Ethical Marketing in ‘Aesthetic’ (‘Esthetic’) or ‘Cosmetic Dentistry’ Part 2

Abstract: This is the second article in a series of three. It is essential to find out from patients what it is that they hope to achieve when requesting an improvement in their dental appearance. Their expectations, hopes and fears need to be explored in detail. The long-term biologic costs of some invasive procedures need to be explained to patients in advance so that they can make properly informed decisions. Failure to do so renders the practitioner vulnerable to a charge of behaving unethically. The differences between ethical marketing and selling are explained including the historic development of marketing.

Clinical Relevance: A practical approach, using a modification of the Edward de Bono Six Thinking Hats model is described to help ethical practitioners to develop sound treatment plans when dealing with complex aesthetic problems.

Ethics and aesthetic dentistry

Ethics relate to a voluntary framework of guiding principles which fills the void between laws on one hand and a ‘free for all’ on the other. In essence, ethics involve a moral code, or a set of principles, to guide behaviour when dealing with aesthetic dental problems. Ethics are different from laws and have sometimes been described as an ‘allegiance to the unenforceable’. In the case of dentistry, Dental Councils and Dental Boards in various countries have the power to suspend or to remove a dentist’s registration, even when no law has actually been broken. Professional ethics and conduct are therefore enforceable indirectly because a dentist’s registration with his/her regulatory body is at stake. Ethical behaviour is essential, not optional, if one is to have a successful career in aesthetic dentistry.

Patient and public expectations in relation to ‘cosmetic’ dentistry

The public at large and patients in particular expect certain things from dentists. Maintaining ethical standards within the dental profession is a duty for all dentists because ethics represent a voluntary code of principles generated from within the dental profession to follow. The fundamental principles on which healthcare relies are ‘doing good’ and ‘acting in the patient’s best interest’ (‘beneficence’) and ‘doing no harm’ (‘non-maleficence’).

In seeking aesthetic or ‘cosmetic’ dentistry, the presumption by patients is that they will benefit from any such intervention rather than being harmed by it. If it becomes evident later on that they have been damaged in the long-term by the provision of ‘cosmetic’ or ‘aesthetic’ dentistry, then it is understandable that they will feel disappointment, anger and possibly become litigious.
Ethical marketing in aesthetic dentistry

Ethical marketing is a complex area. Dentists are under a duty of care to protect a patient's dental health. They should respect their patients' autonomy to make informed decisions about what happens to them and to help them to do so fairly and without prejudice. Almost every clinical decision in aesthetic or 'cosmetic' dentistry has an ethical and/or a legal component. For instance, there are often cultural differences between different countries and races. In recent times there has been almost a cultural hegemony to have very white, very even teeth with no gaps and little defining individuality of teeth or even variations in surface anatomy. To many dentists extremely white and extremely even teeth look attractive, but to many other dentists they look awful and remind them of bad dentures that were particularly prevalent in the 1960s, 70s and early 80s. Older dentists may refer to this look as the 'little pearly white ones look' because that reflected the words used by patients requesting that their teeth be extracted (often unnecessarily) and replaced by 'little pearly white teeth' on their new complete dentures.

The social or cultural norm of extractions and dentures which existed in the UK and elsewhere in the 1960s, and probably the 1970s, is no longer the social norm. People do not see the loss of teeth as a natural part of growing old. Unfortunately, aggressive 'cosmetic' dentistry is now an enormous threat to otherwise healthy teeth because it removes the protective outer enamel and much of the dentine from the teeth in return for what is promised, or perceived to be, a durable aesthetic outcome. However, this is almost certainly not provided at minimal long-term damage to their sound teeth.

The Hippocratic Oath

The Hippocratic Oath includes the exhortation of 'Primum est non Nocere'
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which means ‘Firstly, or most importantly, do no harm’. Dentists need to keep this concept uppermost in their minds when dealing with aesthetic problems.

The Hippocratic Oath also urges that ‘extreme remedies’ should be reserved for ‘extreme diseases’. However, some of the treatments recently touted in many glossy dental magazines showing almost full mouth ceramic veneers for minimal problems are certainly an ‘extreme remedy’ approach. These case reports often show results that must have involved considerable damage being inflicted on the previously sound structure of the treated teeth in order to achieve the outcome of a changed dental appearance. It is no coincidence that pictures of the prepared teeth in their much reduced state rarely get shown in such articles, and it is doubtful if patients get shown the relevant pictures of the destruction involved in preparations for extended veneers or for all-ceramic full coverage restorations. Furthermore, it is not common for some ‘cosmetic dentists’ to show patients the consequences of the failure of aggressive ceramic reconstructions which can be disastrous in the longer term (Figures 1–10).

Marketing versus selling

The terms ‘marketing’ and ‘selling’ are often used as though they are interchangeable. In fact, they have a very different focus. The main focus in selling is on the provider (dentist) and the primary focus in marketing is on the patient or consumer. Ethical marketing is essentially about finding out what benefits, if any, a particular treatment might provide to an individual patient but, in attempting to do this, it also addresses, in advance, the potential problems that any proposed ‘cosmetic’ treatments might pose for the patient in the longer term.

Selling, on the other hand, involves emphasizing the benefits of the services or the products that the dentists can, or could, provide. In terms of aesthetic dentistry, ‘selling’ doesn’t necessarily have as the main focus how those services, or products, would provide long-term, durable, safe, benefits to a patient. Conversely, marketing would involve finding out in detail if those were important issues for an individual patient and would keep those particular issues and concerns clearly in focus in the treatment planning consultations.

