IDA irish dental association

JIDA

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann

Volume 69 Number 2
April/May 2023

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Th!nk Media

Published on behalf of the IDA by
Think Media, 537 NCR, Dublin 1
T: +353 1 856 1166
www.thinkmedia.ie

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abc Audit issue January-December 2021: **3,960** circulation average per issue. Registered dentists in the Republic of Ireland and Northern Ireland.

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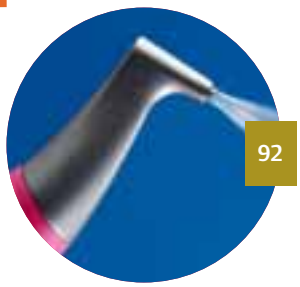

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References: 1. Baysan A et al. Caries Res 2001;35:41-46. 2. Biesbrock AR et al. Community Dent Oral Epidemiol 2001;29:382-389. 3. Ekstrand et al. Caries Res 2013;47:591-6. 4. Schmeiser IF et al. Am J Dent 2007;20: 212-216. 5. Ekstrand et al. Gerod 2008; 25:67-75.

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EDITORIAL

Dr Cristiane da Mata
Honorary Editor

Our past meets our future

The Association's Annual Conference, previewed in this edition, will be a fascinating mix of our history and our future as a profession.

As the days get brighter, and warmer, I have started my planning to attend the IDA Annual Conference in May, which is one not to be missed. This year's conference celebrates 100 years of the Association and offers an outstanding programme, with renowned speakers from Ireland and abroad.

As I was browsing through the conference programme, I started reflecting on how much dentistry has evolved, and wondered what would such an event have been like 100 years ago? I am sure some of the lecture topics would puzzle practitioners from the past and things such as digital dentistry, conscious sedation and the use of artificial intelligence in dentistry would definitely have sounded alien.

And upon reflecting on the cyclical nature of things, I wonder what our conference programme will look like 100 years or more from now. Will our dental materials and procedures keep evolving, or will we be talking again about techniques long forgotten?

I have recently come across an article about the use of maggots and leeches by the NHS in England, as an alternative means to treat some ailments. The practice of using maggots to treat wounds is believed to date back to the beginnings of civilisation. Hundreds of years later, antibiotic resistance has led researchers and medical professionals to look at ancient medicine, and they are now using these "superbugs to fight superbugs". According to the *Observer* (February 27, 2023) between 2007 and 2019, the number of NHS patients treated with maggots increased by 47%. It is just an example of how progress is not linear and how we cannot take things for granted where science is concerned.

Real evolution

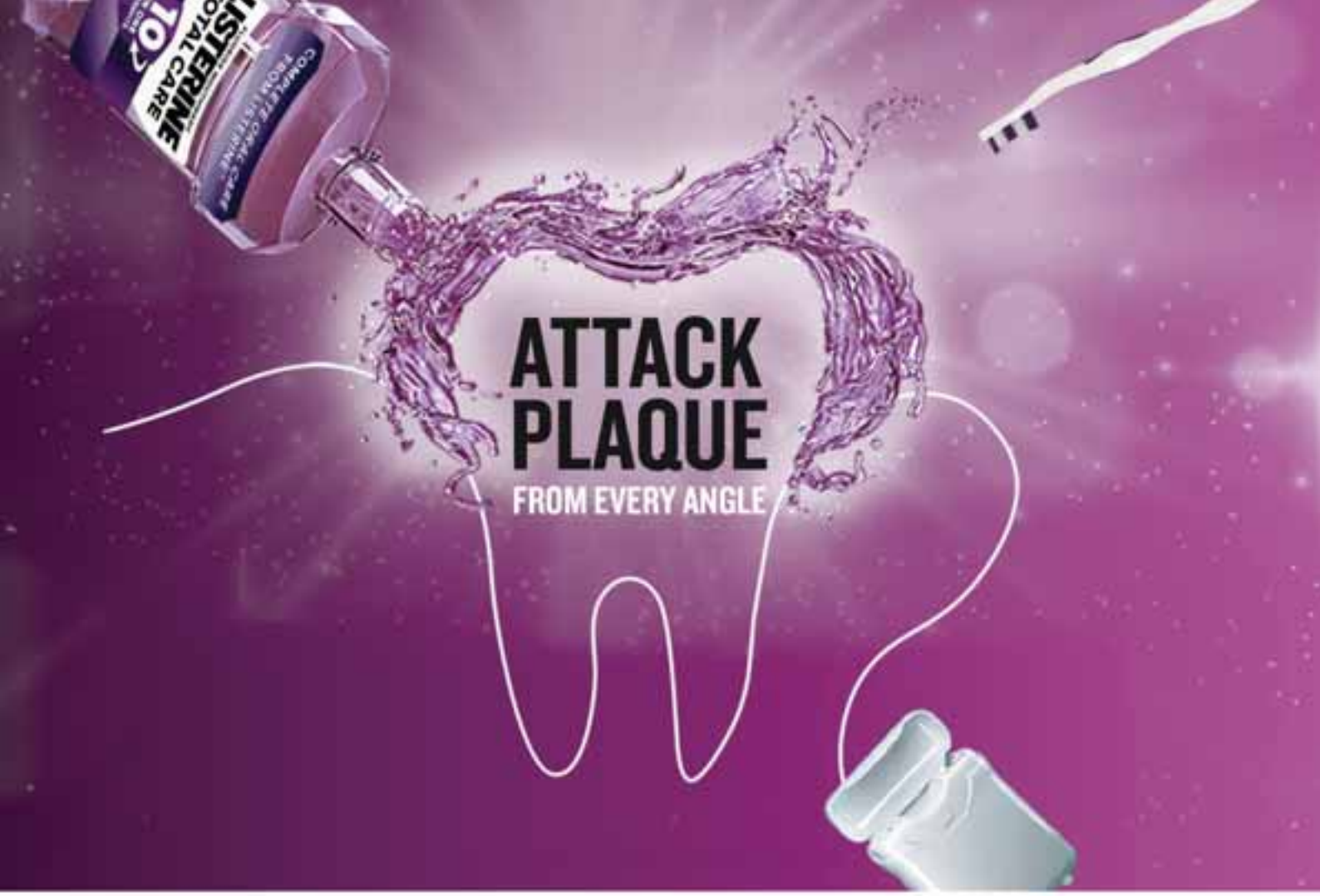
Dentistry has certainly evolved substantially over the past 100 years, and the barbaric techniques used in the past are unimaginable these days. In that regard, maybe one of our biggest achievements was the discovery of anaesthesia and the knowledge we have gained on the preventable nature of some oral diseases (although our preventive efforts are still quite poor). However, there are important points to consider when we think of how far we have come as a profession. First of all, this evolution can be seen mainly in dental materials, instruments and dental technology, but the day-to-day job of a dentist continues to be based on interventionist approaches, mainly drilling, filling and extracting teeth. Also, it is important to note that the high-end dentistry that can correct malocclusions, bleach and improve the aesthetics of darkened teeth, replace missing teeth using bridgework and implants, etc., does not reach all people equally. For a great proportion of the population in Ireland and worldwide, caries and periodontal disease will still result in pain, tooth loss and poor quality of life. Additionally, I am not sure if the image of dentists as the professionals to be feared has changed much. In a contemporary children's book entitled *Demon Dentist* by a famous UK author, the main character is a dentist who is an actual witch. She kidnaps children in the middle of the night and extracts all of their teeth!

It would certainly be fair to say that we still have a long journey ahead to prevent oral diseases, bring good quality dentistry to all, and change this horrible stereotype of the profession.

History of the IDA

Also as part of the Association's centenary celebrations, a book about the history of the Association will be launched during the 2023 conference. I am looking forward to seeing the result of months of hard work by co-authors Drs Frances Nolan and Eoin Kinsella. They have together been gathering information and photographs to provide us with a picture of the evolution of the IDA and the issues affecting the dental profession over the years. I can only imagine what a challenging task this must have been, but also what a pleasant one. I am not surprised when Eoin says in his interview for this edition (which I commend you all to read) how fascinating it was to find out about the changes in dentistry over the last century. Frances also points to how the Association used education and training to fight charlatanism within dentistry, which was a huge problem in the early 20th century.

So it is evident that the history and the future of our profession will meet on equal terms at the forthcoming conference. It promises to be fascinating and I look forward to meeting as many of you as possible there.



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1. Milleman J, et al. Journal of Dental Hygiene. 2022;96(3):21-34.
2. Bosma ML, et al. Journal of Dental Hygiene. 2022;96(3):8-20.

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PRESIDENT'S NEWS

Dr Caroline Robins
IDA President

Dental education – time for a new approach?

As we try to tackle the recruitment crisis in dentistry, is it time to think differently about how we select and educate dentists?

As the Association's centenary year progresses, and in what is my final message for this *Journal*, it's timely to reflect on what the future might hold for the provision of dental care, and for the profession of dentistry.

From a scientific point of view, the developments in the last 100 years have been astonishing, and the future promises more of the same. In another 100 years, will we be able to regenerate a tooth? Will decay be a thing of the past? It's awe-inspiring and fascinating to think about what might lie ahead.

Right now in 2023, however, our concerns are more rooted in the day-to-day challenges of running our practices in a staffing crisis that shows no sign of abating. Addressing this issue was a priority of mine for my year as IDA President, and indeed is a major priority for the Association. I'm delighted to say that the IDA has produced its own document, 'Providing Dental Care in Ireland: A Workforce in Crisis', to offer our solutions to the growing challenges of recruitment and resourcing in the dental sector. You can read a summary of the report's recommendations in the members' section of this edition.

The path to dentistry

For my part, I would like to focus on the training and selection of dental students. The Irish education system rightly has an excellent reputation, but the points race continues to put immense pressure on young people to achieve extraordinary exam results in order to gain very limited places in dentistry and other professions. Certainly, we need more capacity in the dental schools, but I think it's time also to think about the kind of dentists this system produces, and whether there might not be other, better ways to choose the future members of our profession.

I have met many professionals throughout my career, and have come to the conclusion that the most academic/intelligent do not necessarily make the best doctors, dentists, or solicitors. When I look at the CV of a prospective employee, I'm more interested in the person than the points. Is it time to consider a path to dentistry, and its allied professions, that is not purely academic, and that might be more accessible to those who don't achieve the elusive 600 points? Perhaps we need to look at interviews, or to pathways of progression for those who are already working in our teams, such as nurses and hygienists?

Perhaps we need to look at the way we train dentists too. A reintroduction of the vocational scheme is sorely needed, but more practical opportunities outside of university and hospital, with more opportunities for mentorship and to gain experience in the community, can surely only be good for the profession.

Back to basics

One of the reasons for the current issues in recruitment that I see, is that today's dental graduates appear less interested in 'bread and butter' dentistry, seeming to want to focus on more specialised, and perhaps more glamorous areas, such as aesthetics and Instagram-ready smiles. However, old school dentistry is not going away – no matter how many preventive campaigns or oral health policies we launch, people still need basic dental care, and dentists to provide it. And they will need that care regardless of their income, or whether or not they qualify for a medical card.

There are many facets to the problems we face, and many possible solutions. Broadening access to the profession would certainly help increase the diversity within it, which is healthy in any walk of life.

Perhaps it's time to think outside the box, and to have a discussion that is about more than simply producing more dentists, but rather looks at who we are as a profession, and where we're going.

Change can be exciting, like the developments in dentistry we see every year, but it can also be difficult. In the next 100 years, how we select and train those who provide this care is just as important as the scientific advances driving the care itself.

Thank you

As I complete my term as President, I wish to sincerely thank my colleagues on the Management Committee, Council and GP Committee, as well as Fintan, Elaine, Roisín, and all of the team at IDA House for their support and friendship during a fantastic year. I also want to congratulate Dr Eamon Croke as he takes on the role of President, and wish him a fulfilling and successful year.

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Diary of events

IDA Annual Conference
Lyrath Estate Kilkenny, May 11-13

Irish Academy of American Graduate Dental Specialists meeting
Dublin, September 23

Mouth Cancer Awareness Day 2023
September 20

HSE Dental Surgeons Seminar
Midlands Park Hotel, Portlaoise, October 12-13

The Whole Tooth podcast

As part of the Irish Dental Association's centenary celebrations, *The Whole Tooth* podcast is returning for a second series. Host, IDA Chief Executive Fintan Hourihan, will reminisce over the past 100 years and assess where dentistry is in Ireland at the moment and where it's going in the future. Guests include IDA presidents current, past and future, the author of the forthcoming centenary history of the Irish Dental Association, a former Secretary General of the Department of Health, and the first female head of a dental school, among others.

This series is packed full of interesting and informative discussion, and will be available to access for free on all main podcast hosting platforms including Spotify, Apple Podcast, Google podcasts, Amazon music and many more.

The first episode will go live from early April to coincide with the launch of the Irish Dental Association's strategic 'Workforce Plan 2023'. As part of this first instalment, IDA President Dr Caroline Robins and Manager of our Communications and Advisory Service Roisín Farrelly will delve into the current challenges facing dentists in Ireland and discuss immediate actions that need to be taken to overcome them.

Book review: *Practical Periodontics*

A very useful tool for those interested in updating their knowledge in periodontics is the second edition of *Practical Periodontics*, which has been recently published. The book is edited by Prof. Kenneth Eaton and Dr Philip Ower, and covers the essentials of periodontics, from the aetiology of periodontal diseases through to diagnosis and prognosis, treatment planning, the role of oral hygiene methods, and non-surgical and surgical treatment options.

For those who are familiar with the first edition, this book contains the majority of the original contributors, who are all renowned academics, researchers and clinicians. The format is also similar, with a clear and concise text, and a number of high-quality diagrams and figures to illustrate the concepts being discussed in each chapter. This latest edition accounts for the most recent updates in periodontology, including the classification system and clinical treatment guidelines.

Additionally, this edition gives readers access to an extensive amount of online content, including over 400 multiple-choice questions (MCQs), case studies and three hours of video, which shows how to perform the full range of periodontal assessments intraorally.

I would definitely recommend this book to all clinicians, hygienists and students interested in updating their knowledge in periodontics.

Prof. Anthony Roberts

Gum Health Day 2023

Gum Health Day is an international awareness day held every year on May 12. Its aim is to increase public awareness of the importance of taking care of the gums, maintaining good oral hygiene, and visiting the dentist for prevention and treatment. Gum Health Day was created in 2013 with the aim of increasing public awareness of the seriousness of gum disease, the health problems associated with it, and the importance of keeping our gums strong and healthy.

Healthy gums are part of our well-being and beauty. Gum Health Day encourages everybody to prioritise prevention and maintenance of their gum health, which decisively contributes to enhancing people's overall facial aesthetics and therefore their self-confidence in everyday social activities.

The day seeks to remind people that gum health is a key factor for overall health throughout life, and that gum disease is a relevant public health concern because it is linked to serious conditions, including diabetes, heart disease and cerebrovascular disease.

"The journey to create a beautiful smile starts with heathy gums," said Dr Richard Lee Kin, President of the Irish Society of Periodontology.

The class of '82

In January, the Dublin Dental Hospital class of 1982 met for their 40-year reunion, with 26 of the remaining 27 from the class attending. Such were the organisational skills and charm of Dr Eugene Hanna that classmates from as far afield as Sydney, Texas and Oslo made the trip. All who attended enjoyed a wonderful evening. Those who are no longer with us were remembered with great affection. Thankfully, little dentistry was discussed: much more significant topics included reconnecting with happy memories and the achievement of good life balance. It was noticeable that the retirees were extolling at length the joys of life after dentistry to the minority who are still working. It was such an enjoyable evening it is likely that, rather than waiting a further five years, future reunions will be on a semi-annual basis!

By Dr Frank Burke

Class of 1982 reunion attendees, by name at graduation: Front row (from left): Drs Sylvia Roberts, Therese Garvey, Catriona Moran, Ann Cunningham, Bernie Courtney, Deborah Foyle, and Irene Kennedy. Middle row (from left): Drs Mary Clancy, Ann Behan, Dympna Daly, Eugene Hanna, Olwyn Masterson, Josepha McDermott, Elizabeth Ryder, Bill Cleary, Kate Gilmartin, and Gerry Cleary. Back row (from left): Drs Mike Drury, Máirtín Brennan, Ivan L'Estrange, Barry Devaney, Frank Burke, Philip O'Brien, Anne O'Donoghue, Tony Coughlan, and Niall O'Connor. (Photo courtesy of Dr Gerry Cleary).

Bringing dental care to Kolkata's most vulnerable

The Hope Foundation's hospital has been providing healthcare services to Kolkata's street- and slum-dwelling population since 2008. As part of this service, it has an outpatient dental programme and this year established a mobile dental healthcare service. The organisation transformed an ambulance into a mobile dental clinic equipped with relevant equipment. Professional dental personnel will conduct mobile dental care and services to the most vulnerable children and adults.

Activities will include standard dental check-ups, scaling, extractions, fillings, etc., and as required, beneficiaries will be referred to the Hope hospital for further evaluation. The Foundation says that approximately 11,000 people will benefit annually from its mobile dental care.

HOPE urgently requires funding to sustain the implementation of this programme this year. For further information about how to support this vital and innovative dental programme, and about the work of HOPE in Kolkata, please contact Maura Lennon at maura@hopefoundation.ie, or on 087-914 6837, or go to www.hopefoundation.ie.

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Hader and its history

Hader states that it represents 60 years of history, competence, and experience. In 1963, Helmut Hader founded his first factory in La Chaux-de-Fonds, Switzerland, establishing the brand. Numerous patents and inventions of attachments and prosthetic solutions have contributed to the company's history and tradition, and Hader states that this high standard is still used as reference in the dental field today.

According to Hader, while the spirit of Helmut Hader keeps expanding across the globe, its true home remains Switzerland. Hader states that the core of its identity is its sense of perfection and inexhaustible drive for innovation. In 2021, the company revived its original name, Hader, and rebranded in memoriam of Helmut Hader. The company states that it refocused on his values of innovation, quality, and customer care. According to Hader, it is the one-stop-shop for implant components, attachments, and specialty prosthetic items, delivering high quality, fair prices, and CE-marked products conforming with the new Medical Device Regulation (MDR).

Align Technology launches Invisalign Smile Architect

Align Technology states that Invisalign Smile Architect is a facially driven ortho-restorative treatment-planning software that allows general dentists to integrate clear aligner therapy into their comprehensive treatment plans. According to the company, it combines teeth alignment and restorative planning in a single platform. On February 22, Align hosted dentists from across Europe at the Invisalign Smile Architect online launch event, which provided a full overview of the new solution.

Align states that Invisalign Smile Architect combines facially driven and ortho-restorative treatment planning within the ClinCheck 3D software platform, providing flexibility to address a variety of patient needs. According to the company, it assists doctors in designing an end-to-end approach for their patients, with minimally invasive treatment plans that preserve the healthy, natural structure of the tooth. The company lists the new features: restorative specific 3D modifications; a multi-layer visualisation – ortho and restorative; real-time treatment planning; and, tooth mass analysis.

Coltene at BDCDS Birmingham

Coltene will be exhibiting on stand D45 at the British Dental Conference & Dentistry Show (BDCDS) in Birmingham on May 12-13. The company states that it will be showcasing multiple products, including HyFlex, MicroMega, BRILLIANT EverGlow and AFFINIS.

In other news, the company states that its CanalPro Jeni endo motor is an autonomous assistance system, which helps clinicians achieve safer, more efficient and simpler endodontic treatment.

Dr Sagi Shavit is a dentist with a special interest in endodontics, treating patients at Cleveland Terrace Dental Practice in Darlington in the UK. He describes his experience with using products from Coltene's endodontic range: "The HyFlex EDM file system from Coltene allows quick and safe instrumentation of the root canal system, and more time for copious irrigation, the most important part of the endodontic treatment".

Another offering from the company is Superkraft, which Coltene states is the ideal solution for indirect restorations. Coltene believes that this offers the ultimate bond strength for reliable adhesion.

Henry Schein service team

Henry Schein states that its co-ordination team across the island of Ireland is on first-name basis with a host of practice managers and works tirelessly to ensure as efficient a problem resolution service as possible. According to the company, it has invested extensively in IT solutions to ensure a better local-level response to requests for assistance.

Henry Schein Ireland goes on to explain how it has recruited cautiously to ensure that it has a team of technicians who not only repair equipment, but will also partner with customers in ensuring minimum downtime and identification of risk.

The company states that its technician team can offer advice on preventive maintenance, service contracts and validation requirements, and provides a conduit to other areas of the business for further assistance.

Information evenings

Henry Schein will also host two Reveal Clear Aligner information evenings in April and May. The first event takes place in Cork at the Montenotte Hotel on April 27, and the second event is in Limerick at the Great National South Court Hotel on May 17. Both events run from 5.30pm to 8.30pm.

Alison Davies, Orthodontic Product Manager of Henry Schein, will present, and says: "With these informative evenings, we are aiming to help dentists and orthodontists understand how Reveal Clear Aligners can help expand a practice's offerings and provide patients with an affordable and highly aesthetic treatment to enhance their smile".

The Henry Schein Ireland service team (from left): David Coulter; Gareth Strawbridge; William Walsh; Darren Murphy; Kris Krenn; Wayne Curtis; Javier Salazar; Pat Bolger (MD, Henry Schein Ireland); Barry McAleer; Lee Fox; Gary Hillis; Paul Moody; Adam Steenson; David Burke; Eamonn Devlin; and, John Rice.

DP's microscopy systems

DP Medical Systems Ltd states that it has a long history of providing microscopy products to the HSE, NHS and private customers. The company is also proud to be the exclusive distributor of Global microscopes in Ireland and the UK.

According to DP, the Global A-Series microscope is the ideal exam room microscope that offers compact design, easy manoeuvrability, intuitive controls, and a brighter light. The company offers the microscope with three different options of magnification range, a standard extension arm, integrated LED light, and the Axis control system.

DP states that Global microscopes are used by many Irish, UK and international opinion leaders, most dental schools, and many thousands of dentists worldwide. All installations are supported by trained service personnel from DP Medical Systems (Ireland) Ltd.

A century of stories

To commemorate the first 100 years of the Irish Dental Association, a book has been commissioned to document the Association's history. Here co-authors Dr Eoin Kinsella and Dr Frances Nolan talk to the *JIDA* about *The Irish Dental Association: A Centenary History*.

The Irish Dental Association: A Centenary History charts the history of the IDA and the period preceding its formation. Authors Dr Frances Nolan and Dr Eoin Kinsella are currently finishing off work in preparation for its publication in May. Eoin is Managing Editor of the Royal Irish Academy's *Dictionary of Irish Biography*. Frances is a historian and author of *The Jacobite Duchess*.

Colm Quinn
Journalist and Sub-editor
Think Media Ltd

The book explains how the Irish Dental Association came into being throughout 1922 and held its first AGM in January 1923 as a direct result of the Irish Free State breaking away from the UK. However, Eoin says it was a decision motivated by politics rather than a politically motivated decision: "They're doing it because they feel like they should have an independent local voice for Irish dentists … And it's a very smooth process. There's no acrimony in terms of the separation from the British Dental Association. When the Northern Irish branch of the British Dental Association is set up, there's no acrimony there".

