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Journal of the Irish Dental Association
Iris Cumainn Déadach na hÉireann

Volume 65 Number 3
June/July 2019

BRACE AGAINST TIME

A survey of the provision of orthodontics in Ireland

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CONTENTS

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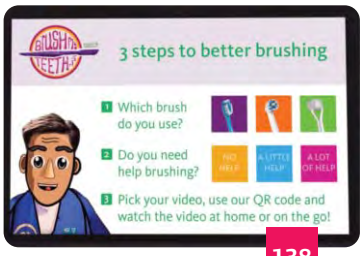

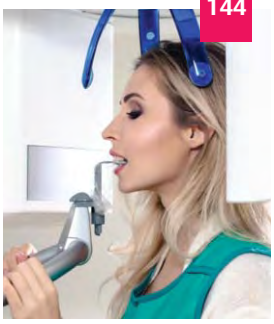

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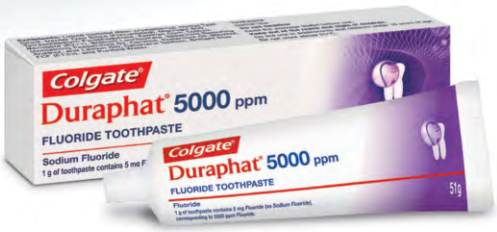

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* patients ≥ 16 years at increased caries risk.

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EDITORIAL

Dr Ciara Scott
Honorary Editor

Engaging for change

This is a time of great change for the Association and the *Journal*, as we formulate our responses to the national oral health policy, and welcome new members to our Editorial Board.

In a small church in Sussex, an 18th century inscription reads: "A vision without a task is a dream, a task without a vision is drudgery, a vision with a task is the hope of the world".

Action that is aligned with purpose is energising. The energy and motivation of the hundreds of dentists who attended the IDA's recent meeting on the new national oral health policy, Smile agus Sláinte, was palpable. It was clear that there is a mandate for change; our public dental services are woefully under resourced and the current DTSS contract was described as "unfit for purpose". It was clear that stakeholders from across the profession wanted to share their opinions and listen to other perspectives. It was clear that dentists had a wealth of insight into the many implications of Smile agus Sláinte and wanted to put what patients need first in implementing change. In this issue, we are delighted to cover this important meeting for members who were unable to attend and I thank those members who have shared their opinions.

Supporting change

The HSE launched a new change guide in 2018 to support staff in implementing change across services, which our CEO Fintan Hourihan mentioned in his opening statement to the Oireachtas Committee on Oral Health (p122). The title, 'People's Needs Defining Change', is based on this principle of defining patients', communities' and staff needs before designing and delivering safer, better services. This was co-designed by a "whole system engagement process". In addition to engagement with HR, reference groups, representative bodies and academics, staff at every level were invited to make submissions, based on their experience of implementing change. I was just one staff member who did this and was then invited to contribute to consultation days, which were very energising and resulted in creating some of the graphics in the final document. I think the document is a reflection of this process and can support us as a profession in now moving forward to define and design services our patients need. The HSE People Strategy refers to staff as their most valuable asset. As a profession we are a very valuable part of the process in designing and delivering changes in oral health care.

Recognition of specialists

Peter Harrison's letter makes some valuable points on the role of specialist trained dentists in future oral health services and the recognition of this training. The Dean of RCSI, John Marley, also highlighted the urgent need to expand the current list of recognised specialities, and to provide pathways for the next generation of specialists and consultants, when addressing the Oireachtas Committee on Oral Health. It is timely that in this issue, we included a survey of the orthodontic workforce in Ireland. Orthodontics is unique at the moment in Ireland in that the HSE established a grade to employ specialist orthodontists in 2001 when the Specialist Register was established to improve service delivery for patients with the highest need. It is unbalanced that this grade is still limited to orthodontists and that there are no clear routes for those with specialist training to contribute and progress in our hospital services. We are at risk of specialist training becoming less special and less attractive to dentists if we do not address this. The Commission for Public Service Appointments has recently instructed the HSE to review the eligibility criteria for consultant orthodontist posts. There is an opportunity to review the training requirements and role of specialists in our profession, and how they will contribute to leading and delivering both training and patient care in the future.

Change at the *Journal*

We have some changes in our Editorial Board. After a long and dedicated service, our JIDA administrator, Fionnuala, retired in May. Dermot Canavan has also stepped back from his role as Deputy Editor in line with IDA governance. I would like to sincerely thank both of them for all they have done for me since I became Honorary Editor and all they have contributed to the smooth running of the *Journal* for many years in supporting the Editorial Board and process, authors, reviewers, advertisers and members. I wish them both every success in the future. I am delighted that Siobhain Davis has agreed to be the new Deputy Editor. Siobhain has a Master's in Health Professions Education from RCSI and is an experienced clinician and educator, and I believe she will be very valuable in supporting me and the Editorial Board in continuing to deliver high-quality content for our readers.

Finally, I would like to thank the whole brushmyteeth.ie team for contributing the clinical feature and poster in this edition. Prevention and maintenance are the cornerstones of good dental health. This new resource reflects the collaboration of dentists, hygienists, nurses, carers, patients, parents, IT technicians and filmmakers in improving patient engagement and empowerment to achieve better oral health.

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Policy must shift from cost saving to patient care

> *Any oral health policy has an obligation to use the resources of the State to the benefit of all its citizens but to ensure the most vulnerable are first served by those resources. This is the ethical principle of justice and is a cornerstone of medical service delivery. This policy, as it has been presented, stands to fail this essential principle.*

Fintan Hourihan, addressing the Oireachtas Health Committee, May 15, 2019.

An oral health plan that puts patients' interests first is not only necessary, but will also mean that it meets the wishes of the dental profession. The most striking feature of the most controversial proposal in the proposed new oral health policy – to dismantle the public dental service and to privatise dental care for children – is the glaring lack of any rationale for this major policy shift. The suspicion remains that this is being mooted for purely economic reasons rather than patient welfare concerns. This in turn highlights the shift which is required to secure the support of the dental profession and ensure the success of the new oral health policy – engage with dentists to frame a new approach which puts patients' interests first.

In May, our Chief Executive Fintan Hourihan and I presented the views of IDA members on the new policy to the Oireachtas Health Committee. This took place in the week immediately following the meeting of Association members to analyse and discuss the policy. Having heard dentists' views, the timing was good and it was a significant opportunity for the Association. It allowed us to speak in a calm and forthright way to parliamentarians about the members' response to the new policy. They listened and asked excellent questions. Unfortunately, the Department of Health representatives could not attend.

We told them that our members' first reaction is disbelief and anger about how few dentists in practice – any form of dental practice – were consulted in any meaningful manner on its preparation. This is particularly relevant (not to mention ironic) given that our practising members are the ones required by the policy to deliver 95% of dental care in future.

Plain speaking

We made our points as clearly and openly as possible:

- 83% of dental care is paid for privately in Ireland;
- in 2009, €100m a year in State support was taken out of dental care;
- as a result, while oral health is improving in Ireland, most of the gains are in the higher income groups;
- we welcome the fact that the Minister for Health has identified reducing oral health inequalities as one of his two major goals for the policy;
- our members' analysis is that this policy will increase oral health inequalities;
- the most glaring weakness in the policy is the section on the provision of free dental care and treatment by the general dental practitioner, with no discussion with the dental practitioners, where one proposal is to extend limited 'free dental care' to under six year olds and eventually to under 16s – it sounds great but is fooling the Irish people and will damage our children.
- the plan takes away the previous provision of much of this care from our HSE public dental service (with no discussion with them) and offers no evidence to justify this decision – it is an unbelievable audacity and shows a lack of understanding by the policy writers on how best oral care might be provided;
- in fact, the policy's proposal is to redirect this service into general practice where identifying risk will be dependent on attendance by the very groups who are least likely to attend;
- these at-risk groups have the worst oral health and the greatest treatment need; and,
- we expressed our wish to replace the unfit-for-purpose DTSS (medical card) scheme, the DTBS (PRSI) scheme and the associated contracts. Our efforts to date had been stymied by the declaration of the Department of Health that this could not happen until a new oral health policy has been published; we hope that now all parties can engage in long-overdue constructive and fair discussions on the State contracts.

It is not all negative

We did say that it is a positive development that we finally have an oral health policy to consider. It will hopefully stimulate constructive and full debate on oral health and that is a good thing. Indeed, the focus on prevention, on screening, the policy's provisions for building links between oral and general health through a common risk factor approach, its proposals on dental workforce, professional development, on research and on critical evaluation, are all positive.

However, that very focus on prevention, which we welcome, will not address the significant amount of untreated oral disease that is already present. Patients with dental disease will progressively deteriorate, leading to vast resources being required to try and get them back to a status quo, and putting more pressure on already overstretched secondary care centres.

Incomprehensible

It remains incomprehensible to all dentists, regardless of where we practise, that the key aspects of the public dental service are, according to the policy, to be privatised. We believe that a movement from a targeted, risk-based model of care to a demand-led model will be catastrophic for patients in areas and groups with high treatment needs. The policy writers' failure to see this reflects the lack of input from the relevant stakeholders in formulating the policy.

All of us are upset at the risks posed by the new proposals in regard to continuity of care, the provision of emergency care for children, and the suggestion that the expert skills and experience of dentists in the HSE public dental service will be lost. We believe that this unworkable model is based on a failed and discredited NHS experiment in England. If this so-called high-level oral health policy is implemented as it is, it will, inevitably, collapse.

In summary, the provisions for care in this policy are seriously flawed, economically unviable and operationally unworkable. Ultimately, we believe this policy fails our patients, our children, and will seriously damage oral and general health for years to come. It is hoped that Minister Harris, Minister Doherty, and the Chief Dental Officer and her advisors will listen and work with us to ensure that something good comes out of this. The good news is that it could not get any worse – I hope.

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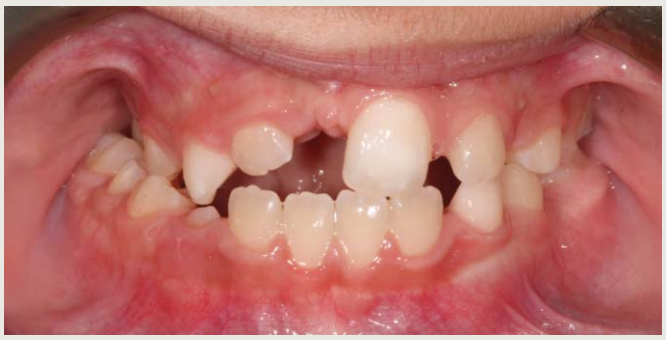
Quiz

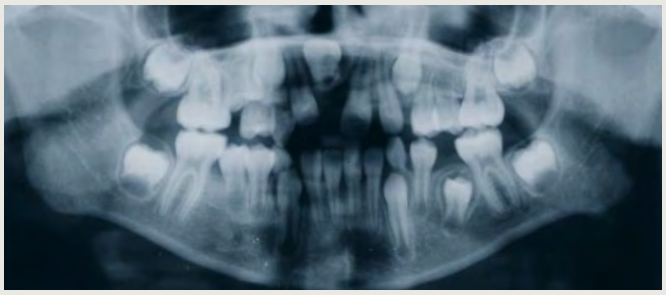
Submitted by Dr Joe Hennessy

Questions

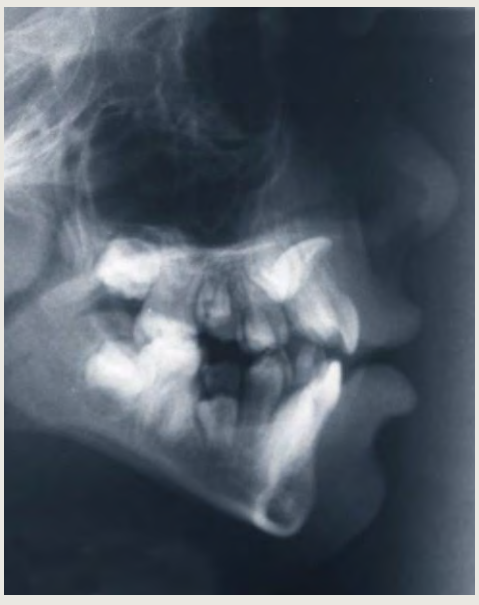
An eight-year-old girl presented with her mother complaining of a missing (right) central incisor.



1. From **Figure 1** (above), what would suggest that the maxillary right central incisor is impacted?



2. From the radiograph in **Figure 2** (above), what is the most likely cause for the delayed eruption of the maxillary right central incisor? What is the incidence of this pathology? What other radiographs would be beneficial?



3. A lateral cephalogram showed severe dilaceration of the maxillary right central incisor (**Figure 3, left**). What treatment was required?

Answers on page 156

Dear Editor,

I attended the recent IDA meeting to discuss the new national oral health policy. The main thrust of the policy appears to be to shift the delivery of care of under 16s from the public service to private practice. The policy will require further clarification in terms of how the proposed new changes will be resourced, and potentially implemented.

It was encouraging to see so many colleagues at the meeting, and regrettable that there was so little consultation with the IDA in the drafting of the policy.

The Orthodontic Society of Ireland (OSI) wishes to re-affirm its continued support to our colleagues working in primary care in both private practice and the public service.

The OSI believes that a consultative approach, involving all stakeholders, has the greatest chance of delivering the best quality care to all our patients.

Dr Ronan Perry
President of the OSI

Dear Editor,

After a generation without a national oral health policy, the Irish Society of Periodontology (ISP) welcomes the long overdue publication of 'Smile agus Sláinte', the new national oral health policy.

