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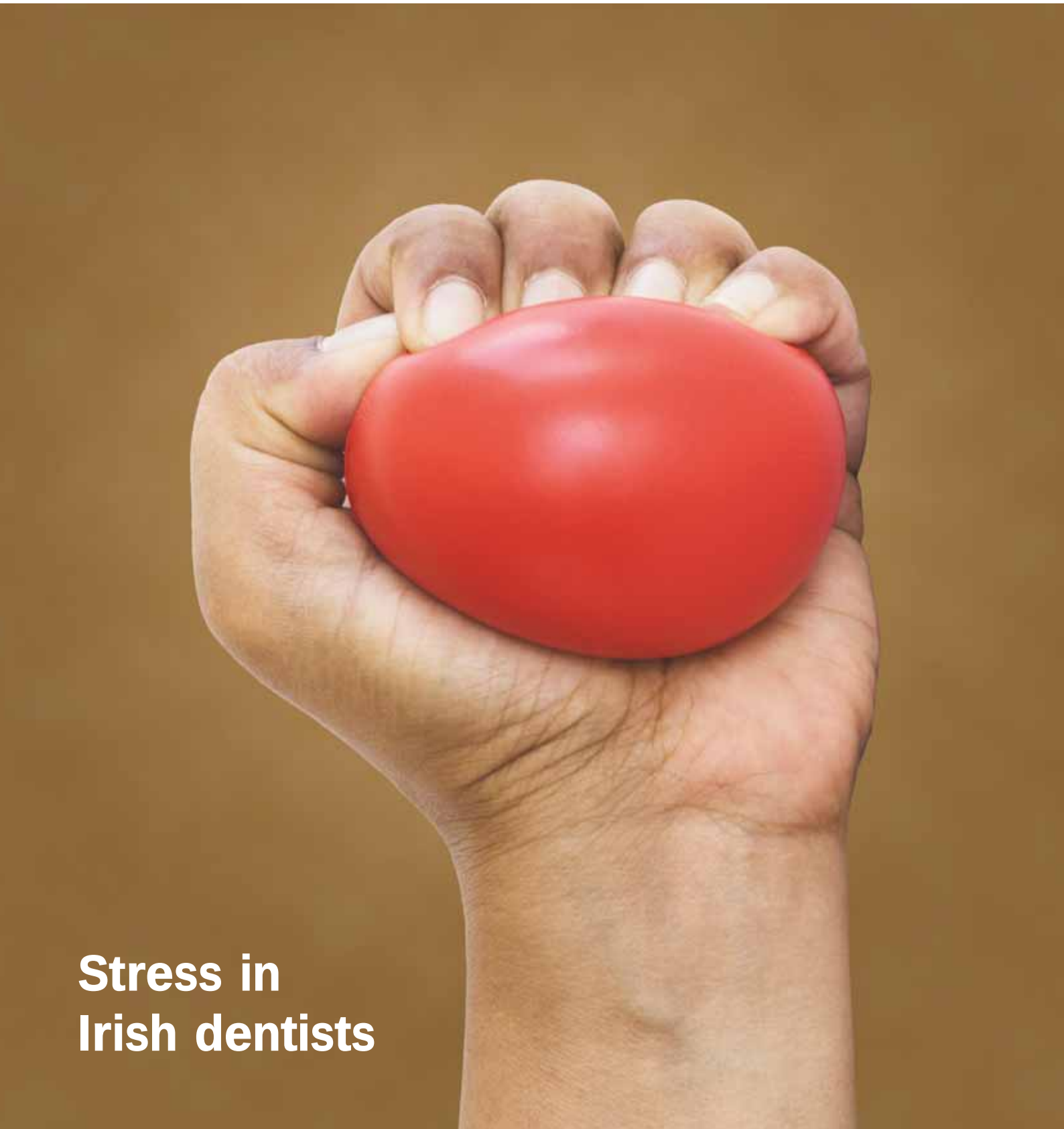
IDA
irish dental association

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann



Stress in Irish dentists

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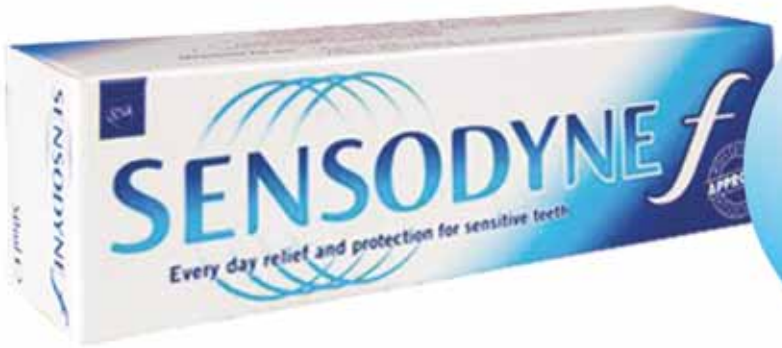

Sensodyne the **number 1** sensitive toothpaste[19]

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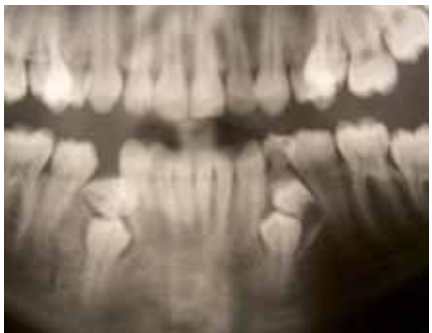

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Protecting patients and educating dentists

Dentists have a responsibility to be advocates for patients, and also for themselves and the whole dental team.

Happy Christmas and best wishes for 2010 from the Editorial Board. At the time of going to print, we are all waiting with baited breath for Budget 2010. There are no easy answers.

Our duty as practitioners is to look after our patients and protect them from 'cuts' that will disadvantage them and their oral/dental health in the future. I have written to the *Irish Times* highlighting the importance of oral health prevention, and the DTBS in particular, in the assessment and early diagnosis of oral diseases and mouth cancer. It may fall on deaf ears/blind eyes, but if we do not speak up for them, who will? The IDA has worked endlessly on your behalf (p. 267 and pp. 274-276) and you need to help them by talking to your local representatives. There is also the opportunity for you to have your say by contacting the IDA about its Strategic Plan (p. 268) for presentation in May. I hope that it prioritises education/training for the whole dental team in a national forum. The use of the IDA website (pp. 268 and 269) as a means of communication is to be encouraged.

CPD is about to become mandatory (p. 266). I can only support this development most strongly, and unfortunately, mandatory CPD is the only way to ensure everybody attends. CPD will help to keep practitioners abreast of what is happening and continual dental education is a very enjoyable way to maintain skills, meet colleagues and develop new modern methods of managing patients. The number of courses available will flourish. My only concern is the lack of resources to support this 'mandatory' training. It is often all about the money. Thank you to the IDA Council, for freezing our membership subscription for 2010 (p. 270).

The PDS seminar was very successful and it highlighted the importance of stress in the workplace (p. 278). This issue is supported by the excellent practice management paper on 'Stress in Irish dentists' (pp. 304-307), and I encourage you all to read it. The pictures on p. 279 show the fun that CPD can be.

Tom talks about Sweden and its decision to increase spending on dental health (p. 283), and also on the issues (pp. 281-283) of "reprocessing single-use medical/dental devices", Bologna, and the dentist of the future and the cross-border healthcare directive.

Our feature on cross infection control (pp. 285-286) highlights the value of CPD for the whole team. Note the 12-point plan for action – ask and you shall receive.

Our scientific section is about career choices for UCC graduates (pp. 288-291) and the drift into VT and obtaining teaching, training and experience abroad. Most (54%) return to work in Ireland. The paper on the demographic and academic profile of consultants/specialists/senior lecturers and lecturers in the dental schools (pp. 296-301) mainly reflects Cork. It highlights the male-dominated regime, despite the large number of females entering dentistry, the fact that our professors/senior lecturers/specialists are on the other side of 40 and we may need to replace them, and finally that a large proportion of the teaching staff are part-time (48%) and relatively young, with less than five years experience (54%). This is not really surprising and certainly benefits the undergraduates in a changing 'modus operandi' of teaching. Small group teaching is the preferred method of most academics but it is resource (staff) expensive and we need to know – is it better? Our senior academics need to reflect their role in a school and use their considered experience to develop this and their research skills to assess it.

Dr Ian O'Dowling unfortunately passed away in October 2009. Our condolences to his family and our support for all his patients, who he looked after all these years. Ian has contributed extensively to the *Journal* over my time as Editor, always addressing the advice given and responding in a very timely manner. It is a credit to his work that we publish this article, which was accepted shortly before his demise. Please read it as a tribute to him. If you have any questions about this paper, please address them directly to the Editor. Thank you for your consideration.

The quiz (p. 273) was too difficult for me, but once I saw the pictures on page 303, I knew what it was all about. This simple quiz demonstrates the importance of broadening our horizons and seeing what others do. If you want to forward a quiz, please do so through our Journal Co-ordinator, Fionnuala O'Brien, who will liaise with the Editorial Board.

The *Journal* can only flourish with its scientific content and the Editorial Board is grateful to the large number of reviewers who have helped this process (p. 273). If your name is missing, please accept my apologies and let me know so that I can get you more papers to review! The amount of work many of you have put into assessing papers, making constructive comments and getting back on time has allowed the *Journal* to grow.

Prof. Leo F. A. Stassen
Honorary Editor

Continuing to campaign

As 2009 draws to a close, IDA President Dr Donal Blackwell highlights the Association's continued efforts on behalf of members.

Budget 2010

Our government faces one of its toughest challenges yet with Budget 2010 just around the corner. Our country's finances are in disarray and we are currently in the worst recession in the history of the state. No one is exempt from these challenging times including the dental profession, and I have spoken to many members over the last while who have had to make very difficult changes to their business model in order to survive.

The suggested abolition of the DTBS (PRSI) Scheme by An Bord Snip would indeed have a detrimental effect on many dental practices around the country and I applaud the Association and in particular the ongoing efforts made by the GP Committee to lobby Government ministers, opposition parties and indeed inform patients in this regard. Your efforts are to be commended.

In a detailed pre budget submission, the IDA reminded the government that children with special needs are being forced to wait up to three years to see a public dentist because of the recruitment ban in the HSE.

The Association has also called for the Government to review the impact of the VAT difference between the Republic and Northern Ireland and to remove VAT from essential dental health products.

Practice management training

I was delighted to have attended two very worthwhile practice management days, in Dublin in June and in Cork in September. There was a healthy attendance at both events and the day included presentations from experts in employment law, marketing a dental practice, financial management, and day-to-day management of your practice. Further practice management events will be arranged for 2010.

CPD

January 1, 2010, will see the introduction of mandatory continuing professional development (CPD) for the dental profession. The IDA welcomes this development and encourages members and non-members to attend the many CPD courses on offer throughout next year. I am delighted to say that the IDA will be launching the online CPD "Engage" system shortly to record, assess and reflect on all continuing education courses. Can I also encourage members to use the members only section of the website (www.dentist.ie) to access many outstanding articles and information on best practice in dentistry.

American Dental Association Annual Conference

I was honoured to be invited by the President of the American Dental Association to attend their Annual Conference in Hawaii in September. It was a fantastic experience to attend the conference, with over 20,000 delegates and over 500 trade stands present. The social programme was extensive with their Annual Dinner being the highlight of the event.

IDA Annual Diary & Directory

Members will already have received their 2010 Diary and Directory. I think you will agree that 2009 has yet again flown by! I hope that you continue to meet the constant demands of running a successful dental practice in 2010 and I encourage you all to use your organisation. Now more than ever you need to be a part of a committed organisation for all dentists in Ireland – the IDA.

May I take this opportunity to wish all IDA members a very happy and joyful Christmas and a peaceful and happy New Year.

Donal Blackwell,
President.

IDA calls on Finance Minister to retain PRSI scheme

The Association has mounted a vigorous campaign in defence of the Dental Treatment Benefits Scheme (DTBS) in recent months, culminating in a meeting on November 24 with the Minister for Finance, Mr Brian Lenihan TD. The IDA delegation, comprising Drs Helen Walsh and John Nolan, IDA CEO Fintan Hourihan, and Clare Dowling, met Minister Lenihan and his Special Advisor Professor Alan Ahearne to outline the value of the DTBS, which is threatened with abolition as recommended in the McCarthy Report.

The IDA emphasised the socially progressive nature of the Scheme and its huge contribution in improvements to the dental health of the population over the past 50 years. They emphasised the vital importance of the Scheme's free check-up in detecting dental and underlying medical problems, and emphasised that up to 400,000 persons had attended for examination in 2008. The fact that contributions of up to €53 per week are being made by working people was also highlighted and the IDA emphasised to the Minister that, given that the working population is likely to bear a disproportionate amount of the strain in the forthcoming Budget, and given the real and tangible benefit of the DTBS, it would make strong political sense to retain the Scheme.

The delegation also drew the Minister's attention to the cost–benefit analysis undertaken by Dr Brenda Gannon on behalf of the IDA, which shows that the State and society would spend €3 for every €1 spent currently on the DTBS should the Scheme be abolished. The Association also emphasised that dentists fully finance their practices and that for Principals, their operating costs are over €100,000 greater in the Republic of Ireland than in Northern Ireland, reflecting the huge cost pressures for dentists in practice in this state.

They also emphasised the fact that dentists have already taken an 8% reduction in professional fees in both the DTBS and the DTSS Schemes, and the fact of the decision to restrict Med 2 tax relief for patients to the standard rate, which had significant implications for dentists on an ongoing basis.

A delegation from the IDA met with the Minister for Finance (from left): Dr John Nolan; Dr Helen Walsh; Minister for Finance Brian Lenihan TD; IDA CEO Fintan Hourihan; and, Clare Dowling.

In conclusion, they emphasised the need for the Minister to recognise the value of the Scheme, as well as its costs, and hoped that he would make any decision on an informed basis. They also took the opportunity to emphasise to the Minister the need to bring forward amendments to Competition Legislation to enable real and meaningful engagement between the Association and the HSE and other agencies in regard to publicly funded schemes such as the DTSS and the DTBS.

In addition, members have agreed to lobby individual government ministers in the run-up to the budget, and the Association is also extremely grateful to all those members who have provided copies of petitions that they have gathered in their surgeries in recent months.

Finally, the Association has also made representations to TDs and Senators in all parties and to non-aligned representatives in recent months, and had a huge turnout of over 50 politicians at its Oireachtas Information Day on October 14 last.

North Western Branch celebrates 50 great years

This year marks the 50th anniversary of the establishment of two branches within the Association – the North Western Branch, covering Sligo, Leitrim and Donegal, and the South Eastern Branch, which covers Waterford, south Tipperary, Kilkenny and Carlow.

The North Western Branch marked its 50th anniversary recently with a splendid dinner attended by current Branch President, Dr Shay McMahon, and fellow branch officers Drs Maurice Fitzgerald and Brian Byrne, as well as former (and future!) officers, including Dr Brendan Flanagan, Peter Doyle and President-Elect of the Public Dental Surgeons Group, Dr Andrew Bolas. Association Chief Executive, Mr Fintan Hourihan, was also in attendance for what was a very enjoyable evening, where epic meetings of the past were discussed, along with plans for a vibrant future.

From left: Dr Peter Doyle; Dr Andrew Bolas; Mr Fintan Hourihan; Dr Shay McMahon; Dr Brian Byrne; and, Dr Noel Sweeney.

Operation Smile

Pictured with Mr Michael Earley, Consultant Plastic Surgeon and Operation Smile Ireland Chairman, at the recent Operation Smile fundraising event at the NCAD, are Dental Volunteers Audrey McGovern, Andrew Norris, Jenny Collins and Ciara Scott. Operation Smile Ireland raises funds and awareness, and provides surgery for facial deformities such as cleft lip and palate in the developing world. Dentists who are interested in volunteering can contact eleanor@operationsmile.ie.

Walrus Dental Seminars

Pictured at the inaugural Walrus dental seminar in Dublin on October 7 are (from left): Gary Dickenson; Aislinn Machesney; Prem Sehmi; Crystal from Walrus Dental; and, Paddi Lund (seated). Prem, a dentist in Yorkshire, set up Walrus Dental Seminars with Gary to bring top international speakers to dental audiences outside London. Speakers were Australian dentist Paddi Lund who, in 'Transforming the experience', described how to build a great practice for patients; Chris Barrow, business coach; and, former All Blacks captain Sean Fitzpatrick.

Find a dentist … are you listed?

Our 'Find a Dentist' section on the IDA website is the main source of information for members of the public who are looking to find a dentist in their area. As a membership benefit, members can include their details in this area; however, you must give permission for this information to be published either on your IDA application form or via email. If you would like to be listed, please Email: Dario@irishdentalassoc.ie.

Code of ethics

The Association has contacted the Dental Council to highlight its wish to make a comprehensive submission in view of the Council's decision to review its Code of Ethical Conduct. Members are welcome to submit their views on appropriate changes by writing to IDA House.

IDA prepares strategic plan

A strategic plan for the Association is to be drawn up for presentation to the Annual Conference in May. Assistance will be provided by management consultants in the preparation of the plan, and the Board and Council will play a full part, along with a representative sample of members, in identifying the key strategic objectives and challenges facing the Association and the range of appropriate responses. The findings of our membership survey will also be examined carefully in preparing our strategic plan. Further information will follow on this matter in due course.

Exclusive website offer for IDA members

The IDA is very aware of the challenges facing dentists in these difficult economic times. Dentists are looking for new and innovative ways to improve business, and using the Internet as a marketing tool could help you to promote your services, as well as providing an information and education service to patients.

With this in mind, the IDA has joined forces with our publishers, Think Media Ltd, to offer an exclusive website service to members.

For a special price of €450 plus VAT for the first 12 months, members will receive:

- registration of your personal website, e.g., drjamesbyrne.ie;
- a choice of three website designs;
- assistance in drafting personalised text for your web pages;
- specially prepared, IDA-approved and regularly updated patient information pages on oral health issues and entitlements;
- hosting and maintenance of the website.

All content will comply with the Dental Council's Code of Conduct Pertaining to Public Relations and Communications. This service is available to IDA members only.

