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IOC 2015

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Capital prepares for 8th International Orthodontic Congress

London © FranSea

By DTI

LONDON, UK: The International Orthodontic Congress (IOC) is held once every five years and offers up to 10,000 orthodontists and allied professionals a unique platform to meet, network and exchange knowledge and ideas with their colleagues and peers from across the globe. The World Federation of Orthodontists (WFO) and the British Orthodontic Society, the two largest dental specialist groups in the UK with over 1,800 members collectively, will be hosting the eighth edition of the congress in London, from 27 to 30 September.

The organiser expect to attract more than 7,000 people. About 4,000 participants have already signed up for the event. It will be officially opened on 27 September at the ExCeL London Exhibition and Congress Centre in the heart of London's Royal Docks, with easy access to central London. The venue is part of a 100 acre site which includes three on-site aboveground rail stations and easy access to the underground network and London City Airport.

In order to cater for both orthodontists and other dental health professionals, such as dental technicians, hygienists, dental attendants and office staff, the WFO will be offering two scientific programmes that will run in parallel. In addition to these programmes, a World Village Day will take place, which will comprise of seven parallel, full-day programmes. To date, 19 distinguished speakers have already confirmed their participation.

The congress lectures and presentations will be held in English, however, simultaneous translation will be provided for some sessions.

Alongside the scientific programme, attendees will have the opportunity to learn more about new products and technological developments at the adjoining exhibition that will run for the duration of the congress.

In addition, during the course of the congress, several social events are planned for the evenings, including an international reception at the famous Madame Tussauds wax museum and a gala dinner at the Old Billingsgate, an extraordinary and unique venue that is situated in a prime position on the River Thames which was once the world's largest fish market. Tickets for these events can be purchased upon registration.

According to the WFO, one of the reasons the congress is taking place in London is because of the city's heritage and its attractions on offer. As a city of history and culture, delegates will have numerous opportunities to enjoy many of the sights, including castles and palaces; historical buildings and monuments; theatres and opera houses and other well-known places that were described by famous authors, such as William Shakespeare and Charles Dickens.

Online registration for the event is open until 17 September online but delegates can also register on-site at the registration desk on 27 September.

Study finds clear aligners are more beneficial than braces

By DTI

MAINZ, Germany: In recent years, clear aligners have become a favourable treatment alternative in orthodontics to fixed orthodontic appliances (FOA). However, there are few studies about the effects of aligner treatment on oral hygiene and gingival condition. A team of German researchers has now compared the oral health status, oral hygiene and treatment satisfaction of patients treated with FOA and the Invisalign aligner system. They found that Invisalign patients have better periodontal health and greater satisfaction during orthodontic treatment.

To date, the majority of patients, particularly during childhood and adolescence, are treated with FOA. However, these appliances tend to complicate oral hygiene and thus interfere with patients' periodontal health. Moreover, treatment with FOA is not very popular in adult orthodontics for aesthetic reasons. Therefore, other orthodontic techniques have been developed to improve aesthetics and simplify oral hygiene procedures. An alternative to FOA is clear aligners, which are discreet and have the advantage of being removable during oral hygiene and eating or drinking. The use of clear aligners has increased greatly in the last decade, one prominent example being Invisalign, produced by Align Technology since 1999. However, only a limited number of studies have compared the effects of Invisalign and FOA on oral hygiene, the researchers from the Johannes Gutenberg University of Mainz pointed out.

Their study included 100 patients who underwent orthodontic treatment, divided equally between FOA and Invisalign, for more than six months. The researchers performed clinical examinations before and after treatment to evaluate the patients' periodontal condition and any changes. Furthermore, a detailed questionnaire assessed the patients' personal oral hygiene and dietary habits, as well as satisfaction with the treatment. All of the patients received the same oral hygiene instructions before and during orthodontic treatment. This included the use of toothbrush, dental floss and interdental brushes three times daily.