We commend the stated goals of supporting every person to achieve their best oral health and reducing oral health inequalities across the population. The periodontal health of the public has long been underserved, particularly since the removal of dental treatment benefits almost a decade ago. In this context, we welcome the increased emphasis placed on disease prevention, oral health promotion and continued professional development in the new policy. Additionally, we welcome the proposal to provide funding for primary care/treatment of periodontal diseases in general dental practice.

However, the "packages of care" discussed in the new policy remain vague on detail. The nature of the treatment supported by the plan must be clarified before dental professionals can fully appraise the Government's commitment to periodontal prevention and treatment. Specifically, it must be acknowledged that periodontal diseases are chronic in nature; consequently, isolated episodes of debridement are unlikely to prove sufficient for many patients. Severe periodontitis is the sixth most common disease worldwide, according to the 2010 Global Burden of Disease study (Kassebaum *et al*., 2014). Consequently, periodontal maintenance and secondary prevention must be incorporated in the approach for periodontal care outlined in the policy. Furthermore, periodontal maintenance in general dental practice must be implemented, and funded, as the standard of care for patients with periodontal diseases.

The Irish Society of Periodontology questions whether the proposed funding for roll-out of 'Smile agus Sláinte' can reliably deliver the policy's stated goals related to periodontal care. Additionally, while the commitment to support advanced periodontal care and implant treatment in secondary/tertiary care centres is positive, it remains to be seen how such treatment can be funded within the budget outlined for implementation of the new policy.

Our profession has seen major changes since the publication of the last Dentists' Act in 1985. This has included alterations to the structure of general dental practice, the advent of allied dental healthcare professionals, changes in expected career pathways for our graduating dentists, and a shift in attitudes and expectations of the public towards our profession. In light of these

developments, the absence of a clear statement on the role of dental specialties – other than oral surgery and orthodontics – in delivering the policy's goals is disappointing and should be a source of concern for the dental profession. ISP members believe that specialisation within dentistry benefits both our profession and the public. It must be a core aspect of discussions on the future of Irish dentistry, particularly in the context of the stated actions of 'Smile agus Sláinte', which include a commitment to graduate education and plans to develop referral pathways for patients. Comparison with our neighbours in the UK is sobering – the General Dental Council regulates and recognises 13 dental specialties that support the work of general dental practitioners. Periodontology is formally recognised as a dental specialty in 11 EU member states. While one can argue that specialisation may be addressed more formally in a new Dentists' Act, the new policy certainly does not signpost a clear vision on the future of dental specialisation nor the wider structures of our profession.

Finally, the ISP echoes the disappointment expressed by the Irish Dental Association regarding the lack of engagement of policymakers with the dental profession during development of 'Smile agus Sláinte'. This policy, and the eventual publication of a Dentists' Act, will affect Irish dentistry for many years to come. As the key stakeholders in delivery of care, we call for active and meaningful involvement of dental professionals in shaping the future of our profession and advocating for the well-being of our patients.

Peter Harrison
President, Irish Society of Periodontology

Reference

Kassebaum, N.J., Bernabé, E., Dahiya, M., *et al*. Global burden of severe periodontitis in 1990-2010: A systematic review and meta-regression. *J Dent Res* 2014; 93 (11): 1045-1053.

Dear Editor,

We firmly believe that GDPs have an integral role in spotting symptoms of systemic illnesses early on and referring to appropriate specialists. Cobblestoning of oral mucosa may be indicative of Crohn's disease, hairy leukoplakia may suggest a diagnosis of HIV, and indeed many illnesses of a genetic, haematological, gastrointestinal nature, etc., can first present in the oral cavity. The dentist must be vigilant and open, and think about the systemic context of any suspicious lesions.

Oftentimes their role is more critical than they even realise. For example, oral leukoplakia is a common reason for patients to be referred by their GDP to specialist care at an oral and maxillofacial unit. While it can be part of a specific pathological process, it may also be indicative of a wider systemic illness.

We recently encountered a case of an individual with oral leukoplakia who had dyskeratosis congenita (DC). DC, aka Zinsser-Cole-Engman syndrome, is a rare progressive congenital disorder, first characterised by Zinsser in 1910. According to Dokal (2001) there is a clear triad of symptoms that characterise DC: nail dystrophy; reticular skin pigmentation; and, oral/mucosal white plaques.[1]

Oral and dental manifestations of DC may include symptoms such as oral lichen planus, smooth atrophic tongue mucosa, extensive caries, and gingival recession. Radiographic signs of DC may include blunting of roots, thinning enamel, and hypodontia.[2]

There is a clear risk of transformation of leukoplakia into squamous cell carcinoma (SCC); of those aged between 10 and 30 years with oral leukoplakia due to DC, 30% progress to SCC.[3] This was not the case with our patient, who has been kept under ongoing review to monitor for such malignant change.

The patient's GDP is integral in regularly monitoring patients for the presence of any suspicious lesions and referring without delay to an appropriate specialist. This can lead to expedited diagnosis and prompt management.

It is integral for patients that GDPs remember that they are treating the patient, not the mouth or the radiograph. With a keener eye you never know the life-saving impact you may have!

Dr Ali Khan BDS (Hons.) NUI, MFDS RCSEd
Mr Vijay Santhanam MBChB, BDS, MRCS, FDSRCS, FRCS (OMFS) PGCME
Department of Oral & Maxillofacial Surgery and Orthodontics,
Cambridge University Hospitals

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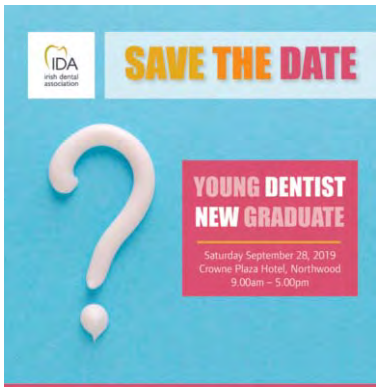
1. **Dokal, I.** Dyskeratosis congenita in all its forms. *Br J Haematol* 2000; 110: 768-779.
2. **Baran, I., Nalcaci, R., Kocak, M.** Dyskeratosis congenita: clinical report and review of the literature. *Int J Dent Hyg* 2010; 8 (1): 68-74.
3. **Fernández García, M.S., Teruya-Feldstein, J.** The diagnosis and treatment of dyskeratosis congenita: a review. *J Blood Med* 2014; 21 (5) :157-167.

IDA flying the flag in Europe

IDA representatives attended the recent Council of European Dentists (CED) General Meeting in Vienna on May 24 and 25. Pictured (from left) are: Dr Jane Renehan; IDA CEO Fintan Hourihan; Dr Nuala Carney; and, Dr Robin Foyle.

Watch this space – Young Dentist Seminar



Following on from a very successful inaugural 'New Graduates/Young Dentist' event last year, we will be holding a similar event this year on Saturday, September 28, at the Crowne Plaza Hotel, Santry. Topics to be covered will include social media, employment law as an associate, how to obtain Government contracts (DTSS and DTBS), financial issues, and much much more. Full programme out soon.

O'Mullane prize awarded

Pictured at the May 2019 meeting of the Irish Society of Dentistry for Children are Dr Aoibheann Wall and Dr Rona Leith. Aoibheann won the O'Mullane Prize for her research project, 'A questionnaire study on perception and clinical management of MIH by Irish dentists', which was supervised by Dr Leith.

Colgate Caring Dentist of the Year Awards 2019

Put Saturday, December 7 in your diary for the social event of the year – the Colgate Caring Dentist of the Year Awards. This year's event will take place at the Clayton Hotel, Leeson Street. All team members welcome. Dress code: black tie. An event not to be missed – see you there!

Retirement Seminar

Our biannual Retirement Seminar will take place this year on Friday, September 27, at the Crowne Plaza Hotel, Santry, Dublin. This day-long seminar is relevant to those thinking of retiring over the next couple of years. Only open to IDA members. Full programme out soon.

PHMP annual report launch

At the recent launch of the Practitioner Health Matters Programme (PHMP) Annual Report 2018 were (from left): Dr Barney Murphy, Board of Trustees, PHMP; Dr Íde DeLargy, Medical Director, PHMP; David O'Flynn, Dental Council of Ireland Registrar; and, Fintan Hourihan, IDA Chief Executive.

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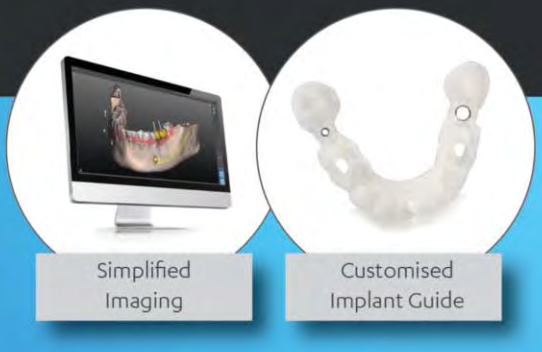

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SMART GUIDE

IDA at Oireachtas Health Committee

IDA President Prof. Leo Stassen and CEO Fintan Hourihan attended the Oireachtas Joint Committee on Health on May 15, 2019, where they raised the Association's concerns regarding the new national oral health policy.

You can access the Oireachtas hearing at:

www.oireachtas.ie/en/committees/32/committee-on-health/

[go to videos and scroll to Wed, 15 May 2019]

and can get the transcripts at:

https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2019-05-15/2/

Diary of events

SEPTEMBER

17 Munster Branch Meeting and AGM

7.30-9.00pm. Maryborough Hotel, Douglas, Cork

HIQA, infection prevention and control and dental practice: what should we expect? Speaker: Dr Jane Renehan

27 Day-long course on snoring and sleep disorders

Dr Roy Dookun, a UK-based GDP, will explain how snoring devices work and how to assess patients. Full programme on www.dentist.ie.

27 Getting long in the tooth – IDA retirement seminar

9.30am-4.00pm. Crowne Plaza Hotel, Northwood, Santry

Seminar for retired and retiring dentists

28 Young dentist/new graduate event

9.00am-5.00pm. Crowne Plaza Hotel, Northwood, Santry

OCTOBER

10-11 IDA HSE Dental Surgeons Seminar

Midlands Hotel, Portlaoise

18 IDA Kerry Branch ASM

Europe Hotel, Killarney

19 Basic life support and medical emergencies

10.00am-4.00pm. Clayton Hotel, Ballybrit, Galway

We aim to help dental practitioners to improve the standard of care provided and increase their confidence in dealing with the acutely ill adult patient by learning an accessible patient assessment and management system. Furthermore, we will address what medical emergency drugs are required, how these drugs are prepared and administered, what dose and route of administration should be used, and contraindications where indicated.

IDA members €195/Non-members €390

26 Basic life support and medical emergencies

10.00am-4.00pm. Radisson Blu Hotel, Dublin Airport

IDA members €195/Non-members €390

NOVEMBER

15 IDA Munster Branch ASM

Fota Island Resort, Cork

DECEMBER

7 Colgate Caring Dentist Awards 2019

Clayton Hotel, Burlington Road

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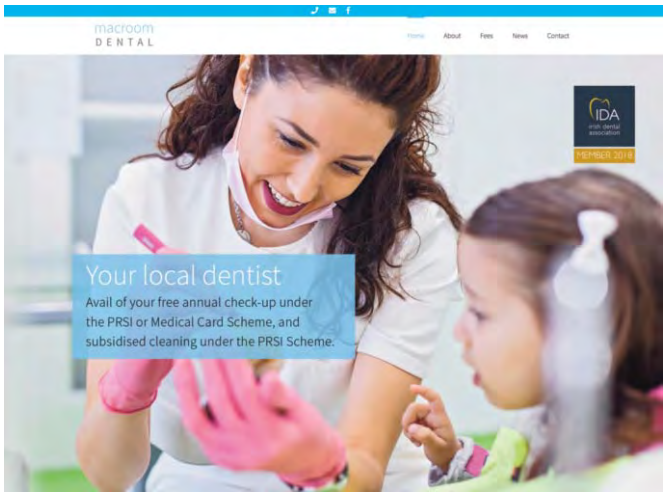

You can see an example of one of the new style websites by visiting www.macroomdental.ie.

When the IDA negotiated a special deal with the publishers of this *Journal*, Think Media, they had no idea that it would prove so popular. Now many members are delighted to report that their websites have not only enhanced their online presence but have proved to be very popular with their patients. These fully responsive websites automatically resize when they're viewed on different devices, whether on a pc, a tablet or a smartphone.

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References: 1. Merry A, et al. AFT-MX-1, a prospective parallel group, double-blind comparison of the analgesic effect of a combination of paracetamol and ibuprofen, paracetamol alone, or ibuprofen alone in patients with post-operative pain. Department of Anaesthesiology, University of Auckland, New Zealand 2008. *compared with the same daily dose of standard paracetamol or ibuprofen alone.