However, in a divided period, not even the IDA could get away without a row erupting within its ranks. Eoin explains how at the IDA's annual dinner in 1923, there were a series of toasts proposed, and one of these was a toast to the king: "That causes an immediate row within the Irish Dental Association and it very nearly splits almost as soon as it's created, because

The book explains how the Irish Dental Association came into being in 1923 as a direct result of the Irish Free State breaking away from the UK.

there's a certain number of dentists within the Association who think that that is the wrong thing to do. They want to set up an Irish Free State dental association".

The row was resolved and there was no split, but Eoin says this story shows a perhaps unexpected nationalist side to the IDA. At the time university access was restricted to a privileged elite and you would expect a professional organisation such as the IDA to have more Unionist leanings during this period: "But that's not actually the case. There's a lot of them who are quite upset about the idea that there would be a toast to the king by the IDA".

Collaboration

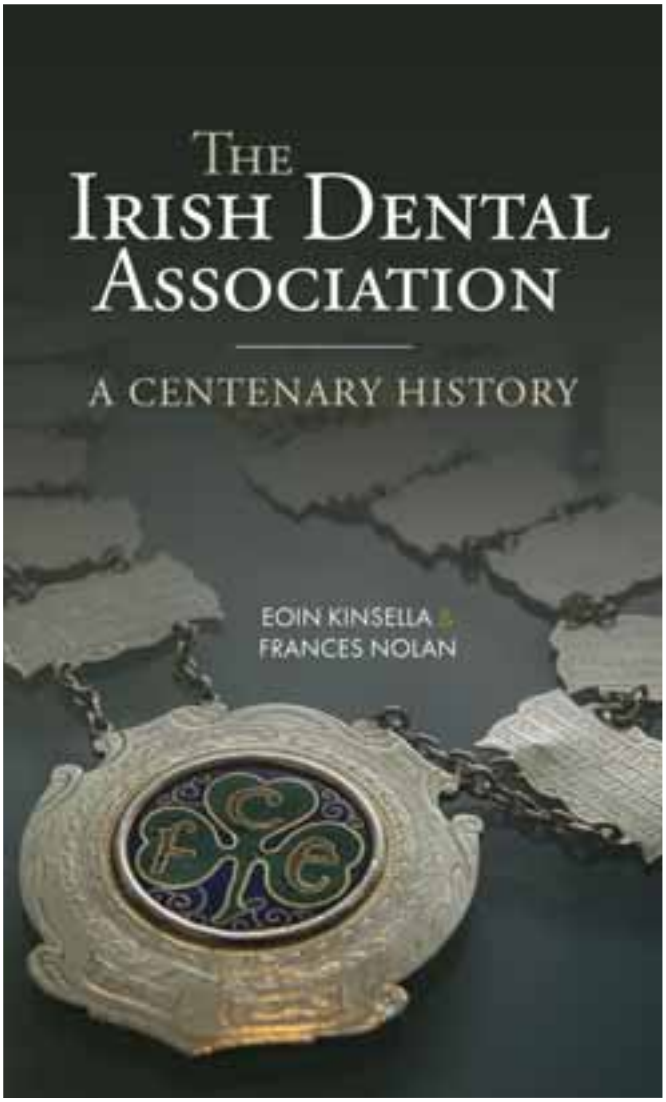
Eoin began working on the book, then asked Frances to help research and co-write. Covering a century's worth of history is a huge task, so the authors split the work into two time periods, with Frances taking the earlier decades and Eoin working on the later period. The collaborative process worked well, says Eoin, because Frances identified themes and trends that he hadn't, then he carried them on and explored them in the more recent decades.

One story that stood out for Frances early on was the story of a family of dentists who were marred by the political divisions of the time: "The O'Duffys are hugely prominent in Irish dentistry. John O'Duffy was active in the late 19th century in particular. He's a leading figure around the establishment of the Irish branch [of the BDA], and then his son Kevin is actually dentist to the Lord Lieutenant, and is a unionist. Kevin's son Eimar [who qualified but never practised] is actually quite a prominent figure in the nationalist movement. So there are real divisions there politically, and John O'Duffy is actually killed; he's a civilian casualty of the 1916 Rising. It's just a fascinating window onto a really divided period in this little family unit".

A project like this provides a window onto things you don't really think of if you're looking at the big picture of Irish history. Frances says the revolutionary period is thought of as a series of huge political events, which it was, but much of the 1920s was taken up with the nitty gritty of State formation: "So to look at it through the lens of an organisation like the IDA, it's fascinating. You just see a very specific case in terms of dentistry, and how that plays out. How can the Association shape policy? How can it shape legislation?"

Before the beginning

Although the book is a history of the IDA, the authors had to look further back to tell the whole story. Pre IDA, there was the Irish Branch of the British



Dental Association. The 19th century was also a very formative period for the professions, dentistry included, and it was hard to tell the story of the IDA without looking at this time.

Frances talks about one development that stood out from that time: "One of the things that really jumps out in the late 19th, early 20th century, is suddenly that women become part of the profession. They had been part of the 'trade', let's say, before it was professionalised, but now they actually make room for themselves in the profession".

This book is not the first history of the IDA. A book was written in 1972 for the 50th anniversary by dentist John B. Lee, and both Frances and Eoin say this was a very helpful source. While they had more modern research tools to help them, Lee had the minutes of IDA meetings, which they didn't, says Eoin: "We had access to a lot of stuff on dentistry in general in Government files, which are held in the National Archives. That was something that John Lee wouldn't have had. We were also able to get much more because newspapers are digitised now. We were able to do much more targeted keyword searches in the different newspapers to get a broader spread. The flipside is that John Lee had the minutes of the IDA, which is a really

important and useful source". The minutes of IDA meetings pre 2000 appear to be lost, so the authors used John Lee's history as a jumping off point to track down other sources.

Noteworthy figures

There have been many figures instrumental to the establishment and success of the Association – far more than can be named here – but the book features many and those who didn't quite fit into the main narrative are highlighted in the 'Operatory lights' section, which are short pieces about important people in the Association's history.

Eoin highlights two lesser-known figures from an IDA delegation to America in 1926: "Two of them were very well known within the profession: Edward Leo Sheridan and Ernest Sheldon Friel. But there are two other dentists that are both women – Irene Dorman and Eva Sterling. They went over as peers. They went over and they gave presentations. This is a huge moment".

The first woman to graduate as a dentist in Ireland was Mary de Sales Magennis, who graduated in 1914 from Trinity, says Frances: "If you go to your dentist today and your dentist is a woman, Mary is the one that took that first step. It was following on from developments in Britain where, particularly in Scotland, women who were graduating from dental schools there. I just found that really fascinating because it is a male-dominated field".

Although female representation in the profession increased from the 1980s onwards, with at least 50% of every class of graduates from Cork and Dublin being female, the Association didn't see its first female president until 2008, when Dr Ena Brennan was elected.

Changes of a century

One thing that stood out for the authors while writing the book is the improvement in dental care over the century. Eoin says it was actually a challenge of writing the book: "We very often found ourselves going down rabbit holes where we were following the thread of the history of dentistry, and you had to pull back a little bit to focus in on the Association and the Association's reaction to it.

But at the same time, there's so much overlap that you can't really write one without writing the other, especially since the Association has been so prominent in the provision of CPD".

Frances says that charlatanism and quackery within dentistry were huge problems in the early 20th century, right up until the 1930s, and that the IDA tackled that by providing educational supports to members and by educating the public also.

Eoin says: "That's one thing that actually comes across in the book quite strongly, that the IDA has been the key facilitator for ongoing training and improving the profession and improving the standards, through education, through better science".

"Female representation in the profession increased from the 1980s onwards, with at least 50% of every class of graduates from Cork and Dublin being female."

An interesting thread from the 1940s onwards was how the IDA represented both public and private dentists. Often the two groups had the same goals, but at other times that wasn't the case. One thing Eoin says is admirable about the IDA is how both parts of the profession have supported each other. The history shows that if the public dentists have an issue, the GPs will row in behind them, and vice versa.

The IDA now has a trade union licence, but originally explored the idea of unionisation in the early 1970s, says Eoin: "In 1974, the Munster Branch put forward a proposal that the IDA would become an actual trade union. It had excepted body status under the 1942 Trade Union Act, which meant that it could negotiate on behalf of members on certain areas, but it wasn't a full trade union. And the proposal that it would be a trade union was investigated and then refused. Again, I think that's probably quite common for professional organisations.

They would think that trade union status is not fully necessary, but fast forward 40 years, and it becomes something that is deemed to be necessary, because you have development where in 2008 the Department of Health decides it is no longer going to negotiate with the IDA and that causes all sorts of issues and hasn't yet been resolved, so trade union status is kind of a result of that".

The different pressures that are in play at the time will inform what the Association will then do, or its response to those kinds of pressures. The authors found it interesting to trace those things through the years, and hope readers will too.

An extract from the book is featured on pages 73-78.

ADVERTORIAL FEATURE

Big opportunity if you worked in the UK

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There are very few investment recommendations that financial advisers can make to clients that are a gold-plated opportunity to guarantee them income for life in retirement from an A-rated guarantor for a minimal outlay.

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Who is eligible for a UK state pension?

To qualify for the minimum UK state pension entitlement, you must have 10 years on your national insurance record. This is the UK equivalent of our PRSI contributions. To qualify for the full UK state pension, you need up to 35 years.

What if I don't have 10 years of contributions?

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Do you need to be UK resident?

You do not need to be a resident of the UK to avail of the voluntary contributions scheme. Normally you can pay voluntary contributions for the past six years with the deadline being April 5 each year, but the current option allows you to buy back to 2006 or an additional 16 years.

Non-residents importantly have the option of paying Class 2 voluntary contributions which are at a much lower cost than UK residents are required to pay. It must be noted, that Class 2 stamps only allow for state pension entitlement and not other benefits like fuel allowance.

Can I claim both the UK and Irish state pensions?

Yes, you can be paid both the UK and Irish state pensions if you qualify for both based on your respective social insurance record in each country.

What is the rate of payment in the UK?

The maximum rate of state pension payment in the UK is £185.15 per week, for this you need 35 qualifying years on your national insurance record. So someone with 10 qualifying years will qualify for:

10/35ths x £185.15 = £52.90 per week

Cost to buy back years

Buying back years for the 2022 to 2023 tax years:

- £163.80 per year for Class 2 (Non-Resident) - 99% of you will be in this category
- £824.20 per year for Class 3 (Resident)

Timeframe

There is a window of opportunity between now and July 31 this year where you can increase your pension entitlement at retirement age by topping up your contributions. There are several supports available so you can see your current situation. https://www.gov.uk/check-state-pension

What is this worth?

To buy an income for life equivalent to the minimum UK pension of £2,750 would cost circa £55,000 on current annuity rates. To buy the full amount would cost closer to £235,000.

Deadline

This temporary arrangement to top up your entitlement was due to end on the on April 6 but due to unprecedented demand this has now been extended until July 31.

What to do now?

Our advice is to send in the CF83 Application form to buy back years from abroad. If you are entitled they will tell you and crucially if it's in on time you will have the option to buy back years to 2006 at Class 2 (non-resident) rates. Make sure this is sent recorded or tracked post and verify arrival. This is too valuable to leave to regular post. Contact us on the details below for a full pack and brochure on this including all the required forms.

Advice

If you are lucky enough to qualify, this will have a significant impact on your financial planning. Your adviser will need to update financial projections and your cashflow model to factor this in.

This will almost certainly have an impact on your current investment allocations as you may be able to de-risk some of your portfolios once you know you have this income guaranteed. Alternatively, with the security of this income you could move into a more risk-on scenario.

This opportunity has highlighted for many that they have no proper financial plan in place and that advice to date consisted of collecting financial products with no goal. Your retirement needs a plan mapped out with full cashflow modeling. Anything else is not at the level of today's adviser market.

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Kieran 086-380 1868 / kieran@mwm.ie
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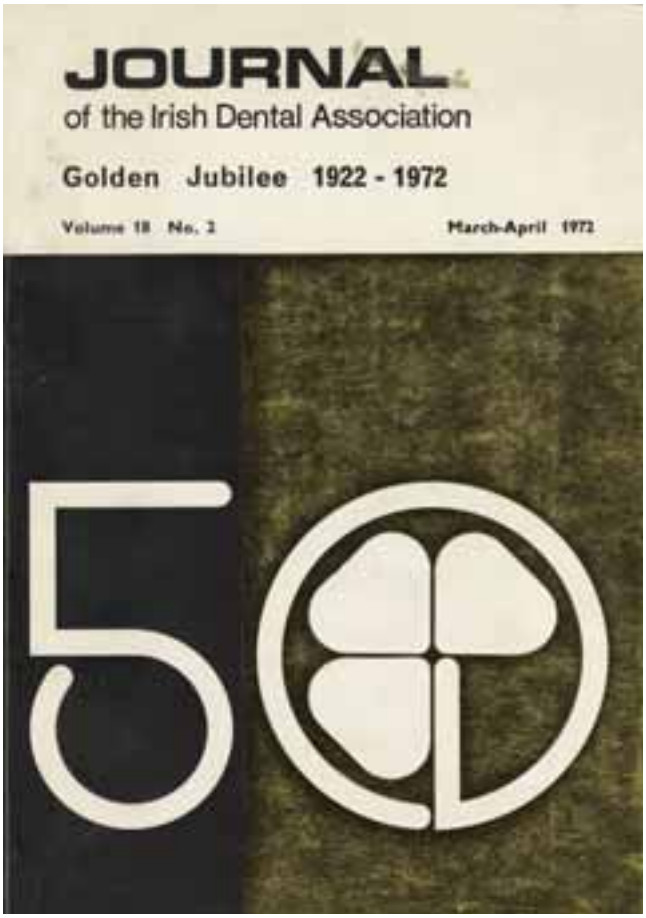
The Irish Dental Association: A Centenary History

The Irish Dental Association: A Centenary History, researched and written by historians Dr Eoin Kinsella and Dr Frances Nolan, will be published by Eastwood Books in May as part of the IDA's centenary celebrations. The following extracts from the book highlight the Association's origins in 1922/3, its reaction to the expansion of publicly funded dental services in the late 1940s, and a contentious proposal for the Association to acquire trade union status in the early 1970s.



The cover of the March-April 1972 issue of the JIDA, published during the Association's golden jubilee year. Courtesy of Conor McAlister.

Origins

Following Dáil Éireann's ratification of the Anglo-Irish Treaty on January 7, 1922, Irish politics and society grew increasingly fractured. That ratification and the subsequent foundation of the Irish Free State prompted the Irish Branch of the British Dental Association – formed in 1887 as the representative body for Irish dentists – to examine its own future.

As the Irish population grappled with the divided reality of the Free State, the Irish Branch of the British Dental Association faced an existential problem of its own. On January 19, 1922, less than two weeks after Dáil Éireann ratified the Treaty, the Branch council met and resolved that "in view of recent political changes a new society of dental surgeons practicing in Ireland be formed".

At a general meeting on February 10, Irish Branch members made the momentous decision to form the Irish Dental Association. The IDA was originally intended to be an all-Ireland professional body, with Northern Irish dentists represented by three members on the Association's committee. A circular letter, signed by 47 dentists who had already agreed to join, was sent to registered dentists across the island. One of the signatories, Arthur W.W. Baker, had been a founding member of the Irish Branch 35 years earlier. Also among those who signed the circular were eight practitioners based in Northern Ireland, offering initial hope that the IDA would indeed be an all-island body. Despite this initial show of support, however, the Northern Irish representatives to the committee declined to appear and eventually elected to form a Northern Ireland Branch of the BDA. Nonetheless, support for the new body within the Free State grew and its membership had reached 180 by the end of 1922 – a significant number given that the Irish Branch had reported a membership of 173 at the end of 1920.

The Irish Branch of the BDA met for the last time on December 15, 1922, and passed a resolution formally dissolving itself, thereby ending the unusual circumstance whereby the nascent IDA existed alongside the Irish Branch. The Irish Dental Association lost no time completing the formalities for its establishment. On January 12, 1923, it held its inaugural AGM, at which Joseph Cockburn was elected president, A.G. Walby and G. Murray as vice-presidents, James E. Hogan as honorary secretary and Mr Doolin as honorary treasurer, along with a council of 12.

Public dentistry

The activities of the IDA were greatly curtailed during the Second World War (known as the Emergency in Ireland), though it soon resumed activities on behalf of members at the war's end. In the late 1940s the Government

From left: Dr Norman Butler (IDA President); Maeve Hillery; Patrick Hillery (President of Ireland); and, Ursula Butler, at the Association's Annual Dinner, May 5, 1984. (Photo from the IDA archive.)

extended the benefits available under the National Health Insurance Scheme (NHIS) to include dental treatment. The move was one greeted with caution – if not outright hostility – by the IDA.

The post-Emergency period brought radical change to many western democracies, not least in the nature of the relationship between the State and its citizens. Among the most contentious of the issues facing the IDA and the profession at large were proposals to extend eligibility for dental benefits under the NHIS. To do so would require significant investment in facilities, presenting a logistical and financial challenge, with the familiar issues of pay and conditions dominating the discourse.

At the Association's 1946 AGM, outgoing president J.B. Moorhead urged dentists to recognise their common cause, asking those who had not joined the IDA to do so. His successor, Herbert J. Wright, warned delegates that with an expanded dental benefits scheme on the horizon, dentists would have to "remain on the alert to keep their place in the world". These sentiments were echoed in a JIDA editorial published in February 1947:

"If the members of the Dental Profession are prepared in individual cases to make small sacrifices and stand fast by the decision of the majority, they will have earned the gratitude of this generation of dentists and the next. By demanding proper equipment, suitable conditions under which to perform their work and equitable remuneration for their professional services, Surgeon Dentists will contribute a very important part in any comprehensive Dental Benefits scheme."

Initial negotiations were adversarial and unsuccessful, and dentists once more withdrew from the NHIS, this time for a year. Agreement was finally reached in 1948, when the NHIS agreed to allocate £131,000 to dental benefit, with full cover provided for operative treatment and half the cost allowed for dentures, up to a maximum of £9.

Following the creation of the separate Departments of Social Welfare, and of Health, in January 1947, Fianna Fáil TD James Ryan assumed responsibility for both portfolios. Ryan quickly introduced a Health Act that proposed to modernise the health service, prioritising several areas including the treatment of infectious diseases, mother and child welfare, and a reorganisation of the health system. Existing arrangements were backboned by the local authorities, who employed medical and dental officers. Decades of under-investment meant that it was difficult for dentists working with local authorities to maintain even adequate standards of practice.

The IDA's Public Dental Officers (PDO) Group had been formed in 1938 in recognition of the different priorities of private and public practitioners; the group's activities were interrupted by the Emergency, leaving P.J. O'Brien as almost the sole active member. At the 1945 AGM, O'Brien spoke of the poor terms offered for public health appointments and urged dental surgeons not to apply for any position that did not comply with the Association's recommendations for public health schemes. In his inaugural address to members the following April, IDA president J.B. Moorhead (who also served as chairman of the PDO Group) called for the appointment of whole-time dental inspectors in the Department of Local Government and Health, and criticised the Government for

"At the Association's 1946 AGM, outgoing president J.B. Moorehead urged dentists to recognise their common cause, asking those who had not joined the IDA to do so."

holding the profession in such low regard. Moorhead provided snapshots of his personal experience working in the school health service. On one occasion, he had been required to work in "a so-called parochial hall, little removed from a stable, with bad light from dirty windows". Sterilisation was performed by heating instruments over a turf fire, with the water in the steriliser attaining "the viscosity of gruel, due to ashes" and thus choking the obstructing needles and syringes. It was a wonder, he concluded, that his patients had escaped sepsis.

Moorhead's experience was not untypical, and the substandard facilities provided by local authorities was a source of ongoing concern for the IDA. In May 1949, the PDO Group convened at the Hibernian Hotel, Dublin, with IDA president and dean of the Cork Dental School, John Daunt, in the chair. The group's secretary, D.P. O'Sullivan, highlighted the inadequacy of services in Dublin City, where just two dental officers were tasked with the care of 80,000 children. O'Sullivan's speech was followed by an open discussion, with dentists from across Ireland criticising the conditions in which they were expected to work. One practitioner spoke of conducting an emergency operation without a dentist's chair, with the child held against a wall while a tooth was extracted. Five months after the meeting the IDA called on the Government to establish a dental health council to oversee the administration of public dental health services. This, the IDA argued, would diminish the stigma (within the profession) of PDOs being managed by civil servants. Honorary secretary Dan Gallivan observed that there was one dentist per 5,000 of the population and any extension of dental benefits would tax the resources of the profession beyond their limits. Addressing the Association's AGM in December, Daunt warned that some dental officers working in rural areas were responsible for more than 10,000 children, often without assistance from a dental nurse. In Daunt's view, without investment in facilities any attempt to expand social services eligibility would negatively impact the profession, which had only one safeguard available – "unity of action".

"Sterilisation was performed by heating instruments over a turf fire, with the water in the steriliser attaining 'the viscosity of gruel, due to ashes' and thus choking the obstructing needles and syringes."

Time for unity?

The IDA's regional branches have historically played a vital role in the development of the Association. Relations with some branches have occasionally been strained. With the Association taking on ever greater levels of negotiation with Government departments on behalf of members, in the early 1970s the Munster Branch proposed that the IDA should form a trade union.

The Health Act of 1970 brought major systemic change to the public health system with the creation of eight regional health boards. It was a move welcomed by the IDA, which was one of several professional organisations invited onto a newly established consultative council, appointed to advise the Minister for Health on the creation of the boards. As the Association's president, Art McGann, observed, it was the first time that professional health organisations had been formally consulted during the decision-making processes within the public health sector, and augured well for the future.

Relations between the Association and the Departments of Health and of Social Welfare, were, however, generally fraught. At the outset of the decade the number of whole-time dental officers employed in the public dental service had increased to 118, from just 74 in 1959, while the number of dentists in private practice participating in the Dental Treatment Benefit Scheme had increased from 61 to 98 over the same period. As the gap steadily widened between the cost of providing welfare-based care, and the fees paid to dentists by the Government, dentists in private practice began to reconsider their involvement. More than 500 had signed up to the Scheme by the start of the 1970s, though 24 dentists had withdrawn from the scheme in November 1969 in protest at the "utter inadequacy" of a proposed 15% increase in fees.

Unhappiness with fees was compounded by broader dissatisfaction with the levels of Government investment in public dental health. The IDA outlined its position in advance of its first AGM of the new decade, held in Ennis over the weekend of April 9-11, 1970. Pulling no punches, an IDA press release highlighted the "failure of successive Ministers for Health to meet the Association to discuss the problems of the community dental care services" and accused the Department of Health of having little interest in addressing these concerns. An emerging dispute with the Department of Social Welfare over a promised but delayed review of the dental benefit scheme compounded the worsening relationship between the profession's representative body and the Government:

"To date, dentists, conscious of their responsibilities as members of a health profession, have been loath to take any action that would inconvenience the public; but there is an increasing awareness that inadequate fees are not compatible with the maintenance of high standards of dental treatment, and many consider that this scheme is in need of careful reappraisal by the profession."