The data analysis showed no differences between the two groups regarding periodontal health and oral hygiene prior to the orthodontic treatment. However, the researchers observed notable changes in periodontal condition in both groups during orthodontic treatment. They found that gingival health was significantly better in patients treated with Invisalign, and the amount of dental plaque was also less but not significantly different compared with FOA patients.

The questionnaire results showed greater satisfaction in patients treated with Invisalign. Only 6 per cent of the Invisalign patients reported impairment of their general well-being during orthodontic treatment, compared with 36 per cent of the FOA patients. Other negative effects that also were significantly higher in FOA patients included gingival irritation (FOA: 56 per cent; Invisalign: 14 per cent), being kept from laughing for aesthetic reasons (FOA: 26 per cent; Invisalign: 6 per cent), having to change eating habits during orthodontic treatment (FOA: 70 per cent; Invisalign: 50 per cent), and having to brush one's teeth for longer and more often (FOA: 84 per cent; Invisalign: 52 per cent).

The researchers concluded that orthodontic treatment with Invisalign has significantly lower negative impacts on a patient's condition than treatment with FOA, both with regard to gingival health and overall well-being.

“The Olympics of orthodontics”

An interview with International Orthodontic Congress chairman Dr Jonathan Sandler, Chesterfield

Dr Jonathan Sandler

Almost a decade in preparation, the International Orthodontic Congress (IOC) is set to return to the UK on 27 September. *Dental Tribune* recently visited IOC chairman and President of the British Orthodontic Society (BOS) Dr Jonathan Sandler at Chesterfield Royal Hospital to talk about the London event and what it will bring to orthodontics in the UK.

> “This will certainly be one of the finest orthodontic conferences that the UK and Europe have ever seen.”

***Dental Tribune:* The IOC is held every five years only. What are the advantages compared with annual events like the BOS's own conference?**

Dr Jonathan Sandler: I think having it every five years is good to build up the excitement and anticipation for the conference. We were awarded the contract back in 2006, so for me it has been a nine-year project really. I have assembled an amazing team of individuals, people I have run the British Orthodontic Conference with for many years, and I am very grateful to the whole team. It is like the Olympics of orthodontics.

The latest figures indicate that over 5,000 participants have already registered for the IOC. Does this number hold up to your expectations?

The bar for us has always been the 2005 IOC in Paris. That congress had about 8,000 delegates, so I hope we can get close to 10,000. As far as I understand, eight weeks before the conference in Paris, only 800 people had registered, so what we hope is that in the next few weeks delegates will keep flooding in.

We are in very good shape at the moment. The edition in Sydney had about 4,000 delegates, so we have already beaten the last IOC in 2010. Thus, we are quite confident that we can significantly increase our numbers.

How many participants do you expect to come from the UK?

There about 1,800 orthodontists in the country at the moment and I am certain the vast majority of them have signed up for the conference or will do so soon. While Europe remains our largest market, the Far East and Australasia also have a good share.

Orthodontics used to be centred primarily in North America and Europe. Considering the huge interest from dental professionals outside of Europe, do you see the specialty having gained importance in the rest of the world?

Definitely, everybody wants to go into the specialty. Until recently, for every orthodontic post in the UK there were ten applicants, so it is incredibly popular. It is also a wonderful lifestyle. Patients visiting an orthodontist as opposed to a general dentist are actually relieved or pleased if the orthodontist says he or she can do something for them, whereas everyone going to the general dentist hopes that nothing needs to be done at all. We are changing people's lives on a daily basis, which is fantastically rewarding.

New short-term techniques have opened up the field for general dentists. What is your opinion on these developments?

I think one of the major concerns to all traditional orthodontists is the threat posed by short-term orthodontics. A lot of it is being done by people who perhaps do not understand the significance of the treatment they are prescribing or do not necessarily have an Option B that might be more comprehensive. Of course, there are situations in which a short six-month course may be appropriate and in such a case, I would be the first one to prescribe that treatment. However, I have to say that about 95 per cent of the orthodontics I perform takes up to two years, because that is the usual duration of a proper course of orthodontics.

