

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann

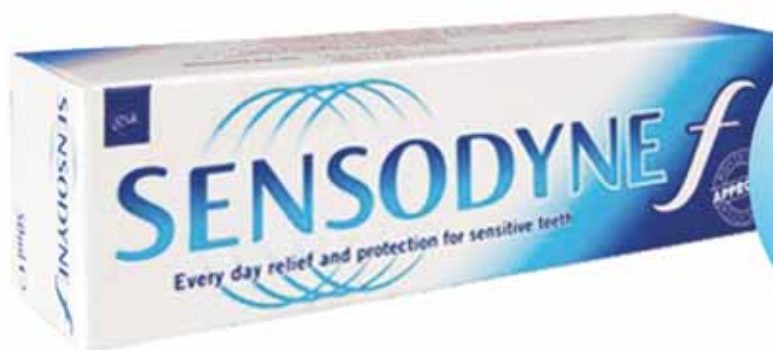
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Pearls of wisdom
Galway
 IDA Annual Conference May 13-15, 2010

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The forgotten profession

The Honorary Editor picks up on Dr Renehan's comments in her interview.

Easter is just past and we are all looking forward to some sunshine, despite the recent snow and rain. The same applies to a lot of the work we do. We all aim to provide the best oral healthcare we can with limited resources. We try to work positively but there is always a downpour threatened, like with the problems our patients are having with their medical cards (p68). Patients will not be able to attend, except to receive emergency treatments, and even that is at a cost both immediately and long term. Our medical card patients will suffer in the long term and our high(er) taxes will need to be used to fund what will be future expensive treatments. It is time for all of us to say No and re-direct monies from TDs' expenses, NAMA and now the Dockland Development Authority. The money wasted on tribunals, despite the good intentions of those involved, has made Ireland think about how it might handle these problems in the future.

Annual Conference

'Pearls of Wisdom' in Galway May, 13-15, 2010, is a ray of sunlight. What a great name. Dr Billy Davis, President Elect, is to be congratulated on this work and I look forward especially to the Dental Team Day on Friday May 14. I hope to see as many of you as possible there and please feel free to talk to me about the *Journal* and give me or any of the Editorial Board your opinion on what we can do to make things better.

Telemedicine/dentistry, distance learning, mentoring and small group teaching are the educational tools of the future. This is shown very well by the innovative collaboration between DDS&H and UCD School of Medicine in the delivery of its online dental radiography programme (p74) available to all in Ireland. Cork and the Dublin Dental School are collaborating in the same way in providing education material for our students – the dentists of the future. There is some great work being done on the provision of x-rays, moulds and photographs to allow clinicians to review and discuss patient care from different parts of the country almost as if they are in the same room. There are exciting times ahead.

The forgotten profession

The interview with Dr Jane Renehan (pp76-78) highlights the problems facing our public dental surgeons and I agree strongly with her statement: "Dentistry in Ireland has been very much the forgotten profession". Her desire for professional unity is paramount to any progress we might make. This needs to be across the Public Dental Service, general and specialist practice and our hospital-based services both in our schools and hospitals.

Essential ingredients

Our letters section (p67) highlights some important points and I leave you to consider the debate. The abstract section (p94) highlights important articles but particularly the issue of orthodontics in the older patient and bisphosphonate treatment.

Please read the very important articles on practice management and, in particular, our series from Dental Protection. Brian Edlin (pp96-98) stresses the importance of working with them, keeping communication channels open and more importantly the necessity for having indemnity. The Clinical Indemnity Scheme for those in the HSE is not enough, particularly in the present downturn, when everybody feels a little frustrated, over-worked in a litigious society. Ashley Latter gives practitioners some excellent advice on how to make things easier for us (pp98-99) with a simple six-point method of how to progress.

Peer reviewed

The peer reviewed section highlights two important areas – special care patients, and the demographics of implant placement and complications. These are the type of patients we all treat. Most special care patients can and should be treated in general practice. The problem is they take time, procedures take longer and the remuneration is poor. Their care will now become more difficult with the change in medical card treatment availability. Many clinicians do not take these patients on to the detriment of their practices and with a little education and support, the rewards far outweigh any disadvantages. The National Centre for Hereditary Coagulation Disorders has teamed up with a Special Needs Team in the School and created a means whereby many patients previously requiring hospital support can be treated in their local community by practitioners. This type of development is to be commended in our present resource-poor environment and the paper is a 'must read' to gain an understanding of this very important part of our oral health dental care.



Leo F. A. Stassen

Prof. Leo F. A. Stassen
Honorary Editor

The Atrium Clinic

The Vision

The Atrium Clinic was conceived by Sean McCarthy to provide World Class facilities in a referral practice for a number of disciplines. At present these include:

- Prostodontics
- Implant Dentistry
- Periodontology
- Orthodontics

After completing his Post Graduate studies in New Orleans, Sean had the opportunity to envisage what a high end referral practice should include. The Atrium Clinic is the result of that vision.

The Clinic is equipped with top quality dental and decontamination equipment, and the latest in Imaging equipment, the Gendex CB 500 Conical 3D Scanning machine, incorporating I-Cat technology.

The professional staff at the clinic includes:

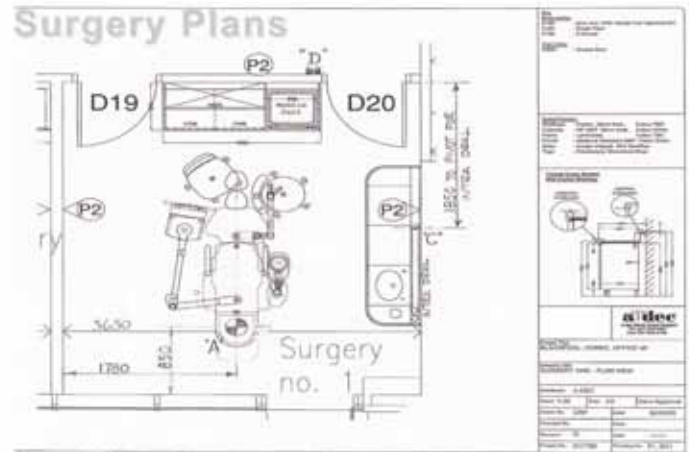
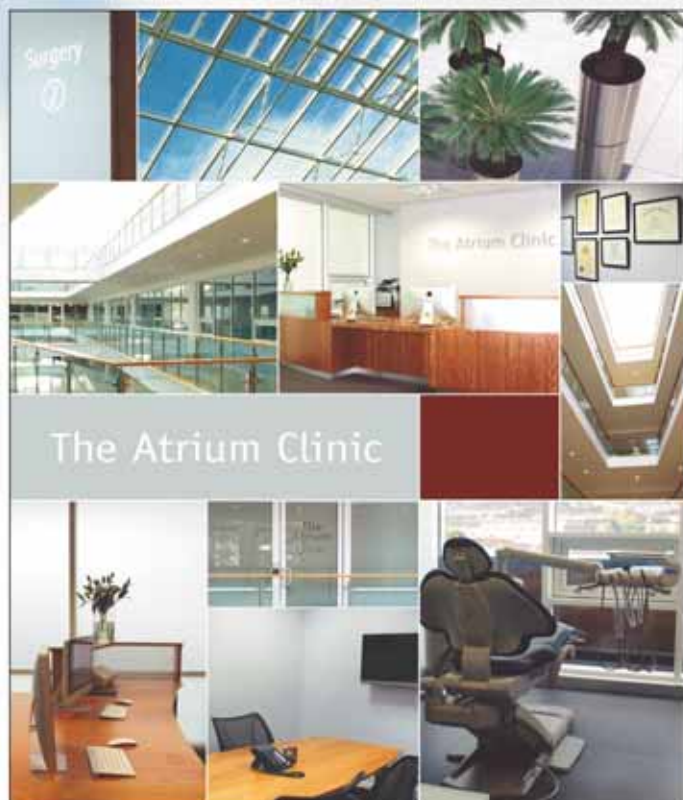
- Dr. Sean McCarthy
- Dr. Marie Brennan
- Dr. Traelach Tuohy
- Dr. Ciara O'Neill

For further information on The Atrium Clinic contact: Dr. Sean McCarthy, The Atrium Clinic, 021 439 9056, or reception@theatriumclinic.ie

The Project

Dental Medical Ireland (DMI) was approached by Dr. Sean McCarthy to bring his vision for the Atrium Clinic to fruition.

DMI'S team was lead by the Director of Equipment



Sales, Aidan McCormack. DMI were primarily responsible for the design and fit out of the following areas:

1. Dental Surgeries.
2. Local decontamination area.
3. Plant area, suction and compressed air.
4. Imaging, including the provision of a Conical Scanning unit

DMI worked closely with the Contractor, Derek Collins of IFS, J P McCarthy and Son, Electrical Contractor, and A-dec in designing the clinic.

The planning included a visit with Sean McCarthy to A-dec's European showroom near Heathrow Airport, organised by Charlie Cope, A-dec's Territory Manager for Ireland. A-Dec are the largest world manufacturer of Dental Surgery Equipment, and have considerable expertise in completing major projects. The showroom has over thirteen fully functional dental surgeries on display. DMI have been representing A-Dec in Ireland for nearly 30 years.

Once the designs were agreed, DMI, IFS, and JP McCarthy worked closely together to ensure the smooth running of the project to equipment installation and com-



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pletion. The design also included future proofing of the surgeries allowing for further equipment to be seamlessly added if required.

The completed clinic is testimony to Sean McCarthy's vision, and the technical and project management of DMI and IFS working together.

The surgeries are fitted with the A-dec 500 concept unit, with High End Clinical, Patient Comfort and Reliability features, providing benefits to both the operator and patient. The imaging equipment features the Gendex Intra Oral eXpert x-ray units, and the latest in Cone Beam Imaging, the Gendex CB 500, with I-Cat technology, providing scanned 3D images, which are invaluable for Implant planning and placement.

Dental Medical Ireland are a full service Dental Company, offering solutions to Dental Clinic design fit out, and ongoing support. They represent both A-dec and KaVo Gendex in Ireland, and are committed to long term relationships with their clients. Aidan McCormack said, "DMI are delighted to be involved with the successful completion of The Atrium Clinic, and that A-dec and GENDEX equipment were chosen for this prestigious Clinic."

IFS is a company committed to customer satisfaction, and are delighted to have been involved in the Atrium Clinic Project. Starting with an empty shell, IFS worked with Sean McCarthy and DMI to create the design and complete the project on time and to budget.

IFS has a proven record in the construction Industry, and has worked with many leading companies in all sectors. We believe in collaborating with our clients and design-



Aidan McCormack DMI; Derek Collins IFS;
Dr Sean McCarthy, Atrium Clinic;
Finbarr McCarthy, J P McCarthy and Sons

ers as members of a team, focused on the successful delivery of the project.

IFS is committed to helping their clients achieve competitive advantage through a flexible and innovative approach to design, construction and fit out. They take pride in exceeding customer expectations.

During the course of the project IFS & DMI forged a very close working relationship. Commenting on the successful project, Derek Collins said "I am delighted to have been involved with the success of the Atrium Clinic, and look forward to further projects with DMI."

J P McCarthy and Son, founded in 1951, was appointed Electrical Contractor to the project. McCarthys offer a complete solution from initial client concept, through design, to final fit out. They offer general electrical services, lighting and emergency lighting design, voice and data solutions, fire detection systems, and access and intruder alarm systems. They liaise with ESB Networks, Telecoms providers, and other external agencies on behalf of the client. Finbarr McCarthy said: "We were delighted to be involved in the Atrium Clinic project, and we wish Sean and all at the Clinic every success"

**For further information contact: Finbarr McCarthy
086 266 7147, info@jpmccarthyelectrical.ie**

The DMI & IFS Partnership

A major benefit of working on the project was the close relationship which developed between DMI and IFS, and this expertise is now available to work on other projects in Munster, and nationwide.

Commenting on the successful project, Sean McCarthy said "I am delighted with the Clinic and appreciate the professional and thorough input of DMI and A-dec in co-operation with Derek Collins of IFS, Finbarr McCarthy of J P McCarthy and Son and Joy Roncken Interiors in bringing the project to fruition. I have no hesitation in recommending them to colleagues."

**For further information contact either of the following: Aidan McCormack, 087 254 7675, or amccormack@dmie.ie or see www.dmie.ie
Derek Collins, 0868033464 or see info@ifsl.ie
www.ifsolutions.ie**

For further details contact DMI

PRESIDENT'S NEWS

Back to business

In his last President's News, DR DONAL BLACKWELL strikes a positive note.

Budget 2010 is now well and truly a reality, but the resilient dental profession is still working hard to meet the many challenges and difficulties that it brought. The winter is now (I hope!) at an end and we face into the longer spring days and hopefully a more positive outlook on the future of the dental profession in this country. We the dental profession continue our commitment to our patients and strive to create better dental healthcare for this nation, despite the constraints under which we operate.

The IDA kicked off the spring positively with the introduction of a range of various CPD (continuing professional development) courses aimed at all members of the dental team taking place throughout the country. These offer great opportunities to you and your staff to avail of expert training, education and development. I am particularly delighted to see so many non-clinical training courses taking place around the country, which are at discounted prices to IDA members.

IDA AGM

A request for motions and nominations to be brought to the Annual General Meeting will be sent to members shortly. I urge you all to give strong consideration to submitting a motion to the AGM. This year's AGM will take place at 5.00pm on Thursday May 13, at the Radisson Hotel, and you are urged to please attend this important meeting of the Association. It is imperative that members submit motions on issues that they would like to see discussed at the AGM. If an issue is not brought up as a motion to the AGM, then it cannot be discussed. This is an ideal opportunity for every member to have his/her say on how your Association works and is governed.

President's farewell

It is with regret that this is to be my last President's news as I step down from the role of President of the Association on May 13 next. I have enjoyed immensely my year as your President and I hope that I have represented you the members and indeed the dental profession in my Presidential role during 2009/2010. It has been a challenging but rewarding experience.

May I also take this opportunity to wish Billy Davis every success in the year ahead.

Finally, may I urge you all to attend what promises to be an outstanding Annual Conference and Annual General Meeting in Galway from May 12-15 next. See you there!

Donal Blackwell,
President





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Pearls of wisdom
Galway

IDA Annual Conference May 13-15, 2010

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The west's awake

The Association's Annual Conference is on in Galway in May. The Journal gets a taste of what delegates can expect.

The Radisson Hotel in Galway is host to this year's Annual Conference of the Irish Dental Association, which takes place from May 13-15. In addition to the Annual General Meeting of the Association, the Conference has a superb scientific programme, a top-class trade show, and great social activity. The organising committee has also ensured that there are interesting presentations for every member of the dental team. There is a change of scheduling this year. Apart from moving to May from its traditional April date, the Conference takes place from Thursday morning to Saturday night. In previous years, it took place from Wednesday morning to Saturday morning.

For those dentists who attend the full conference, they will have met their entire 2010 CPD requirement.

Pre-Conference presentations

The Pre-Conference Programme takes place on Thursday May 13. There is a choice of three full-day sessions, or two half-day sessions. Dr Howard Farren of Dentaltown fame offers a full-day practice management session headed 'The virtues of profitable dentistry'.

Dr Joseph Massad of Scottsdale, Arizona, is giving a full-day session on 'The ultimate impressioning experience for full dentures and implants'. Drs PJ Byrne, Anne O'Donoghue and Declan Corcoran are presenting a full-day programme on 'Crown lengthening – techniques for improving success in restorative and cosmetic dentistry'.

Delegates can also choose to take one of two half-day sessions on digital media from University of Toronto experts, Rita Bauer and Mike Beltrami. These are entitled: 'Capture the perfect makeover and prepare effective marketing and educational material for your practice'.