For further information, please contact Tom Cullen or Paul O'Grady, Think Media, Tel: 01-856 1166, Email: tom@thinkmedia.ie, or paul@thinkmedia.ie.

Cork graduate receives prestigious Award

Dr Chris Lynch, Senior Clinical Lecturer and Honorary Consultant in Restorative Dentistry in Cardiff, and a graduate of UCC and RCSI, was recently awarded the British Dental Editors Forum (BDEF) Young Writer Award for 2008/2009. The purpose of the Young Writer Award is to recognise outstanding young dental writers who have made a significant contribution to dental literature, and to identify and encourage those with the potential to become editors of dental journals in the future. Dr Lynch is pictured with Simon Gambold, BDTA President, and Professor Ken Eaton, BDEF Chairman.

Membership subscriptions frozen in 2010

The Board of Directors has decided to freeze IDA membership subscription rates for 2010 in recognition of the difficulties being encountered by members and the overall downturn in the economy. The Board decided to take this unprecedented action at its November meeting and will review the implications for the Association's resources on an ongoing basis throughout 2010.

IDA pre-Budget submission

The Association made a comprehensive pre-Budget submission to the Minister for Finance recently containing detailed proposals on a wide range of issues, including concerns about the threat to the DTBS, as well as a series of recommendations aimed at alleviating the costs being incurred by dentists in everyday practice, supports which could retain and promote employment in dentistry. The submission also highlights the difficulties faced in the Public Dental Service and offers suggestions in regard to patient safety issues and better dental practice facilities, and commentary on the McCarthy Review Group and the Commission on Taxation proposals. A copy of the submission is available to members on request to IDA House. The contents of the submission are discussed in more detail in an article on page 274 of this issue of the *JIDA*.

Celebrating dentistry today

Honorary Fellowship conferring of Prof. Charles Bertolami, Dean, New York University School of Dentistry, by Dr PJ Byrne, Dean, Faculty of Dentistry, Royal College of Surgeons in Ireland.

Over 120 delegates attended the Royal College of Surgeons in Ireland Faculty of Dentistry Annual Scientific Meeting in October, where the theme was 'Dentistry Today: the current status'.

Dr Patrick J. Byrne, Dean of the Faculty, welcomed attendees, and spoke of the illustrious history of the dental school, which is one of the oldest in the world.

Among the speakers at the Meeting, Dr Terry Gregg of King's College Hospital in London discussed research on treatment of caries in primary dentition, and highlighted the need for recognition of paediatric dentistry as a specialty.

Dr Charles Bertolami, Dean of NYU College of Dentistry, spoke on postgraduate dentistry, describing the need for more than a simply clinical or technical approach.

Brien Lang, Professor Emeritus, University of Michigan, and consultant for Nobel Biocare, gave a brief history of prosthodontics over the last three decades.

The lively question and answers sessions raised issues in relation to holistic care, team work, and moving beyond the purely technical/clinical.

New IDA committee

The Association's newest advisory committee, the Quality and Patient Safety Committee, held its first meeting on Saturday, November 7. This Committee has been established to develop a proactive approach to dealing with, *inter alia*, the recommendations arising from recent policy reports such as the Madden report, the new HIQA guidelines and the new guidelines from the Radiological Protection Institute. The members of this new Committee are amongst the most experienced public and private practitioners in Ireland. The Association is most grateful for their voluntary contribution, the fruits of which will be of great benefit to the entire dental profession.

Healthy margins with Ankylos C/X

The confidence of sustained healthy margins provided by Ankylos dental implants offers clinical benefits for patients and commercial advantages for practitioners, according to Dentsply Friadent. The company states: "The system's proven potential to help dentists recreate natural gingival aesthetics and renew normal masticatory function is complemented by the unique choice of indexed or non-indexed abutments in Ankylos C/X. The lasting natural aesthetics and long-term stability of Ankylos-supported restorations result from the unique TissueCare Connection. The exact fitting conical junction between the implant and the abutment ensures preservation of the surrounding hard and soft tissues".

According to Dr Andrew Moore of Advance Implant Clinic in the UK: "The conical taper provides a bacteria-tight seal, which increases long-term bone level stability, maintaining the soft tissue profile around the implant".

Dr Bill Schaeffer of The Implant Centre, also in the UK, adds: "Ankylos is one of the simplest implant systems to place and one of the most forgiving to restore. Because the connection is mechanically so strong, it effectively becomes a one-piece implant".

Dentsply Friadent makes Ankylos C/X dental implants which, they say, offer clinical benefits for patients and commercial advantages for practitioners.

Dentists can boost their reputation and strengthen the long-term relationship with their patients by including dental implants in the range of treatments offered. Practitioners can offer Ankylos C/X implants by restoring cases referred to a competent colleague, referring the whole case, or learning to place implants themselves. Further information on referral can be found at www.dentists4implants.com. Dentsply Friadent's Dental Implantology Skills Development Programme offers implant training for the whole team (www.courses4implants.com).

Heat seal packaging

Hawo Heat Sealer

According to Christian Wolf, Managing Director, Hawo GmbH, heat sealing is the only 100% effective answer to sterile packaging within dental practices. Self-seal packaging materials continue to be widely used in dental practices in the somewhat mistaken belief that they ensure sterility of the instruments therein until their use on the patient. However, says Christian, studies have shown that they do not offer optimum sealing safety: "According to the Medical Device Directive (MDD), as well as the new packaging standard EN ISO 11607, packaging systems for medical devices must maintain sterility until the point of use. This, however, can only be guaranteed if the packaging system ensures the correct sealing of every single package".

New uniforms

The Happythreads website

A new Irish company, Happythreads, is supplying the koi range of boutique scrubs, the Hejco range of tunics and Alegria ergonomic footwear.

Designed in California, the koi range of uniforms is made from a hardwearing, yet easy care, soft poly-cotton twill. With a great choice of colours and styles for both women and men, they also have trousers that come in different styles and leg lengths so that every size and shape can get the correct fit.

According to the company, Dr Eimear McEniff, IDA member, said that when she felt the soft fabric of the koi scrubs she fell in love with them. She added that they don't require ironing and hold onto their shape and colour very well.

Many Irish dentists are familiar with Hejco, a Swedish company providing practical and hardwearing tunics to the dental profession since 1954. These are extremely durable garments, some of which can be machine washed at 85°.

Footwear is an equally important part of cross infection control and Happythreads is also supplying footwear from Hejco and Alegria. The Hejco plastic clogs can be autoclaved at 130° and machine washed at 92° and come in a range of five colours.

New to Ireland is the Alegria range of ergonomic footwear designed for people who spend long hours on their feet. They feature a heavenly footbed padded with latex and memory foam and a rocker outsole reducing heal and metatarsal pressure. "I tried on a pair and I was instantly hooked, wearing them throughout the latter stages of my pregnancy" said Dr Emer Morgan.

Happythreads also provide an embroidery service with a range of specially designed dental logos and will also embroider specific practice names and logos. The embroidery service is undertaken in Ireland, adding real value to the products.

Journal reviewers

Since its inception, the *Journal of the Irish Dental Association* has been privileged to have the support of a large number of reviewers to assist us in carrying out a peer-review process on scientific and other articles. We would like to take this opportunity to acknowledge and thank them for their contributions.

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*This list is the most exhaustive available at the time of going to print. The JIDA apologises for any omissions.

QUIZ

Submitted by Dr Edward Cotter

Answers on page 303

Figure 1.

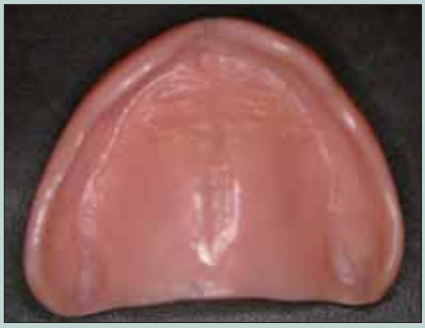

Figure 2.

Figure 3.

An edentulous patient presents at your surgery. They describe that they are unhappy with the facial appearance of their upper lip. They also describe that their lower denture is unstable and it is difficult to control food when they are eating.

1. What is the likely cause of the patient's concerns in the maxilla? (**Figures 1 and 2**)
2. What is the likely cause of the patient's concerns in the mandible? (**Figure 3**)
3. What are the anatomical guidelines in the maxilla and mandible, which will be helpful in correcting the causes?

Dentistry and the Government

The Irish Dental Association submitted a comprehensive document to the Government in the form of a Pre-Budget Submission. Here is a brief summary for Journal readers.

General issues

Taxation

- Med 2 tax relief should be restored to enable relief at the higher rate for taxpayers.
- Tax reliefs for dental treatment should be extended to bring these more into line with reliefs available for medical treatment.
- VAT should be removed from essential dental health products.
- A review of the impact of the VAT difference between the Republic and Northern Ireland should be undertaken.
- A reversion of the Government's decision to reduce the income ceiling for pension tax relief from €275,239 to €150,000 in April's Budget should be carried out.

Government schemes

- We support the introduction of Government Back Loan/Equity Guarantee Schemes.
- We call for the extension of the Government's assurance to pay its bills within 15 days to the HSE.

Business/regulatory costs

- We seek a reduction in the most utilised business costs and regulatory costs to assist the viability and competitiveness of dental practices.

State support for dentists

- We believe that dentists should receive a similar level of funding as is provided to medical general practitioners.

Medical card scheme

- Special ring-fenced funding needs to be set aside for the DTSS to cope with the increase in demand.
- A direction should be issued to the HSE to restore the Examining Dentists scheme.

Social insurance scheme

- The IDA calls on the Government to retain the Pay Related Social Insurance Scheme to ensure the continuance of the improvements gained in oral health in Ireland in the past number of decades.
- The retention of the scheme will assist the financial viability of dental practices and employment in dentistry.

Services for children and special needs patients (HSE)

HSE staffing (see panel story – 'The view on the ground')

- The HSE moratorium on recruitment should not apply to the Public Dental Service because the work of the service deals

The view on the ground

At the recent PDS Seminar in Wexford, ANN-MARIE HARDIMAN asked three public dental surgeons how the moratorium on recruitment is affecting services and morale in their area, and what needs to be done.

Dr Margie Houlihan, Senior Administrative Dental Surgeon, North Tipperary East Limerick.

On the moratorium

"We've had a number of staff go on maternity leave during the last year, including one dental nurse and our special needs dental surgeon, and they have not been replaced. This makes it very difficult to cover if there's sick leave or annual leave.

"As well as that we've had an increase in numbers at our casualty clinics because patients can't afford to attend privately, so there's a greater demand on dentists, dental nurses and hygienists."

On morale

"Morale is extremely poor. Everybody feels that they're doing more work, and they're getting less pay. Dental surgeons in particular I think are very upset about this conference because they're here at their own expense. I've been with the HSE for 30 years and it's the first conference I've attended where there hasn't been funding."

Most pressing issues

"We were very upset that our special needs dentist was not replaced. It's a very poor state of affairs, particularly when they say that they're trying to make sure patients with special needs are not affected.

"Also, I see the lack of continuing dental education as a health and safety risk."

What needs to be done?

"Lifting the moratorium on recruitment and sponsorship of continuing dental education."

mainly with the priority groups of children and people with special needs.
- An explicit commitment is sought to prioritise the employment of front-line clinical staff such as dentists and for the filling of all vacancies to agreed staffing complements as an interim measure.
- We seek the immediate appointment of a senior dentist within the Directorate of Clinical Care and Quality.

Orthodontics/funding for services
- Ring-fenced funding is sought to engage general dental surgeons in extraction and restorative treatments associated with orthodontic care for children.
- National Treatment Purchase Fund funding should be made available to expedite treatment by public dental surgeons for all special needs patients on waiting lists after three months.

Patient impact assessment
- We call for the publication of a full patient impact assessment of any changes proposed in the delivery of dental services by the HSE.

Investment in IT
- The enhancement of services through investment in the existing underperforming electronic patient records systems is advocated.
- We call for the completion and roll-out of the planned National Dental Office to manage the day to day running of the electronic patient records system.

Children's services
- We emphasise the involvement of primary healthcare workers prior to dental intervention in children.
- The development of referral pathways from primary and secondary care institutions for high risk children is advocated.
- We seek a commitment to implementation of the recommendations of the evidence-based guideline "Strategies to prevent dental caries in children and adolescents" (2009).

Senior appointments
- We call for the immediate appointment of a senior dentist within the Directorate of Clinical Care and Quality announced by the HSE in July 2008.
- We call for the immediate appointment of the Chief Dental Officer within the Department of Health.
- We advocate the immediate appointment of a Senior Clinician in the HSE.

Primary care reform programme
- The capital allowances as proposed by the Department of Health and Children in its submission to the Commission on Taxation should be made available to professionals committed to the delivery of primary care services and investors who incur expenditure on qualifying primary care centres.
- Qualifying developments should include all primary care centre developments approved by the HSE since December 2007.

Dr Rosarii McCafferty, Senior Administrative Dental Surgeon, Dublin North East Region, and current Vice President of the PDS Group

On the moratorium

"We were traditionally understaffed in Co. Meath, and then this year we have lost four dentists through natural attrition, and they will not be replaced."

On morale

"Morale is low. We're under immense pressure, and it's not sustainable; things are going to go wrong. The patients who are being seen are extremely supportive, but the patients who are on the end of the phone are not because they're very fed up.

"On top of that we have just dealt with all the pension levies and the cuts."

Most pressing issues

"We have closed clinics in Ashbourne, Dunboyne, Dunshaughlin, Trim and Enfield. We only have three general dental surgeons, so we have pulled everyone in to an emergency service in Navan. This year, for the first time in Co. Meath since school screenings were introduced, we are not offering a school screening service at all."

"I think that what's happened in Co. Meath is showing what is going to happen to everybody."

"They say in the HSE that the standard of treatment has not dropped, but the access to treatment has dropped. If somebody smashes their front teeth, they will get a good standard of care. But there's no prevention, no intervention at all for kids with cavities."

What needs to be done?

"Exempt us from the moratorium – that's all we need."

Competition law restrictions

- The Association should have its role recognised when amendments to the Competition Act are considered.

Incorporation

- Absolute clarity on the interpretation of the law relating to the incorporation of dental practices should be provided.

Patient safety issues

- We believe that specific allowances or accelerated reliefs should be available to assist in the creation of separate decontamination rooms and segregated areas in dental practices.
- Grants or accelerated tax allowances would assist in the cost of the installation or upgrading of amalgam separators.
- We seek a once-off grant or accelerated tax allowances to assist with the installation of digital radiography equipment and retrospective application of any such grant aid or allowances.
- We are calling for the extension of existing tax reliefs of €300 available to dentists employed by the HSE towards meeting necessary and essential expenditure.
- We seek tax reliefs for staff who attend accredited patient safety training courses, manual handling, CPR, ACLS and other relevant courses such as infection control courses.

Practice refurbishment

- The gradual introduction of accelerated capital development allowances should be considered.
- We seek funding for premises access for the elderly, special needs, and mobility restricted cases.
- Supports towards the purchase of expensive dental equipment such as chairs, radiology equipment and other essential matters should be considered.

Promoting employment

- The reliefs granted in the Finance Act (No.2) 2008 in relation to start-up companies should be extended to healthcare professionals.
- We seek the introduction of initiatives to meet the initial cost of employing nursing and administrative staff in dental practices.
- Some form of allowance or contribution towards the increasing costs of professional indemnity insurance for dentists should be considered.
- We call for targeted assistance for practitioners choosing to establish in remote rural settings and inner city locations.
- Assistance towards the costs of participation in clinical audit is sought.
- We are asking that the Department of the Environment, Heritage and Local Government gives urgent attention to our request for a significant reduction in the RPII license fee, either in the form of a reduction in the net amount by approximately 30% or by agreement to have the €300 fee apply for a four-year period as obtained heretofore.
- We are seeking the extension by the HSE of the clinical waste collection scheme to dental practices.

Dr Barney Murphy,
Principal Dental Surgeon,
Dublin South West.

On the moratorium

"We have not been significantly affected but that's through luck rather than design. None of my staff are retiring, resigning or moving on, but I know that the moratorium is biting very hard in certain areas."

On morale

As far as I can tell, morale is good, but then again my staff haven't had to cover for absent colleagues, or double job, or say to parents: 'we're not going to do fourth class this year', like some of their colleagues in other areas."

Most pressing issues

"We don't have a voice high enough within the organisation – a Chief Dental Officer in the Department of Health, who should be the platform to project oral health as an important mission within the Department, and a Chief Dental Surgeon within the HSE, who will go out and fight to keep the resources within oral health, and take a strategic, nationwide overview.

"I was involved in [drafting] the National Oral Health Strategy but that policy isn't being published. We were under great pressure to get it finished, but now the draft is sitting somewhere and nobody is prepared to answer me when I ask when it's going to be published. It's nonsense."

What needs to be done?

"[The appointment of a] Chief Dental Surgeon in the HSE, with proper structures and proper resources to do a job on a national basis."

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PDS Seminar a success despite difficult times

At the gala dinner were (from left): Derek Broaders; Laverne McGuinness, HSE; PDS President Dr Jane Renehan; and, IDA CEO Fintan Hourihan.

The challenges facing the Public Dental Service in these recessionary times were a prominent topic of conversation at this year's Public Dental Surgeons Annual Seminar, which took place from October 7-9. A strong turnout of over 200 members of the whole dental team gathered in Whites of Wexford for a packed programme including lectures, workshops, the AGM and, of course, some lively social events. This year's seminar focused on emerging dental issues, and a distinguished panel of speakers from Ireland and abroad covered topics ranging from dental issues in the paediatric oncology patient to appropriate oral care for older people. As well as clinical issues, speakers covered financial advice, stress management and preventive care. The AGM raised a number of crucial issues in relation to cutbacks in services and the current moratorium on recruitment. The Seminar also featured workshops on CPR and clinical audit in radiology and, as always, a comprehensive trade show offered the latest in equipment and products from the dental industry.

For the first time this year, the Seminar also featured a parallel session with the Oral Health Promotion Research Group (OHPRG) – Irish Link, and delegates from North and South of Ireland came together for the joint programme. PDS Group President Jane Renehan welcomed the OHPRG delegation to the Seminar, and praised their chosen theme: 'Promoting dentists' health – looking after ourselves in challenging times'.