Until relatively recently, dental associations were generally distrustful and somewhat disdainful of the term ‘marketing’ because many dental associations, or at least some of their members, equated ‘marketing’ with ‘advertising’ or ‘selling’. In their view, this was not and, for some, still is not, something that true dental professionals should undertake. In recent memory, anything other than a simple listing of a dentist’s name, qualifications, telephone number and the name of the practice in, for example, the Yellow Pages would be enough to get one into trouble with the regulatory authorities. This is no longer true and now it is not uncommon to see dentists advertising in all sorts of ways to help promote themselves, their products, their services, or their practices’ unique selling points or ‘USP’s.

Training courses, promising to help sell more complex ‘cosmetic’ or ‘smile design’ aggressive dentistry, as a method of increasing dentists’ incomes, are now frequently advertised, with many appearing in un-refereed but widely read ‘dental business focused’ journals.

The history of the development of marketing

The history of marketing falls into four distinctive eras. The first of these was the ‘scarcity era’ where there was a shortage of goods and services. In this era, dentists were scarce and whatever they could provide, patients would have. A classic example of that era would be pain relief, often involving extractions and basic dentures. Subsequently, as happened with a lot of other service providers, the ‘scarcity era’ gave way to the ‘production era’. In this era, there was an increase in the efficiency of the delivery of the services. One general example would be the introduction of the production line in a factory which made, for example, more cars but did this more efficiently.

However, it soon became clear that one could produce more of a product, such as a car, which society did not appear to want. In dentistry terms the ‘production era’ could be represented by a large group practice with teams of dentists, nurses, hygienists and technicians producing more dentistry such as fillings, extractions, crowns, bridges, etc. For instance, in the 1960s and 1970s, it was not uncommon for some people to refer to certain practices as ‘amalgam factories’. However, it became apparent that one difficulty of this approach in dentistry, particularly in relatively affluent areas, was that many people did not want extractions, as they had no pain, nor did they want crude looking, but durable, amalgam fillings. For many such patients and their dentists, crowns and bridges were often deemed to be preferable to having gaps or a removable denture.

In the history of marketing development, the ‘production era’ then led to the ‘selling era’ in which the benefits and features were extolled and products being sold were frequently positioned with other attractions to make them seem more desirable. At that time, the classic car-selling techniques involved ‘positioning’, which sometimes meant photographing the car being sold very close to heavily made up models, some of whom were provocatively dressed. The implication for the target audience (generally the male of the species) was that if they bought the car they would become so much more attractive that they would also ‘get the girl’. Nothing could be further from the truth. What was being sold was ‘attractiveness’, ‘virility’ or other ephemeral aspirations. In any event, over time it became gradually clear that ‘selling’ reached a definite limit in effectiveness, particularly in the case of, for example, large gas guzzling cars which the would-be target consumers no longer appeared to want.

At that point, people began to question how much more effective ‘selling’ could be made as it became apparent that selling could not shift products that consumers really did not want. That realization lead to the ‘marketing era’ when, rather than having a lot of products that one was then having to try to sell, sensible marketers asked questions such as ‘what would the target consumers really want, value and/or desire?’. In the case of cars, it became clear that, at this time, this was often reliability, economy and a car that reflected their self image rather than larger, uneconomical or unreliable cars. This led to making smaller, more efficient or more luxurious, or aesthetically desirable, cars. These were often produced by foreign companies who had carried out serious and serial market research before developing products for different niches of the market based on this detailed information. In other words, they had taken a lot of time and
trouble to get the reliable information on what the consumer actually desired and valued. The manufacturers could therefore make customized products that consumers would actually purchase because that was what they (the consumers) wanted.

When one makes some analogies with dentistry, the ‘scarcity era’ was characterized by the provision of pain relief, often by ‘drillings and fillings’ or extractions, followed by removable or fixed prostheses. In some countries, or parts of countries, that is still the case.

The ‘production era’ would be characterized by group practices with multiple dentists, hygienists, therapists, technicians and dental educators of different genders, ages, colour and sometimes religions or ethnicity. Such practices often had multiple surgeries, in various areas, working a variety of different opening hours in order to maximize their ‘productivity’. Advertisements to provide, for example, sedation or different styles of dentistry, became more popular and were used to draw attention of would-be patients to the various available practice options.

More recently, many corporate practices seek to improve productivity in a variety of ways.

The ‘selling era’ would be characterized, for example, by bridges as an alternative to a removable prosthesis and the benefit that would be stressed in the selling process would usually be that it ‘was fixed’. What often would not be equally stressed that would be stressed in the selling benefit, particularly when one viewed this aggressive and destructive treatment as a concept, became more popular. Some dentists were (and some still are) dismayed when patients with multiple bridges, ‘full mouth rehabilitation’ or multiple veneers, or all-ceramic crowns. These were often ‘sold’ under the guise of providing a fully comprehensive ‘one size fits all’ approach to appearance, or occlusion. In other words, the justification for many of these aggressive, if possibly well meaning, full mouth rehabilitations was that it would provide ‘a perfect appearance’ or ‘a perfect occlusion’. This was in spite of the fact that there was scarcely any worthwhile evidence to suggest that the long-term structural and pulpal damage done to the teeth in providing such ‘full mouth rehabilitations’ would be adequately compensated for by a predictable improvement in function, or appearance, particularly when one viewed this aggressive and destructive treatment 30 or 40 years later. Cynics about ‘cosmetic dentistry’ might argue that amalgam factories have been replaced by ‘porcelain factories’.