There is certainly a great deal of concern about the plethora of short-term orthodontics courses that are being offered. There may be cases that are appropriate for a simpler line of treatment or a short-course fixed appliance treatment; however, it requires specialist knowledge to be able to assess the cases in which it would be in the patient's best interest.

Do you consider this a negative development then?

Overall, I would consider this a negative development. There are a number of benefits from short-term orthodontics, but I am not sure that they are always moving in the direction of the patient. Commercial interests seem to affect the treatment plan increasingly and this is often to the detriment of the high-quality patient care that would otherwise have been prescribed.

Short-term orthodontics will definitely spark debate in London. What other topics will be discussed at the event?

The main congress will be held over three days. We will have 48 of probably the best orthodontic speakers in the world. In addition, short presentations will run alongside the keynote speeches. All in all, there will be up to 100 speakers at the conference, which will cover all the contemporary techniques, as well as some current research in orthodontics, so it is going to be an exciting programme.

One of the subjects that many will definitely find of interest is temporary anchorage devices, which will be covered in great detail. We have three of the world's leading speakers on that subject, all of whom are from Germany or have German roots. Aligner therapy is also very current and increasing in popularity, particularly the Invisalign technique. Dr Timothy Wheeler from the University of Florida is a world expert, and he will give us a very frank and comprehensive interpretation of how he feels it fits into modern orthodontic practice.

Will the congress also look at the acceleration of tooth movement?

There will be scientific material presented about the AcceleDent technique that will allow attendees to draw their own conclusions. It is certainly an area in

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which people have great interest. There have been some worthwhile studies carried out and this up-to-date research will be presented. As far as I understand Prof. Martyn Cobourne from King's College London will be speaking about this very subject, as will one of our arch-sceptics in orthodontics, Prof. Kevin O'Brien from Manchester. He is going to present his views on AcceleDent when he discusses uncertainty in orthodontics.

Digitisation has found its way into almost every dental specialty. Will the congress consider what its impact will be on the field in the future?

Intra-oral scanners are going to become increasingly popular in the next decade and clinicians are just starting to use them for collecting records for their patients. I am very keen to get intra-oral scanners here in the department over the next few months, so that I can start studying the Invisalign technique in more detail.

In my opinion, the use of these technologies is going to be one of the major changes in our field. A number of orthodontic laboratories are getting model scanners now, so that they can empty their model box room and store everything digitally. This technology offers a number of exciting possibilities.

Do you think it will have an impact on treatment processes too?

I am not yet convinced that digitisation per se is going to make significant inroads into improving the quality of treatment overall. This remains to be seen. There are a number of techniques now that are suggesting that one can set up one's cases digitally, setting the bracket position or doing the finishing of the cases on computer and then have robots bend the archwires to produce the changes one would like to produce clinically. At the moment the jury is out, they sound wonderful ...but do they actually deliver the goods. Clinically, it is still open to debate.

Will there be any other special sessions in addition to the main programme?

On Tuesday, we have World Village Day and we give the opportunity for orthodontic societies outside Europe to contribute to the programme with either a full-day programme, something the BOS is doing, or a half-day programme. We have the European Orthodontic Society, two Italian groups and our Chinese colleagues contributing, for example. All in all, we have 18 different groups contributing to World Village Day, so we really have the opportunity to hear from orthodontists from all over the world.

What will the conference bring to orthodontics in the UK?

This will certainly be one of the finest orthodontic conferences that the UK and Europe have ever seen. Specialists here will have the opportunity to hear 30 of the greatest orthodontic speakers, clinicians and researchers. It will give attendees massive exposure to world expertise and bring them up to speed. Participants can tick almost all of their continuing professional development boxes and will not need to go to another meeting for the next three or four years.

Thank you very much for the interview.

LONDON'S **TOP 10** ATTRACTIONS

1. BRITISH MUSEUM

The world-famous British Museum exhibits the works of man from prehistoric to modern times, from around the world. Highlights include the Rosetta Stone, the Parthenon sculptures and the mummies in the Ancient Egypt collection. Entry is free but special exhibitions require tickets.