The parallel session featured a presentation by Dr Ronald Gorter, a clinical psychologist specialising in social dentistry at the Academic Centre for Dentistry, Amsterdam, who carried out research on stress among public dental personnel in Northern Ireland. Dr Gorter spoke about the causes of stress in the dental professions, and then presented some results of his research. Among the study's conclusions was the fact that one-quarter of dentists is at serious risk of burnout, with time pressure, financial worries and difficult patients cited as the most troublesome aspects of work.

Among the presentations at the main programme on Thursday afternoon, Dr Debbie Lewis outlined a range of measures to create a seamless approach to care for older people and people with special needs, whether living at home or in institutional care. She emphasised that education and training for carers is crucial, and that oral healthcare is a human right, but one that it is often lost in other concerns, especially when patients suffer from dementia or other significant health problems.

On Friday morning, Dr Carmel Parnell of the Oral Health Research Services Centre in Cork, gave a presentation entitled 'What's the CRAC? Caries preventive strategies for the Irish Public Dental Service'. CRAC stands for Caries Risk Assessment Checklist, a recently developed evidence-based tool for dentists. The aim of the checklist is to encourage a formal, systematic approach to identifying individual children who may be at high risk of developing decay.

On Friday morning, a presentation on interpretation of radiographs by Dr Donal McDonnell brought an end to another highly successful Seminar.

At the gala dinner (from left): Dr Thomas Brennan: and, former IDA President Dr Ena Brennan.

At the reception in Greenacres (from left): Drs Monica O'Hara; Eimear Clifford; Mary Harding; Carol Hassett; Mary Finn; and, Maeve O'Connor.

Attendees at the PDS AGM.

At the gala dinner (from left): Frankie Finnerty; Deirdre Martin; Bridget Kelly; Dr Ronald Gorter (speaker); and Margaret O'Malley, Chair, OHPRG.

At the gala dinner (from left): Dr Bernie Tiernan; Dr Debbie Lewis (speaker); Dr Anne O'Neill; Dr Colleen O'Neill; Finbarr O'Donoghue; and Dr Carmel Parnell (speaker).

Incoming PDS Group President Dr Jane Renehan (left) presents the new Past President's pin to outgoing President Dr Rosarii McCafferty. The pin was introduced at this year's Seminar.

Mirror, mirror on the wall, who's the best brusher of them all?

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- Brush for at least two minutes – using a timer can help brush for longer
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Sweden increases spending on dental health

CED Honorary Treasurer TOM FEENEY provides an update on European developments.

View of Stockholm.

Reprocessing of medical devices

The European Commission has to prepare, by September 2010, a report for the European Parliament and the Council on the issue of reprocessing of medical devices. To prepare this report, the Commission launched a public consultation in 2007 and organised a workshop in 2008.

The Commission has now asked the Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR) to prepare a scientific opinion on the safety of reprocessed single-use medical devices. The deadline for submission of information is December 15, 2009. The CED is now exploring what its position on this issue should be, through its Medical Devices and Infection Control Working Groups, in order to prepare a thorough response to SCENIHR in December 2009.

Bologna Process

The CED's general position on the Bologna Process remains that the unity of the dental training cycle should be maintained to ensure that the high quality of training of dentists should not be jeopardised or weakened. The CED opposes the implementation of the two-cycle structure for the dental profession and has called on academics and politicians responsible for education and health, for the protection of the dental profession and the public, to exclude dentistry from the two cycles completely, refusing to transform their curricula into the two-tier degree system. The CED notes that individuals with a Bachelor degree in dentistry are not sufficiently qualified to practise dentistry, and that any attempt to allow them entrance to the EU labour market would put patients at risk, as well as clearly contradicting Directive 2005/36/EC.

Since 1999 the European University Association has conducted a biennial survey of the extent to which universities and polytechnics have implemented the Bologna Process. As part of their regular stocktaking exercise, the Bologna signatory governments take note of the survey results. The next survey – 'Trends 2010' – will be presented to ministers in March 2010 when they convene to celebrate the setting up of the European Higher Education Area.

For the first time, the 'Trends' survey features a question on the regulated professions. Responses to the question have already been received from 23% of the estimated 4,000 higher education institutions in Europe. In response to the following question: "If the following professional disciplines are taught at your institution, does the Bachelor/Master structure apply to them as well?" the following table was compiled:

T2010	Yes	No	Not offered at my institution	NA	Total
1. Medicine	13%	18%	53%	16%	100%
2. Dentistry	8%	13%	63%	17%	100%
3. Architecture	19%	6%	59%	16%	100%
4. Pharmacy	11%	12%	61%	16%	100%
5. Nursing	25%	5%	55%	15%	100%
6. Veterinary	5%	6%	72%	17%	100%
7. Midwifery	13%	6%	63%	17%	100%
8. Teacher training	48%	11%	30%	11%	100%
9. Law	37%	11%	40%	13%	100%
10. Engineering	51%	8%	30%	11%	100%

While the number of countries operating the two-cycle training structure in dental education is small, it is growing and is likely to grow further in the coming years.

Amalgam

The World Health Organisation (WHO) Global Oral Health Programme, alongside the United Nations Environment Programme (UNEP), is planning to consult on the necessity to propose a worldwide ban of the use of dental amalgam. The main driver for this proposal is environmental with a concern about health outcomes from a risk of contamination of the environment by mercury.

The FDI proposed in Singapore that it, as an organisation, leads on a united professional response and involvement in the consultation. At the same time, the FDI asked that dental associations in all countries lobby appropriately, making sure that, worldwide, we are consistent in our messages.

Within the European context, the Commission is also beginning to prepare for a revision of the 2005 Community Strategy on Mercury and has asked the CED for information about environmental issues. The CED is aware that the Parliament is seeking to revise the 2005 Community Strategy on Mercury during 2010. The Commission expects the questions in preparation for the revision to centre on the environmental challenges rather than safety per se of materials, which was addressed by the SCENIHR report in 2008. The CED has been asked some preliminary questions in regard to the storage, preparation, transportation and disposal of amalgam and its constituents, and also the associated costs. The questions refer to the implications for both practitioners and suppliers.

At the forthcoming CED General Meeting, the Amalgam Working Group will propose that the CED amends its current resolution to bring it up to date and supports the global response to the WHO/UNEP, and that the Amalgam Working Group co-ordinates activity in terms of lobbying and communication with the EU Commission.

Update on the cross-border healthcare directive

On April 23, 2009, the European Parliament adopted, during the first reading, the report on the proposal for a directive on the application of patients' rights in cross-border healthcare. The EPSCO Council (EU ministers for health) discussed the draft directive during their meeting on June 8-9. As expected, no agreement was possible.

Of most interest to the CED was the discussion about whether some healthcare providers should be excluded from the directive. About half of member states, including Portugal, Poland, Italy, Ireland, Hungary, Slovenia, Cyprus, Romania, Lithuania, Malta and Slovakia, felt that private providers or providers not registered or contracted to the national health system should be excluded from the scope of the directive; the other half felt that they should be excluded only if they do not satisfy safety and quality standards.

In July, the responsibility for the draft directive was transferred to the Swedish EU presidency. During the same month, the Swedish presidency produced a compromise proposal for the directive. The Swedish compromise text was discussed in the Council Working Party on Public Health at several meetings in September and October. By the end of October no agreement had been reached. Spain, Portugal, Belgium and Italy were reportedly most opposed to the proposal. The Swedish presidency was preparing another version of the document to be discussed in the Council in November, and remained optimistic that an agreement could be achieved in time for the health ministers' meeting scheduled for November 30 to December 1.

If the health ministers support the directive, it will need to return to the European Parliament for a second reading. The Swedish compromise text was based on the Commission proposal for the directive and many suggestions adopted by the European Parliament in their report of April 2009 were not included. As a result, we can expect that the Parliament will have many comments on the Council text. If the health ministers reject the Directive, the discussions in the Council will have to continue in 2010 under the Spanish and Belgian EU presidencies. As both countries appear to be opposed to the draft directive in principle, not much progress in expected during their terms.

The CED Brussels Office has monitored the discussions in the Council during the past months and has been in contact with both the Czech and the Swedish EU presidencies. CED Task Force Internal Market has been regularly updated on new developments. CED activity in 2010 will depend on the outcome of the health ministers' meeting scheduled to take place at the end of November. If an agreement is reached by the health ministers and the issue returns to the European Parliament, the CED would again have the opportunity to lobby the MEPs and propose its own amendments to the directive.

Brussels office update on co-operation with EPF

At its meeting on September 18, 2009, the CED Board confirmed its interest in further developing co-operation with the European Patients' Forum (EPF). The Board agreed that a member of the EPF Board would be invited to the CED General Meeting in Santiago de Compostela in May 2010 and that, at a later stage, further steps could be envisaged, such as signing a co-operation agreement or an agreement on common principles, developing joint practical projects, and organising a joint meeting of Boards.

At a recent meeting of the CED with EPF President Anders Olauson in Brussels, discussions took place on the structures and priorities of the two organisations. The EPF functions as a European umbrella organisation of patients' organisations, either national organisations or organisations of patients with specific interests. They do not have member organisations focusing specifically on dental issues and are for that reason even more interested in working with the CED. They are interested in co-operation with the CED in areas such as health literacy, patient safety and quality of care, exchange of information (newsletters) and e-Health (a priority for the EPF).

Stockholm City Hall, location of the annual Nobel Prize dinner.

Tobias Nilsson, Special Adviser to the Swedish Minister for Health & Social Affairs, addressed the CED Board Meeting in Stockholm in September 2009.

Sweden increases spending on dental health

At the recent Board meeting in Stockholm the guest speaker, Tobias Nilsson, Special Adviser to the Swedish Minister for Health & Social Affairs, spoke about reforms to the Swedish national insurance systems in order to provide better dental care for the population. The current government continued the reforms started some time ago by the previous government. In short, a need for more dental care was identified and the government has substantially increased spending at a time when most EU states, and very notably our own, are looking at ways to cut back on funding of health services. The system is structured so that those in greatest need of treatment get most.

The system that is now in place consists of the following:

1. To encourage regular examinations and prophylaxis every citizen gets:
- €30/year that can be aggregated for two years (20-28 and >75 years of age); and,
- €15/year that can be aggregated for two years (29-74 years of age).

2. The real benefit comes in the area of high cost treatments. For every treatment there is a reference price on which the reimbursement is calculated. The dentist is free to charge according to his own price list:
- the patient pays 100% up to €300;
- from €300 to €1,500, the patient gets a 50% reduction of the reference price;
- over €1,500, the patient gets an 85% reduction of the reference price; and,
- if the dentist charges more than the reference price, the patient has to pay 100% of the surplus.

3. The next step is to reform the existing rules about dentistry delivered to patients with complicated anomalies and to people with sickness that has an influence on their oral health. These groups are at present regulated at county level and the patients that are included in this category get their dental care in the health and sickness insurance system. When the patient has paid €90, he/she gets the rest of the treatment free in that year. All of these treatments have to be examined and approved in advance.

Patient safety

At their meeting on June 9, 2009, EU health ministers adopted a recommendation on patient safety, including the prevention and control of healthcare-associated infections. In relation to healthcare-associated infections, Member States were encouraged to adopt and implement a strategy for prevention and control of such infections at national and/or regional levels, and to improve procedures at the level of healthcare institutions.

On September 24, 2009, CED Head of Office Nina Brandelet-Bernot attended the first meeting of the Commission-led Patient Safety and Quality of Care Working Group. The Group, which over the past few years contributed to the development of a draft Council Recommendation on Patient Safety, discussed its new mandate. The Commission has suggested that the Group should now focus on developing input for a possible future Joint Action on Patient Safety or Patient Safety and Quality of Care (to be adopted at the earliest in 2011) and developing ideas for possible policy actions at EU level on quality of care.

The CED Brussels Office will continue to participate in the Patent Safety and Quality of Care Working Group and report on any relevant developments.

FEATURE

Cross infection control

Dental team members heard of impending new standards in cross infection control at a recent meeting in Dublin. The *Journal of the Irish Dental Association* was present.

The large meeting room was full.

There was a very strong turnout for the Metropolitan Branch's meeting (in association with the Irish Faculty of Primary Dental Care) on 'Cross Infection Control and Prevention' at the former Berkeley Court Hotel (now D4) in Ballsbridge in Dublin in October. A marked feature of the event was the number of dental team members that were present.

Microbiology in the surgery

Professor David Coleman is a microbiologist at the Microbiology Research Unit in the Dental Hospital attached to Trinity College Dublin. He initally identified Pseudomonas as potentially nasty organisms which live in waterplugs and are present in most handbasins. "They can live on Dettol and Savlon and are ubiquitous. However, they are not normally a problem unless they enter broken skin." Of much more concern for Professor Coleman in relation to dental surgeries were biofilms, which he decribed as 'the norm' and very dangerous. It is, he said, comparable to dental plaque. Water hoses and suction pipes all tend to have biofilm contamination. A particular problem with biofilm in water lines and suction pipes is that protozoa and Legionella can live and thrive in them. He advises that water lines be disinfected and flushed through for at least a minute at the start and end of each day. The hot water coming to your tap should be greater than 50 degrees and the cold water less than 18 degrees. There are commercially available taps with built-in sensors when you put your hand under the tap, water will flow at a comfortable temperature to wash your hands, without having to handle the taps.

Also, according to Professor Coleman: "Legionella is common in dental chairs but regular disinfection will deal with it".

Mary J. O'Donnell addressed the development of an infection prevention and control policy, as well as personal health elements including hand hygiene, and waste management. Mary, who trained initially as a dental nurse, and has recently submitted her PhD thesis, was a member of the investigation team for the Independently Chaired Report on Legionellosis at Waterford Regional Hospital. Among her more frightening pronouncements was the fact that 87% of endodontic files get re-used – despite the fact that they are single-use items. There are other single-use items she is aware of that are used more than once.

Dr Ronnie Russell has specific interest in applied microbiology and immunology research and is based at the Moyne Institute of Preventative Medicine at TCD. His expertise in microbiological policy, legislation and standards was reflected in his presentation in which he outlined the policy for cleaning, disinfection and sterilisation of reusable invasive medical devices, which is likely to be implemented in Ireland in the near future.

The appliance of science

Dr Barry Harrington, part-time lecturer at the DDH, went through the details of the Central Sterilisation Unit (CSU) or Central Decontamination Unit (CDU), which will be required to be in every dental surgery in the future (when the new National Standards for the Prevention and Control of Healthcare Associated Infections come in). A brief summary of that Unit's sequence of work follows, but first he posed and answered a question: how can you prove that Mrs Murphy did not get a cold from dirty instruments in your surgery? Answer: you must operate your decontamination unit, you must keep records of its use, and you must have an annual external check. Through that process and the traceability made possible through your records, you will be able to demonstrate that you know which instruments were used on Mrs Murphy and that they had been fully sterilised prior to their use on Mrs Murphy.

That process works (and this is a very brief summary) as follows:

- dirty instruments should be put into a holding area;
- they should be put through a cleaning process including an ultrasonic unit and a washer-disinfector unit;
- there should be a rinsing facility (sink);
- there should be a packing area;
- when packed they are put through an autoclave; and,
- then they should be put in a storage area, ready for use.

Perhaps they key issue here is that all dental clinics will have to have a designated non-clinical area (separate from all other work areas) called the Central Decontamination Unit. This area must have adequate lighting and ventilation and the walls must be smooth, washable and water resistant. It must have a room temperature of 18-22 degrees Celsius and have low humidity (35-60%). Flooring should be of the washable and non-slip type. All surfaces must be washable and special

Speakers photographed with the President of the Metropolitan Branch (from left): Professor David Coleman; Mary J. O'Donnell; Metro President Dr Lynda Elliott; Dr Ronnie Russell; and, Dr Barry Harrington.

Dr Tom Feeney chatting with Dr Vinnie Nolan.

Angela Connolly; Mary Lynch; Jenny Collinge; and, Dr Edward Cotter, all from Dr Cotter's surgery.

Sarah Cregan and Audrey Walsh from the Fitzwilliam House Dental Practice.

attention must be paid to those areas where surfaces meet and junctions occur. The area must be managed by a trained and designated person. That person, in association with the dentist(s) in the practice, must develop a strict protocol for the operation of the unit, which ensures that instruments are properly sterilised, remembering that it is impossible to sterilise a dirty or wet instrument.

Dr Harrington then outlined the instrument flow from dirty to clean to sterilised and ready for use. A couple of important points emerged:

- washing by hand of contaminated dental instuments will not be an approved procedure for dirty dental instruments; and,
- the washer steriliser should be set into a wall dividing the 'dirty area' from the 'clean area' and have doors on either side for loading the dirty instruments on one side and unloading the clean instruments on the other.

The implications of the cost to dentists were very clear to Dr Harringon. He concluded: "The viability of the single-handed practitioner to be able to sustain such costs, in the light of the current economic climate, is to be seriously questioned.

There is no doubt that a properly run CSU could service two to four dentists or more, for practically the same capital and labour costs of servicing one practitioner."

12-point plan for action

Dr Harrington has compiled a 12-point plan for surgeries to comply with the new standards. He says: "It is important to realise that though the legal position is that the new rules are on the statute book, and will be implemented at some date in the future, this will not happen overnight. This means that we all have time to organise, consider financial implications, and implement a programme to prepare our practices for the forthcoming implementation of this programme, and to develop your practice's response to developing your own CSU."

The 12-point plan is available from Dr Harrington and may be available from the IDA in the future.

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Plan now for 2010

In a previous edition (Journal of the Irish Dental Association, October/November 2008), accountant DAVID McCAFFREY looked at how dentists needed to manage their practice cash flow. In this article, he looks at the need to prepare for further change.

At a recent meeting organised by the Irish Dental Association and Omega Finance, Jim Power, Chief Economist with Friends First, gave a very sobering assessment of the state of the Irish economy and the prospects for the future. For 2010 the ESRI is predicting consumer spending to fall by 2% which will follow an expected 7% fall in 2009. Growth may return to the economy at the back end of 2010 but any growth in 2011 looks as if it will be weak. It is difficult to see any change in the economic environment that will lead patients to increase spending on dental treatments in 2010 or 2011. According to the latest report from the Organisation for Economic Co-operation and Development, living standards in Ireland are likely to remain "permanently lower". The upcoming budget for 2010 has the potential to place further pressure on dental income, in particular any reduction to the PRSI dental scheme.