Figure 11. Mirror view of failed lower right second molar ‘all-ceramic’ crown with consequential death of the tooth.

Figure 12. Gross destruction of the crown of the tooth to create space for a ceramic crown has removed between 63% and 72% of the tooth and killed it. This was not a ‘permanent’ crown as the patient had been promised.

Figure 13. A lower second molar is virtually invisible in most people. Losing most of the load-bearing structure is usually not a price worth paying for an ‘all-ceramic’ crown.

Figure 14. Yellow gold has preserved the buccal wall of the patient’s lower left first molar which had been root-filled. Gold may not be pretty but it is durable and a better biologic deal for a root-filled tooth. Patients need to know that before making their decision on which material is to be used for their problem.

not appear interested in having extensive and expensive dentistry which, from that particular dentist’s values, education and point of view, would improve the patient’s appearance and, possibly, his/her oral function. Much time and effort was sometimes spent in developing the ‘ideal treatment plan’, often involving extensive or complex expensive dentistry which was then carefully presented to the patient and often equally quickly rejected by him/her. Many discerning patients developed a cynicism about the dentist’s real motivations in suggesting so much dentistry as being good for them.

In marketing involving aesthetic dentistry, it is important that dentists find out early, and in great detail, precisely what changes, if any, the specific patient is really seeking to achieve in his/her dental or facial appearance. It is also essential that dentists understand that very many patients will not necessarily be as educated about the various negative aspects of having supposedly just ‘cosmetic’ dental treatment.
Dentists providing such ‘cosmetic’ dental services ought to be well aware of the negative aspects of any such treatment. For instance, full coverage crowns have been reported to be associated with pulpal death in up to 18% of cases, and sensitive ethical dentists should share that sort of relevant information, in an understandable way, with patients as part of the informed consent process. For instance, modern full coverage preparations for tooth-coloured, all-ceramic type restorations are at least as destructive of sound dental tissues as porcelain fused to metal full crowns. In many cases, preparation is even more destructive of sound tooth structure, eg for CAD CAM zirconia-based ceramic, as well as the restoration or residual tooth structure possibly being less durable or, at the very least, unproven, in proper long-term unbiased clinical trials (Figures 11–14).

What problems are there with marketing aesthetic services?

**Why marketing? Why now?**

Fluoride in toothpaste resulted in an up to 50% decline in tooth decay and, with improved cleaning, it became apparent to many dentists that they could not rely on their previous market of routine conservation, extractions and pain relief, even with cheap and often ‘suboptimal endodontics’. It was at that stage that developing a number of other products, or service lines, became more attractive. For instance, by that stage, acid-etching had been proven to improve the retention of composite to enamel. The re-introduction of porcelain veneers by Calamia and Horn, in 1983, following an idea of Pincus, in 1937, appeared to offer a technique which rapidly improved the appearance of teeth. This technique was reliable provided the preparations were kept within enamel. However, there is a limited market for veneers that can be placed wholly within enamel, and it became apparent, with the advent of supposedly more reliable dentine-bonding agents, that more aggressive preparations for porcelain veneers or dentine-bonded ceramic crowns might offer a possible solution for a larger number of patients, some of whom had more difficult, or more extensive, aesthetic problems.

**Ethical and technical problems with claims of efficacy**

Some of the claims for dentine-bonding agents, in their early stages of development, were based on laboratory tests on human dentine, or worse, dead cows’ dentine, at 24 hours, and were frankly outrageous and largely irrelevant. There is, for instance, no fluid movement in the dentine of dead cows’ teeth and most clinical dentists do not treat dead cows’ teeth. Dentine fluid movement in dead human teeth is equally rare but this obvious flaw in the laboratory model for testing ‘dentine bonding’ materials was, somewhat conveniently, forgotten.

In real life clinical practice, which involved trying to bond to wet dentine in humans, often with gingival crevicular fluid flow or salivary contamination in close attendance, the clinical results proved to be very disappointing. Adhesion to enamel was very predictable but, in the early stages of dentine-bonding agents, this was very much less so. This did not stop manufacturers continuing to make claims based on laboratory studies of adhesion to bovine teeth or dead human teeth specimens.

These bond strengths were often reported after 24 hours on dead cows’ teeth where there never was any possibility of fluid movement in the dentinal tubules. Many gullible dentists believed the claims of these manufacturers based on these largely irrelevant laboratory studies and consequently removed vast amounts of healthy enamel and dentine from their patients in order to deliver composite-retained porcelain veneers, or other even more destructive ceramic restorations, to their trusting patients.

In clinical practice it transpired that some pulps died or sometimes part, or all, of the restorations failed, to a greater or lesser extent, probably because of technical problems and because live human dentine is very different from the laboratory model of dead bovine or human dentine. Real human beings have an inconvenient and irritating propensity not to act like they should according to some laboratory experiment, or based on some fashionable, but idiotic, computer model.

This is not limited to dentistry. For instance, many countries in the world have been nearly bankrupted because some economists and idiotic, greedy or crooked bankers believed some financial computer modelling without ruthless analysis. While dentine-bonding agents have, indeed, improved recently, the ethical dilemma still facing most sensible and caring dentists in providing aesthetic dentistry for their patients is just how much sound tooth structure can I sensibly, or reasonably, remove here in order to place an extensive veneer or a dentine-bonded ceramic veneered crown?

