IDA irish dental association

JIDA

Journal of the Irish Dental Association

Iris Cumainn Déadach na hÉireann

Volume 69 Number 3
June/July 2023

IDA irish dental association
100 YEARS
1923 - 2023

The ITeeth Crowd

The risks of smartphone and mobile technology for the dissemination of clinical data by dental professionals

Dental Protection

Vicarious liability
for practice principals

Membership benefits for practice principal members now includes protection against vicarious liability and non-delegable duty of care claims*.

- Free for current practice principal members*
- Provides peace of mind and protection against vicarious liability claims

If you are a Practice Principal, but do not currently have specific Practice Principal membership with us, amend your membership now

2303214874:05/23

CONTENTS

The *Journal of the Irish Dental Association* is the official publication of the Irish Dental Association. The opinions expressed in the *Journal* are, however, those of the authors and cannot be construed as reflecting the Association's views. The editor reserves the right to edit all copy submitted to the *Journal*. Publication of an advertisement or news item does not necessarily imply that the IDA agrees with or supports the claims therein. For advice to authors, please see: https://jida.scholasticahq.com/for-authors.

Think Media

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

MANAGING EDITOR **Ann-Marie Hardiman** ann-marie@thinkmedia.ie
EDITORIAL **Colm Quinn** colm@thinkmedia.ie
Rebecca Pollard becky@thinkmedia.ie
ADVERTISING **Paul O'Grady** paul@thinkmedia.ie
Calum Petit calum@thinkmedia.ie
DESIGN/LAYOUT **Rebecca Bohan, Tony Byrne, Meliosa Fitzgibbon**

abc Audit issue January-December 2022: **3,906** circulation average per issue. Registered dentists in the Republic of Ireland and Northern Ireland.

Irish Dental Association Unit 2 Leopardstown Office Park, Sandyford, Dublin 18.
Tel: +353 1 295 0072 Fax: +353 1 295 0092 www.dentist.ie
Follow us on Facebook (Irish Dental Association) and Twitter (@IrishDentists).

Colgate® SENSITIVE INSTANT* Relief

Don't let patients with sensitivity settle for less.

Give them the solution with **superior†** **pain-blocking power[1,2]**

Instant*[1] relief

60.5% pain reduction‡
immediately after application.

Long lasting§[2] relief

80.5% pain reduction‡
at 8 weeks.

Recommend instant*[1] and long lasting§[2] relief with **Colgate® SENSITIVE INSTANT* Relief**

*For instant relief, apply as directed to the sensitive tooth and directly massage for 1 minute.
†vs 2% potassium ions.
‡vs baseline in an air blast test, $p<0.05$.
§Lasting relief with 2x daily continued brushing.

References: 1. Nathoo S, Delgado E, Zhang YP, 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, Maturo P, 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

EDITORIAL

Dr Cristiane da Mata
Honorary Editor

Women in dentistry

This edition features women who have left a mark during their careers in dentistry and who, despite all odds, have navigated a traditionally male-dominated field.

It is inspiring to read the stories of our amazing women in dentistry, and I thank them all for sharing these with us.

We have obviously come a long way in dentistry, as far as gender equality is concerned. According to a report published in 2020 by the European Dental Students' Association, in many European countries, women currently constitute between 50% and 70% of dental students. In Ireland, women graduates account for approximately 65% of current dental students.

This is certainly a reason to celebrate, but women still face many challenges in the workplace. The vast majority of senior positions in dentistry in the UK are still held by men, and males typically earn higher salaries than females.[1] This can be attributed to various factors, such as gender biases, differences in work experience, and practice ownership. And these cannot be addressed separately from other social factors, such as the role women usually have as family carer.

In the research field, the impact of the Covid-19 pandemic on already existing gender inequalities was measured by Elsevier, showing that even though the rate of submissions increased by 63% in health and medicine journals during the pandemic, women submitted fewer manuscripts than men. Interestingly, however, women seem to have taken more responsibility in acting as referees, benefitting men who were submitting papers.[2]

So, even though dentistry is becoming increasingly feminised, the role women play in the profession seems to differ from that of male dentists. This has implications for the profession, health systems and patients, and trying to fully understand and address these imbalances is a task for all of us.

The lifecycle: why we have to care

This edition features articles that discuss the treatment of children in dental practice (p.147), and the management of caries in older adults (p.154).

These made me reflect on how these two extremes of the lifecycle – childhood and old age – present with unique oral health needs and challenges. Maybe this is why they are still seen as completely separate groups. However, when we think about the impact of losing a permanent front tooth at the age of 12, or experiencing heavy caries at 14, on future oral health, we realise that it is impossible to separate the child's oral health and disease experiences from the adult's dental status.

So, it is not surprising that a growing body of evidence has been challenging the view that separates the different stages in life, with many studies adopting a life course perspective to try and understand how early life experiences impact on the lifelong trajectories of oral conditions, a concept known as life-course epidemiology.[3]

We face very challenging treatment decisions when managing heavily restored teeth later in life, and a lot of this is due to the restorative burden that these patients bring to our practices. Teeth that entered the restorative cycle when patients were young, and have now been restored multiple times, may become unrestorable when these individuals are frail or chronically compromised.

People are living longer, but the currently available restorative materials do not have the same longevity: a filling placed in an eight-year-old will have to be replaced and/or repaired multiple times during that person's life. This means more dental tissue loss every time, and more room for error and failure. Additionally, restorations placed in older patients tend not to last as long as those placed in younger adults.[4]

So, the question is: is there something we as dentists could have done (or more likely not done!) to that child, as far as restorations are concerned?

We are all aware of the restorative cycle: uncertain caries diagnosis, together with an urge to place restorations, leading to restorative errors and restorations of increasing complexity.

Add to this the fact that dentistry is technically demanding, recall intervals are uncertain and risk factors may not always be identified, and the cycle is perpetuated.

Therefore, I urge us all, especially those treating children and young adults, to adopt a minimal intervention oral care (MIOC) approach, in order to help minimise the restorative burden and maintenance for future generations.

I acknowledge that we need to rethink our reimbursement systems in order to fully implement this concept; however, this may be a first step towards better oral health for our future elderly.

References

1. Tiwari T, Randall CL, Cohen L, Holtzmann J, Webster-Cyriaque J, Ajiboye S, *et al*. Gender inequalities in the dental workforce: global perspectives. *Adv Dent Res*. 2019;30(3):60-68.
2. Squazzoni F, Bravo G, Grimaldo F, García-Costa D, Farjam M, Mehmani B. Gender gap in journal submissions and peer review during the first wave of the COVID-19 pandemic. A study on 2329 Elsevier journals. *PloS One*. 2021;16(10):e0257919.
3. Nicolau B, Thomson WM, Steele JG, Allison PJ. Life course epidemiology: concepts and theoretical models and its relevance to chronic oral conditions. *Community Dent Oral Epidemiol*. 2007;35(4):241-249.
4. Burke FJT, Lucarotti PSK. 2009. How long do direct restorations placed within the general dental services in England and Wales survive? *Br Dent J*. 2009;206(1):E2-E2.

HENRY SCHEIN IRELAND LIMITED | Rely on Us

OUT OF OFFICE

CHECKLIST
THINGS TO DO BEFORE YOU GO

- [x] Book your annual equipment service
- [x] Book holiday
- [x] Block time off in your diary
- [x] Pack your bags
- [x] Find someone to water your plants

NOW IS THE TIME to book your annual dental equipment service.

Have this work carried out while you are away, book your preferred date and time now!

Pre-planning saves being disappointed if you can't get any last minute booking

Call the service team today on **01 456 5288** to book your appoinment

Annual Service Visits

- Prolong the life of your equipment and minimise inconvenient and costly break-downs through an annual service.
- Henry Schein use manufacturer recommended Service Kits and parts for all equipment Henry Schein supports.
- At the same time our manufacturer trained engineer will advise on any other parts or remedial action required helping to prolong the life of your equipment.

Taking care of everything dental 01 456 5288 equipment@henryschein.ie

• Business Solutions • CADCAM • Consumables • Decontamination • Digital Imaging • Education • Equipment • Laboratory • Lasers • Orthodontics • Service and Repair • Software • Surgical

Dr Eamon Croke
IDA President

Where now for CPD?

Two recent events served to capture the vicissitudes of continued professional development for dentistry in Ireland.

Something that leaps off the pages of *The Irish Dental Association: A Centenary History* is the immutable ethos of continuing education and the advancement of the profession, from the establishment of the British Dental Association (BDA) in 1880 and the approval of its Irish Branch in 1887 to the formation of the IDA in 1923 and for a further hundred years. Both the Irish Branch of the BDA and the IDA itself held scientific meetings within a year of their formation. The task of maintaining this core ethos is continued by the Association at local and national level to this day.

Stark contrast

Recently, two events occurred, miles apart but within hours of each other, which captured the vicissitudes of continued professional development (CPD) for dental healthcare professionals in Ireland. One was loose with the truth and frustratingly disappointing, while the second combined meticulous preparation with a joyous informality.

On May 10, in Dáil Éireann, the Minister for Health, Stephen Donnelly TD, feigned support for Deputy Róisín Shortall's amendment to the Regulated Professions (Health and Social Care) (Amendment) Bill 2022, which would have placed mandatory CPD for registered dental healthcare professionals on the statute books. The Minister expressed support for the principle of the amendment but iterated a number of tired excuses for not supporting it.

One has to assume that his Department has relegated the Dental Council's 2021 submission, elucidating a holistic approach to a new Act, because it is out of step with the piecemeal proposals of its flawed 2019 National Oral Health Policy, Smile agus Sláinte. The Minister's Dáil response laid bare one of the "priorities" of the Policy to "update the Dentists Act 1985" (Action 28) and, as such, consolidated the vote of no confidence in the Minister, his officials and the Chief Dental Officer passed unanimously by the IDA's AGM days earlier.

In contrast, the following day, delegates gathered in Kilkenny to attend the Association's Centenary Conference. It was a positive experience from beginning to end for which the Annual Conference Committee deserves total credit and my enduring thanks. The educational component was widely praised to the credit of the presenters. The range of topics was broad but relevant, looking into all corners of the day job. The choice was tantalising. It was the best of CPD.

The 'value' of CPD

These events have renewed an ongoing discussion within the Association on CPD delivery.

The Association held an exploratory meeting recently with a representative cross-section of members. A recurring theme was the value of CPD. The link between

CPD and monetary value was mentioned regularly. This is a very narrow interpretation of CPD, which is viewed by the Dental Council as a means to assist dentists to meet their ethical obligation to keep their professional knowledge and skills up to date, to support lifelong learning and promote patient safety. CPD should have a multitude of outcomes.

Since 2019, the Dental Council has categorised CPD activities as either 'structured' or 'self-directed'. Anecdotally, the removal of the previous 'verifiable' classification has caused a shift in the type of CPD activities undertaken. There appears to be a shift towards 'maintenance of clinical skills', which may have a monetary value in clinical practice, as opposed to 'core subjects', which relate to patient safety and regulatory compliance. The Dental Council guides that, over a five-year period, a dentist should complete at least 250 hours of CPD, of which a minimum of 100 hours should be structured and divided evenly between 'core subjects' and the 'maintenance of clinical skills'. I get a strong sense that this requirement has been diluted when choosing CPD activities.

Another hot topic for CPD providers is how best to provide these activities. Since the pandemic restrictions, webinars and online courses have become the most popular form of CPD. Webinars are advantageous for reasons of convenience and sustainability. Unfortunately, there is a potential but worrying downside. The classroom is our natural learning habitat. Social engagement is central to mental health. What was most notable at the Conference was the festive atmosphere around the coffee docks and trade stands. Interestingly, this translated, to my surprise, to delegates choosing live over pre-recorded presentations.

Clinical or core? URL or IRL? Mandatory or obligatory? Irrespective, continuing education and the advancement of the profession is an essential ethos worthy of empowerment.

BRAEMAR FINANCE

Part of Close Brothers Group

Specialist **dental finance**

Fast decisions on tailor-made and tax efficient finance solutions.