Easolief Duo 500 mg/150 mg film-coated tablets Each tablet contains paracetamol 500 mg and ibuprofen 150 mg. **Presentation:** A White, capsule shaped tablet with breakline on one side and plain on the other side. **Indications:** Short-term symptomatic treatment of mild to moderate pain. **Dosage: Adults/elderly:** The usual dosage is one to two tablets taken every six hours up to a maximum of six tablets in 24 hours. **Children:** Easolief Duo is contraindicated in children under 18 years. **Contraindications:** Severe heart failure, known hypersensitivity to paracetamol, ibuprofen, other NSAIDs or to any of the excipients, active alcoholism, asthma, urticaria, or allergic-type reactions after taking acetylsalicylic acid or other NSAIDs, history of gastrointestinal bleeding or perforation related to previous NSAID therapy, active or history of recurrent peptic ulceration/ haemorrhage, severe hepatic failure or severe renal failure, cerebrovascular or other active bleeding, blood-formation disturbances, during the third trimester of pregnancy. **Warnings and precautions:** This medicine is for short term use and is not recommended for use beyond 3 days. Clinical studies suggest that use of ibuprofen, particularly at a high dose may be associated with a small increased risk of arterial thrombotic events. Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses should be avoided. Careful consideration should be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events. The use of paracetamol at higher than recommended doses can lead to hepatotoxicity, hepatic failure and death. Patients with impaired liver function or a history of liver disease or who are on long term ibuprofen or paracetamol therapy should have hepatic function monitored at regular intervals. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, though rare, have been reported with ibuprofen. Paracetamol can be used in patients with chronic renal disease without dosage adjustment. There is minimal risk of paracetamol toxicity in patients with moderate to severe renal failure. Caution should be used when initiating treatment with ibuprofen in patients with dehydration. The use of an ACE inhibiting drug, an anti-inflammatory drug and thiazide diuretic at the same time increases the risk of renal impairment. Blood dyscrasias have been rarely reported. Patients on long-term therapy with ibuprofen should have regular haematological monitoring. Like other NSAIDs, ibuprofen can inhibit platelet aggregation. GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered. Use with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided. NSAIDs may lead to onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensive medicines with NSAIDs may have an impaired anti-hypertensive response. Fluid retention and oedema have been observed in some patients taking NSAIDs. NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis and Stevens-Johnson syndrome. Products containing ibuprofen should not be administered to patients with acetylsalicylic acid sensitive asthma and should be used with caution in patients with pre-existing asthma. Adverse ophthalmological effects have been observed with NSAIDs. For products containing ibuprofen aseptic meningitis has been reported only rarely. 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CLONMEL HEALTHCARE

Anatomy of a class reunion

BACK ROW (from left): Philip Christie (Dublin); Brian Malone (Arklow); John Carpendale (Montreal); Kieran Ryan (Tullamore); John Conry (Minnesota); John O'Keefe (Ottawa); Aidan McGrath (Ballinasloe); Tom O'Connor (Dún Laoghaire); Billy Hayes (Dublin); Edward Lynch (Warwick); Fergal Connolly (Cavan); and, John Nolan (Dublin).
MIDDLE ROW (from left): Oscar O'Herlihy (Basingstoke); John Pierse (Tipperary); Shivaun Suleman (Stafford); Carmel Greene (Cardiff); Mary Rothwell (Ballinasloe); Mona McCarrick (Dublin); Freda Creavin (Enniscorthy); Claire McInerney (Waterford); and, Eamon Croke (Dublin).
FRONT ROW (from left): Niall MacDonagh (Dublin); Joe Nolan (Galway); Tom Daly (Harwich, Essex); and, Conor McAlister (Dublin).

The class of 1979 recently held its 40-year reunion. Dr Conor McAlister reminisces about, among other things, the great dental rebellion of 1977.

The Dublin Dental Hospital (DDH) class of 1979 celebrated its 40-year reunion in Galway recently to coincide with the IDA Conference. In a clever piece of 'rebranding', the reunion was marketed as a celebration of 45 years, since we commenced our dental studies in four different institutions in October 1974.

In October 1977, a group of 42 students came together to form what was then known as Third Dental in the DDH. The group was made up of four students from University College Galway, six from the Royal College of Surgeons in Ireland, 13 from Trinity College Dublin and 19 from University College Dublin. Each group had completed three years of 'pre-clinical' training in the four institutions, in direct contrast to the present day, when students begin to attend the hospital in their first year. The education received in those pre-clinical years was variable and unco-ordinated, to say the least. Students in the RCSI had six lectures in pharmacology, whereas students in TCD had two terms in the same discipline. In TCD, we were informed that a mistake had been made and that we should not have attended for the second term. Anyone who remembers the humiliation and embarrassment of being asked by a medical consultant to examine a patient's hernia, while trying to hide at the back of a medical students' ward round, will understand what life was like for a dental student in those days. In Trinity, a large part of our 'pre-clinical' time was spent fighting for extra lectures and expressing our discontent at being treated like second-class medical students.

Interesting times

Our time in the DDH was often turbulent and somewhat traumatic, but always fun. In December 1977, we were informed that our course was to be extended by six months because of teaching time lost due to an ongoing dispute. The dispute was between the Teachers' Union of Ireland, representing six instructor dental technicians, and the hospital board. In those days, an inordinate amount

of student time was spent in the prosthetics laboratory learning the technicalities of denture fabrication. The extension of our course to six years was the proverbial 'last straw'.

In early December 1977, the class decided it was time to take action. Having repaired to the Lincoln Inn one Friday evening at 5.00pm after a day in the hospital, we returned at 6.00pm and asked the hospital porter and cleaning staff to leave. So began the 1977 DDH Lockout, otherwise known as the occupation of the Dental Hospital. Our demands were very simple. We wanted the dispute to be resolved so that we could sit our final exams on schedule in December 1979.

The occupation lasted for 10 days and was well organised by certain individuals, who shall be nameless! After a couple of days, our negotiators relented and permitted the accident and emergency clinic on the ground floor to reopen. The top floor of the then rather dilapidated building was transformed into a dormitory.

The recently installed Kavo chairs in Cons1 made for excellent beds. Catering took place on the second floor and the first floor was converted into a casino (poker was popular!) and occasionally a disco. A personal memory is of leaving the hospital every morning, down the fire escape, in order to deliver my morning Christmas postal round and then returning to Lincoln Place for picket duty in the afternoon.

The occupation ended on December 16, 1977, having made headlines in the newspapers and the evening news on RTÉ television. The dispute between the dental technicians and the hospital board was resolved a short time later. We were back on target to sit our final exams in November/December 1979. It was a victory of sorts. Of the 42 students who came together in 1977, only 18 qualified on schedule because so many failed the final exam.

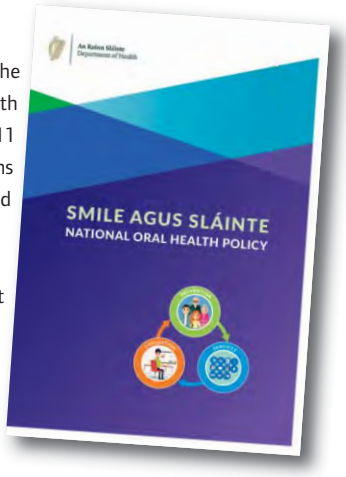
A personal memory is of leaving the hospital every morning, down the fire escape, in order to deliver my morning Christmas postal round and then returning to Lincoln Place for picket duty in the afternoon.

It was little wonder that our class did not hold its first class reunion for 25 years. Since then, we have had four reunions, each one more enjoyable than the last, and all of them far too short. Sadly we have lost classmates along the way – John P. Walshe, Vincent Marren and, more recently, Paul Kelly. Their loss has, if anything, brought us closer together, as indeed do our recollections of the events described above. As the song goes: "and it's the laughter, we will remember".

As a matter of interest, of the 42 who came together in 1977, approximately 21 continue to work in dentistry and 18 are now retired or work in other fields. From a personal point of view, nothing much has changed. I now seem to spend a lot of time campaigning for equal rights for mouth cancer patients. Meanwhile, other classmates endeavour to get proper funding for and meaningful implementation of the recently announced national oral health policy, which would truly benefit all of our patients.

Unfair and unworkable

IDA members at the recent meeting on the national oral health policy were adamant that the policy in its current form will not and cannot be implemented.



The *Journal* spoke to dentists who attended the IDA's meeting on the new national oral health policy (NOHP) – Smile agus Sláinte – on May 11 to get their views on the policy and what it means for dentistry and oral health in Ireland. We asked the following questions:

1. How do you think the new policy will affect you?
2. What are your impressions of the policy?
3. What would you like the Association to focus on in its negotiations with the Government?

Dr Tim Lynch,
general dental practitioner,
Killorglin, Co. Kerry

1. I think the policy is a disaster for dentists and for dentistry. Maybe there was thought put into it but it doesn't look like there was that much thought.

2. I can't see how it could come in its current form. I can't see too many dentists wanting to treat all the children in the country. I think we have a HSE system that should be financed properly. I don't think dentists would have any interest in capitation payments, because in England it's just gone down a slippery slope and the profession has been completely undermined, and I think the same thing would happen in Ireland.

3. I would like the IDA to focus on the existing contract that we have with the HSE for adults, to refinance that and get that going before we start trying to introduce anything else.

Dr Philip Mulholland,
public dental surgeon,
Kildare/West Wicklow

1. The new policy is incredibly vague. We have waited for so long for a new policy and now we have a document that is not prescriptive. Therein lies our problem.

2. Overall it reads like a protracted vision statement rather than a policy. Some of the ideas are fine in print but we have no idea of how they would work in practice. Another big worry is that the research on which the policy is based may not be credible.

3. I would like them to really focus on patient care. The big question is how our most vulnerable patients are going to be affected. Additionally, the current members of the public dental service need to be given assurances on their future. Any changes to their terms and conditions, and especially to their scope of practice, can only be negotiated with the Association in consultation with members.

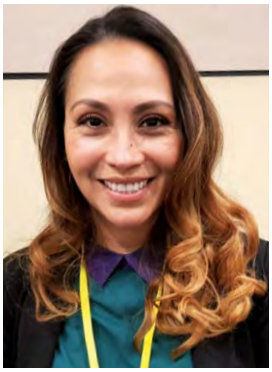
Dr Gillian Smith,
general dental practitioner,
The Dental Suite, Bray,
Co. Wicklow

1. I think that the way the Department has gone about the implementation of this new structure is a disaster. Nobody's happy – the general dentists or our colleagues in the HSE – and it just beggars belief that they would try to introduce a new system on both groups without consulting them in any meaningful way.

2. I'll have to close my doors with the numbers they're talking about. Ultimately, it will come down to numbers. We all run businesses and I think there is no shame in that. We're clinicians too, we want to do the best for our patients, but we all have a business.

3. Being able to come here today and hear the opinions of my colleagues is great. My feeling on it now is should we negotiate at the current point? Or should we say: "Well actually, you didn't invite us to the table". We've tried to contact them numerous times. Maybe we should just say: "Come to us if you want to engage with us and offer us something meaningful".

Dr Marcela Torres Leavy,
general dental practitioner,
mixed practice,
Kinnegad, Co. Westmeath.



1. The policy will affect me greatly. We don't have the staff or the resources in our practice to do what appears to be required of us – and we don't get any supplementary funding from the HSE. I think capacity is going to be a really big issue and I am concerned that the per capita payment will be inadequate to allow us to do the work being asked of us.

2. I think the policy is really bad. They (the authors) don't seem to see the full picture of prevention. It is very poor on oral health and oral health habits, and appears to be wrong on fluoride for 0-6 year olds.

3. The Association should focus on the contracts that we hold to update the [Medical Card] Scheme and to extend treatment available to patients. For example, it should not just cover two fillings but also cover prevention of periodontal disease. And, of course, the Association will have to negotiate a fair payment for our work.

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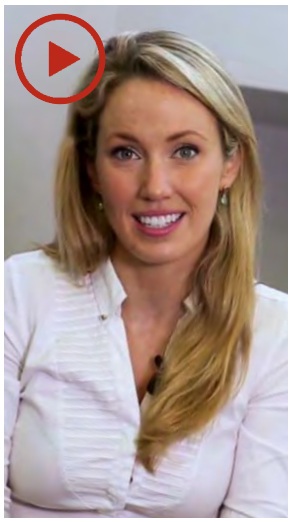
New products from VOCO

VOCO states that its VisCalor bulk combines the benefits of both flowable and sculptable materials. For dentists, if an adhesive technique is selected for a restorative procedure, then another decision that must be made is whether to use a flowable or sculptable material. Dentists often start by using a flowable composite but these are difficult to carve. To solve this problem, the dentist either uses a sculptable bulk composite as an additional layer, or right from the outset.

According to VOCO, its VisCalor bulk combines the benefits of both techniques (composite bonded to flow). Using extraoral warming means that the composite can initially be placed in the cavity in flowable form, but then changes its consistency within a few seconds to become sculptable. Also new from the company is the VisCalor Dispenser, which VOCO states enables the warming and application of composite caps immediately using one device.

Malawi fundraiser



Dentist Dr Marie Sanfey will be travelling to Lilongwe in Malawi this summer with her doctor husband Mike to volunteer in Daeyang Luke Hospital there. Marie would be very grateful for donations of oral surgery instruments and disposables, or for donations to help fund their work. The funds raised will go directly to provide healthcare to the patients in Lilongwe.

To donate equipment, please contact mariesanfey@hotmail.com, or call 087-632 5401. To make a financial donation, please go to www.gofundme.com/f/Marie-and-Mike-volunteer-in-Malawi-hospital.

Quintess Denta supplying 3D printers

Mike Lemaic, Sales Manager at EnvisionTEC (left), with James Hamill, CEO, Quintess Denta and QUORIS 3D.

Quintess Denta has become the latest distributor for EnvisionTEC's range of dental 3D printers and materials through its new 3D-printing sister company, QUORIS 3D. Quintess Denta states that the business, which operates across the UK and Ireland, brings with it a wealth of knowledge about the industry and is one of the first authorised to sell the Envision One cDLM Dental 3D printer.

Peter Greene, Managing Director at Quintess Denta, said: "Quintess Denta are delighted to launch QUORIS 3D alongside our new partnership with EnvisionTEC. This move into the exciting world of 3D printing gives our customers access to the best dental and orthodontic focused 3D printers and materials in the market".

Greene continued: "Adding this portfolio of solutions complements our current range of products and adds some truly ground-breaking technology. The Envision One machine in particular will change the way dental and orthodontic professionals look at 3D printing".