There are two presentations for dental nurses taking place in the Mutton Island Suite on Thursday afternoon. One is from Michael O'Connor entitled 'New technology use in dental practice', and the other is 'Recession busting tips for your practice' from Fiona O'Shaughnessy.

On Thursday evening at 5.00pm, the Association's AGM takes place in the Inis Mór Suite and there is a Dental Team Table Quiz in the Veranda Bar that night.

CONFERENCE COMMITTEE



Pat Cleary
Chairman



Dennis Daly



Elaine Hughes



Aislinn Machesney



Paul McEvoy



Paul Moore

IDA ANNUAL CONFERENCE



Dental Team Day

Friday is Dental Team Day with a series of presentations for all members of the dental team. These cover good communication, four-handed dentistry, cross-infection control, digital photography, emergency medicine, record-keeping, and growing a dental practice. The day is broken by a lunchtime meeting of IDA members that are GPs, and is topped off by the Trade Show party from 5.30pm until 7.00pm.

Latest products, equipment and technology at Trade Show

There is a superb trade show taking place over the full duration of the Conference. Thirty-eight companies covering every possible aspect of dentistry and oral healthcare are present and displaying their products and technology. The fees paid by the companies to exhibit make a significant contribution to cost of running the Conference and allow the Association to provide a higher level of Conference content than

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would otherwise be possible. As IDA President Billy Davis says: "The trade show will showcase new and advanced products, equipment and technology from the dental industry. All members of the dental team will have the opportunity to discuss new products and the various advances in products and services with our trade colleagues". See the list of exhibitors and trade show layout.

Something for everyone on Saturday

There are two parallel full-day programmes for dentists on the Saturday of the Conference. The lecture halls are beside each other and delegates can move between the two. There are also half-day programmes for hygienists and also for technicians.

Unusually, Programme 1 for dentists starts with an Open Forum on issues affecting recently-qualified practitioners. The remainder of Programme 1 and all of Programme 2 consists of presentations from experts on a myriad of topics. These range from radiography technique to local anaesthetics to endodontics to addictive behaviours. Also covered are intelligent aesthetics, soft tissue management, prosthodontics, implant overdentures and, from Spencer Woolfe, a presentation on 'The Good, the Bad and the Ugly – 30 years of implant experiences'.

Formal affair

The Conference concludes on Saturday night at the Annual President's Dinner. It commences with a drinks reception at 7.30pm and delegates are advised to book early. The dress code is black tie. Join in what is sure to be a very celebratory end to an excellent Conference.

CPR for CPD

Cardio-pulmonary resuscitation (CPR) is a mandatory requirement for continuing dental education. All registered delegates will have the opportunity to take part in a CPR course on Friday May 14 and Saturday May 15. Delegates must register for the courses on the days of the Conference. All members of the dental team are welcome.

President's Golf Competition



Galway Golf Club plays host to the President's Golf Competition on Wednesday May 12. Conference delegates, accompanying persons and all trade exhibitors are welcome to play. The tee is reserved from 2.30pm and play will be in three balls. Spaces must be booked in advance.

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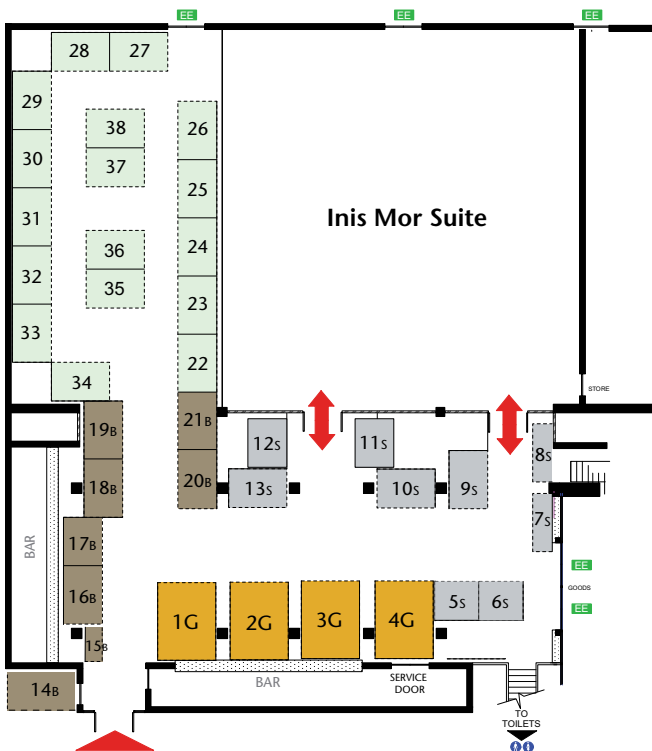


Table and poster presentations

The Dr Joe Moloney Award and the Tony Costello Memorial Medal will be awarded as usual based on the table and poster presentations that will take place at the Conference from 2.00pm to 5.00pm on the Friday of the Conference.



Pearls of wisdom
Galway

IDA Annual Conference May 13-15, 2010

IDA Annual Conference | 2010

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Dear Editor,

Howard Farran asks in the February/March 2010 edition of your journal (page 43) whether one should really be doing a root canal, build up and crown on an anterior incisor without a 3mm ferrule, or whether the tooth should be extracted.

The next line implies that the former treatment is "herodontics" and the patient will return within a year with the tooth in their hand. In the following paragraph he states that one has to treatment plan aggressively enough so that the treatment lasts five years.

A 2009 study in the *Journal of Dentistry* (Signore *et al*) followed up 526 maxillary endodontically treated anterior teeth for a mean of 5.3 years. Survival rates were 98.5% for glass fibre posts and 100% for dual-core composite cores underneath full ceramic crowns. Survival was higher for teeth with three or four coronal walls, compared to one or two, though nowhere is a 3mm complete ferrule mentioned as the difference between success and failure.

If restoring a tooth with nearly 5mm of supracrestal tooth structure is "herodontics", I wonder is extracting it "dim-plantology"?

Yours sincerely

Jarlath Loftus

Sydney, New South Wales, Australia

Dear Editor,

I am writing in relation to the quiz on page 11 of the February/March *Journal of the Irish Dental Association*. The quiz mentions several possible causes of the peri-implantitis affecting the upper central incisor. It omits, however, possibly the most important factor, which Carl Misch suggests is occlusal trauma.

The implant in this case has been placed deeply, which increases the vertical lever effect, as there is a larger crown root ratio (this is only significant if the crown is involved in lateral movements). There is also evidence of some parafunction with wear faceting on the lateral incisor and canines. This means that there is a large degree of force on the crestal bone of the implant. Over time, when bone loss occurs due to excessive force, the area will become colonised by bacteria, which will need treatment as suggested by the author. Without appropriate occlusal adjustment and possibly nightguard fabrication, the condition is likely to return with additional bone loss over time. Once the initial bone loss has occurred there is now a larger vertical lever effect present, which will accelerate the bone loss.

An alternative treatment, which Hilt Tatum would propose, would be to perform a vascularised osteotomy where the implant and the bone are moved coronally. This would reduce the crown height and lever aspect to the case as well as providing better access to hygiene (clearly the procedure outlined in the article would also be needed).

All general dentists should be aware of the occlusal adjustments that implants may need over time. Unlike teeth, implants are more susceptible to bone loss from occlusal trauma and occlusion should be checked with marking paper and shimstock at all check-up appointments.

Yours sincerely,


Dr Edmond O'Flaherty

Seapoint Clinic, 23 Seapoint Avenue, Blackrock, Co. Dublin

QUIZ

Submitted by Carmen Sheridan, Dental Nurse Tutor, Dublin Dental School and Hospital.

Question

1. What does the following symbol indicate? 
2. Which of the following medical devices would display this symbol on their packaging?
 - Steel burs
 - Matrix bands
 - Endodontic files and reamers
 - Bristle brushes
 - Impression trays
3. Who bears the responsibility and liability for the reprocessing and subsequent use of a single-use item?

Answers on page 101



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IDA NEWS

IDA warns of half a million fewer treatments for medical card holders



Pictured at the press briefing are (from left): Dr John Nolan, IDA General Practitioner Committee; Fintan Hourihan, IDA CEO; and, Dr Jane Renehan, President, IDA Public Dental Surgeon's Group.



Pictured speaking at the briefing is Dr James Turner, a member of the IDA's General Practitioner Committee.

The Irish Dental Association (IDA) has warned that new cutbacks in the dental scheme for medical card holders will lead to hundreds of thousands of patients being denied vital dental treatments.

At a press briefing in Dublin, which attracted considerable media coverage, the IDA said that all medical card holders, including the over 70s, children and patients with special needs, will be affected by the cuts. New figures show that a 30% reduction in the number of treatments means there will be a total reduction of over 468,000 treatments.

IDA Chief Executive Fintan Hourihan said that if the HSE proceeds with these cutbacks next month, the dental health of the nation will be set back by decades.

"As it is the system is barely limping along. These new cuts are akin to the introduction of rationing. Not for the first time the most vulnerable in our society will suffer most and these measures will widen the divide between the less well off and those who can afford to be treated privately."

According to the IDA there has been an increase of 138,000 medical card holders in the last two years, while this year 144,000 more people will join the scheme. The IDA believes it is grossly irresponsible of the HSE to cut spending back to 2008 levels with hundreds of thousands more people now holding medical cards, and argues that spending should be increased by €30m to €100m to cope with the increased demands on the system.

Hourihan says dentists will be placed in impossible situations in the coming months. "Fillings and root canal treatment will only be allowed in 'approved emergency circumstances'. Who is going to make that call? The HSE says dentures will be prioritised based on need, but again the criteria are not stated. This is a recipe for disaster and there is no way that hospitals and HSE clinics will be able to deal with the extra demands placed on them."

The IDA is calling on the Minister and the HSE to examine all alternative means of limiting the impact of these cuts, including agreeing supplementary funding, using the National Treatment Purchase Fund and prioritising the spending on the medical card scheme within the wider dental budget.

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AIDI certificate provides industry standard

The Association of the Irish Dental Industry (AIDI) has announced that it is running the AIDI Training Certificate: Introduction to Dentistry, in conjunction with the British Dental Trade Association (BDTA). The course will enable the Association to have its own industry standard in Ireland.

The Training Certificate is a course designed by the BDTA to raise the level of understanding and give an appreciation of the work of the whole dental team. It has ten modules providing a basic understanding of dentistry, and is designed for those new to dentistry and those who supply and provide a service to the dental industry. The course can be taken online, with support seminars for participants taking place in the offices of Henry Schein Ireland in Dublin. The course consists of 10 modules:

- 1 **Welcome to dentistry:** The structure and organisation of the dental profession and the services it provides.
- 2 **Oral and dental anatomy and physiology and dental charting:**



The basic underpinning knowledge of dental anatomy, physiology, terminology and dental charting.

- 3 **Oral health and disease:** The most common oral diseases and conditions, and methods of prevention.
- 4 **Diagnosis and radiography:** The processes of a dental examination and the equipment used in dental radiography.
- 5 **Restorative dentistry:** The techniques and materials that are used routinely in restorative dentistry.
- 6 **Dental technology:** Topics that depend on the close co-operation between the dentist and the dental technician.
- 7 **Laboratory procedures:** Laboratory procedures, including an insight into the work of the dental technician.
- 8 **The dental environment and dental equipment:** The basic concepts of the dental environment and surgery design, and the functions of items of dental equipment.
- 9 **Infection control in dentistry:** The rigorous standards and procedures that must be implemented and adopted to minimise or eliminate cross-infection.
- 10 **Minor oral surgery, anaesthesia and sedation:** The various minor oral surgical procedures that may be performed in either a general dental practice or hospital oral surgery department.

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IDA NEWS

Building the compleat dentist

Members of the Metropolitan Branch of the Irish Dental Association met on Friday, February 26, for their Annual Scientific Meeting. Welcoming delegates to the D4 Jury's Hotel in Ballsbridge, Branch President Dr Lynda Elliott introduced the theme of the meeting, 'The Compleat Dentist', and speakers covered a wide range of clinical and management-focused topics.

Dr Rory Maguire discussed the mechanism and management of periodontal disease, and presented a number of papers demonstrating the evidence base for treatment and prevention. In particular, he emphasised the importance of patient compliance, and the need for strict criteria for maintenance by patient and periodontist.

Dr Abigail Moore gave a comprehensive presentation on the importance of behaviour management techniques in treating children. Many factors can affect a child's attitude to treatment, and Dr Moore described a range of techniques from ensuring a friendly and non-threatening atmosphere in the surgery, to verbal and non-verbal communication techniques and voice control.

In a presentation on aesthetic considerations in prosthodontics, Dr Tom Canning talked about patient expectations, and discussed the importance of ensuring gingival and periodontal health before beginning work on aesthetics. He presented a number of cases to illustrate different aspects of aesthetic restorations, including balancing gingival levels and monitoring light transmission to achieve excellent results.



Pictured with Metro Branch President Dr Lynda Elliott were (from left): Speakers Fintan Hourihan, IDA CEO; Dr Elliott; Dr Tom Canning; Dr Anne O'Donoghue; Dr Abigail Moore; and, Dr Rory Maguire.

Dr Anne O'Donoghue and IDA CEO Fintan Hourihan both addressed the subject of dental tourism. Dr O'Donoghue talked about the perceived threat to business from patients going abroad or to Northern Ireland, and asked whether dentists can turn this new environment into an opportunity by addressing patient misconceptions and demonstrating the excellent patient care that Irish dentists provide.

Fintan Hourihan discussed forthcoming EU guidelines for patients who are considering going abroad for treatment, and said that the answer to dental tourism and consumerism is quality dental care. He spoke about the challenges that face the IDA, and the Association's plans to deal with these, including the need to engage members, whether on committee



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Trade exhibitors at the Annual Scientific Meeting, pictured with the President of the Metropolitan Branch, Dr Lynda Elliott. Front row, from left: Catherine Smith, Glennons; Althea Ellis, Henry Schein; Nuala Beecher, GlaxoSmithKline; Dr Elliott; Berty O'Neill, DP Medical; and, Suzanne Haveron, McDowell & Service. Back row, from left: Niall Tynan, Glennons; James Way, Henry Schein; Dave Greham, 3M; Tommy Maguire, Kerr; Stephen Ginn, McDowell & Service; Jonathan Savage, Optident; Úna Lannon, Biomet 3i; Niall Mac Canna, Bank of Ireland; and, Lisa Phelan, Bank of Ireland.

work, or in speaking about dentistry to local media. He emphasised that the Association is monitoring the situation with regard to dental insurance closely.

Other presentations on the day focused on marketing and financial management, and afternoon workshops offered practical education for

delegates. There was also an excellent trade show, which members could visit to see the latest clinical and financial products on offer.



From left: Drs Fergus Somers; Norma Kelleher; Bryan Duggan; and, Ray McCarthy.



From left: Drs Rachel O'Connor; John Bowe; and, Aoiheann Wall.

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BUSINESS NEWS

Nobel Biocare presents new and promising clinical results

Nobel Biocare has presented latest clinical data documenting the efficacy of several of its main products: NobelActive, All-on-4 and TiUnite.

High survival rates and bone gain

The new NobelActive implant system allows clinicians to expand treatments to more clinical indications. Ongoing NobelActive studies (18 centres, 119 patients, 177 implants) demonstrate high cumulative survival rates (CSR) of 96.6-98.3%, stable bone levels, and favourable soft tissue parameters after one year when subjected to immediate function under various clinical conditions. Preliminary two-year results from one five-year study continued to show very favorable trends during the second year: no soft tissue recession, stable papilla and stable bone level, with more than 60% of recorded NobelActive implants showing bone gain from one to two years. [Submitted to International Association for Dental Research Annual Meeting, Barcelona, 2010.]