- Equipment finance: Hire Purchase and Lease
- Business Loans*
- Start-up business finance available
- Flexible terms: 1-7 year options
- No deposit options
- Facilities from €1,000

Speak to us today, we're here to help.

braemarfinance.ie/ad-dental

SCAN ME

Republic of Ireland - Lorraine Blake
lblake@braemarfinance.ie
086 772 7552

Northern Ireland - Gail Cormack
gcormack@braemarfinance.co.uk
+44 7919 598 577

*Business Loans are only available to Limited companies.

ADVOCACY AND CAMPAIGNS UPDATE

Fintan Hourihan
IDA CEO

Working for dentists in Ireland

Advocacy and campaigning for members is at the core of what the Association offers dentists in Ireland. In each edition of the *Journal*, we will offer a summary of the many different aspects of what we do on your behalf.

Being an IDA member is vital to ensuring that we represent our members from a position of strength, and also means that you are provided with essential information and can influence what we do on your behalf.

Campaigns

The Association's campaign priorities have focused firstly on resolving the dental workforce crisis, and secondly on improving access to dental care for the entire community. In regard to the dental workforce crisis, we published a detailed policy document in April, outlining the steps that need to be taken to improve the recruitment and retention of dental staff. We are currently pursuing a hearing with the Oireachtas Health Committee to push for progress.

The IDA has also published a detailed document on improving access to dental care for all sections of the community. The Association has met with the Minister for Health to explain its position on the oral health reforms programme and reiterated its opposition to the piecemeal approach being suggested, such as the proposals to introduce a new scheme for the treatment of children under seven.

The IDA is also in touch with senior Government ministers across all parties, as well as leading Opposition politicians, the result of which can be seen in the large volume of debates and questions in the Dáil on oral health.

Fees reviews and contracts

The Association has concluded a framework agreement with the Department of Social Protection to allow a review of fees paid to dentists participating in the DTBS in a manner that is compliant with competition law. The contract for dentists is also under discussion. We expect that overdue fee increases will be announced in the coming weeks.

DTSS contract holders saw a significant increase in fees paid for certain treatments in mid-2022 when the Association highlighted the complete anomaly in fees paid. However, our priority is not amending the current contract but to have it replaced with an entirely new scheme that works for dentists and their patients. We are continuing to campaign for talks to begin under an independent chair and with the removal of the threat of legal sanctions against the Association and its negotiating team.

Individual representation

Professional representation by our officials has seen agreement reached in a number of HSE probity investigations for general practitioners holding DTSS contracts. We have also helped members in the HSE to resolve a number of disputes, and have made representations in a small number of cases where private practitioners were denied indemnity cover.

Legislation

Our focus in recent times has been on securing support for a detailed amendment providing for the introduction of mandatory CPD for dentists. Ultimately, an entirely new Dental Bill is needed and we identified the priorities for reforms in a submission to the Department of Health in January 2022.

Meetings

The Association meets regularly with State agencies and third parties to represent the concerns of members, exchange information and collaborate where appropriate. Meetings have taken place in recent weeks with Challenge Insurance, Dental Protection, the Dental Council and Medisec, among others. At our meeting with the Dental Council, we represented members' views and concerns in regard to workforce planning and the syllabus for statutory exams for non-EEA candidates. Clarification was received on new codes of practice to be published shortly and also on refugee dentists/mentoring.

International

The Council of European Dentists (CED) is a European not-for-profit association, which represents over 340,000 dentists across Europe. This year marks 50 years of membership by the IDA. Dr Robin Foyle represents dentists at the CED as a member of the Board, and also as a liaison between the Board and the Task Force on Dental Materials and Medical Devices. Dr Nuala Carney is Chair of a Working Group on Professional Qualifications, and Dr Kieran O'Connor participates in a Working Group on Patient Safety, Infection Control, and Waste Management.

HSE/public service pay talks

The IDA represents members employed by the HSE in a number of negotiating forums. Talks at the Workplace Relations Commission (WRC) will resume shortly on reporting relationships, sessional rates and CPD funding/protected time. A long-running disagreement on the so-called sectoral bargaining negotiations also saw the IDA secure full pay increases for dentists in the public service after a protracted delay. This involved attending a number of meetings at the WRC.

The Association has also attended a number of exploratory discussions with the Department of Health and the Department of Public Expenditure and Reform on sectoral bargaining. These discussions come ahead of the resumption of talks, which will take place over the summer, on extending the current public service pay agreement.

Mouth Cancer Awareness Day 2023

Mouth Cancer Awareness Day 2023 will take place on Wednesday, September 21. More information will be available closer to the time at: www.mouthcancer.ie.

HSE Dental Surgeons Seminar 2023

The annual HSE Dental Surgeons Seminar returns to the Midlands Park Hotel this October! Mark off Thursday, October 12, and Friday, October 13 in your diaries for this event for all those employed in the public dental service.

Colgate Caring Dental Awards 2023

The IDA is delighted to announce that the Colgate Caring Dentist Awards will continue for 2023. Applications are now open for patients to nominate their dentist and/or dental team. Remember, the awards are only nominated by your patients. The IDA will forward information to dental practices to use on social media platforms over the next few months. Get the tuxedos/party dresses dry cleaned and the dancing shoes polished for a night to remember on Saturday, November 18, at the InterContinental Hotel, Dublin. Further details to follow. To nominate a dentist or dental team for an award, go to www.colgatecaringawards.ie.

CPD webinars online

Did you know that as a valued member of the IDA, you can view the majority of webinars in the 'Members Only' section of the IDA website. There is a wealth of information in these webinars, and members can log on at a time and day that suits them.
Log on to the website, and select CPD at: www.dentist.ie.

Webinars autumn/winter 2023

Interested in giving a webinar? The IDA CPD Committee is now putting together the online CPD programme for autumn/winter 2023. If you are interested in presenting a webinar for the next series, please contact elaine@irishdentalassoc.ie.

Costello Medal 2023

From left: Tony Costello (grandson of Dr Tony Costello); Costello Medal winners Laith Aljohmani and Fargol Nowghani; and, Anna Costello.

The 2023 recipients of the Costello Medal, representing Dublin Dental School & University Hospital were Laith Aljohmani and Fargol Nowghani.
The title of their presentation was 'Accessibility and Distribution of HSE Dental Clinics'. With a rapid decline in participation of private dental practices in publicly funded schemes, the provision of care to populations in need falls on Health Service Executive (HSE) dental facilities. The accessibility of these facilities is not well understood, given that the current policies in place are based on outdated population demographics. The aim of the winning study was to determine the geographical mapping of HSE clinics relative to the population demographics per county in the Republic of Ireland. With this knowledge, policymakers and healthcare providers can develop targeted interventions, which can improve access to dental care and reduce disparities in Ireland.
This year the poster demonstrations were adjudicated by visiting lecturers Dr Martin Kelleher and Dr Mili Doshi, and IDA President Dr Eamon Croke.

IDA must be central to policy reforms says former Health Secretary General

"I think that the Irish Dental Association has to be central to all policy development in the context of dentistry including appropriate structures for the various aspects of dentistry, including general dental practice and including the HSE practice." That's the view of the only dentist who has served as Secretary General of the Department of Health, Dr Ambrose McLoughlin, who is interviewed in the latest episode of the IDA podcast series *The Whole Tooth*.

Dr McLoughlin is interviewed alongside Prof. June Nunn, first chair of special care dentistry in Britain or Ireland and also first female Dean in an Irish dental school. To listen to the podcast please use this link: https://apple.co/42yONKf.

Dr McLoughlin says that "a consultative forum is the key to getting agreement on so many things such as a new Dental Act, the key to getting agreement on new dental schemes but it's also the key for the dental profession to develop an opportunity for those who have careers in dentistry into the future.

"The establishment by the Association and others of the National Oral Health Forum in 2013 was an attempt to create a coalition of the willing to focus on oral health. I was very pleased that the Association was prepared to lead with this initiative and I had hoped that the Forum would be the coalition of the willing that would transfer their thinking onto things like a new Dentists Act, which would design and reshape policies on oral health.

"I believed that the Forum would be the catalyst that was going to drive change. The Forum was also the vehicle for consultation. I believe in growing policy from the ground up, listening carefully to the people who are going to be involved in the implementation".

Prof. Nunn recounts the many positive initiatives with which she is associated, including the opportunities when she arrived in Dublin in 2001. She dispels many of the myths around special care dentistry and also recounts many other exciting developments in her time as Dean, on the Dental Council and as a member of the Association.

Previous interviewees on *The Whole Tooth* have included: Dr Caroline Robins and Ms Roisín Farrelly, who discuss the dental staffing crisis; Drs Eamon Croke and Garry Heavey, who discuss the changes they have seen in Irish dentistry; and, Dr Eoin Kinsella on the centenary history of the Association.

Follow our podcast series *The Whole Tooth* and look out for future episodes.

ADVERTORIAL FEATURE

BREAKING NEWS
Deadline extended to April 2025

Opportunity extended to qualify for UK pension giveaway

MOORE WEALTH MANAGEMENT

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.

However, the option to buy a UK state pension currently exists for anyone who has worked in the UK and should not be passed up.

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?

Even if you haven't worked the required amount of time to reach the minimum 10 years on your UK National Insurance record, you have the option to make voluntary contributions to increase your record to either bring you up the minimum requirement or to increase your record to bring you closer to the 35 years required for the full state pension.

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)

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

On the 12th of June, the UK Government announced an extension on this offering to April 2025 due to overwhelming demand from eligible people in the UK and Ireland.

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 qualify, this will have a significant impact on your financial planning. Your adviser will need to update financial projections and your cashflow model to account for this.

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

This 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 to end of life with full cashflow modelling. Anything else is not at the level of today's adviser market. Moore Wealth Management has been advising members of the dental community for over 20 years and has a clear understanding of your sector from start-up to business exit and are perfectly positioned to give you the clarity and certainty your hard work deserves.

Contact Colm 086-860 3953 / colm@mwm.ie
Kieran 086-380 1868 / kieran@mwm.ie
See also www.mwm.ie.

Henry Schein, ADEE and EDSA student awards

The Association of Dental Education in Europe (ADEE), the European Dental Students' Association (EDSA) and Henry Schein will co-operate to launch the 2023 Oral Health Professional Educators' Practice Green Awards for dental schools and societies.

The organising associations state that the awards aim to embed an ethos of sustainability within the education lifecycle for oral health professionals, and within their educational and clinical practice settings. Best practice examples will be showcased and recognised through participation in this programme.

Participants in the awards are invited to submit their application on sustainability projects under three categories:

- faculty campus initiative;
- faculty curriculum initiative; and,
- faculty procurement and product use initiative.

EDSA President Martha Adam stated: "EDSA has long advocated for academic institutions to embrace sustainable and green practices within the undergraduate curriculum and beyond. We are delighted to be invited to associate with this new innovative award and look forward to seeing the impact on practice".

The award was named after Henry Schein's recently launched international sustainability programme, Practice Green, which the company states is designed to empower the healthcare community to positively impact the future of the planet by reducing the ecological footprint and promoting sustainability.

The awards will be presented at a gala event held as part of the ADEE 2023 annual meeting in Liverpool on Friday, August 25, 2023.

Coltene impression material

Coltene states that its Affinis impression material is key to creating accurate lab-fabricated restorations. According to the company, the material has a fast affinity to tooth and gingival tissues, and a self-contouring consistency, which allows it to capture every detail.

Dr Rupert Monkhouse, a dentist who uses the Affinis range, says: "I find the interaction between the materials and layers work seamlessly to produce reliable and excellent results, giving me confidence in my outcomes".

Also available from the Coltene is the Crios reinforced composite bloc, which the company states can be used for inlays, onlays, conventional and implant-supported crowns, and veneers. According to the company, Crios combines the advantages of a hybrid composite with those of CAD/CAM fabrication, such as no separate firing process, and constant thermal curing provides good shock absorption. Coltene believes Crios is ideal for bruxism patients.

Shining brightly

The IDA marked its centenary in style with a fantastic Annual Conference in Kilkenny.

This year's Annual Conference at the beautiful Lyrath Estate in Kilkenny was a truly special occasion, as it marked 100 years of the Irish Dental Association. Even the weather was in keeping with this year's theme of 'Shining Brightly for 100 Years', as the sun shone on three days of education, collegiality and friendship.