Integrating digital equipment into your practice

In late June, Henry Schein Ireland is staging Digital Showcases in Athlone, Drogheda, and Limerick. Leading manufacturers including Dentsply Sirona, Acteon, and 3Shape will display a varied range of innovative digital equipment. In addition, there will be one-to-one demonstrations and tips on how to integrate the digital equipment into the daily office workflow in an optimum way.

The Showcases take place at The Limerick Strand Hotel, Ennis Road, Limerick, on Tuesday, June 25; at The D Hotel, Scotch Hall, Drogheda; and on Thursday, June 27, at The Radisson Hotel, Northgate Street, Athlone. The events start at 1.00pm each day.

These events are part of Henry Schein ConnectDental, the company's platform created to help dental professionals comfortably enter or expand further into the world of digital dentistry, not only by just looking at the individual technology and products available on the market today, but also by uncovering how these solutions can best be integrated into the practice or laboratory, and seeing how it can enhance the care they provide to patients. Contact Henry Schein in Dublin to register.

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Brushmyteeth.ie is a new resource designed with special needs patients in mind, but which can be used by all dentists to educate their patients, and by patients to take ownership of their oral health.

Dr Caoimhin Mac Giolla Phadraig speaking at the launch of brushmyteeth.ie with filmmaker Cionna Mac Giolla Phadraig, left, and stars of the videos Ann-Marie Reid and Anne-Marie Chalkey.

The power of brushing

Effective oral hygiene is perhaps the dental profession's best weapon to battle common oral diseases. This goes for everyone, not just people with disabilities. As dental professionals, we know that tooth brushing enables the regular application of fluoride-containing toothpastes to the teeth, crucial in the effort to prevent caries.[1] The regular chemo-mechanical disruption of biofilm prevents and reverses plaque-induced gingivitis, and is essential for the management of periodontal disease.[2-4] Because of these benefits, we often provide oral hygiene advice to improve oral hygiene behaviours and ultimately improve health.[5,6] Compared to professional-led treatments like scaling, this advice has the added benefit of targeting behaviours that the individual can potentially maintain, thereby taking ownership of their own health.

Traditional oral hygiene advice requires patient visits, preferably repeated for effect.[7] However, most of the population are not regular dental attendees. Dental visits are also resource intensive from both patient and professional perspectives. Community-based approaches are therefore attractive but have traditionally failed to demonstrate meaningful impact.[8]

Therefore, our profession needs a way to influence patient and public behaviour in a way that is accessible to all people: regular and irregular attenders, disabled or not. Of course, any intervention should be based on evidence, and the evidence is far from clear.[6] In fact, even the most effective means of self-performed plaque removal with regular toothbrushes is unclear.[9,10] While the modified Bass technique is most commonly recommended, our tooth brushing messages to our patients are unacceptably inconsistent.[11]

Brushmyteeth.ie

Brushmyteeth.ie is an unlikely collaboration of dentists, dental hygienists, disability professionals, people with disabilities, academics, and creative artists, which produces free online resources that you can use with your patients to "make brushing better". Our client groups consist of people who have difficulty maintaining their oral health. Specifically, we are talking about patients with developmental disabilities such as autism, or acquired disabilities like dementia – patients who we all see from time to time. So for this project, we made an extra effort at inclusive design. When our vulnerable patients get oral diseases like caries and periodontitis, the outcomes are often poorer and the treatment often more complicated than for the average dental patient. This leads many of our most vulnerable patients onto waiting lists, into anaesthetic theatres, and ultimately to edentulism. The hard part for us, our patients and their carers, is that these diseases are preventable through simple measures like tooth brushing.

Using the tools

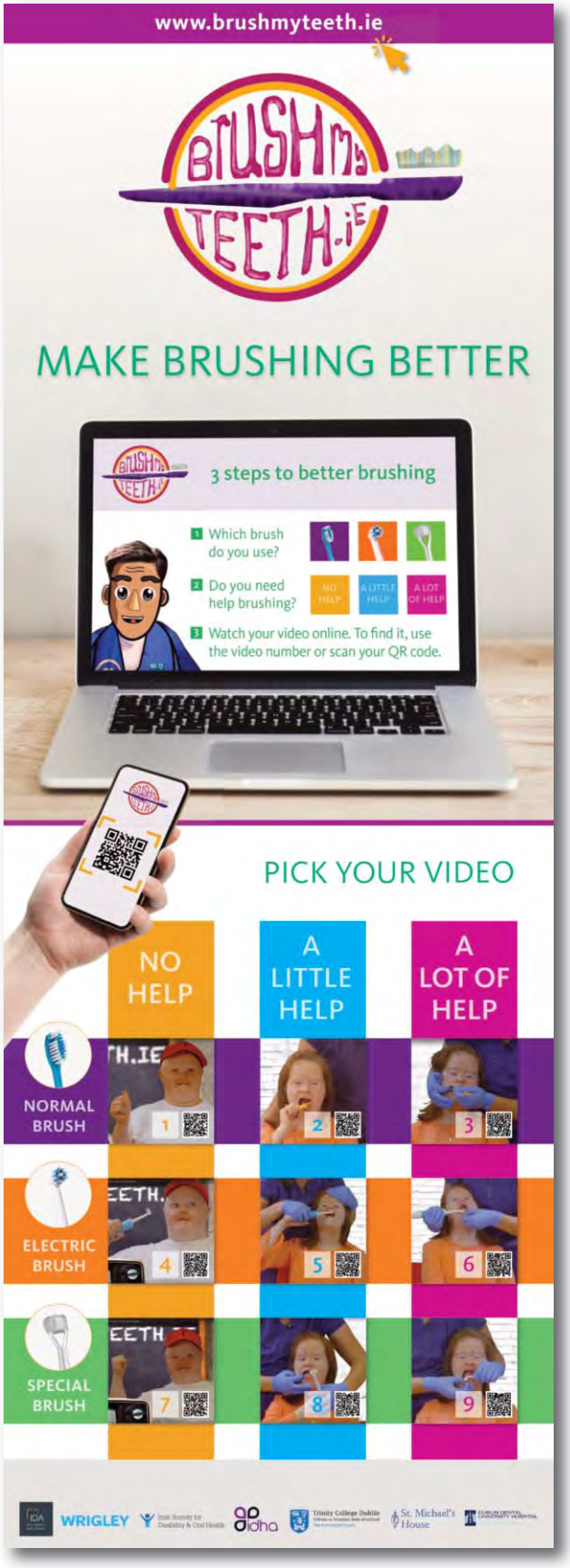
Brushmyteeth.ie hopes to provide a resource that offers consistent, evidence-based oral hygiene advice to a wide range of people and patients. To maximise our ability as a profession to meet our patients' diverse needs, Brushmyteeth.ie gives video instruction for as many different types of brushes as you can think of. Well, three, to be exact: a normal brush; an electric brush; and, a Barman's Special (Superbrush). Our videos show how to use these brushes based on the best available evidence.[6,10-13] Given our focus on inclusivity, we show how this brushing can be done for people with different levels of ability.[14] Therefore, we have produced videos across three levels of support need:

- brushing with no help;
- brushing with a little help; and,
- brushing with a lot of help.

In total, this gives nine videos across three levels of support and three types of toothbrush (see poster graphic on page 139).

Caoimhin Mac Giolla Phadraig
Trinity College Dublin

Ceara Cleary, HSE
Catherine Waldron, Trinity College Dublin
Ann Spencer, St Michael's House
Lorraine Ledger, St Michael's House
Cionna Mac Giolla Phadraig, Independent filmmaker
Ann-Marie Reid, Ace Communication Ireland
Anne-Marie Chalkey, Disability Advocate
Teresa Gadd, ACE Communication Ireland
Sarah Cronin, ACE Communication Ireland
June Nunn, Trinity College Dublin



Brushmyteeth.ie will be most useful for the possibly rare occasion when a patient with a disability such as dementia or autism arrives into the surgery. In such instances, these resources mean that there is no need to recall obscure tooth brushing techniques or re-invent methods. Just ask two simple questions:

- What type of toothbrush do you want to use?; and,
- Do you get help brushing your teeth?

This can act as a basis for personalisation of the technique shown. You can guide the patient or carer to select the video that suits them, or patients can select this independently.

In practice, most patients will probably use a normal toothbrush with no help, meaning that Brushmyteeth.ie Video 1 will suit them. Of course, we can also direct the patient towards other videos. If, for example, we want the patient to try an electric brush, you can suggest Brushmyteeth.ie Video 4.

At its simplest, patients or caregivers can take photos of the recommended resource on their phones so they can look at www.brushmyteeth.ie in their own time, at home, at care staff meetings or even in your waiting room. Letting patients take a photo or scan the QR code so they can bring the message with them is quick and easy, especially for busy practices. Other suggestions for how to use this website are available at https://www.brushmyteeth.ie/how-to-use-this-website.

Of course, there is more to Brushmyteeth.ie than just videos. The website has an FAQ section that will help you and your patient to address most of the issues and barriers that arise. We have developed accessible tooth brushing charts and oral healthcare plans for you to use with your patients. We have also designed a checklist to match each video so that patients can engage with the material across media. These resources can be used creatively to develop personalised interventions for better brushing. For example, when we recommend Video 9 in our practice, which we do a lot, we give out a printed brushing chart and Video 9 checklist with encouragement to engage, practice and record how tooth brushing goes. We also arrange a follow-up to problem solve and assess effectiveness.

We need to think about how we translate oral hygiene advice into better behaviours and onward to better health.

So far, Brushmyteeth.ie is simply a tool to connect dental professionals and their patients with accessible, inclusive, evidence-based information. This means that these resources only become useful when they are applied and how that is done is important. Evidence suggests that it is actually tricky to get this right.[15]

Just the beginning

Now we are up and running, but we realise that this is just the start. Brushmyteeth.ie is a work in progress. The resources are not perfect. For example, we have not focused on interdental cleaning.[12] We have yet to test these resources systematically, so our work continues. However, our resources have the potential to benefit all people, particularly those who need it most. So we encourage you to have a conversation among your teams about how we can improve oral health for all our patients. Get involved. Hang the poster or print the handouts. Use the website. Let us know what you think. Together, we can make brushing better.

Over and out!

Acknowledgements

This project was made possible through bursaries from the IDA, Wrigley Company Foundation and Irish Society for Disability, and hundreds of hours given voluntarily.

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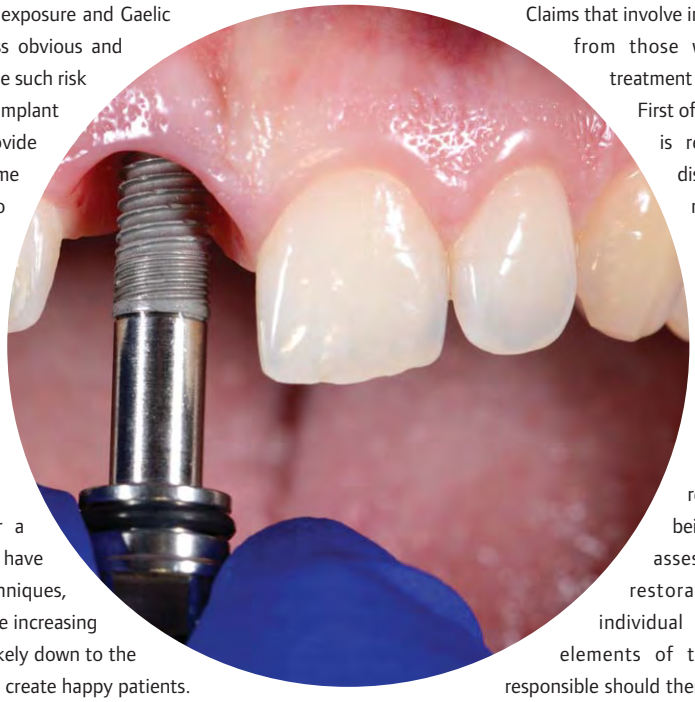
Are you implanting risk?

Dental implant use is growing and improving quality of life for many patients, but the treatment also carries the risk of expensive claims against dentists.

Risk can present in different forms. Some activities have clearly known risks, such as smoking, excessive sunbed exposure and Gaelic football. Sometimes, however, risk is less obvious and can come from an unexpected quarter. One such risk to dentists is involvement in dental implant treatment. Many dentists in Ireland provide treatment involving dental implants. Some place the implants themselves, some do the subsequent restoration work, while others carry out both. Such treatment is clearly an important part of modern clinical dentistry and there is an expectation that this should be a treatment option available to patients. There has therefore been a steady increase in the availability of this treatment in recent years.



Dental implants have been around for a considerable amount of time, and there have been many developments in the techniques, which are designed to improve results. The increasing popularity of implant treatment is most likely down to the impressive results produced, which in turn create happy patients.

As with any clinical procedure, success will of course depend upon a careful technique and assessment, as well as ensuring that the aim of the treatment and result achieved is matched to patient expectations. In the vast majority of cases, treatment is successfully delivered, and both patient and dentist are satisfied with the result.

Anyone who has ever picked up a handpiece will agree that providing clinical care is not without its hazards. Misjudgements and/or simple errors with planning or execution of treatment can compromise results. Similarly, if patient expectations are not managed, there is a risk of the "disappointment gap" appearing if the end result is not what the patient was expecting. This can all too often be a powerful driver of patient complaints, particularly if there are relatively high costs involved. These factors are not unique to implant treatment however, and also apply to other forms of dental care.

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Unique implant risks

Claims that involve implant treatment can be distinguished from those which arise from other forms of treatment on account of some specific factors. First of all, in cases where remedial treatment is required, the cost of this is often disproportionately high. If there is a need to remove and replace implants, carry out bone grafting and provide replacement restorations, it is not difficult to see how the costs claimed can quickly build up – particularly if the time commitment and inevitable patient inconvenience are also included.