Porcelain is brittle and the ‘preparation’ (a euphemism for ‘destruction’) of the sound tooth often has to be quite extensive to compensate for this brittleness. Enamel is only about 0.7 mm thick in the cervical region, and exposure of dentine high up near the necks of the teeth brings the preparations perilously close to pulp there. If that area is not temporized adequately between the time of preparation and the time of placement of the veneer, it is likely that there will be at least two problems. One is that, if the temporary restorations are not bonded adequately in the cervical region, then bacterial contamination will damage the vulnerable pulps by micro-leakage in that region going straight through to pulp. Alternatively, if the restorations are bonded there to stop contamination and the temporary restorations are over contoured, there will be difficulties in gaining a predictable bond for the porcelain restoration in the most critical area near the cervical margin. This is usually because of increased crevicular fluid or frank gingival blood contamination at the time of cementation. Furthermore, the material that is used for cementation of these brittle ceramic restorations is a poorly filled resin and the dentine bond, even if adequate initially, may well degrade over time, possibly due to ongoing activity by pulpal metalloproteinas.

In such a scenario the veneer is still, thereafter, likely to be held in position by the greater bond strength of the composite to the enamel, which would still be available further down towards the body and incisal part of the tooth, but the restoration may well leak in the cervical area at any point (Figure 15). In ethical marketing of any such restorations, patients who are, in effect, making a decision to trade their previous and non-renewable resource of enamel and dentine for ceramic-based restorations, need to be made very aware that they are
The patient needs to understand what is proposed together with the reasons and any *significant risks, side effects* associated with it in the longer term as well as understanding the various alternative treatment options.
Worryingly, the application of guidelines on preparations for the placement of veneers in the UK is poor. The guidelines for the provision of treatment with porcelain veneers involves following a strict clinical protocol involving special depth bur cuts, a high degree of precision in the preparations, a meticulous impression technique, a faultless temporization of the prepared teeth and considerable isolation and cementation skills. If some, or many, of these elements are missing in a particular case, it is likely that some harm to the patient will ensue in the longer term.

As previously noted, the first part of the Hippocratic Oath is ‘do no harm’. Elective removal of enamel and dentine is doing harm and can only be justified if there is a long-term, sustained benefit to the patient, preferably with good fallback positions. Ideally, patients should be no worse off at the end of treatment (if treatment does go wrong) because the treatment undertaken was elective. Further on in the Hippocratic Oath there is the statement that ‘extreme remedies should be reserved for extreme diseases’. From an ethical perspective it is highly questionable whether some mildly discoloured or slightly irregular teeth could be regarded as an extreme disease, but some ‘remedies’ involved can certainly be considered to be verging on the extreme (Box 3).

Porcelain veneers do certainly have a role, but only in the hands of highly trained, skilled, meticulous operators with flawless techniques and excellent technical support.

**Ethical considerations in extensive or ‘full mouth’ rehabilitation**

There are fashion changes and cultural differences in dentistry, particularly between the United States and Europe. Some high profile dentists in the United States in particular appear to have managed to convince their patients that what nature has provided for them in terms of the appearance, or function, of their teeth is a good starting point, but that ‘American Dentistry’ can improve on this. A brief review of the history of dentistry from that region will show that patients have often had extensive ‘equilibrations’ or full mouth rehabilitations, for example, TMJ problems or wear of teeth, and that this was based on nothing more dangerous than ‘an anterior slide’ or some ‘non-working side interferences’. Sadly, such apparently dangerous occlusal interferences are often still used by some, probably well meaning but unscientific dentists, as a justification for extensive interventions for patients with, for example, temporomandibular joint dysfunction or mild toothwear. At one end of the market in managing wear there are relatively simple devices, such as soft guards, Michigan splints or Tanner devices. Full coverage occlusal ‘splints’ are unlikely to do great harm, although the actual, or scientifically provable, relationships between occlusion and toothwear or temporomandibular joint dysfunction continue to remain controversial.

Variations on occlusal splint...
therapy, or at least detailed occlusal analysis and laboratory wax-up of models, are often included as part of the ‘aesthetic work-up’ when considering doing extensive veneers or all-ceramic restorations for supposedly ‘cosmetic’ reasons. This is, of course, a recognized view of a responsible body of dentists in treating aesthetic problems caused by wear but it is now a somewhat old fashioned approach, especially when one considers the amount of unnecessary destruction that it will involve for many of the relatively intact, innocent adjacent or unaffected teeth.

It is doubtful if patients would consent to such extensive all-ceramic or zirconia-based, or CAD CAM type crowns or porcelain fused-to-metal crowns if they knew that somewhere between 63% and 72% of the structure of their teeth was on the line and would be destroyed by the high speed drill in the preparation process for such multiple crowns (Box 4) (Figures 16 and 19).

Many patients would probably be even less enthused about extensive tooth destruction for full coverage ceramic restorations if they knew that one in five of the teeth would be likely to die as a result of such intervention (Figures 16–19).

Ethically, dentists have to warn patients what is really involved with the full mouth rehabilitation approach involving full, or nearly full, coverage ceramic veneered restorations undertaken for aesthetic reasons.

It is not sensible, not reasonable, not ethical and not professional to conceal from a patient the relevant and material negative aspects that are involved in his/her potentially dangerous treatment. In discussion about their options, the elective destruction of sound teeth, that is needed in order to provide the appearance change that the patient undoubtedly desires, should be emphasized. Potential patients need to be warned that such cosmetic treatment would often be less good for them, or their teeth, when viewed from a structural or long-term biologic point of view. No dentist should advertise in any form of communication in a false, misleading, deceptive or fraudulent manner that conveniently or deliberately omits the relevant negative aspects of elective ‘cosmetic’ treatment.