The large number of dentists and dental team members who travelled to share the experience was evident in packed lecture halls and in the bustling trade area, where friends and colleagues could reconnect over a cuppa and see all the latest products and services available to the profession. In between lectures, there was the art exhibition, the poster presentations, and the 'Cinematic' experience to enjoy, as well as golf and outdoor yoga for those who wanted to relax in the fresh air.

Insight into skills

On Thursday, those who had chosen to take on a pre-Conference course had the benefit of expertise from right across the specialties. Courses on endodontics, posterior composites and handling surgical complications took place alongside essential guidance for those hoping to improve their paediatric dentistry skills, and those taking on the role of radiation protection officer.

As ever, Friday and Saturday saw parallel lectures taking place, with the best of local and international speakers sharing their expertise on an enormous range of topics.

Dr Chris Orr is a cosmetic and restorative dentist who practises in London and he presented on 'Traditional crown preparations: time to say goodbye?' He asked the question that when we are considering the longevity of restorations, are we really considering longevity of the right thing? Dr Orr said that when comparing restoration longevity for different restorations, the evidence is that onlays do the same job as crowns with only a 2% difference in functionality (76% versus 78%) after 15 years, but of course onlays are a more conservative approach. His wide-ranging address also asked why we are still preparing teeth for crowns in 2023 when in many instances, onlays and veneers can do a similar job with superior aesthetics and reduced invasiveness.

Prof. Anne O'Connell took the audience through new developments in dental trauma. The International Association of Dental Traumatology (IADT) guidelines now offer clear guidance to practitioners, and will enable better data capture on types of injuries and outcomes, which will hopefully enable better treatment (and prevention) in future. Prof. O'Connell discussed educating parents and young people on the importance of properly fitted (and properly cleaned) mouthguards, and on what to do when a dental trauma occurs (citing the ToothSOS app as one of many resources available). She finished by discussing exciting new research into regenerative endodontic therapy, which may eventually lead to autotransplantation of pulp in the dental clinic.

Dr Sally McCarthy also spoke about dental trauma and dental care, this time in the elite athletes that she treats both pitch side and in her surgery. She talked about the importance of tailoring treatment to the specific needs of this extraordinary group of people, where precisely calibrated training cycles, constant travel, and even the pressure of celebrity can impact on both routine dental care and the treatment of traumatic injuries.

Local anaesthesia is of course a major part of general dental practice, and Dr John Alonge had a range of tips and tricks for practitioners. From needle and syringe choices, to the type and dosage of local anaesthetic, he took the audience through the evidence, and his own extensive experience. He also discussed the best techniques, giving tips on administering inferior alveolar nerve blocks using the Gow-Gates technique, and on the Vazirani-Akinosi block, among others.

Drs Ed Madeley and Rory Boyd shared the podium for a lecture on combined prosthodontic and periodontic planning for anterior aesthetic cases. Detailed smile analysis is essential to identify any issues ahead of treatment, and they took attendees through a forensic analysis of what makes a smile, from lipline, to tooth dimensions and proportions, with a gallery of images to illustrate each example. Treatment planning is equally important. Keep it simple and respect the biology were two key messages in this fascinating look at how two areas of dentistry can work together to achieve great results for patients.

Reflections

Friday's session finished by bringing delegates together for two fascinating, and very different, presentations. Dr Martin Kelleher spoke on the good, the bad and the ugly of his 50 years in dentistry, with a passionate argument against 'destructodontics', as he described the trend to carry out ever more invasive dental procedures for aesthetic or 'fashion' reasons that have long-term biologic consequences. Enamel is the best substance by a mile, he said, and needs to be maintained. He said there needs to be a rebalancing away from 'maximising' (which he said was a cover for destructive dentistry) back to 'satisficing' – dentistry that is sufficient to be satisfactory as judged by the patient. Success, he said, is avoiding loss, and he praised the concept of the 'daughter test', whereby every practitioner needs to ask whether they would carry out a particular treatment on a loved one, as a great guide for any treatment.

The final event of the day was the official launch of *The Irish Dental Association: A Centenary History*, the official history of the IDA commissioned especially for this centenary year. Authors Dr Eoin Kinsella and Dr Frances Nolan took us through some of the key themes of the book, from the

foundation of the IDA in 1923, through the role of women in the profession and the Association, and the history of IDA representation of public health dentists. It's clear from the history that from its beginnings, the Association has advocated for and campaigned strongly on behalf of the profession – both public and private dentists – and the oral health of the public, with many run-ins with authority along the way. IDA CEO Fintan Hourihan and President Dr Eamon Croke both drew parallels with current events, citing the proud tradition of advocacy, and saying that it was needed now more than ever as the Association moves into its second century.

Innovation and evidence

On day three of the conference Dr David Gerdolle started the day with case-based advice on direct anterior composites in daily practice. The aim is to produce a cost-effective restoration that is aesthetically satisfying for the patient, but that is also functional, and that will last. Like other lecturers, he talked about the importance of smile design and detailed treatment planning to achieve the best results. Colour matching is complex, especially as enamel becomes more translucent over time. To achieve excellent function, Dr Gerdolle said that it may be necessary to look at the patient's occlusion, which may need to change (what he called 'deprogramming' the patient) so that treatment will work.

Time is money, but with endo, the faster you work, the lower the success rate. That was the message from Dr Matt Zehnder in his lecture on modern concepts of endodontic irrigation. He said that success depends a lot on tooth anatomy, which dictates the best instruments to use (round instruments to clean round roots). He advised cleaning chemo-mechanically with bleach, as it's the only substance that can dissolve biofilm, and illustrated techniques with case images and videos. He discussed the research evidence on the use of sodium hypochlorite (NaOCl), which shows that there is less pain with NaOCl, and significantly less treatment failure. However, NaOCl is not enough by itself – he said dentists need to use a decalcifying agent on top, such as EDTA.

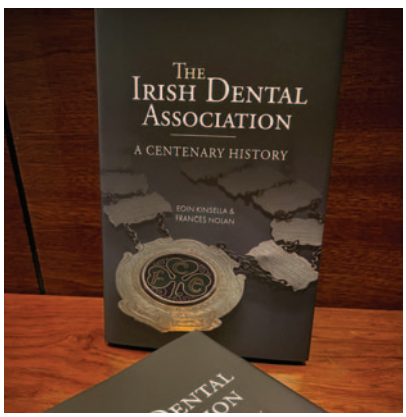
This year saw an innovation at the conference in the form of pre-recorded lectures, and perhaps appropriately, Dr Falk Schwendicke availed of the technology for his lecture on the potential of artificial intelligence (AI) in dental diagnostics and decision support. Dr Schwendicke gave a potted history of AI's development, up to current discussions where there is both huge excitement and trepidation about its potential in all areas of life. He reminded the audience that AI depends on humans to feed it information from which to 'learn'. For example, in order for AI to successfully analyse a radiograph, or other medical image, it must have access to a large number of radiographs, and be 'told' by an expert what they indicate. Dentistry produces a massive amount of radiographs, so there are enormous possibilities for AI as a diagnostic support. However, research into its effectiveness compared to a human is so far

A special centenary Past Presidents' Lunch brought together many of those who have served the IDA as President. Back row (from left): Dr Andrew Bolas; Dr Martin Holohan; Dr Charles O'Malley; Dr Kieran O'Connor; Dr Joe O'Byrne; Dr Pat Cleary; Dr John Barry; Dr Eamon Croke; Dr Garry Heavey; Dr Noel Walsh; Dr Donal Blackwell; Dr Tom Feeney; Dr Gerry Cleary; Dr Conor McAlister; and, Dr Robin Foyle. Front row (from left): Dr Seán Malone; Dr Gerry McCarthy; Dr Ena Brennan; Dr Rory Boyd; Dr Vincent O'Connor; Dr Caroline Robins; Dr Barry Harrington; Dr Anne O'Neill; Dr PJ Byrne; Dr Billy Davis; Dr Clodagh McAllister; Dr Cathal Carr; and, Dr Leo Stassen.

Margaret Croke and IDA President Dr Eamon Croke.

From left: Dr Emma Vahey and Dr Clair Nolan.

Dr Emma Rose McMahon and Dr Ambrish Roshan.



The Irish Dental Association: A Centenary History *by Drs Eoin Kinsella and Frances Nolan was launched at the Annual Conference.*

Dr John Alonge had a pre-Conference course on handling surgical complications, including hands-on suturing.

Prof. Anne O'Connell lectured on new developments in dental trauma.

The Henry Schein team (from left): Siobhán Cleary, National Sales Manager; Patrick Bolger, Regional Business Manager SOE (Software of Excellence); and, Ian Simms, Practice Valuation Manager – Henry Schein MediEstates.

David Walkerdine and Stephanie Gribben of Colgate.

inconclusive. For those who fear that AI will make them obsolete, Dr Schwendicke reassured the audience that there's no need to worry yet, as the technology has a long way to go. However, data-driven tech is not going away, and in the long run it may be enormously beneficial.

Dr Mili Doshi is a consultant in special care dentistry, and her lecture focused on managing the oral health of adults with a neurodisability. She discussed the impact of traumatic brain injury, and the place of dentistry in a multidisciplinary approach to rehabilitative care. Challenges for dentistry can include mobility issues, cognitive impairment, and medication. She offered tips on communicating with patients, including the importance of taking time, asking simple yes or no questions, and possibly using visual symbols and tools. She said that minimally invasive dentistry is a very good approach for this group, and that treatment planning is vital and should prioritise keeping the patient pain, disease and infection free, with a functional dentition that is cosmetically acceptable and easy to maintain.

In another pre-recorded lecture, Dr Brett Duane looked at PPE and dental decontamination from the perspective of sustainability, asking how dentists can find the right balance between patient (and practitioner) safety and harming the planet. He looked at a wide range of products, from gloves and wipes to hand gels and soaps, and what the available evidence tells us about which products are the most sustainable.

When all factors are taken into account, some of the results are surprising. For example, single use wipes come out better than reusable products as they contain less disinfectant. Energy consumption is important too, from reducing paper use to using renewable energy to power equipment like washer-disinfectors. The message is that dentists need to think about all of the products and processes they use: look at the full lifecycle and follow the standards, but question them too.

The final lecture of the conference was given by Prof. Avi Banerjee, who brought his enormous knowledge of minimally invasive (MI) dentistry to the topic of MI management of the deep carious lesion, with case examples to illustrate the approach, and the challenges.

There is now a huge body of evidence to support the MI approach, and dentists shouldn't be afraid to use it, so long as they record their treatment decisions and discuss them with patients. Despite the evidence, there is huge resistance to change, including in terms of public healthcare delivery models, and Prof. Banerjee spoke about the need to bring about institutional change so that patients benefit from the evidence.

Dr Eamon Croke then brought this very successful centenary conference to a formal close.

Celebrating women in Irish dentistry

For our centenary feature in this edition, we spoke to seven remarkable women who represent the very best in Irish dentistry.

From the first woman to be dean of a dental school, and the first woman to be President of the IDA, to women running practices around the country, and women who have chosen to make Ireland their home, their lives and work show the diversity of the profession, and the huge contribution of women to dentistry and oral health in Ireland.

Dr June Nunn

June has had a long and impressive career, including pioneering the focus on special care dentistry in Ireland. She was born in Kilkenny, before moving to the UK with her parents. She completed her undergraduate degree in dentistry in Dundee, Scotland, and began her career in Birmingham, working at the dental school there. She later worked at the dental school in Newcastle, where she mentioned working alongside "great colleagues and a very good boss who really made sure that you achieved things in your career and complemented the rest of the department with your skills".

She then decided to further her studies and undertook a PhD in special care dentistry, an area she dedicated most of her career to.

This led her to a post at the Dublin Dental School. Having previously been the first Chair in Special Care Dentistry and the President of the British Society for Disability and Oral Health, she felt that it was a golden opportunity to return to Ireland to bring her expertise here: "It was a blank canvas with a remit to put special care dentistry really on the map here. The mission was to set up higher education and training, to have a secondary-tertiary-level clinical service in a national centre, and to undertake research, so that everything we were doing was evidence based, and gradually build a team. It was important to have that recognition because very many of us had worked with children with special healthcare needs, and those children grew up and became adults, and there wasn't any service to look after them".

"It's great being a leader, but a leader is no good unless they've got followers, so you have to bring people along with you."