2009 trends are challenging

Many dentists have been challenged in 2009 by trends in patient attendances whereby practices have experienced an increase in patient attendances only to be followed by a sudden drop. Dentists are having to see more patients in order to maintain income levels as the fee income per patient has reduced. This can be difficult to manage within a practice and can place a large strain on dentists. Dental associates have suffered in particular as principals have naturally tried to protect their income by cutting back on sessions worked by associates.

Last year we emphasised how cash flow management in dental practices was going to become increasingly critical, and this has been borne out over the last year. Many dentists have found the payment of taxation this year particularly difficult to manage, with preliminary tax obligations for 2009 having to be reduced. For most dentists finance is still available for short and longer term projects, although the banks have become much more demanding and challenging on the information required to back up an application for finance. As well as the previous year's financial accounts, good quality management accounts are being requested.

Prepare forecasts

Dentists now more than ever need to prepare forecasts for the coming year. Practice forecasts do not have to be complicated and can be kept at a high level. The important thing is to be able to assess the impact on the profitability of the practice of any change in the key income or expenses categories. If we look at the profitability of a practice for 2008 compared to 2009 where income falls by 10% and there are modest inflationary increases in the laboratory and fixed costs, the resulting practice income falls by 31%. A decrease of this magnitude would have a significant impact on a dentist's disposable income.

	2009 €'000	2010 €'000	% Change
Turnover	340	306	-10%
Lab costs	32	33	+2%
Fixed costs	187	189	+1%
Income	121	84	-31%

Examine your expenses

Where PRSI and GMS payments can make up to two-thirds of income in many practices, the impact of any potential changes to either of these schemes needs to be understood well in advance and contingency plans considered. All elements that make up expenses need to be reviewed, fully understood and challenged.

For example:

- property rental costs – review terms relating to rent reviews;
- wages – are there options to change staffing patterns, can any of the employees be paid on an hourly basis rather than flat weekly wages?;
- consumables – are you getting the best prices, are you shopping around?;
- consumables – when is stock being ordered? By ordering at the beginning of a month you may be able to extend credit terms as most dentists pay on statements issued at month end.
- laboratory costs – bear in mind that dental laboratories are also suffering due to a fall in your elective work. Can any deals be done without sacrificing quality?;
- office consumables – are you getting the best prices by shopping around?; and,
- loans/leases – are there options to refinance structural loans relating to the practice?

Keep on top of performance

Once again we recommend that practices prepare internal management accounts in order to keep on top of how practices are performing. As planning for taxation liabilities in 2010 will again be important you should try to give your accountant the practice books early in the New Year and get a view on the cash required well in advance so money can be set aside. In the current challenging environment dentists need to be proactive in reviewing the services offered and advertising those services. Costs should be reviewed to prepare the business for the coming year of challenges and in preparation of the eventual upturn in the economy.

David McCaffrey MBS, ACMA, is a partner with specialist dental accounting practice MedAccount.

PEER-REVIEWED

Career choices on graduation – a study of recent graduates from University College Cork

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Précis

Increasing numbers of new graduates from University College Cork (UCC) are choosing to take part in vocational training. In addition, many graduates initially move away from Ireland.

Abstract

Introduction

Irish dental graduates are eligible to enter general dental practice immediately after qualification. Unlike their United Kingdom counterparts, there is no requirement to undertake vocational training (VT) or any pre-registration training. VT is a mandatory 12-month period for all UK dental graduates who wish to work within the National Health Service. It provides structured, supervised experience in training practices and through organised study days.

Aims

This study aimed to profile the career choices made by recent dental graduates from UCC. It aimed to record the uptake of VT and associate posts, and where the graduates gained employment.

Methodology

A self-completion questionnaire was developed and circulated electronically to recent graduates from UCC. An existing database of email addresses was used and responses were returned by post or by email. A copy of the questionnaire used is included as Appendix 1.

Results

Questionnaires were distributed over an eight-week period and 142 were returned, giving a response rate of 68.9%. Responses were gathered from those who graduated between 2001 and 2007; however, the majority came from more recent classes. Overall, the majority of graduates took up associate positions after qualification (71.8%) with smaller numbers undertaking VT (28.2%). Increasing numbers have entered VT in recent years, including 54.3% from the class of 2007. Overall, the majority of graduates initially took up positions in England (43%); however, in recent times more have been employed in Scotland. Subsequent work profiles of the graduates illustrate that the majority are now working as associates in general practice (51.4%) and in Ireland (54.2%).

Conclusions

- There has been an increase in the proportion of UCC graduates undertaking VT.
- Graduates tended to move away from Ireland initially to gain employment.
- There has been a shift away from employment in England towards Scotland where the majority of new UCC graduates are now initially employed.
- The majority of graduates returned to Ireland for employment after the initial move away.

Journal of the Irish Dental Association 2009; 55 (6): 288-292.

Table 1: Respondents categorised according to year of graduation.

Graduation year	Respondents (N)	Respondents (%)
2001	6	4.2
2002	9	6.3
2003	18	12.7
2004	24	16.9
2005	24	16.9
2006	26	18.3
2007	35	24.6

Table 2: Positions immediately after graduation analysed according to year of graduation.

Graduation year	Position immediately after graduation (%)	
	Vocational training	Associate
2001	0	100
2002	0	100
2003	0	100
2004	12.5	87.5
2005	20.8	79.2
2006	50.0	50.0
2007	54.3	45.7
Total	**28.2**	**71.8**

Introduction

Irish dental graduates are eligible to enter associate positions within general dental practice in Ireland or the United Kingdom (UK) immediately after qualification. There is no requirement to undertake any formal pre-registration training or examinations as seen in other medical disciplines. Since 1993, vocational training (VT) has been a compulsory requirement for all UK dental graduates who wish to work independently as practitioners within the National Health Service (NHS).[1] It is a 12-month training period designed to provide an introduction into general practice, which allows for strengths and weakness to be identified and built upon.[2] Vocational dental practitioners (VDPs) work in approved practices with designated trainers who provide supervision, in-house training and help on demand throughout the training period.[3] VDPs are paid a set annual salary irrespective of patient through-put in order to reduce financial pressures. The benefits of VT have been well documented; it can help to improve young dentists' confidence levels[4] by providing exposure to patients and procedures that they felt uncomfortable with while undergraduates.[5] It can also aid future career planning[6] and engender a commitment to continued professional development.[7]

VT was introduced as a pilot project in the Republic of Ireland in 1999. The scheme is voluntary and is open to all new dental graduates. As part of the training period, VDPs spend two days per week in general dental practice, two days in the Health Services Executive (HSE) Dental Service and one day on day release attending lectures. The VDPs are paid an annual salary by the HSE[8] and they can provide treatment for medical card, PRSI and private patients in general practice, as well as patients attending HSE dental clinics. Any fees earned by the VDP while working in the practice accrue to the practice, in addition to a training grant paid by the Postgraduate Medical and Dental Board towards practice expenses.

In recent years it has been reported that Irish dental graduates have begun to take up VT positions in the UK. This study aimed to detail the uptake of VT and associate positions by graduates of University College Cork (UCC) in Ireland and the UK. The geographic locations of these initial positions and subsequent work profiles of the graduates in their years after graduation were also determined.

Table 3: Location of employment analysed according to year of graduation.

Graduation year	Location of employment immediately after graduation (%)				
	Rep. of Ireland	England	Wales	Scotland	Other
2001	50.0	50.0	0	0	0
2002	0	100	0	0	0
2003	22.2	66.7	5.6	0	5.6
2004	16.7	70.8	0	8.3	4.2
2005	20.8	50.0	4.2	16.7	8.3
2006	26.9	15.2	0	46.2	11.5
2007	22.9	11.4	0	62.9	2.9
Total	**21.8**	**43.0**	**1.4**	**28.2**	**5.6**

Method

A self-completion questionnaire was developed to gather information from recent dental graduates of UCC. A copy of the questionnaire is included as **Appendix 1**. The questionnaires recorded demographic information from respondents, including gender and year of graduation. Participants were asked to record their choice of position after graduation, i.e., VT or associate position, where they were employed geographically and their current work profile.

A pilot study was conducted by providing 12 junior hospital staff in the University Dental School, Cork, with questionnaires and evaluating their feedback and comments. After some minor modifications to the layout, the questionnaire was widely distributed. The questionnaires were sent electronically to recent dental graduates from UCC using an existing database of email addresses. A total of 224 questionnaires were distributed over an eight-week period.

Completed questionnaires were returned and forwarded blind to an independent statistician, where they were analysed for response frequency and the results tabulated using SPSS®. Statistical significance was set at $p<0.05$.

Results

Over the eight-week period, 224 questionnaires were distributed. Eighteen email addresses were inactive and, of the remainder, 142

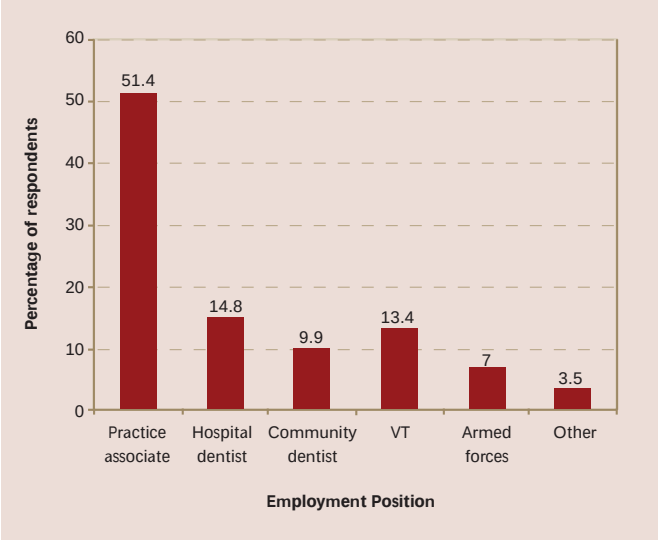

FIGURE 1: Employment positions of respondents in 2008.

FIGURE 2: Employment locations of respondents in 2008.

successfully completed questionnaires were returned, giving a response rate of 68.9%. Eight questionnaires were spoiled, each due to sections left uncompleted. The respondents consisted of 94 females (66%) and 28 males (34%). Responses were received from those who graduated in the years 2001 to 2007 (**Table 1**).

Overall, the majority of graduates took up an associate position immediately after graduation (71.8%), with a smaller percentage undertaking VT (28.2%). Analysis of the responses according to year of graduation showed that a higher percentage of more recent graduates took part in VT (**Table 2**). Results indicate that the number of VDPs has increased year on year from 2004. Of the class of 2007, 54.3% (19 respondents) indicated that they had taken part in VT, with two undertaking VT in Ireland and 17 in the UK.

Respondents were also asked to record in which geographical location they took up employment immediately after graduation (**Table 3**). Overall, the majority of participants initially took up employment in England (43.0%), followed by Scotland (28.2%) and the Republic of Ireland (21.8%). Further analysis illustrated that these employment locations have changed over time. The greatest majority of graduates were employed in England for the period 2001/'02 through to 2005, while in 2006 and 2007 the most popular location was Scotland. A Chi-Square test indicated that there was a statistically significant difference in employment location for those graduates from 2001-2003 compared to 2007 ($p<0.05$).

Respondents were asked to detail their current work profile in terms of what position they held (**Figure 1**, **Figure 2**) and where they were now working. The majority of participants indicated that they were now working as associates in general practice (51.4%), followed by those working in hospital practice (14.8%), and those still completing VT (13.4%). Information was also gathered on where the respondents were now working. The majority were now practising in the Republic of Ireland (54.2%), followed by smaller numbers in Scotland (22.5%) and England (16.9%).

Discussion

The aim of this study was to record the career profiles of recent dental graduates from UCC. It aimed to measure the uptake of VT among a sample of Irish dental graduates and map their employment locations. Information was recorded after surveying graduates using a questionnaire distributed via email. An existing database of graduate email addresses, normally used for sending information on postgraduate courses and alumni events, was used.

The questionnaires returned a response rate of 68.9%. This was achieved by resending the questionnaire via group email on two occasions thanking those who had returned the questionnaire and reminding those who had not to complete it. A higher response rate was achieved among more recent graduates, which could be explained by the fact that the email database is more up to date for those participants and they may be more familiar with modern communications technology. Unfortunately, in using the email database the possibility for confidentiality was eliminated in the electronic responses received, but this was offset by reduced distribution costs and an expected higher response rate as compared to a postal survey.[9,10] Anecdotally, some of the respondents struggled with completing the questionnaire online. This could have been overcome by using online survey software such as Survey Monkey® or Zoomerang®. This would also alleviate concerns about the lack of anonymity in the format used for this study. It was possible to print the questionnaire, complete it and return it by post; however, only 14 (9.8%) respondents chose to avail of this option.

The information recorded illustrated a shift in the numbers of new graduates choosing to undertake VT. There has been a steady increase in the numbers choosing VT year on year since 2004. The results recorded no graduates having undertaken VT between 2001 and 2003; however, personal communication would indicate that some of these graduates did undertake VT but were omitted due to the poor response rate among this group. Of the most recent graduates from

2007 the majority undertook VT as opposed to an associate position. A statistically significant difference was recorded in the uptake of VT for those graduates from 2001-2003 as compared to those from 2007. VT has been proven to be a successful structured introduction to general practice for UK graduates.[11] In fact, surveys of UK dental graduates would indicate that they would actually be unwilling to enter the general dental service without VT.[12] While associate positions do exist for newly qualified graduates, many practice owners in Ireland do prefer candidates with experience. In addition, with VT a mandatory requirement for UK graduates who want to work within the NHS, some employers in the UK may be unwilling to employ those who have not completed the scheme.

The majority of new graduates from UCC actually moved away from Ireland initially in order to secure employment. Many areas of the UK suffer from a lack of dentists to meet the needs of the population, especially in NHS practices.[13] In addition to larger numbers of jobs available throughout the UK, certain areas, including Scotland, offer financial inducements to entice new graduates. Such "golden hellos" were introduced around 2004 for all of those taking up new positions throughout the country and more money was offered for those working in designated "rural" areas.[14] In addition to the shift from associate positions to VT there has been a movement of new graduates in this survey travelling to Scotland instead of England. There was a statistically significant difference in employment location for those graduates from 2001-2003 compared to 2007 ($p<0.05$). The results indicate that this shift first began to become apparent with graduates from 2004 onwards, after financial incentives for recruitment and retention of NHS dentists in Scotland became available.[15] Since 2004 the numbers of new graduates travelling to Scotland has increased annually, with the result that over 60% of the most recent graduating year surveyed was employed there after graduation.

As expected, the majority of graduates were now working as associates in general practice with smaller numbers employed in the hospital and community settings.[16] Some graduates were working as dentists within the armed forces and the majority of these were made up of overseas graduates who had returned home. A small percentage of graduates were no longer working as dentists, although this group also included those who have returned to undertake medical degrees. The majority of the respondents are now also employed in the Republic of Ireland. This is compared to initial results showing that the majority actually moved away from Ireland after graduation in order to take up employment.

This survey was carried out among graduates of UCC only and therefore collected a limited amount of data. Caution must be exercised in extrapolating these results to all Irish graduates, as those from Trinity College Dublin and Queens University Belfast were not included. However, the increased uptake of VT among more recent UCC graduates should be viewed as a positive development and must add weight to the case to make such a scheme more widely available throughout Ireland.

Conclusions

This study provides a profile of the professional careers of recent dental graduates from UCC. It illustrates that there has been an increase in the number of graduates undertaking VT in recent years. It showed that UCC graduates tended to move away from Ireland to the UK initially to gain employment. Within the UK there has been a shift away from employment in England towards Scotland, where the majority of new UCC graduates are now initially employed. In addition, the study shows that the majority of graduates returned to Ireland for employment as general practitioners after their initial move away.

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PEER-REVIEWED

Appendix 1
Decision Making by Irish Dental Graduates After Leaving University

DEPARTMENT OF RESTORATIVE DENTISTRY, UNIVERSITY DENTAL SCHOOL AND HOSPITAL, WILTON, CORK, IRELAND.

Information about this questionnaire

This questionnaire is part of a study which aims to explore the choices made by Irish dental graduates when seeking employment after university. We want to record your thoughts and experiences in order to try and improve the process for future years.

Your name and address do not appear anywhere on the questionnaire. If you have any further questions you can contact Dr Gerald McKenna on (+353) 021 490 1100 or email g.mckenna@ucc.ie.

We are well aware of the time and effort it takes to complete a questionnaire like this and we are very grateful for your participation, thank you. When you have completed the questionnaire please return it by email to g.mckenna@ucc.ie.

Please answer the questions below by ticking the boxes which apply. For certain questions you may be asked to give more detail regarding the answer you have given: please do so in the space provided.

1. When did you graduate from university?

☐ 2001 ☐ 2005
☐ 2002 ☐ 2006
☐ 2003 ☐ 2007
☐ 2004

2. Which gender are you?

☐ Male ☐ Female

3. Where did you gain employment immediately after graduation?

☐ Republic of Ireland ☐ Northern Ireland
☐ England ☐ Scotland
☐ Wales
☐ Other location (please state):_____

Please state the general area which best describes where you were employed, e.g., London, Cardiff, Cork: _____

4. Was this your first choice of employment location?

☐ Yes ☐ No

5. If the answer to Question 4 was NO:
Where was your first choice of employment location?

☐ Republic of Ireland ☐ Northern Ireland
☐ England ☐ Scotland
☐ Wales ☐ Other location (please state): _____

6. If the answer to Question 4 was NO: Why did you move away from your preferred employment location?

☐ Lack of employment opportunities
☐ Family reasons
☐ Desire to move with friends/colleagues
☐ Opportunity to undertake VT in the UK
☐ Other reason (please specify): _____

7. Which of the following best describes the position in which you were employed immediately after graduation?

☐ Associate in practice
☐ Vocational trainee
☐ Community/health board dentist
☐ Hospital dentist
☐ Armed forces dentist
☐ None of the above

If these options do not describe the position in which you were employed immediately after graduation please give details:

_____

8. Which of the following best describes your current employment position?

☐ Associate in practice
☐ Vocational trainee
☐ Community/health board dentist
☐ Hospital dentist
☐ Practice partner/owner
☐ Armed forces dentist
☐ None of the above

If these options do not describe the position in which you are employed please give details: _____

9. Where are you currently employed?

☐ Republic of Ireland ☐ Northern Ireland
☐ England ☐ Scotland
☐ Wales ☐ Other location

Please state the general area which best describes where you are employed, e.g., London, Cardiff, Cork._____

PEER-REVIEWED

Supernumerary pre-molar teeth in the mandible

Journal of the Irish Dental Association 2009; 55 (6): 293-295.