2. NATIONAL GALLERY

The crowning glory of Trafalgar Square, London's National Gallery is a vast space filled with Western European paintings from the 13th to the 19th centuries. In this iconic art gallery you can find works by masters such as Van Gogh, da Vinci, Botticelli, Constable, Renoir, Titian and Stubbs. Entry is free but special exhibitions require tickets

3. NATURAL HISTORY MUSEUM

As well as the permanent (and permanently fascinating!) dinosaur exhibition, the Natural History Museum boasts a collection of the biggest, tallest and rarest animals in the world. See a life-sized blue whale, a 40-million-year-old spider, and the beautiful Central Hall. Entry is free but special exhibitions require tickets.

4.TATE MODERN

Sitting grandly on the banks of the Thames is Tate Modern, Britain's national museum of modern and contemporary art. Its unique shape is due to it previously being a power station. The gallery's restaurants offer fabulous views across the city. Entry is free but special exhibitions require tickets.

5.THE LONDON EYE

The London Eye is a major feature of London's skyline. It boasts some of London's best views from its 32 capsules, each weighing 10 tonnes and holding up to 25 people. Climb aboard for a breathtaking experience, with an unforgettable perspective of more than 55 of London's most famous landmarks – all in just 30 minutes!

6. SCIENCE MUSEUM

From the future of space travel to asking that difficult question: "who am I?", the Science Museum makes your brain perform Olympic-standard mental gymnastics. See, touch and experience the major scientific advances of the last 300 years; and don't forget the awesome Imax cinema. Entry is free but some exhibitions require tickets.

7. VICTORIA & ALBERT MUSEUM

The V&A celebrates art and design with 3,000 years' worth of amazing artefacts from around the world. A real treasure trove of goodies, you never know what you'll discover next: furniture, paintings, sculpture, metal work and textiles; the list goes on and on… Entry is free but special exhibitions require you to purchase tickets.

8. TOWER OF LONDON

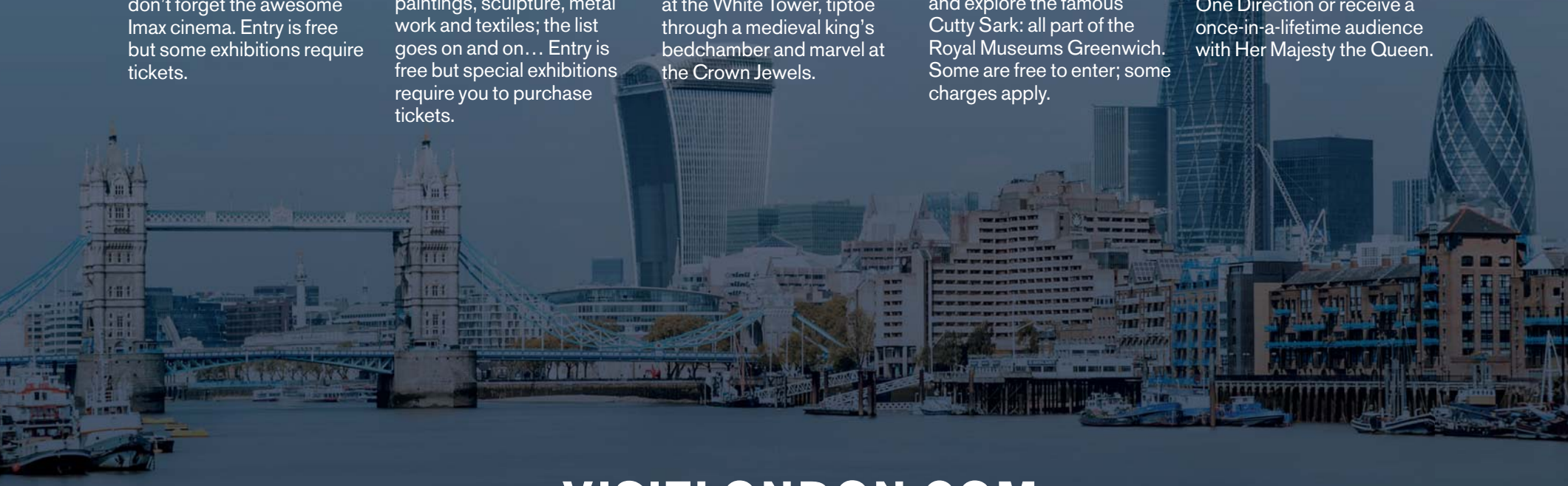
Take a tour with one of the Yeoman Warders around the Tower of London, one of the world's most famous buildings. Discover its 900-year history as a royal palace, prison and place of execution, arsenal, jewel house and zoo! Gaze up at the White Tower, tiptoe through a medieval king's bedchamber and marvel at the Crown Jewels.