Five-year follow-up data on efficacy

Nobel Biocare states that All-on-4 is an evidence-based, predictable and cost-effective solution for full-arch restorations immediately loaded on four implants. A clinical follow-up study (up to five-year results) demonstrates cumulative survival rates of 98.36 and 99.73% in both edentulous maxillae and mandibles. Results showed favourable marginal bone remodelling ($0.9 \pm 0.7\text{mm}$ in the maxilla – 204 implants, 51 patients; and, $1.2 \pm 0.9\text{mm}$ in the mandible – 292 implants, 73 patients) measured from time of prosthetic insertion and soft tissue parameters. [Aglardi E, Panigatti S, Clerico M, Villa C, Malo P. Immediate rehabilitation of the

edentulous jaws with full fixed prosthesis supported by four implants: interim results of a single cohort prospective study. *Clin Oral Implants Res 2010*(e-pub ahead of print).]

Excellent results in demanding clinical situations

TiUnite is Nobel Biocare's patented implant surface. It is in clinical use for more than 10 years and, according to the company, is the most documented modern implant surface on the market with up to 10 years of clinical data. Nobel Biocare states that the surface has a proven advantage of increasing the speed at which implants osseointegrate and thereby reduces the risk of early implant failure. A recently published ongoing five-year study now demonstrates that TiUnite also performs very successfully long-term. A five-year, cross-sectional, retrospective, follow-up study conducted by the Brånemark Clinic in Gothenburg, Sweden, demonstrated that TiUnite – placed in demanding indications – performed equally well compared to machined surface implants, which are the reference when it comes to long-term (>35 years) success rates. Cumulative survival rates for the two implant surfaces were favourable at five years (97.1-99.1%), and the marginal bone loss was low and similar for both implant surfaces. [Friberg B and Jemt T. Clinical experience of TiUnite implants: a 5-year cross-sectional, retrospective follow-up study. *Clin Implant Dent Relat Res 2009* (e-pub ahead of print).]



Nobel Biocare adhering to very demanding study protocols

According to Nobel Biocare, a literature-based review of prevailing clinical study protocols and radiographic baseline setting documented substantial differences between three major implant manufacturers (Nobel Biocare, Straumann and Astra Tech).

Clinical studies can differ in terms of surgical protocol, timing of (provisional) prosthetic delivery and outcome assessment, which can all have an influence on the reported results. Surgery can be accomplished using a one-stage surgical approach, with access to the implant head during the healing period. Alternatively, a two-stage procedure can be used, with the implant submerged beneath the soft tissue during the healing period, and later exposed in order to attach the soft tissue penetrating part of the prosthesis.

Similarly, the prosthetic restoration can be installed at various time points, commonly described as immediate loading (within 48 hours), early loading (after 48 hours and up to three months) or delayed loading (three months and later).

To measure how bone responds to implant insertion and subsequent function, x-rays are taken and the bone level change measured with the first x-ray as reference, also called the radiographic baseline. Since the majority of bone response typically occurs during the first months after surgery, different time points for the baseline readings will influence the published bone remodelling result.

The research screened 10,560 peer-reviewed clinical articles listed in MEDLINE, published from January 1995 to July 2009. Of these, 37 Astra Tech (1,230 patients, 3,402 implants), 49 Nobel Biocare (1,987 patients, 5,356 implants) and 34 Straumann (1,540 patients, 2,894 implants) articles met the inclusion criteria.

The review showed that Nobel Biocare study groups used the highest percentage of one-stage protocols (84%), the highest share (45%) of immediate loading approach and begin measuring marginal bone remodelling most frequently (79%) at implant insertion.

According to Nobel Biocare, these results demonstrate that it uses very demanding study protocols and is very transparent in its reporting of bone remodelling.

Websites for dentists



The first of several websites that are in preparation for members of the IDA has gone live. It is www.waterforddentist.ie, which showcases the Durands Court Dental Practice run by Dr Maurice O'Brien. Several other websites for IDA members are very close to completion and are expected to go live shortly.

Members of the IDA can have a website for their practice at a cost of just €450 plus VAT by contacting Think Media, publishers of the Journal.

Techceram's ACE Lab Group

Five laboratories based in Northern Ireland are among the 80 members of Techceram Ltd's ACE Group of Laboratories. According to the company, each is dedicated to delivering ultimate aesthetic restorations to dentists and patients through their commitment to their "All-Ceramic Excellence" concept:

- Totten & Connolly Dental Laboratory, Bangor;
- Gordon Watters Dental Laboratory Ltd, Belfast;
- The Dental Studio, Bangor;
- Bright Dental Ceramics; and,
- Dundee Dental Laboratory, Newtownabbey.

The All-Ceramic Excellence (ACE) Concept is a patient-centred "quality controlled network loop", which promotes maintenance of and continuous improvement in quality, by means of Techceram's unique quality feedback card system. It also promotes teamwork between the practice, ACE Dental Laboratory and substructure manufacturer (TTC - Techceram's in-house dental laboratory), enabling patients to receive a five-year guarantee, conditional on the clinician following the recommended clinical procedure and returning Techceram's Quality Feedback Cards.

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NEWS FEATURE

The implementation of an online dental radiography programme

CARMEN SHERIDAN describes this programme, which was recently re-introduced.



The Dublin Dental School, in association with the Diagnostic Imaging Department in UCD School of Medicine and Medical Science, has re-established the dental radiography programme for dental auxiliaries. The programme delivery method has been shifted from the traditional face-to-face programme to a blended learning environment, which incorporates information and communication technologies along with face-to-face learning. This combination allows the programme to be available to all employed, qualified dental nurses and dental hygienists who are registered with the Dental Council, in any geographical location. The previous programme required students to attend the Dental Hospital on specific sessions during the working week for training; the new platform introduces the flexibility of studying 'anywhere and anytime'. Students are required to attend a technique training session in the Dental Hospital during their time of study.

The 29-week pilot programme commenced in January 2010. Upon completion of the pilot, the programme will run with a biannual intake of students, with programmes commencing in January and August of each year. Upon successful completion of the programme the students will be awarded a Certificate in Dental Radiography, awarded by the Dublin Dental Hospital and approved for registration with the Dental Council.

Quality assurance

The programme was designed to meet the needs of the practising dental



Dental radiology programme pilot group. Back row (from left): Aneta Wisniewska; Grace Walsh; Mairead Finnegan; Claire McNally; Marie Brennan; Jacinta Sutton; Nadine Cummins; Kim Behan; and, Pamela Edghill. Front row (from left): Lucyna Wollinska; Geraldine Ormsby; Martina Holden; Katrina Stafford; Samantha Devitt; Eugenie Mullarkey; Aisling Connolly; and, Resalatus Salam.

professional while ensuring quality of design and execution. The programme design utilises the expertise of the dental practitioner to support the student in the completion of a 'Record of Experience'. Acknowledging the importance of consultation and standardisation in practice, the development of the Record of Experience evolved from consultation with various stakeholders, including: general dental practitioners; specialist dental practitioners; staff from the Dublin Dental School and Hospital; and, staff in the Diagnostic Imaging Department in UCD, and the Record of Experience incorporates similar criteria to those set out by the Clinical Audit in Dental Radiology 2009, published by the Irish Dental Association.

At the completion of the programme successful candidates will have demonstrated proficiency in the technical skills necessary to produce intra (periapical, bite-wing and occlusal) and extra (panoramic and cephalometric) oral dental radiographs to an acceptable diagnostic quality. Training also encompasses cross-infection control practices, analysis and critique of exposed radiographs, and safe practice in dental radiography in accordance with national and European legislation. Practical and theoretical knowledge are assessed through formative and summative examination procedures, some of which are executed online. The Dublin Dental School recognises the importance and benefit of a team approach to continued professional development, and has extended an invitation for the practitioners to be involved in the practical training session.

A commitment to continued professional development is one of the key avenues to ensure that the dental team is equipped with the skills and knowledge to carry out their duties efficiently and safely. The Dental Radiography programme is a welcome initiative in response to the need for the dental profession to give professionals the skills needed to provide a safe, efficient service to the public.

For more information on this programme, please contact the nursing administrator at 01-612 7315, or dentalnursestutor@dental.tcd.ie.

Carmen Sheridan CDA RDN Dip Ad Ed MA is a dental nurse tutor in the Dublin Dental School and Hospital. She is a trained level II Dental Assistant with expanded duties, and qualified in Alberta, Canada.



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INTERVIEW

A dedicated public dental surgeon

ANN-MARIE HARDIMAN spoke to Dr Jane Renehan, President of the Public Dental Surgeons Group of the Irish Dental Association, about public health, cutbacks and professional unity.



On the day I speak to Dr Jane Renehan, she is addressing the Irish media at an IDA press briefing on proposed draconian cuts to the medical card scheme. In these troubled economic times, getting the message out about the importance of maintaining the public dental service is a vital part of her role as President of the IDA's PDS Group,

and as Principal Dental Surgeon in Dublin North West. It's a role that suits her well as, 30 years after qualifying from Trinity College Dublin, she remains passionate about public dentistry.

"I've always worked in Ireland, and always in the public sector. It's something intrinsic in me. I wanted to work with people who

were not getting dentistry, who couldn't afford dentistry, and improve their health."

Jane worked in Kildare, and then for eight years in Donegal, which was a formative experience in terms of her beliefs about service delivery. "There was very little dentistry in Donegal, although there was a lot of money from European funding. I saw that money wasn't the whole answer. You needed to get out to people with outreach programmes to promote health. This brought down the barriers and made dentistry accessible."

Jane returned to Dublin to work with the then Eastern Health Board, spent five years in the Dublin Dental Hospital as full-time lecturer in Public Dental Health and, in 1998, she was promoted to the role of Principal Dental Surgeon in Dublin North West. She brought the lessons she had learned in Donegal to her new role: "I don't wait for the patients to come into us in the health centre. I promote, whether it's sending staff out into crèches, schools or nursing homes and being involved in general nurse and teacher training, or getting involved at policy level".

She feels that this is important to facilitate the recognition of dentistry in the whole healthcare structure.

"Dentistry in Ireland has been very much the forgotten profession. It's not in the 'acute' service, or included in the Primary Care Team. Dentistry impacts on most people in society, but for all that impact, it gets forgotten in the planning."

"A lot of it is down to how well we've been doing our job. As professionals we've been very dedicated, but we haven't been good at advocating for our patients or for our profession."

For Jane, advocating includes emphasising the successes of the public scheme. "The medical card scheme is a success, [as is] the move over the last decade in the HSE public dental service towards the specialised treatment we provide to under 16s, people with special needs and vulnerable adults. It works if it's resourced, and if we're allowed to get on with what we do. And we've provided extremely good value for money."

A varied role

Jane's role as Principal Dental Surgeon has three main components. The first is the day-to-day running of services, ensuring that surgeries

are functioning properly and that staff training and best practice takes place, monitoring budgets, etc. The second major component of the job is managing the medical card scheme, which includes personally signing off on every D-approval form that arrives on her desk. Jane sees her role very much as a facilitator for patients and contracted dentists. "It's about making the scheme run smoothly for the patients, and for private dentists. It's very important that we have good communication, that they understand the pressures I'm working under and I understand the huge pressures they're working under."

The final aspect of Jane's role is the strategic 'lead role' assigned to each Principal Dental Surgeon. Jane's role encompasses health and safety, radiation safety and risk management, and she regularly meets with colleagues to try to form national policy and keep abreast of the latest issues. Indeed, Jane is the only dentist on the National Radiation Safety Committee.

Jane concentrates on management and administration rather than clinical work, with an excellent local team supporting her in clinical supervision and patient care. The management role is one she's very comfortable with, and she feels it is vital to focus on those tasks that will maintain services, especially in difficult times. "As a clinical manager my energy must go to maintaining what I have built. You mustn't lose anything so that when the good times come you can build on that. I take my responsibilities very seriously – I'm accountable."

Hard times

The current economic crisis has affected different regions in different ways, and Jane is very aware of the difficulties faced by colleagues around the country. "There are black spots in the country as a result of the moratorium [on recruitment], so some parts of the country are down to emergency care only. It's often driven by the overall local HSE budget. If cuts need to be made in a local health office, they're often right across the board no matter how good services are or how demands on services are increasing. So many of my colleagues are in situations where they have almost no dentists, or if people go on maternity leave they are not covered, and if someone retires they're not replaced. And that has a direct impact on services."

A fantastic team

Jane is full of praise for her colleagues in the PDS Group. "Rosari McCafferty has been a wonderful example. She put such energy into what she was doing – no task was too big or too small. I admired her commitment and enthusiasm and the way she brought younger members of the profession in. I wanted to carry on her legacy. My own President-Elect is Andrew Bolas from Sligo. He's young, keen and enthusiastic and will bring his own dimension to the role."

"It's been a presidency of three. I make very few decisions on my own. Also, the committee has been excellent, a mixed group of people who have a lot of experience in public sector dentistry and younger recruits to the service. We have to foster those younger people coming along – succession planning is very important."

Group Secretary Carmel Parnell also comes in for praise. "Carmel is unique in public health dentistry, in the breadth of understanding that she has not just of clinical dentistry, but of research and academia. I feel very honoured to be working with this team."

All of this work is, of course, facilitated by the excellent team at IDA House, in particular CEO Fintan Hourihan. Indeed, the knowledge that she would have this level of support was influential in her decision to take on the role of PDS President. "You cannot underestimate what Fintan and his team are doing for dentistry. I knew that I would learn a lot, that it would be an interesting time and a very positive place to be, and it has proven to be even more than that."

INTERVIEW

Life outside work

It's hard to imagine that Jane could have much free time, but she manages to fit in a range of interests. She is married to Derek, who also works for the HSE in a management role. "This presidency couldn't have happened without his understanding, the support he has given me and his insight." As Jane is originally from Kilkenny, marriage to a Wexford man makes for some interesting hurling conversations! They spend every weekend in their Wexford home,

which they've been renovating for some years, and also share an interest in fine wine, especially burgundys. Jane loves to read, especially contemporary literature, and she also supports her elderly parents as much as possible.

A lot of Saturdays have been taken up with IDA business this year, which has taken her away from Wexford, but she is happy to give up her time: "It's for the greater good!"

"In 1999 there was a recommendation that there should be 350 public health dentists. It's very hard to get an accurate figure on how many there are, but we think there are a little over 200 at the moment. Since 1999 there has been a huge increase in demand for our service, so the moratorium has put public sector dentistry backwards in many parts of the country."

President

Jane considered all of these issues when she decided to accept the role of President of the PDS Group. "I knew that 2009 and 2010 were going to be very difficult years. I was conscious of the overall economic environment in the country and the impact that was going to have on both public and private dentistry. I knew that whoever went in as President was going to have a large job, not just profiling public dentistry but working with our private practice colleagues to find a way forward. That is very important because I believe as a profession we have to be cohesive and united; if we don't understand one another's issues and the tensions we're working under, we'll never advocate properly for this very small profession."

The lack of a senior dentist in the HSE is a source of ongoing frustration, but some development is finally taking place. At the PDS Seminar in Wexford last year, Laverne McGuinness of the HSE announced a plan to appoint a clinical director for oral health. The role should be filled on an interim basis shortly, with a longer-term appointment to follow. "That has been our first major success. But we've got to keep pushing and make sure the office is well funded, well structured and well resourced. And we must now look to the Minister and ensure that she recognises the need for a Chief Dental Officer representing us at a national and European policy level."

The other issue affecting her Presidency is the range of new demands on all healthcare professionals, including the introduction of radiation audit, the advent of inspections by HIOA and mandatory continuing professional development. Jane is full of praise for the proactive manner in which the IDA is responding to these issues. She also feels that the Association's proposed strategy, which is currently under development, is a tremendously positive step. "The Association is putting together a strategic plan and setting targets and goals that will be adaptable to the changing environment. We must be proactive and the strategy will allow us to do that."