Introduction

Supernumerary pre-molar teeth may be defined as extra teeth occurring within the dental arch. The prevalence of supernumerary teeth in the permanent dentition varies from 0.45%[1] to 4.5%.[2] In Ireland the levels vary between 2.2%[3] and 3.7%.[4] However, the prevalence of supernumerary teeth occurring in the mandibular premolar region is quite low. Prevalence rates vary from 0.14%-0.9% (Piattelli & Piattelli,[6] Saini et al[7]). In a recent study of supernumerary teeth among Irish schoolchildren[5] only 7% of all supernumerary teeth occurred in the mandibular pre-molar/canine region.

Individual case reports have been described by Piattelli & Piattelli,[6] Saini et al,[7] Lesan and Wandenya,[8] Gibson,[9] Cochrane et al,[10] Scanlon and Hodges,[11] and Arigbede.[12] This paper examines the records of 10 patients who attended the Regional Orthodontic Unit for the Public Health Orthodontic Services in the counties of Cork and Kerry.

Material and methods

The orthodontic records of all patients from the discharge files combined with the records of ongoing patients attending the Public Health Orthodontic Service for the counties of Cork and Kerry were examined. A total of 7,959 records were examined. The OPG radiographs for each patient were examined. The radiographs were examined by one person using an illuminated viewer, which was table mounted. Radiographs were viewed in a darkened room only if the quality of the radiographs required such a change. All radiographs were examined in a fixed sequence beginning at the right maxillary third molar and moving to the left maxillary third molar. The mandible was examined in the same manner.

The information obtained was as follows:

1. The name, gender and date of birth of each patient.
2. The date of the first radiograph taken that identified the presence of the supernumerary teeth.
3. The position and number of the supernumerary teeth.
4. The eruption status and state of development of the supernumerary teeth.
5. The effect of the supernumerary teeth on the dentition.
6. The treatment provided.

Results

The ten cases described were the only cases found among the 7,959 cases examined. This indicates a prevalence rate of 0.12%.

Table 1 indicates the distribution and frequency of the supernumerary mandibular premolar teeth in the cases identified in this study. In all, 10 patients were identified as presenting with supernumerary mandibular premolar teeth. Seven of the patients were female and three were male. The age of the patients varied from 10 to 18 years of age. This was the age when each patient was identified on radiograph as presenting with a supernumerary mandibular premolar tooth. The position of the supernumerary teeth is variable from the position in **Figure 1**, where the teeth are in the 4.4 and 3.4 region to **Figure 2**, where both supernumerary teeth are in the 4.5 region. Bilateral supernumerary teeth were found in six of the cases and in one case (**Figure 2**) two supernumerary teeth were found on one side.

Table 2 outlines the eruption status and the state of development of the supernumerary teeth. It was not unexpected to find that all of the supernumerary teeth were unerupted and were therefore discovered on radiographic examination. However, the state of development of the teeth varied from case to case. With an age range of 10 to 18 years of age, it is always likely that there will be a variation in the stage of development. Only two cases were observed where the crown and

Dr Ian O'Dowling BDS FDS FFD DORTH

Dr Ian O'Dowling passed away suddenly in October 2009. The *Journal of the Irish Dental Association* would like to extend sincere condolences to his family, friends and colleagues at this time.

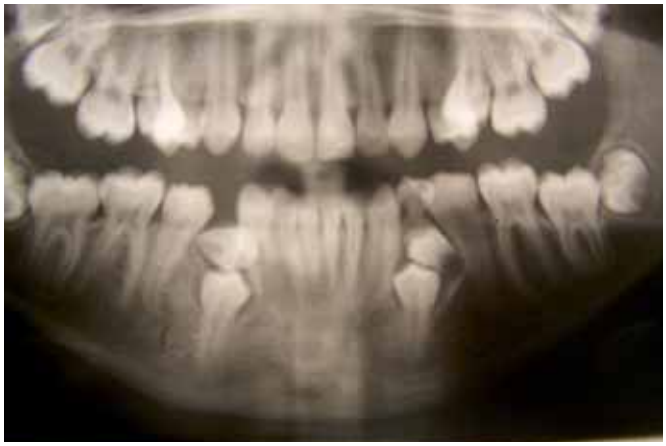

FIGURE 1: Case No. 1 from Table 1.

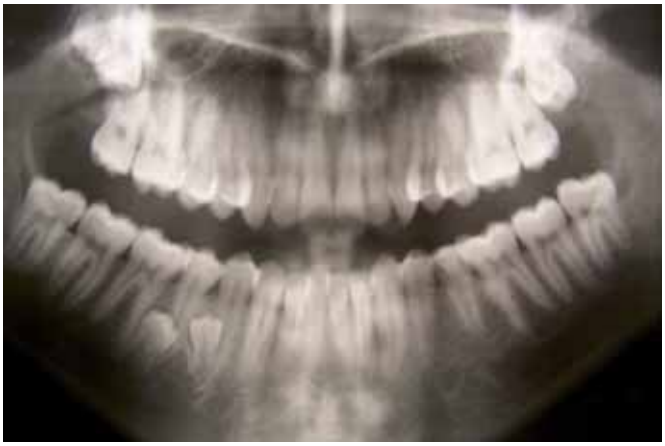

FIGURE 2: Case No. 8 from Table 1a.

Table 1: Distribution and frequency of the supernumerary mandibular premolar teeth.

Case No.	Male/female	Age	Site	Number
1	Male	13	$\overline{4/4}$	2
2	Female	16	$\overline{4/}$	1
3	Female	15	$\overline{54/45}$	2
4	Female	15	$\overline{/56}$	1
5	Female	17	$\overline{54/}$	1
6	Female	14	$\overline{54/45}$	2
7	Female	10	$\overline{43/34}$	2
8	Male	18	$\overline{5/}$	2
9	Female	14	$\overline{54/45}$	2
10	Male	15	$\overline{43/45}$	2

Table 2: The eruption status and stage of development of the supernumerary teeth.

Case No.	Eruption status	Stage of development
1	Unerupted	Crown complete
2	Unerupted	Crown/root complete
3	Unerupted	Crowns incomplete
4	Unerupted	Crown/root complete
5	Unerupted	Crown complete
6	Unerupted	Crowns incomplete
7	Unerupted	Crowns incomplete
8	Unerupted	Crowns complete
9	Unerupted	Crowns incomplete
10	Unerupted	Crowns incomplete

the root development were complete (Case No. 2, Case No. 4). Case No. 2 presented at 16 years and Case no. 4 presented at 15 years. In three other cases the crowns of the supernumerary teeth were completed (Cases 1, 5 and 8). The ages of these patients were 13, 17 and 18. With the exception of Case No. 1, the other two cases were at the older age range whereas those remaining five cases with the incomplete crowns were in the 10- 15-year age range. From this table we can determine that supernumerary mandibular premolar teeth are late in their development and the older the patient is at presentation the more likely the tooth is to have completed its crown development or crown root development.

Table 3 outlines the effect of the supernumerary tooth on the developing dentition and the subsequent treatment. In seven cases the supernumerary teeth had no effect on the development or the eruption of the permanent dentition. In Case 1 (**Figure 1**) the supernumerary teeth obstructed the eruption of the 4.4 and 3.4 and were subsequently extracted along with other premolar teeth as part of a comprehensive orthodontic treatment plan. In Case 4 (**Figure 3**) the supernumerary tooth and the 4.5 were both impacted. Both teeth caused root resorption of the 4.6. The 4.6 was extracted, the 4.5 erupted and the lower left supernumerary tooth was subsequently extracted. In Case 7, the supernumerary teeth were obstructing the 4.3 and 3.3, and these teeth were subsequently displaced. Therefore, the supernumerary teeth and the 4.3 and 3.3 were subsequently extracted as part of a comprehensive orthodontic treatment plan. In four cases where the teeth had no effect on the developing dentition the supernumerary teeth, along with other premolar teeth, were extracted as part of an orthodontic treatment plan. However, in Case 5, the teeth were left *in situ* and orthodontic treatment continued, and in Case 8 and Case 9 the patients refused extraction of the teeth and refused orthodontic treatment.

Discussion

In the cases presented in this paper the presence of the supernumerary tooth was an incidental finding on radiograph, as all of the supernumerary teeth were unerupted. This is in keeping with other studies where case reports have been presented. In general supernumerary premolars are thought to occur three times more commonly among males than females;[13] however, in this study the reverse is true with a female/male ratio of 2:1.

The age at identification of the supernumerary is quite high and this would be indicative of the late development of these supernumerary teeth. Previous case reports show a large age variation depending on when these teeth are identified on radiograph. In the ten cases described, aside from three patients, all of the other patient records were

Table 3: The effect of the supernumerary teeth on the developing dentition and their treatment.

Case No.	Effect on dentition	Treatment
1	Obstructing $\overline{4/4}$ eruption	Extraction of $\overline{5\$/\$4}$
2	No effect	Extraction of $\overline{4/\$/}$erupted
3	No effect	Extraction of $4/4$
4	Impaction /$\overline{5}$, root resorption /$\overline{6}$	Extraction /$\overline{6\$}$
5	No effect	Left in situ
6	No effect	Extraction of $\overline{\$/\$}$
7	Obstructing $\overline{3/3}$	Extraction of $\overline{\$3/3\$}$
8	No effect	Refused treatment
9	No effect	Refused treatment
10	No effect	Extraction of $\overline{\$4/4\$}$

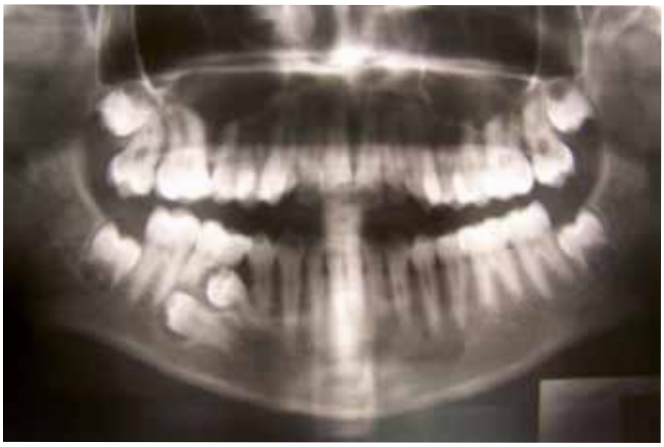

FIGURE 3: Case No. 4 from Table 1.

found in the discharge files within the unit from a time when the age profile at commencement of treatment was a lot older than it is now. Case No. 1 was identified at age 13, and the crowns of the teeth were complete, but Case No. 3 was identified at 15 when the crowns were incomplete, so there is a variation in the stage of development from case to case.

The stage of development of the supernumerary teeth is in keeping with the late development of these teeth, so in general the earlier the tooth is identified the less well developed the tooth presents. Also the older that the patient presents then the more likely that there is full development of the crown or even the crown and the root of the supernumerary tooth. The effect on the dentition is such that the supernumerary tooth may prevent or delay the eruption of permanent teeth; this can be seen in Case 1 where the supernumerary teeth obstruct the eruption of the 4.4 and 3.4. Removal of the supernumerary teeth allowed eruption of the underlying premolar teeth. In other cases the supernumerary tooth had no effect. The most interesting is the fourth, where root resorption of the first permanent molar was caused both by the 4.5 and by the supernumerary tooth. Extraction of the first molar allowed eruption of the 4.5; however, the unerupted supernumerary tooth continued its horizontal movement. It can be seen from Case 4 (**Figure 3**) that cystic lesions can develop around the crowns of the unerupted teeth, whether this is the supernumerary or the permanent tooth. Previous case reports even from the UK outline cases from a non-Caucasian population. However, in this case presentation, with the exception of Case 1 all patients were Caucasian.

Supernumerary teeth are often identified with certain syndromes such as Gardener's syndrome. However, none of the patients in this study presented with any syndrome.

The aetiology of supernumerary teeth is complex; cases of familial supernumerary teeth[13] have been described. However, it is generally agreed that, although a genetic component may exist, environmental factors cannot be discounted.[14] In the cases presented here, there is no familial history of supernumerary teeth.

Conclusion

Supernumerary premolar teeth in the mandible are rare. They are generally an incidental finding on radiograph. Usually the teeth are unerupted and may have no effect on the developing dentition. However, in some cases they may lead to impaction, cyst development and root resorption of the adjacent permanent teeth.

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PEER-REVIEWED

The demographic and academic profile of Irish dental school faculty members

Précis: This study provides a detailed profile of Irish dental school faculty members, considers future challenges and explores staff perceptions of faculty duties.

Abstract

Aim: This paper reviews the demographic, academic and professional profile of Irish dental school faculty members. Faculty duties are explored.

Methods and materials: Custom-designed questionnaires were distributed to faculty members for self-completion, adopting a 'mixed-method' approach with quantitative and qualitative components. Response rate was 64.6%.

Results: Demographic profile reveals a male-dominated regime (64%). Males also occupy a disproportionate number of senior academic positions. The age profile mirrors international trends with 75% of staff over 40 and c.33% over 50, including 78% of professorial staff ($p<0.001$).
Dental school faculties are comprised of highly educated professionals with the following qualifications: 89% BDS, 43% FDS, 39% Masters, 16% Doctorates. Most (77%) have 10+ years of clinical experience, while 47% have over 20 years' experience. Clinical experience varied by age, rank ($p<0.001$) and gender ($p<0.05$). A review of contractual agreements and duties confirms the major role of part-time clinical staff in dental education, comprising the largest single group (48%) delivering the bulk of the clinical teaching. However, 54% of part-time clinical staff have less than five years teaching experience. This study also explores staff views of various faculty roles.

Conclusions: This report provides a benchmark profile of Irish dental school faculty members. It reflects on the heavily skewed age groups of our current dental educators and the impending retirement of many senior academics. Educational organisations need to explore ways to make a career in dental education financially and sociologically attractive and provide adequate support for existing faculty to ensure their development during these challenging times.

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Introduction

The last 50 years has been a period of unprecedented change in higher education, combining tremendous growth and pedagogical advances with unparalleled challenges for all involved. Changing economic, social and knowledge contexts have resulted in a paradigm shift from the traditional post-war model of the teacher as an autonomous professional. Indeed, what students learn, "what they must achieve as the outcome of learning and what standards apply are now explicitly the everyday business of government".[1] Faculty members face many complex challenges, including increased public accountability, higher student expectations, and increased student diversity, as well as the impact of technological advances, and changing paradigms in teaching and learning.

Dental school faculty members must also face additional challenges due to shifting disease patterns and patient demographics, changing societal culture affecting demand for treatment, and the need to integrate scientific advances into practice, along with

demands from accreditation bodies for radical curricular change. Furthermore, as "dental education is the most costly professional degree within the entire university portfolio",[2] dental faculty members face mounting pressure to maintain high educational standards against the current background of fiscal constraints and dwindling resources. Faced with such challenges, the changing nature of academic appointments and the income differential between academic dentistry and private practice, many institutions are now facing a shortage of faculty staff. International research suggests that dental faculty staff are ageing, and notes a paucity of enthusiastic applicants seeking to replace those who reach retirement age. This paper provides a detailed demographic, academic and professional profile of Irish dental school faculty members, explores the duties undertaken by faculty members, and the degree of satisfaction derived from these tasks, issues previously unexplored in this country.

Methods and materials

All 130 dental faculty members at Cork University Dental School & Hospital (CDH), UCC, and Dublin Dental School (DDH), TCD, were invited to participate in this study. "Faculty" was defined as "all part-time and full-time staff involved in teaching undergraduate/ postgraduate dental and/or dental hygiene students" in an Irish dental school. The research methodology involved a custom-designed self-administered questionnaire (31 fields), using a 'mixed quantitative/qualitative' approach.

The overall response rate was 64.6%. While an excellent response rate was achieved in the Cork centre (50/55, 90.9%), a much lower response rate of 45.3% (34/75) was achieved from Dublin Dental Hospital. There were 83 valid respondents, 50 (60.2%) from CDH and 33 (39.8%) from its equivalent in Dublin. The lower response rate from DDH may be related to the inability of the researcher to gain direct access to DDH staff on the grounds of privacy and confidentiality. The subsequent loss of control over questionnaire distribution, and inability to issue personalised reminders and to verify staff rank and numbers may have introduced a certain degree of volunteer bias. Bell[3] warns that "non-response is a problem because of the likelihood – repeatedly confirmed in practice – that people who do not return questionnaires differ from those who do". While 'volunteer bias' of this nature may be overcome by offering incentives to encourage participation, sending reminders and making follow-up calls to those who do not respond initially, the provision of anonymity in this study removes these options. Data analysis was therefore undertaken for the combined data and by individual site, to investigate response patterns and reduce the impact of volunteer bias. Statistical analysis was undertaken using SPSS-14, standardised statistical descriptive techniques and Chi-square tests.

Results

Basic demographics: age and gender profile

Analysis of the demographic profile of Irish dental school faculty members reveals a male-dominated regime (64%), with a marked gender imbalance noted among the 30- 39-year age group (85% male), as highlighted in **Figure 1**. Indeed, 70% of DDH respondents and 60% of CDH staff were male. Males also occupy a disproportionate number of senior academic positions – 57% of lecturer/consultant positions, and 89% of professorial appointments. This concurs with international reports of lower rates of advancement among female dental faculty staff.[4,5]

Several authors have commented on the ageing profile of dental faculty members internationally, expressing concern regarding the impending retirement of many senior academics.[6,7] The age profile of Irish dental school faculty members mirrors international trends as 75% of staff are over 40 years of age and almost one-third (28% in CDH, 33.3% in DDH) are over 50, including 78% of the professorial staff ($p<0.001$). A similar ageing profile is noted among full-time faculty members as most (77%) are over 40 and one-third are over the age of 50. Only eight (9.6%) of the respondents were under 30, while 13 belonged to the 30-39 years category.