In terms of her experience as a woman in the field, June says: "I never felt there was ever a glass ceiling. Whatever you wanted to do, you could do. I have always had very supportive bosses and managers who have been very enabling, and there was never a situation where I felt a male colleague was given priority over me, or that I couldn't do things because I was a woman".

However, she did notice that her experience as a woman dentist, or more specifically, a mother and dentist, meant that she had to work hard to achieve a work/life balance: "I had to do a fellowship, I had to do a PhD, I had to do higher specialist training. I had to do all those things part time because I was doing them all together. And then you're trying to juggle children as well, and so inevitably things take longer. I think it's just a sacrifice you make if you want a fulfilling life, and you want children as well". June was appointed as Dean of Dublin Dental School in 2009, and held the position until 2015, the first female dean of a dental school in Ireland. She says that she places value in the people who worked with her during that time, for the collaborative, joint effort that is involved when acting as dean: "It's great being a leader, but a leader is no good unless they've got followers, so you have to bring people along with you". She advises the next generation of female dentists to strive to do work that fulfils them and that has a positive, innovative impact on oral care.

Dr Meriem Abbas

Meriem is a young, successful, and ambitious associate dentist, clinical tutor, and Editorial Board Member for the *JIDA*. Meriem graduated from Cork Dental School, before relocating to the UK to work for the National Health Service (NHS) in a busy inner-city practice: "I learned so much, and you have to put everything into practice straight away, so it was intense, but it was good".

After that, she returned to Ireland and has been working as an associate dentist and clinical tutor for the dental school at UCC ever since. Meriem communicated an appreciation for general dental practice, saying: "I like being able to do a little bit of everything. I like the fact that you see everybody from all walks of life, and every day is different. My focus now is just to keep upskilling, and just get really good at everything. Because I think that's a lot more satisfying for me than just doing one thing".

Her experience as a young Muslim woman dentist has been somewhat different to the majority, in that she has had to face discrimination in her efforts to succeed: "I found it very hard at the start to get people to give me a chance.

Colm Quinn
Senior Journalist,
Think Media Ltd

Rebecca Pollard
Journalist and sub-editor,
Think Media Ltd

When I graduated and was applying for jobs, it was a rude awakening that not everybody sees you the way you feel, not everybody can see past your physical appearance".

"You need to build your self-confidence and that strong core belief in yourself because that will translate into all aspects of your life, not just your job."

Meriem recalled her first job interview, which went awry due to a racist interviewer who did not hire her due to her ethnicity: "It did upset me because I was in that bubble of thinking 'I'm an Irish graduate. That's it, full stop'. But I did experience that I would send CVs and just get zero. You wouldn't even get the time of day. And it's not for lack of trying".

Meriem also draws particular attention to the advancement of careers for minority women in Ireland. In particular, she thinks that having a mentor is imperative for advancing a career in dentistry: "I was working in corporate practices for a long time because that's all I could get, and I think a lot of Muslim women or foreign dentists are in the same boat. While the staff were lovely, if you want to further your career and genuinely want to get better, you don't have that support. I consider myself really lucky that I have this opportunity to be where I am right now, because a lot of people don't, or it's a lot harder for them than it would be for somebody else, and it shouldn't be. If you work hard, and you apply yourself, everybody should get the same opportunities to excel".

To other young women in dentistry, Meriem advises investing in your own personal growth just as much as your career: "You need to build your self-confidence and that strong core belief in yourself because that will translate into all aspects of your life, not just your job".

Dr Siobhan Doherty

Siobhan Doherty is HSE Principal Dental Surgeon for Kildare/West Wicklow and Dublin South West. She says the role is demanding, comes with a lot of responsibility, but is also very rewarding: "It's a senior clinical management post in the HSE and it's diverse and it's very challenging. But as a clinician, I remain close to the patients and the staff, and have a deep understanding of the issues involved in dental practice and in a healthcare system".

Siobhan thinks dentistry makes a great career for women: "I enjoy working in healthcare and I have a good mix in my job of the clinical and of management work. The whole area of dentistry is changing so much and I like being part of that and I like being involved in an organisation, i.e., the IDA, helping to shape the profession in Ireland. Dentistry affords women the same opportunities as it does men in my experience … I must say, I'm proud to be a female dentist, working in an area where things are developing so much".

Part of her advice to young female dentists is to seek out opportunities and develop a passion for an area of dentistry that they're good at and enjoy. Stay involved in education and updated about what's going on: "I'd advise them to develop and encourage support networks from colleagues for well-being and work–life balance. I'd also advise them to search out good mentors. I was very fortunate in having two very good mentors in my career: Dr Frank Daly and Dr Barney Murphy. I'd advise them to shape their own future, to stay engaged, and to actively contribute to the dental profession".

"I knew my areas of interest were in paediatric dentistry, in special care and in public health. The HSE dental service allowed me to work and expand my skills in these areas."

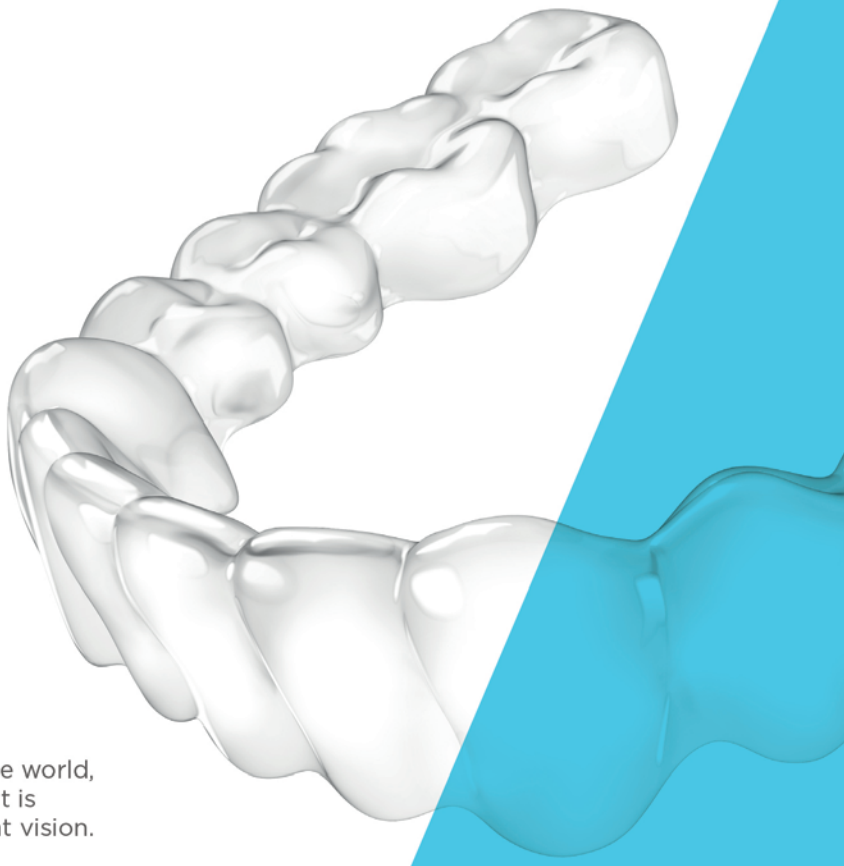
Siobhan is a member of the IDA Management Committee. The Management Committee is tasked with upholding the IDA's Code of Conduct, which includes ensuring that financial and operational aspects of the organisation are protected and preserved. Ultimately, the Management Committee is responsible for developing and ensuring the IDA's strategic direction, and Siobhan says it is enjoyable: "It allows me to network with colleagues and friends while at the same time allowing me to be involved in an organisation that represents and advocates for dentists".

The biggest attraction to public service dentistry for Siobhan was working within a larger team environment where her clinical practice was supported: "I knew my areas of interest were in paediatric dentistry, in special care and in public health. The HSE dental service allowed me to work and expand my skills in these areas".

The HSE offers good career development, work–life balance and has also allowed her to be involved with public health campaigns as well: "For example, community oral health projects, working with schools and HSE programmes such as Making Every Contact Count. I get to work with and for the most vulnerable in society. My interest in management developed early in my career and the HSE was an ideal place to develop these interests. The HSE has opportunities to progress along clinical or clinical management roles dependent on one's interests".

SPARK™

CLEAR ALIGNER SYSTEM



ADVANCED CLEAR ALIGNER TECHNOLOGY

DESIGNED TO MEET YOUR NEEDS AS A PROVIDER OF INVISIBLE ALIGNERS

With clinical experience from trusted doctors around the world, Spark has created an advanced clear aligner system that is designed to meet your needs and deliver your treatment vision.

From Ormco, where your Practice is our Priority.

ALIGNER INNNOVATION REDEFINED

The TruGEN™ is the latest material innovation, with higher sustained force retention than the leading aligner brand.1

FLEXIBLE 3D SOFTWARE

Proprietary Spark™ Approver software, designed to put more control in the doctors hands.[1]

100% OF PATIENTS SURVEYED WOULD RECOMMEND SPARK TO A FRIEND

Spark aligner system is more clear, more comfortable and more stain resistant than the leading brand.[2,3]

The TruGEN aligner material is crystal clear and the software interface is amazing.

– Dr. Stuart Frost*

*The opinion that is quoted in this material is that from Dr. Frost. Cinicians use your own judgement in treating your patients.

WANT TO LEARN MORE?

Visit our website **ormco.uk/spark**

YOUR REPRESENTATIVES

Myles Turley
Senior Territory Manager
Ireland & Iceland
myles.turley@envistaco.com
T. +353872329930

Chris Kenny
Territory Manager Ireland
chris.kenny@envistaco.com
T. +353 83 0120317

Ormco™

[1]Spark™ Clear Aligner is designed to have high force retention than the leading aligner based on laboratory analysis against a reference standard. Data on file.
[2]Spark™ Clear Aligner is designed to be more clear than the leading aligner based on laboratory analysis against a reference standard. Data on file.
[3]Spark™ Clear Aligner is designed to be more comfortable than the leading aligner based on laboratory analysis against a reference standard. Data on file.

Dr Ghazal Maher

Ghazal Maher is a fully-committed and determined dentist from Afghanistan, who sadly had no choice but to flee her home country to seek refuge in Ireland. Her path through dentistry has been fraught with many obstacles from the beginning of her education in childhood to her current situation: "Being a small kid, I was deprived and banned from going to school only because I was a girl".

Ghazal had to live out her childhood in Pakistan in order to receive education, and moved back to Afghanistan with a passion to fill the gender gap in dentistry there: "I chose to be a dentist because culturally in Afghanistan, women prefer going to a female dentist. I knew that I could see females avoiding treatment because they did not want to go to a male dentist".

Ghazal completed dental training at Kabul Medical University with an honours degree, and was one of the first female valedictorians at her university.

She then completed a four-year residency programme in oral-maxillofacial surgery. By the end of the programme, Ghazal had been studying and practising for 11 years. She then opened her own very busy dental practice in Kabul while still completing her residency programme, where she practised all areas of dentistry.

"We are determined to work. I want to see myself in a position that I can contribute more to society."

Ghazal had decided she could not stop there and began the exam and review process to enter Kabul University as a lecturer, but was impacted terribly when the Taliban overthrew the government in Afghanistan, so decided to leave with her family for their safety: "I was supposed to sit this exam in September 2021, but I left Afghanistan in August, and my notes were still on my desk when I left my country, and I could never take that exam".

Despite the terrible experience of fleeing her home country, Ghazal has remained determined to continue her passion for providing dental care: "When I was on the plane to Dublin, in my mind I was thinking, what's going to happen to your career? Just a few days ago, I used to be a very busy person, having so many things to take care of. I had to deliver lectures, I had my appointments arranged, and what's going to happen to my career? On the plane, I decided that I would use any opportunity, I would go to any stage to just continue this profession".

Since moving to Ireland, Ghazal has worked alongside Dr Eamon Croke as a dental nurse and is in the process of getting her qualifications and academic records recognised in Ireland. She is grateful for her residency in Ireland and speaks on behalf of other refugees that she has met: "So many professionals are here. They have skills, they have knowledge. They just need a little bit of adjustment in terms of improvements, standards, rules and laws. We are determined to work. I want to see myself in a position that I can contribute more to society".