At the moment, cuts rather than increases in funding seem more likely, but Jane argues persuasively for a positive outlook on the

situation. "A lot can be done within existing resources. There are some parts of dentistry that are well funded, and at a time when we're rationalising services, we must make the tough choices. There's no magic wand.

We need to keep the core values going, and keep shouting: the squeaky wheel gets most grease!"

Obviously, as the press briefing illustrates, this involves working with the media. "You have to be trusted by the media and by the patients. Dentistry hasn't been very well trusted. It had a poor image and had done very little to rectify that, but I think there has been a turnaround in the way we're addressing that, working with the media to get the real stories out."

With all the negatives, Jane still feels that it has been a very positive year so far. "In the mid-2000s when there was so much money, we were constantly expected to come up with plans, developments, incentives. But nobody cared if you consolidated or kept the ideas going after a while. I think now is the time to consolidate and improve what we're doing."

The upcoming report on the public dental service from PA Consulting will hopefully assist in that process. "I hope they report quickly and promptly. The feedback has been that they were well informed, that they asked appropriate questions, and that they took all the information that was given to them. That gives me high hopes. We've had a lot of reports over many years that are still gathering dust on shelves, but my hope is that this will be one report that the HSE will listen to – that the recommendations will be enacted in full."

Professional unity

It's been a busy year so far, with many high points, but Jane draws particular attention to one aspect of her role. "What I've especially enjoyed has been getting to know people in the private side of dentistry that I wouldn't have known. In order to do my role I have had to listen to them and try to get into their heads and that has been an eye-opener. I've been struck by the dedication and selflessness of my colleagues in private practice, and I have a huge respect for them. I hope that I in turn have acted as an ambassador to my private sector colleagues to allow them to have some insight into the difficulties that we have in the public sector, and what we are trying to do within limited resources. I strive for unity in the profession – I have tried to put unity as a theme of my presidency. I think we have more in common than we might think."

Do you want to change your lifestyle and can you walk the walk as well as talk the usual talk? I may be able to facilitate more than one applicant so this may be the big opportunity for a couple.

EXPERIENCED DENTAL SURGEON



Independent, hard-working ethical enthusiastic individuals with a sense of humour and loyalty who want to succeed in life will do very well here.

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- We have a highly competent Practice Manager, Mrs Cathy Laing, using a practice management system to evolve procedures and policies, generating a very efficient practice with written dynamic systems. (What a difference that makes to efficiency!)
- We have a completely preventative-based in-house maintenance program for all of our adult patients with a large complement of patients.
- I want you to look after between 700 and 1,000 patients seeing them for twice-yearly check-ups and maintenance.
- You will then have the time to treat their needs using true clinical freedom and materials.
- We place our own implants with our visiting implant specialist every month and there is an opportunity to advance your skills in all aspects.
- Your patients are committed to the program and the practice, and are very receptive to maintaining their oral health.
- You must be highly committed to quality dentistry.
- You must have **excellent** oral and written communication skills.
- We have also invested in the CEREC system and have the benefit of our clinical director Dr John Rautenbach as your in-house established colleague to help you with this if you need help!
- You must be willing to commit to living and working in this very special environment as the practice is situated in the Orkney Islands in one of the safest communities in the country. We have access to quality schools, outdoor pursuits, in fact whatever we need for a great quality of life. We can also access the rest of the country relatively quickly by superb air links.

Finally you will earn a very substantial salary as evidenced by our existing colleagues who are delighted to testify and act as referees.

Email your CV in the first instance to me, Dr John Barry on johnbarry@thedentalplan.co.uk.

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Provision of dental care for special care patients: the view of Irish dentists in the Republic of Ireland

Précis:

A greater focus on the promotion of, and education in, special care dentistry among primary dental care providers is required in Ireland.

Abstract:

Statement of problem: Part 2 of the Disability Act 2005 requires that all people with a disability are entitled to a needs assessment and, by implication, provision of identified care needs. This process started with children aged 0-6 in 2007 and will roll out to all people with disabilities by 2011. Oral health is part of that needs assessment but it may be that dentists are not in a position to provide that care, by virtue of a lack of education, training or facilities. The majority of dental care delivered would seem, from information gathered as part of this study, to be of an emergency nature. This study aimed to identify the shortfalls in service provision, and their potential causes, to inform what it is hoped will be a positive directive on special care dentistry (SCD) in the proposed National Oral Health Strategy.

Purpose of study: To assess the provision of dental services for special care patients (SCPs) by dental practitioners in Ireland. To review the educational background of primary dental care providers in SCD.

Materials and methods: A postal and online questionnaire was sent to every third dentist on the Dental Register in Ireland. An analysis of data was performed using Statistical Programme for Social Sciences (SPSS).

Results: There were 782 questionnaires distributed. Of the 274 (35% response rate) dentists returning questionnaires, 236 were deemed suitable for inclusion; those dentists working in general practice or the Health Service Executive (HSE) only were included. Treatment provided by dental practitioners included emergency services (77%), extractions (72%) and restorative intervention (72%). Oral hygiene instruction for the carers of SCPs was provided by 52% of respondents. Of those surveyed, 25% claimed an awareness of the Disability Act 2005. Qualitative analysis of a definition of SCD and the perceived barriers to care were recorded. Additional fees for the treatment of SCPs were deemed necessary by 78% of respondents. An experience of training in SCD was recorded by 41%, and 65% of dentists expressed a willingness to partake in some/further training.

Conclusions: While the treatment of SCPs was reported by the majority of respondents (66%), the most common service provided was the management of dental emergencies. The need for a greater emphasis on preventive care was highlighted. Knowledge of the Disability Act 2005 was limited and responsible agencies need to increase awareness of the requirements for professional groups, like dentists, under the Act.

Key words: Access, disability, dental health.

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Introduction

Despite advances in dental care in recent decades, the oral health of people with disabilities remains poor.¹⁻⁶ While dental caries prevalence may be similar to that in non-disabled populations, the way it is managed is very different, and in some countries it may not be treated at all. Other oral health needs may be higher, for example, periodontal disease.⁷

This is against a background of an acknowledged increase in populations who will have special healthcare needs.^{8,9} Approximately 20% of the US population has some form of disability and, of those, 12% have severe disabilities.¹⁰ In the UK, over 200,000 adults have profound learning disabilities and/or complex medical conditions.¹¹ It is increasingly recognised that oral health contributes to well-being and that, conversely, poor oral health at the very least impacts significantly on quality of life¹² and can be life threatening.

Dentists traditionally have been reported as being reluctant to provide services to people with disabilities.¹³⁻¹⁵ The reasons for this reluctance are numerous and range across physical barriers in their practices,^{14,16} economics,^{13,15} and lack of education.¹⁷ However, identification of such barriers can be the first step in addressing the deficiencies, as outlined by Edwards and Merry in 2002.¹⁸ In Ireland, the Disability Act of 2005,¹⁹ which aims to promote equality and social inclusion, defines disability as "a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment". Access to dental services for such individuals comes under the remit of this Act. However, inequalities in the provision of dental services for children and adults with disabilities in Ireland have been identified through the national oral health surveys conducted during 2002/3.^{5,6}

The treatment of special care patients (SCPs) presents challenges for the general dental practitioner (GDP) that may ultimately become a barrier to the provision of high quality care. In the United Kingdom, a policy document was developed to aid practitioners in addressing some of these barriers, most notably aspects of consent and physical interventions.²⁰ In the light of the foregoing, this study aimed to:

- ascertain the provision and range of oral health services for SCPs provided by primary care dental practitioners in Ireland;
- identify barriers to oral/dental care that may exist in this country, as perceived by primary care dental practitioners; and,
- evaluate the education and training in the care of people with disabilities received by primary care dental practitioners in Ireland.

Materials and methods

The Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin, gave approval for the study.

The questionnaire was designed to collect both quantitative and qualitative data. To develop the survey instrument, 20 clinical supervisors and house officers in the Dublin Dental School and Hospital agreed to take part in a pilot study. Subsequent to this, the

responses were analysed for further development of the questionnaire. Every third member on the 2007 Dental Register, with an address in Ireland, was selected. A paper-based questionnaire was provided but each recipient was given the option of an online questionnaire to complete as an alternative. Questionnaires were posted and participants were asked to return these by the end of November 2007; a stamped addressed envelope was provided to facilitate return. One month later, a reminder was published in the newsletter of the Irish Dental Association to encourage return of the completed questionnaires.

The questionnaire topics covered were demographic factors (age and gender) and practice-related demographics (field of dental practice, dental school graduated from, practice location and distance from nearest dental hospital). Participants were asked to define SCD and their experience and opinions of training in SCD were also assessed. Experience of the treatment of SCPs, and concerns and satisfactions, as well as their opinions regarding additional fees in the treatment of SCPs, were determined. The provision of oral health instruction for carers, the opportunity to work with a trained dental nurse and hygienist, and the issue of physical access to the practice, were explored. Knowledge of the Disability Act 2005 was assessed. Further suggestions were invited at the conclusion of the survey in an open-ended section of the questionnaire.

The data were entered into a Microsoft Excel spreadsheet. An analysis of the data obtained was undertaken using SPSS statistical software.

Results

Of the 782 dental practitioners to whom the survey was mailed, 272 returned the paper-based survey and two responded via the online version, a total response rate of 274 (35%). A total of 236 were analysed (30%), after the exclusion of 38 questionnaires: 11 were retired/no longer at given address and 27 were deemed unsuitable for inclusion as they did not meet the criteria of a primary care provider (14 in specialist practice, five hospital-based and eight working in both specialist practice and a dental hospital). The number of respondents working solely in general practices or the HSE was 154 and 51, respectively. The number working in a combination of general practice, HSE, specialist practice, hospital dentistry or research was 31; this group was included in the total number analysed.

Respondents were predominantly GDPs (65%) and males over the age of 51 (20%). The reported proportion with previous training in SCD was 41%. Of this proportion, experience of undergraduate training was recorded for 47%, postgraduate for 28%, and both undergraduate and postgraduate for 25% of respondents. Of those surveyed, 58% reported having had hands-on experience with SCPs during training. A further 65% expressed a willingness to participate in training.

Of those responding, 66% claimed to treat SCPs. Of the 154 respondents exclusively from general practice, 89 (58%) claimed to be currently treating SCPs. This is compared with the 51 dentists working solely for the HSE where 42 (82%) claimed to be treating SCPs.

PEER-REVIEWED

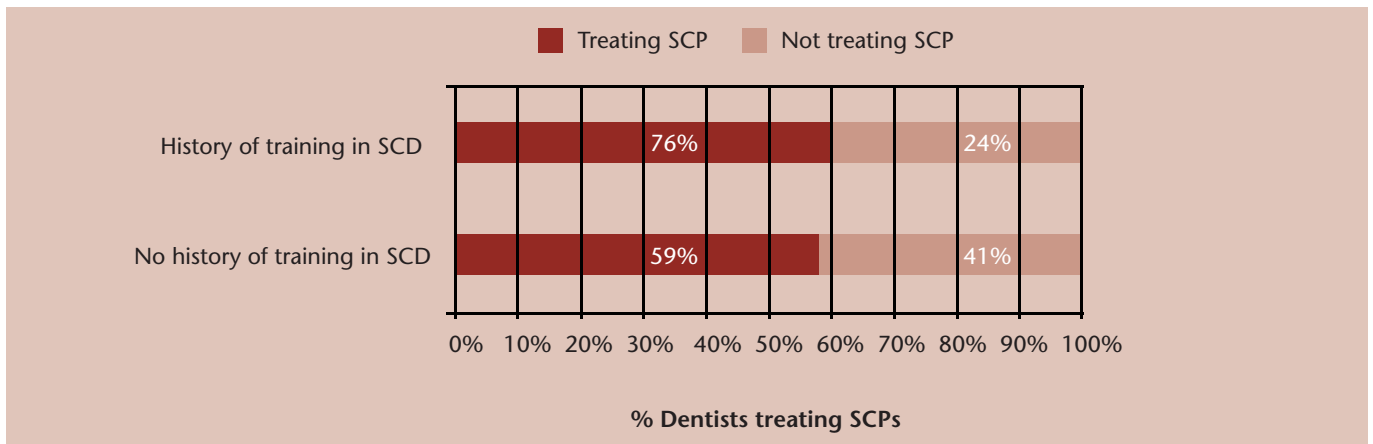


FIGURE 1: Dentists who treat special care patients and their history of training in special care dentistry.

Of those dentists with previous training, 76% reported treating SCPs; of the dentists who claimed to have no previous training in the field, 59% are currently treating SCPs (Figure 1).

The proportion of dentists offering different forms of treatment to SCPs were: 77% emergency services, 72% extractions, 72% restorative, 61% dental screening, 57% periodontal, 48% dentures, 11% sedation, 8% outreach screening programmes. Oral hygiene instruction (OHI) to the carers of SCPs was provided by 52% of respondents. Of those who returned questionnaires, 25% claimed an awareness of the 2005 Disability Act. Access to their dental practice was reported as inadequate by 44% of the study group.

Barriers to care cited by the respondents included: behaviour and communication difficulties (29%); the treatment of SCPs being outside the practitioner's remit/capabilities (22%); concern regarding medical history of SCPs (23%); concerns with finance and time (20%); inadequate sedation/GA referral facilities (14%); physical access problems (12%); consent (8%); carer lack of knowledge (5%); treatment relapse (5%); and, staffing issues (2%).

When asked to define SCD, 25% alluded to mental or physical disabilities only, or both, with 10% providing a more comprehensive answer in line with the definition outlined in the Disability Act (2005). Practitioners were asked for their opinion regarding the need or otherwise for additional fees for the treatment of SCPs, and 78% of dentists responded positively to this.

Discussion

This study reports the findings of a questionnaire-based survey of Irish primary care dental practitioners and the provision of services for SCPs. While the results could provide guidance on planning for the provision of oral healthcare for SCPs and education/training of dentists, the poor response rate means that the results need to be interpreted and extrapolated with caution. Efforts to improve the response rate were restricted as the survey was anonymous and non-responders could not be pursued. As the study was awarded the Undergraduate Research Prize by the Metropolitan Branch of the Irish

Dental Association, a reminder was placed in their newsletter to encourage participation. The effectiveness of this form of reminder is limited, being entirely dependent on levels of membership of the Association. The results presented refer to primary care providers only; the response rate from those in specialist practice or hospital dentistry is too small for separate analysis. However, response rates as seen in this type of enquiry are to be anticipated; Pourat *et al* (2007) reported a 46% response to a similar questionnaire-based enquiry, and Loeppky and Sigal (2006) reported a response rate of 52% from general dentists.^{21,22}

The results reported here demonstrate a low level of previous training in SCD, yet a high level of interest in undertaking further education and training in this field. This is encouraging, as similar research has highlighted education and training as a means to improve service provision for this patient group.²³⁻²⁵

The treatment of SCPs was reported by approximately two-thirds of participants. The most commonly reported treatments included emergency services, extractions and some restorative care, with a low level of oral hygiene instruction provision. Central to the promotion of public health is prevention. Never is this more relevant than with SCPs. The high prevalence of poor oral health and the significant challenges that exist in the provision of treatment underline the importance of preventive strategies. The results from the national oral health survey of children in special needs schools⁶ highlights this need, as do the results from the earlier national oral health survey of adults with an intellectual disability in residential care in Ireland.⁵

Glassman and Miller² make the point that "people with special needs are the most underserved of the underserved in our society". The authors outline the development of programmes that are community based, to include oral care plans, which embed customised oral healthcare with the patient in the setting where they reside. For the many patients who will not undertake oral hygiene measures effectively of their own volition, the education and training of carers is at least as important as that of the dental team.