Academic achievements

As expected, the vast majority (89.2%, 74/83) of the series were dental graduates. The nine non-dental graduates comprised five females and four males; all bar one were over the age of 40; the majority (88.9%, 8/9) worked in CDH. Analysis of the qualifications held by this sub-group revealed that four were science graduates (two had attained a masters degree and one a doctorate), while the remainder held various diplomas. Two were employed as instructors, three as college/clinical lecturers and four were part-time clinical staff.

Almost half of the respondents (43%, 36/83) held a fellowship degree – 50% of females (15/30) and 40% (21/53) of males. Approximately one-sixth of the respondents had attained a Masters of Science (16.9%) or doctorate (15.7%) while one-tenth had been awarded a Masters in Dental Surgery. The proportion of respondents with doctorate degrees was similar at both study sites (16% in CDH, 15.2% in DDH); all bar one were over 40 years of age and the majority were male (10/13). Those with a Masters of Science degree were predominantly male (85.7%, 12/14), most were dental graduates (11/14, 78.6%), and 64% were CDH faculty members (9/14). On the other hand, a significantly higher proportion of the Masters of Dental Surgery graduates were employed by the DDH (24% versus 2%; $p<0.001$). Just five (6%) respondents held both medical and dental degrees.

Timing of last degree

While 32% (26/81) of the faculty members had completed a degree course within the last six years, almost half (43%) of the respondents had not engaged in formal education for over ten years. Indeed, one-sixth, including all professorial staff, had not done so in 20 years ($p<0.001$). The time elapsed since last degree was inversely related to rank and age ($p<0.001$). While all NCHDs had completed degrees within five years, only eight experienced staff members obtained a formal degree/diploma in this time, and just one professor had gained additional qualifications since 1990.

Clinical experience

The study indicates that Irish dental school faculty members are largely comprised of experienced clinicians. Indeed, the vast majority

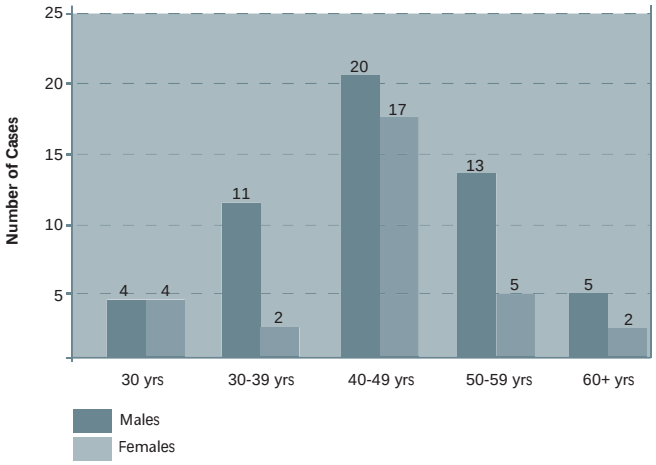

FIGURE 1: Age category distribution by gender.

Table 1: Frequency distribution of academic rank by site and sex.

Academic rank	Frequency %	CDH	DDH	Male	Female
NCHD – SHO/ registrar	4 4.8%	4 8%	-	3 (6%)	1 (3%)
Instructor	2 2.4%	2 4%	-	1 (2%)	1 (3%)
Part-time clinical	40 48.2%	25 50%	15 45.0%	25(47%)	15 (50%)
Lecturer	14 16.9%	5 10%	9 27.3%	8 (15%)	6 (20%)
Consultant/ Senior lecturer	14 16.9%	9 18%	5 15.2%	8 (15%)	6 (20%)
Professor	9 10.8%	5 10%	4 12.1%	8 (15%)	1 (3%)
Total	**83 100%**	**50 100%**	**33 100%**	**53**	**30**

(77%, 60/78) have at least a decade of clinical experience, with similar rates reported by Cork and Dublin respondents (76.6% CDH, 77.4% DDH); almost half (47%) have over 20 years' experience with similar rates recorded in both sites (42.5% CDH; 45.1% DDH). Not surprisingly, older and more senior staff tend to have more clinical experience ($p<0.001$). Interestingly, clinical experience varied significantly between males and females, 54% of males having over 20 years' clinical experience (compared to 38% of females) and 29% of males having over 30 years' experience compared with only 7% of females ($p<0.05$).

Teaching experience

The study indicates that most (76%) of the Irish dental school faculty members have at least five years' educational experience and more than half (54%) have been involved in dental education for over a decade. Not surprisingly, older and more senior staff tended to have greater teaching experience ($p<0.001$); senior academics generally have at least ten years' teaching experience and most (78%) of the professorial staff have over 20 years' educational practice ($p=0.002$). However, more than half (54%) of the part-time clinical teachers have less than five years' teaching experience; few (12.5%) have more than 20 years' experience. As clinical teaching is the 'linchpin' of dental education and the bulk of this work is undertaken by the part-time clinical staff, this finding is quite significant. This sub-group accounts for 48% of the entire dental school faculty (**Table 1**). Indeed, one-sixth (15.3%) of the respondents are employed on an occasional basis (less than one session a week).

Irish dental school faculty duties and satisfaction rating

The questionnaire explored the various duties undertaken by Irish dental school faculty members, focusing primarily on the tasks attributed to university faculty members in the literature, namely: delivery of formal lectures and tutorials/seminars; laboratory and clinical supervision; and, curriculum development. All 83 respondents completed this section of the questionnaire. Respondents were also asked to select their most and least preferred teaching format. Eleven subjects were excluded from this part of this analysis, as six (7%) omitted this section (Q10) and four (5%) said they "enjoyed all" teaching formats, while one consultant "enjoyed none", resulting in 72 valid responses (**Table 3**).

(i) Formal lectures

Less than half (43%) of the respondents deliver formal lectures (**Table 2**) with similar rates recorded for Cork (42%) and Dublin (45.5%). Lectures were generally delivered by those in senior academic positions. Indeed, 50% of the lecturers, 93% of the consultant/senior lecturers and 89% of the professors were involved in this process, compared with 17% of the part-time clinical staff ($p<0.001$). Most of those involved in lecturing (88.9%) were over 40 years of age ($p,0.05$), and the vast majority (75%) were employed on a full-time basis ($p<0.001$). However, while most of the lecturers have a wealth of clinical and teaching experience, qualitative data from two open-ended questions asking respondents to state which teaching format they most enjoy and which they least enjoy, suggest that formal lectures are unpopular with faculty members. In fact, only one respondent said the formal lecture was his preferred teaching format while another expressed a joint preference for formal lectures and "hands-on" teaching (both male DDH faculty members). Indeed, over half (52%) of the respondents said the formal lecture was their least favourite method of teaching. A higher rate of dissatisfaction with the lecture format was recorded among Cork faculty members (58%) than Dublin respondents (43%). Qualitative comments suggest that staff find the "transmission mode delivery", "daunting" and "sterile", declaring that it offers "little opportunity for feedback". In fact, faculty members expressed major reservations on the value of this teaching format saying: "A lot of content can go unexplained if students feel they can't ask a question". The age-old issue of 'coverage versus content' was also raised as staff felt lectures required "too much material to be covered in too short a time frame", while providing "no evidence of student learning". Time was also a major issue as several staff complained about the "amount of time involved in preparation". However, two respondents preferred the didactic approach, contending that with "formal lectures you get the background of the topic" and "you are sure all the relevant information has been covered".

Table 2: Frequency distribution of faculty duties by site and significant factors.

Role	N	%	CDH	DDH	Significant variables
Formal lecture	36	43.4	42%	45.5%	Age, rank, contact hours
Tutorial	50	60.2	58%	63.6%	Age, rank, clinical experience, contact hours
Laboratory	27	32.5	32%	33.3%	Formal lecture, tutorial
Clinical supervision	72	86.7	86%	87.9%	Age, rank, contact hours
Curriculum development	29	34.9	32%	39.4%	Age, rank, full-time, teaching and clinical experience, contact hours. Lecture/ tutorial delivery.

Table 3: Preferred teaching format by frequency and site.

Preferred format	N	%	CDH (43)	DDH (29)
Clinical	47	65.3	67.4% (29	62.1% (18)
Seminar	11	15.3	18.6% (8	10.3% (3)
Miscellaneous**	5	6.9	2.3% (1)	13.6% (4)
All small group teaching	4	5.6	7.0% (3)	3.4% (1)
Laboratory based	3	4.2	4.7% (2)	3.4% (1)
Formal lecture	1	1.4	0%	3.4% (1)
PBL	1	1.4	0%	3.4% (1)
Total	**72**	**100%**	**100%**	**100%**

***Clinic and seminar (2); Lecture and hands-on (1); Curriculum development (1); Clinic and laboratory (1); PBL (1)*

(ii) Clinical teaching

The vast majority of the respondents (over 90%) preferred the small group teaching sessions (clinic, laboratory, seminar teaching) to formal lectures (**Table 3**). Clinical teaching was clearly the preferred format (65.3%) followed by seminar teaching (15.3%). While most staff (87%) are involved in clinical supervision to some degree, including 64% of the lecturers, 89% of professors and 93% of senior lecturers/consultants ($p<0.005$), part-time clinical staff play a major role in this teaching format. Indeed, 74% of the clinical teaching load is carried by staff with less than 15 contact hours per week ($p<0.005$). The qualitative data suggest that faculty members derive considerable personal satisfaction from clinical teaching, enjoying the combination of "hands-on patient care" and "one-to-one interaction", "helping the students … to try and develop good habits early in their career" and "seeing students develop in their clinical skills and professionalism". Staff find clinical teaching "much more manageable" than other teaching formats and "feel confident and experienced in clinical environment – second nature compared to classroom work". Many faculty members feel that clinical teaching is particularly helpful to the students as it is the direct "application of knowledge and skills" … "applicable for work for rest of professional life", forming the "basis of dental practice". However, many staff find clinical teaching quite stressful due to "conflict between best interest of students and patients". Operational issues, such as red tape, hospital politics, inadequate working conditions, inappropriate student numbers and time constraints were cited as issues that compound the difficulties faced by those engaged in clinical teaching, as illustrated below:

"*Having too many students to supervise with difficult problems and having to treat patients myself at the same time. Too stressful and potentially dangerous"* [R 25]

"*Clinical – lots of red tape and problems associated with the politics*" [R 23]

"*Clinical teaching – poorly organised – not enough DSAs*" [R 38]

(iii) Seminar/small group tutorial teaching

Seminar teaching is the second most preferred teaching format and is considered by many to be the most predictable, relaxed and effective teaching environment. Seminar (tutorial) teaching is mainly undertaken by senior staff – 86% are over 40 years of age, 62% hold a rank of lecturer or above ($p=0.006$) and most (83%) have over 15 years' clinical experience ($p<0.05$). A significantly higher proportion of full-time staff are involved in this teaching format (80% of full-time versus 43% of part-time, $p<0.05$). Qualitative comments suggest that faculty members think that seminars give a "better opportunity for interaction", are "more student orientated than dictatorial", and provide the ideal format to "encourage good patient care and treatment and to help students with their clinical studies with small tips of advice". However, staff also criticised the lack of structure and guidance given to those involved in seminar teaching while some felt vulnerable "due to lack of training and experience" and uncertainty regarding "exact hospital teaching" and "recent advances in dentistry".

(iv) Laboratory-based teaching

Most of the staff involved in laboratory teaching felt it provided a "great time to teach the basics and teach them correctly" as the "hands-on approach" "offers opportunity to engage with the students … individuals can be catered for more easily", giving "better interaction all-round!" However, some found lab teaching "unfulfilling, abstract and boring". Interestingly, 70% of those involved in this format were also involved in lecturing ($p<0.001$) and tutorial delivery (89%, $p=0.006$), and thus they were well positioned to compare the various formats.

(v) Curriculum development

One-third (34.9%, 29/83) of the respondents were involved in curriculum development (DDH 39%, CDH 32%). Those involved

tended to be full-time faculty members (79%, 23/29; p=0.001) who are over 40 years of age (93%, p=0.017), drawn from the higher academic ranks (p<0.001). Most have at least 16 years of clinical experience (88.5%) and over 11 years of teaching practice (62%), (p<0.005). While over 90% are also involved in lecture and tutorial delivery (p<0.001), only 21% (6) had more than 20 student contact hours per week (p=0.002). Interestingly, consultants appear to have a greater input into curriculum development than professors (79% versus 67%), while relatively few lecturers and part-time clinical staff are involved in this process (36% and 21%, respectively).

(vi) Problem-based learning (PBL)

In recent years, the use of problem-based learning (PBL) has grown in popularity in many dental schools. While the curriculum in the DDH is almost entirely based on a PBL format, this approach has not been adopted in CDH. However, some Cork staff had previous experience of PBL. It is therefore interesting to note that none of the Cork respondents and only one Dublin respondent listed PBL as their preferred teaching method. While this individual [R42, DDH] suggested that PBL promoted "lasting learning", two of his colleagues [R47, R51] said PBL was their least preferred teaching format as it "often leaves large gaps that are not consistent between groups in a year". These results suggest that clinicians and academics alike do not favour this approach.

Discussion

One of the main aims of this study was to develop a greater understanding of the professional and demographic profile of Irish dental school faculty members. A major issue exercising the minds of those charged with the provision of dental education is how to ensure a sufficient number of highly trained faculty members into the future. Several authors have commented on the ageing profile of dental faculty members, expressing concern regarding the impending retirement of many senior academics.[6,7,8] Indeed, dental education is said to be facing "a crisis … unless interventions occur soon to develop, recruit, and retain future faculty".[9] The age profile of the Irish dental faculty members in this study is heavily skewed in line with international trends, as reported by Livingstone *et al.*[5] Most (75%) of the respondents were over 40 years of age and almost one-third (28% in CDH, 33.3% in DDH) were over 50, including the vast majority (89%) of the professorial staff. While DDH staff appear to be significantly older than their Cork colleagues, as none of the Dublin respondents were under the age of 30 compared with one-sixth of the Cork staff (0% in DDH; 16% in CDH; P<0.05), this finding is considered attributable to either 'volunteer bias' or the exclusion of the non-consultant hospital dentists (NCHDs) by those charged with questionnaire distribution.

This study indicates that Irish dental school faculties are male dominated (64%), with a marked gender imbalance noted among the 30- 39-year age group (85% male). Similar trends have been reported in the US where females comprise 52% of the overall population, but just 24% of the dental faculty.[10] Males also occupy a somewhat disproportionate number of senior academic positions, accounting for 57% of the lecturer and/or consultant positions and 89% of the professorial appointments. While this may, in part, be related to the longer service record attained by males, both in terms of teaching and clinical experience, lower rates of advancement among female faculty members have also been reported elsewhere. Indeed, Waldman[4] noted that only 6% of female dental educators achieved professorial level compared with 22% of their male colleagues, while Nesbitt et al,[5] reported rates of professorial achievement of 43% in men versus 15% among women. Such reports lead Livingstone *et al*,[7] to conclude that "gender diversity has yet to be achieved in dental education".

Irish dental school faculty members are largely comprised of highly educated professionals as the vast majority (89%) have completed the five-year Bachelor of Dental Surgery Degree programme, while a high proportion attained further qualifications including Professional Fellowships (FDS; 43.4%), Masters Degrees (38.5%) and Doctorates (15.7%). Furthermore, many members seem to have maintained their interest in education, as one-third (32%) completed third-level degree courses within the last five years. It is worth noting that half of this cohort (recent graduates) belonged to the senior academic ranks, and three had been involved in dental education for more than 20 years. Conversely, almost half (43.3%) of the respondents had not engaged in formal education for over a decade, while one-sixth, including all the professorial staff, had not dipped their toes in the educational pond for more than 20 years (p<0.001).

This study indicates that Irish dental school faculty members have a wealth of clinical experience. Indeed, the vast majority (77%) have at least a decade of clinical experience behind them while almost half (47.4%) of the respondents have been actively involved in the provision of dental treatment for over 20 years. Many are also experienced teachers, with 54% having more than ten years' teaching service. Not surprisingly, older and more senior staff tended to have more clinical and teaching experience (p<0.001). However, the bulk of clinical teaching is undertaken by part-time clinical staff, more than half (54%) of whom have less than five years' teaching experience.

A review of the contractual agreements and faculty duties once again confirmed the major role played by the part-time clinical staff in dental education, as they comprised the largest single group in the dental faculty (48%), followed by lecturers (17%), consultants/senior lecturers (17%) and professorial staff (10.8%), as outlined in **Table 2**.

Livingstone[7] noted that "obtaining a promotion to a higher paying academic rank requires time and effort … and does not provide positive recruiting material when trying to induce a colleague to enter dental education". Indeed, since the average age of full professor was 59 years, Livingstone[7] declared that "even with an optimal working environment, asking potential faculty to exhibit patience regarding this delayed compensation for their talents is unrealistic". The age profile of the professorial ranks in this study was quite similar, as all were over 50 years of age and two were over 60. Thus, Irish dental school faculties appear to be largely comprised of

part-time staff members in the lower academic ranks. As fewer than half (45%) of the respondents were full-time faculty employees, this suggests that, while many dentists are interested in contributing to dental education and enjoy the intellectual stimulation of the dental school environment, they do not consider full-time faculty employment a viable financial option. Indeed, international studies suggest that graduates have minimal interest in entering dental academia[7] Only 16% of endodontic residents said they would be willing to devote more than 1.5 days per week to dental education.[11] This situation may also lead to a certain degree of isolation as reports have suggested that part-time staff may not be "accepted totally as a real teacher".[12]

The study also explored the various duties undertaken by the faculty members. While clinical teaching was undertaken chiefly by the part-time clinical staff, as outlined above, most (87%) of the staff were involved in clinical teaching to some degree. Lectures were delivered almost exclusively by the full-time senior academics ($p<0.001$), while two-thirds of those involved in tutorial delivery and laboratory teaching were in tenured positions with a rank of lecturer or above; most (83%) of them also had at least 15 years' clinical experience ($p<0.05$). On the other hand, curriculum development was largely the remit of the relatively small number of full-time senior academics, with consultants having the greatest input (79%), while relatively few lecturers (36%) and part-time clinical staff (20.7%) were involved in the decision making process.