Dr Marcela Torres Leavy

Marcela is the owner of Kinnegad Dental in Co. Westmeath. She began her career in her home country of Guatemala, where she studied dentistry at the University of San Carlos of Guatemala (USAC). Growing up, Marcela's mother was a lawyer, but formerly a nurse, and her dad was an artist: "I think from the beginning, I was encouraged and interested in science and artistic things. Dentistry offered the two things, the science side and then the artistic side, and with all that came the social part of it".

The social side of dentistry is one of the factors that fuels Marcela's passion for the profession. She completed a year of social dentistry after her studies, giving back to communities in need in Guatemala: "I think it was very important to understand, not just the technical part of dentistry – the science, the art – but also how to manage relationships with people. And I think that gave us a lot of insight of what will come when you're on your own, out of college".

"I think it was very important to understand, not just the technical part of dentistry – the science, the art – but also how to manage relationships."

After college, Marcela and her husband moved to Ireland after four years of living in Guatemala. Moving to a new country came with its own struggles, as Marcela had to undergo rigorous exams for the recognition of her title in Ireland: "I thought: I have to make it, there is no other option. And thankfully, I did. I had my title recognised in 2008, so I was ready to practice at the end of that year. It was an exciting time, a hard time as well: integrating in a new country, new language, new everything really".

By 2012, Marcela had opened Kinnegad Dental, and she credits the support of people around her and the need for a practice in Kinnegad for its success: "I think that the help of the community and the need as well at the time made things happen. It was not only our dentist there, yes, but the help and the confidence of the people that were around. I had doctors in the primary care centre, they supported me and the pharmacist there, obviously my husband, and other dentists. So that was tremendous really for me and for the small team that I had at the time". As a woman in dentistry, Marcela believes that it is a great profession for women, but feels there is an innate struggle between professional life and home life for mothers particularly: "I think it's hard to balance family and profession, because I think it is expected from you as a professional that you are there 100%. And I think, again, that's the hardest part of everything, to balance that out and to avoid burnout".

Marcela believes that a good support system and team can help tremendously: "I think that has helped me, in my experience, to have people that I can count on, and to maintain good relationships with my peers and other colleagues, knowing that I'm not alone".

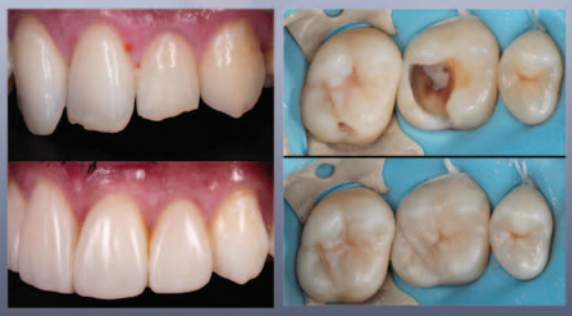
Marcela's advice to other women at the beginning of their careers in dentistry is to be passionate about your profession, learn to be resilient, and maintain good relationships with your team.

Universal submicron hybrid composite

BRILLIANT EverGlow®

Enduring gloss – made brilliant

Thanks to its sophisticated load composition, BRILLIANT EverGlow® immediately produces an exceptionally smooth, glossy and satin-finished surface as soon as the filling is put in place. Polishing is simplified and a very aesthetic restoration can be done in no time. In addition, the versatile Brilliant EverGlow® filling material excels in its enhanced gloss retention.



- → Exceptional polishability and long-lasting brilliance
- → Aesthetic single-shade restorations
- → Versatile shade system with three translucency levels
- → Excellent sculptability and smooth consistency
- → Good wettability with minimal stickiness to the instrument

OFFER

3+1

ON REFILLS

Available from participating suppliers

WATCH THE VIDEO

Your COLTENE Territory Manager - Nick O'Keeffe Mob: **+353 8641 35766** Email: **nicholas.okeeffe@coltene.com**

WWW.COLTENE.COM

COLTENE

Dr Ena Brennan

Dr John Barry handing over the chain of office to Ena Brennan in 2008, when she took over as IDA President.

Dr Ena Brennan became the first female President of the IDA in 2008. She graduated from the Dublin Dental School in 1966 having spent her first two years training in Galway. Her career involved time in the UK and Ireland, and she still does a couple of mornings a week 57 years after she qualified. She says found her involvement with the IDA very worthwhile. In her class in the Dublin Dental School there were four women. Ena says it was a different era: "After I left college, I was told about a big scandal in my class: one person didn't go to mass!"

Ena says that when she qualified, dentistry was one of the few careers where there was equality of fees and work: "We never had any hint of prejudice".

In her final year in the dental hospital, she advertised herself in the jobs wanted section of the *British Dental Journal*. She got over 20 replies and ended up working in Southampton. In 1967, she moved back to Ireland and started working as a public dental surgeon in the school service in the west of Ireland. She attended her first IDA Conference that year, which took place in Mulranny, Co. Mayo: "The dental conference was always the highlight of my year because I would meet up with colleagues and refresh my knowledge".

After another period working in Southampton, she set up a practice in Newbridge, Co. Kildare, and got more involved with the IDA: "I was always very interested in the political affairs in the Irish Dental Association, basically because I enjoy them".

After starting in Newbridge, Ena met her husband Cork graduate Thomas Brennan at a postgraduate course in Kilkenny. She moved to Co. Wexford where he practised and has been living there since. Thomas got ill in 2012 and passed away in 2019. Ena says he was always very supportive of her work with the IDA. Ena took on the presidency of the Association in 2008 and says it was a big undertaking: "It was very challenging but I was glad I did it".

Like all presidents, Ena had to juggle the demands of the role with working. There was a lot of travel involved but she says she enjoyed every minute of it. Ena says dentistry can be a challenging career but that: "It hasn't changed much over the years, even though people might think it has. The basics are still the same".

Her advice for young female (or male) dentists is to join the IDA and go to conferences, as they are a lifeline: "The IDA touches on everything and offers a lovely social life and a lovely way to get to meet people that you don't see from one end of the year to the other. To celebrate the centenary, we had the big dinner in Lyrath House at this year's conference and that was amazing".

Ena says it can take courage to go to these things but that they are rewarding because dentists often work alone. Dentistry has been a marvellous career for Ena. It offers great opportunities, whether that means working a lot to make a substantial living or working a bit less so you have time for other things. It's a very flexible career with a good income.

Dr Sorcha White

Sorcha is a GDP and Principal of Tramore Dental in Co. Waterford. She graduated from Trinity in 2002 and joined the former owner of the practice, Dr David Kenny, on a vocational training scheme, before deciding to stay on as an associate in 2003. Four years later, she bought the practice. Sorcha says that dentistry is a great career for a woman: "It's flexible, sociable and intellectually stimulating. There are great options to work part-time, particularly if you're prepared to put in some late evenings to compensate for finishing early on others. I really enjoy meeting such a wide variety of people every day in general practice, from poets to farmers to CEOs. I love hearing all the different viewpoints".

"Collegiality is very helpful and I have always found more experienced dentists to be extremely generous when I've asked for their advice."

Sorcha has four children between the ages of three and 14. In her practice, she works full-time overseeing an associate, hygienist and four DSAs: "All this is made possible by the support of my husband Ronan who holds down the fort at home as well as carrying out any handyman repairs in the surgery!" Her advice for new female dentists is to keep learning, which she believes is invaluable for increasing the scope of your practice and maintaining a love for what you do, and also: "Collegiality is very helpful and I have always found more experienced dentists to be extremely generous when I've asked for their advice. I think women can worry more, blaming themselves for every setback and falling easily into an imposter syndrome mindset. Hearing the experiences of others can bring an invaluable perspective".

One other piece of advice Sorcha has for female dentists is plan having your family well: "Having babies while running your own practice is achievable but it might be easier to do it when you are an associate!"

Things have changed for female dentists since Sorcha started out: "When I graduated first, older patients would often assume I was the nurse, even asking me *after* the extraction if the dentist would come in now to see them! That doesn't happen anymore. In general, so many more of our academics, conference speakers and practice owners are now women, which is so encouraging particularly for younger women qualifying. I think a healthy balance of male and female role models gives us all something to aspire to and facilitates an environment in which everyone feels able to speak up and ask questions".

Working in a rural practice brings benefits and challenges. It is great to get to know your patients says Sorcha, as this can sometimes allow you to see patterns and know what issues to look out for when treating younger members of a family.

Knowing your patients so well can also be a challenge, where a trip to town can turn into an impromptu consult. More seriously, she says: "When I qualified first, most specialist referrals meant a trip to Cork or Dublin, so there was a lot of pressure to do things yourself, even if they were out of your comfort zone. Happily, we now have several excellent specialists in Waterford, which eases that burden considerably".

The first Irish woman dentist – Mary de Sales Magennis (1886-1971)

Born in 1886 in Lurgan, Co. Armagh, Mary de Sales Magennis earned her BDentSc from Dublin University (TCD) in 1914, just ten years after women were first admitted to the university as undergraduates. She was a pioneer in many respects, not least in that as the first woman to graduate BDentSc from TCD, and almost certainly the first Irish woman to formally qualify as a dentist, her graduation was a landmark moment in the history of Irish dentistry. She was also one of the signatories of the letter circulated in February 1922, informing Irish dentists of the intention to establish the Irish Dental Association. She thus appears to have been the first woman to become a member of the IDA.

On November 4, 1914, de Sales Magennis enrolled on the Dentists Register. She practised for a time from 55 Harcourt Street, later moving a short distance up the road to practice from no. 86, her father's house. During the First World War she was quite active on the Irish 'Home Front', serving as a dentist in the Voluntary Aid Detachment hospital established at TCD. In July 1960 she shared some reminiscences with 'Pro-Candida', a regular contributor to *The Irish Times*. The report described de Sales Magennis, then in her mid-seventies, as:

"…a plump, jolly woman, who remembers her student days vividly. Trinity was a different place in those days, and the incursion of the female was still obviously regarded with a strong mixture of disapproval and cynicism, as well as pleasure. 'You didn't', said Miss Magennis, 'talk to any man in the college park, and if you did someone probably told your tutor or the Lady Registrar'. Nor did you sit beside a man at lectures, or have tea in his rooms without a chaperone. You were expected to dress fairly quietly, even though what you wore was partially hidden by your gown. Miss Magennis was once reproved, and told that the men leaning out their windows said, "What is Mollie wearing today?'. She was advised to preserve a strict college attitude – if she could".

In addition to her practice in 86 Harcourt Street, Magennis also worked in a clinic run by the Women's National Health Association. Patients, she said, received her with some amazement at first, but she soon got on very well with them: 'Men, though, were inclined to make you feel you were trying to do a man's job'.

Her father Edward Magennis, Sr, died in 1938, after which de Sales Magennis gave up her practice.

Magennis died on September 30, 1971. She is buried with her parents and two brothers in Glasnevin Cemetery, Dublin, where there is nothing on the headstone to indicate her pioneering status as Ireland's first qualified woman dentist.

Edited extract from *The Irish Dental Association: A Centenary History*, by Dr Eoin Kinsella and Dr Frances Nolan.

Volume 69 Number 3
June/July 2023

MEMBERS' NEWS

Dentistry at a crossroads

The GP town hall meeting at this year's IDA Annual Conference in Kilkenny heard that dentists are thoroughly disillusioned with the Minister for Health and his Department, but will continue to advocate for patients.