During the AGM on April 10 members discussed a motion calling for a phased withdrawal from the scheme, in tandem with a publicity campaign to highlight the losses incurred by dentists under the scheme; the motion was narrowly defeated. A meeting with the Minister for Social Welfare, Kevin Boland, later that month failed to produce substantial progress. By the end of the year another 23 dentists practising in the midlands (all IDA members) had withdrawn from the scheme, citing both the inadequacy of fees and the Department of Social Welfare's intransigence in negotiations. The impact of these withdrawals, on top of those in late 1969, was immediately apparent with towns such as Boyle, Loughrea, Portumna, Birr, Carrick-on-Shannon, Tullamore, Portlaoise and

The Irish Dental Journal*: official organ of the Irish Dental Association, published April 1943. Due to paper shortages, only one issue was ever published before the journal was revived, under a different name, in 1946. (Courtesy of the DDUH Library.)*

Mountrath left without any social welfare dental service.

Dissent rumbled into 1971. During an address at the Association's annual meeting in Bundoran in April 1971, Joseph Brennan (Boland's replacement as Minister for Social Welfare) risked provoking attendees' ire by rebuking the Association for its intention to reject an offer of a 12% increase in fees paid under the welfare scheme. His words had the opposite effect to that intended, and by the end of the year 382 dentists had withdrawn. Writing at the end of 1972, The Irish Times medical correspondent, David Nowlan, wryly noted that

"It was the first time that professional health organisations had been formally consulted during the decision-making processes within the public health sector, and augured well for the future."

Members of the Irish delegation attending the FDI congress in London, 1952. (From the IDA archive.)

the "ancient grumblings" between the dental profession and the Department of Social Welfare were finally resolved in February 1972, just in time for the Association's golden jubilee conference.

Given the turbulent nature of relations with the Government in the early 1970s, it was perhaps inevitable that greater consideration of the potential benefits of unionisation would arise. At the time the Association held 'excepted body' status under the terms of the Trade Union Act of 1942. That status had only been granted in 1963, following an application to the Minister for Industry and Commerce, Jack Lynch, in which the Association described itself as:

"a group of professional people banded together for the furtherance of their common interests in the scientific and economical sphere. While the Association does seek to improve the terms of contract, remuneration and other conditions of its members, as a professional group it is not its intention to resort to industrial action in support of its claims."

As a statement of ideology, that description very neatly encapsulates a contradiction that has stood at the core of the Association's identity for the last half century – how to leverage its collective strength while simultaneously remaining reluctant to resort to collective industrial action.

The Association's application for 'excepted body' status noted that it had a membership of 380, of whom 70 were employed by local authorities. It had been prompted to seek legal recognition of its right to negotiate on behalf of members by the introduction of a scheme for conciliation and arbitration within local authorities, which had the potential to affect public dental surgeons. Their case was strong, given the IDA had previously represented public sector dentists in negotiations with various Government departments, as well as with the Irish Transport and General Workers Union (ITGWU) on behalf of private practice dentists who employed dental technicians. Moreover, the application had the support of the Minister for Health, Seán MacEntee, who had been granted honorary life membership of the Association in 1962 in recognition of his support for fluoridation.

Excepted body status was formally granted on April 22, 1963, following the promulgation of a Statutory Instrument signed by Jack Lynch. The Association thus joined a select group of eight organisations with the status, including the Association of Hospitals and Public Pharmacists, the Irish Nurses Organisation, and the Irish Medical Association.

Given the levels of conflict with Government departments in the early 1970s, it was perhaps inevitable that the question of unionisation would be placed on the

"As an 'excepted body' the Association was already recognised as a representative organisation with rights of negotiation, and was a member of the local government conciliation and arbitration scheme."

Association's agenda. The executive council established a committee in 1974 to "examine the advantages or otherwise to the Dental Profession in Ireland of unionisation". The origins of the committee lay in the actions of the Munster Branch, which effectively forced council's hand. In early 1974 the Branch had circulated a questionnaire to Cork-based dentists, seeking their views on unionisation. It claimed an 86% response rate in favour and established a Union Action Committee to explore options available to dentists. Acting without the approval of the IDA's executive council, members of the Munster Branch entered discussions with the Irish Medical Union (IMU), securing its agreement to pass a motion enabling it to call an EGM for the purpose of admitting registered dentists, if requested to do so by a sufficient number.

The Munster Branch's actions were, however, precipitous. Its failure (whether intentionally or through genuine oversight) to seek approval from the executive council led to accusations that its actions were both tendentious and ultra vires, and that a militant minority were manipulating the Branch. Eager to avert an internal crisis, the executive council established its own committee to investigate unionisation. The committee's membership consisted of A.C. Canty, C.K. Collins, J.F. Fleming, J. McAlister, J.B. Maloney, B.F. O'Gorman and the secretary general, Thomas Leacy. Its terms of reference were broad, encompassing in the first instance a general examination of "the idea of unionisation" – a daunting task in and of itself. The committee also examined the practicalities of unionisation, and how it might proceed: whether through an individual's personal application for membership of the Irish Medical Union (IMU); an application for membership of or affiliation to another trade union; or, whether the IDA should establish its own union.

Advice was sought and received from several national and international organisations with links to Irish dentistry, including the British Dental Association, the Fédération Dentaire Internationale, the Irish Congress of Trade Unions, the Federation of Professional Associations, the Incorporated Law Society of Ireland, and the IDA's own PDO group and social welfare committee. Others were invited to give their views, but either declined to do so or did not submit in time, including the Dental Board and the IMU.

The committee's report was short and to the point. As an 'excepted body' the Association was already recognised as a representative organisation with rights of negotiation, and was a member of the local government conciliation and arbitration scheme. This twin status conferred on the IDA "complete negotiating capacity on behalf of dental surgeons in both the public and private sectors", and the committee saw no need for a legal right to place picket lines during an industrial dispute, which it viewed as the principal benefit associated with unionisation.

Apart from its views on the (de)merits of unionisation, the report also offered an insight into the profile of the dental profession, and a glimpse into the extent of the IDA's membership and its reach. The number of dental surgeons in the State remained at approximately 800, of whom about 200 were employed in the public sector. The remainder were private practitioners, each of whom employed at least one other person in their practice. Though the report noted that the Association did not enjoy the active support of most dental surgeons, it was nonetheless the "accepted negotiator on their behalf; that is to say the whole profession benefits from any negotiating success the Association may achieve".

In that rationale lay perhaps the genesis of the committee's report. Fracturing of the profession's cohesion during negotiations with the Department of Social Welfare in late 1970/early 1971 had clearly hampered discussions and emboldened the Department. While the midlands dentists who withdrew from the Dental Benefit Scheme in December 1970 were perfectly entitled to do so, the fact that they had attempted to negotiate with the Department independently of the IDA had weakened both parties. Minister Joseph Brennan had seized upon the strategic error: "It was suggested by [the midland dentists] that I was unable to refute the arguments in a memorandum submitted by them … I simply refused to treat with them, as I considered, and still consider, that the official negotiators of [the IDA] were the only ones with whom I or my Department should properly deal".

***The Irish Dental Association: A Centenary History* will be available from the IDA and in all good bookshops.**

All roads lead to Kilkenny in May

It's almost time for the 2023 IDA Annual Conference, which this year celebrates the Association's centenary with a fantastic programme of speakers, courses and events.

This year, dentists and team members will gather in Kilkenny's beautiful Lyrath Estate from May 11-13 for a very special centenary Annual Conference. An exceptional programme of lectures and courses is planned, as well as great social events, including this year's Annual Dinner on May 12, which will be the highlight of the Conference.

Pre-Conference Programme

The Pre-Conference Programme on Thursday, May 11, features full- and half-day courses on a range of topics essential to the general dentist. Drs Aisling Donnelly and Roberto Careddu will offer a full-day course on 'Maximising your success in endodontics', while Drs Rona Leith and Abigail Moore and Prof. Anne O'Connell present 'Practical paediatric dentistry for the dental practitioner'. Dr Chris Orr will deliver a half-day hands-on course titled 'Posterior composites in 2023: can we simplify without compromise?'. Dr Andrew Bolas covers the role of the radiation protection officer in dentistry, while Dr John Alonge returns to the IDA's Annual Conference with a half-day course on 'Handling surgical complications including hands-on suturing'.

Main Conference

On May 12 and 13, parallel sessions will offer presentations on a wide range of topics. Simultaneously kicking things off on the Friday morning at 8.00am, Prof. Avijit Banerjee looks at preventive dentistry using the minimum intervention oral care approach, and Dr Marilou Ciantar goes through the implementation of the S3 periodontal guidelines in general dental practice.

Dr Mary Clarke will look at conscious sedation, while Dr Niall Neeson covers practical tips for managing dental anxiety. Dr Sally McCarthy will speak on sports dentistry and dento-facial trauma, and Dr John Ed O'Connell's presentation will be on contemporary management of oral cavity cancer.

After the presentation of the Costello Medal, the two sessions merge for a reflection from Dr Martin Kelleher on the good, the bad and the ugly following 50 years in dentistry, and the day will conclude with a talk from Drs Eoin Kinsella and Frances Nolan on 100 years of the IDA.

Saturday's programme promises to be just as exciting, with presentations from Dr Owen Crotty on orthodontics in our digital world, Dr Mili Doshi on managing the oral health of adults with a neurodisability, and Dr Brett Duane on sustainability.

The IDA's annual GP Meeting takes place at lunchtime, and is a must to hear the latest developments on the issues of importance to GDPs.

In the final lectures of the conference, Dr Alison Dougall will take delegates through the need for antibiotic stewardship, and Prof. Avijit Banerjee will look at minimally invasive operative management of the deep carious lesion.

Don't fear the fear!

Dr Niall Neeson is a GDP with a practice limited to dental anxiety, based in Boyne Dental in Navan, where he designed the 'Dental Fear Solutions' service and receives referrals for dental phobia/treatment under sedation.

What will your presentation at the IDA conference cover?

I'm very much focusing on the practical side of things – offering tips and tricks that every single one of us can use. I'm going to talk through the patient journey, targeting how we can make life easier for people each step of the way.

What do you hope practitioners will take from your presentation?

There are so many things that we, as dentists, can do to allow people to feel more comfortable, more in control, more safe. I hope that every delegate will be able to take away one or two nuggets that they will be able to introduce immediately – from Monday morning! I'd also love to reframe dental anxiety for other dentists. I'm always keen to emphasise the advantages of managing dental anxiety more effectively – not just for the patient, but for your practice and for us as dentists too. I promise you, it can genuinely be really enjoyable!

As the IDA celebrates its centenary, what developments would you like to see to build on the last 100 years and prepare for the next?

It's great to see how dentistry has become so patient centred in recent decades and this can only be positive for dental anxiety. Interestingly, despite advancements in dentistry, levels of dental fear/anxiety have remained similar since the 1940s. I'd love to see a more integrated approach, embracing psychological support as is more common in Scandinavia. There is plenty of strong research backing up the use of cognitive behavioural therapy (CBT) for example. To me, this offers hope

that combining psychology alongside modern dentistry could potentially make a significant difference in finally reducing the prevalence of dental anxiety in society.

Technological advancements are also very exciting – virtual reality is already being utilised effectively in King's College London, offering initial 'virtual' exposure to the dental environment or procedures.

I think for patients though, the holy grail for dental anxiety is the silent drill. The sound of the drill is such a common trigger for feelings of fear/panic. That sound alone is a barrier to accessing dental treatment for many, many people. So a noiseless drill would be an absolute game changer. I'd like to think within another 100 years we'd have cracked that!

The minimum intervention approach to caries

Prof. Avijit Banerjee is Professor of Cariology & Operative Dentistry/Hon. Consultant and Clinical Lead, Restorative Dentistry, at the Faculty of Dentistry, Oral & Craniofacial Sciences, King's College London/Guy's & St. Thomas' Hospitals Foundation Trust, London.

What will your presentations at the IDA conference cover?

My keynotes cover the topic of modern practical management of dental caries, one of the most prevalent non-communicable diseases affecting humans on the planet.

They will discuss overall preventive care as well as the minimally invasive operative management of the deeper carious lesion. They will offer evidence of modern concepts, based on the team-delivered, patient-focused minimum intervention oral care framework. Practical implementation as well as the use of the workforce will be discussed.

What do you hope practitioners will take from your presentations?

They should take away new evidence-based concepts of managing dental caries preventively, as well as practical clinical tips and how to optimise patient care delivery in primary care through the oral healthcare team workforce.

As the IDA celebrates its centenary, what developments would you like to see to build on the last 100 years and prepare for the next?

As I am a cariologist, my views will be biased! Clinicians exist to help patients. All oral healthcare team members need to be focused on delivering better oral health, based on preventive practice. Unfortunately, not much has changed in this aspect of our profession and I would like to see implementation and reward, for both patients and practitioners, for the use of the minimum intervention oral care delivery framework, combined with improved detection, clinical and biomaterials technologies.

Paediatric dentistry can be for everyone

Prof. Anne O'Connell leads paediatric dentistry in Dublin and has trained numerous specialists in paediatric dentistry. Drs Rona Leith and Abigail Moore will join Anne to deliver a full-day interactive course on practical paediatric dentistry at the conference. Anne will also deliver a separate lecture on 'New developments in dental trauma'.

What will your course at the IDA conference cover?

We want to show practitioners that dental care for children is fun and rewarding, and there is nothing to be afraid of. New developments have changed how dentistry for children is delivered, and evidence shows that drilling is often not necessary. The course will update and assist the practitioner to be confident in modern concepts. There have also been recent changes in managing dental trauma in both primary and permanent teeth in children. New materials, techniques, and time-saving gadgets will be demonstrated. We will reinforce how to make treating children a fantastic experience for you, the child and the parent, and that it can be a real practice builder.

What do you hope practitioners will take from your course?

At the end of the course, the dentist should feel confident to be able to treat a range of children in their private practice. We want to give them the tools – the tricks and tips for confident decision-making. The majority of children can be treated in general practice.

It's really putting the general practitioner in the centre of care for families and for children. It is equally important to know what you don't know, and when and what to refer to specialists.

As the IDA celebrates its centenary, what developments would you like to see to build on the last 100 years and prepare for the next?

We need to get the message out that caries is a preventable disease. We haven't succeeded in the last 100 years, so maybe for the future, that message will result in lower levels of disease. We need more and better training at undergraduate level for children's dentistry, and an emphasis much more on prevention and minimally invasive dentistry within the profession and as a public health message. If we can prevent caries, then treating children for all these other issues, such as trauma, or developmental defects and eruption problems, will be simplified. So for the future, let's tackle prevention, starting with establishing the age one visit to the dentist.

Beyond the education

The Annual Conference is a tremendous source of CPD for dentists and dental team members alike, but there's a lot more on offer as well. The trade show will feature the very best in dental equipment and consumables, and there will be plenty of opportunities to tour the stands and meet the exhibitors.

The President's Golf Competition for dentists takes place on the Thursday at Mount Juliet while exhibitors who golf will compete for the JIDA Cup. Yoga sessions on Friday and Saturday will offer another opportunity to relax.

Thursday evening trad session

This year we are also delighted to invite all delegates and trade show partners to an evening of live traditional Irish music in the beautiful surroundings of Lyrath Estate on Thursday evening at 9.00pm. We hope to see as many there as possible.

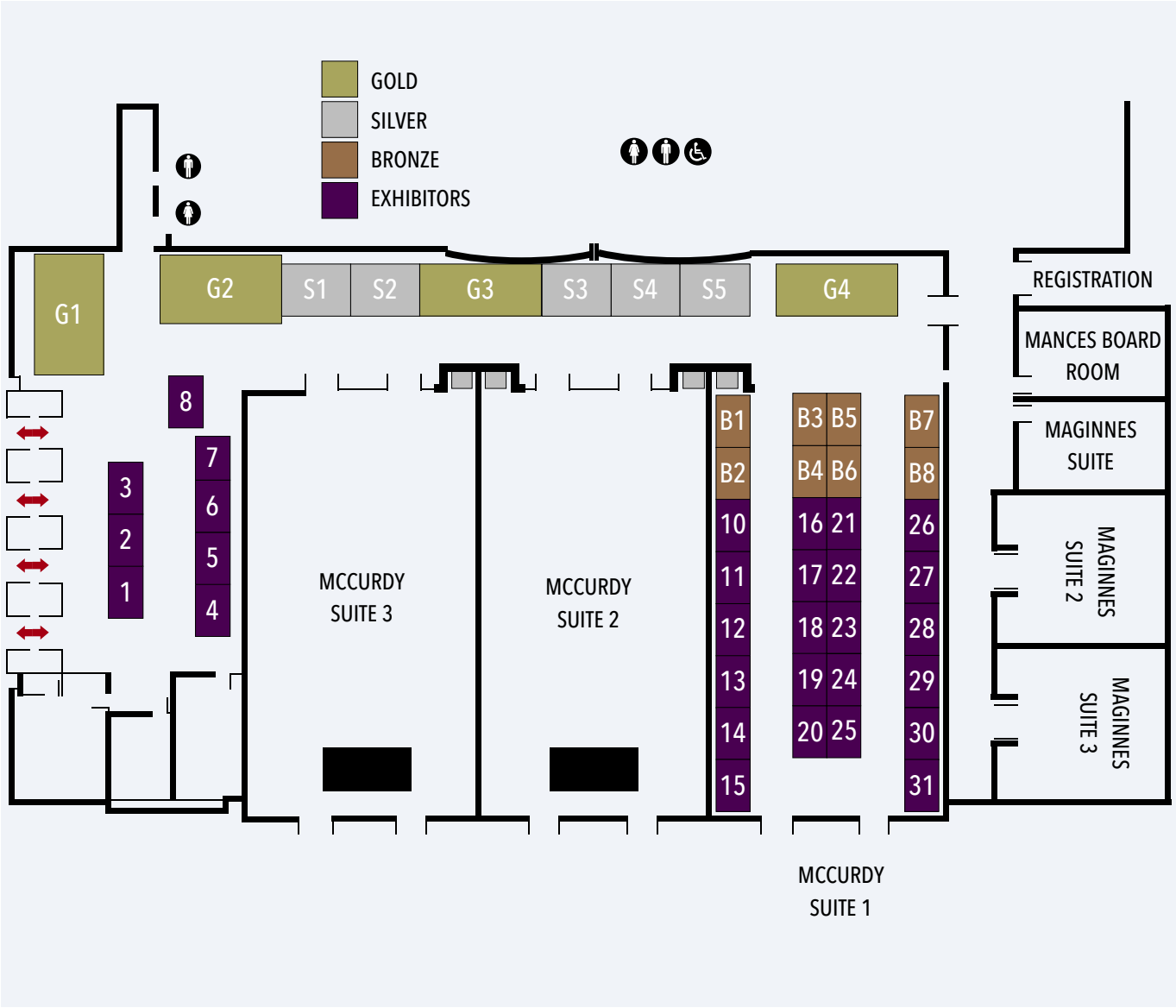
Art exhibition – Shining Brightly

As part of Annual Conference 2023, the IDA will also host an art exhibition. Delegates are invited to submit a piece of art for display in the Lyrath Hotel on Friday, May 12. Pieces are invited from all disciplines of the arts including painting, photography, sculpture, woodwork, textiles, etc. Artworks will be displayed for exhibition purposes and adjudicated.

To exhibit, please contact aoife@irishdentalassoc.ie.

For full details of the Conference, see: https://www.dentist.ie/_fileupload/AnnualConference2023_web.pdf.

TRADE SHOW



LIST OF EXHIBITORS

GOLD

G1	Colgate
G2	Medisec
G3	Henry Schein
G4	Dental Medical Ireland

SILVER

S1	Johnson & Johnson
S2	Coltene
S3	Walfrid Private
S4	Rockwell Financial
S5	DeCare Dental

BRONZE

B1	Irish Dental Jobs
B2	Dentsply Sirona
B3	Biomet 3i
B4	Oral-B
B5	Braemar Finance
B6	Diamond Design Uniforms
B7	Straumann
B8	Pamex

EXHIBITORS

2	Kulzer
3	3M
5	Irish Oxygen
6	IDHA
7	EMS UK
8	Omega Financial Management
10	MedAccount Services
11	Dental Protection
12	Morris Dental
13	McDowell + Service
14	SME
15	Align Technology
16	NSK
17	Q-Sip
18	Kerr
19	Ordoline
20	Design Specific
21	Moore Wealth Management
22	Hader
23	Dental Health Foundation
24	Quintess Denta
25	Karma Sales + Services
26	Gallagher Insurances
27	Ocean Healthcare
28	BF Mulholland
30	DP Medical Systems
31	Handpiece Harry

IDA
irish dental association

Volume 69 Number 2
April/May 2023

MEMBERS' NEWS

A workforce in crisis

The IDA has prepared a proposal to address the growing challenges of recruitment and resourcing in the dental sector.

In 2023, the Irish Dental Association marks its centenary year. Our mission is and has always been to advocate for the highest standards in oral health provision on behalf of our more than 1,800 members.

A resourcing and staffing crisis is now looming large as we enter the next chapter in our history. This is already being felt across the dental profession, and, critically, among those who require dental treatment and services, many of whom are among the most vulnerable in our society and communities.

Our analysis shows that we need at least 500 extra dentists across the private sector and public service immediately.

Currently, private dental practices cannot recruit dentists to fill vacancies and this is having a real impact on patient access to dental care, whereby

Worryingly, we are also not retaining enough of those that are graduating every year from our dental schools at UCC and TCD, given the reliance of these institutions on the fees generated by international students who generally return home upon graduation.

In practice, what this means is that barely half of the 90 dentists who graduate every year opt to practise in Ireland long term.

Within this plan, we have identified a number of measures that, through co-operation, collaboration and effective co-ordination, can alleviate what will only become a more acute issue if not urgently addressed.

We are ready and waiting to sit down to discuss and develop the best pathway forward to ensure access to essential oral healthcare for all.

INCREASED EDUCATION AND TRAINING

Increase graduate places at Ireland's dental schools

The staffing crisis cannot be separated from the lack of training and education places. The two dental schools in Dublin and Cork are struggling, due to entirely inadequate funding to cope with the existing numbers in training. There is no capacity to quickly or significantly increase the total numbers in training – and no progress has been made on the building of a new dental school in Cork since the sod was turned on the site in 2019.

In addition to the lack of capacity, there is also an issue concerning the number of graduate dentists who remain in Ireland and practise here.

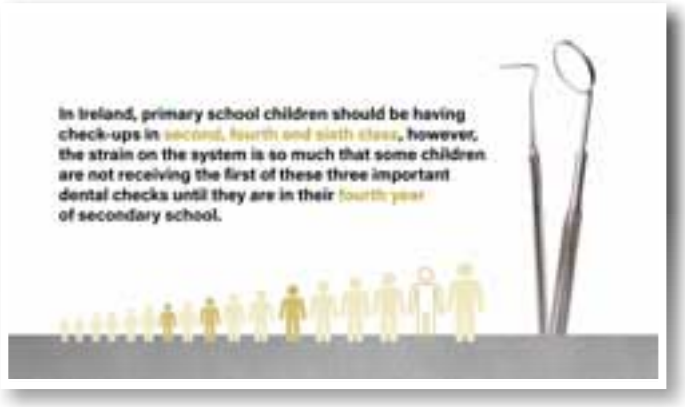
Currently, the dental schools graduate about 90 dentists each year. However, just a fraction of these graduates are among the dentists who newly register with the Irish Dental Council.