A lot of this advice in relationship to aesthetic dentistry sounds and perhaps looks negative, but it is stated in order for it to provide the balancing information that patients need. It is emphasized here because some of the highest claims against dentists are in relationship to elective, supposedly ‘cosmetic’ dentistry (Kevin Lewis, Dental Protection Ltd, 2011 – Personal communication acknowledged with thanks). The numbers of such claims, as well as their size, have increased dramatically in the last 5 years. Over 50 cases have been settled for in excess of £30,000 and two cases are currently reserved (expected to cost) £250,000 each.

Reading the market

Patients have different hopes and aspirations in the care they seek for their aesthetic dental problems. It is well known for instance that women spend approximately three times more on cosmetics than males, although that ratio may be changing, with ‘metro-sexuals’ becoming more interested in cosmetic and grooming products, and there is also increased awareness of appearance and ‘the fashion’ in younger people.

What have you to market?

There are a number of characteristics which normally affect the marketing of consumer services. These are:

- Tangibility;
say that patients purchase things they want or desire rather than things that ‘they need’. This can prove very frustrating to many old fashioned dentists who often have a different view of what the patient ‘needs’ as opposed to what the patient ‘wants’. Many such dentists feel that they have a real duty to protect patients from thinking of their teeth as a frivolous fashion accessory which some airhead patients seem to think should be available in spring or autumn versions!

The potential for ethical conflict in ‘cosmetic’ dentistry is considerable. Most of this sort of dentistry is best paid for out of discretionary, post tax, income rather than it being provided by third parties such as the National Health Service or other private dental schemes. Aesthetic or ‘cosmetic’ dentistry is often an optional service that can be postponed indefinitely. Such aesthetic services include elective veneers, bleaching and/or bonding, crown and bridgework, or adult orthodontics of various types, visibility and stability.

Market research – finding out what the patient wants, desires, or is in the market to receive

The De Bono Six Thinking Hats model

Successful marketing is based on gaining good quality information about the patient’s desires, feelings and wants, as well as his/her possible needs. Once reliable information has been obtained, it is possible to start identifying ways to help fulfil the patient’s aspirations, and satisfy those wants, desires or ‘perceived needs’, hopefully in a ‘win-win’ fashion. Market research in aesthetic dentistry involves systematically gathering, recording and analysing appropriate information about the patient and identifying possible solutions, while also being aware, ahead of time, of the potential problems with most of those possible solutions.

A useful model is the Six Thinking Hats one which has been proposed by Edward De Bono. In this model, six different-coloured hats are used. To think about the overall problem one mentally puts on a Blue hat first, in order to think about the sequence in which one is going to address the patient’s aesthetic and other possible problems and solutions.

A White hat is then mentally placed on one’s head to think about the

Facts. Relevant facts might include: ‘What is known about this particular patient?’ and importantly ‘What is not known about this patient?’ Thinking while wearing a White hat also focuses on what information is missing and how could one get that information. Is it testable? Is it provable? Is it reproducible? Is it a belief or a fact? Is it conjecture? At this stage, no emotion or judgement is involved. In applying this approach to aesthetic or ‘cosmetic’ dentistry, one would probably take a very detailed history of all aspects of the patient’s opinions and views, as well as taking the normal clinical histories and, where relevant, take accurate study models, photographs and appropriate radiographs.

Other useful relevant information would include the usual periodontal indices, a detailed history of any previous dental problems or interventions, and especially information about any other aesthetic treatments that have been received to any part of the body. These could include having a nose operation for appearance reasons, breast augmentation, tummy tuck, botox injections, or the use of various fillers around the face. These patients are sometimes referred to as ‘frequent flyers’. In other words, they are seeking to improve every physical aspect of the body that they can afford to, or wish to, change. The patient’s satisfaction with such interventions needs to be evaluated carefully. Any history of them being dissatisfied with any of the previous aesthetic interventions should start to ring loud alarm bells in any sensible dentist’s head.

In the De Bono Six Thinking Hats model, a Red hat is then exchanged for the White hat and this refers to the emotional aspects of the problems. The Red hat is all about how the patient feels about the problems and what his/her hopes, fears, aspiration, desires and wants really are. Considerate, gentle, but focused probing in this area is essential, as is ensuring that one is ‘fully present’ and utilizing careful listening skills. The old adage that ‘God gave us two eyes, two ears and one mouth to be used in that proportion’ is an apt one at this point. One has to listen very carefully to the words, phrases, emphasis and nuances, as well as watching for body language clues. It is probably sensible if the nurse writes down well as watching for body language clues. It is probably sensible if the nurse writes down well as watching for body language clues. It is probably sensible if the nurse writes down
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or phrases that have been used when addressing the patient in an 'interested' way shows that the dentist is 'actively listening' but, importantly, it often gets a patient to elaborate on what he/she really has on his/her agenda. It is important not to intervene with any challenges at this point but rather to let the patient express very openly and in detail how he/she feels about the whole problem. Acknowledgement and feedback that one is listening very carefully may help the patient to elaborate more fully, provided he/she is made to feel comfortable about disclosing this very personal information. The visual analogue scale described in the first of these articles can be very valuable to determine how the patient feels about 'self preservation' with 'self improvement' as opposed to 'self destruction'.

A patient’s self-esteem and proportionality are important parts of this exercise. Undue concern about a minor aesthetic problem should also put a dentist on notice that they may be dealing with somebody who may have body image issues, or at the extreme end, body dysmorphic disorder. Another important question is: ‘Why do they want the treatment?’ and, more importantly, ‘Why do they want it now?’ Gentle probing as to whose idea it is that they should seek treatment, and why now, is also important. Discreet enquires about his/her personal and social life can often be gained by allowing the patient enough time to talk and by using open questions ('Why? When? What? How? Where? Who?').

