right before other patients leave us for the same reason. This is the huge unseen opportunity of complaints, and the reason why they should not always be viewed as the unwelcome threat and insult that we often see them as.



Complaints used to arrive by letter or phone, or arrive out of the blue at the front desk. Practice owners now need to understand the central role that search engines now occupy in the business and personal lives of the majority of the UK population. They can bring huge benefits or massive risks in equal measure but like it or not, we are in the age of the empowered consumer. The internet and your practice's website has replaced the brass plate as the signpost to your practice.

Patients can and do post feedback and other comments about their dentist and their experiences of a particular dental practice on a range of readily accessible websites. The Care Quality Commission invites and encourages patients to post their comments and they remain there for all the world to see, long after your occasional CQC inspection is over. Your inspection results are there for all to see anyway.

These days, of course, online channels and social media are increasingly being used by patients who want to have their say. Conversations are taking place that you may not know about, and information, views and opinions about you are being shared more widely than you would ever imagine – but are you listening?

Why some people complain, when others don't

Many different factors will influence whether or not an individual patient will move from being 'silently dissatisfied' to voicing a complaint in one way or another.

- Their personality and assertiveness
- It takes time and effort and this might deter them if they are busy
- Is it made easy for them to complain, or are obstacles placed in their way ?
- They may be resigned to the view that *"It won't make any difference"*
- Some desired outcomes just can't happen unless they raise their concerns
- It's easier just to vote with your feet and tell everyone you know
- It also depends on what went wrong and what kind of factors are at work

Although it seems counter-intuitive, we should invite, actively seek out and welcome feedback in all its forms, including complaints. Good communication right across the dental team, then, makes a major contribution to patient satisfaction. Happy, satisfied and appreciative patients:

- Are less likely to complain.
- Are less likely to sue the dentist – even when mistakes occur
- Are more likely to be loyal, regularly attending patients
- Are more likely to recommend others to use your services
- May well rush to your defence if anyone is criticising you on social media

Consider for a moment what the GDC has to say on this subject in ***Shifting the Balance*** (see reading list)

First tier complaints resolution

We want to work with the profession to ensure that resolution is sought and found in the most appropriate place. This involves ensuring patients know how, and feel confident, to raise their concerns by the most appropriate route. It also means working to maintain high standards in complaint handling across the profession.

One of the challenges in resolving complaints in the practice is influencing patient behaviour, encouraging them to seek resolution of problems at an early stage with the professional from whom they have received care. Patients therefore need to feel able to approach the practice or treatment provider with feedback.

Expanding complaints handling expertise and access to independent complaint resolution

There are clear benefits for patients and professionals in a system which enables early, quick and low-cost resolution of complaints and disputes. This is particularly true in an environment where patient expectations are increasing, and professionals find themselves navigating unfamiliar territory when faced with complaints, sometimes feeling unable to seek the support of their colleagues or peers.

We would encourage professionals, as part of a joint effort to improve outcomes for patients, to actively seek feedback from patients and use it to improve performance and identify where changes within the service are required.

Encouraging and acting upon feedback

Acting on feedback reassures patients that they are being listened to and can prevent future complaints.

Encouraging and using patient feedback to improve services is likely to be practice led – with practice management and administration taking a lead role. As such, this is something that will be considered as we revise our guidance for employers.

REQUIRED GDC ACTION: Work with the profession and partners to promote, embed and encourage customer service and complaints handling in all stages of education, training and CPD, and to encourage dental professionals to seek help and advice when appropriate.

If you approach a marketing consultant with a view to maximising your practice promotion and flow of new patients, they will almost certainly emphasise the importance of digital media in your marketing "mix". Before rushing headlong to accept all their recommendations, remember that they may not be aware of the special constraints imposed by having a professional regulator. Make sure they have read and understood Standards for the Dental Team and any other relevant guidance published by the GDC.

Once the digital marketing and social media genie is uncorked it is very difficult to get it back in the bottle. Testimonials can only be placed on a dental practice website with the patient's knowledge and prior consent in writing.

If artificial positive postings are made on a practice website or on other sites either by a practitioner or on behalf of and with the knowledge of the practitioner they would be viewed very seriously by the GDC as an act of deception and dishonesty – even though many marketing companies actively recommend this as a method for boosting your online profile.

What are people looking for when they complain?

Instead of rushing to 'defend' ourselves against complaints and allegations made about us, and assuming perhaps that all the patient wants is money, a more constructive strategy is to find out what we need to do in order to resolve the complaint, which may be a combination of the outcomes listed below.