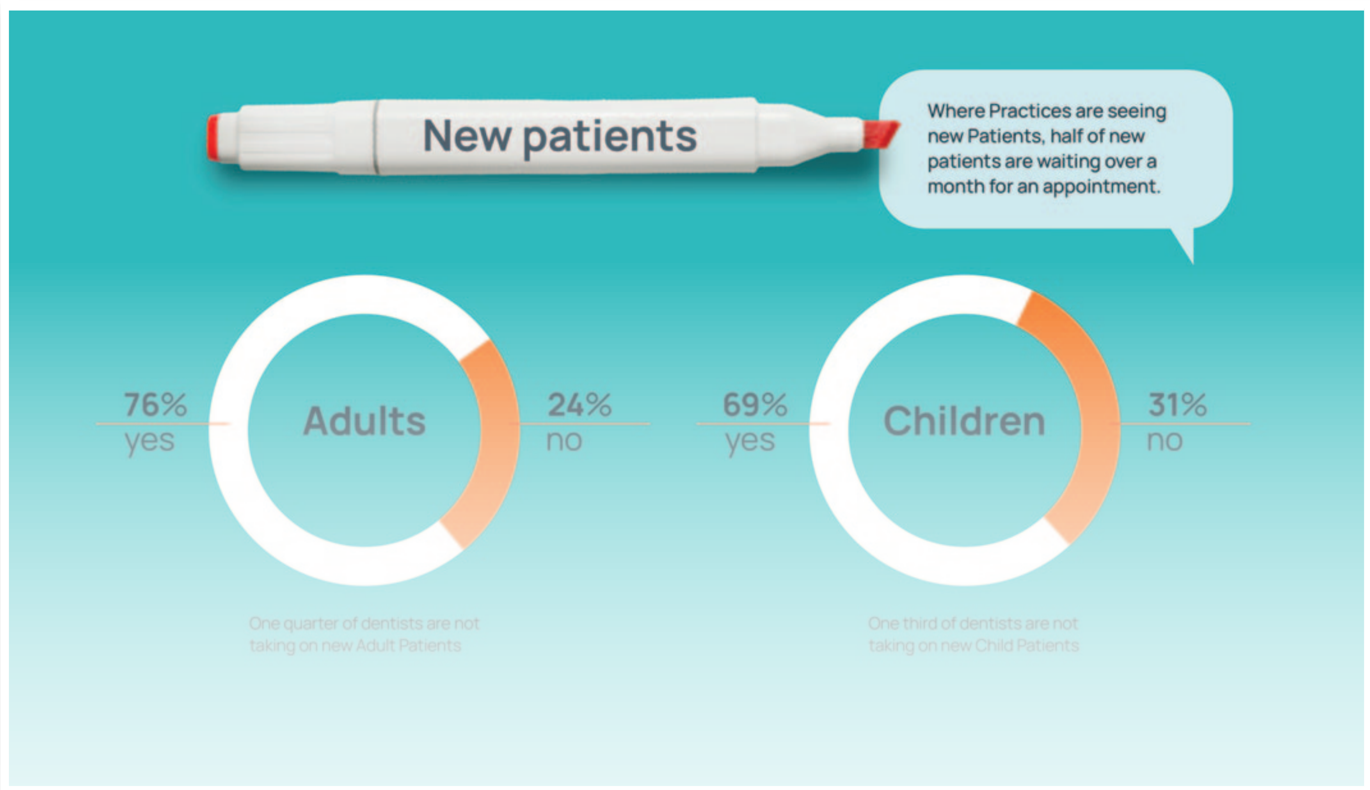
The IDA's GP Group held a town hall meeting at the Association's Annual Conference in Kilkenny, which updated members on the Group's activities, and on the IDA's campaigns with regard to the current recruitment crisis in dentistry.

GP Group

GP Group Chair Dr Will Rymer outlined the Group's work over the last year on what he called the various crises that have been washing over the profession in the last few years. This has included working to develop alternative proposals to those in the national oral health policy, Smile agus Sláinte, which combine the IDA's best alternative to the DTSS (the voucher scheme) and a new model for the HSE dental service.

He said that the Association recently met with the Minister for Health, Stephen Donnelly TD, a meeting that came 16 years after the Department walked out of talks on a new DTSS contract, but that unfortunately was disappointing: "During this meeting the Minister made various placatory

dentistry into line with European and world norms: "Preferring instead to play politics, he quashed the amendment on a technicality and alleged that they will work on the legislation in their own time".



remember that behind these broken promises, false hopes and sad political clichés are broken, sad patients – broken because of their failing oral health, and sad because of the misery that State-sponsored neglect has foisted upon them".

He reiterated his view that despite these disheartening and frustrating experiences, "the fight goes on", and said it was his sincere belief that the IDA must continue to lobby and to advocate for the vulnerable.

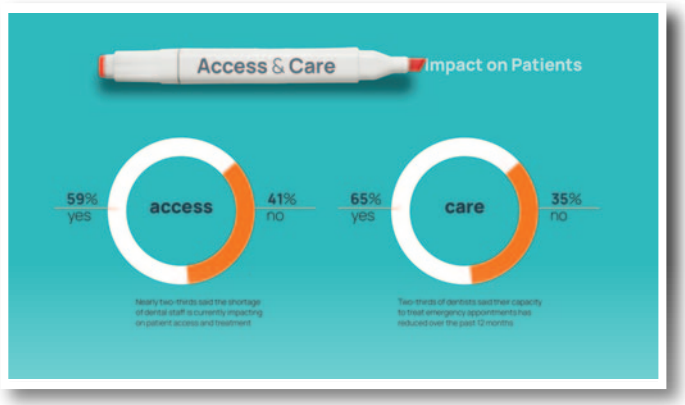
Dr Rymer ended his presentation with a call for fresh talent from all sections of general dental practice in Ireland, but especially from younger dentists and associates, to increase the diversity within the GP Group so that it can be more representative of the wider dental workforce: "Commonly, I hear that younger dentists wouldn't have the experience for a national committee. The important thing to remember is that a younger dentist is the only person able to represent the interests and needs of their classmates and recent graduates. Often our GP Group is seen as a practice owners' group, but we must also represent the interests of a growing number of younger

facing the sector, which is having a measurable impact on how dentists do their job, and on patient access to oral care.

The Bridging the Gap campaign was launched last year, and is a patient-focused and data-driven campaign to raise awareness among the profession, the public, Government and other stakeholders of the issues around recruitment in dentistry, and to come up with workable solutions. So far the Association has carried out three surveys to support the campaign and Roisín thanked all of the dentists who took the time to respond, as well as offering particular thanks to those dentists who put themselves forward as media spokespersons, as this has been crucial to the campaign.

She drew attention to the IDA's workforce plan, which was published in April as part of the campaign. The plan contains a number of key recommendations:

- significant investment in and expansion of the dental schools at UCC and TCD;



This document was presented to the Oireachtas Committee on Health and will be presented to the Minister.

Roisín then presented the results of the IDA's latest workforce survey, which was completed by over 350 dentists.

Recruitment

The figures for recruitment of dental staff are stark; of those dentists surveyed who said that they had tried to recruit a dentist in the last 12 months, 58% were unable to find a suitable candidate.

About two thirds of practices have tried to hire a dental nurse or a hygienist in the last 12 months. Of these, 79% were unable to recruit a hygienist, and 43% failed to find a satisfactory candidate for a dental nurse position.

Contracts

The survey also addressed the issue of State contracts, particularly in light of the mass exodus of dentists from the inadequate medical card scheme, and the stated aim of Smile agus Sláinte to transfer dental care for children to dental practices in the community. The survey asked dentists if they would consider taking a State contract to treat children, and a staggering 82% said that they would not.

With regard to DTSS (medical card) contracts, only one-third of respondents held a DTSS contract, and of those, 79% are not currently in a position to take on new medical card patients.

Roisín said that the Minister has asked dentists to return to the contract on the understanding that successful negotiations will result in an improved contract for dentists and patients.

Speaking out

Below is a sample of the media coverage during Annual Conference 2023.

Dr Caroline Robins speaking on RTÉ News.

Dr Eamon Croke at the IDA Annual Conference.

Dr Rory Boyd.

The Minister for Health "can consider himself fortunate not to be reliant on the system that he presides over. Our Annual General Meeting passed a vote of no confidence in the Chief Dental Officer and the Minister based on an assurance over a year ago that there would be meaningful engagement on a new scheme that's fit for modern Ireland and since then … zero progress has been made".

Dr Will Rymer speaking on RTÉ Radio's *Morning Ireland*

The waiting lists are "a manifestation of a problem of capacity in the system. That's something that requires action, something we have asked the Minister for Health to address. We've presented a series of proposals … There's a lot of problems but there's very little being done about them".

Fintan Hourihan speaking on *Newstalk Breakfast*

"Tinkering [with the system] isn't going to solve the problem… We need commitment from the Minister … both to the profession and to our patients".

Dr Caroline Robins interviewed on Today FM's The Last Word

Dentists pass vote of no confidence in Minister for Health

for specialist care, including orthodontic and oral surgery, a new survey reveals today. The survey was released by the Irish Dental Association as it holds its annual general meeting in Kilkenny, and it comes on the back of growing problems in recruiting dentists.

Irish Independent

Dentists vote no confidence in Donnelly amid frustration over 'crumbling' system

The Irish Dental Association (IDA) has issued a vote of no confidence in Health Minister Stephen Donnelly. The Association says this is due to the direct result of ongoing recruitment issues and a capacity crisis across the sector … The President of the Association, Eamon Croke, described the results as "stark".

Irish Examiner

At least 50,000 children missing out on dental checks due to staff shortages

Meanwhile, one in six dental patients are waiting over three months for an elective appointment, according to the survey by the Irish Dental Association of its members. More than half have to wait longer than three months for specialist care, including orthodontic and oral surgery, a new survey reveals today. The survey was released by the Irish Dental Association as it holds its annual general meeting in Kilkenny, and it comes on the back of growing problems in recruiting dentists.

Confidence without competence

What happens when we have confidence without the competence to back it up?

Confidence in clinical practice is the belief that one has the ability to deal with situations and clinical challenges effectively, and it is an attribute that patients value.

A careful analysis of clinical negligence cases suggests that competency plays a significant part and may be overlooked, particularly when the failure is compounded by poor or incomplete communication. Accidents and inadvertent errors are facets of human fallibility. As famously said, "to err is human".

The research

In one US study involving medical trainees, of the 240 cases reviewed, 72% related to errors in judgement, 70% related to teamwork and communication breakdowns, and 58% were attributed to lack of technical competence.[1]

The focus of risk management is usually the fall-out from the adverse outcome because it is not always possible to analyse competency-related variables that may have contributed, sometimes significantly, to the clinical outcome. In endodontics for example, experience suggests some suboptimal outcomes can be attributed to lack of procedural knowledge and skill. In other words, the primary cause of failure is related to competency, with other factors also contributing to the outcome.

Successful execution of clinical procedures is therefore a function of competency and the technical skills required refer to the psychomotor action, which requires good hand-eye co-ordination and manual dexterity.

Competence and competency

Competence and competency are sometimes used synonymously, but there is a distinction. Competence is about the ability to do a defined task to a predetermined standard. Competencies describe the knowledge, skills, experience, and attributes necessary for competence. Competence is conceptualised in terms of knowledge, abilities, skills, and attitudes displayed in the context of clinical practice.

The stages of learning model is a useful psychological framework that explains how people become more competent when learning a skill.

Level 1: unconsciously unskilled

People do not appreciate how unskilled they are. To use a common phrase, they don't know what they don't know. There may be many reasons why a clinician may not be aware of their limitations – isolated practice, lack of peer review and ignoring colleague feedback are among them. These are, therefore, risk factors when it comes to potential complaints and claims. Litigation risk is understandably high because mistakes are made.

The individual must recognise their own incompetence — only then are they able to address their shortcomings. We also observe what is described as self-serving bias, where any failure is attributed to situational factors rather than to oneself.

If the dentist has a growth mindset, the errors should motivate the clinician to do something about it.

Level 2: consciously unskilled

The individual may not know how to do something, but they recognise the deficit. They are aware of the need to learn new skills, and this is therefore an intermediate stage of learning. Mistakes are made, but the difference between level 1 and level 2 is that the individual is aware of the mistakes at level 2.

Level 3: consciously skilled

At level 3, the individual is now aware that they have acquired the appropriate skills. Risk is reduced because the individual is often aware of their limitations. Confidence grows justifiably because it is built on the foundations of competence.

Level 4: unconsciously skilled

Work is carried out effortlessly. Clinical procedures are second nature and performance has been described as intuitive. This concept of intuition is often cited and reported but remains nebulous. It is almost like a sixth sense when it comes to managing risk.

If you happen to be an observer, it is a joy to watch the unconsciously skilled at work. Risk is low, but the unconsciously skilled may be distracted so it is important to maintain concentration. The use of checklists, for example, is still advocated because it focuses the mind at key stages of a given procedure.

Vicarious experience

Competencies are acquired mainly through experience — our own experience and that of others who share theirs. This vicarious experience involves watching others at work and observing the outcomes of interventions as well as the consequences of behaviours in general. The value of this approach should not be underestimated; when observers watch people like themselves, it strengthens their belief that they too can be like them.