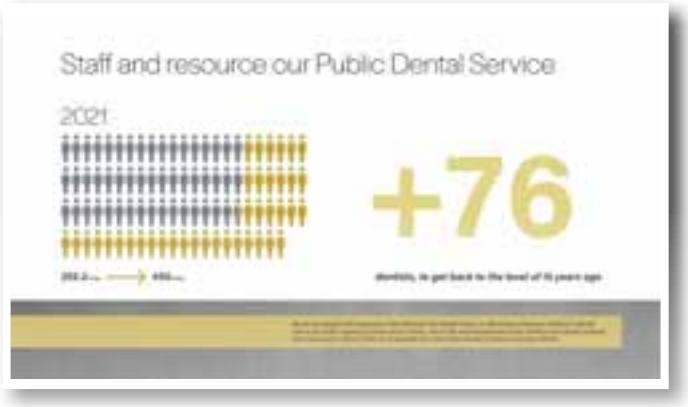
There needs to be a significant increase in funding made available to our dental schools in order to increase the number of places available to dental graduates.

group teaching as part of continuing dental education.

In 2013, a group of stakeholders, including the IDA, the two dental schools, the Royal College of Surgeons in Ireland, and the Dental Council submitted a proposal to the Department of Health that a Dental Foundation Training programme be re-established whereby trainees from the two dental schools would rotate through different areas of work experience in both the public and private sectors. The report outlined that the programme would help to address the considerable unmet dental need of the Irish population while, at the same time, it would underpin continuing professional development of new graduates here in Ireland.

The proposal had the full support of the dental profession in Ireland. Unfortunately, the Department of Health did not support the proposal at the time. We believe it is vital that this Foundation Training Programme be introduced as a matter of urgency as part of the solution to the workforce crisis in the sector.





such as location, services provided, and hours worked. This would give a reliable overview of the number and availability of practising dentists in the country, and allow an informed assessment to feed into workforce planning for the sector.

CRITICAL CHANGES TO WORK PERMIT RULES

Reform of work permit rules for non-EEA citizens seeking work as dental nurses is urgently required since dental nursing was added to the list of ineligible occupations for work permits. This means that non-EEA dental nurses can no longer get a work permit to work in Ireland. This is in contrast to medical nurses, who have long been named on the critical skills list for work permits.

We are calling for the decision to place dental nursing on the ineligible occupation list to be urgently reversed in order to enable non-EEA dental nurses to take up these vital roles within dental practices. We believe that dental nursing should be added to the critical skills list.

We are also calling for changes to work permit rules for non-EEA dentists

upholding of standards. However, some consideration should be given to amendments that could be made to modernise and make it more efficient, particularly regarding the curriculum for these examinations, the frequency with which they are held and the feedback given to candidates

We believe the exams could be held more frequently (they are currently held just once a year).

The curriculum to be assessed should be clear and easily accessible, with the use of multiple-choice questions such as those used in the Canadian entrance exam. We consider certain elements of the examination to be unnecessarily onerous and could focus more closely on the day-to-day skills, knowledge, attitudes and competencies required of a dentist in general practice.

Furthermore, detailed feedback should be provided to candidates who fail to meet the required standard in the examination.

HIQA dental practice inspections – what are the issues?

Over 30 dental practice inspection reports of compliance with medical exposure to ionising radiation regulations have been published by HIQA to date. Below we set out a brief overview of the main areas examined and common areas of compliance failure.

Information exclusive to IDA members

If you have questions about your requirements under the ionising radiation regulations, log in to our members' website and view Best Practice: S.I. 256 of 2018. This information is available exclusively to IDA members.

Members will find information on the legal requirements imposed by Statutory Instrument 256 of 2018, and get an insight into the practical steps they need to consider in order to fulfil the requirements. They will be able to access information to aid preparation of their site-specific protocols, and associated records, which must be available for inspection by HIQA if requested.

HIQA inspections

Most of the inspections focused on the following regulations:

Regulation title	
Regulation 4	Referrers
Regulation 5	Practitioners
Regulation 6	Undertakings
Regulation 8	Justification of medical exposures
Regulation 10	Responsibilities
Regulation 11	Diagnostic reference levels
Regulation 19	Recognition

Regulation 19: Recognition of medical physics experts
Regulation 20: Responsibilities of medical physics experts
Regulation 21: Involvement of medical physics experts in medical radiological practices
Regulation 11: Diagnostic reference levels

Self-assessment questionnaire

A number of practices were inspected due to the fact that they had failed to complete the mandatory self-assessment questionnaire.

Dental undertakings should ensure they have completed the HIQA self-assessment questionnaire for dental services providing medical exposure to ionising radiation. Undertakings who have not completed this questionnaire are likely to be inspected.

Medical physics experts

The inspections also found that a high number of undertakings did not have a medical physics expert (MPE) in place on the day of the inspection. Where there is no MPE in place, then the undertaking will usually fail the following six regulations:

Regulation 6: Undertaking – responsibility to appoint an MPE and keep [illegible]

Oral health information – more resources from the DHF

DHF Dental Health Foundation Ireland

The Dental Health Foundation plays a pivotal role in oral health promotion. We provide information for parents/carers/health professionals on healthy behaviours and making healthier life choices.

The Dental Health Foundation (DHF) is always exploring ways to collaborate, and build on relationships with colleagues, from public health nurses to Special Olympics Ireland, the Association of Ukrainians in Ireland, and the public dental service.
We produce evidence-based oral health information for the public through their life course and have listened to healthcare professionals in making this available in a useful and accessible format.

New brochure on children's teeth

Recently, we responded proactively with a resource for parents/carers that signposts them to crucial information for keeping their young children's mouth healthy.

This new brochure 'Caring for Your Child's Teeth 0-5 years of age', in partnership with Dr Evelyn Crowley, Senior Administrative Dental Surgeon and Ms Fiona McKeown, Assistant Director Public Health Nursing, provides oral health information for all child health professionals and will assist them deliver the following messages.

- The most important things that parents/carers can do to help prevent their child from getting tooth decay
- Dietary advice for parents/carers by highlighting the types of food and drinks that contain sugar, feeding practices
- Avoiding putting babies to bed with a bottle—at night or at nap time.
- Advising parents/carers to avoid transfer of oral bacteria to their child
- Oral hygiene and fluoride advice to parents/carers that is specific for 0-2 years and 2-5 years
- Information on teething
- Lift the lip of children aged 0-5 years to look for early signs of tooth decay
- Visiting the dentist by a child's first birthday
- Signposting to important information on the Food Pyramid, HSE www.mychild.ie and further information to a FAQ Section on www.dentalhealth.ie

Tooth decay and baby bottle

In conjunction with this we have also updated our 'Tooth decay and baby bottle' poster which clearly explains the causes of baby bottle decay and how to prevent it. A practical resource for primary care centres and dental surgeries.

Stickers

We have developed stickers with colourful designs, incorporating our suite of characters and engaging theme to motivate children to brush their teeth. The messages are: 'Well done! Keep brushing', 'Take care of your smile', 'Your smile is amazing!'.

New Sugar Risk Animation

The DHF understands the importance of reaching the public in different ways and has launched a new and catchy Sugar Animation which is suitable for all ages. It clearly identifies sugar as the most important risk factor for tooth decay and promotes oral health messages including the use of fluoride toothpaste, less sugar and good oral hygiene. It highlights the World Health Organization sugar intake guideline to reduce free sugar to less than six teaspoons per day for overall benefit to oral health and healthy weight. It can be shown on tablets, phones and screens for surgeries, schools and preschools. It is freely available on the Dental Health Foundation website at https://www.dentalhealth.ie/resources/educational/sugar-video/

The DHF strives to make every contact count with its oral health promotion resources. We continually raise awareness that tooth decay is the most common childhood disease worldwide.

Our suite of evidence-based resources and information is for everyone through the life course to help them understand the importance of good oral health habits from cradle to grave. They provide tips which include brushing children's teeth, teaching children how to brush, eating healthy snacks, avoiding sugary drinks and foods, and visiting the dentist.

Health professionals can use both our brochure and video to teach patients about the importance of oral care and hygiene. You can explore more of our resources on our website to help you speak with parents/carers about making healthy choices for their children at www.dentalhealth.ie.

From left: The cover of the new brochure from the DHF.

The new animation from the DHF.

Section of updated poster from the DHF.

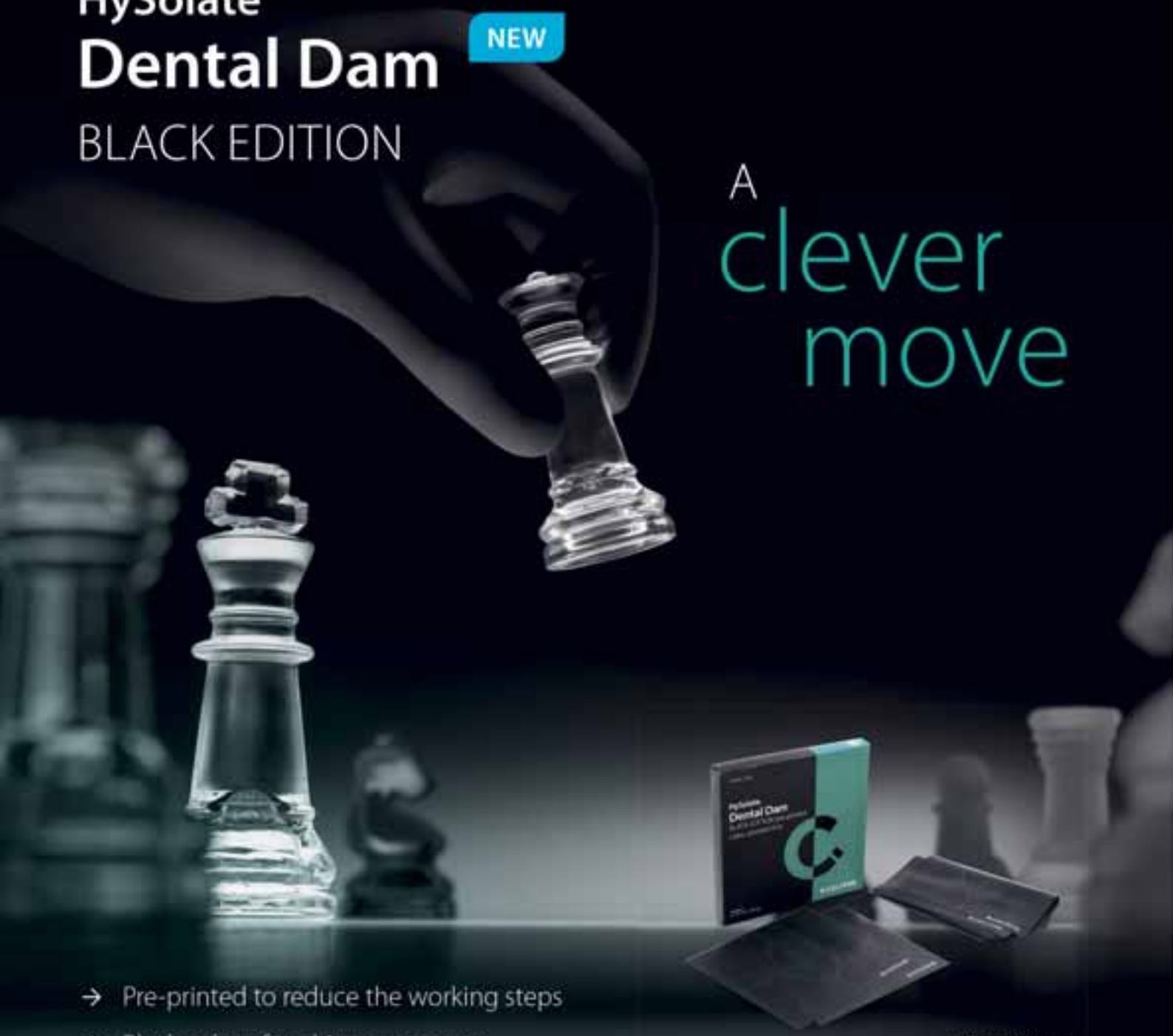
TOOTH ISOLATION

HySolate Dental Dam

NEW

BLACK EDITION

A clever move



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- → Black colour for ultimate contrast
- → Less hypersensitivity – low protein and powder free latex dam

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Contact Nick O'Keeffe on **+353 8641 35766** or **nicholas.okeeffe@coltene.com**

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Navigating mid-career changes

A number of issues can arise for a dentist considering a career change, and having risk management strategies in place can help you along your career journey.

Throughout your professional life, many different and exciting opportunities may present themselves, making it likely that you'll change course many times. You may potentially head in the same general direction, but on a different route – or you may change your destination completely.

Begin with the end in mind

Stephen Covey in his seminal book *The Seven Habits of Highly Effective People* talks about "beginning with the end in mind". How is this relevant to your dental career? With the excitement of starting out in any new role, it might seem like an inauspicious time to be considering your exit strategy! However, good risk management tells us that this is the best time to reflect upon and plan for different possible scenarios that may arise.

At Dental Protection, we are regularly asked for advice when disagreements arise between colleagues – especially between principals and associates. This can be particularly challenging when the parties have gone their separate ways on less than amicable terms. Some of the resultant issues and disputes could have been mitigated if there were more clearly defined and thought through parameters in place from the beginning.

Contract

It is always best practice to have a robust contract in place, whether as a self-employed associate or an employee. This will normally have a section on, or clauses concerning, terminations. Some of the (non-exhaustive) issues for both associate and principal to consider and discuss at the beginning of a professional relationship include:

1. Does the associate contract stipulate a certain notice period to be given by either party to terminate the contract?
2. Are there any restrictive covenants after departing the practice, e.g., preclusion from working within a specified geographical radius?
3. What are the financial arrangements for outstanding patient bad debts when you leave?
4. Have you considered how both parties (principal and now ex-associate) would negotiate any disputes between yourselves?
5. What are the arrangements for providing locum cover for sickness or parental leave? Many contracts place this onus on the associate, which can add additional stresses at an already difficult time.
6. How are costs going to be shared – for example laboratory fees and fees for referring patients to a hygienist?
7. Will the practice retain any fees from your final payment for the provision of any remedial treatment necessary to repair treatment you provided before leaving the practice?

Unfortunately, dentists are not provided with any training in this area prior to graduation, and we do see instances of disputes between parties that can rapidly escalate. We would encourage anyone starting in a new role to have their contract reviewed by a suitably qualified legal professional.

Continuity of care

It is an ethical requirement mandated by the Dental Council that: "If you leave your dental practice, you must arrange continuing care for your patients who are undergoing active treatment. With your patient's consent, you should transfer care to a colleague or arrange to refer your patient to another dental professional. The transfer or referral should be to a dental healthcare professional you are satisfied is competent to complete your patient's treatment".[1]

It continues: "If you accept a patient for treatment, you must do your best to complete the agreed course of treatment safely and to a satisfactory standard".

These are, therefore, important considerations to bear in mind when leaving a practice. Are all outstanding treatment plans completed? If not, what are the arrangements for continuity of clinical care? If you had a specific clinical interest, e.g., short-term orthodontics, will your successor or the practice itself be able to provide follow-up care?

The simplest way of overcoming the difficulties thrown up by patient continuity of care is to plan your exit from a practice well in advance. By doing so, you will be able

Dr Noel Kavanagh
Senior Dental Educator, Dental Protection

Dr George Wright
Senior Dental Educator and Dentolegal Consultant

to notify your patients ahead of time and this will help you to avoid any surprises. You may also be in a position to refer complex treatment plans to colleagues to avoid the patient having to change clinician mid treatment.

Robust record keeping is one of the central pillars of clinical risk management. Your records come into very sharp focus when a colleague takes over the care of your patients on your departure. Are your clinical records of an adequate standard, e.g., to facilitate another practitioner in taking over from where you left off?

A helpful exercise can be to review some records from a few months back and consider whether you can easily understand what discussions you had with the patient, what treatment options were explored, what risks and benefits were considered, and what the final agreed treatment plan was. If this basic information is missing, it will make it harder for any dentists taking over the patient's care and can start the ball rolling for patient complaints.

Complaints process

It is again very prudent to have discussed what process is in place for any patient issues or complaints when you're no longer working at a practice. Will you be informed and asked for your comments? Will you be notified of all patient complaints or just the ones the practice considers to be significant? Who will respond to the patient: you or the practice? If remedial treatment is required – and the patient feels they shouldn't have to pay (or the practice principal feels likewise) – what financial arrangements are in place (especially regarding retained sums)? What if you disagree with the practice/principal's approach to the complaint?

At Dental Protection we see a number of difficult situations arise out of disagreements surrounding how complaints are handled, particularly after the treating clinician has left the practice. Ordinarily, it is preferable for the practice to inform the treating dentist of any and all complaints made by patients, so that they may then provide a response to the patient having had an opportunity to review the clinical records. The risk of the practice attempting to handle the complaint is twofold: it is very challenging (and ordinarily inappropriate) for an individual not responsible for the treatment to comment on the clinical issues; and, perhaps more significantly, the complaint may not be handled as the treating dentist would like and can occasionally cause unnecessary escalation of the complaint. It is unfortunately not uncommon for an outgoing dentist to first become aware of a complaint when it has escalated to a point where the chance for a simple intervention to nip it in the bud has been lost.

Patient base

It is not unusual upon leaving a practice (and particularly if you continue working locally) that some patients may wish to continue attending you. Patients may consequently request the details of where you now practise. Again, what will the practice policy be? Can records be forwarded? Is reference to ownership of records in your original associate contract? It is worth highlighting that the regulator, the Dental Council, expresses a view on this issue. The 2022 Code of Practice relating to Professional Behaviour and Ethical Conduct states: "You must not canvass patients directly or try to persuade patients to leave another dentist or practice. This is particularly important when a dentist is leaving a practice".

On the other side of the coin, you do not want to be seen as obstructive or evasive when asked by patients about where you are leaving to. A simple discussion with the practice principal to agree on what you can say, when asked, will avoid any unnecessary conflict. You may, for instance, wish to reach an agreement for patients undergoing treatments, such as orthodontics or implant treatment, where it may be preferable for you to continue the treatment and avoid the patient having to switch dentist mid treatment.

Communication is key

Unfortunately, when changing course in your career, it is not uncommon for issues to arise. As with many dentolegal issues, communication is the key to early resolution and avoidance of any unnecessary escalation. The value in parting on good terms cannot be overstated. Likewise, it is important to keep in touch with your former practice – updating them if your contact details change and, particularly in the early days and months after your departure, perhaps reaching out to them every once in a while to check in on how former patients are doing.

We hope that by following some of the above basic principles, any change in career direction can be easily managed with minimal stress. As always, Dental Protection's team of dentolegal experts remains on hand to answer any specific concerns that may arise before, during, or long after you have moved on to pastures new.

Reference

1. Dental Council Code of Practice relating to Professional Behaviour and Ethical Conduct (2022) at para 14.1 & 4.7.

Quiz

Submitted by Dr Cristiane da Mata.

Biologic width has been the term used to describe the height between the deepest point of the gingival sulcus and the crest of the alveolar bone.

1. What new term was introduced to replace biologic width, following the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases?
2. What is its average dimension?
3. What are the considerations regarding biologic width when restoring the lower right molar (46) shown in **Figure 1**?
4. You are planning a crown to restore the LR6. What procedure must be undertaken before restoration placement?

Answers on page 94.

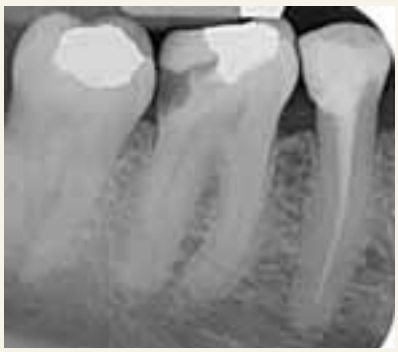
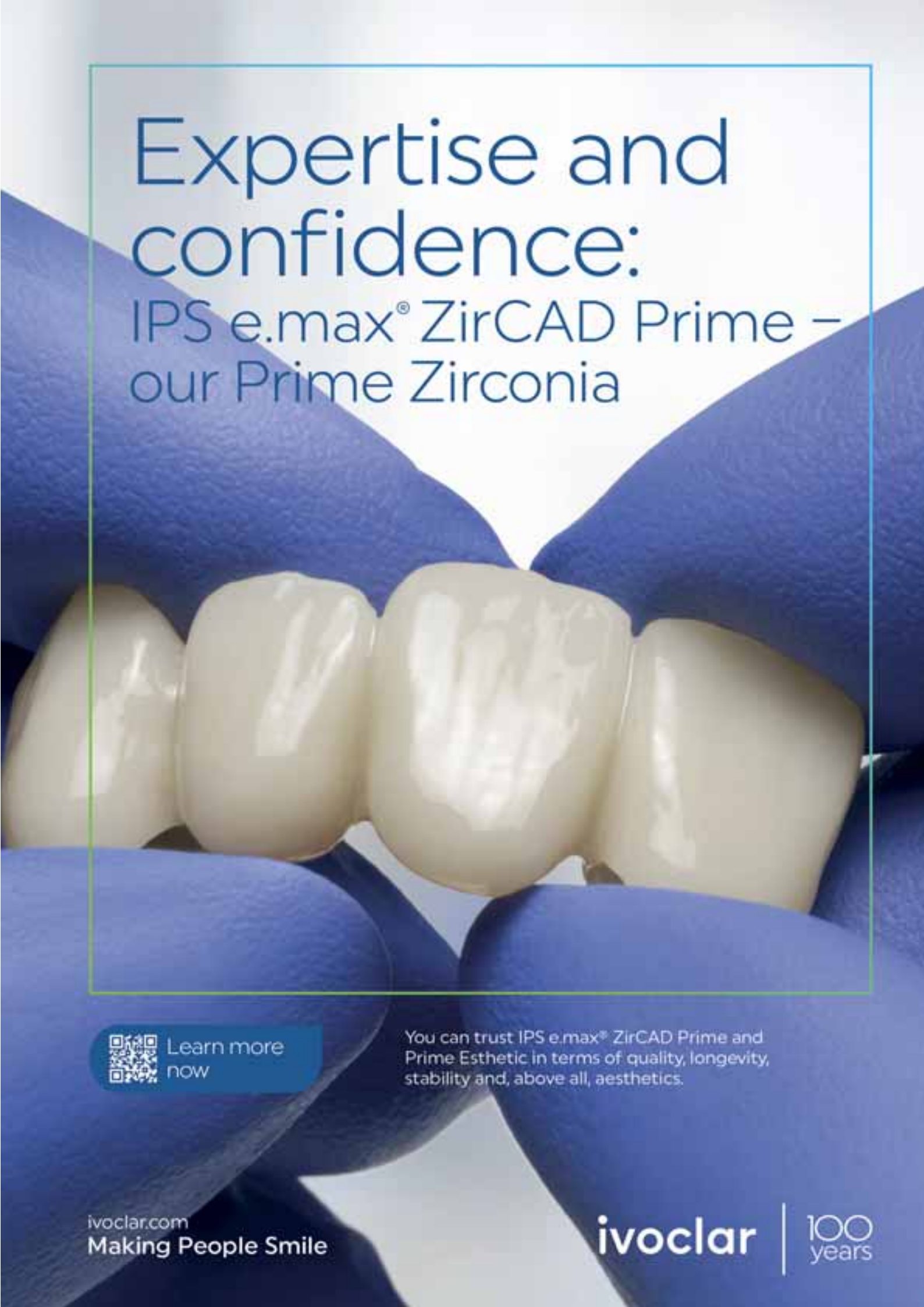


FIGURE 1: X-ray of lower right molar.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Subgingival instrumentation for the treatment of periodontitis

Treatment using subgingival instrumentation can reduce probing pocket depths, gingival inflammation and the number of diseased sites.