A dentist who both places and restores implants has the advantage of being in control of the whole process of assessment, planning, placement and restoration. The downside is that the individual needs to be equally good at all elements of the treatment and will be solely responsible should there be any issues.

Arrangements where the process of placing and restoring is divided between two, or perhaps more, clinicians have the benefit of allowing each member of the team to play to his or her strengths. This can work very well but has the disadvantage that if there is an issue with the final outcome, determining the responsibility for the primary cause can be challenging. Who is responsible for the choice of implant location? Has the restoration been compromised by the implant or has the implant been compromised by the restoration? Clinicians can fall out.

Often it is not clear where the responsibility lies. Sometimes there is more than one fault and needless to say, claimant solicitors will look for any opportunity to identify issues and exploit any apparent weaknesses in all parts of the treatment. The result is often that all of the dentists involved in the patient's care become parties in the legal claim.

Something else that can generate significant expense in legal claims is chronic pain. Obviously, nerve damage can result from direct trauma but pain can arise even if the cause is unclear.

There is scarce literature around the prevalence of "neuropathic pain" and/or altered sensation following dental implant treatment; however, it does feature in legal claims. Neuropathic orofacial pain (NOP/atypical odontalgia/phantom tooth pain/persistent idiopathic facial pain/atypical facial pain) sufferers present with persistent and severe pain with no clearly identifiable clinical cause.

Whatever the mechanism at play, this is an outcome that can arise in virtually any case, even with an experienced practitioner providing treatment with no technical fault. The issue is simply that following treatment the patient develops persistent intractable pain.

Any legal claim that involves chronic pain, particularly if compounded by allegations of "psychological effects", will inevitably involve high claims for damages. Ireland has a legal environment in which the level of awards for damages can be considerably higher than in other jurisdictions and this does encourage claims. The net result is that dentists who are involved in implant treatment may find themselves at risk of being involved in compensation claims with high levels of damages being sought.

Can anything be done?

Being able to demonstrate that valid consent was obtained is essential when defending a dentist's position should a claim arise. The patient should be aware of the risks of treatment before embarking on it. In accordance with the principles set out in *Geoghegan v Harris*,[1] the patient must be made aware of material risks to ensure that there are no nasty surprises should the treatment not achieve the ideal outcome. The possibility that pain can develop following implant treatment, which is not necessarily on account of any fault with the treatment, is a fact the patient should be made aware of. The incidence of this effect may be low but given the potential impact, the consent process should take this into account when treatment options are being discussed.

Any legal claim that involves chronic pain, particularly if compounded by allegations of "psychological effects", will inevitably involve high claims for damages.

It is advisable for all dentists who provide implant-related treatment, whatever part they are involved in, to ensure that patients are aware of the risks of such treatment. Although there will be no problem with the vast majority of cases, both clinicians and patients need to be aware of the fact that problems can arise. The consent process for all stages of treatment should be robust and clearly documented. Although clear records may not prevent implant problems arising, they are of great value in defending a dentist's position should a claim arise.

Reference

1. *Geoghegan v Harris* [2000] IEHC 129; [2000] 3 IR 536.

Important information about x-rays

There have been some significant changes to the way in which dentists who take x-rays are regulated.

Do you take x-rays? Have you made a declaration to HIQA?

All dentists – including self-employed associates – who take x-rays should be aware of their responsibilities under the Medical Exposures Regulation, SI 256 of 2018. Dentists should ascertain whether they need to submit an undertaking declaration (NF200) form to HIQA without delay, if they have not already done so. Under new regulations, HIQA is responsible for the regulation of patient medical exposure to ionising radiation. All undertakings that administer radiation were required to declare themselves to HIQA on or before April 8, 2019.

Who is an undertaking?

On March 29, 2019, HIQA published a Regulatory Notice regarding the definition of an undertaking. On foot of this new notice, the IDA sought clarity from HIQA as to "who is an undertaking in legal and regulatory terms as understood by HIQA"?

In response, HIQA stated: In situations where a dentist is not employed by or contracted by another undertaking yet **the dentist conducts medical exposures as a self-employed individual, the dentist is an undertaking in their own right as per the regulations and must submit an NF200 form**.

If you are unsure whether you should make that declaration, you are advised to contact HIQA directly and seek clarity without delay. You can contact HIQA on 01-828 6750 or email radiationprotection@hiqa.ie.

Those members who have already been declared an undertaking but who practice in a location(s) other than where they are the dental x-ray licence holder, including public hospitals, are advised to also seek advice from HIQA as to their particular working circumstances, or to resubmit a revised NF200 as the original declaration may be incomplete.

Completing form NF200

The IDA also sought advice on how to complete the NF200 form for a self-employed associate. HIQA advised that section A1 should be completed as follows: "Please enter the address and relevant Eircode of the principal place of business of the undertaking. If the undertaking has registered itself as a business (where applicable), please use the address associated with that registration (www.cro.ie). The address submitted by the undertaking must be regularly monitored and should enable HIQA to readily communicate with the undertaking.

"If a self-employed dentist conducts exposures at a number of different installations they should indicate the number and complete Section A3 listing the radiological installations in which these exposures are conducted. The medical radiological installation address is the address where each of the undertaking's exposures are conducted."

Partnerships

HIQA stated: "The definition of partnership has not changed. In the case of a partnership, the undertaking will be the persons who form the partnership, with each partner being legally responsible for the undertaking. Section A1 should be completed to reflect the partnership name. Section A2 for the undertaking representative must reflect one of the partners, and Section B2 must be filled in to formally list the partners legally responsible as the undertaking."

New EPA Code of Practice on Ionising Radiation in Dentistry

The Environmental Protection Agency (EPA) has launched a new Code of Practice on Ionising Radiation in Dentistry to help dentists comply with new regulations. The new regulations mean that most dental practices will no longer need an x-ray licence and will instead pay a once-off registration fee of €300 later this year.

The once-off registration fee of €300 is a welcome development when compared to the existing licence charge of over €1,200, about which the Association has been protesting over many years.

Move from licensing to registration

New regulations on ionising radiation (SI 30 of 2019) came into effect earlier this year. The new regulations allow those with lower-risk radiological practices to move from a licensing system with the EPA to registration.

The EPA anticipates that the majority of dentists will move from licensing to registration. Registrations will be issued on an indefinite basis and will incur a once-off registration fee of €300, with an additional fee of €75 per additional premises operated under the same registration.

Licensing will continue to apply to higher-risk practices and the use of hand-held intraoral x-ray equipment will remain subject to licensing. Under the new system, licences are renewed every 10 years and the 2019 fee for dentists who are subject to licensing is €475.

The EPA will write to dentists over the summer to set out the next steps in transferring them to the new registration system. **You should note that your current licence remains valid until then and you do not need to do anything now**.

The new Code of Practice is available on the EPA website in the Publications and Downloads section under Radiation.

If you have any queries about the new regulations or the declaration process please contact Roisín in IDA House.

A survey of the provision of orthodontics in Ireland 2018

Précis

A survey of current orthodontic workforce levels in Ireland, showing stable practitioner to populations ratios since 2007.

Abstract

Workforce planning is important in all aspects of healthcare; in orthodontics, this must take into account several issues including the need for orthodontic treatment, the number of specialist personnel available to provide treatment and the role of orthodontic auxiliaries.

The aim of this study was to collect information on the orthodontic workforce in Ireland and to compare this information with previous studies (2001, 2007) in order to determine longitudinal trends in the orthodontic workforce in Ireland.

The study was carried out in the form of a survey. The survey included orthodontic specialists practising in the Republic of Ireland. A list of these practitioners was obtained via the Orthodontic Society of Ireland (OSI) and the orthodontic specialist register of the Dental Council of Ireland.

The study was circulated both via email and post for completion by March 31, 2018. The electronic version used SurveyMonkey software, which provides a user-friendly interface between the operator and the target population. Data was then collated using both hard copy and online survey responses.

The survey showed that the number of orthodontists in Ireland has increased since 2007, with the practitioner ratio to the number of 12-year-olds remaining stable. It also highlights the increasing role for orthodontic auxiliaries, which may affect future workforce levels.

Workforce planning must consider current specialist practitioner numbers, population growth and the increasing role of auxiliaries in orthodontic practice, along with the older age profile of practising orthodontists.

Journal of the Irish Dental Association June/July 2019; 65 (3): 145-150

Introduction

Quantifying the number of health workers is an important aspect of healthcare planning. Predicting orthodontic workforce requirements is complex and must take into account the demand for treatment as well as the changing trends in how orthodontic treatment is provided. There is an increasing trend towards the role of orthodontic auxiliaries and general dental practitioners (GDPs) in the provision of orthodontic treatment. In addition, geographic factors and access to orthodontic services must be taken into consideration. The levels of orthodontic specialist practitioners in Ireland were previously recorded in 2001 and 2007.[1,2] Knowledge of longitudinal trends in workforce levels will help to

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Table 1: Distribution of orthodontists by age range and place of work

	AGE RANGES				
Place of work	31-40	41-50	51-60	60+	Total
Private practice	14	25	16	6	61
HSE	5	25	7	2	39
Total	19	50	23	8	100

Chi-square = 5.196, df = 3, p = 0.158 (ns); 100 of 101 dentists responded

plan for current and future population treatment needs. The aim of this study was to establish the numbers of orthodontic practitioners (orthodontic specialists and orthodontic therapists) working in Ireland in 2017/18. Secondary aims included highlighting the working practices of orthodontists working in Ireland.

Aims

The aims of this study were to:

a) collect information on the orthodontic workforce in Ireland;
b) compare results with previous workforce studies (2001, 2007) in order to determine longitudinal trends in the Irish orthodontic workforce;
c) determine the ratio of orthodontists to the 12-year-old child population;
d) highlight the working practices of orthodontists working in Ireland; and,
e) determine the number of orthodontic therapists currently working in Ireland.

Materials and methods

Practitioners with orthodontic specialist qualifications living in Ireland were identified from the specialist register of orthodontists of the Dental Council of Ireland, as well as the membership list of the Orthodontic Society of Ireland (OSI). This information was obtained via the Dental Council, where it is freely available. Those with overseas addresses were omitted as it was assumed that these practitioners were not working in the country at this time. A total of 163 practitioners were identified, of which 20 lived overseas. Thus 143 orthodontic specialists were included in the survey. Questionnaires were distributed via an online survey (SurveyMonkey), as well as a paper survey, between November 2017 and March 2018.[3] These questionnaires were based closely on the questionnaires circulated in previous studies.[1,2] Those who failed to respond after the initial circulation received three further emails and postal reminders, followed by direct telephone contact. Questions asked included age range, sex, type of practice (public/private), percentage of adult patients, percentage of clear aligner use, percentage of extraction cases, number of orthodontic therapists, as well as the estimated age of retirement. Chi-square tests were used to assess the significance of difference between different groups. For the purpose of this study, those who spent over 50% of their working time in private practice were considered as "private practitioners", and those who spent 50% or more time in hospital were considered to be "hospital practitioners".

The population figures were obtained from the Central Statistics Office (CSO) website.[4] Twelve years of age was taken as the average age of orthodontic treatment in line with previous studies.[1,2] For the purpose of this study, the number of live births in 2006 (64,426) was used to estimate the number of 12-year-olds in 2018. To calculate the number of 12-year-olds requiring orthodontic treatment, figures from the North-South Survey of Children's Dental Health in Ireland (2002) were used. This survey found that 36% of 12-year-olds had a definite need for orthodontic treatment according to the Index of Orthodontic Treatment Need (IOTN).[5]

Results

Of the 143 questionnaires circulated, replies were received from 101 respondents giving a response rate of 71%. A total of 90% of the questionnaires were completed in full.

Gender and training location

Of the respondents, 49% were female (n=50) and 51% were male (n=51). This shows an increase in the numbers and proportion of female practitioners in comparison to previous studies. In all, 56% of hospital practitioners were female (n=22), while 53% of practitioners in private practice were male (n=33). In total, 68% of respondents trained in the UK, 27% trained in Ireland and 5% trained in the USA or EU.

Practice type

A total of 31% of practitioners worked in both private practice and hospitals (n=31), 25% of practitioners worked exclusively in hospital practice (n=25), and 44% worked exclusively in private practice (n=45).

Age profile

Half of the respondents were in the 41-50 age group and 23% were in the 51-60 age group. There was no significant difference (p=0.158) in the distribution of Irish orthodontists by age range and work in either private or hospital practice. Statistical analysis is outlined in **Table 1**.

Hours of work

The mean working week was 35.1 hours (SD=7.7). Females worked an average of 33.2 hours per week (SD=6.6) over a 4.3-day working week (SD=0.83). Males worked 37.5 hours per week (SD=8.1) over an average of five days (SD=1.3).

Adult cases (18+)

The mean reported percentage of adult cases treated was 23.6% (SD=15.6). For those in hospital practice, the average was 15.9% (SD=14.0). The percentage of adult patients in private practice was predictably higher at 28.5% (SD=14.7).

Surgical cases

The average percentage of cases treated with a combined surgical and orthodontic approach was 7% in private practice (SD=6.17). Approximately 80% of these were dentoalveolar and the remaining 20% were orthognathic. In hospital practice, an average of 21.8% of cases were treated with a combined orthodontic and surgical approach (SD=16.5); 64% of these were dentoalveolar and the remaining 36% were orthognathic.

Aligner use

The total average percentage of aligner use was reported to be 6% (SD = 9.6). The average in private practice was 9% (SD=10.8).