Dunning-Kruger effect

This is a type of cognitive bias that results in an overestimation of capability. It is named after David Dunning and Justin Kruger, the two social psychologists from Cornell University who first described it in their seminal paper published in 1999. It relates to an overestimation of ability. People who perform poorly are unable to judge their own performance accurately, and this has been shown to be the case in a wide range of tasks. People who frequently performed poorly overestimated their performance, and those who performed well often subjectively underestimated their performance compared to others.

In **Figure 1**, as seen at point A, the inexperienced have a false sense of

Dr Raj Rattan
Dental Director at Dental Protection

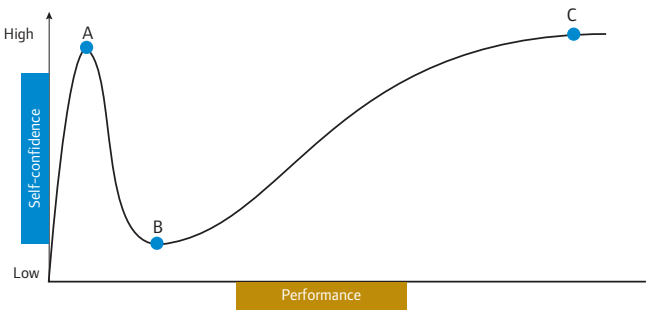


FIGURE 1: The Dunning-Kruger effect.

confidence about their performance. After some time and more experience, they realise that they had been unaware of some aspects of their work that had been done poorly, and their confidence plunges to despair at point B. Over time and with more experience, their confidence increases again on what is described as the 'slope of enlightenment' until they reach point C.

It is worth reflecting on the words of David Dunning in an article he wrote back in 2017: "In many cases, incompetence does not leave people disoriented, perplexed, or cautious. Instead, the incompetent are often blessed with an inappropriate confidence, buoyed by something that feels to them like knowledge."[2]

The false sense of confidence at the outset may be exaggerated even more if training programmes encourage participants to adopt new techniques and treatment modalities without adequate training. The Dunning-Kruger effect prevents people from overcoming their weaknesses (knowledge or skills) because one of the prerequisites for self-regulated learning is awareness of one's own deficit. It is something that we are aware of from a risk management point of view and is a concern going forward.

Misplaced confidence

Society at large places a premium on being confident; a confident demeanour is also considered attractive and persuasive. We know from research that self-confidence is an attribute that patients value.

It is not surprising then that people invest time and money to try and learn how to appear more confident. There is no shortage of courses and self-help books to choose from. But is this the best way to build confidence? Are we missing the point? If someone is able to feign confidence without the competence to back it up, then that confidence is illusory. But confidence is so highly prized that many people would rather pretend to be skilled than risk looking inadequate in front of colleagues and patients. The idea that it is acceptable to 'fake it till you make it' is troubling to say the least, and is a recipe for risk.

Low confidence is not always a bad thing if it is the result of an accurate self-assessment of competence. Awareness of this bias will encourage inexperienced dentists to be introspective and recognise their weaknesses. Educators should not rely on measures of self-confidence as a measure of competency.

Tomas Chamorro-Premuzic is a Professor of Business Psychology at both University College London and Columbia University. In his book *Confidence: How Much You Really Need and How to Get It*, he emphasises the importance of competence over confidence. He concludes that the reason exceptional achievers have confidence is that they are also exceptionally competent.[3]

We should beware the illusion of confidence. It is a trap unless it is born of competence, a bedrock obligation. It is about becoming better rather than simply feeling good.

References

1. Singh H, Thomas EJ, Petersen LA, Studdert DM. Medical errors involving trainees: a study of closed malpractice claims from 5 insurers. *Arch Intern Med*. 2007;167(19):2030-2036.
2. Dunning D. We are all confident idiots. *Pacific Standard*, June 14, 2017.
3. Chamorro-Premuzic T. *Confidence: How Much You Really Need and How to Get It*. Plume Books; 2014.

Quiz

Submitted by Dr Clair Nolan.

A 38-year-old male presents for a routine dental examination. On examination, suppuration on palpation was identified associated with the maxillary right central incisor, which was an implant-retained crown that had been placed when the patient was 22 years old. The patient had never experienced symptoms from the implant and had not noticed the suppuration coming from around the implant. The patient smoked 20 cigarettes per day and did not use any special oral hygiene technique around the implant.

1. How do you assess the health of a dental implant during dental clinical examinations?
2. What risk factors are associated with dental implant failure?
3 How do you classify the health of an implant?
4. How would you best treat this patient?

Answers on page 159.

Examining children in dental practice

The best approaches when examining young children, including specific positions and general considerations for this cohort of patients.

Children under the age of six have been identified as a priority group in the national oral health policy, Smile agus Sláinte. Three 'packages' of care have been proposed for this group. Package one covers children from birth to two years old, and packages two and three cover children from two to six years old.[1] While epidemiological evidence regarding the oral health status of young children in Ireland is limited, a recent cross-sectional study indicated that early childhood caries affects at least one in three young children by the age of five.[2] Early engagement with oral healthcare professionals offers an opportunity to develop a good rapport between practitioner and child, acclimatise the child to the dental environment, and provide early preventive oral healthcare advice.[2] With appropriate planning, simple techniques, and a flexible approach, a first appointment can be a productive and positive experience for all involved.

General tips

1. The dental team should be friendly and engaging, and the surgery should be clean and tidy. Avoid having a lot of distractions present, e.g., unnecessary equipment.
2. If possible, set expectations in advance of a visit, using pre-visit communication such as cartoons/stories.
3. Always discuss planned techniques with the parent/guardian and obtain consent in advance.
4. Booster cushions are available for dental chairs and are suitable for children under 150cm in height.
5. A loupe light or mirror with an attached light can be extremely useful for out-of-chair examinations (**Figure 1**).
6. A toothbrush and gauze are useful, non-threatening, and familiar tools for examining children.
7. Ask parents ahead of the appointment to bring weighted blankets, comfort blankets, or cuddly toys as these can be very soothing, especially for small children on their first visit.
8. Engaging a child in a choice of no consequence can reduce dental anxiety and aid behaviour management, e.g., "What colour toothbrush would you like?"

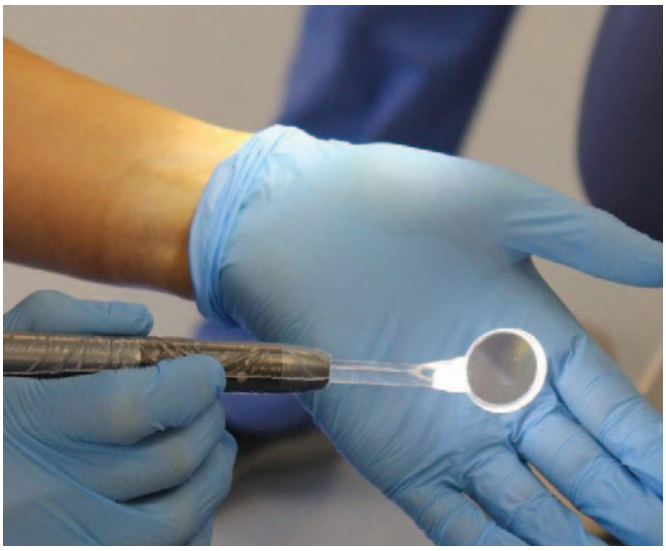
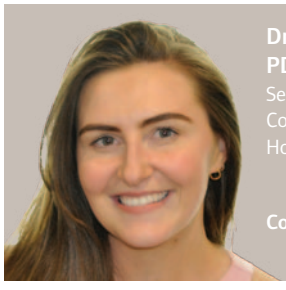


FIGURE 1: An LED pen light with dental mirror attachment (DENTMATE LUMINDEX 3).

FIGURE 2 (left): Knee-to-knee exam: The child's head is supported on the way down. FIGURE 3 (right): The dentist's and parent's knees act as a flat surface for a child to lie on.



Dr Rachel O'Donoghue BDS NUI PDip PCD RCSI
Senior House Officer Paediatric Dept. Cork University Dental School and Hospital

Dr Siobhán Lucey BDS PGDip(TLHE) MFDS MClinDent MPaedDent FDS (Paed Dent) RCSI
Consultant/Senior Lecturer in Paediatric Dentistry. Cork University Dental School and Hospital

Corresponding author: Dr Rachel O'Donoghue, E: rodonoghue@ucc.ie

Treatment positions

Accommodating certain children may require a combination of examination positions, for example, using a knee-to-knee technique in an alternative setting such as an office space. The main goal is to see as much as one can with the optimum lighting while keeping a young child comfortable and content, which is not an easy feat! **Table 1** and **Figures 2-7** describe and display positions in which young children can be examined.

Knee-to-knee position

The knee-to-knee position, which is described in detail in **Table 1**, is a particularly useful tool and worth explaining to the accompanying adult in depth. The dentist is close to the adult and child, so it is imperative to ask for permission to use this approach. Firm foot contact with the ground to maintain a solid base for the child is best. This can be achieved by using a standard set of chairs or lowering a rotating dental chair or saddle. This position is most successful when both adults are relaxed, and the child is kept as calm as possible and soothed when needed. The slow descent of the child's head ensures safety and comfort (**Figure 2**). Eye contact between the child and adult, as seen in **Figures 3** and **4,** can have a pacifying effect. A dental assistant can be helpful in providing encouragement to both child and adult while ensuring good lighting and charting. This position can also be utilised at home by parents for brushing a child's teeth and checking for the arrival of new teeth.

Conclusions

Examining children aged six and under requires flexibility in approach, an open mind, and patience. Early engagement is key in preventive dentistry. This age group are some of the most enthusiastic patients and seeing them in practice can be both a pleasure and a privilege.

References

1. Department of Health. Smile agus Sláinte – national oral health policy. Dublin, Dept of Health. 2019.
2. James P, Harding M, Beecher T, *et al.* Fluoride and caring for children's teeth (FACCT): Clinical fieldwork protocol. *HRB Open Res.* 2018;1(4):7-13.
3. Neumann L. Once upon a time. *Ins Dent.* 2008;4(5):1-13. Available from: https://www.aapd.org/assets/news/upload/2008/2637.pdf.

Table 1: Suggested positions for examining young children.

	The 'knee-to-knee' exam (Figures 2-7)	Child on parent's lap	Alternative chair/setting
What?	The child sits in his/her parent's lap and leans back into the lap of the dentist.	Child sits with a parent, facing the same direction as the parent. The child's head may be positioned in the nook of the parent's elbow.	Child may be seated on a beanbag, a wheelchair/buggy or on the floor.
Who?	From birth to two years approximately.	Children aged two years and older.	Children aged two years and older.
Where?	Dental professional and parent on standard chairs.	Parent can sit on dental chair.	May take place in a waiting room, car or office space.
Advantages	Avoids separation anxiety; child and parent are facing each other at all times. Parent plays active role in holding child. Good visibility for parent. Can be completed in a non-dental environment.	Parent assists in holding the head and/or hands. Access to dental light, air and water syringe, and bracket table. Introduces the dental chair.	Child may feel more comfortable. Can be used to empower a child by giving them a choice. Can be completed in a non-dental environment.
Disadvantages	Dental professional, child and parent in very close proximity. Child may resist lying back.	May become reliant on parent.	Lighting may not be ideal. May be more difficult to access air and water syringe and bracket table.

FIGURE 4: Eye contact with the baby is maintained by their parent/ guardian and their hands held.

FIGURE 5: An examination in a buggy.

FIGURE 6: Examination on a beanbag.

FIGURE 7: An examination taking place with the child's head in the crease of their parent's elbow.

The risks of smartphone and mobile technology for the dissemination of clinical data by dental professionals

Précis

Technical support and digital professionalism training are required to facilitate the appropriate use of smartphone technology for dental clinicians practising in the Republic of Ireland.

Abstract

Statement of the problem: Smartphone technologies have changed the landscape of digital communication across society. The Covid-19 pandemic has accelerated the adoption of and requirement for technical solutions to facilitate remote clinical communications. Despite the benefits of smartphones in a clinical communication context, there are risks associated with their use.

Purpose of the study: The primary purpose of this study was to determine the extent of smartphone use among dental professionals in the Republic of Ireland (ROI). In addition, we sought to determine the perception and knowledge of potential pitfalls, risks, and limitations of these technologies among the same population. A smaller cohort of UK dental professionals was surveyed for comparison.