This study also examined the degree of satisfaction derived from various faculty duties. The feelings engendered by the various teaching formats were surprisingly uniform. Formal lectures were almost universally unpopular, staff considering this format sterile and daunting, with little opportunity for discussion and feedback. The vast majority (over 90%) prefer small group teaching sessions (clinic, lab or seminar based) to formal lectures. While faculty members enjoy clinical teaching, 65% listing it as their first preference, many find the conflict between the best interests of students and patients stressful and even "potentially dangerous". The tension between the learning needs of the student and the duty to prevent harm to the patient was also noted by Fugill.[13] Similar concerns have been raised by medical educators.[14] However, it must be acknowledged that dental education is unique in that irreversible operative procedures are routinely performed on members of the general public, including children and medically compromised individuals, by undergraduate students. This survey suggests that the inherent stress of this situation is exacerbated, on occasion, by inappropriate student numbers, time constraints and inadequate working conditions.

Conclusions

This report provides a benchmark on the current profile of Irish dental school faculty members. It reflects on the heavily skewed age groups of our current dental educators and the impending retirement of many senior academics. It suggests that a collective effort should be made by the dental education system to entice graduates to consider a career in dental education. Steps must also be taken to provide adequate resources to address the needs of existing faculty as they struggle to provide a top class dental education in these challenging times.

The modern vision of dental education requires motivated, adaptable teachers, capable of delivering consistently high quality teaching in a constantly changing environment. Frank Rhodes[15] stated that: "We need our best scholars to be our teachers, and we need them to give the same creative energy to teaching as they do to scholarship. We need to identify, support and reward those who teach superbly". Failure to do so may place the future of dental education as a whole in a precarious situation.

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ABSTRACTS

Are encapsulated anterior glass-ionomer restoratives better than their hand-mixed equivalents?

Dowling, A.H., Fleming, G.J.

Objectives: The performance of encapsulated anterior glass-ionomer (GI) restoratives was compared with their hand-mixed equivalents for the range of powder to liquid mixing ratios routinely encountered clinically. The clinically induced variability of powder to liquid mixing variations of an anhydrous GI restorative formulation was also compared with conventional GI restorative formulations that contained a polyalkenoic acidic liquid.

Methods: Mean compressive fracture strengths, mean elastic moduli and mean total volumetric wear were determined for the encapsulated anterior GI restoratives mechanically mixed in a Capmix™ or Rotomix™ machine and the hand-mixed GI restoratives prepared with powder contents reduced from that recommended by the manufacturer (100%) in 10% increments to 50% for a constant weight of liquid. Multiple comparisons of the group means were made using a one-way analysis of variance (ANOVA) and Tukey's multiple range tests employed at $p<0.05$.

Results: For the encapsulated GI restoratives, the mean compressive fracture strength, mean elastic modulus and *in vitro* wear resistance were significantly increased compared with their hand-mixed equivalents prepared with powder contents below that recommended by the manufacturers. The conventional GI restoratives resulted in a linear deterioration ($R^2>0.95$) of the mean compressive fracture strength and mean elastic modulus with powder content compared with the bi-modal deterioration for the anhydrous GI restorative.

Conclusions: Encapsulated anterior GI restoratives outperform their hand-mixed equivalents for the range of powder to liquid mixing ratios routinely encountered clinically, such that they are advocated for use in clinical practice. Anhydrous GI restorative formulations are more susceptible to clinically induced variability on mixing compared with conventional GI restorative formulations that contained a polyalkenoic acidic liquid.

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Re-osseointegration on previously contaminated surfaces: a systematic review

Renvert, S., Polyzois, I., Maguire, R.

Objectives: The aim of this review was to search the literature for the existing evidence of re-osseointegration after treatment of peri-implantitis at contaminated implant surfaces.

Material and methods: A search of PubMed, as well as an additional hand search of articles, was conducted. Publications and articles accepted for publication up to November 2008 were included.

Results: A total of 25 animal studies fulfilled the inclusion criteria for this review. Access surgery with closed healing has been observed to positively influence the rate of re-osseointegration when compared with non-surgical decontamination of the implant surface with open healing. Open debridement including surface decontamination may result in re-osseointegration and this integration was more pronounced on rougher than on smooth implant surfaces. The adjunctive use of regenerative procedures resulted in varying amounts of re-osseointegration.

Conclusions: It is possible to obtain re-osseointegration on a previously contaminated implant surface, and it can occur in experimentally induced peri-implantitis defects following therapy. The amount of re-osseointegration varied considerably within and between studies. Implant surface characteristics may influence the degree of re-osseointegration. Surface decontamination alone cannot achieve substantial re-osseointegration on a previously contaminated implant surface. No method predictably accomplished complete resolution of the peri-implant defect.

Clinical Oral Implants Research 2009; 20 (s4): 216-227.

Evaluation of the cost-effectiveness of root canal treatment using conventional approaches versus replacement with an implant

Pennington, M.W., Vernazza, C.R., Shackley, P., Armstrong, N.T., Whitworth, J.M., Steele, J.G.

Aim: To evaluate the cost-effectiveness of root canal treatment for a maxillary incisor tooth with a pulp infection, in comparison with extraction and replacement with a bridge, denture or implant-supported restoration.

Methodology: A Markov model was built to simulate the lifetime path of restorations placed on the maxillary incisor following the initial treatment decision. It was assumed that the goal of treatment was the preservation of a fixed platform support for a crown without involving the adjacent teeth. Consequently, the model estimates the lifetime costs and the total longevity of tooth and implant-supported crowns at the maxillary incisor site. The model considers the initial treatment decisions, and the various subsequent treatment decisions that might be taken if initial restorations fail.

Results: Root canal treatment extended the life of the tooth at an additional cost of £5-8 per year of tooth life. Provision of orthograde re-treatment, if the root canal treatment fails, returns further extension of the expected life of the tooth at a cost of £12-15 per year. Surgical re-treatment is not cost-effective; it is cheaper, per year, to extend the life of the crown by replacement with a single implant restoration if orthograde endodontic treatment fails.

Conclusion: Modelling the available clinical and cost data indicates that root canal treatment is highly cost-effective as a first line intervention. Orthograde re-treatment is also cost-effective, if a root treatment subsequently fails, but surgical re-treatment is not. Implants may have a role as a third line intervention if re-treatment fails.

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Clinical detection of caries in the primary dentition with and without bitewing radiography

Newman, B., Seow, W.K., Kazoullis, S., Ford, D., Holcombe, T.

Background: Inadequate detection of caries in the primary dentition due to non-use of bitewing radiography is commonly encountered in paediatric practice. The present study investigated the increased benefits of using bitewing radiography in addition to the visual-tactile examination technique for detection of primary dentition caries in a non-fluoridated community, and determined the prevalence of "hidden" occlusal caries in the primary dentition.

Methods: Primary teeth were scored for caries at the restorative threshold using a visual-tactile technique followed by bitewing radiographic examination in a sample of 611 schoolchildren aged 6.4 ± 0.5yrs to 12.1 ± 0.8yrs residing in a non-fluoridated city.

Results: Overall, at the restorative threshold, the visual-tactile technique could detect 62% of occlusal caries compared to 74% for bitewing radiography ($p<0.001$). The prevalence of "hidden" occlusal caries was 12%. In contrast, for primary molar proximal surface caries, the visual-tactile technique could detect only 43% of caries compared with 91% for bitewing radiography ($p<0.001$).

Conclusions: In the primary dentition, use of bitewing radiography increases the detection rate of proximal surface caries substantially. It is recommended that bitewing radiography be included as part of the routine examination of children with proximal surfaces that cannot be visualised.

Australian Dental Journal 2009; 54 (1): 23-30.

Quiz answers *(from page 273)*

From left: Figure 1, Figure 2 and Figure 3.

1. The upper teeth are set too far palatally.
2. The plane of the lower teeth is too high.
3. In the maxilla, the facial surface of the upper incisors should be 9-11mm in front of the incisal papilla. The incisal edges of the upper incisors should just dance off the wet/dry line of the lower lip during fricative speech, e.g., "55". When you look from the fitting surface of the denture down the facial surface of the labial flange, you should just see the facial surface of the anterior teeth.
   In the mandible, the occlusal plane should be approximately halfway to two-thirds up the retromolar pad. The plane should be level with the height of contour of the lateral border of the tongue.

Stress in Irish dentists: developing effective coping strategies

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Abstract

Recent research has highlighted the need to recognise occupation-specific risk factors contributing to stress and burnout. As health professionals, it is important for dentists to recognise the symptoms and the effects of stress on physical, psychological and professional well being. This article reviews the relevant scientific evidence, and provides practical cognitive psychological measures to guide improved well-being for dentists. Any stigma-related factors need to be acknowledged and addressed for the well-being of dentists and their patients, and the dental profession is well placed to provide leadership on this issue. Peer support is central to meeting this challenge.

Introduction

A recent survey of 440 Irish dentists has identified that work impinges on quality of life to a great extent in 11% of those aged 40-49, and that morale is also lowest in this age group, with 18% reporting it to be "fairly low" or "very low". Assessment of current morale versus that of five years ago revealed that 46% indicate a "decline" or "great decline" in morale. Finally, stress levels were also highest in those aged 40-49, with 5% reporting "heavy and unmanageable stress", and a further 56% reporting "heavy but manageable stress".[1] Obviously, dentists are not immune to the experience and consequences of stress, and much data exists to suggest that dentists may be at elevated risk for the health (physical and mental) complications of stress.[2, 3] The data from the recent IDA Irish survey indicates that all dentists are experiencing some stress, and suggest that certain sections are particularly vulnerable at certain times to increased levels of stress, and physical and mental illness.[1]

Learning from stress in doctors

Stress has been defined in many ways. The current consensus attributed to Lazarus (1984)[4] is that stress is a condition or feeling experienced when a person perceives that demands exceed the personal and social resources the individual is able to mobilise. Among doctors, there is an increased recognition of the effects of stress, not only

Table 1: 10 steps for keeping yourself well.	
1	Find mentor support for all career stages.
2	Incorporate regular self-care into your routine (e.g., 30 minutes' exercise four days a week).
3	Learn about and engage in reflective practice (acknowledge emotions about difficult patients or challenging clinical scenarios).
4	Learn about basic cognitive behavioural therapy techniques, which can help you to challenge unhelpful beliefs you may have about yourself or your work (see **Tables 3 and 4**).
5	Be sure to reserve regular time for family and friends.
6	Set boundaries around work to influence your own happiness and honour your personal values (social, religious, spiritual).
7	Identify and rectify any skills deficiency, and take a remedial course (time management is a most common deficit).
8	Be alive to mental health problems, depression, alcohol and drug dependence.
9	If in difficulty, seek help early – act without delay.
10	Everyone should have a general practitioner, and have an annual assessment.

Adapted from: Iverson et al.[5]

Table 2: 10 early warning mental health signs for depression.	
1	Unexplained physical symptoms
2	Little interest or pleasure in doing things
3	Feeling down, depressed or hopeless
4	Feeling tired with little energy
5	Trouble falling asleep, staying asleep, or sleeping too much
6	Poor appetite or overeating
7	Feeling bad about yourself – that you are a failure or have let yourself, your patients or your family down
8	Trouble concentrating
9	Moving or speaking so slowly that other people have noticed, or being very fidgety or restless
10	Thoughts that you'd be better off dead or of hurting yourself in some way

Adapted from: PHQ-9, Kroenke et al.[10]

on doctors themselves, but also on patient care.[5] Iverson et al[5] suggest that stressed doctors are more likely to be self-critical and thus report errors. However, more objective studies suggest that reducing stress for doctors is good for patients. A case-control study found that the introduction of stress management courses to 22 hospitals was associated with a significant reduction in the rate of malpractice claims compared with the control hospitals.[6] It is more than likely that the same finding would apply to dentists in this regard.

Burnout

Occupational burnout is regarded as a consequence of chronic work-related stress. However, there is no universal consensus on the definition or diagnostic criteria.[2]

Few studies of sufficient methodological quality exist on burnout intervention and prevention to date.[7] A follow-up study of 2,555 Finnish dentists identified a reciprocal relationship between burnout and depressive symptoms, moderated through job strain. The study found that job strain directly predisposes to burnout, and indirectly predisposes to depression through burnout.[2] A postal survey sent to 2,456 UK doctors working in their first year showed that these doctors found that talking through their problems, either with a colleague, or with someone outside medicine, was a helpful coping strategy.[8] Formal mentoring schemes embedded in training (separate from appraisal) may therefore help. **Table 1** outlines strategies for doctors that may be equally applicable for dentists as individuals to take for preventing stress.[5]

Identifying symptoms of stress

Stress commonly presents with a physical symptom. In dentists, this may most commonly present as lower back pain, headaches and gastro-intestinal problems.[3] Anxiety and depression are the most common psychological disorders associated with prolonged stress. While in most cases these disorders are mild and self-limiting, depressive disorders require early recognition and early intervention to avoid tragic complications, which typically arise early in the course of the episode.[9] **Table 2** outlines the early warning symptoms in relation to deteriorating mental health.[10]

Suicide risks

International research data does not support the notion that dentists per se are at significantly increased risk for suicide, and there are some data that in fact suggest the opposite.[11] In the USA, dentists tend to enjoy better physical health and live longer than people in other occupations, but their mental health has been shown to be poorer.[12, 13]

National suicide rates in Ireland are now three times what they were 20 years ago.[14] This increased exposure brings an added risk to all exposed communities,[15] to which dentists are not immune. This needs to be recognised and addressed, particularly if stress levels have indeed increased in Irish dentists in the past five years. Once again, the role of peer and mentor support structures, early recognition of key symptoms and signs, regular medical review, and work training psychoeducation programmes will all assist in addressing this sensitive psychological and societal issue. To date, we have no estimate of the risk of suicide among Irish dentists (or doctors), or knowledge of the factors that may contribute to this risk. A research study to address this knowledge gap would help to inform early intervention and prevention policies, as was successfully undertaken in Irish military personnel.[16]

Stigma

There remains a lot of stigma related to health professionals seeking help for stress-related illness. Doctors and dentists in particular fear the lack of confidentiality, or alternatively think that seeking help may result in challenges to their 'fitness to practice'. Additionally, in the wider culture of the medical and dental professions, an image of

Table 3: Five CBT steps to overcome anxiety-related stress.
1 Understand anxiety – Anxiety diary: keep a record of your anxiety level (0-10) and activity each hour for a two-week period.
2 Identify triggers and problems – make a list and brainstorm possible alternative solutions and coping mechanisms.
3 Reduce physical symptoms – progressive muscle relaxation, controlled breathing and distraction are all ways of improving these symptoms.
4 Alter your thoughts related to anxiety – keep a thought diary in relation to stressful events, identify thinking errors such as exaggerating, jumping to conclusions and focusing on the negative, and challenge these thoughts by identifying a more balanced alternative.
5 Change your behaviour related to anxiety – identify what you are avoiding/escaping, set yourself small achievable goals starting with the least fearful, and test out your anxious thoughts: are they realistic?

Adapted from: Newcastle, North Tyneside and Northumberland Mental Health Trust. 'Stress and Anxiety: A Self-Help Guide', 2001.[19]

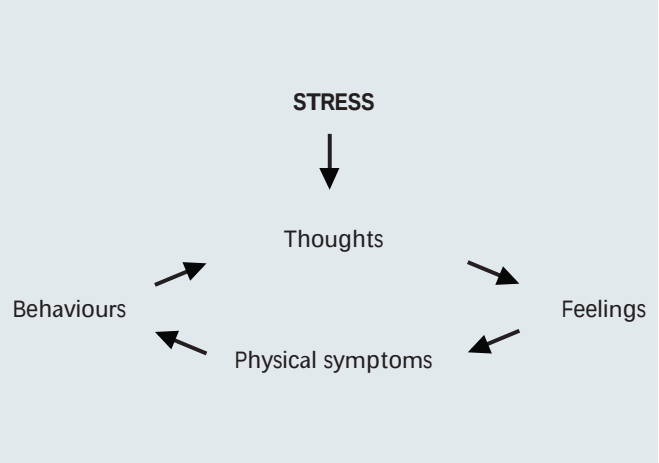

FIGURE 1: The vicious circle of mind-body stress.

Table 4: 10 CBT steps for overcoming depression.
1 Behavioural activation: Make a daily life plan including all those things you have been avoiding doing, tackling each one by one starting with the easiest. Incorporate relaxation and exercise as these have been shown to improve well being.
2 Mastery and pleasure: Identify those activities that give you a sense of pleasure and achievement and build on these.
3 ABC of changing feelings – identify: A – the event; B – your thoughts about it; and, C – your feelings about it.
4 Balancing: Identify the negative, critical thought and balance it out with a more positive alternative. Identify the thinking errors – are you exaggerating the negative, over generalising bad events or ignoring the positive?
5 Double column technique: Place negative automatic thoughts in one column and the more balanced positive thought in the other.
6 Positive diary of past and recent events.
7 Problem-solving: Brainstorm – how have you coped in the past, what would a friend advise you?
8 Critical beliefs: Challenge any longstanding self-critical beliefs.
9 Work stress/life stress: Acknowledge the effect of work-related stress and significant life events – it may be more difficult to cope if several happen together, but it may be hard to do this without help.
10 Help: Get further help from a GP, a CBT therapist, a psychologist or a psychiatrist.

Adapted from: Newcastle, North Tyneside and Northumberland Mental Health NHS Trust. Depression and Low Mood: A Self-Help Guide, 2001.[24]

invincibility is encouraged, and vulnerability is denied.[17] While this needs to be addressed by wider society, obviously a cultural shift within the medical and dental profession is needed, from the commencement of professional training. Health professionals, including dentists, have an opportunity to challenge the stigma surrounding mental health issues, and to take a leadership role in this regard.