Background

Periodontal disease is the most common chronic inflammatory non-communicable disease in the human population. It is estimated that severe periodontitis affects 11% of the world's population, with prevalence increasing with age.[1] The diagnosis of periodontal disease includes history, examination and screening initially. Subsequently, a full periodontal assessment should be carried out where indicated (e.g., BPE Code 3, Code 4 and/or Code*). Radiographic assessment (periapicals or OPG/DPT) should be carried out where clinically justified. The diagnosis of periodontal disease is outside of the scope of this article; however, the author would recommend the use of the 2017 'Classification of Periodontal Diseases to Reach a Diagnosis in Clinical Practice' from the British Society of Periodontology (BSP)[2] to aid the diagnostic process.

What is subgingival instrumentation?

Subgingival instrumentation refers to all non-surgical procedures, either performed by hand (i.e., curettes) or with power-driven instruments (i.e., sonic/ultrasonic devices).

When is subgingival instrumentation indicated?

- To treat periodontitis in order to reduce probing pocket depths, gingival inflammation and the number of diseased sites; and,
- to remove subgingival biofilm and calculus – "cause-related therapy".[3]

What do I use for subgingival instrumentation?

It is recommended that subgingival periodontal instrumentation is performed with hand or powered (sonic/ultrasonic) instruments, either alone or in combination.[3]

Ultrasonic scalers

- **Magnetostrictive scaler (e.g., Cavitron select):** energy is converted to vibrations from the elliptical stroke patterns of the unit's metal rod or stack of metal sheets. All surfaces of the tip are active in the removal of debris (**Figure 1**).

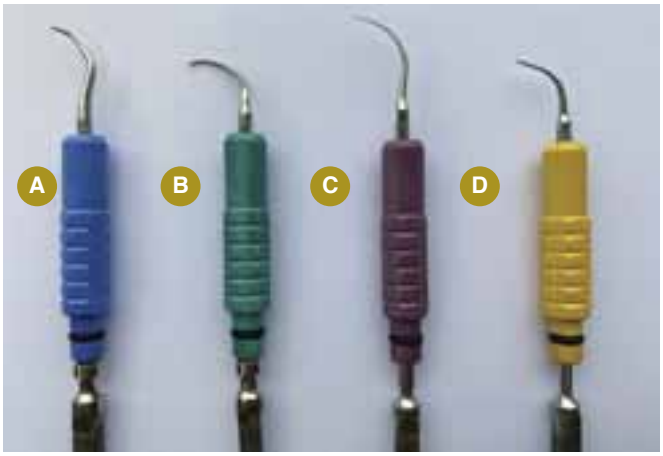

FIGURE 1: Cavitron Select ultrasonic tips: A: 'Powerline' ultrasonic insert – thicker insert with larger tip for efficient removal of heavier deposits; B: 'Slimline' ultrasonic insert – light to moderate calculus removal; C: 'Thinsert' ultrasonic insert – extra thin tip for access to difficult-to-reach areas, e.g., imbrications, interproximal surfaces and areas of tight tissues; and D: 'SofTip' insert – removes plaque and calculus around titanium implants and abutments.

FIGURE 2: Satelec scaler tips: A: tip no. 10X for supragingival scaling; B: tip no. 10Z for subgingival scaling – recommended for scaling pockets <4mm; and, C: tip no. 1 universal scaling tip recommended for simple cases and gross supragingival scaling.

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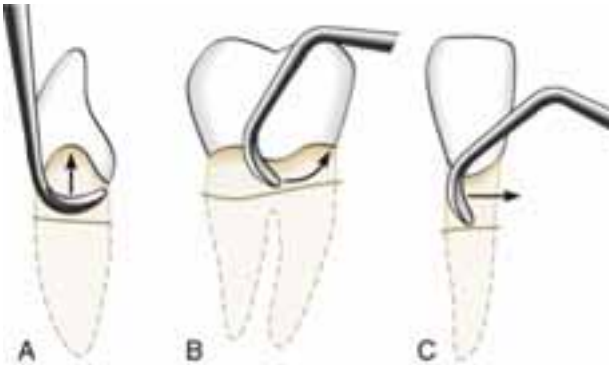

FIGURE 3: Illustration of subgingival scaling strokes: A: vertical; B: oblique; and, C: horizontal.

- **Piezoelectric scaler (e.g., Satelec):** strokes occur in a linear pattern via crystals activated by the ceramic handpiece. Only the lateral sides are effective in the removal of debris (**Figure 2**).

Protocol for use of an ultrasonic scaler:

- use a chlorhexidine rinse (0.2%) pre-operatively to reduce the number of viable bacteria sprayed onto the operator during scaling;
- use at half power with adequate water coolant;
- use light but firm pressure;
- hold tip parallel to long axis of the tooth;
- keep tip moving at all times to avoid damage to the root;
- always use the side of the ultrasonic insert, never the tip (the tip can be used for supra-gingival stubborn calculus deposits only);
- use short strokes, alternating between horizontal, vertical and oblique/crosshatch strokes (**Figure 3**), completely covering the root surface; and,
- ensure that the tip of the ultrasonic insert being used is not worn – the last 4mm of the insert is referred to as the tip's 'active' area.

Gracey curettes

How to use Gracey curettes:

- select the correct Gracey curette according to the colour coding in **Table 1**;
- insert working end passively and parallel to long axis of the root (review radiographs to assist with root morphology navigation);
- ensure secure finger rest;
- turn the 'toe' of the working end to engage the root surface; and,
- vertical, circumferential/horizontal and oblique/crosshatch strokes should be used **(Figure 3).**

Clinical tip

A disclosing agent (solution, gel or tablet) can be used pre-operatively before scaling, both as a patient motivator and also to help visualise and identify plaque biofilm on tooth surfaces supragingivally and subgingivally.

Guided biofilm therapy

Guided biofilm therapy (GBT) is a new regimen where there is a sequential removal of plaque and calculus by initially detecting it with a disclosing agent, followed by the use of air abrasive powder (typically glycine-based powder or erythritol powder) for the removal of plaque and stains. Finally, the subgingival plaque and calculus are removed with a specialised nozzle (**Figure 4**) and (if required) eventually scaled with a specialised tip. GBT involves removal of biofilm from surfaces above and below the gumline prior to the removal of calcified deposits.

Table 1: Gracey curette colour coding and recommended area of use.

Code	Colour	Colour	Area of use
1/2		Pink	All surfaces of anterior teeth
7/8		Green	Buccal and lingual surfaces of posterior teeth
11/12		Orange	Mesial surfaces of posterior teeth
13/14		Light blue	Distal surfaces of posterior teeth
15/16		Brown	Mesial surfaces of difficult posterior teeth
17/18		Purple	Distal surfaces of difficult posterior teeth
ODU		Lilac	Detection of subgingival calculus (sharp tip)

FIGURE 4: GBT Airflow Max Handpiece (EMS Dental).

Why use GBT?

Once the plaque biofilm (which is 'slimy' in nature) is removed from tooth surfaces (both supra and sub-gingivally), it is easier to tactically and/or visually identify remaining calcified deposits. Patients report that GBT is more comfortable than conventional scaling and root planing, and takes less time. It is an effective way of removing subgingival biofilm and can be used in conjunction with traditional ultrasonic and hand instruments when it comes to tenacious subgingival calculus deposits or heavy staining.

What instruments are used?

There are two types of nozzles used for air polishing, namely the supragingival and subgingival nozzle. The supragingival nozzle, otherwise known as the standard nozzle, is used to remove supragingival plaque and stains. On the other hand, subgingival nozzles can be used for the removal of subgingival biofilm and calcified deposits, as well as in the treatment of peri-implantitis. The subgingival nozzle typically features a clip-on, calibrated, sterile, single-use tip for precision subgingival application, and is approved for subgingival use in periodontal pockets up to 5mm (US Food and Drug Administration).

How do I use the subgingival nozzle?

- Insert nozzle tip to the bottom of the pocket and pull the nozzle back 1mm and later activate the spray; and,
- move nozzle continuously in a vertical-incisal motion to cover the entire length until removed from the pocket for about five seconds.

When do I review my patient following subgingival instrumentation?

Patients should be reviewed three months after undergoing subgingival instrumentation (with or without the use of systemic antimicrobials as determined by the treating practitioner). The maintenance protocol for a patient with a stable periodontium (i.e., bleeding on probing (BoP) <10%, pocket probing depths (PPD) ≤4mm and no BoP at 4mm sites)[2] should be:

- supportive periodontal care;
- reinforce oral hygiene, risk factor control, and behaviour change;
- regular targeted professional mechanical plaque removal (PMPR) as required to limit tooth loss; and,
- consider evidence-based adjunctive efficacious toothpaste and/or mouthwash to control gingival inflammation.

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Quiz answers

Questions on page 90.

1. Supra-crestal attachment.

2. 2mm. However, as this is hard to measure clinically, when preparing crown margins, a figure of 3mm is used taking into account possible measurement errors.

3. The radiograph shows that the carious lesion margin is less than 1mm from the crestal bone. Placing a restoration there would impinge on the supracrestal attachment and a constant inflammation would be created as a result. This would be made worse by the patient's inability to clean this area, with a risk of alveolar bone resorption. The body will attempt to recreate room between the alveolar bone and the margin to allow space for tissue reattachment.

4. Crown lengthening.

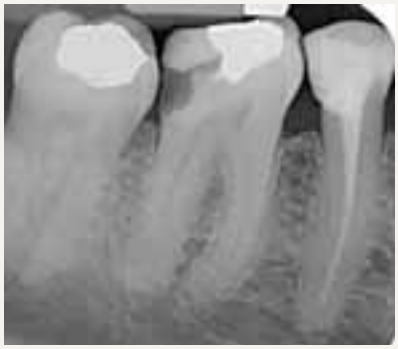

FIGURE 1: X-ray of lower right molar.

Senior academics' perceptions of undergraduate prosthodontics curriculum and teaching: a qualitative study

Précis

Divergence in undergraduate teaching methods in prosthodontics could impact on graduate dentists' competence and affect patient safety, especially with mobility of dentists internationally. This study highlights the need to minimise this divergence.

Abstract

Introduction: Divergence in undergraduate teaching methods in prosthodontics is widely reported, and this could impact on graduate dentists' competence and affect patient safety.

Objectives: To explore the perspectives held by senior dental academics worldwide regarding the undergraduate prosthodontics curriculum, teaching and assessment methods, and teaching staff profile.

Materials and methods: Twelve senior dental academics from seven countries participated in semi-structured interviews exploring their perspectives and opinions of the undergraduate prosthodontics curriculum, and current and best teaching and assessment methods. Interviews were undertaken virtually, video-recorded and auto-transcribed. Semantic thematic analysis was used for data analysis.

Results: Academic professors, consultants and specialists were considered the most suitable staff members to supervise students during preclinical hands-on sessions due to their experience level. Additionally, participants mentioned the availability of suitable patients for treatment, dental schools' curricula, and the level of students' skills as factors influencing the start of clinical sessions in fixed prosthodontics. The course contents and the extent of teaching on dental implants were different between schools. Tailoring the curriculum according to what is expected from the graduating dentists and allowing students to observe dental implant cases before dealing with simple cases were suggestions made by the participants, to include an implant course at undergraduate level.

Conclusions: Despite some differences in opinions and current practices in different institutions, barriers to the implementation of an ideal curriculum seemed to be similar in the different institutions. This study provided deeper understanding of the current divergence in prosthodontics teaching, which would allow for future improvement in the dental curriculum.

Journal of the Irish Dental Association April/May 2023; 69 (2): 95-100

Introduction

Prosthodontics is a broad and complex course consisting of four main disciplines: complete dentures (CDs); removable partial dentures (RPDs); fixed prosthodontics (FPs), (which include crowns and bridges); and, dental implants (DIs). Learning of these disciplines may start at the early stages of dentistry courses and continue until the completion of the bachelor's degree.[1] Traditionally, undergraduate dental education engages students in lectures for basic sciences along with dental sciences and laboratory settings during the first two years of their preclinical training. Afterwards, clinical subjects and training are introduced until the end of the programme, followed by one year of internship or vocational training (dental

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Table 1: Study participants' demographic information.

Sequence number	Participant's title	Years of experience	Country
01	Consultant/Senior Lecturer*	Less than 5 years	Ireland
02	Professor**	More than 15 years	New Zealand
03	Professor	More than 20 years	Singapore
04	Consultant/Senior Lecturer	More than 10 years	United Kingdom
05	Associate Professor	More than 20 years	United States
06	Assistant Professor	Less than 10 years	Singapore
07	Professor	More than 20 years	United Kingdom
08	Assistant Professor	Less than 10 years	Qatar
09	Associate Professor	More than 20 years	Australia
10	Professor	More than 15 years	United States
11	Professor	More than 10 years	United Kingdom
12	Associate Professor	Less than 10 years	Ireland

*Professor, associate professor, assistant professor and senior lecturer are academic titles.
**All professors were consultants but not all consultants were professors.

foundation training) in some countries.

However, dental school programmes around the world are not similar and programme curricula are tailored according to various aspects such as available resources, but mostly according to local dental council guidelines. As a result, discrepancies in undergraduate prosthodontics curricula, and dental students' teaching and assessment methods, can be seen nationally and internationally.[2,3] In addition, discrepancies in the teaching and assessment methods of the four disciplines in prosthodontics have also been reported in the literature.[4-11] These differences encouraged organisations such as the Association for Dental Education in Europe (ADEE) to set a well-justified and harmonised basis for training high-quality dentists by promoting convergence towards a higher standard of dental education, training and service to the ultimate benefit of patients. Furthermore, the ADEE called on dental schools for further refinement and harmonisation of the dental undergraduate curricula across Europe, which are also recommended to be applied internationally.[12]

In the first phase of this study, a comprehensive survey was conducted using the Delphi method.[13] Delphi methodology is a process used to arrive at a group opinion or decision by surveying a panel of experts. It has been used to determine the range of opinions on particular matters, to test questions of policy or clinical relevance, and to explore or achieve consensus on disputed topics.[14] The aim was to investigate what the best teaching and assessment methods in prosthodontics are, and to attain consensus among senior academics in dental schools internationally. Although consensus was achieved in the majority of the areas assessed, there were still some divergent opinions regarding some teaching and assessment methods, such as "who would be most suitable to supervise students during the hands-on/practical skills sessions?", and "who would be most suitable to supervise students during the clinical sessions?".

Therefore, this qualitative study aimed to further explore the perspectives and opinions held by senior dental academics worldwide regarding undergraduate prosthodontics teaching and assessment methods.

Materials and methods

Participants and setting

The study participants included senior dental academics who are active in teaching undergraduate prosthodontics, nine of whom had taken part in Phase 1 of this study (Delphi study).[13] An invitation email was sent including the study information leaflet, the consent statement and a hyperlink to a meeting organiser form using Google Forms. Participation in the study was voluntary and completing the meeting organiser form was considered an agreement to participate. In addition, verbal consent was obtained at the beginning of each interview. The interviews were conducted until data saturation was reached. This is when the participants' responses do not provide new information or new themes for analysis.[15]

Ethical approval

Ethical approval (Log 2021-063A1) for this study was granted on February 4, 2022, by the Social Research Ethics Committee (SREC) at University College Cork, Ireland.

Interview procedure

A semi-structured interview guide, including nine open-ended questions followed by prompting questions to probe into details, was followed during interviews to elicit responses about current and best teaching and assessment methods in undergraduate prosthodontics. Topic guide questions were taken from our previous work using the Delphi method, and these included questions that had not reached consensus. The interviews were conducted virtually via Microsoft Teams or Zoom. Interviews were undertaken in March 2022 and lasted between 10 and 30 minutes; they were video-recorded, auto-transcribed, and all transcripts were checked by the lead researcher to ensure verbatim transcriptions.

Thematic analysis process and coding

After transcription, phrases were first coded into "current teaching and assessment methods", "ideal or best teaching and assessment methods", and "sub-themes", such as "teaching challenges and their resolution". The initial codes were then peer validated by a second researcher to ensure the rigour and appropriateness of the codes (NVivo 12 Software).

Results

Twelve senior dental academics who are active in teaching undergraduate prosthodontics participated in this study (five professors, three associate professors, two assistant professors and two consultants/senior lecturers). The participants were from seven countries, namely Australia, Ireland, New Zealand, Qatar, Singapore, United Kingdom, and United States (**Table 1**). Out of the 12 interviews, 322 phrases were identified and coded, followed by thematic analysis. These phrases were assigned to nine main themes and a number of sub-themes associated with ideal teaching methods, challenges in teaching, and how the challenges could be resolved (**Figure 1**).

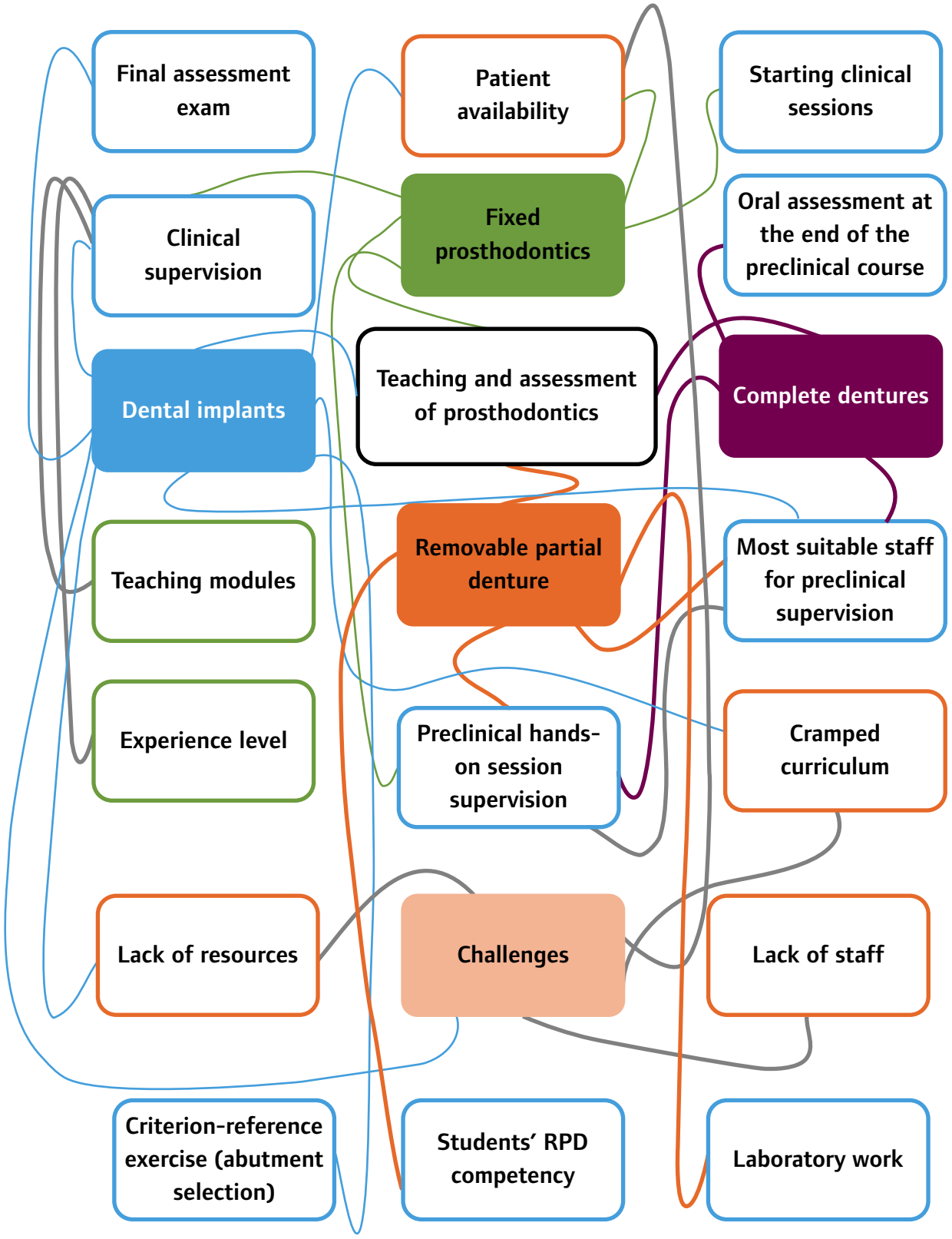

FIGURE 1: Study's emerging themes and sub-themes.

Teaching and assessment methods in removable and fixed prosthodontics

Five participants stated that senior lecturers currently supervise students during the hands-on preclinical sessions on the CD, RPD and FP courses in their teaching institution. In the remaining schools, these sessions are supervised by consultants or specialists (4), general dentists (2) and lecturers (1).

Experience was considered the most important factor in deciding who is the best member of staff to supervise students in the pre-clinical hands-on sessions:

"…depending on the experience rather than the actual title if you like…" (04).

"…it's important when you're given the preclinical and all the theory that it's someone with some academic background as well as having their clinical expertise in that area…" (12).

A lack of academics at professor level was one of the reasons for members of staff at junior level to currently supervise students in some institutions:

"…few clinical academics who are professors. We've got four, and so, the reason I selected senior lecturer was because of that…" (02).

The majority of participants believed that the beginning of clinical sessions of FP should happen in the third year of the course (6). Three participants stated that beginning these sessions in fourth year is ideal:

"…I would say third, if the earlier the better to start always, but you need to consider what are the previous experiences or where it's located in relation to other disciplines in the curriculum? … So, it's never that alone, it's that in combination with a multitude of other things…" (05).

"…In fourth year, because the students have time to develop the skills to get patients dentally fit as well before doing fixed prostheses…" (02).

Applying an "integrated curriculum" in one dental school allows students to start the clinical FP sessions during the second year.

Table 2 illustrates the teaching staff currently supervising students in CD and RPD clinical sessions.

Participants from dental schools that have lecturers and general dentists to supervise CD and RPD clinical sessions explained that:

"…For conventional dentures and partial dentures, I would be OK with it being a generalist, and again, that could be somebody at lecturer level … generalist because they are the ones treating more cases of CDs and RPDs, and the amount of people who are comfortable teaching removable prostheses, in my experience, is going in that direction…" (pointed down) (03).

Most participants' opinions were that those who supervise students in clinical sessions should be familiar with module teaching:

"…they do not have to be involved with the teaching of the module, but they should be familiar with it…" (07).

Some 50% of participants (6 out of 12) believed that it is important for students to complete the laboratory work of the acrylic RPD (one to two cases) by themselves in order to gain experience:

Table 2: Teaching staff supervising students during the clinical sessions of removable prosthodontics (CD and RPD).

Staff member level	Number of dental schools
Consultant/specialist	3
Senior lecturer	4
Lecturer	2
General practitioner	2
Dental technician	1
Total	**12**

"…I don't think it's important that they do all of their own lab work, but I think it's useful for them to get experience, one or two cases just to get experience…" (03).