Table 2a: Brands of the more commonly used systems and technologies used by practitioners

Technology used	Brand
Self-ligating brackets	Damon, Empower (AO), In-Ovation (GAC)
Edgewise brackets	Victory MBT, Roth, Sprint (Forestadent)
Ceramic brackets	Inspire ICE, Clarity (3M), Radiance (AO)
Aesthetic wires	Euroform (Ortho-Care), Sentalloy (Dentsply GAC)
Lingual braces	Incognito, WIN
TADS	AbsoAnchor, Forestadent, Spider Screws, Infinitas, VectorTAS, Benefit
Functional appliances	TBA, MOA, Bionator, Reverse TB, Frankel, Andreasan, Herbst
CAD-CAM	Cerec
Digital radiographs	Planmeca, Sidexis, Siemans, Gendex
IO cameras	Carestream, Canon Kodak
CBCT	Planmeca, iCAT
3D models	3Shape TRIOS

Table 2b: Percentage and number of orthodontists using each bracket brand.

Bracket brand	Percentage and number of orthodontists using the following bracket brands
Victory MBT	30% (n=38)
Damon	29% (n=37)
Clarity	20% (n=26)
Empower	19% (n=24)
In-Ovation	15% (n=19)
Radiance	8% (n=10)
WIN	5% (n=6)
Inspire ICE	4% (n=5)
Incognito	4% (n=5)
Roth	2% (n=3)
Sprint	1.5% (n=2)

Latex-free practice

In private practice, only 15% of respondents had a latex-free clinical practice. This figure was much higher in the hospital practice, where 37% of respondents had a latex-free clinical practice.

Technology used

Table 2a illustrates the various systems and technologies used by practitioners. It was noted that those in hospital practice used CBCT more often than those in private practice (possibly due to the complexity of cases treated in these settings). Twin block appliances and medium opening activators were the most commonly used functional appliances. Damon brackets were the most popular self-ligating brackets. Victory and MBT were among the most popular edgewise appliances used (**Table 2b**).

A reported 55% of practices were fully computerised, with a further 35% of practices partially computerised. Some 81% of the fully computerised practices were private. A total of 64% of partially computerised practices were hospital based. Software types are listed in **Table 3**, with CS Orthotrac (Carestream Dental) highlighted as the most commonly used software.

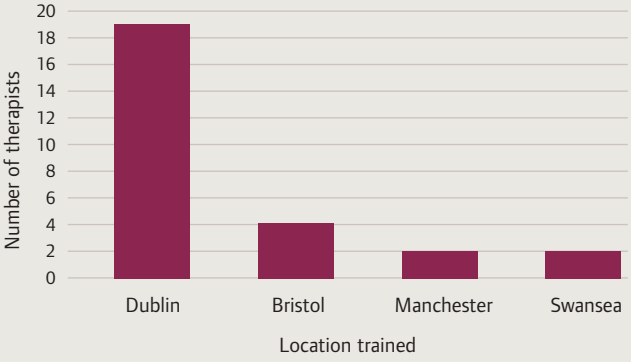

FIGURE 1: Number of orthodontic therapists and location where they trained.

Therapists

A total of 77% of respondents (n=78) did not utilise orthodontic therapists. Some 23 practitioners had at least one therapist in their practice. Data was available for 27 therapists' training location, with 19 having completed their training in Dublin (**Figure 1**). Four therapists completed their training in Bristol, and two each completed their training in Manchester and Swansea. Interestingly, 42% of respondents (n=42) intended to train or employ therapists in the future.

Referral pathways

In all, 76% (n=77) of respondents had access to publicly funded oral and maxillofacial surgery services; however, the waiting time for treatment was on average 13.5 months (SD=10). Some 65% of respondents (n=66) reported not having access to publicly funded prosthodontic or restorative services.

HSE tendering and cross-border directive

The majority of those who had taken part in the HSE tendering process were reportedly not satisfied with this process. Dissatisfaction largely stemmed from lack of payment for work carried out. Other respondents highlighted a lack of contact from the HSE regarding the process. Those respondents who took part in the cross-border directive mainly provided an advisory role to patients applying for the directive. Others used the facility to refer surgical cases for treatment with a shorter waiting time.

Change of practice

In total, 79% of practitioners reported having no intention of changing their practice in the future (n=80). Some 13% (n = 3) of those in a hospital-based setting were planning to change their practice to either full private practice or part-time private practice. Just 3% (n = 1) of those in private practice were planning to change to hospital-based practice in the future. This has implications for future workforce planning in the public orthodontic services.

Discussion

Workforce planning

The workforce situation in Ireland has altered dramatically in the last 25 years, with the number of orthodontists over four times that of 1992.[6] The current

Table 3: Number of practitioners using each type of orthodontic software

Software	Number of orthodontists using
Orthotrac	39
topsOrtho	20
Orthochart	3
Aerona	2
Bridge-IT	2
Exact	2
iPMS	2
Panara	1
Dentally	1
CoinciDental	1
Medicom/DGL Ltd	1

number of orthodontic specialists working in Ireland is 143, with 38 orthodontic therapists.[7] The number of specialists follows previous predictions by McGuinness and Collins in 2007[2] and is outlined in **Figure 2**. There has been an increase in the proportion of female orthodontists (49%) in comparison to previous studies.[1,2,6] The percentage of females in orthodontic practice in 1998 and 2007 was 26% and 33%, respectively. This shows a gradual increase in the number of female orthodontists practising in the Republic of Ireland. In comparison, 50% of practicing orthodontists in the UK were female in 2017.[8] **Figure 2** shows that the projected increase in numbers of orthodontic specialists to date follows a polynomial pattern, and this suggests that the number of orthodontic specialists in Ireland is levelling out and may not increase much in the next 10 years. If, however, a linear model is assumed (**Figure 3**), and using this as a guide, it would suggest that the number of orthodontists in Ireland in 2027 would be approximately 178. **Figures 4a** and **4b** show the number of births from 2006-2017 and the resulting number of 12-year-olds requiring treatment from 2018-2029. Using the CSO predictions of births in 2015 as a prediction of 12-year-olds in 2027 (65,536), the ratio of orthodontists to 12-year-olds at that time will be increased at 1:368. This would suggest an excess of orthodontists per 12-year-old. However, the older age profile of the majority of practitioners may indicate a future need for recruitment to replace this workforce as these practitioners come to the retirement age in approximately 15-20 years' time, assuming the age of retirement is approximately 65 years of age. The current ratio of orthodontists to 12-year-olds is 1:449. This is much the same as that in 2007, which was 1:435.[2] The ratio of orthodontists to 12-year-olds in 1980 was 1:2,773. These ratios are illustrated in **Figure 5**.

Todd and Dodd (1983, 1990) identified that 64% of children were in need of orthodontic treatment in the Child Dental Health Surveys of 1983 and 1990,[9,10] but their method of assessment did not use the IOTN. The North-South Survey of Children's Oral Health in Ireland (2002)[5] found that 36% of 12-year-olds and 29.2% of 15-year-olds had a definite need for orthodontic treatment using the IOTN.[11] The percentage of 15-year-olds who had undergone or were undergoing orthodontic treatment at the time of the survey increased from 13.9% in 1984 to 23.4% in 2002.[5] A planned level of 480 UK specialist practitioners was outlined in the Task Group for Orthodontics Report in 1998; however, this took into account the preservation of numbers in the Hospital Dental Service and Community Dental Service.[12] It also took into consideration the creation of orthodontic auxiliaries.

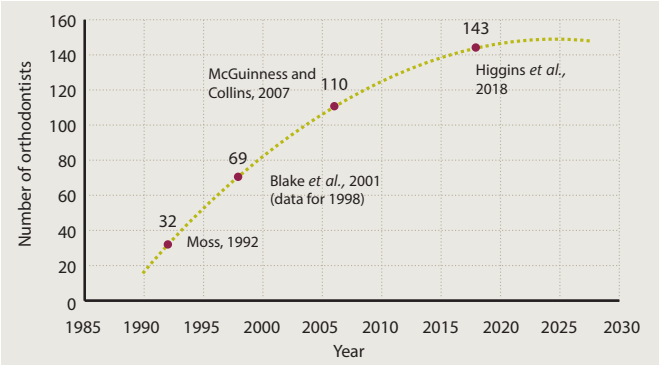

FIGURE 2: Numbers of orthodontic specialists in Ireland to date.

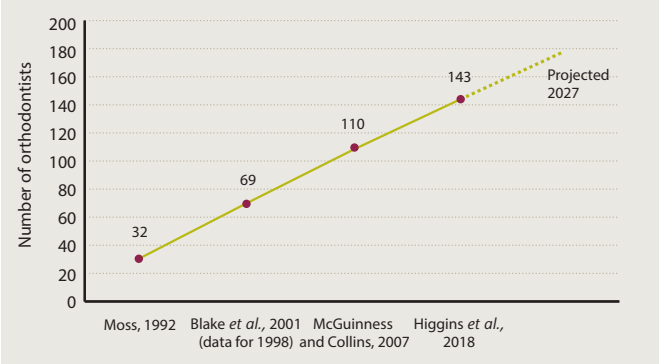

FIGURE 3: Future predictions of orthodontic workforce (using a linear model).

Using the figure quoted for the 12-year-old population earlier, along with the data from the North-South survey, a figure of 23,553 can be deduced as the estimated number of patients requiring treatment in the Republic of Ireland at the present time. This figure has been reached by using the number of 12-year-olds according to the CSO (65,425) divided by the percentage of 12-year-olds requiring treatment according to the North-South survey (36%). However, this does not take account of any changes in the number of 12-year-olds that may present in the future. According to the Irish Consultant Orthodontists' Group report to the Oireachtas Committee on Health and Children in 2002, a safe caseload for a specialist in full-time practice is 400 patients.[13] Patients are generally treated over a time period of 18-24 months. This equates to approximately 200 patients completing treatment in one year. Dividing the current number of 12-year-olds of 23,553 by 200 results in a figure of 118. This means that 118 full-time specialists would be required to treat the one-third of the 12-year-old population requiring treatment. This does not consider those that wish to undergo treatment for purely aesthetic reasons, those that fall within grades 1-3 of the IOTN, or adults undertaking orthodontic treatment. It also excludes patients who may not have been able to access treatment as children. We must also consider changes in the workforce with the introduction of orthodontic therapists.

The impact of Brexit on the workforce in Ireland may be significant. A total of 67% of respondents to this survey trained in the UK. Irish students may be considered international students after Brexit and may have to pay international fees as a result. This is likely to reduce the number of Irish applicants to UK training programmes. The Irish Consultant Orthodontists'

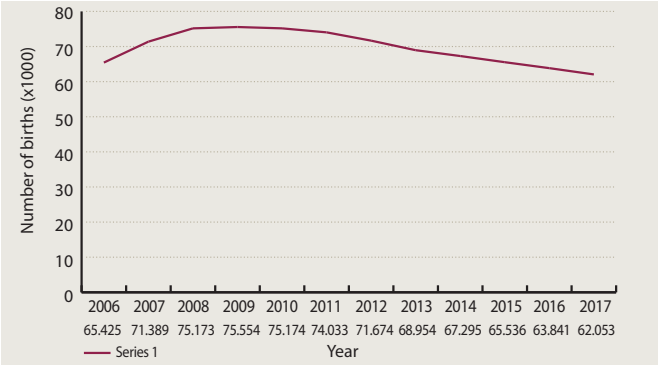

FIGURE 4a: Number of births in Ireland (x1000) from 2006-2017.

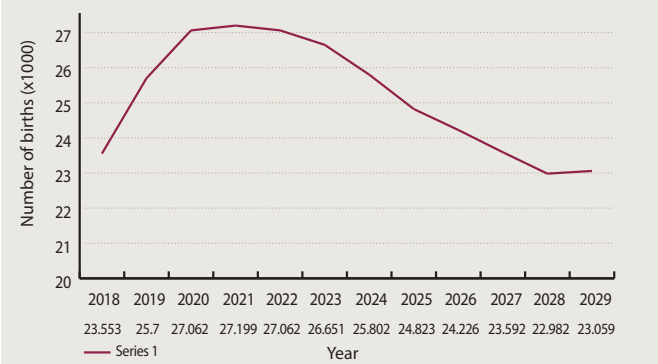

FIGURE 4b: Projected number of 12-year-olds requiring treatment.

Group report to the Oireachtas Committee on Health and Children in 2002 suggested that more training positions be made available in Ireland and consideration be given to sponsorship of training positions in other EU countries.[13]

Development of the therapist grade

Orthodontic therapists are relatively new members of the orthodontic auxiliary team. Until 2014 there had been no training programme available to orthodontic therapists in Ireland and so allowances were made by the Dental Council of Ireland to recognise orthodontic therapists who trained in the UK and carried out their placement in Ireland. More recently, the Dublin Dental University Hospital has started its Diploma in Orthodontic Therapy, with the first cohort graduating in 2015. This is reflected in the results of this survey, with 77% of orthodontic specialists without orthodontic therapists currently. However, 42% of orthodontists plan to employ or train orthodontic therapists in the future. O'Brien *et al.* (1988) suggested that increases in productivity ranged between 40% and 130% when dental auxiliaries were employed in various practice settings.[14] Feedback from patients suggested a high standard of satisfaction with the treatment delivered by the therapists, comparable to that delivered by the dentist. According to the Dental Council of Ireland register, there are currently 38 orthodontic therapists registered to work in the Republic of Ireland.[7] This number is likely to increase. This may increase the efficiency of orthodontic treatment provision in the future; however, the effect of this on workforce planning is difficult to predict.