If dentists are not good at this aspect of the history-taking, they are often wise to get a chatty, intelligent, capable nurse or other person in the practice to spend significant time on this information-gathering exercise. However, the dentist cannot really delegate this process completely in case certain subtle aspects ‘get lost in translation’.

A finding at the beginning of aesthetic treatment is called ‘a diagnosis’ and a finding at the end of aesthetic treatment is called ‘an excuse’.

A Green hat is the next hat to be used in order to think about possible solutions that might be considered – not necessarily at the first visit but perhaps at a subsequent visit, when the study models, photographs, radiographs and history can be reviewed together with the patient to ensure that both sides have a clear understanding of the patient’s perceptions of his/her various aesthetic issues.

A Yellow hat is then used to refine and consider further any other, possibly better, solutions or ideas, or variations on these than those thrown up by the initial Green hat thinking. The real question is usually ‘Is there an even better way of doing this?’ Ideally, these further developments of ideas would be an improvement, a better variation, or a closer fit with the patient’s desires or aspirations.

A Black hat is then mentally donned in order to think about the negatives and dangers of each possible treatment, such as the ethical, legal, regulatory, reputational, financial, or other consequences that might be involved with the various different possible aesthetic treatments, especially if things happened to go wrong or the patient did not like the outcome at the end of treatment. ‘What would they be left with if it goes wrong later on?’, or ‘Is this possible situation going to be retrievable?’ are just two of the obvious questions that need to be addressed under Black hat thinking.

These hats can be used in various combinations, as appropriate, to help develop a sensible treatment plan with the patient’s full knowledge and consent in relationship to any proposed treatment.

Test questions are an important part of this such as: ‘Even if it goes very well, do you realize and accept that any cosmetic dentistry is not permanent and will need maintenance, attention and remarks from time to time?’ Far from putting patients off treatment, most sensible (not airhead) patients are pleased by this honesty, particularly if the dentist also draws attention to the ‘lack of permanence’ of top of the range cars, expensive clothes or expensive holidays, which are often the real competition for their discretionary spending power.

Promotion and marketing

In many patients presenting with what they perceive to be a cosmetic dental problem there is usually quite a wide range of possible treatments available to them. At one end of the spectrum of choices is ‘to do very little’ because there is very little sensible reason to interfere, or the prognosis for doing anything is so guarded that it is probably prudent not to make a bad situation worse. At the other end of the market are major interventions, such as multiple extractions, orthodontics, dentures, implant-retained crowns or bridges, implant-retained dentures, or orthognathic surgery.

Bleaching is at the conservative end of the range of possibilities and various ceramic full coverage crowns are at the more radical end. In the middle ground lies bleaching prior to composite bonding, orthodontic alignment of varying types and varying stability and, progressively (and more destructively), various preparations for porcelain veneers and dentine-bonded restorations made of varying materials, eg pressed ceramic, zirconia-based restorations or Procera.

Patients need to be aware of this treatment range and be helped to understand where they will most likely be able to gain a sensible solution to their dental appearance problems. When dentists are describing these products or services, or promoting them to the general public, or to individual patients, they need to be very aware that they are in the middle of a legislative, legal and regulatory minefield. Because cosmetic dentistry doesn’t have to be undertaken, patients seeking possible treatments are perhaps best considered as consumers of the ‘cosmetic products’. Consumers are very aware of what their rights are under various bits of consumer protection regulation.

Consumer (Patient) Protection – Legal issues in the marketing of aesthetic products or services

Consumer protection regulation is covered by the Unfair Trading Regulations which came into force in May 2008. This implemented the European Commission’s Unfair Commercial Practices Directive (UCPD). These regulations apply to dentists and other dental healthcare professionals. They have replaced most parts of the Trade Descriptions Act 1968 and the Consumer Protection Act of 1987.

The European Commercial Practices Directive bans any practice that is misleading, whether by an act of omission or an act of commission and which might cause, or would be likely to cause, the ‘average
consumer’ to take a different decision.

There is a separate definition of a ‘vulnerable consumer’ which describes vulnerability in terms of mental or physical infirmity, age (very young or elderly) and fragility.

‘Fragility’ means how gullible patients are likely to be and how easy it would be to take them in, or to deceive them. ‘Fragility’ in a vulnerable group is easy to exploit and some unethical dentists are proficient in taking advantage of this weakness. Gullible patients may readily believe anything a dentist tells them (eg ‘The Perfect Smile’), or be taken in by specific claims, or susceptible to be influenced by claims of a certain type. It is unethical to exploit such patients for commercial gain, or to play on their vanities, frailties, or personal emotional insecurities.

It is also wrong to make them fearful as to the supposed potential problems in the future if they do not have a particular treatment (‘if you don’t have the treatment you’ll struggle to get a job or lover, etc’).

In law a ‘misleading action’ occurs when a practice, or practitioner, misleads by virtue of the information he/she sends, explains, or provides in such a way that it causes the average consumer to make, in this context, a different cosmetic decision. Claims for some dentistry could be deemed to be misleading, particularly if the dentist making the statement to the patient has no reasonable results available that the material, or technique, being proposed or used has been well proven in relevant long-term, well-designed clinical trials, or that the dentist has other good experience, or scientific grounds, on which to base any such claims. This information needs to be much more robust than anything an enthusiastic representative for the cosmetic material company or a ‘hired gun’ lecturer may well proclaim to be ‘the evidence’ for that material or technique.