The other half considered it "not important" but desirable. The lack of resources or the overcrowded curriculum were reasons why it is not currently done in those schools:

"…I would say that it would be ideal if they could do the lab work, but practically the reason that we don't sustain that now is because of the curriculum. We just don't have space so ideally, yes, practically, no…" (02).

The majority of participants (9 out of 12) believed that oral assessments at the end of preclinical CD courses are not important.

"…if you're looking to assess theoretical knowledge, I don't think oral examination is the best way to do it. I prefer competency testing…" (03).

"…if you're doing a good simulation assessment or a good clinical assessment associated with a written exam…well, you don't need an oral examination…" 0(05).

Teaching and assessment methods in dental implants course

Half of the participants (6 out of 12) have a DI course, either preclinical only or preclinical and clinical, and consultants or specialists were considered to be the most suitable members of staff to supervise students in six dental schools, whereas senior lecturers (5) and lecturers (1) were considered suitable in the remaining schools.

Most of the participants considered DIs too advanced for undergraduate level or difficult to teach due to overcrowded curricula:

"…as things progress that may change in the future where restoring implants may become part of the undergraduate curriculum but at the moment I don't see space for that and I don't see it as a priority…" (01).

"…I think it's probably too advanced, certainly in our institution, we cannot incorporate that as part of the undergraduate education, but it is important for them to know the theoretical steps. I think beyond the scope of undergraduate education at the moment – five-year course…" (04).

Four out of the six dental schools that have a DI course set a minimum competence level for their students:

"…I would say, a single tooth for replacement, like a single crown and overdenture,

lower overdenture case. I think that would be the minimal competence they should be able to do. It executes the prosthodontic phases…" (05).

Challenges in undergraduate prosthodontics teaching

Some challenges regarding teaching of the undergraduate prosthodontics course were identified during this study and solutions to these were also suggested by participants.

An overcrowded curriculum was considered by participants to be one of the greatest challenges in the teaching of undergraduate prosthodontics. It was pointed out as an obstacle to building students' skills and to adding new course material to the curriculum:

"I think there's a lot to fit into the undergraduate curriculum, and treatment has become more complex…I think there is a challenge to get them enough experience and enough cases and treating…" (01).

Updating the curriculum regularly and starting the clinical sessions as early as possible were suggested as ways to overcome this problem.

Participants considered the curriculum, patient availability, and lack of resources as barriers to incorporating the teaching of DIs at undergraduate level:

"…Ideally yes, teaching dental implants in the programme…the more that we can have students competent on graduation across the full range of industry the better…" (02).

"…Practically, it becomes quite difficult to actually make it really effective because of the surgical disciplines and availability of patients…" (02).

Participants suggested some ways of incorporating/including DI teaching into the undergraduate curriculum, such as adjusting the curriculum according to what is expected from the graduating dentists, and allowing students to observe DI cases and then start dealing with simple and straightforward cases.

Discussion

This qualitative study explored topics in prosthodontics teaching and assessment methods. We demonstrated the divergence between participating dental schools and revealed to some extent the background of this divergence, which enabled us to understand the views of senior academics from four different continents. Nine prosthodontics teaching and assessment topics that did not reach consensus in our previous study[13] were investigated. Of them, only the oral assessment at the end of the preclinical CD course topic reached consensus (not important) among the participants (9 out of 12). In comparison, the divergence in the remaining topics was clear between the participating dental schools. This divergence is attributed to several factors, such as the overcrowded curriculum, lack of experienced senior academics and lack of resources. In addition, the difference in the participants' opinions was clear between what teaching or assessment methods are currently used and what is ideal or should be applied. However, the ideal method was not always similar between the participants. For instance, some participants believed that teaching the prosthetic part of the DI course is the ideal. On the other hand, some participants believed that being familiar with the DI indications and considerations and then referring the patient is the ideal at undergraduate level.

During the preclinical hands-on practical sessions in CD, RPD and FP, the majority of participants agreed that the level of experience is the most important factor in determining who is the most suitable to supervise students. These findings are similar to what was reported by Lynch *et al.* as they reported that members of staff who most currently supervised the removable prosthodontics clinical sessions were senior lecturers, followed by consultants or specialists.[7] However, dental schools that selected junior members of staff to supervise the removable prosthodontics sessions did so either due to the refusal of some members of staff to supervise these sessions, or due to the lack of senior academic members, as previously reported.[8] Overall, the staff's level of experience was considered as an important factor when deciding who should supervise students.

Being involved in the module teaching was also found to be the most important consideration when choosing the most suitable members of staff to assess students' competence level during RPD clinical sessions. In regard to students' completion of laboratory work on their own RPD cases, half of the participating schools considered it important for students to complete at least one or two cases in order to gain experience, whereas schools that did not consider the laboratory work as an important skill for their students mentioned lack of resources and overcrowded curriculum as challenges they face.

Moreover, half of participating schools commence the FP clinical sessions in year three of the five-year course, followed by year four, which is comparable to the findings of a previous study.[2] However, applying an integrated curriculum allows one school to commence the FP clinical sessions in year two. Commencing FP clinical sessions was also reported to be subject to various factors, such as the availability of suitable patients for treatment, the school's curriculum and the level of student skills. In 2017, a study reported that early clinical exposure in prosthodontics will help to solve many problems encountered during learning and contribute to a better understanding.[1] Similarly, two studies in 2018 and 2020 found that students' confidence levels in carrying out prosthodontics treatment would be improved further by increasing clinical experience.[16,17]

DI course material complexity and the staff's level of experience were the main reasons for participating schools to select consultants or specialists as the most suitable members of staff to supervise the preclinical hands-on sessions, and the clinical sessions if available. Dental schools that set a minimum competency level for their students expect them to know how to assess patients, treatment plan, be familiar with medical considerations, and restore at least one or two DIs (prosthetic part only). Most of the participants believed that the DI course is too advanced for undergraduate students and it is only suitable for postgraduate students. In contrast, the ADEE[12] and the European Workshop of Dental Implant Education[18,19] recommend that dental schools update their curricula and incorporate a DI course in undergraduate programmes.

The overcrowded curricula, lack of resources and the lack of availability of patients were found in the current study to be the contemporary challenges that prevent some of the participating dental schools from teaching DIs; similar challenges were reported by Chin *et al.* in 2018.[20] Tailoring the curriculum according to what is expected from the graduating dentists and allowing students to observe DI cases before dealing with simple and straightforward cases were suggested as ways of overcoming some of these challenges. It was recommended that further development and improvement of implant teaching in dental undergraduate schools in the UK and Ireland are required, particularly with respect to the amount of direct clinical experience provided.[20] It was also suggested by a recent study that knowledge of DIs should be enhanced among undergraduates by conducting more structured teaching programmes, and this should positively impact on dentists' future clinical practice.[21]

Conclusion

This qualitative study presented a deeper understanding of the current divergence in prosthodontics teaching and assessment methods. These results could be considered as a reference to develop recommendations for stakeholders involved in undergraduate curricula in dental schools worldwide.

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CPD questions

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

IDA irish dental association

CPD

1. The Association for Dental Education in Europe (ADEE) was encouraged to set a well-justified and harmonised basis for training high-quality dentists because:

- ○ A: There are discrepancies in undergraduate dental students' teaching and assessment methods
- ○ B: Dental curricula should be the same everywhere
- ○ C: Dentists are not currently being well trained
- ○ D: The dental councils should not influence curricula

2. Programme curricula in dental schools are tailored according to various aspects such as:

- ○ A: Available resources
- ○ B: Local dental council guidelines
- ○ C: Patient needs
- ○ D: All of the above

3. In this study, what were considered the barrier(s) that prevent dental schools from incorporating the teaching of dental implants at undergraduate level?

- ○ A: Overcrowded curriculum
- ○ B: Patient availability
- ○ C: Lack of resources
- ○ D: Dental implants course is too advanced for undergraduate students
- ○ E: All of the above

Oral ulceration

Abstract

General dental practitioners (GDPs) frequently encounter patients presenting with oral ulceration. Oral ulceration has a variety of aetiologies and clinical presentations, which can aid in the diagnosis and management of the condition. This article discusses the different aetiologies, classical clinical findings, and management regimes for oral ulceration. Furthermore, this article will also support GDPs to identify cases of oral ulceration that may require referral to a secondary care setting.

Learning outcomes

- To recognise the common causes of oral ulceration and their classic clinical appearance;
- to discuss appropriate management strategies for oral ulceration in the primary dental setting; and,
- to develop an awareness of when patients with oral ulceration should be referred to secondary care.

Introduction

Oral ulceration is a painful, common clinical finding, affecting up to 25% of the population, with many seeking advice and treatment from their general dental practitioner (GDP). The aetiology of oral ulceration can range from trauma to the oral mucosa, to an underlying systemic disease, a side effect of medications, or recurrent aphthous stomatitis (RAS). Rarely, an ulcer may be the presenting finding of an intraoral malignancy. Therefore, it is essential to understand the aetiology of the ulceration as this underpins its management.

Ulceration may be managed within the primary dental care setting by removing any causative factors, such as trauma sources if present, and managing the patient's symptoms with topical treatments such as local anaesthetic sprays and topical corticosteroids. In some cases, liaising with the patient's general medical practitioner (GMP) may be necessary, in order to investigate any underlying deficiency states (iron, B12, folate) or systemic diseases. However, in cases involving ulceration resistant to topical treatments, severe ulceration or suspected malignancy, referral to a local oral medicine or oral and maxillofacial unit is required.

Aetiology of oral ulceration

Traumatic ulceration

Trauma to the oral mucosa from a fractured tooth, a sharp cusp or a denture clasp may result in the formation of an ulcer (**Table 1**). In these cases, ulcers are variable in size and appearance (**Figure 1**). They are often painful with raised white borders with a yellow base, and tend to affect the buccal mucosa, tongue, and lower lip.

Table 1: Traumatic ulceration aetiology, management and review.

Aetiology	■ Direct trauma to the intraoral mucosa
Management	■ Photograph of ulcer (to aid monitoring at review appointment) ■ Removal of any identified traumatic sources ■ Benzydamine oromucosal spray 0.15% may be prescribed for symptomatic relief
Review	■ Review the patient two weeks following the removal of the suspected traumatic cause ■ Consider referral to oral medicine/oral and maxillofacial surgery (OMFS) if no improvement to ulcer after two-week review

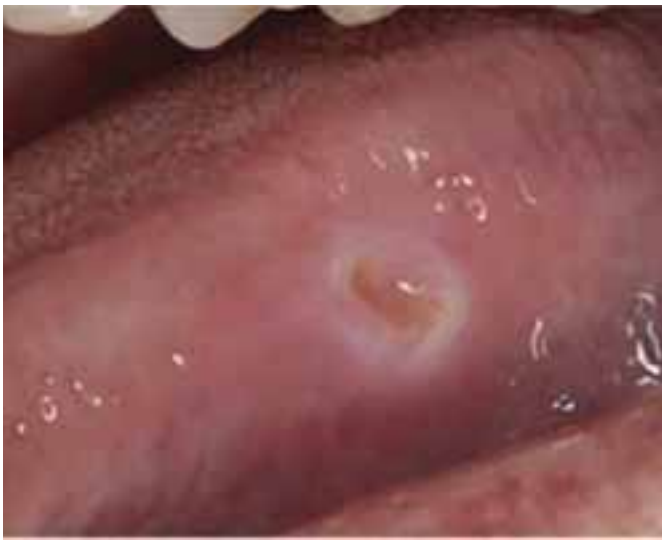

FIGURE 1: Traumatic ulcer.

Recurrent aphthous stomatitis

RAS ulceration usually affects the non-keratinised mucosa. Its aetiology is unclear, but it is thought to be driven by a dysfunctional cell-mediated immune response (**Table 2**).[1] Predisposing factors include: stress; trauma; deficiency states (iron, B12 or folate); smoking cessation; menstruation; or, the use of sodium lauryl sulfate-

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Table 2: RAS ulceration aetiology, management and review.

Aetiology	■ The aetiology of RAS is unclear but is likely due to a dysfunctional cell-mediated immune response
Management	■ Trial an SLS-free toothpaste ■ Ask patient to keep an ulcer diary to record features of ulcers between appointments ■ Liaise with the patient's GMP for blood investigations (full blood count, haematinics) ■ Benzydamine 0.15% mouthwash or benzydamine spray for symptomatic relief ■ Consider topical corticosteroid preparations if local analgesic measures are insufficient
Review	■ Review with results from blood investigations and assess management of symptoms ■ Refer to oral medicine/OMFS if symptoms are poorly controlled or RAS is severe

Table 3: Systemic-cause ulceration aetiology, management and review.

Aetiology	■ The aetiology for ulcers occurring secondary to systemic disease is varied depending on the underlying condition
Management	■ Enquire whether a patient with ulceration is experiencing any other symptoms, e.g., skin rashes, genital ulceration, change in bowel habit ■ Manage oral ulcers with topical corticosteroids and local analgesic preparations ■ Refer to GMP for further investigation and management of systemic disease ■ Refer to oral medicine/OMFS for biopsy if unusual or very extensive ulceration with systemic features
Review	■ Once the patient's systemic disease is under control and ulceration managed, the GDP should review the patient at least every six months for any relapses with regard to their oral symptoms

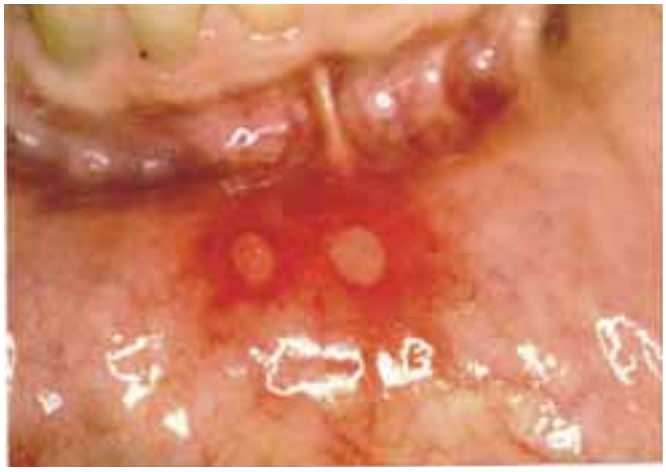

FIGURE 2: Minor aphthous ulcer.

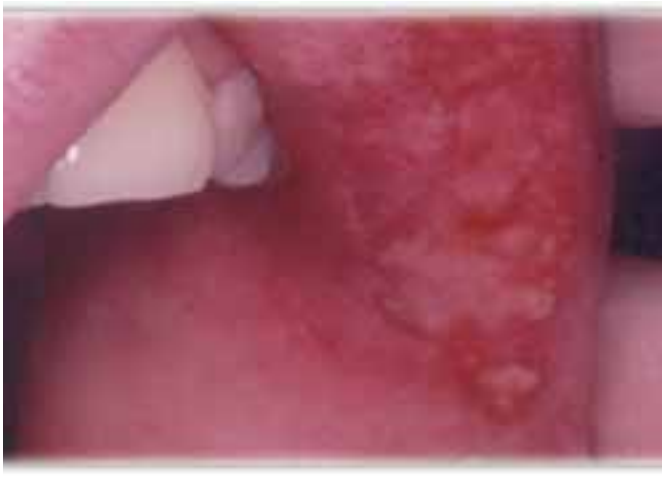

FIGURE 3: Herpetiform ulceration.

(SLS) containing toothpaste. There are three distinct forms of aphthous ulceration, which are characterised by:

- the size of the ulcer;
- the number of ulcers present at one time;
- the length of time to resolve; and,
- the presence of any scarring after healing.

Types of RAS

Minor aphthae: painful small ulcers (usually <1cm), have a fibrinous base surrounded by a red inflammatory halo and occur on the non-keratinised mucosa. Ulcers appear in crops of one to six that heal within 10 days in the absence of scarring (**Figure 2**).

Major aphthae: differ from minor aphthae in their size (>1cm), pain and healing time, which will usually be several weeks. When major aphthae heal there can be scarring present.

Herpetiform ulceration: the least common form of RAS. These are multiple pinpoint ulcers ranging in size from 1-3mm that are markedly painful and coalesce into larger ulcers after a few days. They can take approximately 14 days to heal but do not scar, helping to differentiate them from major aphthae. They tend to affect the ventral tongue and upper lip (**Figure 3**).

Systemic causes

Systemic disease can result in ulceration, which has the same clinical features as ulceration in RAS. However, the aetiology differs from RAS as the ulceration is secondary to the systemic disease rather than due to immune dysregulation in RAS.

Gastrointestinal diseases such as coeliac disease or Crohn's disease may cause oral ulceration. It can be helpful to ask any patient presenting with ulceration whether they have had any gastrointestinal symptoms (**Tables 3** and **4**). An onward referral to the patient's GMP would be prudent for further investigation.

Table 4: Oral ulceration and oral signs secondary to systemic disease.

Body system	Systemic disease	Key oral features of the condition
Gastrointestinal	Crohn's disease	■ Aphthous-like ulceration and linear ulceration in sulci ■ 'Cobblestoned' appearance of buccal mucosa ■ Swelling of the labial and buccal mucosa ■ Angular cheilitis ■ Stag horning of the floor of the mouth
	Ulcerative colitis	■ Aphthous-like ulceration ■ Pyostomatitis vegetans ■ Glossitis
Haematological	Leukaemia	■ Generalised oral ulceration ■ Spontaneous gingival bleeding ■ Gingival hyperplasia ■ Petechiae haemorrhages ■ Opportunistic infections
	Anaemia	■ Recurrent oral ulceration ■ Mucosal pallor ■ Glossitis
Mucocutaneous	Lichen planus (erosive type)	■ Irregular, large painful erosions or ulcers occurring on the tongue, vermillion border or the buccal or labial mucosa, which are slow to heal ■ Scarring on the site of a healed erosion may occur ■ Desquamative gingivitis
	Beçhet's disease	■ Recurrent aphthous-like ulceration is often the first sign prior to the onset of genital ulceration or ocular manifestations such as anterior uveitis ■ Arthralgia ■ Skin manifestations
Miscellaneous conditions	Reactive arthritis (Reiter's syndrome)	■ Superficial small ulcers affecting the tongue, palate, and buccal mucosa ■ Lesions on the tongue, which closely resemble geographic tongue
	Lupus erythematous	■ Superficial ill-defined ulcers affecting the palate, buccal mucosa and tongue, which lack an erythematous halo ■ 'Sun-ray'-like lesions ■ Xerostomia ■ Burning sensation affecting the oral mucosa ■ Butterfly malar rash
Infective	Primary herpetic gingivostomatitis	■ Multiple yellow vesicles with a red halo affecting buccal mucosa, tongue, palate, pharynx, lips ■ Submandibular or cervical lymphadenopathy
	Herpangina	■ Diffuse erythema affecting the soft palate and tonsillar region ■ Multiple vesicles and ulcers

This may initially include blood investigations to detect any deficiency states resulting from blood loss or malabsorption, and a faecal calprotectin test, which may be elevated in patients with active gastrointestinal inflammation. The patient's ulceration can be managed symptomatically in the same way as with RAS. However, appropriate management of their gastrointestinal disease may lead to the resolution of the ulceration.

Multisystem inflammatory disorders such as Beçhet's disease and MAGIC syndrome (a rare syndrome characterised by features of both Beçhet's disease

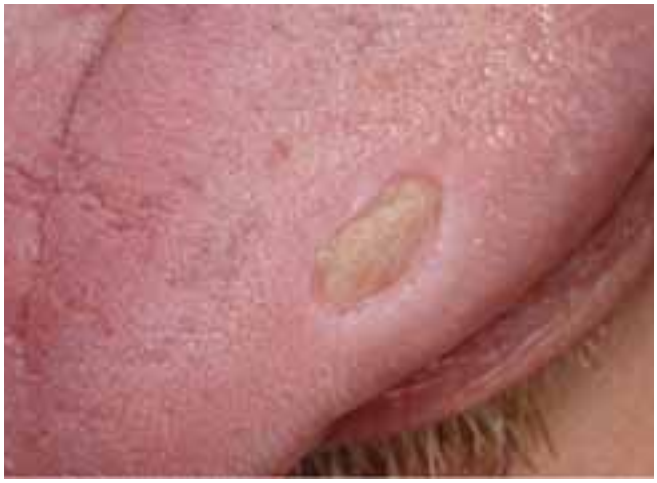

FIGURE 4: Nicorandil-induced ulceration.

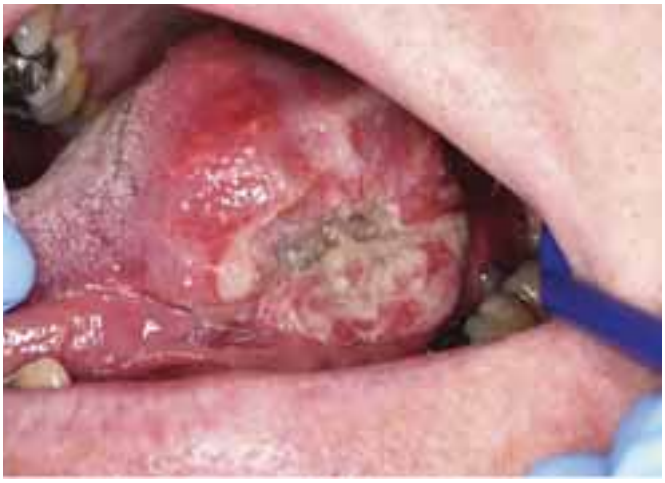

FIGURE 5: Ulcerated OSCC lateral border of tongue.

and the recurrent inflammation of cartilage as seen in relapsing polychondritis) can also cause oral ulceration. These patients may also suffer from genital ulceration and ocular manifestations.[2] Therefore, when taking an ulcer history, it is important to enquire if patients experience ulceration on other body sites. Various autoimmune conditions can cause extensive oral ulceration. Pemphigus vulgaris affects the oral mucosa (as well as other mucous membranes) causing vesicles, which quickly burst to leave superficial erosions with ragged edges before the onset of skin vesicles or bullae, which also break down to give painful ragged erosions. Patients presenting with these symptoms should be urgently referred to an oral medicine consultant or dermatologist for assessment and management, which involves immunosuppressive treatment.

More commonly seen in patients presenting to their GDP is lichen planus. In its erosive form, there are shallow areas of ulceration with a yellow fibrin plaque covering the surface of the erosion. Sometimes these patients will have striae at the periphery of the ulcerated area and may also have skin involvement with <5mm itchy purplish papules with a shiny surface, and striae often on the forearms and wrists.

Drug-induced oral ulceration

Oral ulcers may be induced by systemic medications and can present as single or multiple areas of ulceration.[3] Drug-induced ulcers are typically flat with a whitish base and a raised clear margin (**Figure 4**). These ulcers tend to be resistant to topical treatments. Below is a list of the classes of medications, which are often linked to drug-related ulceration:

- antihypertensives (e.g., bisoprolol);
- bisphosphonates (e.g., alendronic acid);
- immunosuppressants (e.g., methotrexate);
- potassium channel activators (e.g., nicorandil); and,
- antimalarials (e.g., chloroquine).

Should drug-induced ulceration be suspected, you should liaise with the patient's GMP or the consultant who prescribed the medication to enquire if the dosage could be reduced or temporarily stopped to allow healing of the ulcer (**Table 5**).