9. ROYAL MUSEUMS GREENWICH

Visit the National Maritime Museum - the world's largest maritime museum, see the historic Queen's House, stand astride the Prime Meridian at Royal Observatory Greenwich and explore the famous Cutty Sark: all part of the Royal Museums Greenwich. Some are free to enter; some charges apply.

10. MADAME TUSSAUDS

At Madame Tussauds, you'll come face-to-face with some of the world's most famous faces. From Shakespeare to Lady Gaga you'll meet influential figures from showbiz, sport, politics and even royalty. Strike a pose with Usain Bolt, get close to One Direction or receive a once-in-a-lifetime audience with Her Majesty the Queen.



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Short-term gains...long-term problems?

The emergence of STO and its future implications in general practice

By Aws Alani, UK

The provision of orthodontics can be a life-changing experience for young patients whose "crooked" teeth can affect their confidence and self-esteem. Indeed, where mature patients present with a history of malalignment, equally beneficial and fulfilling results can be achieved. In government-funded systems, patients with congenital abnormalities receive treatment that is essential to their ongoing oral health. Restorative dentists work closely with orthodontists, who can appreciate how small details can aid in achieving positive restorative outcomes.

As a young dentist, I corrected a tooth in crossbite with a simple T-spring appliance. It was enjoyable and brought a different type of delayed gradual satisfaction to the more cerebral but tenuous molar endodontics or the more artistic and instant composite build-up. I was not a specialist, but I managed to do some orthodontics. In contrast to my experience, general dental practitioners are now more routinely providing tooth movement with the emergence of short-term orthodontics (STO). This has resulted in some conjecture as to the methods of achieving "straighter" teeth. Indeed, some may consider STO as an emerging entity competing with specialist orthodontics, but should it be?

The specialist training pathway for orthodontics involves a competitive-entry three-year full-time course linked with the achievement of a master's level qualification that many may feel daunted by. Indeed, navigating the pathway from start to finish can be difficult academically and financially when factoring in fees and loss of earnings during training. Once qualified, the majority of these specialists reside, like the majority of all specialists, in the south-east of England. With this skewed distribution of specialists and assumed need for access, it might seem prudent for general dental practitioners to contribute to meeting the need for orthodontics.

Indeed, the long-cited managed clinical networks have yet to be fully realised, although all planning and documentation related to managed clinical networks identify general dental practitioners as integral to the function of the network. The number of orthodontic therapists has gradually increased over the last ten years or so since inception of the first courses in Wales and Leeds. Therapists are allegedly more cost-effective to train and employ in a large orthodontic practice; however, unlike their hygiene or therapy colleagues, they cannot practise without a specialist's treatment plan and supervision.

Patients who qualify for orthodontic treatment under the UK government-funded system need to be assessed according to the index of orthodontic treatment need. There will be an obvious shortfall of adults or adolescent patients with minor malocclusions who do not meet the criteria who would like their teeth straightened. This cohort may have to seek treatment privately from orthodontic specialists or general dental practitioners. As such, these minor or straightforward cases may be managed in a number of different settings utilising various techniques with the advent of STO. This may have resulted in some territorial paranoia between the two camps of traditional orthodontics versus STO systems. Conversely, it may be that differing scientific, technical and ethical ethos on managing the same problem is the source of the debate.