The Consumer Protection Act established the concept of ‘undue influence’. This is defined as: ‘Exploiting a position of power in relation to the consumer (patient) so as to apply pressure, even without using, or threatening to use, force, in a way which significantly limits the consumer’s ability to make an informed decision’. Many dentists would be considered to be in a ‘position of power’ and they ought to use that position of power ethically and wisely for the benefit of the patient, even if, in doing so, it doesn’t generate a financial profit to the dentist. In other words, if a patient in seeking an aesthetic dental improvement requests a dangerous, or inappropriate, treatment from a dentist, who ought to be in a position to advise the patient of the benefits and potential problems of that treatment/intervention, or any other practical treatments, and if the dentist then omits to tell the patient about these potentially negative aspects of the treatment, or the practical (but perhaps less lucrative for the dentist) options, they could be said to be abusing that ‘position of power’.

Regulation 6 refers to ‘misleading omissions’. In essence, this means causing a patient to make a different decision by failing to give him/her the relevant, appropriate, timely information that he/she needs to make an informed choice.

There is no ethical or legal excuse for omitting or hiding relevant information or providing it in an unclear, unintelligible, ambiguous or other inappropriate way. There is no such thing as a minor lapse in integrity.

Recent legislation (2008) about business protection from misleading marketing regulations has significant implications for aesthetic dentistry. This covers marketing and promotional activities, some of which are, or could be, designed to have patients referred to, or from, another health provider.

**Content of marketing or promotional material**

This is a multi-faceted and multi-layered problem. The conduct overall has to be considered when trying to determine whether the marketing has been deceptive, or misleading, by accident, or design. Dentists vary enormously in how they portray themselves and their practices. It is not infrequent now to see such words as ‘Perfect’, ‘Perfection’, ‘Outstanding’, ‘Excellent’, or ‘A1’ being used in a somewhat, or very, egotistical way by some dental practices, or practitioners. Such terms are sometimes used regardless of any proven justification for any such claims. Indeed, many dentists will look at other dentists’ promotional material, or their practice images as advertised, and their eyebrows will sometimes shoot up underneath their hairline as they realize that there is a fairly significant discrepancy between what is being portrayed to the patients (consumers) at large and what individual dental colleagues know about that particular dentist, his/her current practice ethos, his/her skills, training, education, or ethics.

In any event, it is dangerous to seek, or to follow slavishly, the advice from supposed ‘experts’ in the field of marketing and advertising, who may very well not be fully aware of the professional restrictions that apply to dentistry and may not be particularly aware of the tight regulatory framework in which dentists practice in an individual country.

Marketing or business ‘experts’ may have little practical understanding of the subtle differences between success and failure in ‘cosmetic dentistry’. They may not even be aware that it is the individual patient who is the sole judge as to the acceptability of an aesthetic outcome and that this will depend on his/her individual or idiosyncratic expectations, regardless of how realistic or ridiculous these may be.

Apart from bleaching, possibly coupled with minor direct composite bonding, many of the other areas of ‘cosmetic’ or aesthetic dentistry are irreversible in nature, especially those involving the placement of large ceramic restorations. In seeking to improve the appearance of a patient’s teeth with such procedures it is wise to remember the adage that ‘dentists are not selling knickers and bras to temporarily improve somebody’s attractiveness’.

What dentists do has a tendency to be irreversible or, at the very least, not readily reversible. Dentists who rely on marketing or advertising ‘experts’ to help them with the promotion of their products need to be fully cognisant of the variations in the regulatory framework of the country in which they practice. For instance, in Australia, recently introduced restrictions on advertising by dentists could only be described as ‘draconian’.

Dentists need to be aware of the fact that it is they, themselves, who carry all the responsibilities for any problems rather than these being the responsibility of the marketing or advertising ‘guru’ who led them into trouble with the regulator, or with the patient, or with the patient’s lawyers.

Any dentist seeking to expand by advertising in this potentially dangerous
market would be wise to consider getting the appropriate protection society or indemnifying organization to review the contents of any website or, as a sensible precaution, to get them to look at draft promotional or marketing literature well before they are finalized in order to save embarrassment. It is certainly wise to do this in advance of spending large sums of money in trying to promote aesthetic or ‘cosmetic’ services or products of any practice.

**Duty of care in ‘cosmetic’ dentistry**

It is often quite difficult to be absolutely precise about a dentist’s duties in providing ‘cosmetic dentistry’ because there is no absolute agreement among dentists, or probably among patients, as to what constitutes ‘ideal’ or ‘dental duty’ in relationship to ‘cosmetic’ dentistry. Damaging teeth to produce a supposedly ‘cosmetic improvement’ is still damage regardless of how many books or articles one reads on the subject, or how many lectures one attends on the ‘golden proportion’ or other tenets of the ‘cosmetic’ dentist’s faith.

Devotees of dental cosmetic ‘gurus’ often seem to believe glib statements from them as though they are provable facts rather than mere beliefs.

It is wise to remember the adage of Peter Drucker, a well known American management consultant, that ‘Americans prefer the word “guru” because they cannot spell the word “charlatan”’. In the ‘cosmetic dentistry’ field, opinions and beliefs are common but (provable) facts are rare.