The increasing focus by the World Health Organisation on the

importance of the primary care approach opens up the possibility of oral and dental care being part of this and, in particular, integrated in the common risk approach.²⁶ This is as relevant for SCPs as for the general population.

As might be anticipated, a higher percentage of those dentists who indicated that they had previous training in SCD reported treating SCPs (Figure 1). The literature confirms this relationship but also highlights the variables that contribute to the willingness or otherwise of dentists to provide care for underserved groups in society. These variables need to be considered in designing educational programmes.²⁷ There is debate too as to whether the education and training is more effectively delivered at an under- or postgraduate level.²⁸ In response to a questionnaire-based survey of general dental practitioners in one area of the UK, the authors identified barriers, which were then addressed by training and access grants. This was necessary in the context of the UK's Disability Act, which requires dentists to make reasonable efforts to accommodate people with disabilities in their practices.²⁹

Interestingly, the majority of dentists surveyed here feel additional fees are required for the treatment of this patient group.

The poor level of knowledge regarding the law as it relates to the provision of treatment for people with disabilities emphasises the need for increased awareness of the 2005 Disability Act, given the way in which this legislation places the onus on service providers, such as dentists, to respond to the reasonable needs and demands of people with disabilities. In Ireland in 2007 there were 25,613 people with an intellectual disability, that is, those in receipt of services on the National Intellectual Disability Database,³⁰ with a recorded increase of 37% since 1996 in those over 55 years of age. For those with a physical or sensory disability, there were 29,089 people registered as service users on the relevant database³¹ in 2007, of whom 74% had a physical impairment and two-thirds were adults. Many of the younger patients will have had a lifetime of dentistry and positive expectations of dental services. The dental profession needs to be in a position to respond to the needs and demands of this community, many of whom have significant spending power.

A similar study to the current one, but targeting Irish health board (now HSE) dental surgeons treating patients with special needs, was conducted in 2001.³² It assessed the current dental health services for those categorised as 'special needs' by the Department of Health and Children. The study made a number of recommendations for the development of the service in Ireland. It advocated for the development of policies for the provision of care for special needs groups, the introduction of a specialist register for those with specialist education and training, and the establishment of training programmes. It advised that planning more appropriate preventive dental health programmes was necessary. The need for the expansion of existing services for the treatment of SCPs under general anaesthetic was also highlighted.³² Subsequent reports have reiterated these recommendations, which, despite the resources directed towards disability services following the publication of the 2005 Disability Act, have not been implemented.^{25,33}

Conclusions

While it is evident that some primary care practitioners provide a service to SCPs, from the level of response to this survey, they are in the minority. These dentists do, however, provide a reasonable range of services against a background of little or no formal education or training in SCD. Education of carers in oral health maintenance receives insufficient emphasis, given its pivotal role in oral health maintenance. This, as well as topics identified as barriers to providing care for SCPs, could be adequately addressed by continuing education courses, for which there will be an increased demand once continuing professional development becomes mandatory for dentists in Ireland. Given the implications of the 2005 Disability Act, there is a clear need to significantly improve the awareness among dental practitioners of their responsibilities under the Act.

Based on the findings from this study, a number of recommendations can be made:

- there is a need for education and enhanced training in SCD at an undergraduate level, with an emphasis on hands-on clinical experience in a supervised environment. The level of interest in further training would suggest a potential for postgraduate courses in SCD, in addition to modules within continuing professional development programmes to address perceived barriers to care;
- effective, evidence-based education and training programmes for the carers of SCPs ought to be established, with a focus on community-based prevention.³⁴ The inclusion of consideration of oral health into the primary healthcare team, based on a common risk strategy approach, will promote the better maintenance of oral healthcare for vulnerable groups; and,
- the requirements embodied in the Disability Act, introduced in Ireland in 2005, should be promoted among the dental profession.

Key messages

- Two-thirds of dentists surveyed claimed to be currently treating SCPs
- A higher percentage of those dentists with previous training report treating SCPs
- Only 25% of respondents have an awareness of the implications of the Disability Act 2005 for their practice
- Emergency dental services are the most frequent treatment provided for SCPs
- Behaviour and communication difficulties are the most frequently cited barriers to care

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Demographics of implant placement and complications of a patient subgroup in a dental hospital population

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Précis

A significant number of complications occurs following implant placement, but most of these are minor. Patients with implant-supported overdentures have more complications than those with fixed prostheses. Patients should be advised that ongoing maintenance of implant prostheses should be anticipated.

Abstract

Statement of problem: Little has been reported about the demographics of implant placement in the Irish population and the complications that occur. This is important in terms of service planning and providing patient information.

Purpose: The purpose of this study was to construct a database of patients who had implants placed in the Dublin Dental School & Hospital from 2000 to 2006. Also, we wanted to compare the complications that occurred in patients who had overdentures to those with a fixed prosthesis.

Methods: Hospital records were searched for all patients who had implants placed over a seven-year period and we recorded demographic information, as well as details of the implant site, implant type and restoration. Patients who had four or more implants placed for an implant-supported overdenture or fixed prosthesis were invited to attend for a clinical examination.

Results: A total of 1,111 implants were placed in 452 patients over the study period – half of the implants supported single crowns, while the other half supported mainly overdentures and full arch fixed prostheses, with few fixed partial dentures. The 40- to 60-year-olds had the greatest number of implants placed of any age group and most implants were placed in the anterior region. Patients with implant-supported overdentures recorded more complications (52%) compared to those with fixed prostheses (32%). The most common complications associated with both treatments were gingival inflammation and peri-implant mucositis. Overdentures additionally had a significant number of retentive clip fractures.

Conclusions: Implant-supported overdentures and fixed prostheses were both clinically successful. However, patients and clinicians should be aware that soft tissue and mechanical complications are common.

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Introduction

For many years, only one treatment was available for the management of edentulism – conventional dentures. These rely on the form of the remaining bony ridge for support and retention, but even when the dentures are judged to be excellent, many edentulous patients cannot eat certain foods or speak clearly because of lack of denture retention.¹ Today there is a range of other prostheses available to restore an edentulous arch,

including: an implant-retained and tissue-supported overdenture; an implant-supported (and retained) overdenture; or, an implant-supported fixed prosthesis. Unfortunately, the majority of studies evaluating the outcomes of these prostheses have not used validated instruments, which makes direct comparisons difficult. Hence, prosthodontists are limited in making treatment planning decisions and in

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Table 1: Relative advantages of fixed or removable prostheses for each jaw (Strassburger, 2006).

	Maxilla	Mandible
Removable	Speech function	Ease of cleaning
	Ease of cleaning	Aesthetics
	Aesthetics	Stability
Fixed	Comfort	Stability
	Speech function	Chewing ability
	Stability	Ease of cleaning

providing information to patients with regard to long-term outcomes. While there were some early attempts to assess implant treatment by including patient-centered outcomes, Albrektsson proposed criteria that have been broadly accepted² but focus on the success of individual implants. Smith and Zarb also suggested that patient comfort, sulcus depth, gingival status, damage to adjacent teeth and violation of the maxillary sinus or mandibular canal were not attributable to the material or design of the implant and, therefore, should be considered independently.³ Mische recommended that implant survival by itself is not an acceptable criterion to evaluate an implant system and must include the restoration because that is the most important component to the patient.⁴ As the placement of implants is now considered quite predictable in most situations, more attention has been given to patient-centred outcomes, including patient satisfaction and treatment complications.¹²

When placement of a sufficient number of implants is feasible, the prosthesis can be purely implant supported; in such a situation one must make a choice between a fixed or removable design. A fixed prosthesis is not the automatic choice: for overdentures, congruence of the position of implants and prosthetic teeth is not necessary, facilitating management of aesthetic concerns, such as tooth position and facial morphology. Removal of the prosthesis for cleaning by the patient is seen as a major advantage.^{7,8} Strassburger proposed that a table be used to inform patients before a treatment decision is made, as it shows the relative advantages of fixed and overdenture prostheses in the maxilla and mandible (Table 1).⁹

Prosthetic complications directly impact on the patient's and dentist's experience with implant prostheses, but have been studied less than other aspects. Perhaps treatment-related problems are accepted as normal, but even minor complications mean inconvenience, increased surgery visits, increased cost and loss of confidence.¹⁰ With regard to complications of fixed prostheses versus overdentures, no clear conclusions can be drawn from the literature. In a review of the literature from 1981 to 2001, Goodacre and colleagues¹¹ identified the types of complications associated with implant prostheses and their incidence, namely: surgical complications; implant loss; bone loss; peri-implant soft tissue complications; mechanical complications; and, aesthetic/phonetic complications.¹² Implant overdentures are associated with more complications than any other type of implant prosthesis and they have been more successful in the mandible than in the maxilla.^{9,13} Studies have shown that loss of retention is a major complication with implant-retained overdentures.^{11,14-16}

Previous studies have mainly compared overdentures supported by two implants (simple overdentures) with fixed complete dentures,¹⁵ or did not distinguish between different types of overdentures.¹⁶⁻¹⁸ However, the profile of a patient who receives two implants to stabilise their denture is considerably different from a patient who is generally younger, has more available bone and is potentially suitable for a fixed prosthesis or a 'complex' overdenture. For the purposes of treatment planning and patient information, it would be more meaningful to compare the complications of fixed prostheses and overdentures supported by four or more implants.

In this study we sought to compare the complications occurring in patients who had implant-supported overdentures to those who had a fixed prosthesis. However, there was no database of Irish patients who had implant treatment. Indeed, even though osseointegrated dental implants have been placed in Ireland since the 1980s, there were no basic demographic data available regarding implant patients or the types of prostheses they received. In order to provide a context to assess complications, the first aim of this study was to begin documenting the implant patient population in Ireland. A database was constructed of all Dublin Dental School and Hospital patients treated with implants between 2000 and 2006. This database reflects the type of demand for implant treatment in the Irish population and reveals the trends in treatment provision.

From this database, patients were identified who received at least four implants in an edentulous arch and either a fixed prosthesis or overdenture. The second aim of this study was to compare the complications that occurred in patients with these prostheses. Patients were examined clinically and their records checked for the occurrence of complications. This allowed for a direct comparison between fixed and overdenture-supported prostheses, which could be useful for treatment planning and patient information.

Materials and methods

Implant database

In the first part of this study a database was constructed that recorded the details of every implant placed and restored in the Dublin Dental School and Hospital from 2000 to 2006. Surgical day lists were hand searched to compile a list of patients who had dental implants placed and a search of the hospital's electronic patient record system was also carried out. The charts for these patients were then hand searched for the types of implants placed, their lengths, diameters and sites, as well as the prostheses they supported over the seven-year period. Demographic details on all patients who received implants were noted. The database was designed so that data could be analysed on an implant or patient basis. Patients were excluded from the database if their records were unavailable for analysis or if the implants had not yet been restored. Charts that were unavailable for analysis were requested a second time at a later date in order to maximise the chance of recording every implant.

Analysis of clinical complications with fixed prostheses versus removable overdentures

The objective of this part of the study was to compare the complications

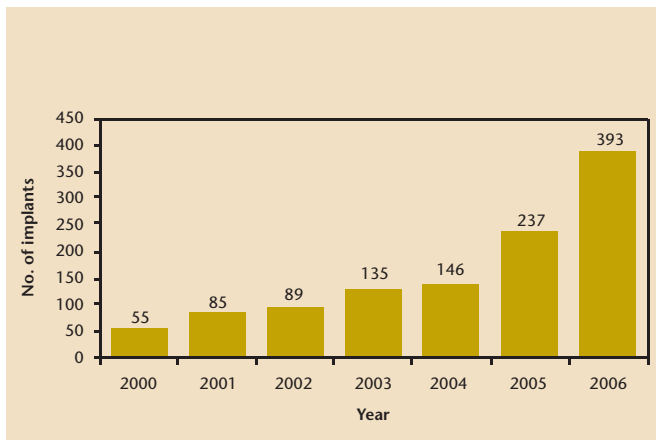


FIGURE 1: Number of implants placed in the Dublin Dental School & Hospital each year (2000-2006).

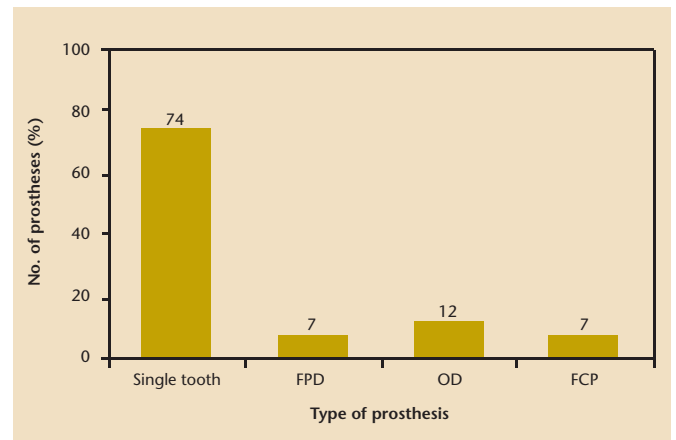


FIGURE 2: Types of implant prostheses provided (percentages). (FPD = fixed partial denture; OD = overdenture; FCP = fixed complete prosthesis.)

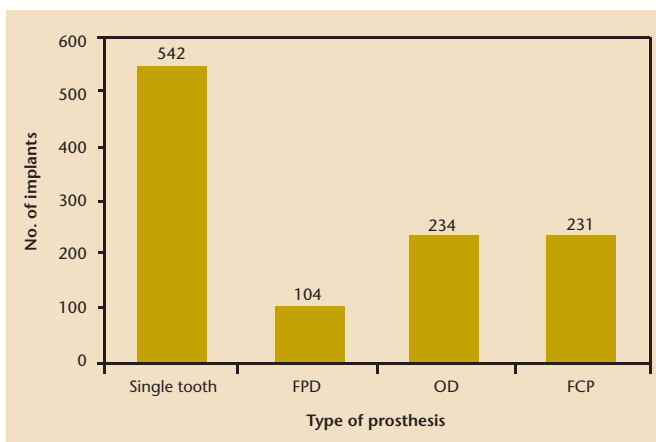


FIGURE 3: Number of implants supporting different types of prostheses. (FPD = fixed partial denture; OD = overdenture; FCP = fixed complete prosthesis.)

that occurred with complete implant fixed prostheses and those that occurred with removable implant-retained prostheses (overdentures). A minimum of four implants was required for the overdenture group to facilitate a meaningful comparison between the overdenture and fixed prosthesis patients. Fifty edentulous patients who had received a total of 62 implant prostheses (either an overdenture or a complete implant fixed prosthesis or both), constituted the study population. Treatment was carried out by staff and postgraduate students of the Dublin Dental School and Hospital. All patients had worn their prosthesis for at least one month and they agreed to participate in the study by signing a written consent. Exclusion criteria included patients who had either the surgical or restorative phases carried out elsewhere, or patients who had psychological problems or learning difficulties, which precluded them from participation.

Ethical considerations

Ethical clearance for the study was obtained from the Research

Committee at the Faculty of Health Sciences, Trinity College Dublin. All patients who were asked to participate in the study had received information leaflets and signed the consent forms. The confidentiality of the patients' information was guaranteed.

Data collection

Eligible patients were mailed: 1. an introductory letter from the Director of the Graduate Prosthodontic Program; and, 2. a package, which included a cover letter, information leaflet and consent form. Patients were invited to attend for a check-up appointment at no charge. A clinical examination was carried out and any necessary adjustments or repairs of the prostheses were carried out. Advice regarding oral hygiene and maintenance of the prostheses was also given. Details of any complications, including their timing, were recorded, and note was taken of the length of time between the surgical phase and prosthesis delivery.

