Going private: keeping patients

Nigel Jones discusses one of the perceived barriers to moving from NHS to private practice – the fear of losing too many patients

How many patients do you need to retain to make the move from NHS to private dentistry a success? This is what seems to be the million-dollar question – or rather, the ‘whatever amount you need to be financially viable’ question – for most dentists.

While the answer may vary from practice to practice, and relies on a number of different factors, the chances are it’s not as many as you think. Yet it can often be a barrier, even if it is unfounded, to becoming more private.

But with yet more tales of woe in the media about the NHS – one of the most recent being that the deficit at the end of the third quarter had risen to £886 million, which is £300 million more than the target and will do nothing to allay concerns about the lack of funding or precedence allotted to the NHS – it is becoming more pressing to consider the alternatives.

That’s the dictionary definition. But is real life the difference? How many patients could you lose and still successfully convert to private? In some cases, it is possible to retain only 50% of the patient base.

Alongside the patient-related factors above there are also a range of elements to consider when knowing if the private practice path is the right one for you. For instance, you need to consider your financial targets, your working pattern, the number of holidays you want to take – to name but a few.

Robust analysis of all these influences will help you to make a well-informed, calculated decision, and it is here that many dentists find it most useful to have additional support, in breaking down all the components and knowing how much weight to give to each in order to come to a considered conclusion and plan how best to make a successful move to private dentistry.

Why postgraduate education?

We look at the pros and cons of postgraduate education with a case example from Anwara Chambers

An undergraduate is someone who has not graduated from university. A postgraduate is someone who is continuing his education after he has obtained a basic dental degree (BDA). Postgraduate degrees include master’s degrees and doctorate degrees (PhD).

That’s the dictionary definition. But is real life the difference between a postgraduate degree or specialism and a regular BDS is noticeable today and will be huge tomorrow.

NHS dentistry is moving towards a system like that currently employed in the US. Basic treatment is carried out by other dental professionals, while the more complex treatment is done by the dentist. Periodontics, orthodontics, restorative dentistry and implant dentistry is referred out as well as other specialist work.

Normally in the US the dentist is a specialist with postgraduate education and qualifications in one of the specialties. Then not all specialist treatment needs to be referred away from the practice.

NHS England has already expressed a desire for the easier treatments to be done by hygienists and dental therapists. The cost saving to the NHS would be significant in the future.

And speaking about the future, a dentist considering the future really should seriously consider post graduate education in order to future-proof their dental career and potential income.

We know from Anwara Chambers who is training in implant dentistry and reflects on his first implant placement at the multi-system course certificate course mentor school. But look at the mentoring support afforded this beginner in implant dentistry.

Under Cemal Ucer

I enrolled on the Multi System Implantology Certificate Course, in Manchester in October 2015. This is a long established postgraduate teaching programme that has been running for more than 20 years under the direction of Professor Cemal Ucer. The course is run over 12 monthly sessions, and was a fully structured programme providing academic learning, by a mix of expert lectures and clinical ‘hands on’ training under Prof Ucer’s supervision to fulfil the requirements of the FGDP/GDC Training Standards in Implant Dentistry (TSD, 2012, 2016). On completing of the basic academic learning, practical training on raising flaps, suturing, sinus, atrophic extractions, socket augmentation, the GER technique and soft tissue grafts was undertaken using pigs’ heads and the implant placement surgery was practised initially on plastic jaws using different types of implant system to complete the preclinical training requirements of this course.

Cemal is a respected authority in dental implant education and a co-author of the training standards in the UK and Europe so, as expected, the course he runs is fully structured to achieve all the requirements and learning outcomes necessary for the attainment of clinical competence in this vast field of dentistry.

Having not had any previous experience of implant systems, the only ones I had heard of were Straumann and Nobel. I now know that there are many different systems on the market with varying levels of long term documentation, research and development and it is a matter of personal choice for each individual practitioner to look into the systems and decide what is suitable for their particular practice.

Cemal insists that a process of critical appraisal should be performed when selecting a system that can be fully trusted and relied upon especially for the beginners. When starting in this field the practitioner needs to have confidence on every aspect of the hardware. Ongoing support from the implant company is also another requirement.

Megagen was chosen

I decided that of the three systems we studied, the Megagen system would be most suitable for use in my practice because it appeared to be more user-friendly, due to them being a reduced amount of restorative components. Another thing in its favour was the support offered.

After the completion of the academic part of the course we were given the option to treat a patient either provided by the Mentee School at ICE Postgraduate Institute and Hospital or bring a patient of our own to treat under supervision of a university accredited mentor. I had a patient in mind, who had recently had an extraction of an upper left central incisor, and who was keen to explore the possibility of an implant to restore the space; but I was concerned about the aesthetic considerations that apply when replacing an implant in the aesthetic zone (AZ) (Figure 1).