Quick and easy?

Commercialisation has modified the provision of orthodontics in the UK. Indeed, there are now orthodontic brands with courses attached and a

faculty of individuals who promote their particular product. Companies tend to boast that their product is the best with limited complications and treatment being low risk, predictable and easy. Somewhat surprisingly, courses are being run on how to convert patients into orthodontic clients. There are books describing strategies on promoting and increasing revenue. They outline detailed strategies on attracting more patients than one's local competitor—or is that colleague? Sounds more like capitalism than commercialism to many interested observers.

The rapid development of STO has not escaped the venture (or some may say vulture) capitalists. In the same vein as DIY whitening and sports guards, one can now have one's teeth straightened via online companies using products delivered by Her Majesty's Royal Mail and so cut out the middleman (i.e. the dentist). To my knowledge, STO has yet to make it on to the price list of Samantha's, a beauty salon in Peckham.

What may cause fear and worry is that the provision of tooth movement set against a backdrop of a focus on increasing revenue and patient conversion may detract from the real reasons we are providing the treatment. The risk and benefit of treatment must remain balanced or be rebalanced in favour of the patient.

The best things in life are rarely quick, easy and without reflection. While learning or training, one gains stature from one's mistakes and learns by way of osmosis from those of individuals one hopes to emulate. Becoming an expert in many a field requires time, effort and experience. Orthodontics is a complicated discipline that is difficult to deliver optimally and efficiently. Treatment planning should be performed in person not only to appreciate the challenges the patient presents with but also to develop a lasting patient rapport. Equally important, patients need to be diligent during treatment and forever more for purposes of retention. Is it possible that a one- or two-day course with a treatment plan lasting half a year or less can provide equally optimal results to a specialist orthodontist utilising traditional means? In any case, placing a time limit on any treatment could be considered contentious. Patients ask me all the time 'How long is this treatment going to take Doc?' I always reply 'Ill tell you when its finished'. As such I am rarely wrong.

Advertising cosmetic treatments the fair dinkum way

The Australian health ministry recently examined the provision of cosmetic procedures and in particular the modes of promoting the treatments. The working group found that advertising and promotion more often than not focused on the benefits to the consumer, downplaying or not always mentioning risks. The group went on to identify advertising practices that were not driven by medical need and where there was

significant opportunity for financial gain by those promoting these. They identified the need to regulate promotion and advertising ethically with factual, easily understood information from a source that is independent of practitioners and promoters. This is unfortunately not always readily available. In some Australian jurisdictions, there are specific guidelines that need to be adhered to for promotion of cosmetic treatments and they specifically cover before and after treatment adverts, which we know in the UK is a popular practice among the cosmetically driven. This is commonly one ideal, perfect case showcased on the front end of the practice website with no mention of any problems, either acute or chronic. Another aspect of the report detailed prohibition of time-limited offers or inducing potential customers through free consultations for the purposes of treatment uptake. The latter is something that has seen STO promoted by way of voucher deals on the Internet or via smartphone applications. Others may consider such a practice as loss leading; one could ask who is losing and who is gaining and at what price?

One important aspect of the report identified the wider social impact of cosmetic procedures in that people may become increasingly dissatisfied with themselves and their appearance, culminating in deeper concerns for the person and reducing scope for individuality. Many dentists throughout the country may have a slipped contact here, a rotation there or a space distal to a canine who are unlikely to be waiting in earnest for the next voucher deal alert on their iPhones. Inducing misgivings or raising concerns about the patient's tooth position where the teeth are otherwise healthy and the patient presents with no concerns could be considered unethical and worryingly dishonourable.