Results

Implant database

A total of 1,111 implants were placed in 452 patients during the period from January 2000 to January 2007. The numbers of implants placed annually increased exponentially during this period, going from 55 fixtures in 2000 to 393 in 2006 (Figure 1).

The implants supported 731 prostheses: 74% of these prostheses were single implant restorations, 7% were fixed partial dentures, 12% were implant overdentures and 7% were implant fixed complete prostheses (Figure 2). The number of implants supporting single restorations was almost equal to the number supporting multi-unit restorations. A total of 542 (49%) implants supported a single prosthesis, 104 (9%) supported a fixed partial denture, 234 (21%) supported an overdenture and 231 (21%) supported a fixed complete prostheses (Figure 3).

With regard to the anatomic distribution of the implants, 58.5% of implants were placed in the maxilla and 41.5% were placed in the mandible. The anterior maxilla, followed by the anterior mandible, were the two most common sites for implant placement, with 32% and 22%,

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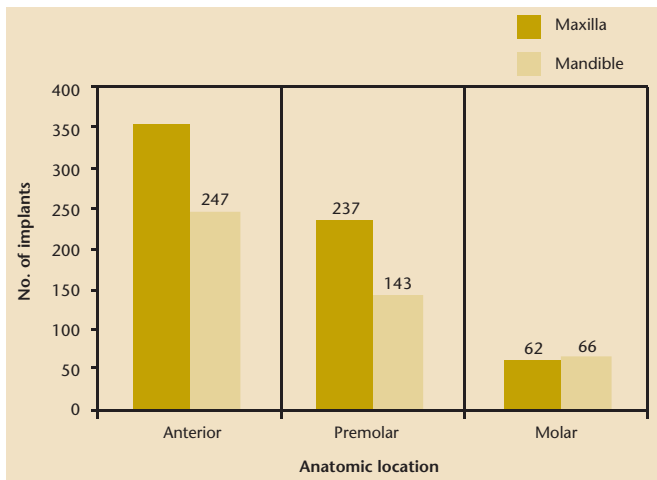


FIGURE 4: Distribution of implants anatomically.

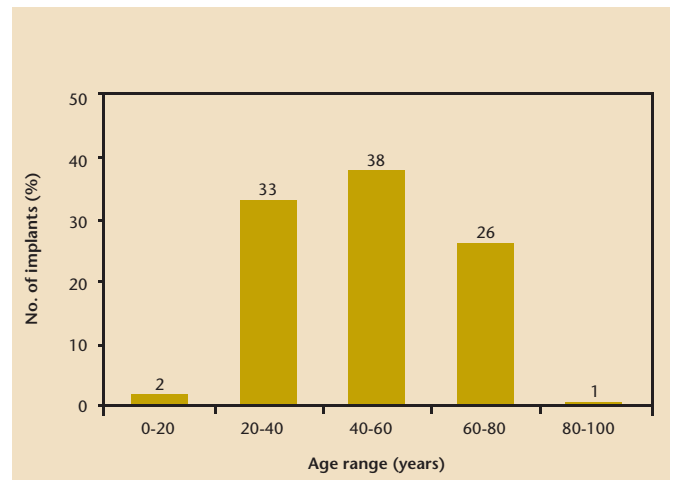


FIGURE 5: Age profile of patients who received implants (percentage of implants in each group).

Table 2: Number and type of complications in overdenture group (n=25).

Overdenture complications	Number of patients affected	% of patients affected
Soft tissue complications		
Gingival inflammation/hyperplasia	5	20
Peri-implant mucositis	4	16
Peri-implantitis	2	8
Denture stomatitis	2	8
Mechanical complications		
Clip fracture	3	12
Loosening of retentive mechanism	2	8
Fractured temporary prosthesis base	2	8
Prosthesis screw loosening	2	8
Prosthesis screw fracture	1	4
Other		
Implant loss	1	4
Neuro-sensory disturbance	2	8
Speech	1	4
Aesthetics	1	4

Table 3: Number and type of complications in fixed complete prosthesis group (n=37).

Fixed prosthesis complications	Number of patients affected	% of patients affected
Soft tissue complications		
Peri-implant mucositis	5	14
Peri-implantitis	3	8
Mechanical complications		
Fractured teeth	1	3
Fractured temporary prosthesis base	1	3
Prosthesis screw loosening	2	5
Other		
Implant loss	2	5
Neuro-sensory disturbance	2	5
Aesthetics	1	3

respectively, of the total number of implants placed in these regions (Figure 4). Conversely, the posterior maxilla and mandible were the sites that received the smallest number of implants.

The implants used during the study period came from five different manufacturers. The greatest number was supplied by Biomet 3i (69.8%), followed by Straumann (13%) and Branemark/Nobel Biocare (11.5%). Astra and Bicon implants constituted the remaining 4.3%.

The mean age of the patients who received dental implants was 53.4 years. The age group that most frequently received dental implants was the 40- to 60-year-olds, with 38.5% of the implants being placed in this group (Figure 5). The next most represented age group was 20- to 40-year-olds, followed by the 60- to 80-year-olds. Only 1% of implants were placed in over 80-year-olds and 2% in the 0-20 years age group (Figure 5).

Complications: overdenture group

Twenty-five patients were identified from the database who had overdentures placed on four or more implants. These patients (mean age 57.5; 11 males, 14 females) attended for examination and had their records searched.

Of the 25 patients who received an overdenture prosthesis, 13 experienced at least one complication (52%) (Table 2). The most common complication that occurred in this group was gingival inflammation or hyperplasia of the tissues surrounding the implants and Dolder bars (Figure 6). This occurred in five out of the 25 patients (20%). Peri-implant mucositis was the next most commonly occurring complication, occurring in four patients (16%). This is defined as a "reversible inflammatory process in the soft tissues surrounding a functioning implant"¹⁴ and clinical features are mainly swelling and redness.



FIGURE 6: Gingival hyperplasia under Dolder bar of maxillary overdenture.



FIGURE 7: Fractured clips in implant overdenture.



FIGURE 8: Peri-implant mucositis affecting abutments of fixed implant prosthesis.



FIGURE 9: Fracture of teeth on fixed complete implant prosthesis

Peri-implantitis occurred in two patients (8%). Peri-implantitis is an “inflammatory process additionally characterised by loss of peri-implant bone”. Clinical symptoms include presence of an inflammatory lesion in the peri-implant mucosa and the loss of peri-implant bone. Bleeding on probing, as well as bone loss on radiographs, had to occur for a diagnosis of peri-implantitis to be made. Only one patient in the group lost an implant and this was due to peri-implantitis. Two patients (8%) experienced denture stomatitis. The second group of complications was mechanical; clip fracture occurred in three patients (12%) (Figure 7), loosening of the retentive mechanism in two patients (8%), fracture of the temporary denture prosthesis in two patients (8%) and fracture of the acrylic base in one patient (4%) (Table 2). Prosthesis screw loosening occurred in two patients (8%) and screw fracture occurred in one patient (4%).

Two patients (8%) reported a neuro-sensory disturbance, which was transitory, one patient (4%) had speech difficulty, which resolved after a few weeks, and one patient had the prosthesis remade as they were unhappy with the aesthetic appearance of the teeth (4%).

Complications: fixed complete denture group

Out of the 37 patients who received a fixed complete prosthesis (mean age 56; 12 males, 25 females), 12 patients experienced at least one complication (32%) (Table 3). Peri-implant mucositis accounted for the most common complication, occurring in five out of the 37 patients (14%) (Figure 8). Peri-implantitis occurred in three patients (8%) and implant loss occurred in two patients (5%). Mechanical complications included prosthesis screw loosening in two patients (5%), fractured teeth in one patient (3%) (Figure 9) and fracture of a temporary denture in one patient (3%) (Table 2). Temporary neuro-sensory disturbance was reported in two patients (5%) and one patient had the prosthesis remade as they were unhappy with the aesthetic appearance of the teeth (3%).

Discussion

While the main purpose of the database in this project was to identify our study population, namely patients who had received a fixed complete implant prosthesis or an implant-retained overdenture with at least four implants, it also provided some useful data about implant

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treatment provided in the Dublin Dental School and Hospital over a seven-year period. Prior to this, there was no record of any details of implants placed or restored in the Dublin Dental School and Hospital. This database will be useful for further research, including the calculation of survival/success data. As data were recorded for implants, as well as patients, it will be useful to identify populations who received a particular type of implant or prosthesis.

The number of implants placed each year reflects the ever-increasing popularity of implants as a treatment modality. There was a seven-fold increase in the number of implants placed between the years 2000 and 2006. Implant dentistry has enjoyed an expansion of new applications, techniques, materials and devices since the early 1980s. Together with documented high success rates, this has resulted in the number of dental implants procedures increasing steadily worldwide, reaching an estimated one million dental implants placed per year.¹⁹ Anecdotally, most of the increase in treatment has been patient driven and there is a high level of interest in implants among patients.

In this study, 452 patients received 1,111 implants, with an average of 2.45 implants per patient. Lazarra and co-workers documented the placement of 1,969 implants in 653 patients over a five-year period, with an average of 3.03 implants placed per person.²⁰

The average age of patients in our study was 56.7 years, with the highest percentage of patients being in the 40- to 60-year age group (38.5%). Other studies have reported a similar trend. Mundt, in 2006,²¹ reported on private practice results of 663 implants in 159 patients and found the average age to be 54 years. The average age of patients in a study carried out in a dental school in Spain was found to be 44.5 years.²² In a retrospective study carried out on 1,925 consecutively placed implants in a private practice, Wagenberg and Froum reported the average age to be 57.9 years.²³ This could be a reflection of the age when patients tend to lose their teeth or begin to have problems wearing dentures due to advancing resorption. It could also be due to an improved financial situation during this time frame. Advancing age in itself would appear not to be a contraindication to implant treatment based on the results of this study; 26% of the total number of implants placed were in the 60- to 80-year old group. Indeed, Lazzara found that the largest percentage of patients (31%) in his report was in the 61- to 70-year-old age group.²⁰

With regard to the type of prosthesis supported by the implants, nearly half (49%) of the implants placed supported a single tooth restoration, only 9% supported a fixed partial denture, 21% supported overdenture prostheses and 21% supported fixed complete prostheses. In a five-year retrospective study, Penarrocha reported that only 10% of implants supported a single unit prosthesis, 26.5% supported a fixed partial denture, 44% supported an overdenture and 19.5% supported a fixed complete denture.²² The high number for the single unit prostheses and the relatively low number for the fixed partial dentures seems to reflect a preference in this hospital to place a separate implant for each missing tooth and/or the tendency to place conventional restorations where larger edentulous spaces exist.

A higher proportion of implants was recorded in the maxilla (58.5%) than the mandible (41.5%) in this study. This is similar to other authors; 58% maxilla, 42% mandible by Mundt²¹ and 62% maxilla, 38% mandible by Wagenberg.²³ Possible explanations of the higher

proportion in the maxilla may be tooth loss due to trauma or a higher demand in the maxilla for aesthetic reasons. Indeed 32% of all implants placed in this study were in the anterior maxilla and a similar figure (29.5%) was recorded in Wagenberg's study.²³

Only 11.5% of all implants were placed in the molar region (5.5% maxilla, 6% mandible) in this study. This is likely due to the increased surgical risks posteriorly and may reflect lower patient demand for implants outside the aesthetic zone. Other studies report a much higher percentage of implants in the molar region: 33% in the molar region²¹ and 24% (10.5% maxilla, 13.5% mandible) by Wagenberg.²³

Implant overdentures are generally accepted as having greater complication rates than fixed prostheses. Walton reported that removable implant-supported prostheses required three times as many adjustments and twice as many repairs compared to fixed prostheses.¹⁶ In a later study, she found that maintenance appointments were longer for the removable implant-supported prostheses and the repair costs 60% higher than for fixed prostheses.¹⁸ In this study, 52% of the patients who received an overdenture prosthesis experienced at least one complication; the corresponding figure in the fixed complete denture prosthesis group was 32%. The average follow-up periods were 25.5 months (range of three to 66 months) and 24 months (range three to 80 months) for the overdenture and fixed groups, respectively. This is a reasonable period in which to assess complications, as previous studies indicate that the highest maintenance requirements for implant-supported prostheses occur during the first year of function.¹⁶⁻¹⁸ Hemmings and co-workers noted that after the first year, fixed implant-supported prostheses required more maintenance than removable prostheses.

While the figures for complications in this study seem high, it should be noted that the majority of the complications were minor in nature. A complication was defined by Goodacre²⁴ as: "A secondary condition that developed during or after implant surgery or prosthesis placement". He also stated that: "The occurrence of a complication does not necessarily indicate (and most of the time does not indicate) that substandard dental care was provided and also does not necessarily mean that clinical failure has occurred". Nonetheless, patients should be advised that complications are likely to occur following implant treatment and this will necessitate further visits.

One patient in the overdenture group (4%) and two patients in the fixed group (5.4%) suffered from implant loss, the cause of which was deemed to be peri-implantitis. In the overdenture group, nearly half of the complications that occurred were related to the soft tissues (44%). Gingival inflammation/hyperplasia was the most common of these (20%) followed by peri-implant mucositis (16%) and denture-stomatitis (8%). General observations included a lack of space to permit adequate hygiene under the Dolder bar and a low awareness among the patients of the existence of these complications. Goodacre, in his meta-analysis, reported a similar figure of 19% for gingival hyperplasia/inflammation associated with overdenture prostheses.¹¹ The fixed group had a much lower incidence of soft tissue complications (13.5%), as is generally reported in the literature.²⁵

With regard to mechanical complications, a higher incidence was also observed with the overdenture group (36%) compared to the fixed

group (8%). Fracture or loosening of retentive clips is described as the most common mechanical problem with implant overdentures.¹⁵⁻¹⁸ Goodacre¹¹ also reported a high incidence of mechanical complications, with 30% of overdenture prostheses suffering from a loss of their retention mechanism – 16% of these being related to clip fracture. In this study, a slightly lower incidence of clip fracture occurred (12.5%). Earlier studies found that fractured screws were the most frequent mechanical complication with fixed prostheses,^{10,15,16} while later studies noted this problem less often.^{17,18} In the present study, no fractured screws were observed in the fixed prosthesis group (though one occurred in the overdenture group). This trend most likely reflects improved screw properties, geometry and coatings,²⁶ along with the routine use of abutment-level prostheses and calibrated torque drivers. Similarly, there were no failures of the fixed prosthesis frameworks, which may be due to the use of milled titanium structures and conservative cantilevers.

Neuro-sensory disturbance was the most common surgical complication to occur, affecting two patients (8%) in both groups. All patients recovered completely in a short time. This is very close to the mean incidence of 7% reported by Goodacre.¹¹ He also reported a slightly higher incidence in patients who were having implants placed in association with implant overdentures, presumably due to the more extensive bone resorption typically seen in these patients.

The incidence of aesthetic complications was very low in both groups, with only one patient in each group having the prosthesis remade due to unsatisfactory appearance of the teeth. This is surprising given the statistically significant higher proportion of overdenture patients who were less satisfied with the aesthetic outcome of their prosthesis (unpublished data). It may be that patients who were less satisfied with their prostheses failed to voice their concerns to the treating dentist. A study by Riefel has shown that successful direct communication with patients is an important factor in determining patient satisfaction.²⁷ Surprisingly, no complications with speech were reported in the fixed group and only one patient in the removable group experienced this complication. In a crossover study comparing maxillary fixed prostheses with overdentures, Heydecke reported that subjects made a significantly higher percentage of sounds correctly with overdentures compared to fixed prostheses.²⁸ It has also been suggested that patients' ability to adapt and time are responsible for the low frequency of speech complications.²⁴

Conclusions

- There was a dramatic increase in the provision of implants in the Dublin Dental School and Hospital between 2000 and 2006;
- the demographics of patients receiving implants was similar to that found in international studies;
- there was no difference in implant or prosthesis survival between fixed complete dentures and implant-supported overdentures;
- implant overdentures were associated with a higher number of complications (52%) than fixed prostheses (32%). The most common findings were: gingival inflammation; peri-implant mucositis; and, clip fracture; and,
- in the fixed prosthesis group, peri-implant mucositis and peri-implantitis were the most common complications.