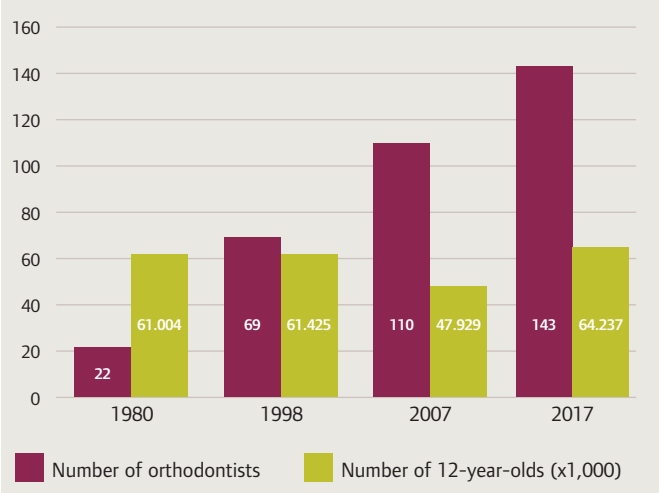

FIGURE 5: Ratios of orthodontists to 12-year-old population.

Aligner treatment and adult cases

The percentage of cases treated with aligners by orthodontic specialists is self estimated by clinicians at around 6%. This appears to be a small proportion of respondents' caseload. McMorrow and Millett reported that only 19% of orthodontists in Ireland use clear aligners, often in adult cases.[15] This is not a percentage of cases treated by aligners but a percentage of orthodontic practitioners who describe their use of them in adult cases as "often". The low numbers of aligner use in practice is mostly due to the nature of cases being completed and a reflection of the age profile of the orthodontists in Ireland currently. It could also be attributed to the more prevalent use of aligners by general dental practitioners (GDPs), although there is currently no reliable information outlining the use of such aligners among GDPs. Aligner use in hospital practice was difficult to determine in this study as many respondents who worked primarily in hospital also worked in private practice where they used aligners. Fixed and functional appliance use varied greatly among practitioners. The mean reported percentage of adult cases treated was 24%. We could assume that the high percentage of adults being treated in the HSE is most likely due to the long waiting lists and older age in treatment as a result, as well as the number of orthognathic cases completed in this setting.

Technology used

The survey showed that a wide range of technologies were used. In some cases where practitioners worked in both private and hospital practice it was difficult to discern where certain technologies were primarily used. The majority of hospital-based practices were non-computerised; however, this is likely to change in future as computerisation of all remaining HSE units is planned.

Study limitations

To enable comparisons to previous studies we have used the orthodontist:12-year-old population ratio.[1,2] This does not take into account the increasing demand for aesthetic treatment from children and adults. The demographics of people seeking treatment has changed over time.

In reality, very little workforce planning is done in Ireland outside a limited amount done by the public health service. Private practitioners open a practice depending on their own interpretation of the market in a given area. In orthodontics in Ireland a number of workforce surveys have been completed over

the years by interested practitioners in collaboration with the OSI. Practitioners were grouped into private or hospital-based clinicians based on their majority workload. In future studies it would be worthwhile dividing practitioners into three groups: private; hospital-based; and, mixed private/hospital-based.

As a survey this one has inherent biases including response bias. Our response rate of 70% is lower than that of previous surveys and may have been increased by anonymising the survey further or providing incentives, which have been shown to increase response rates by Dillman in 2017.[16] It is possible that those who did not respond are different to those who did. Increased awareness of data protection, along with the concurrent introduction of the General Data Protection Regulation (GDPR) in 2018, meant that enthusiasm for data sharing was reduced and this made collecting data both over the phone and via survey difficult.

Future projections are speculative and the effects of Brexit and changes in the NHS in the UK may be substantial. A large number of HSE orthodontists were trained in the UK between 2000 and 2010 when the numbers in the service grew substantially. This cohort will be retiring in approximately 20 years' time and this will need to be anticipated to ensure succession planning and avoid gaps in service.

This study has provided information on the current orthodontic workforce in Ireland and can be used for future national and Europe-wide study comparison.

Conclusion

The estimation of future workforce requirements is complex. The well-established IOTN is used to estimate treatment need, but it does not necessarily consider the demand for treatment, which is potentially limitless. The number of orthodontic specialists and the changing role of orthodontic auxiliaries will have an impact on provision of orthodontic treatment. Any workforce planning should also take into account the older age profile of orthodontists currently in practice. McGuinness and Collins (2007) suggested that 66% were less than 45 years old at the time of this particular survey, while in this study, 71% are now over 45. The overall gender distribution of orthodontists was almost equal, compared to a 1:2 female:male ratio in 2007. This study showed that aligners are used in only 6% of cases and that there was great variation in appliance types, both fixed and functional, used in practice.

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CPD questions

To claim CPD points, go to the MEMBERS' SECTION of www.dentist.ie and answer the following questions:

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1. Which one of the following best outlines the influencing factors in manpower planning?

- ○ A: Age of the workforce, years in practice, technologies used, and gender of the workforce.
- ○ B: Need and demand for treatment, number of practitioners, deployment of auxiliaries, and financial considerations.
- ○ C: Global manpower levels, medico-legal changes, and age of retirement.

2. In Ireland, older clinicians are more likely to work in private practice:

- ○ A: True
- ○ B: False

3. Which of these statements most accurately describes current manpower levels?

- ○ A: Manpower levels are lower than previous studies and the age profile of the workforce is younger than in previous years.
- ○ B: Manpower levels are similar to previous studies, and are likely to increase in the coming years with the introduction of orthodontic auxiliaries.
- ○ C: Manpower levels are similar to previous studies, and are likely to decrease in the coming years due to the older age profile of current practitioners.

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Double full-arch fixed implant-supported prostheses: outcomes and complications after a mean follow-up of five years

Papaspyridakos, P., Bordin, T.B., Natto, Z.S., Kim, Y.J., El-Rafie, K., Tsigarida, A., et al.

Purpose: To retrospectively assess complications and clinical and radiographic outcomes of edentulous patients treated with double full-arch implant-supported fixed complete dental prostheses (IFCDPs) after a mean observation period of 5.1 years.

Materials and methods: The single-visit clinical and radiographic examination included medical and dental history review, and clinical assessment of biologic and technical complications encountered with all implants and IFCDPs. Life table analysis and Kaplan-Meier survival curves were calculated. Analysis was conducted to evaluate the association between prosthesis survival and several risk factors such as type of opposing occlusion, nightguard use, and presence of bruxism.

Results: Nineteen edentulous patients restored with 38 IFCDPs were included. A total of 249 implants were placed and two implants failed after a mean observation period of 5.1 years (range: 1-12 years), yielding an overall implant survival rate of 99.2% and prosthesis survival rate of 92.1%. Three out of 38 IFCDPs were lost, one after implant losses and two due to technical complications. The most frequent minor biologic complication was soft tissue recession, with an estimated five-year rate of 45.5% (95% CI: 39.4-57.5), while the most frequent major complication was peri-implantitis, with an estimated five-year implant-based rate of 9.5% (95% CI: 6.7-11.3). The most frequent minor technical complication was wear of the prosthetic material, with an estimated five-year rate of 49% (95% CI: 37.4-76.4), while the most frequent major technical complication was fracture of the prosthetic material, with an estimated five-year dental unit-based rate of 8% (95% CI: 6.6-10.1).

Conclusions: After a mean use time of 5.1 years, high implant and prosthesis survival rates were observed. The most frequent major biologic complication was peri-implantitis, and the most frequent major technical complication was fracture of the prosthetic material. The five-year estimated cumulative rates for "prosthesis free of biologic complications" was 50.7% (95% CI: 33.7-65.4) and for "prosthesis free of technical complications" was 57.1% (95% CI: 39.3-71.5).

Journal of Prosthodontics 2019; 28: 387-397.

A century of change towards prevention and minimal intervention in cariology

Innes, N.P.T., Chu, C.H., Fontana, M., Lo, E.C.M., Thomson, W.M., Uribe, S., et al.

Better understanding of dental caries and other oral conditions has guided new strategies to prevent disease and manage its consequences at individual and public health levels. This article discusses advances in prevention and minimal intervention dentistry over the last century by focusing on some milestones within scientific, clinical, and public health arenas, mainly in cariology but also beyond, highlighting current understanding and evidence with future prospects. Dentistry was initially established as a surgical specialty. Dental caries (similar to periodontitis) was considered to be an infectious disease 100 years ago. Its ubiquitous presence and rampant nature – coupled with limited diagnostic tools and therapeutic treatment options – meant that these dental diseases were managed mainly by excising affected tissue. The understanding of the diseases and a change in their prevalence, extent, and severity, with evolutions in operative techniques, technologies, and materials, have enabled a shift from surgical to preventive and minimal intervention dentistry approaches. Future challenges to embrace include continuing the dental profession's move toward a more patient-centred, evidence-based, less invasive management of these diseases, focused on promoting and maintaining oral health in partnership with patients. In parallel, public health needs to continue to, for example, tackle social inequalities in dental health, develop better preventive and management options for existing disease risk groups (e.g., the growing ageing population), and the development of reimbursement and health outcome models that facilitate implementation of these evolving strategies. A century ago, almost every treatment involved injections, a drill or scalpel, or a pair of forceps. Today, dentists have more options than ever before available to them. These are supported by evidence, have a minimal intervention focus, and result in better outcomes for patients. The profession's greatest challenge is moving this evidence into practice.

Journal of Dental Research 2019; 98 (6): 611-617.

Accuracy of dynamic virtual articulation: trueness and precision

Hsu, M.R., Driscoll, C.F., Romberg, E., Masri, R.

Purpose: To study the effects of altering condylar settings and pin openings on the trueness and precision of virtual articulators vs mechanical articulators.

Materials and methods: Maxillary and mandibular typodonts with fiducial markers were mounted on a mechanical Artex-CR articulator, and the mandibular teeth were prepared to allow guidance solely by the posterior determinants of the articulator and the incisal table. The relationship of the mounted typodonts was preserved digitally by scanning using manufacturer transfer plate adaptors. On the mechanical articulator, pattern resin was allowed to set between the maxillary and mandibular occlusal surfaces (area #25-30) at the endpoints of dynamic movements at three condylar inclinations (SCI) (10°, 30°, and 45°; n=12/inclination), or at three incisal pin openings (2, 5, and 10mm; n=12/opening). All other articulator settings were kept constant. Resin specimens attached to the typodonts were scanned within five minutes of setting, then removed, and the articulated typodonts rescanned. Fixed dental prostheses (FDPs) #25-30 were designed on the virtual articulator using identical parameters to the mechanical articulator. Dynamic virtual movements were used to sculpt the design, and a file of the design was saved. The files of both types of samples were aligned and overlaid. Inter-occlusal separation was measured in triplicate at the indentation created by the mesio-labio-incisal point angle on the incisal edge of #8 and the mesio-bucco-occlusal point angle of #3. Trueness and precision of both types of articulators were calculated and compared using one-way ANOVA, followed by the Tukey HSD test (α=0.05).

Results: There was no statistically significant difference at altered pin openings in either trueness (F=0.202, p=0.37) or precision (F=3.134, p=0.09) for the majority of measurements. The only significant difference was in the precision between the two types of articulators at 5mm incisal opening, and only at the anterior measurement point (F=15.134, p=0.0008); however, these differences were less than 100μm. When the SCI was altered, there was no statistically significant difference (F=3.624, p>0.05) between the virtual and mechanical articulators in

trueness for five of the six measurements obtained (F=3.624, p=0.07), or for all of the precision measurements (F=3.529, p=0.07). The one trueness measurement that was significantly different (F=9.237, p=0.006) occurred at SCI of 10°, and it was less than 100μm.

Conclusions: Dynamic movements on the virtual articulator were shown to be as true and precise as the mechanical articulator. When there were deviations, these deviations were less than 100μm and thus, these deviations may not be clinically relevant.

Journal of Prosthodontics 2019; 28: 436-443.

What is the heritability of periodontitis? A systematic review

Nibali, L., Bayliss-Chapman, J., Almofareh, S.A., Zhou, Y., Divaris, K., Vieira, A.R.

The aim of this study was to systematically appraise the existing literature on the yet-unclear heritability of gingivitis and periodontitis. This review was conducted following the PRISMA guidelines. A search was conducted through the electronic databases Medline, Embase, LILACS, Cochrane Library, Open Grey, Google Scholar, and Research Gate, as complemented by a hand search, for human studies reporting measures of heritability of gingivitis and periodontitis. A total of 9,037 papers were initially identified from combined databases and 10,810 on Google Scholar. After full-text reading, 28 articles met the inclusion criteria and were carried forward to data abstraction. The reviewed data included information from >50,000 human subjects. Meta-analyses were performed by grouping studies based on design and outcome. Heritability (H^2) of periodontitis was estimated at 0.38 (95% CI, 0.34 to 0.43; I^2 = 12.9%) in twin studies, 0.15 (95% CI, 0.06 to 0.24; I^2 = 0%) in other family studies, and 0.29 (95% CI, 0.21 to 0.38; I^2 = 61.2%) when twin and other family studies were combined. Genome-wide association studies detected a lower heritability estimate of 0.07 (95% CI, –0.02 to 0.15) for combined definitions of periodontitis, increasing with disease severity and when the interaction with smoking was included. Furthermore, heritability tended to be lower among older age groups. Heritability for the self-reported gingivitis trait was estimated at 0.29 (95% CI, 0.22 to 0.36; I^2 = 37.6%), while it was not statistically significant for clinically measured gingivitis. This systematic review brings forward summary evidence to confirm that up to a third of the periodontitis variance in the population is due to genetic factors. This seems consistent across the different studied populations and increases with disease severity. In summary, up to a third of the variance of periodontitis in the population is due to genetic factors, with higher heritability for more severe disease.

Journal of Dental Research 2019; 98 (6): 632-641.