Evidence-based cognitive behavioural strategies to moderate stress effects: cognitive behavioural therapy for anxiety-related stress

Anxiety can affect emotional and physical feelings and actions. Significant life events may precipitate anxiety, but the chronic effects of work can precipitate and maintain the symptoms. A vicious circle of thoughts, feelings and behaviours can arise with 'fear of the fear' and avoidance playing a significant role. Learning to effectively cope with anxiety is the most effective prevention. Cognitive behavioural therapy (CBT) is an effective evidence-based therapy that involves looking at the way we think about things and what we are doing.[18] **Table 3** summarises useful and simple techniques to address anxiety.[19]

Like dentists, GPs have been shown to experience the effects of high stress and low morale.[20,21] The effectiveness of a cognitive behavioural stress management training programme conducted in a group of GPs found an improved quality of life and morale and decreased work-related and general psychological distress following the programme. The best long-term benefits came from a problem-focused style to cope with life and work events, which would be readily applicable to practising dentists.[22]

CBT for depression-related stress

Signs and symptoms of depression as outlined above need to be recognised. A negative cognitive triad often plays an important role in maintaining depression – negative thoughts about self, the world and the future.[23] This then feeds into a vicious cycle of mind-body stress (**Figure 1**).

There are several practical CBT-informed steps one can take to help overcome these depressive thoughts and feelings, and these are summarised in **Table 4**.[24] Research in this field has shown that behavioural activation alone may be sufficient to overcome the symptoms of depression – "change the outside and the inside will change".[25,26] Using any of these techniques alone without any guidance can sometimes be difficult. Using a self-help guide to cognitive behavioural techniques such as Helen Kennerley's *Overcoming Anxiety*,[27] or Paul Gilbert's *Overcoming Depression*[28] may be sufficient. However, seeking out the input of a professional for a short series of structured sessions is the approach most supported by evidenced-based research.

Summary and conclusions

As is the case with all caring professions, stress is an inevitable part of professional dental practice. Dentists should not fear learning effective coping strategies to minimise the effects of stress. Stress management should be included in the dental educational curriculum and as part of continued professional development.[29] Dentists should assess their own attitudes and expectations as part of reflective practice. Dentists should insist that high quality services, providing confidential counselling, coaching, psychotherapy and psychological medicine are visible and promptly available throughout their training and continued professional development. Dentists often feel they 'don't have time to be a patient' or that they are somehow 'letting the side down' by taking the time off to consult or be treated. In truth, the contrary is the case. As with all health professionals, the duty of care for dentists serving patients best will most likely be achieved when they are in their best possible physical and psychological health.

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CLASSIFIED

Classified advert procedure

Please read these instructions prior to sending an advertisement. On the right are the charges for placing an advertisement for both members and non-members. Advertisements will only be accepted in writing via fax, letter or email (fionnuala@irishdentalassoc.ie). Non-members must pre-pay for advertisements, which must arrive no later than January 4, 2010, by cheque made payable to the Irish Dental Association. If a box number is required, please indicate this at the end of the ad (replies to box number X). Classified ads placed in the Journal are also published on our website www.dentist.ie within 48 hours, for 12 weeks.

Advert size	Members	Non-members
up to 25 words	**€75**	**€150**
26 to 40 words	**€90**	**€180**

Non-members must send in a cheque in advance with their advert. The maximum number of words for classified ads is 40.

Only if the advert is in excess of 40 words, then please contact:
Think Media
The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie

Please note that all classified adverts MUST come under one of the following headings:
Positions Wanted
Positions Vacant
Practices for Sale/To Let
Practices Wanted
Unwanted/Second Hand Equipment for Sale

Classified adverts must not be of a commercial nature. All commercial adverts must be display advertisements, and these can arranged by contacting Paul O'Grady at Think Media, Tel: 01 856 1166.

POSITIONS WANTED

Locum dentist available for work immediately, anywhere in Ireland. Male Irish Trinity graduate with four years' experience. Please Tel: 087-283 0748.

Irish dentist with five years' experience seeks position in the Dublin region from mid- November. Please Email: dentist09@ymail.com.

Experienced Cork graduate available for full/part-time locum/associate position in the Munster area. Vocational training, NHS and private practice experience. Tel: 086-832 3405.

Cork graduate with one year's NHS experience seeks locum/part/full-time work in Munster area. Email: darrylbarry100@yahoo.ie.

Trinity graduate with 18 months' experience seeks associate position in Dublin from January 2010. Tel: 086-175 5066, or Email: katiewilson02@hotmail.com.

Experienced endodontist available for sessions three days per week, Dublin Northside. Please Email: endodontist999@gmail.com.

Cork graduate with five years' experience seeks associate position from January 2010. Will consider locum position. Please Tel: 087-652 7658.

Dental hygienist seeks employment in Munster area. Willing to work flexible hours. Available to commence immediately. Tel: 086-379 8552, or Email: joelle.mousset@gmail.com.

POSITIONS VACANT

Associate dentist required to join a busy family practice in South East County Galway. Modern surgeries, full chair-side and clerical support, OPG, Ozone, etc. Please Tel: 086 809 5809, or Email: rothwellauct@eircom.net.

Associate required for Lucan dental practice Tuesdays and Fridays to start. Immediate start. Busy and modern, with full support staff. Tel: 086 1686056, or log on to www.lucanclinics.ie.

Associate dentist required for busy, Westport, Mayo practice. Ideal location in a friendly environment. Excellent opportunities available. Contact Theresa, Tel: 098-26611, or Email: theresadentist@eircom.net.

Associate dentist required. Very busy new dental practice, Abbeyleix, Co. Laois. Two days initially to build to more. Mixed, good portion private. Brand new equipment, very efficient and well run practice. Would suit keen and enthusiastic dentist. Email: abbeyleixdental@ireland.com.

Associate required for immediate start in modern West Dublin practice. Good mix of private, PRSI and medical card patients. Excellent chair-side and clerical support. For further information please Tel: 087-834 4001, or Email: jpdheaney@eircom.net.

Associate dentist F/T required for eight-surgery NHS practice, Blackburn, UK. See www.accringtonroaddental.co.uk. SoE

Exact OPG and OTE, €80K. Would suit keen, enthusiastic and hardworking dentist. Tel: 0044 079 8074 1496, or Email: CV to: s.shah@pharmalogical.com.

Dentist required for a modern, purpose-built medical centre, Dublin 15 area. Digital radiography, fully computerised, latest equipment, etc. Part-time with a view to full-time. Private, PRSI, GMS. Immediate start. Email: dentistwest@gmail.com.

Part-time/sessions for dentists available immediately nationwide in one of our modern digital clinics. Public–private mix, great conditions. Email: emmet@smiles.ie.

Experienced dental surgeon required to work in a very busy, long-established practice, West of Ireland. Good mix of private and PRSI patients. For details please Email: dentist.10@hotmail.com.

We are seeking an enthusiastic ethical dentist to join our Waterford City practice. Private public mix with excellent conditions and an immediate start. Contact Emmet, Tel: 086-818 7373.

Orthodontist wanted to replace departing colleague one day per week in general practice – full support given – other visiting specialists attending – well established book – flexible terms and conditions to suit – South East region. Please Tel: 087-266 6524.

Oral surgeon/periodontist. Oral surgeon available for part/full-time work in Dublin or country wide with special interest in implantology and peridontal surgery. Contact: Maxfaxsurg@hotmail.com.

Periodontist required. Busy general practice, South County Dublin. Tel: 01-280 9753.

Part-time endodontist required Galway City Centre. Operating microscope, fully trained experienced staff, flexible on days. Please Tel: 087-682 4551 after hours, or Email: drpmoore@mac.com.

Endo position available. Sessions available in South Dublin for dentist proficient in all endo. Miscoscope/rotary, etc., available. Email: susan@seapointclinic.ie for further details.

Experienced DSA for 24 Lower Baggot St, Dublin 2. Friendly enthusiastic person to join team of three. Chair-side and reception skills needed. Four-day week, start mid-November. Email: paddygowen@me.com, or post CV to P Gowen, 24 Lower Baggot Street, D2.

Qualified dental nurse required for part-time position in newly renovated general dental practice in Dublin 6W. Please contact Una, Tel: 01-490 9153, or Email: ganterandcrowe@eircom.net.

Dental hygienist required for part-time post in multi-specialist practice, Naas, Co. Kildare. Position available from end of October/start November. Experience in implant and paediatric dentistry necessary. Please Email CV to: info@naasdental.ie.

PRACTICES FOR SALE/TO LET

Units in specialist Dublin clinic to rent, close to LUAS line. 650sqft, ample parking, two- to three-surgery unit, theatre for day surgery, GA available. Digital dental x-ray facility on site. Tel: 01-496 7111, Ext. 240.

Practice for sale – Dublin City Centre. Two surgeries – superbly-equipped, fibre optics, OPG, intra-oral camera. Central Sterilising. Fully computerised. Thriving, vibrant, very busy, highly efficient practice. Private patients – very high. Active hygienist. Low overheads. High profits. Tel: 086-807 5273, or Email: niall@innovativedental.com.

Unit to rent/buy: suitable for dental surgery, Ballylynan, Co. Laois. 950sqft, bright and spacious. Close to amenities (school, town centre). Also, large two-bedroomed apartment above unit. Can be sold separately or together with unit. For further information, Tel: 087-258 5498.

Chair available to rent two days/week for specialist dentist only, in an ultra modern building that already houses a dental practice and an orthodontic practice. Nurse/reception provided if so wished. 20 minutes Cork City. Tel: 089-418 5301.

Dental practice for sale in Mayo. Superb two-surgery practice located in a much sought after location. Modern, friendly with a high turnover. Great room for expansion. Price extremely competitive, owner prepared to negotiate. Email: dentalpractice08@gmail.com.

Galway. Busy three-surgery practice for sale. All enquiries will be dealt with confidentially. Replies to Box No. J609.1.

Premises to let, 126 Terenure Road North, Terenure, Dublin 6W. Beside Centra supermarket and numerous other businesses. Quality building c.1,050sqft on two floors – two entrances, substantial vehicular and pedestrian passing trade. Ideal for dental practice. Tel: 086-258 9378, or Email: info@tommaher.ie.

Surgery to let on sessional basis in new orthodontic practice in South Dublin. Would suit specialist. Tel: 085-720 3111, or Email: dermot_kavanagh@hotmail.com.

Space available in orthodontic practices in Swords and Charlemont Clinic, D2, (opposite LUAS stop). Fully equipped, x-ray facilities, pay and display parking. Would suit endodontist, periodontist, prosthodontist or oral surgeon. Email: suzanne@dublinorthodontics.ie.

The Irish Dental Hygienists Association provides a FREE EMPLOYMENT SERVICE to help dentists find the right dental hygienist for their practice! Contact our new employment officer, Yvonne Power, Tel: 086-057 44969, Email: idhaemployment@gmail.com, or visit us at www.irishdentalhygienists.com.

DIARY OF EVENTS

DECEMBER 2009

IDA Golf Society – Christmas Hamper
December 11 The Royal Dublin Golf Club

JANUARY 2010

Joint Metropolitan Branch and Irish Endodontic ociety Meeting
January 21 Hilton Hotel, Dublin
'Diagnosis, differential diagnosis and management of orofacial pain', presented by Dr Asgeir Sigurdsson, Iceland, UK and USA. Contact: Karina Lawless, Tel: 01-269 2442.

Irish Endodontic Society Annual Scientific Meeting
January 22 Hilton Hotel, Dublin
'Managing Endodontic Failure in Practice'. Contact: Karina Lawless, Tel: 01-269 2442.

FEBRUARY 2010

Council of the Irish Dental Association – Meeting
February 6 IDA House

South Eastern Branch – Annual Scientific Conference
February 19 Faithlegg House Hotel, Waterford
Speakers to be confirmed.

Metropolitan Branch – Retired Dentists Social Evening
February 25 Hilton Hotel, Dublin, 6.00pm
All dentists, whether retired or not, are very welcome to attend and have a chat with colleagues who have 'been there' and 'done that'.

Irish Endodontic Society Meeting
February 25 Dublin Dental Hospital, 7.30pm
Case presentation night.

Metropolitan Branch – Annual Scientific Day
February 26 Grosvenor Room, D4 Ballsbridge Court Hotel (formerly Berkeley Court Hotel)
'The Compleat Dentist': work/life balance, science, research, clinical practice, practice management, finance, table discussions and trade show.

MARCH 2010

Metropolitan Branch – Scientific Meeting
March 11 Grosvenor Room, D4 Ballsbridge Court Hotel (formerly Berkeley Court Hotel)
'Radiation in the dental surgery', presented by Mandy Lewis, Stephen Fennell, Dr Maurice Fitzgerald, and Dr Andrew Bolas.

Irish Endodontic Society – Presentations by recent endodontic graduates
March 25 Dublin Dental Hospital, 7.30pm.

APRIL 2010

Council of the Irish Dental Association – Meeting
April 17 IDA House

MAY 2010

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

JULY 2010

The 2nd International Scientific Conference of Faculty of Dentistry at Jordan University of Science and Technology
July 7-10 Holiday Inn Hotel, Amman, Jordan
Abstract submission, registration, scientific and social programmes are available on the conference website – www.just.edu.jo/jidc. For more information, please Email: ziadd@just.edu.jo.

NOVEMBER 2010

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

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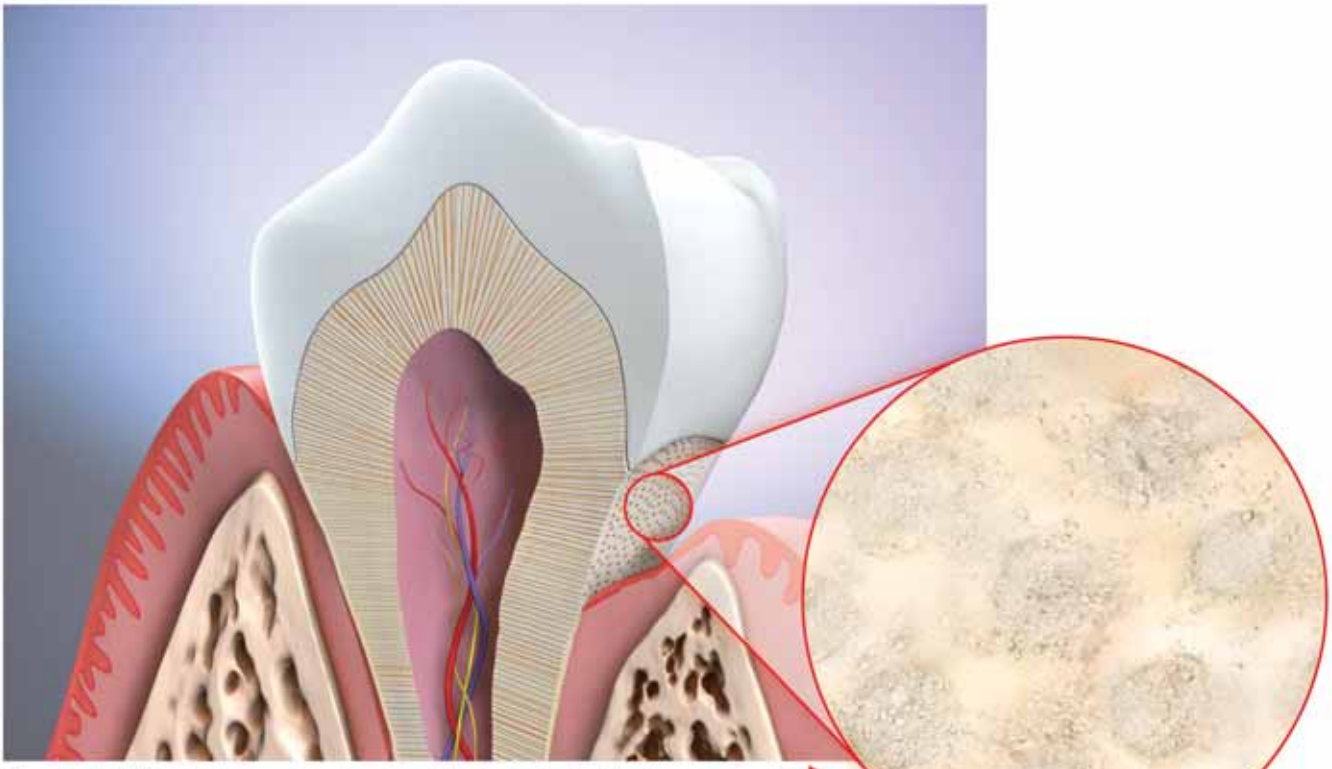

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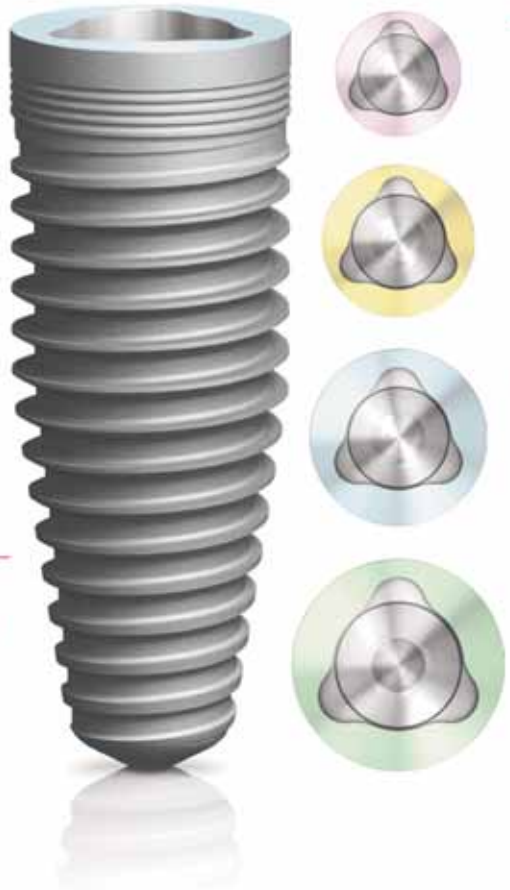

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* Source: Millennium Research Group

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