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ABSTRACTS

Treatment strategies for ankylosed primary molars*Kennedy, D.B.*

Aim: The purpose of this article is to focus on aetiology and appropriate treatment techniques concerning ankylosis of primary molars.

Literature: The dental literature is reviewed in detail concerning aetiology, frequency of occurrence, diagnosis and longevity of ankylosed primary molars without successors. Treatment concepts are discussed. Long-term implications of treatment decisions made in the mixed dentition are emphasised. Areas of treatment that are unsupported by evidence are identified as potential research topics.

Conclusion: When the underlying premolar is present and the infra-occlusion is not progressive, then observation is appropriate. Only when there is severe disruption to the occlusion and/or the underlying premolar, extraction and space management may be appropriate. When the ankylosed primary molar has no underlying premolar, orthodontic input is needed to determine if extraction and space closure, extraction and transplantation, or extraction and prosthetic replacement is the best plan.

*Eur Archs Paediatr Dent 2009; 10 (4): 201-210.***Long-term, retrospective evaluation (implant and patient-centred outcome) of the two-implants-supported overdenture in the mandible. Part 1: survival rate***Vercruyssen, M., Marcelis, K., Coucke, W., Naert, I., Quirynen, M.*

Abstract objective: This retrospective analysis evaluated the long-term outcome of two implants supporting an overdenture in the mandible, as well as the significance of some confounding factors (smoking, implant length, bone quality).

Material and methods: All mandibular overdenture cases (n=495) treated during the past 25 years in our centre (with ≥ 5 years loading of the implants) were included in this study. General information (medical history, implant data, report on surgery) was retrieved from the patient's file. A large number of patients (n=248) were willing to visit the clinic for an additional follow-up visit. For the others, information on implant survival was collected by phone (n=121), or contact was impossible (57 had died, three were hospitalised and 66 could not be reached). In the latter group, information was used up to their last visit to the clinic. An implant was considered as surviving if it was still in function in the mouth, without clear adverse effects (pain, swelling, mobility). A failure was defined as early if it occurred within the window, insertion-final prosthesis placement; afterwards, it was considered as late.

Results: Most of the inserted implants (Brånemark type) were of the turned (machined) type (95.5%); the remainder were anodised (TiUnite). The anchoring system was a bar (86.3%), ball attachments (11.7%) or magnets (1.6%), and only some patients changed from one to the other (0.4%). Kaplan-Meier analyses showed a survival rate of 95.5% after 20 years of loading. Factors that influenced the outcome included smoking (90% rate for smokers) and the surgical protocol

(reduced survival rate for one-stage-placed implants). Implant length and bone quality had no impact.

Conclusions: These results fully support the two-implant overdenture concept in the mandible even in the long run.

*Clin Oral Impl Res Jan 22 2010: 357-365.***Bisphosphonate treatment and orthodontic considerations***Ghoneima, A.A., Allam, E.S., Zunt, S.L., Windsor, L.J.*

Currently, the use of oral and systemic forms of bisphosphonates is increasing dramatically in a large group of patients, either in the form of anti-osteoporosis medications or as part of a chemotherapeutic regimen for several malignant diseases. As adult orthodontic treatment has become more widely accepted in most orthodontic practices, orthodontists must be aware of the risks, benefits, and effects of bisphosphonate use on the patient's general health status, as well as on their orthodontic treatment outcomes. This review aims to discuss the use of bisphosphonates, the complications associated with their use, and their impact on orthodontic treatment.

*Orthod Craniofac Res 2010; 13: 1-10.***Fluoride toothpastes of different concentrations for preventing dental caries in children and adolescents***Walsh, T., Worthington, H.V., Glenny, A.M., Appelbe, P., Marinho, V.C., Shi, X.*

Background: Caries (dental decay) is a disease of the hard tissues of the teeth caused by an imbalance, over time, in the interactions between cariogenic bacteria in dental plaque and fermentable carbohydrates (mainly sugars). The use of fluoride toothpaste is the primary intervention for the prevention of caries.

Objectives: To determine the relative effectiveness of fluoride toothpastes of different concentrations in preventing dental caries in children and adolescents, and to examine the potentially modifying effects of baseline caries level and supervised toothbrushing.

Search strategy: Searches were undertaken on the Cochrane Oral Health Group's Trials Register, CENTRAL, MEDLINE and several other databases. Reference lists of articles were also searched. The date of the most recent searches was June 8, 2009.

Selection criteria: Randomised controlled trials and cluster-randomised controlled trials comparing fluoride toothpaste with placebo or fluoride toothpaste of a different concentration in children up to 16 years of age with a follow-up period of at least one year. The primary outcome was caries increment in the permanent or deciduous dentition as measured by the change in decayed (missing), filled tooth surfaces (D(M)FS/d(m)fs) from baseline.

Data collection and analysis: Inclusion of studies, data extraction and quality assessment was undertaken independently and in duplicate by two members of the review team. Disagreements were resolved by

discussion and consensus or by a third party. The primary effect measure was the prevented fraction (PF), the caries increment of the control group minus the caries increment of the treatment group, expressed as a proportion of the caries increment in the control group. Where it was appropriate to pool data, network meta-analysis, network meta-regression or meta-analysis models were used. Potential sources of heterogeneity were specified *a priori* and examined through random-effects meta-regression analysis where appropriate.

Main results: A total of 75 studies were included, of which 71 studies, comprising 79 trials, contributed data to the network meta-analysis, network meta-regression or meta-analysis. For the 66 studies (74 trials) that contributed to the network meta-analysis of D(M)FS in the mixed or permanent dentition, the caries preventive effect of fluoride toothpaste increased significantly with higher fluoride concentrations (D(M)FS PF compared to placebo was 23% [95% credible interval (CrI) 19% to 27%] for 1,000/1,055/1,100/1,250 parts per million (ppm) concentrations, rising to 36% [95% CrI 27% to 44%] for toothpastes with a concentration of 2,400/2,500/2,800ppm), but concentrations of 440/500/550ppm and below showed no statistically significant effect when compared to placebo. There is some evidence of a dose response

relationship in that the PF increased as the fluoride concentration increased from the baseline although this was not always statistically significant. The effect of fluoride toothpaste also increased with baseline level of D(M)FS and supervised brushing, though this did not reach statistical significance. Six studies assessed the effects of fluoride concentrations on the deciduous dentition with equivocal results dependent upon the fluoride concentrations compared and the outcome measure. Compliance with treatment regimen and unwanted effects was assessed in only a minority of studies. When reported, no differential compliance was observed and unwanted effects such as soft tissue damage and tooth staining were minimal.

Conclusions: This review confirms the benefits of using fluoride toothpaste in preventing caries in children and adolescents when compared to placebo, but only significantly for fluoride concentrations of 1,000ppm and above. The relative caries preventive effects of fluoride toothpastes of different concentrations increase with higher fluoride concentration. The decision of what fluoride levels to use for children under six years should be balanced with the risk of fluorosis.

Cochrane Database Syst Rev 2010; 20 (1).

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PRACTICE MANAGEMENT

Working without indemnity is professional suicide!

In the latest article in Dental Protection's series on risk management, BRIAN EDLIN highlights the importance for all dentists, irrespective of their specialty, of having adequate and appropriate indemnity.



In common parlance, indemnity is often used as a synonym for compensation or reparation. In the ever-changing dental world, the indemnity and assistance provided by a protection organisation such as Dental Protection Limited (DPL) needs to be flexible and all-embracing: its function is to assist, support and protect dentists in the various challenges and threats that they face during their professional career.

The indemnity offered by DPL is occurrence-based, which means that when a member pays a subscription for a particular period of time, they are indemnified for any act or omission that occurred during that period of membership, irrespective of the length of time that elapses before a complaint or claim arises, without the need for any further payment to be made. This differs from the indemnity provided by a claims-made insurance contract where a policy must be in force when a claim is reported. Claims from the past may have to be covered by the payment of an additional premium or run-off cover. If run-off cover is not in place then the dentist will not be indemnified against a retrospective claim on the policy.

Interestingly, although claims of negligence against dentists in Ireland account for only 20% of the cases that DPL opens each year, these cases tend to account for a considerably higher percentage of expenditure, as they incorporate not only the damages that may be payable when the patient has suffered avoidable harm, but also the legal fees incurred during the case through to its conclusion, which can often take many years.

The Dental Council's Ethical Guidance states that dentists are obliged to hold professional indemnity, and it is likely that any dentist discovered not to have indemnity in place would be sanctioned by the Council's Fitness to Practice Committee. In some countries in Europe it is illegal to practise medicine or dentistry without professional indemnity. In Ireland, a Private Members' Bill entitled The Medical Practitioners (Professional Indemnity) (Amendment) Bill 2009,

sponsored by Dr James O'Reilly TD (Fine Gael spokesman on Health) was introduced in the Dáil on July 8, 2009. The Bill seeks to introduce mandatory professional indemnity for medical practitioners and it is likely that this will include dentists, should the Bill be passed.

Support for dentists

DPL is the main indemnifier of dentists in Ireland, and has experience in assisting members in every branch of dentistry, together with the various potential problems that might arise from their chosen field of practice. Dentists are encouraged to contact their protection society for advice and assistance whenever their sixth sense alerts them to a problem, preferably before the patient's complaint actually arrives.

The ability to speak to a fellow dentist (dento-legal adviser) to discuss the case in an empathetic and impartial manner can be particularly reassuring, as well as offering an objective view of a potentially turbulent situation. It is often a great relief, after receiving a patient's complaint, to have a dento-legal adviser available to discuss the situation and help to draft a response. Dental Protection's dento-legal advisers have considerable experience in dealing with patients' complaints and are often able to help resolve the complaint by advising the member on what response should be made. It is extremely difficult for any professional person to deal objectively with a complaint made about them personally, because they may be too close to, and emotionally involved in, the complaint to deal with it dispassionately. It is for this reason that we suggest that our members obtain dento-legal advice from us, before any response is made.

Investigations

HSE probity inquiries are becoming increasingly common in Ireland and often more penetrating, with the inquiry going back many years. The advantage of seeking advice from DPL is that the member's views can be translated simply and concisely in a response to the HSE with

assistance from the dento-legal adviser, if necessary, and if appropriate, accompanied by a supportive expert report. Inquiries by the HSE can often be time consuming and exhausting for the colleague involved, and dentists are advised to seek advice at an early stage.

Complaints to the Dental Council by patients and the HSE are also becoming more common in Ireland and they should certainly be taken seriously. Dentists are strongly encouraged to seek advice from DPL or their own protection society before making any response. It is often tempting, when receiving a complaint, for the dentist to produce a knee-jerk reaction and write back a vitriolic response, often by return of post. Although this may make the dentist feel better at the time, it is important to remember that any such letter is likely to be read both by the complainant and members of the Dental Council's Fitness to Practice Committee! It may be quite cathartic to write such a response in the heat of the moment, but not always very sensible to send it to the Dental Council. Instead, send it to your protection society for their views first.

If the complaint to the Dental Council has the potential to be serious (even if the dentist believes it is not) then Dental Protection would normally instruct solicitors in Ireland to provide further advice and, if necessary, to provide a robust or mitigating response to the Dental Council. It is likely that we will see more cases being investigated by the Dental Council in the future, as patients become better informed, more vocal and more assertive. As we all know, the cost of advice and assistance from experienced solicitors can be very high, but any legal advice that is provided to members through DPL is funded by DPL on the member's behalf as one of the many benefits of membership.

Dentists working in the public sector (hospitals, universities, armed forces and the HSE) already have the benefit of indemnity through the Clinical Indemnity Scheme (CIS), which covers their employers for claims in negligence. This indemnity covers the interests of the employer rather than the individual dentist, and does not provide assistance for disciplinary action by the employer or by the Dental Council. Dentists who work in the public sector are strongly advised to have access to their own indemnity and assistance from DPL or another protection society in order that they may obtain their own unfettered and impartial advice.

This is particularly relevant today, as dentists working for the HSE are being asked to participate in mass vaccination programmes for swine flu and any indemnity offered by the CIS would not, in the event of an untoward incident, cover representation at a Dental Council investigation or other type of complaint or inquiry.

In summary, working without indemnity is considered to be both unethical and financially unwise! Certainly in today's climate, where accidents will always happen, and patients are much more demanding, it is strongly recommended that all dentists should have access to indemnity, advice and assistance to provide them with the reassurance and support on the day when something doesn't quite go to plan.

The following two case studies arose in other jurisdictions, but could be equally applicable to Ireland, and demonstrate the need for the assistance and support provided by DPL. Some of the details have been changed to preserve anonymity.

Case 1: the lecture

A senior dentist working in the community service had been asked to provide a lecture for a mixed audience, which comprised dentists, doctors and solicitors.

He was asked to present a number of unusual trauma cases that he had dealt with. He agreed to present three case studies involving young patients who had sustained facial and dental trauma as a result of an accident. The lecturer, in an attempt to preserve anonymity of the patient in one of the cases, decided to change some of the clinical details. During his presentation he gave his view on one patient's current condition and, more importantly, their future prognosis.

In the audience, listening to the presentation, was a solicitor who recognised some of the clinical details, which related to a client he had acted for some years previously. The lecturer's account of the case and the patient's current condition were not sufficiently disguised to provide total anonymity of the patient who was involved in the accident. The solicitor in the audience also recalled instructing this particular dentist to provide him with a report on his client's current condition and prognosis after the treatment for the accident had been completed.

The aspect of the lecturer's presentation dealing with the patient's future prognosis differed significantly from the report the solicitor had received from him some years earlier. In fact, the prognosis presented to the audience had been less positive than the prognosis set out in the member's report to the solicitor.

The solicitor was concerned that he might have been misinformed by the dentist when he had acted as his expert when assessing the amount of damages to be claimed, and which had yet to be agreed. In addition, he was concerned that the case was being discussed in a professional forum without, to his knowledge, his client's consent. After the lecture the dentist received an unpleasant letter from the solicitor who had previously instructed him, asking him to explain why he had disseminated details of this case before it was settled, and without his client's consent. The letter also asked why there was such an inconsistency between the report he had written for the solicitor and what had been said during the presentation.

The dentist, who had supplementary membership with DPL, contacted us for advice and admitted that he had not sought permission from the patient to report this case; firstly because, as he had written the report some time ago, he believed the case was now closed; and, secondly because he believed his anonymised presentation did not allow the patient to be identified. To help with anonymity, the dentist explained that the prognosis he described to his audience during the presentation was deliberately different to the actual prognosis he believed the patient could expect, because he thought it helped to disguise the case.

The dento-legal adviser dealing with the case drafted a letter for the dentist to send to the solicitor explaining that the case he presented was a composite of a number of cases and that the predicted outcome in the presentation bore little resemblance to the actual outcome of the case he advised on for the solicitor. The response was accepted and nothing further was heard.

PRACTICE MANAGEMENT

Case 2: poor performance

A dentist working in one of the branches of the salaried services contacted Dental Protection for advice because his temporary contract with the hospital was not being renewed due to his allegedly poor performance.

The dentist was in the process of climbing the career ladder and was given a two-year temporary contract within his specialty. It was made clear to him at the outset that he would need to publish a certain number of papers in his subject as well as provide clinical support within the department.