Cemal had advised me to select a potential implant site that was not in the AZ due to the potential difficulties and high demands when operating in this area. However, full case assessment I had carried out under Cemals close supervision revealed that this case was not a complicated one for various reasons, given her older age, dental aesthetics was not the most important factor for this patient’s requirement. Full surgical and restorative risk assessment revealed that she did not have a high smile line. The main objective for the patient was improved function and comfort - she was finding it difficult to cope with a one-tooth denture. Her options were limited, due to her adjacent central incisor having post-crown with a guarded prognosis which would not have been an ideal abutment for a bridge. She had a good soft tissue type.

Cemal had asked me to write up a dental report and a treatment plan based on my full assessment including radiographs. To accomplish this, the patient was booked for further diagnostic tests to assess fully her intra and extraoral.
A small field of view (40x40) CBCT scan was taken using the state of the art Moora scanner at ICE Diagnostic Centre. This very high definition but low radiation scan showed that there was sufficient bone in which to place an implant in 3D. The patient was happy with the plan and the final hole was dug as a result and a date was set for the initial surgery for implant placement. We discussed the advantages, disadvantages of implant treatment and its alternatives and the nature of the treatment with the patient in full details before seeking consent for treatment. The adjacent U1 was highly compromised with aesthetic deficiencies but the patient was reluctant to have this tooth treated at this stage in absence of any symptoms.

Cemal would be my supervisor so I wasn’t really nervous about it because I had previously observed him doing his own surgical placements and making them look so easy. I was aware he had placed a very large number of implants (over ten thousand), used many different implant systems and that he had been teaching implants to dentists from all corners of the UK for over 25 years. Cemal has trained a vast number of dentists including a large number of today’s trainers who run their own courses throughout the UK.

I hugely relied on Cemal and assumed that, if needed, he would take over but I was wrong! The overall planning as well as his guidance and instruction were delivered well, so that I did the entire treatment from start to finish myself, with total confidence and ease. The only occasion that Cemal intervened was to suggest a minor correction to the angulation of the drill when placing implants to display the super and state-of-the-art training and clinical facilities offer by the Mentee School at ICE Hospital. I can now continue my career development in implant dentistry by progressing to the MSc in Implant dentistry offered by the Mentee School at ICE Hospital. I can treat unlimited number of patients provided by the mentee school or bring my own patients to the centre. In doing so I am slowly building my confidence, clinical experience and my portfolio of cases in implantology.

In preparation for the surgical procedure, we had to gown up appropriately and set the surgery for an aseptic surgical procedure. I hadn’t done this for many years so and was unfamiliar with the protocols; but there was an experienced nurse to hand who helped. There was also a second nurse who was not as experienced with surgical procedures but was on a NBED training programme in dental implant nursing and was being guided by the more experienced nurse. Implant surgery requires a close teamwork and typically the surgeon is assisted by an experienced scrub nurse and a less experienced nurse is on hand as a “circulating nurse” to dispense materials and equipment as and when needed. Aesthetic surgical field is thus maintained by having appropriate members of the team doing their respective jobs. I could have used the a-FPR technology but the scan did not indicate, in this case, a need for simultaneous grafting so use of this exciting new technique would have to wait until my next case.

After confirming consent and administering the local anaesthetic to the patient, Cemal instructed me to raise a small flap, and to extend it where I thought necessary. Because we had recently practiced raising flaps during the pig head sessions, I felt comfortable being able to do this. Cemal then asked me to extend the flap, for better access, without going into the papilla. This was something I hadn’t done before, but I was given good instruction and feedback, enabling me to confidently continue in a competent manner. The gingiva was a thick biotype, so it was harder to raise the flap, but eventually an adequate flap was raised buccally. The palatal gingiva was retracted either side of the opposing teeth to assess the palatal bone and get a more optimal view of the ridge.

Having not been nervous prior to the procedure, I soon felt the nerves kick in when having to drill a pilot hole for the implant. I had already done surgical extractions which necessitated bone removal, but now I was in the position of having to preserve the bone. The initial pilot hole was positioned very slightly on the palatal aspect. Once it was deemed that the implant site was located correctly, the drills, in the sequence, were used until the site was ready for the implant. I reviewed her at my own practice 10 days later, expecting her to inform me that she had suffered with after pain following the surgical procedure. However, this was not the case, and she was happy to inform me that she had gone out that evening and had experienced very little discomfort, which was a pleasant surprise for me. On examination, the site was healing fine (Figure 2) and the patient was very happy with the result (Figure 5).

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