Patients undergoing chemotherapy (and those receiving radiation to the head and neck region) may develop oral mucositis. This is a very painful condition causing inflammation and widespread ulceration of the oral mucosa, which usually develops four to seven days after starting a chemotherapy regimen. The ulcers tend to be deep with an irregular outline occurring on the non-keratinised mucosa and have a fibrinopurulent exudate. These patients will usually be closely reviewed by their oncologist, who will often manage the oral mucositis. Typical management involves chlorhexidine digluconate 0.2% mouthwash to prevent secondary infection, as well as local analgesics and mucosal coating agents such as Gelclair. The patient will also often receive systemic analgesia and their dose of chemotherapy may be adjusted to enable the resolution of the mucositis, which usually occurs in two to four weeks.

Table 5: Drug-induced oral ulceration aetiology, management and review.

Aetiology	■ Drug-induced ulceration is commonly linked to starting or increasing dosages of antihypertensive, immunosuppressant, bisphosphonate, potassium channe activator, or antimalarial medications
Management	■ Benzydamine 0.15% spray applied directly to the ulcer to aid symptomatic relief or mouthwash if ulceration is widespread or inaccessible ■ Contact the patient's GMP to enquire if the dose of the medication can be temporarily reduced or stopped to allow for healing of the ulcer
Review	■ Review at three weeks ■ Refer to oral medicine/OMFS if the ulcer still persists after three weeks with no sign of improvement

Malignancy

The most common intra-oral malignant neoplasm is oral squamous cell carcinoma (OSCC), which clinically can present as a non-healing ulcer (**Figure 5**). While an OSCC can develop at any site within the mouth, the most common sites are the floor of the mouth, the postero-lateral tongue border, and the gingivae.

A clinician should be suspicious of OSCC in any patient who is presenting with a solitary unexplained ulcer, which is persistent (>14 days), particularly if they have

Table 6: Malignancy-caused ulceration aetiology, management and review.

Aetiology	■ The aetiology of an OSCC is multifactorial – risk factors in its development include: 1) tobacco use; 2) betel nut or paan consumption; 3) excessive alcohol consumption; or, 4) past personal or family history of oral cancer
Management	■ Thorough history and examination ■ Correct any potential traumatic causes of the ulcer if detected
Review	■ Refer a suspected cancer pathway to a local oral and maxillofacial department for assessment plus or minus a biopsy if suspicious of malignancy

any risk factors for the development of an OSCC including tobacco or betel nut use, heavy alcohol consumption, or past or family history of oral cancer (**Table 6**). Other worrying symptoms include unexplained paraesthesia of the lower lip or tongue, and an unexplained persistent lump in the neck.

The classical clinical features of an ulcerated OSCC involve an ulcer with raised rolled margins and which is indurated on palpation. These ulcers rarely cause pain, but patients may report discomfort in the later stages, as well as a tendency of the ulcer to bleed to mild trauma or spontaneously.

After taking a thorough history from the patient and examination, if a practitioner suspects the ulcerated area represents oral cancer the patient should be referred urgently to their local oral medicine/oral surgery or maxillofacial department for assessment, confirmation of diagnosis and onward management.

Case report

A 56-year-old female was referred to the Oral Medicine Department at Belfast Royal School of Dentistry for a non-healing ulcer on the left lateral border of her tongue. She reported that this ulcer was painful on contact with foods and had been present for six weeks. The patient had no recollection of any preceding trauma or cause.

Her past medical history included eosinophilic granulomatosis with polyangiitis that was being managed with rituximab. She was otherwise fit and well. She was a non-smoker and did not consume alcohol regularly.

Extraoral examination did not display any cervical lymphadenopathy or facial asymmetry. However, the patient did have notable pallor of the face. Intraoral examination revealed a large 3x3cm raised ulcerated lesion on the lateral border of the tongue, with rolled margins and a speckled surface. The ulcer was indurated and painful to palpate **(Figure 6)** and lay adjacent to a lingually positioned LL5 with a fractured restoration. The differential diagnoses considered were:

- traumatic ulcer;
- squamous cell carcinoma; and,
- granulomatosis disease.

An incisional biopsy was taken alongside routine blood investigations to aid in diagnosis. The biopsy revealed that the ulcer was consistent with a traumatic aetiology. The blood investigations found that the patient had a microcytic anaemia due to low iron. Therefore, a working diagnosis was made of a traumatic ulcer secondary to the fractured LL5 with delayed healing associated with low iron.

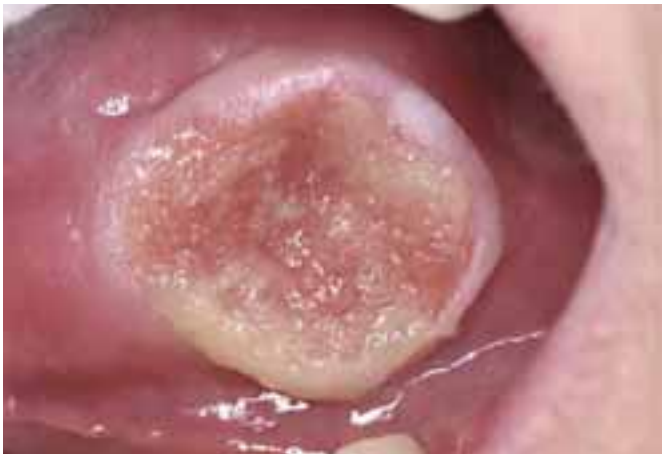

FIGURE 6: Raised ulcer lateral border of tongue

The patient's LL5 was temporised and Difflam Spray was prescribed for symptomatic relief. She was also referred to her GMP to correct her iron levels. At review after six weeks, the ulcer was significantly reduced in size and had resolved at a further two-month follow-up.

Referral

The UK's National Institute for Health and Care Excellence (NICE) produced guidelines in 2015 for head and neck cancers, which recommend referral on a suspected cancer pathway for people with unexplained ulceration in the oral cavity lasting for greater than three weeks, or a persistent and unexplained lump in the neck. Furthermore, referral to an oral medicine or oral maxillofacial unit may be made for ulceration with the following features: [4]

- an ulcer that is indurated with a raised rolled margin;
- ulceration that cannot be adequately managed with topical treatments;
- investigations that cannot be undertaken in the primary dental care setting; and,
- recurrent ulceration of unknown aetiology.

Summary

Oral ulceration can occur due to a variety of reasons. Investigations should be undertaken to identify any predisposing cause but most often ulceration will be due to trauma or RAS. Management is aimed at symptomatic relief through local analgesic preparations or, if unsuccessful, topical corticosteroid treatments. Patients who are resistant to treatment or who have red-flag symptoms should be urgently referred to oral medicine or oral and maxillofacial surgery units for further investigation.

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Ten-year clinical evaluation of posterior fixed-movable resin-bonded fixed partial dentures

Lam WY, Chan RS, Li KY, Tang KT, Lui TT, Botelho MG.

Objective
Two-unit cantilevered resin-bonded fixed partial dentures (RBFPDs) offer long-term retention for anterior and premolar-sized spans. At this centre, molar and longer spans have been restored with fixed-movable (FM) RBFPDs to overcome the lower retention rates of fixed-fixed RBFPDs. This retrospective study aimed to evaluate the long-term longevity and the patient-reported outcomes of posterior FM-RBFPDs.

Methods
Posterior FM-RBFPDs that had been inserted for at least five years were reviewed. Survival was "retention of the original prosthesis in mouth" and success was "survival of prosthesis and absence of complications requiring treatment intervention". Prosthesis location, number of units, insertion year, tooth/teeth replaced and operator experience were collected. Patients' acceptance of FM-RBFPDs was assessed using a prosthesis satisfaction questionnaire and an oral health impact profile (OHIP-49). Results were analysed using log rank and Cox-regression tests at significance level α = 0.05.

Results
A total of 101 prostheses were examined. The mean observation time was 126.4 ± 32.2 months. Some 36 (35.6%) and 63 (62.4%) FM-RBFPDs were rated as successful and surviving, respectively. Prostheses inserted after the year 2001 (n = 69) experienced 42% (n = 29) success and 75.4% (n = 52) survival, and their survival rate was significantly better than those inserted in or before 2001 (p = 0.01). The five- and ten-year cumulative survival probability of FM-RBFPDs inserted after year 2001 were 82.3% and 74.1%, respectively. The most frequent complications were debonding among 34 (33.7%) prostheses. Patient acceptance was high.

Conclusions
More recently inserted prostheses showed improved longevity and patient acceptance to posterior FM-RBFPDs was high.

Clinical significance
FM-RBFPDs are a viable tooth replacement option in the posterior region.

J Dent. 2019;86:118-125.

Survival and success of implants in a private periodontal practice: a 10-year retrospective study

Bäumer A, Toekan S, Saure D, Körner G.

Background
To assess long-term results of implants (XiVE/Frialit-2 Synchro) in a private periodontal practice according to survival and success rates (biological and technical complications) and to detect possible influencing factors, retrospectively.

Methods
Implant placement of at least one implant took place 10 years (± six months) before clinical and radiographic re-examination. Incidence of implant loss as main outcome and incidence of mucositis/peri-implantitis as secondary outcome were detected. Also, patient-related and implant-related influencing factors were determined by regression analyses.

Results
A total of 100 patients (59% female) with 242 implants were included into the analysis. Survival rate was 94% (XiVE: 97.7%; Frialit-2-Synchro: 66.7%). Mucositis was found in 77.6% of all patients, and moderate/severe peri-implantitis in 16.3%. In logistic regression analyses, a statistically significant influencing factor for implant loss was implant type ($p < 0.001$), for mucositis a wider implant diameter ($p = 0.0438$) and a high modified plaque index ($p = 0.0253$), and for peri-implantitis number of implants per patient ($p = 0.0075$) and a wider implant diameter ($p = 0.0079$). Technical complications were found in 47 implants (19.4%).

Conclusions
XiVE implants showed a high survival rate over 10-year follow-up. On the other hand, Frialit-2 Synchro implants had worse survival rates. Success rates regarding biological complications are in line with other implant systems.

BMC Oral Health. 2020;20:1-10.

Cantilever resin-bonded bridge design: a review

Albert JR, Livingstone DW, Manivasakan S, Ravichandran V.

Abstract
Resin-bonded bridges (RBBs) were first described in the 1970s. The present forms of RBBs have evolved from many significant developments. Splinting of periodontally compromised teeth was the initial objective of these prostheses. Their use eventually expanded to replace missing anterior teeth. The cantilever resin-bonded fixed partial denture (RBFPD) is a conservative alternative approach to fixed-fixed partial dentures in replacing missing teeth and should be included as a treatment option wherever possible. For fixed replacement of missing teeth, RBBs can be considered to give a reversible, minimally invasive, aesthetic, and predictable restorative outcome in spite of many problems, such as debonds. Two-unit cantilevered RBFPDs had a better clinical retention than fixed-fixed RBFPDs because a cantilever RBB eliminates adverse inter-abutment stresses associated with fixed-fixed designs. The longevity of RBBs is influenced by numerous factors. To achieve successful long-term survival, careful case selection and consideration of variables such as materials used and occlusal protection are crucial.

J Sci Dent. 2020;10:28-30.

Administration of systemic antibiotics during non-surgical periodontal therapy – a consensus report

Pretzl B et al.

Aim

The aim of this meta-review was to evaluate whether there is a meaningful clinical benefit regarding the use of systemic adjunctive antibiotics in the treatment of patients with periodontitis. Additionally, a consensus regarding possible recommendations for future administration of antibiotics should be reached.

Methods

A structured literature search was performed by two independent investigators focusing on systematic reviews (SRs) covering adjunctive systemic antibiosis during non-surgical periodontal therapy. Additionally, recent randomised clinical trials (RCTs, July 2015 to July 2017) were searched systematically to update the latest SR. Results were summarised and discussed in a plenary to reach a consensus.

Results

Mostly, systematic reviews and RCTs showed a significant positive effect of adjunctive systematic antibiosis compared to controls. These positive effects gain clinical relevance in patients with severe periodontal disease aged 55 years and younger.

Conclusions

Systemic antibiotics as an adjunct to non-surgical periodontal therapy should be sensibly administered and restrictively used. Only certain groups of periodontitis patients show a significant and clinically relevant benefit after intake of systemic antibiosis during periodontal therapy.

Clinical relevance

Avoiding antibiotic resistance and possible side effects on the human microbiome should be a focus of dentists and physicians. Thus, sensible administration of antibiotics is mandatory. This manuscript suggests guidelines for a reasonable use.

Clin Oral Investig. 2019;23:3073-85.

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Associate dentist required for our busy dental practice in Co. Galway. Fully digital, OPG, IO scanner, visiting endodontist. Private/PRSI. Full book. Great terms and a super team and patient base! Contact drrothwelldental@gmail.com.

Part/full-time associate required in modern north Dublin practice. Flexible days/hours. Private/PRSI and great earning potential. Applicants must be IDC registered. Contact 1988dentalsurgeon@gmail.com.

Associate dentist required for modern practice in Kilkenny. Full/part-time considered. Digital, OPG, hygienist. Excellent remuneration, support staff. Part-funded education opportunities. Experience preferred. Contact dentalassociatekilkenny@gmail.com.

Full-time associate sought to replace departing colleague. Busy private practice in Navan, Co. Meath. Excellent, friendly and supportive team, OPG. Experience preferred. Contact Deirdreodwyer4@me.com.

Enthusiastic associate required to work in a busy general practice in Edenderry, Co. Offaly. Excellent friendly support staff, modern and well-equipped practice. Exact software and fully digital radiography, including OPG. PRSI, GMS. 50% remuneration. Partnership considered. Contact roniekennedy@gmail.com.

Part-time associate required for Naas dental practice two days per week. Private, PRSI. No GMS. Cerec, CBCT, microscope. Reply with CV to james@theclinicnaas.ie.

Aesthetic-minded associate dentist required for busy clinic in Chatham Street, D2, with heavy influence on Invisalign and bonding. Full digital workflow with iTero scanners, digital x-rays, etc., in operation. Invisalign training provided for the right candidate. Contact louise@clearbraces.ie.

Dame Street Dental seeking full-time associate dentist to join our team of 18 dentists. CBCT, intraoral scanners, specialist dentistry, in-house lab. Must have three or more years of experience and experience restoring implants. Excellent remuneration. Nine chairs. Fully private. Contact orla@trulydental.ie.

Experienced associate required to work part-time in a busy, friendly, modern, computerised general practice in Malahide, Co. Dublin. Private/PRSI. Please email CV to dentistjobmalahide@gmail.com.

Full/part-time associate required for a busy private practice in Wicklow, only 30 minutes south of Dublin. Modern clinic with excellent support staff. Contact wicklowdentist@hotmail.com.

Part-time associate required for Slade Castle Dental Practice. Two days per week.

Classified advertisements are accepted via the IDA website – www.dentist.ie – only, and must be pre-paid. The deadline for receipt of advertisements for inclusion in the next edition is **Friday, May 12, 2023**. Classified ads placed in the *Journal* are also published on www.dentist.ie for 12 weeks. **Please note that all adverts are subject to VAT at appropriate rate.**

Advert size	Members	Non-members
up to 25 words	€80	€160
26 to 40 words	€95	€190

The maximum number of words for classified ads is 40.
If the advert exceeds 40 words, then please contact:
Think Media, The Malthouse, 537 North Circular Road, Dublin 1.
Tel: 01-856 1166 Fax: 01-856 1169 Email: paul@thinkmedia.ie
Please note that all classified adverts MUST come under one of the following headings:

- Situations wanted
- Situations vacant
- Practices for sale/to let
- Practices wanted
- Equipment for sale/to let

Classified adverts must not be of a commercial nature. Commercial adverts can be arranged by contacting Paul O'Grady at Think Media.

Private and PRSI. Friendly, modern, computerised general practice in Saggart. Contact sladecastledental@gmail.com.

Associate dentist required for busy, fully private practice in north Dublin. Full/part-time considered. Digital scanner, OPG, Exact software. Hygienist, endodontist and periodontist also working in practice. Excellent remuneration, flexible hours and experienced support staff. Contact dublindentistrecruitment@gmail.com.

Cork: Full/part-time associate wanted to join busy, newly renovated practice in Youghal, east Cork, an easy 40-minute commute from the city. Four surgeries, full book, fully digital, excellent support staff. Please email youghaldentist@gmail.com.

Associate required, Colm Smith Dental, Monaghan and Cootehill. Full/part-time sessions in our refurbished and expanding surgeries. Good terms, accommodation available. A great opportunity to work with Ireland's finest specialists, dentists and excellent support staff. IDC registration required. Contact drcolmsmith@gmail.com.

Associate dentist required to join our fantastic team in Co. Galway to replace departing colleague. Private/PRSI, digital, IO camera and scanner. Hygienist and visiting specialist. Excellent terms. Great opportunity! Contact drrothwelldental@gmail.com.

Associate required Fridays (9.30am-5.00pm) for busy practice in Midleton, Cork. Five chairs, excellent support, OPG/CBCT, full book. Please email carmel@corabbeydentalclinic.ie.

Part/full-time position available in a very busy private dental practice in north Dublin. Intraoral scanner present. Endodontist and hygienist are present. Highly experienced nurses. Excellent earning potential. Flexible working hours. Mentoring available. Contact northdublindentalassociate@gmail.com.

Dentists

Dentist required for private Athlone practice. OPG, CBT, hygienist, full support staff, excellent remuneration. Experience preferred. Part/full-time. Email reception@mearesdental.ie.

Ideal opportunity for bright, enthusiastic dentist keen to work in paediatric or orthodontics. Full-time (part-time considered) replacing a fully booked colleague. Generous salaried position. Minimum one year of experience. On-site residence available. Starting May 2023. Contact drtuite@childrensdentistry.ie.

The Hungarian Dental Clinic is looking for a caring, enthusiastic dentist in Letterkenny, Co. Donegal. Highly experienced and supportive staff, modern clinic with intraoral scanner, Private, PRSI, GMS. Full-time, but flexible with days and hours. Contact office.hundental@gmail.com.

Dental Care Ireland, south Dublin – we have an exciting high-earning opportunity available. Three to four years minimum experience. An established, modern practice, with high earning potential and busy patient books. Flexible options, part/full-time. Contact careers@dentalcareireland.ie.

Dental Care Ireland, Midlands – great opportunity for an experienced dentist to join our established practice. Flexible days, high earnings on offer within our modern practice. Contact careers@dentalcareireland.ie.

Dental Care Ireland – high earnings, flexible days, modern established practice, experienced and friendly support teams in place. Our Ballsbridge and other Dublin/south east practices have fantastic roles on offer. We look forward to hearing from you. Contact careers@dentalcareireland.ie.

Award-winning north-east practice seeks part-time dentist one hour from Dublin/Belfast. For further info contact mbcar06@gmail.com.

Full-time position available in a well-established friendly dental practice. Excellent support staff and facilities. Would suit an enthusiastic and motivated dentist, high-earning role. Contact email careerscamdendental@gmail.com.

Castleknock Dental Practice seeks a part-time experienced general dentist to join our successful team. The ideal candidate must be focused on delivering quality dentistry in a digital environment. Please email cover letter and CV to cdprecruitment2018@gmail.com.

Full/part-time IDC-registered dentist required for well-established, mixed-practice dental surgery in Longford. Excellent remuneration. Contact maddensdentalsurgery@gmail.com.

New graduate dentists – Smiles Dental is hiring! We have exciting opportunities available for 2023 for newly qualified dentists looking for their first practice role. We can offer well-established lists, full- or part-time and great earning potential! Contact Sophie.Collier@bupadentalcare.co.uk.

General dentist Limerick – Smiles Dental is looking for an enthusiastic dentist to join our well-established, high-earning practice in Limerick. We can offer full- or part-time, a well-managed busy diary and great practice staff support. Contact Sophie.Collier@bupadentalcare.co.uk.

EU general dentists – Smiles Dental is looking for dentists across Ireland to join its fully private, well-equipped practices. We have opportunities across various locations, offers up to five days per week, established patient book, high earnings! Contact Sophie.Collier@bupadentalcare.co.uk.

Enniscorthy – Smiles Dental is looking for a passionate dentist to join us, full- and part-time available with an established full patient list, great earning potential and career opportunities! Contact Sophie.Collier@bupadentalcare.co.uk.

Bray – Smiles Dental opportunity available for a full- or part-time dentist to join an experienced team. Great earning potential, established list and clinical support. Contact Sophie.Collier@bupadentalcare.co.uk.

Great patients, great staff, lovely location, coffee shop downstairs – what more could you want? Kiwi Dental is looking for an enthusiastic dentist with a decent sense of humour to join our team. Mentoring offered. Full/part-time considered. Contact: caroline@kiwidental.ie.

Full/part-time dentist required for a busy modern practice in Claremorris, Co. Mayo. Private clinic. Highly experienced and friendly support staff. Excellent remuneration. Contact dr.danaher@alexandradental.ie.

Seeking part or full-time dentist to join our clinic in Athy, Co. Kildare. Private, PRSI, medical. Three or more years' experience. Email maddendentalclinic@gmail.com.

Dental Care Ireland North Dublin – high earning opportunities in our established modern practices. Busy patient books, fully flexible part- and full-time hours on offer. Experience required for this great opportunity. We look forward to hearing from you. Contact careers@dentalcareireland.ie.

Dental Care Ireland Limerick – opportunity to join our modern, established practice. Strong patient books, flexible hours full or part-time, private and PRSI only. Strong support team in place. Experience is required. Contact careers@dentalcareireland.ie.

Full/part-time dentist and orthodontist required. Exciting opportunities for enthusiastic, self-motivated and experienced dentists in D8-D1 areas. Modern, well-equipped practices, fully computerised. Email CV to dublinicdentalclinics@gmail.com or WhatsApp 089-951 0378.

Part-time dentist required for well-established north Dublin practice. Digital X-ray, OPG. Flexible hours. Email CV to app2dental@gmail.com.

Dentist – maternity leave position available in a long-established expanding practice in Mullingar. Full/part-time position available, digital practice, scanner, digital X-ray/OPG. Great support team consisting of dentist, oral surgeon and two hygienists. Start date flexible June/July. Contact info@lakelandsdental.ie.

Specialist/limited practice

Paediatric dentist position available in a very busy private dental practice in north Dublin. Intraoral scanner, OPG and nitrous oxide facilities present. An endodontist and hygienist are present. Highly experienced nurses. Excellent earning potential. Flexible working hours. Contact dublindentistjob@gmail.com.

Oral surgeon/implantologist position available in a very busy private dental practice in north Dublin. Intraoral scanner and latest radiographic equipment available. An endodontist and hygienist are present. Highly experienced nurses. Excellent earning potential. Flexible working hours. Contact northdublindentalassociate@gmail.com.

Part-time orthodontic specialist required for busy practice in D15. Great atmosphere and supportive staff. Please send CV and cover note to orthodentaldublin@gmail.com.

Calling all specialists and dentists with special interests. Great opportunities available at our growing specialist clinic. Ultra-modern clinic. Part/full-time positions. Contact reception@kingdomclinic.ie.

Part-time oral surgeon/implantologist required for private practice in Ballsbridge. Good patient base and support staff. Digital radiographs and OPG. Contact dentistdublin10@gmail.com.

Orthodontists – Smiles Dental is looking for orthodontists in the following locations: Ballsbridge, Galway, and Limerick. Established patient lists, specialist-interested dentists considered. High-earning potential! Contact sophie.collier@bupadentalcare.co.uk.