**The advice of protection societies or indemnifying organizations**

Dental Protection Ltd (www.dentalprotection.org) has published practical tips (Riskwise37) in which dentists are strongly advised to review the content of the websites or any advertisements they wish to place. They are advised to review their practice information sheets and any other promotional literature that they routinely, or occasionally, make available to patients. General information in such practice leaflets may not apply at all, or only partially, to a particular patient. Care needs to be used when writing to an individual patient to outline possible, or agreed, treatment options. Extreme care needs to be taken in describing fairly the relative benefits of one type of treatment as compared to another. The information needs to be presented in a balanced, neutral way rather than giving the patient just the information about the treatment the dentist would like to provide, either because they like doing it, believe, feel or think that they are very talented or trained at doing it, or might, possibly, be financially influenced to do it.

**Marketing and competition amongst dentists**

It is not smart to ‘knock the opposition’. A dentist’s view about another dentist’s ‘cosmetic talent or skills’ should probably be best kept to him/herself. It is the patient’s view that is most important and ought to be sought and considered as ‘judge and jury’ on the matter. It is unwise to make comparisons between charges that one would make oneself for any ‘cosmetic’ treatment rather than charges a competing dentist might make. Any statements that can’t be substantiated in a court of law ought to be avoided.

**Promises about aesthetic improvement**

It is both sensible and prudent to be modest in the description of one’s aesthetic skills or talents before starting treatment and to ‘leave something in the margin for later’. By that it is meant that dentists should ‘under promise and over deliver’. If aesthetic treatment exceeds a patient’s expectations then both the patient and the dentist emerge as winners. If such treatment barely matches the patient’s expectations, that may be acceptable. However, if the aesthetic outcome falls below the patient’s expectations, even if that expectation is ridiculous or unrealistic, then the treatment will be considered to be a failure by the patient.

The patient may merely express disappointment to his/her spouse, partner, friends or relations, or the ‘bad moulding’ may travel beyond that. This is known as the 3/11ths rule. This means that, if a patient has a really good experience with the dental team and is happy with the aesthetic outcome he/she will tell three friends. If unhappy with the aesthetic outcome he/she will tell 11 friends. Such negative advertising by word of mouth about dentistry generally, but about cosmetic or aesthetic dentistry specifically, is a potential practice killer.

Conversely, if a patient is delighted with the dentist and his/her team because expectations have been exceeded, he/she will often become enthusiastic ambassadors for that practice, or just that dentist, who provided his/her perceived aesthetic benefits. Such satisfied patients are probably the best people to influence their friends or relations to seek care from that dentist, or practice, which has provided the treatment which they judge to be better, or maybe much better, than they were expecting.

In practical terms, dentists should set the aesthetic/cosmetic bar lower than they believe, or think, is achievable and get written agreement on this being the agreed standard well before starting any irreversible treatments.

A direct diagnostic build-up in composite on un-etched enamel in order to simulate what might be achieved allows the patient and/or any significant other person in his/her life enough time to assess the proposed changes. Much more importantly, it allows the treating dentist to evaluate the patient’s reaction to those proposed changes. Any negative ‘vibes’ at that stage of the ‘walking diagnostic composite bond-up’ should set alarm bells ringing in the dentist’s mind. It is sometimes sensible to get the patient to leave the surgery with this ‘walking diagnostic bond-up’ in position for a number of hours in order to give the patient and others enough time to evaluate this appearance change before the temporary (ie not bonded) composite falls off and returns them to their usual appearance (Figures 21–24).

**Dos and don’ts in the marketing of cosmetic dentistry**

It is prudent to avoid the use of ‘perfect’ or ‘excellent’. Other good words to avoid like the plague are ‘world class’, ‘centre of excellence’, ‘fantastic’, ‘brilliant’, ‘permanent’, ‘long-lasting’, ‘durable’ or
‘problem-free’. These are populist but subjective terms and very few, if any, of these words apply to dentistry and certainly not to ‘cosmetic’ dentistry. Don’t claim to have any experience, expertise or qualification that you don’t really possess or cannot prove in a court of law.

Don’t allow a patient’s unrealistic expectations go unchallenged. By this it is meant that, if a patient says ‘I hear you are brilliant at doing veneers’ a quiet nod or a modest shrug of the shoulders or, worse, a reply such as ‘Yes I am’ or ‘So you have heard’, allows the patient to get tacit agreement that they are going to get an excellent result. This is sometimes expected by a patient even when his/her problem is significantly more difficult to manage than the case of a friend or relation, on which he/she is basing that flattering, but very dangerous, statement.

Don’t make promises your hands can’t keep.

Do be very careful about not offering promises or guarantees of any form.

Don’t make the mistake of raising the bar of what the law reasonably expects of a competent dentist by giving further or additional undertakings that are likely to leave you exposed to a claim of breach of contract.13

Summary

Tempting as it might be to promote the practice, product, or dentist with self-indulgent phrases or praise in order to attract extra patients, this is a very dangerous game to play. Using words or images in order to persuade patients to accept treatment, or extra restorations, that may not be strictly necessary in order to improve the profitability of the practice is, in many cases, capable of being deemed as being unethical behaviour.

Any extra income gained in such circumstances has to be measured against the consequential loss of professional status and/or other, potentially more serious, risks. It is probably fair to say that aesthetic or ‘cosmetic’ dentistry provides more tests about ethical professional standards than many other forms of dentistry, especially when dentists are seeking to promote or expand their dental business, in particular in the current tough economic times.

Author’s note and acknowledgement

This article is largely based on Dental Protection Ltd modules 1 and 25 but applied to aesthetic dentistry with the author’s own perspectives. For fuller details go to www.dentalprotection.org

References

10. Unilever: www.unilever.com