The dentist was keen to progress within his specialty with both his clinical expertise and research, but found he was placed under undue pressure within the department to see patients, often to the detriment of his research projects. Quite often his supposedly protected time to work on his research project was interrupted at short notice by him being requested to attend the clinic to deal with patients. It was in fact the lead clinician within the department who ironically was relying on the research dentist to assist him with his clinics, but who also expected him to produce the requisite number of papers, with his own name being attached to the publications!

Dental Protection asked its employment law consultants to look at the member's contract with the Hospital Trust and to listen to the dentist's point of view. They believed the Hospital Trust was acting improperly by not renewing the contract for the reasons they had stated. A meeting was therefore set up between, on the one hand, the Trust's representative, including a member of their human resources staff, and on the other hand, the dentist concerned together with the employment consultant and the dento-legal adviser dealing with the case on behalf of DPL.

The employment consultant suggested that the member's professional position had been compromised through the directions of the lead clinician who had, quite unfairly, taken the member away from the protected time set aside for his research. The human resources representative, after discussions with the lead clinician, upheld the research dentist's argument and the decision not to renew the contract was rescinded.

The dentist subsequently had time to complete his research and was in fact offered a permanent position within the department.



Brian Edlin BDS is Dental Protection Limited's lead for dental members working in Ireland.

Brian regularly lectures in Ireland and along with the rest of the DPL team has frequent meetings with members and also with the IDA.

Change your mindset to increase your income

ASHLEY LATTER explains why 'sales' needn't be a dirty word.

I recently asked the following question at a presentation I was delivering to over 300 people from the dental profession: "How many people here are in sales?" Only a few hands went up, maybe fewer than 20%. So why is it that only a few hands went up? And how do you feel about the word 'selling'?

Maybe you don't see yourself as a salesperson; after all, you spent over five years studying dentistry/orthodontics, not communications or business skills. However, every day you have to sell your ideas, whether to patients/clients or to other staff members. If you are not convincing and you are not speaking the language of the person you are selling to, they probably will not buy into your ideas. This article is not going to give you a 180% change in your way of thinking; however, even a small change in your thinking can enable you to become more successful in generating more income and giving the patient what they want.

Here is a simple exercise. Think about a person you know who is successful in dentistry and make a list of all the skills, attitudes and attributes that person has. Once you have done this, list them as 'skills', 'attitudes' and 'product knowledge'. I bet that on the list there are many skills, such as good communication and listening skills, and the ability to build empathy with the patient. On the attitudes side, are there things like positivity and enthusiasm? Have you also got product knowledge? On occasion, when I have a discussion with dentists, the technical skills are often left out. Although vital, the technical skills involved in doing a job usually only account for about 10-15% of a person's success, and without good communication skills, and the ability to build empathy and gain patient commitment, you might never be able to put your technical ability into practice.

So why is there sometimes negative thinking about the word 'sales'?

Well, maybe our national media doesn't help. It seems that whenever



we see something in the news about selling, it is often about unscrupulous tactics from sales people supposedly conning vulnerable customers. I often think that this is unfair, as it represents a very small percentage that might give the many millions of good sales people out there a bad name. If you think about it, without the ability to sell, the whole country would come to a halt and nothing would ever get made.

It may also be associated with the assumption that 'sales' is about pushing something on a customer when they don't really want it. It is hardly surprising that when I ask the question, 80% of the room don't consider themselves to be in sales.

What is the definition of sales?

A dictionary definition will tell you that it is to exchange goods and services for money or kind, or to convince of value.

There is nothing in the definition that states that it is about pushing people or forcing people into decisions. Let us look at another key word here – the word value. I think value is about finding out what the true value is to the other person in their particular situation. So what about changing your mindset from one of selling, or pushing, to:

- finding out what the patient thinks is valuable (wants and needs); and,
- showing them how you can satisfy their need?

When they believe you can do this, that person will probably buy.

Simple structure

It really isn't about selling; it is about being the provider of significant value. To do this effectively, you just have to follow a few simple, common sense steps. These include:

1. Preparing for your appointment – here you can check the previous notes from your patient's records, have a team meeting on the day

and ensure that you are fully prepared mentally, and that you are positive about your day. You are serving the public: be excited and positive.

2. Building rapport – spend just a few minutes building rapport and making the patient feel important. Talk about work, then, become genuinely interested in the person and make them feel like they are the most important person in the world. Put them at ease.
3. Asking questions – after building rapport you can carry on asking questions, but this time about their clinical health – what they like or don't like about their appearance and what they would like to change. Find out their vision.
4. Providing a solution – only when you fully understand the patient's goals do you provide a solution. Present the benefits of the solution to the patient and do not use language that is too technical. Use evidence to back up what you are saying. An example of evidence could be some before and after pictures of previous treatment you have undertaken. Please ensure that you have written consent from your patients if you are going to show these.
5. Testing for commitment – once you have provided a solution, ask the patient if they are happy and what their reaction is.
6. Asking for commitment – if the answer is positive, ask for commitment.

So think about how you can change your mindset. Look inside yourself and ask what is stopping you. If you think you provide significant value to patients, then why not give more patients the opportunity to have more of the same services? You are doing them and you an injustice if you don't. Pay attention to what you are saying to yourself, such as 'I can't', or 'I won't', and change to 'I can' and 'I will'. Change your mindset to the fact that: "I provide significant value every day to patients", and read some of the letters that you receive from happy patients.

Your team's jobs exist because of your ability to influence people, and if you think about it, without these skills, the Irish economy will come to a halt.

Being able to sell yourself is something to be proud of. Without your ability to communicate well and listen emphatically, patients will not get what they need and in most cases want, and no one then benefits: when done right, both parties benefit.



Ashley Latter is a business coach and has delivered his 'Two Day Ethical Sales and Communication Programme' to over 4,000 dentists/orthodontists, nurses, hygienists, and practice managers in the last 10 years.

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Fully equipped dental surgery or surgeries available in Dublin South suburb. To share premises with two other existing dentists and

hygienist. Would suit general dentist or specialist. Replies to Box Number J210.001.

For sale – South Dublin. City centre two miles. Very busy location with excellent footfall. Good equipment. Room for expansion, plans available. At present expense sharing, overheads low. No medical card. Great figures. Competitively priced. Tel: 086-807 5273, or Email: niall@innovatedental.com.

Quiz answers (from page 67)

1. Single use, do not reuse or use only once, ISO EN 980:2003.
2. All of these items are single use and should not be reprocessed for reuse.
3. "Users who ... prepare single use products for further use, are transferring legal liability for the safe performance of the product from the manufacturer to themselves, or to the organisation that employs them and have become the manufacturer of the device." (Health Services Executive, (2009) Part 5b: Recommended Practices for Dental Services in a Local Decontamination Unit. HSE.)

Do you know your income for 2009?

Do you know your practice profitability in 2010?

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DIARY OF EVENTS

APRIL 2010

Munster Branch Meeting – Communicating with your patients
April 14 Maryborough House Hotel
Speaker is Brendan Barrett of Carr Communications.

Western Branch Scientific Meeting – ‘Failing Endo – what next?’
April 14 Radisson Hotel, Galway
Speaker is Dr Pat Cleary, endodontist. Dr Billy Davis will also present on the Annual Conference 2010 – ‘Pearls of Wisdom’.

IDA First Aid Training Course
April 14 Rochestown Park Hotel, Cork
Course on once a week for three weeks from 9.00am-8.45pm. For further information contact Dario in IDA House, Tel: 01-295 0072.

IDA Training Course – Overcoming Local Anaesthesia – problems in general practice
April 16 69 Eglinton Road, Donnybrook, Dublin 4
Facilitated by Dr Dermot Canavan – Time 11.00am to 6.30pm.
Registration at 10.30am. For further information contact Dario in IDA House, Tel: 01-295 0072.

IDA Board Meeting
April 16 IDA House

IDA Council Meeting
April 17 IDA House

Dental Protection Workshop – Discover the “H” Factor
April 19 Athlone Spring Hotel
Time 6.00pm-8.45pm. For further information contact Dario in IDA House, Tel: 01-295 0072.

Dental Protection Workshop – Discover the “H” Factor
April 20 Hilton Hotel, Charlemont, Dublin 2
Time 6.00pm-8.45pm. For further information contact Dario in IDA House, Tel: 01-295 0072.

Midlands Branch Scientific Meeting
April 21 Tullamore Court Hotel
Meeting is at 8.00pm. Dr Pat Cleary, endodontist, will present on ‘Failing Endo – what next?’, and Dr Billy Davis on IDA Annual Conference 2010.

Legal seminar in conjunction with Hayes Solicitors – ‘Working within the law’
April 22 Burlington Hotel, Dublin 4
Cost €75 for IDA members, €150 for non-members. For further information contact Dario in IDA House, dario@irishdentalassoc.ie.

Course on bone grafting in implant dentistry
April 24 & 25 Altamash Institute of Dental Medicine,
Clifton, Karachi

Dental Protection Workshop – Discover the “H” Factor
April 28 Clanree Hotel, Letterkenny, Co. Donegal
Time 6.00pm-8.45pm. For further information contact Dario in IDA House, Tel: 01-295 0072.

Dental Protection Workshop – Discover the “H” Factor
April 29 Sligo Park Hotel, Sligo
Time 6.00pm-8.45pm. For further information contact Dario in IDA House, Tel: 01-295 0072.

IDA Golf Society – The Lyttle Cup – Irish Dental Association vs Northern Ireland Branch of the British Dental Association
April 30 Royal Portrush Golf Club, The Dunluce Course
For further information contact Dr Ciaran Allen, 12 The Diamond, Monaghan.

MAY 2010

IDA Annual Conference – ‘Pearls of Wisdom’
May 12-15 Radisson Hotel, Galway

Irish Society of Dentistry for Children – Annual Conference
May 20 The Clarion Hotel, Limerick

JUNE 2010

European Society of Dental Ergonomics – Annual Meeting
June 4-5 Ghent University Hospital, Ghent, Belgium
“An ergonomic way of sitting, looking and organising in dental practice. An analysis of important aspects”. For further information contact www.esde.org or secretary-general@esde.org.

Australian Healthcare and Hospitals Association Conference – ‘Chomping into Reform – improving the delivery of oral and dental health’
June 8 and 9 Melbourne, Victoria, Australia
For further information email changechampions@bigpond.com or log on to www.changechampions.com.au.

The World Aesthetic Congress 2010
June 11-12 Queen Elizabeth II Conference Centre, London
For further information, Tel: 0044 1923 851 777, or visit www.independentseminars.com/wac.

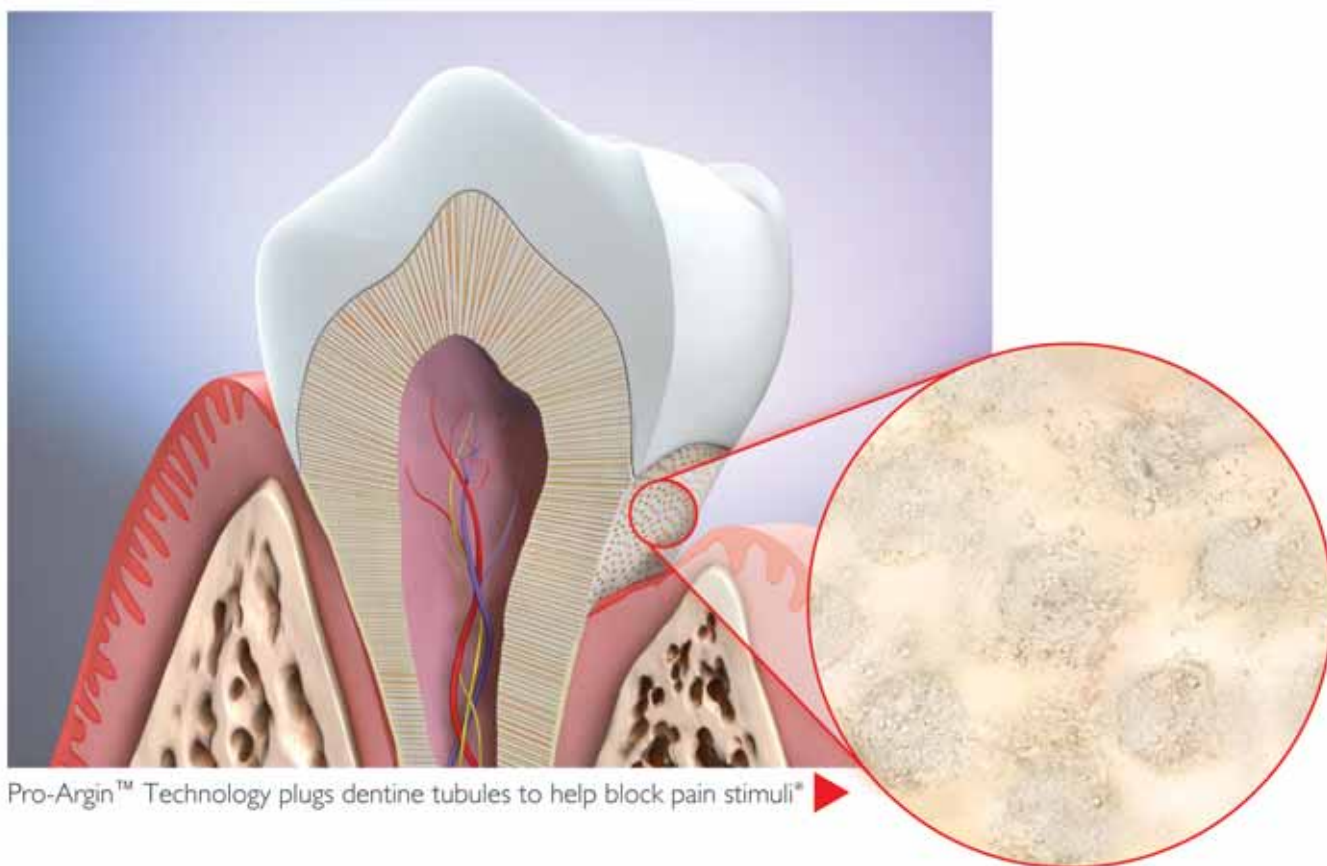
OCTOBER 2010

IDA Public Dental Surgeons Seminar
October 6-8 Clarion Hotel, Sligo
Further information contact Dario in IDA House, Tel: 01-295 0072.

NOVEMBER 2010

FTI 2010 – The 2nd Future Trends in Implantology International Dental Conference
November 11-13 Florence, Italy
For further information contact www.ftidental.com.

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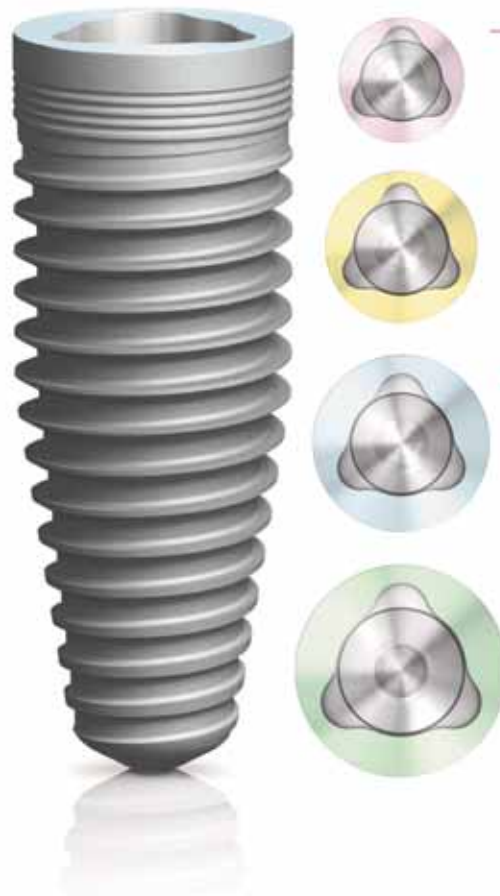
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