Relapse of confidence

In a recent publication from an indemnity provider, orthodontics was identified as an emerging area for claims against their clients. This is likely to be the tip of the iceberg, whose size will probably continually grow as more and more orthodontics is provided and the repercussions of which may only become apparent gradually in the future.

In the now highly litigious arena of UK dentistry, the failure of orthodontic treatment against the backdrop of *Montgomery v. Lanarkshire Health Board* is likely to result in increased litigation. The movement of teeth into what the patient and the dentist feel is the correct position may be possible in the short term, but in the long term complications may arise owing to a variety of soft- and hard-tissue factors that cannot accommodate this new and supposedly "right" position. Indeed, orthodontics requires the appreciation of detail where symmetry and alignment are "king", but long-term stability is the likely "empress". Relapse of position is a common complaint and where patients have paid handsomely for a result they may have been happy with at the time of the cheque clearing, over time tiny tooth shuffles can result in disproportionate and vehement dissatisfaction. Where teeth are moved indiscriminately, recession in the labial segment is a complication difficult to explain and remedy in the high lip line of a conscientious and ambitious corporate female patient. Indeed, more haste, less speed may result in a case being etched longer in the memory of the patient and the clinician for the wrong reasons.

Clear steps to business building

A cornerstone of a successful business is the repeat customer who values the dentist and his or her service and returns with no qualms or misgivings about what the dentist feels should be provided. A successful business relies on patients returning in the long term owing to their positive experiences. Focusing on short-term gains without due consideration of quality or reliability of the treatment provided has potential repercussions for patients, the business of dentistry and perception of the profession.

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Orthodontic contract transfer: An ongoing point of discussion

By Amanda Maskery, UK

The issue of orthodontic contracts is a topical one at present, with much discussion around the uncertainty regarding partially completed treatment and the sale of a practice. The issue of incomplete treatment arises not just with General Dental Service (GDS) contract sales, but also with Personal Dental Service (PDS) orthodontic contracts.

The difficulty in transferring contracts between buyer and seller, and the issues around dealing with payment are well documented. It is proving to be an ongoing point of discussion, both with my clients, as well as among my fellow members of the Association of Specialist Providers to Dentists and the National Association of Specialist Dental Accountants and Lawyers.

In GDS work, partially completed treatment is paid for pro rata, but in PDS orthodontic work, it is paid to start but not to finish it, raising potential problems around clawback. When a contract is terminated owing to a sale, the entire caseload is passed to the buyer and next provider, who then picks up the ongoing matter and its associated income. From the seller's point of view, there is no longer any obligation to finish the cases, so no matter the patients' stage of treatment (somewhere between appliance fit and debond) all of the cases are transferred and the seller walks away.

For the buyer, he or she needs to take into consideration the caseload he or she will take on as a result of the purchase, while bearing in mind that no units of orthodontic activity can be claimed for finishing the cases. Undoubtedly, this can prove a problematic issue, but is a case in point of why it is essential for both a buyer and a seller to instruct a specialist adviser to act on his or her behalf.

By structuring payment clearly and laying out the terms very clearly in the sale agreement, hopefully the situation will be agreeable to both sides of the sale or purchase.

Amanda Maskery *is one of the UK's leading dental lawyers. She is Chair of the Association of Specialist Providers to Dentists (ASPD) in the UK and a Partner at Sintons law firm in Newcastle. She can be contacted at amanda.maskery@sintons.co.uk.*

Treatment coordinator: The bridge to case acceptance

By Lina Craven, UK

You might think that in financially challenging times the last thing you need is a new member of staff. For a practice to thrive and prosper in a difficult financial climate, however, it has to become more efficient, more competitive and more profitable. One way to do that is to introduce a treatment coordinator (TC) into the team or if you already have one then to offer appropriate training. This is a relatively new role to the European market, but in the US, where the role is a central part of any practice, it has proven to dramatically add value to the patient experience, reduce in chair time and increase case acceptance.

The introduction of a well-trained TC will change your entire approach to new patient care, as well as increase profitability. While many practices know how to attract patients, their case acceptance ratio is low. The first contact, first visit and follow-up are the most important elements of the new patient process, yet they frequently represent a wasted opportunity because of a lack of skill, focus, time or all three.