Modern busy practice in the Midlands is looking for an endodontist one day per week. The practice has experienced, longstanding associates, a supportive practice team and a well-managed appointment book. CBCT/all digital. Established referral base and only 45 minutes from Dublin. Contact midlandsassociate@gmail.com.

Full or part-time paediatric dentist required for very busy private practice. Nitrous oxide sedation available. Experienced friendly support staff. State-of-the-art equipment and materials. Digital scanner and OPG available. Hygienist and endodontist on site. Flexible hours. Contact dublindentistrecruitment@gmail.com.

Private general specialist practice based in Skerries with highly equipped surgeries delivering quality service alongside an excellent support team, is looking for a specialist or general dentist with special interest in restorative dentistry on a part-time basis. Contact yoursmile2612@gmail.com.

Part-time orthodontist required one to two days per month for a busy practice in Limerick. OPG, CBCT, digital scanner and 3D printer. Contact cornmarketdental@gmail.com.

Locum orthodontist required for a friendly specialist orthodontic practice in Raheny from end June. Three days per week but with significant scope for flexibility. Contact info@rahenyortho.ie.

Dental nurses/receptionists/managers

Dr Paul O'Boyle seeks enthusiastic dental nurse for full-time permanent position. Four-surgery private practice, air con, sterilisation room, scanner, friendly dedicated team. For more details see: https://1drv.ms/p/s!Au2G9pTl1owEqgEp5HCw1CjYAaCe?e=cxXZNE or contact poboyleriverside@gmail.com.

Exciting, rare opportunity for enthusiastic part-time nurse to join our excellent, multi-award-winning team in Co. Meath. Experienced friendly team, excellent rates of pay and conditions, flexible hours. Fully computerised, digital X-rays. Staff car park. Contact dentaljobireland1@gmail.com.

Four-surgery private practice in Ballsbridge area seeking experienced full-time dental nurse. Monday-Friday only. Convenient local transport and on-site parking available. Recently refurbished sterilisation room. Digital radiography including CBCT. Most importantly – friendly supportive team! Contact info@visiondental.ie.

Dental nurse three to four days per week required in friendly orthodontic practice. Nursing with orthodontist/therapist. Lovely team, excellent pay, working conditions and opportunities. Contact orthosull@gmail.com.

Full-time vacancy available for dental nurse who would like to join our modern practice at Renmore Dental. Experience ideal but not essential as on-site training provided. Please send your CV to Laura at office@renmoredental.ie.

Dental nurse position available with immediate start for Tues/Wed/Thurs. Gorey, Co. Wexford. Mixed general practice. No reception duties or late evenings. Email: jonnyk289@gmail.com for further info.

Dental nurse position in multi-specialty Kilkenny practice. Starting beginning of May to cover maternity leave with possible long-term full- or part-time position. Contact info@drjmahon.com.

Part-time dental nurse position available in OC Dental Gorey. Modern bright practice with friendly team. Huge potential for progression and professional development. Flexible hours. Contact eleanor@ocdental.ie.

Opportunity for friendly, professional and motivated dental nurse to join our orthodontic team. Modern surgery, friendly and professional team. Located at Sligo clinic with one day per week at our Ballina clinic. Full-time with excellent conditions. No previous orthodontic experience required. Contact practice.westcoastortho@gmail.com.

Dental hygienists

Dental hygienist required one to two days per week for a busy modern practice in Ballsbridge, Dublin 4. Excellent support staff and great remuneration. Contact jobs@alexandradental.ie.

Dental hygienist required one to two days per week in modern practice in Dublin 3. Great support staff, excellent remuneration, flexible working hours. Contact pauleggles@gmail.com.

Part-time hygienist required for maternity cover in a busy, private practice west Dublin. Two days per week: Tuesday/Friday. Please forward CV by email to lucandentalcare@gmail.com.

Dental hygienist required for our new clinic in Blackrock. One to two days per week with further days and locations in other clinics available. Contact jobs@shieldsdentalclinic.ie.

Dental hygienist required to work in busy practice in Naas, Co. Kildare. Flexibility for days, working times and start date. Newly refurbished surgery. Contact hello@platinumdental.ie.

Co. Kerry. Part-time hygienist required. Flexible hours. To apply please forward CV to info@ballybuniondental.ie.

Dental hygienist position full-time. For details, please contact Cleary FitzGerald Dental Practice, Sligo, at 071-914 3927, or email info@clearyfitzgeralddentalpractice.ie.

Dental hygienist position available from March in Gorey, Wexford, to cover maternity leave three days a week. Days flexible. Full support staff. Computerised. No weekends or late evenings. Email jonnyk289@gmail.com.

Pembroke Dental is looking for an experienced, organised and talented dental hygienist at our Waterford City location. Excellent communication and patient care skills essential. If you would like to join our friendly, experienced team, please send your CV to specialists@pembrokedental.ie.

Dental hygienist required one to two days per week for a busy modern practice in Kilkenny. Excellent remuneration, supportive staff and lovely working environment. Contact info@gentledentalcare.ie.

Dental hygienist required for a busy modern practice in Ballincollig, Co. Cork. Excellent remuneration, supportive staff and lovely working environment. Contact info@guineydental.ie.

Full- or part-time dental hygienist positions available. Busy private practice with full book. Florida probe, air polisher. Excellent support staff provided. Flexible hours. Mentoring component offered. No late evenings or weekend work. Contact dublindentistrecruitment@gmail.com.

Bowe Dental Clinic is looking for a hygienist(s) for maternity leave cover in its Roxboro clinic. Two to four day per week. Fixed-term of 26 weeks. Experienced support team. €40/hour. Monday-Friday. Contact eamonn@bowedentalclinic.ie.

Hygienist required for a few sessions a week at a busy practice in Cork. If you would like to be part of our friendly team, send your CV to drcahill@cobhdentalclinic.com.

Full-time dental hygienist positions available. Busy private practice with full book. Excellent and friendly support staff. Flexible hours. Competitive hourly rate, DNA and cancellations paid. Contact deirdre@thejamesclinic.com.

Specialist practice with an orthodontist/periodontist/dentists requires a part-time hygienist. We are in Glasnevin, Dublin. Please contact orthosull@gmail.com for more information.

PRACTICES WANTED

Implant surgeon with 15 years' experience is looking to buy/take over fully private 2+ surgery practice in Ireland, preferably Dublin or the surrounding counties. Contact implant.surgeon1@gmail.com.

Specialist looking to rent surgery or practice in Dublin, Meath, Wicklow or Kildare. Medium-term rental ideal. Perfect for outgoing dentist. Potential to purchase premises in long term. Contact joseph.oc@live.ie.

PRACTICES FOR SALE/TO LET

Munster: Very-busy, long-established, well-equipped three-surgery practice. Decontam, OPG in place. Excellent location – strong footfall. Freehold/leasehold options. Very good figures/profits. Long-term associate in place. Priced to sell – principal retiring.

Orthodontic practice Dublin 6: waiting list of new starts. Near schools, M50. Transferable brand name. Premises not included. Sole orthodontist winding down 2023. Prosperous area. Loyal patients. Very strong new patient demand, adults, especially teenagers. For more info contact orthopracticedublin@gmail.com.

Dublin: 3km from city centre. Excellently located, long-established two-surgery practice with ample room to expand. Free parking on site. High new patient numbers. Low rent. Modern, well equipped, computerised. Dentist retiring/transition available. Priced for speedy sale. Contact niall@innovativedental.com.

Good price practice. Excellent location, fully equipped, scanner, etc. The owner/dentist is available for transition. Details and photos by email at modernsurgerydublin7@gmail.com.

Fermanagh/Monaghan border (Roslea). Busy single-surgery practice (planning permission for second). Established 33 years, extensive loyal private patient base and NHS list. Easy to run. Excellent RQIA report (available online). Great potential. Contact StephenEHForster@yahoo.co.uk.

Dublin south/north Wicklow. Excellent location. Long-established in the area. Very busy/large passing trade. Two surgeries, separate decontamination room. Low overheads and rent. Good room to expand. Modern equipment – digitalised OPG. Ample parking available. Transition period available. Contact niall@innovativedental.com.

Dublin 12 practice for sale. Three-surgery general practice plus X-ray room. Computerised (SOE), good patient mix. Two days of hygienist. Enquire in confidence to steven@medaccount.ie or call 086-068 1242.

Co. Westmeath: Very busy, active two-surgery practice with room to expand. Prime location. Ample parking close by. Very low overheads, rent, etc. Computerised, digitalised, hygienist. Strong new patient numbers. Dentist retiring, fairly priced for speedy sale. Contact niall@innovativedental.com.

Long-established three-surgery practice in city centre location. OPG room, computerised. Good hygiene book. Excellent opportunity to grow. Contact steven@medaccount.ie in confidence or call 086-068 1242.

Cork City suburb (Blackpool). Long-established, busy mixed practice. Expanding local population. Great opportunity for growth. Contact corkdentalsale2023@gmail.com.

Dublin City, south. High-profile location with good access. Busy, existing two surgeries with room to expand. Very low overheads including low rent. Excellent profits. No medical card. Principal retiring. Excellent value. Huge potential – presently no social media presence. Reply niall@innovativedental.com.

EQUIPMENT FOR SALE/WANTED

I will consider buying old equipment, especially hand equipment, forceps, etc. Please text dentist Jacques Lumbroso at 087-686 6180.

Planmeca Promax 2D OPG for sale – 10 years old. Very good condition, serviced by Medray. High-quality pictures. Reason for sale: getting CT. Contact hungariandentalinfo@gmail.com.

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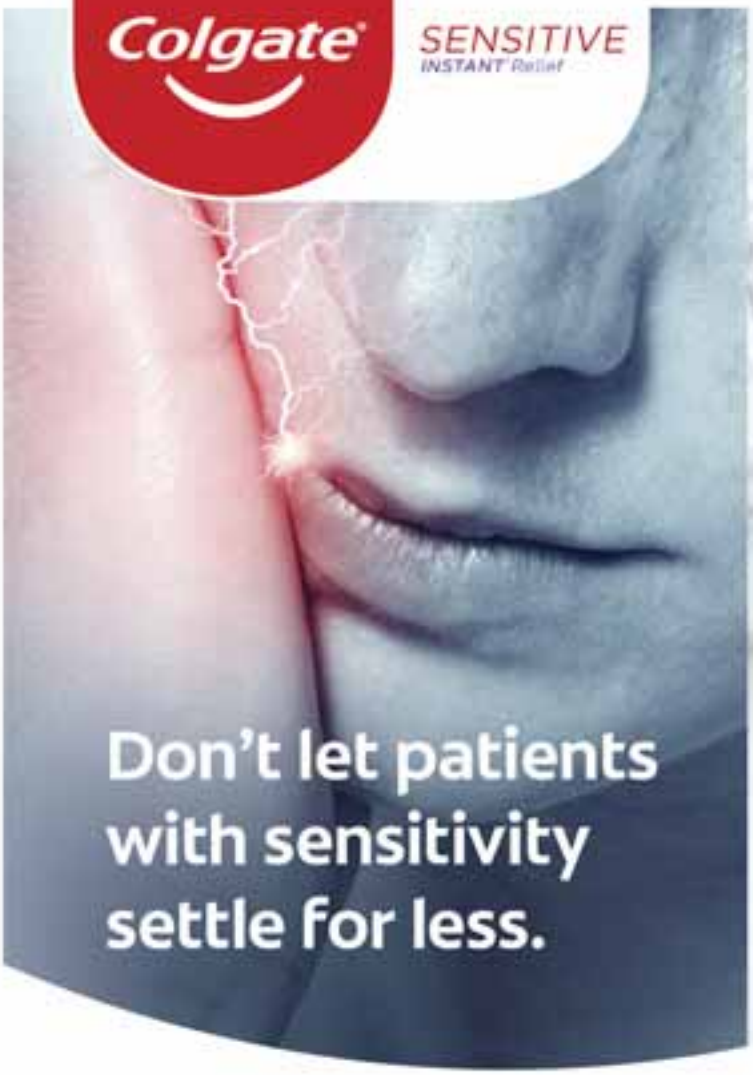

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References: 1. Nathoo S, Delgado E, Zhang YR, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising toothpaste containing 2% potassium ion and 1450 ppm fluoride, and to a control toothpaste with 1450 ppm fluoride: a three-day clinical study in New Jersey, USA. *J Clin Dent*. 2009;20(Spec Iss):123-130. **2.** Docimo R, Montesani L, Mauro R, et al. Comparing the Efficacy in Reducing Dentin Hypersensitivity of a New Toothpaste Containing 8.0% Arginine, Calcium Carbonate, and 1450 ppm Fluoride to a Commercial Sensitive Toothpaste Containing 2% Potassium Ion: An Eight-Week Clinical Study in Rome, Italy. *J Clin Dent*. 2009;20(Spec Iss):17-22.

Scan here to learn more

A sporting life

Dr SALLY McCARTHY is a Specialist Research Doctor in Endodontics at the Royal National ENT and Eastman Dental Hospital, London, and has competed for Ireland in a number of sports, including modern pentathlon. Sally will be speaking at this year's annual conference on sports dentistry and dentofacial trauma.

Can you tell me about your background and what led you to a career in dentistry?

I wanted a career that would let me help people in a practical way and that would give me the independence that comes from being self-employed. My sister studied dentistry in UCC ahead of me – she was having fun, so that was a big factor too.

Can you tell me about your current role and specialisms?

I completed a three-year full-time MClinDent in Endodontology at the Eastman, and stayed on for two years after that, doing clinical research in dentofacial trauma.

That's where I'm still working. I also teach on the Master's programme at the Eastman and I work in private practice. Separate to that, I work with professional sports teams in the UK and at international competitions, including the Commonwealth Games, providing pitch-side dentofacial trauma treatment. Typically this is in contact or semi-contact sports such as hockey, soccer, rugby, and boxing.

What led you to get involved in the IDA and how did that involvement progress?

The IDA came to UCC in our final year. They provided support for us starting work and that made it really easy to become involved. Then I had the chance to work on the IDA's Quality and Patient Safety Committee, and that was a really positive experience for me. I'm really looking forward to speaking at the annual conference: the IDA has been a big support to me throughout my career, so it meant a lot to be asked.

Can you tell me about your sporting career?

Well, I was lucky to grow up in Fermoy in Cork where we had lots of great local sports clubs on our doorstep, and most importantly supportive parents who were fine with me joining them all (thanks Mum and Dad). It was always really fun for me to compete.

When I went to UCC, that developed further with the chance to train with world-class athletes and coaches. I played basketball and hockey in school and competed internationally in athletics and modern pentathlon, which is running, swimming, shooting, show jumping and fencing. Separate to that, I competed internationally in water polo, sailing and swimming.

How have you managed to balance the demands of elite sports with a career in dentistry?

I was really lucky. I had a lot of support from the UCC dental hospital and also the medical and PE departments at UCC, and most of all my family. My parents were always helping me to keep things balanced. My sister Daisy helped me a lot with notes in college, and I have good friends in dentistry who are also involved in sport. Overall, I feel like they complement each other. I love doing both and I think each gave me energy for the other. I finished playing water polo internationally when I came to study at the Eastman, but I still do running competitions, which I really enjoy.

In this centenary year, what are the big issues you think the IDA needs to focus on?

Public education is still very important in terms of dental health and dentistry in general. Mentorship of young dentists is also important, which I think the IDA does really well already. It's been a big help to me and has really shaped my career. And then also maybe supporting dental professionals to remain in the workforce through raising families and other life events.

How would you like to see the Association progress in the future?

From the research I've been doing here, I think there have been really exciting developments with artificial intelligence (AI) and its use in dentistry, so it would be great to see the IDA promoting and thinking about the use of this in Ireland, and keeping ahead of the curve with education and regulation.

What will you be speaking about at this year's Annual Conference?

I'm going to look at factors relating to sports dentistry in terms of managing amateur and professional athletes and I'm going to look at the endodontic sequelae associated with dentofacial trauma. That will cover patient factors, pitch-side management, helpful technical skills, and will involve some discussion about the future of trauma management and rehabilitation.

Unsurprisingly, Sally loves the outdoors, and is happiest anywhere in nature or by the sea. She also loves coming home to Cork to visit friends and family, and has recently taken up ballroom dancing but does not expect to reach competitive standard.

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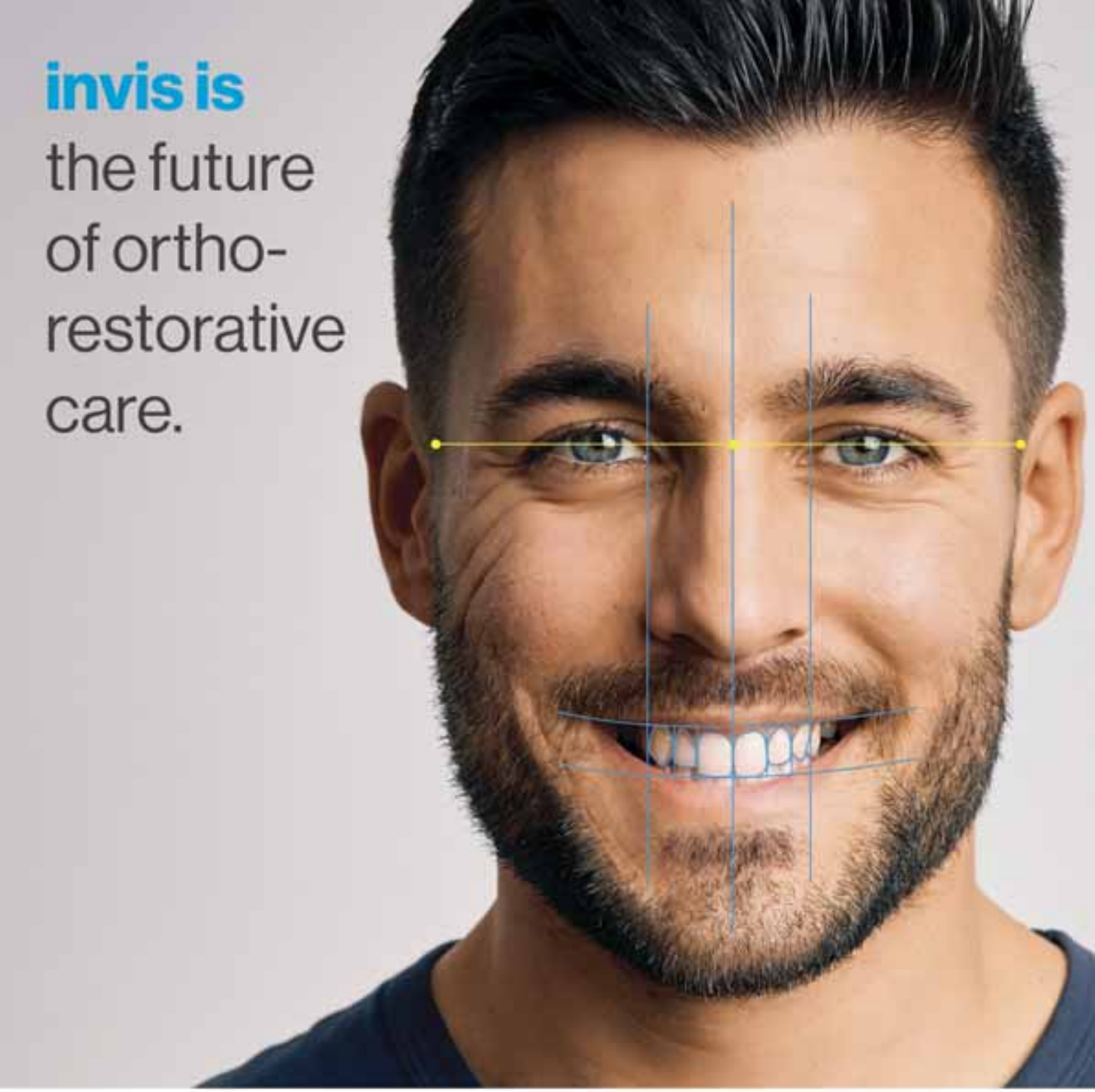

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Help, hope and urgent action required

Support granted for the first quarter of the financial year needs to be extended beyond June – and the structural problems with the support for NHS dentistry need to be addressed

A recent letter from the Department of Health (the Department) has confirmed that the fee enhancements for high street NHS dentists under the Rebuilding Support Scheme will continue into the first quarter of the 2023/24 financial year.

We acknowledge the efforts made to maintain vital financial support for the struggling service. However, continued support will be required beyond June. A further review will take place to consider the Department's position on the 10% enhancement for the remainder of 2023/24.

The £14.30 Enhanced Children's Examination Fee implemented in January carries over for another three months into quarter one (Q1) but will then cease. This enhancement is aimed at easing the financial barriers and dental access difficulties impacting on young children.

The Chair of the BDA's Northern Ireland Dental Practice Committee, Dr Ciara Gallagher, commented on this outcome: "We recognise the concerted effort that has been put in to ensure this vital support will remain in place. Today's announcement only covers the period to June.

"Dentists will require continued support and certainty for the remainder of the financial year, and beyond, if we are to stem the flow away from Health Service dentistry. With patient care continuing to be severely impacted in the wake of Covid, we must find a way of measuring and addressing the costs of delivering NHS dental care, to make NHS dentistry financially viable for practitioners.

"Below-inflation uplifts, which bear no resemblance to soaring costs of care, will no longer cut it. We must use the next three months to put dentistry on a sustainable footing".

Departmental pressures

We do know that the Department is facing unprecedented budgetary constraints and its own battles to address health priorities and inequalities. We recognise recent initiatives from the Department such as the denture enhancement of 25%, the PUPAS Pilot for unregistered patients and the children's registration initiative. Positive though they are, they represent a sticking plaster on a haemorrhage, and on their own will have little effect on the exodus from NHS dentistry.

Cost of care

Dr Gallagher also stated recently: "It's vital that the public fully understands the pressures of providing NHS care in many dental practices throughout Northern Ireland. If the business model worked, we would not have the current problems in terms of access to, and availability of, NHS dentistry. We have repeatedly asked the Department to commission an independent cost-of-service review to inform a recalibration of fees. The Department has no official figures on practice costs to provide care, they have no dental business model on which to track changes, and therefore no measure of how the economics of their contract translate at practice level. In our recent media coverage, we shared examples of practice-level costs, alongside the fees that are publicly available in the Statement of Dental Remuneration, to illustrate the dire economics of NHS dentistry".

"If the business model worked, we would not have the current problems in terms of access to, and availability of, NHS dentistry."

Next steps

The BDA believes that practices need help, they need hope, and they need urgent action from the Department to know that they have a future. The BDA will be conducting a timings study to establish evidence of the time involved in completing various clinical treatments.

This will also help to establish the labour costs of treatments, and lab fees, and will provide an evidence base to support contract reform across the UK. The study will replicate and update the 1999 Heathrow Timings Study and predecessor studies.

Alongside a cost-of-service investigation, we want to create the evidence base to support contract reform across the UK, and a recalibration of fees based on modern realities. An objective piece of work by a third party will validate the issues we are campaigning on. Practices need support so that they are not being financially starved out of the NHS.

We will continue to press for a fair and equitable outcome as we liaise with the Department on this and other issues, and I welcome your views. Please get in touch to share your opinions.