- **OUTLET** (letting off steam), being taken seriously and listened to
- **APOLOGY** doesn't always need to be an admission of fault
- **EXPLANATION** but only if that is what the patient wants
- **REMEDY** only the patient knows what will put things right in their eyes
- **REDRESS** compensation does not always need to be monetary
- **RETRIBUTION** settling the scores – often a vexatious motive

What is your best protection against complaints and litigation?

Many UK dentists – and especially young dentists – are fearful that they are powerless to protect themselves against the depressing facts that

- UK dentists (outside Scotland) are sued more often than UK medical GPs , and more than dentists anywhere else in the world
- They are more likely to face regulatory challenge than UK medical GPs and more than dentists in any other part of the world
- UK dentists have more complaints than other health professionals

Infact, on closer inspection, the Pareto Principle (80:20) is as true of this as it is of many other things in life. Some people go through their entire careers, without ever being sued or facing any serious complaint or GDC challenge – even clinicians who work in higher risk specialties and who regularly carry out high risk procedures on high risk patients. In contrast, a small number of people are regularly at the wrong end of complaints and claims. Which of these groups we end up in is much more in our own control than we might imagine :-

- Know your limitations and work within the limits of your competence.
- Work hard at developing rapport with each of your patients – especially those who you feel less comfortable with.
- Treat people, not teeth.
- Be mindful enough to realise that there is a small minority of patients that you would be safer not to be treating at all
- Don't be too proud to seek out further training and development in areas such as communication skills, listening skills, non-verbal communication ('body language'); the skills you will develop on courses such as this will help to protect you against the risks that will result from many of the other courses you might be attracted to
- Concentrate your own efforts – and those of every member of your team – on making sure that your patients are happy and satisfied. If for any reason they aren't, make sure that your in-house complaints procedures are outstandingly good and easily accessible, so that patients tell you rather than telling others or escalating their dissatisfaction to other parties such as the GDC or litigation. This gives you the added benefit of finding out things that you can and should improve, so that other patients don't experience the same dissatisfaction about the same things.

SUMMARY

Hopefully the lasting legacy of this programme will be a recognition that we need to look outside dentistry and mainstream dental courses (and be prepared to think "outside the box") in order to achieve a fresh perspective on today's dental professional environment here in the UK. Not all of the answers to the challenges of primary care dentistry here in the UK are to be found within the normal CPD diet. Borrowing ideas from great thinkers and writers can re-charge our batteries and inspire us when everyone else is taking a breather, wallowing in all the gloom and doom and giving up hope.

More things are within our personal control than we might have imagined at the start of the day. Every one of us can apply our intellect, time and energy in different and more constructive ways, and thereby achieve more things more easily than we might have imagined.

Re-framing, ie trying to look at things from a different and more positive perspective, is an invaluable tool for kick-starting a rethink of where you are and what you plan to do next. Try to imagine what the most successful practices will look like in 2020, plot a course for getting there and start your journey right now. We may be in a period of economic constraint, wage controls and low growth - but it's also a period of unprecedented low interest rates and relatively low inflation.

There are plenty of reasons to be cheerful.

OTHER READING

Where drawing heavily from key source material, the relevant authors and books are specifically referenced in an appropriate point in the text above. Other sources mentioned in the lecture include :-

Edward de Bono Opportunities (1978) ISBN: 9780140137811 (includes the Train Driver –Doctor – Fisherman-Farmer analogy): The Six Action Shoes (1991) ISBN: 9780887305139 : The Six Value Medals (2005) ISBN: 9780091894597: Simplicity [latest edition 2015] ISBN: 9780140258394 *See also where referenced in text.*

Malcolm Gladwell The Tipping Point (2000); What the Dog Saw (2009)-a compilation of short essays and observations : David and Goliath (2013)- handy for those trying to compete against corporate dentistry. *See also where referenced in text.*

Kruger, Justin; David Dunning (1999). "*Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments*". Journal of Personality and Social Psychology 77(6) : 1121-1134

Gordon Bethune ("the customer is always right" is wrong). From Worst to First – Behind the Scenes of Continental's Remarkable Comeback (1999)

Alistair Beaton The Little Book of Management Bollocks (2001)

Mark McNeilly Sun Tzu and the Art of Business (2011) A modern-day application of the principles of warfare expounded by Sun Tzu in 500BC, which make remarkable sense in terms of succeeding in any competitive environment. And let's face it, they have stood the test of time !!

Shifting the Balance (GDC, 2017). Includes 'moving upstream' (sic) as part of its new strategic approach to becoming a better, fairer regulator.

KJLewis_1@hotmail.com