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Part-time dental surgeon required in busy Cavan town dental practice. Good earning potential. Please submit CV to churchstdental@gmail.com.

Dentist required for Monday and Tuesday at a modern, friendly practice. Fully computerised with excellent staff. Private and PRSI patients. Email info@blessingdental.com.

Co. Clare. Experienced general dentist required, working three days per week. Computerised and digital x-ray, GMS, PRSI, private and supported by a well-trained, professional team. Very good terms for the right candidate. Email niallmcrty@gmail.com.

Experienced general practitioner required in north east. Three to four days per week in a friendly, modern, busy and expanding practice. Fully computerised with digital x-rays. Private/PRSI/GMS and excellent support staff. CVs to dentistnortheast01@gmail.com.

Waterford. Smiles Dental (part of Bupa Dental Care) has an exciting opportunity for a general dentist to join our state-of-the-art, well-established practice in Waterford. Offers five days, relocation package and initial guaranteed earnings. Email joanne.bonfield@smiles.co.uk.

Drogheda. Smiles Dental (part of Bupa Dental Care) has an exciting opportunity for a general dentist to join our state-of-the-art, well-established practice in Drogheda. Offers five days, established book and initial guaranteed earnings. Email joanne.bonfield@smiles.co.uk.

Enniscorthy. Smiles Dental (part of Bupa Dental Care) has an exciting opportunity for a general dentist to join our state-of-the-art, well-established practice in Enniscorthy. Offers five days, relocation package and initial guaranteed earnings. Email joanne.bonfield@smiles.co.uk.

Dentist required with implant experience at the Seapoint Clinic, Blackrock. The working environment is modern, fully equipped, onsite lab, supported by a well-trained, professional team. We offer a competitive associate package with shared lab fees and bonuses. Email victoria@seapointclinic.ie.

Position in an award-winning practice in Greystones. Two days a week to start – will increase to four for maternity cover. Experience with periodontist a plus. Apply to anthonypower@smilesolutions.ie.

Exciting opportunity available at our busy, friendly dental surgery, located in Tralee, Co. Kerry. Opportunity to develop your skills in dental implants, cosmetic and general dentistry. Full- and part-time candidates considered. We look forward to receiving your CV to pmorandental@gmail.com.

Experienced general dentist – special interest in cosmetic dentistry or implants, one to two days per week – to work alongside our team of specialist and general dentists. Young, enthusiastic dentist required one to two days. One hour from Dublin against the traffic. On-site parking. Email specialistdental2019@gmail.com.

Part-time dentist required for Buncrana with experience. General dentistry. Digital X-rays, intraoral camera. Two to three days per week. Please send your CV to crana.dental18@outlook.com.

Locums

Locum dentist required from start of June to end of September in busy, well-established practice in midlands town, approx. one hour from Dublin/Kilkenny. May lead to ongoing position. Experienced candidate preferred. Please reply by email. CVs appreciated, if available, to Cedar.clinic.dental.surgery@gmail.com.

Dublin 13. Full-time locum required for well-established single-dentist practice. Friendly, enthusiastic, general dentist with two years' minimum experience required. Position starting July 2019. For more information or to apply please send CV to jobs@meridianclinic.ie.

Specialist/limited practice

Dynamic team looking for oral surgeon to complete wisdom and surgical extractions, apicectomies, and other surgical procedures. Email CV to petra.polonkai@carlowdentalcentre.ie.

Dynamic team looking for an orthodontic specialist to join a modern, fully computerised practice in the Midlands. Email CV to petra.polonkai@carlowdentalcentre.ie.

Specialist orthodontist required for busy orthodontic practice in Limerick. Email ted@tgmcnamara.com.

Endodontist wanted to join our specialist team at our new ultra-modern clinic in Killarney. All equipment provided. Onsite CBCT, laser and sedation, etc. Email tomas.allen77@gmail.com.

Specialist oral surgeon offering IV sedation wanted to take over established clinic on a regular sessional basis. Modern, three-surgery general practice with state-of-the-art facilities in Dublin 4. Treatments mainly implant placement and wisdom tooth removal. Email d4dentalclinic@gmail.com.

Specialist orthodontist required to cover maternity leave in fully private, modern clinic, 45 minutes from Dublin. Part-time, three days per week – hours can be flexible. Salary €90,000-110,000. Email info@dentaloptions.ie.

Periodontist or implantologist one to two days per month, endodontist two days per month, cosmetic/restorative dentist one to two days per week, botox/fillers dentist (monthly). Beautiful, modern, multidisciplinary practice one hour from Dublin against traffic. On-site parking. Intraoral scanner. Email specialistdental2019@gmail.com.

Dental nurses/managers/receptionists

Killarney. Dental nurse wanted for new ultra-modern clinic in Killarney. Great pay and conditions. The role with suit a candidate wishing to progress their career. Experience not essential as all training will be provided. Email tomas.allen77@gmail.com.

Northern Cross Dental. Experienced dental nurse. Supervisory level. Confident providing a high level of service. Demonstrate the ability to multitask and prioritise as well as being flexible and adaptable. If the above describes you, please contact us for a copy of our job specification. Email manager@ncdental.ie.

Killarney. Receptionist wanted for new ultra-modern clinic in Killarney. Great pay and conditions. The role will suit a candidate wishing to progress their career. Experience not essential as all training will be provided. Email tomas.allen77@gmail.com.

Qualified dental surgery assistant required for modern, busy and friendly practice in Limerick. Full- or part-time. Immediate start. CV to wallacedentalclinic@gmail.com.

Experienced dental nurse/receptionist required for a busy, friendly dental practice, north Cork area, 24 hours a week (three-and-a-half days). A team player is a must. Experience in dental software is an advantage. Email nualacagney@gmail.com.

Qualified dental nurse required for practice in Killybegs, Co. Donegal. Please send CVs to falcondental@eircom.net.

Experienced receptionist wanted for full-time position in Galway city centre. Please forward CV to dentalreception22@gmail.com.

Hygienists

Dublin. Smiles Dental has exciting opportunities for enthusiastic dental hygienists to join our modern, well-equipped, well-established Smiles Dental practices across Dublin. Two to five days per week. Candidates must be IDC registered. Email joanne.bonfield@smiles.co.uk.

Hygienist required to join the team of a modern, progressive, west Limerick dental practice. Practice has in-house prosthodontist and visiting periodontist. Please apply to info@mullanedental.ie.

Limerick: dental hygienist required from July 2019 for four to five days a week. Would suit new graduate. Excellent support staff and modern equipment. Please forward CV to jobs@alexandradental.ie.

Enthusiastic hygienist required for full-time position in busy Limerick practice with an established book. Excellent support staff and modern, well-equipped dental surgery with new A-dec chair and Cavitron Touch. CVs to liz.bowedental@gmail.com.

Donegal county. Hygienist wanted for busy, friendly, popular and progressive practice. Applications to siomurr@hotmail.com.

Orthodontic therapists

Dublin. Orthodontic therapist required for specialist orthodontic practice. Part-time leading to full-time position. Applicant required to work in more than one location. Must have excellent manual dexterity and people skills. Reply with cover letter and CV to elaine.hand@dublinorthodontics.ie.

PRACTICES FOR SALE/TO LET

Commercial unit to let, Adare, Co. Limerick. Adare Village Centre. High-profile retail opportunity. Suitable for professional tenant, dentist, etc. Existing tenants include pharmacy, medical centre, boutique, food market. Email info@adareproperties.com.

Practice for sale: Galway city centre. Well-established city centre practice for sale. Two surgeries, predominantly private practice, excellent location. Contact steven@medaccount.ie in confidence or call 01-280 6414.

For sale, Cork. 130sq m, ground floor, computerised (Coincidental), HSE certified, large reception, consultation room, three surgeries, laboratory, sterilisation room, parking, large potential, excellent opportunity. Email douglasclinic@gmail.com.

Practice for sale – north Dublin. Two surgeries, leasehold/freehold, flexible. Excellently equipped, computerised. Very busy, long established, good footfall. High new patient numbers. Very low medical card. Well-established hygienist. Good profits. Excellent potential for growth. Email niall@innovativedental.com.

South East. Long-established, busy, full-time, four-surgery general practice in an excellent location. Experienced, loyal staff. Digitalised, partially computerised. Modern equipment. Low medical card. Hygienist service. Good new patient numbers. Great potential for growth. Immediate sale. Email niall@innovativedental.com.

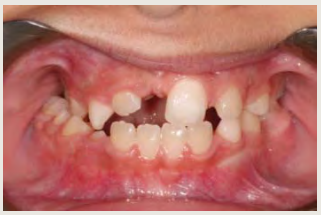
Quiz

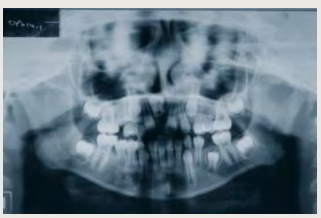
Answers (questions on page 118)

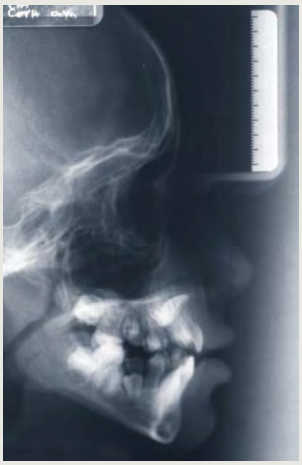
1. When assessing patients during mixed dentition, the eruption sequence of the permanent teeth is very important. In this case, the maxillary lateral incisors are erupting before the maxillary right central incisor. This is out of sequence and should be investigated. The maxillary left central incisor appears to be fully erupted. During normal eruption, the contralateral tooth should erupt within six months. Finally, the maxillary incisors should normally erupt within one year of the mandibular incisors. An orthopantomogram was prescribed for this patient.

2. The maxillary right central incisor is dilacerated. The incidence of dilaceration is rare, approximately 0.2%. The most common causes of dilaceration are trauma to the area or a genetic predisposition. A lateral cephalogram may be beneficial to show the extent of the dilaceration. A cone beam computed tomograph may also assist treatment planning.

3. This tooth required a surgical extraction.







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Balancing rights

Dr Nuala Carney is an IDA representative at the Council of European Dentists (CED) and a former Treasurer of the Association. In 2015 she decided to broaden her knowledge with a Master's in Law from Cardiff University.

What has your participation in the Irish Dental Association meant to you and what is its biggest benefit?

I really appreciate the enormous effort and work of IDA staff, and the members who volunteer, and how much expertise is out there. I've also learned a lot about governance and regulation, and strategic planning. The biggest benefits were the friendships, the collegiality and support.

What motivated you to do the Master's in Law? What did it involve?

I've been interested in medico-legal matters since I qualified, and work with Dental Protection as a local advisor. I'm interested not just in the negligence part of medico-legal matters, but in ethical decision-making and what drives that, and I wanted to know more. Doing the master's involved two-and-a-half years of travelling to Cardiff, as well as distance learning. It was a whole different way of learning and a lot of work, but it was worth it.

How has your legal knowledge added to your practice as a dentist?

It's made me very aware of issues around consent and records. I did a lot of reading around mediation and apology, and that has been very helpful in diffusing challenging situations in the practice.

What are the challenges of running a practice and studying?

I work as an associate, so didn't have the challenge of running a practice. The biggest issue was that I never had free time. I worked a four-day week – Friday was study day, but I studied on the weekends as well. I was constantly tired and it was hard during the week, but it was worth it. It was rejuvenating to find that you can still be excited by something academic. Of course, I couldn't have done it without the help and support of my husband Paul.

Your dissertation was on open disclosure globally and in Ireland. What were your findings?

The essence of open disclosure is to find a balance between the rights of patients to information after an adverse outcome, and protecting doctors from vexatious claims and damage to their reputation. The international evidence shows that cultural and behavioural change for the medical profession is extremely difficult, and only occurs when you've got very strong leadership within the profession, and support from the organisations that are providing the care. That's very difficult to do on a national scale. When there's been an adverse incident, apology is absolutely crucial and this is where the tension lies with the law. I found the huge amount of research on apology particularly fascinating – how and why we apologise, and why we don't, trying to maintain and rebuild trust. It's not just about legislation – it's about building support and training. At the moment the only way to ensure that this happens is to try to make it mandatory, but it goes way beyond that. In healthcare systems where this works, the institutions are supportive and personnel are highly trained to manage these situations in a positive way and unfortunately in Ireland we're so far away from that.

Do you think there's more scope for research in this area?

There's been a tonne of research, and I don't think any more would add to it. What we need to focus on in Ireland is training. There are models around the world where they have much more effective ways of dealing with this and I think that's where the scope is. The training available in the HSE is totally inadequate, totally underfunded, and not driven from within the institutions. There are better ways of doing this, and I think that's where the Government should be looking.

How can research like yours help dentists and the Association?

This needs to be part of core training. There is a lot of research about the impact on professionals of adverse events and on trying to train our young professionals in our medical and dental schools, making it clear to them that these things will happen, and how to deal effectively with that situation at the time and afterwards. We need more training and awareness at postgraduate and undergraduate level. I'm involved in the law and ethics teaching in the DDUH, but it's not enough. There is huge potential for developing not only new skills but also support structures.

The IDA is doing a lot of work already in this regard. The Association's mentoring scheme is crucial, but people have to be open to using it.

Nuala practises at Dorset Dental Clinic and Fairview Dental Clinic in Dublin, and is a clinical supervisor at the Dublin Dental University Hospital. She also works as a local dental advisor for Dental Protection in Ireland. When she completed her Master's, she was delighted to be awarded the Cardiff Law School LLM first prize over all disciplines, and the Cardiff Law School LLM Dissertation Prize.

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