In my experience, a major downfall of practices is the unwillingness of practitioners to delegate the new patient process to staff, or what we call the TC role. This is often due to a wide range of factors, including the practitioner's perception that the patient wants communication on his or her treatment to come from the practitioner, the perception that patients pay to see the practitioner, a lack of trust to empower staff or time to train staff, and the financial implications of introducing the new role.

Relinquishing new patient management to well-trained staff is not a new trend, although its application has been limited in Europe. However, patients' expectations, competition for private work and the team's demand for career progression and job satisfaction are key drivers for introducing the TC role.

The TC concept

A TC is someone in your practice who, with the right skills and training, will facilitate the new patient process. He or she bridges the gap between the new patient, the practice and the staff. The TC promotes and sells the practice and its services by demonstrating their true value to prospective patients, frees up the practitioner's time, increases case acceptance ratios and, resultantly, increases practice profits.

Consider the time spent by the practitioner with the new patient and calculate how much of that time is non-diagnostic. A TC can often reduce up to 60 per cent of practitioner–patient time. Rather than this being a barrier to patients—which is indeed what many practitioners perceive to be the case—in my experience, patients actually feel much more at ease with the TC and therefore better informed. Doctor time is not always doctor time. As a typical example: if an new patient appointment is 30 minutes, but the clinical part is actually only 15 minutes, there is potentially 15 minutes still available. Think about the impact an additional 15 minutes for every new patient in the appointment diary could have.

A good TC will manage all aspects of the patient journey, from referral to case start, and potentially increase your case starts. He or she is the first point of contact. People buy from people, so the development of a relationship and establishing of rapport between the TC and the new patient are crucial to the success of your conversion from referral to start of treatment. The TC informally chats to the new patient prior to consultation. This helps not only to foster rapport but also to gain a better idea of the patient's needs and wants.

I recommend to all my TCs to be present at the consultation to listen and understand clinically what is and is not possible in order to allow the TC to determine how he or she will conduct a top-notch case presentation.

The TC carries out the case presentation, reiterates the treatment options available to the patient, discusses these, answers any questions the patient may have, and clarifies proposed treatment. He or she also discusses the informed consent, shows before and after photographs of similar cases, and addresses any barriers or concerns the patient may have. The TC also explains the financial options and determines the most suitable payment method for the patient's needs, as well as prepares the walk-out pack. The value of a walk-out pack should not be underestimated and should reflect the values of the practice, including all information the patient needs, the finance agreement or contract, diagnostic report, photographs of the patient (an excellent marketing tool), informed consent and anything else the practitioner feels adds value to the consultation.

Too many new patients are lost due to lack of follow-up. A good TC follows up and provides monthly information on patient conversions to assist with strategic planning. All practices should have a patient journey tracker.

> "A good TC will manage all aspects of the patient journey, from referral to case start..."

Filling the role: An internal solution?

There are no hard and fast rules. It depends upon the size and aspirations of your practice and the qualities of existing members of your team. If you have a team member who fulfils the characteristics of a TC and he or she wants the challenge, then the answer is yes. Keep in mind that you may well need to fill that person's current position.

Some practices streamline job descriptions allowing them to create the new role without having to hire another staff member. Whether it is a full-time role or not depends upon various factors, including the size of the practice; the number of practitioners, chairs and patients; and the profit aspirations. Many practices implement the role and monitor its progress and impact. This often helps the team to accept the change and gives the practitioner the opportunity to assess any training needs of the TC and to access how remuneration will be affected.

The role of your TC should fit in with your practice's culture and aspirations for patient care. However you choose to implement the role, the only guarantee is that you will benefit enormously. Augmenting your team with a well-trained TC can reap tremendous rewards for you, the team and your patients. A TC's tailored and personal approach to care, follow-up and communication with patients fosters trust and increases patient satisfaction and retention.

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