Materials and methods: An online quantitative survey was distributed to evaluate dental professionals' knowledge and understanding of the risks and limitations of smartphone and mobile technology, providing general understanding of the current use of smartphone technology in healthcare in the ROI and the UK.

Results: A total of 123 responses were received from dental professionals in the ROI (UK: n=77). The majority of dental professionals confirmed that they were aware of the risks associated with smartphone use and perceived that they were adequately skilled in digital professionalism. However, concerning practice regarding the communication of sensitive patient data was identified, with the potential for these data to be stored on insecure devices and cloud servers. Many ROI and UK dental professionals confirmed that they would need support to remove patient-identifying data when trading in their device.

Conclusions: App, smartphone and mobile device ownership among dental professionals for clinical communications is widespread in the ROI (and UK), with respondents using their devices to send images (photos and radiographs) to one another. However, the risks of such activities are only partly acknowledged, with many having a lack of insight into data security.

Journal of the Irish Dental Association June/July 2023; 69(3):149-153

Introduction

There is an ever-increasing accessibility and availability of smartphone and mobile technology across society. The functionality of these 'bring your own devices' (BYODs) is vast, enabling a range of current media-rich communications between users.[1] From simple text messaging or image sharing (clinical photos and/or radiographs), to video conferencing, the intention of digital clinician communications is to improve patient care.[2] These technologies were widely adopted across healthcare during the Covid-19 pandemic, when minimising in-person meetings led to the heightened use of BYODs and digital solutions to aid remote and efficient clinical

Bernadette John
BSc (Hons) PG Dip RGN RM PHN
Cork University Dental School and Hospital
University College Cork

Christine McCreary
MA MD FDS(OM)RCPS FFD RCSI
Senior Lecturer/Consultant in Oral Medicine
Cork University Dental School and Hospital
University College Cork

Anthony Roberts
BSc(Hons) BDS(Hons) PhD FDS RCPS(Glasg) FDS(Rest Dent) FFD RCSI FHEA
Professor/Consultant in Restorative Dentistry
Cork University Dental School and Hospital
University College Cork

Corresponding author: Bernadette John E: 118225957@umail.ucc.ie

Table 1: Age and gender demographics of respondents.

	Republic of Ireland			United Kingdom		
Age (years)	Female	Male	Total	Female	Male	Total
20-29	5 (6%)	1 (2%)	6 (5%)	6 (13%)	–	6 (8%)
30-39	20 (26%)	3 (7%)	23 (19%)	17 (36%)	5 (17%)	22 (29%)
40-49	16 (21%)	9 (20%)	25 (20%)	14 (30%)	7 (23%)	21 (27%)
50-59	21 (27%)	15 (33%)	36 (29%)	8 (17%)	11 (37%)	19 (25%)
60-69	15 (19%)	14 (30%)	29 (24%)	2 (4%)	6 (20%)	8 (10%)
>70	–	4 (9%)	4 (3%)	–	1 (3%)	1 (1%)
Total	77 (63%)	46 (37%)	123 (100%)	47 (61%)	30 (39%)	77 (100%)

Table 2: Dental professional and employment demographics.

	Republic of Ireland	United Kingdom
Dental role	Total	Total
Dentist	92 (75%)	55 (71%)
Dental specialist	22 (18%)	18 (24%)
Dental hygienist	1 (1%)	0 (0%)
Clinical dental technician	0 (0%)	1 (1%)
Dental nurse	8 (6%)	3 (4%)
Main employment		
Public sector	45 (37%)	55 (71%)
Private sector	78 (63%)	22 (29%)

communication between clinicians and their patients.[3] Clinical communications using BYODs have been the subject of a recent scoping review, which demonstrated knowledge gaps around digital security and risk assessment for the security of clinical data.[3] Health professionals must demonstrate the appropriate competence or skill when using digital media (digital professionalism), and yet security and privacy issues are often absent from or only superficially acknowledged in the published literature.

Despite the clear advantages of improved clinical communication for all, the implementation of the European Union (EU) General Data Protection Regulation (GDPR)[4] resulted in increased regulatory requirements around the technology for hosting and processing sensitive data. This, along with the catastrophic cyberattack on the Health Service Executive (HSE) in 2021, resulted in growing concern around the use of digital modalities for clinical communication for everyone involved in current healthcare/dental practice in Ireland.[2] Given their ubiquitous nature and the potential for sensitive patient data to become compromised, it is timely to determine the culture of smartphone use among the dental profession.

Materials and methods

An online questionnaire was adapted (with the permission of the authors) from relevant published studies in the Republic of Ireland (ROI) and the United Kingdom (UK)[5,6] to explore BYOD smartphone and mobile technology use among dental professionals. Ethical approval was granted (UCC Ref: 018-131) for dissemination of a Google Form weblink to dentists and the wider dental profession (dental specialists, dental hygienists, dental nurses, etc.). The invitation to complete the questionnaire provided a convenient sample open to any dental care professional in the ROI (and UK). The questionnaire included the anonymous demographic characteristics of each individual, current use of BYOD smartphones and mobile technology for communicating patient data, and the level of perceived risk associated with their use. The questionnaire was a blend of closed- and open-style questions to allow free text/elaboration. The ROI questionnaire was distributed as a weblink across a number of organisations: Cork University Dental School and Hospital (May 2020); a Dental Council of Ireland newsletter to all registrants (August 2020); an Irish Dental Association webinar (October 2020); online attendees to the Irish Division of the International Association of Dental Research (February 2021); and, the Orthodontic Society of Ireland (March 2021). Plans for wider dissemination at face-to-face conferences that had been planned were curtailed due to the Covid-19 pandemic. UK dissemination of the questionnaire was undertaken through the British Dental Association and the British Association of Oral Surgeons. The resulting data are presented descriptively with no statistical analysis undertaken.

Results

Respondent demographics

A total of 123 dental professionals from the ROI and 77 dental professionals from the UK completed the online survey. A similar gender balance was observed between the ROI (females n=77; 63%) and UK (females n=47; 61%) (**Table 1**). A wide age range for respondents was observed, with respondents in the 20-29 and >70 year categories in both jurisdictions. The majority of ROI respondents were in the 50-59-year age category (n=36; 29%), and for the UK the largest number of responses were seen in the 30-39-year age category (n=22; 29%).

The vast majority of ROI respondents were dentists in general practice (n=92; 75%), or dentists in specialist practice (n=22; 18%), with smaller numbers of dental hygienists, dental technicians and dental nurses (**Table 2**). A similar distribution pattern was observed for respondents from the UK.

The demographic relating to employment type differed between the ROI and the UK – a much higher percentage of respondents work in the private sector in the ROI (n=78; 63%) than in the UK (n=22; 29%).

Current use of smartphones and mobile technology for communicating patient data

High levels of smartphone use were observed among respondents (ROI 98%; UK 100%), with the Apple iPhone the most popular device (ROI n=78; 63%, and UK n=58; 75%). Android devices were less popular in the ROI (n=41; 33%) and UK (n=18; 23%), with the remainder using "other devices".

Respondents were asked to answer questions in the following domains (**Table 3**):

- Technological skills: A majority of respondents from both jurisdictions (ROI n=105; 85%; UK n=71; 92%) perceived that they had an "appropriate level of technological skill to use a smartphone", although this belief was not evenly distributed across employment type in the ROI. The majority of those ROI

Table 3: Current use of smartphones and mobile technology for communicating patient data.

			Republic of Ireland			United Kingdom		
			Total	Public	Private	Total	Public	Private
1	Technological skills	Yes	105 (85%)	42 (34%)	63 (51%)	71 (92%)	50 (65%)	21 (27%)
		No	18 (15%)	3 (2%)	15 (12%)	6 (8%)	5 (6%)	1 (1%)
2	Usefulness	Yes	95 (77%)	34 (28%)	61 (50%)	70 (91%)	49 (64%)	21 (27%)
		No	28 (23%)	11 (9%)	17 (14%)	7 (9%)	6 (8%)	1 (1%)
3	Sending images by instant messaging and/or app	Yes	78 (63%)	21 (17%)	57 (46%)	48 (62%)	35 (46%)	13 (17%)
		No	45 (37%)	24 (20%)	21 (17%)	29 (38%)	20 (26%)	9 (12%)
4	Currently have patient/ clinical information on smartphone	Yes	62 (50%)	13 (10%)	49 (40%)	29 (38%)	22 (29%)	7 (9%)
		No	61 (50%)	32 (26%)	29 (24%)	48 (62%)	33 (43%)	15 (19%)
5	Multiple devices streaming between each other	Yes	36 (29%)	12 (10%)	24 (20%)	22 (29%)	15 (19%)	7 (9%)
		No	87 (71%)	33 (27%)	54 (44%)	55 (71%)	40 (52%)	15 (19%)
6	Devices streaming to the cloud	Yes	61 (50%)	21 (17%)	40 (33%)	30 (39%)	21 (27%)	9 (12%)
		No	62 (50%)	24 (20%)	38 (31%)	47 (61%)	34 (44%)	13 (17%)

Table 4: Level of perceived risk associated with smartphone and mobile technology use.

			Republic of Ireland			United Kingdom		
			Total	Public	Private	Total	Public	Private
1	Risk awareness	Yes	94 (76%)	38 (31%)	56 (46%)	67 (87%)	47 (61%)	20 (26%)
		No	29 (24%)	7 (6%)	22 (18%)	10 (13%)	8 (10%)	2 (3%)
2	Skilled in digital professionalism	Yes	66 (54%)	25 (20%)	41 (33%)	50 (65%)	34 (44%)	16 (21%)
		No	57 (46%)	20 (16%)	37 (30%)	27 (35%)	21 (27%)	6 (8%)
3	Awareness of IT support available	Yes	25 (20%)	7 (6%)	18 (15%)	23 (30%)	13 (17%)	10 (13%)
		No	98 (80%)	38 (31%)	60 (49%)	54 (70%)	42 (55%)	12 (16%)
4	Would value IT support	Yes	114 (93%)	42 (34%)	72 (59%)	74 (96%)	53 (69%)	21 (27%)
		No	9 (7%)	3 (2%)	6 (5%)	3 (4%)	2 (3%)	1 (1%)

respondents who perceived that they did not possess an appropriate level of technological skill to use a smartphone were in the private sector. Only six UK respondents felt that they did not have the technological skills to use a smartphone, with one of these being in the private sector.

- Usefulness: The majority of ROI respondents (n=95; 77%) confirmed that they found their smartphones useful for the meaningful exchange of clinical information (UK n=70; 91%) and this occurred in both public and private sectors.
- Sending images by messaging: Of the ROI respondents, the majority (n=78; 63%) confirmed that they use or have used their smartphones to communicate images, via WhatsApp or standard picture messaging, with a similar pattern observed in the UK (n=48; 62%). Of the ROI respondents who confirmed sending images, the majority were from the private sector.
- Patient/clinical information stored on their smartphone: Half of ROI respondents confirmed that they had or might have clinical information currently stored on their BYOD smartphones and, of these, the majority worked in the private sector. UK respondents who had patient/clinical information stored on their smartphone were mostly public sector.
- Multiple streaming devices: The majority of ROI respondents (n=90; 73%) confirmed that they own multiple smart devices and, of these, almost one-third (n=36; 29%) confirmed that data does (or has the potential to) stream between these devices, with respondents in both the public and private sectors, a finding also seen in the UK.
- Streaming to the cloud: Half of ROI respondents confirmed that their devices did (or had the potential to) stream sensitive patient data to the cloud, an activity that was observed in both the public and private sectors, with similar results seen among UK responses.

Level of perceived risk associated with smartphone and mobile technology use

Respondents were asked to answer questions in the following domains (**Table 4**):

- Risk awareness: The majority of the respondents from the ROI (n=94; 76%) considered themselves aware of the risks associated with the use of smartphones and smart devices for the communication of work-related data; respondents were in both the public and private sector, with a similar UK trend (n=67; 87%).
- Skilled in digital professionalism: Approximately half of ROI dental professionals believed themselves to be skilled in digital professionalism (n=66; 54%); respondents were in both public and private sector, with a similar UK trend (n=50; 65%).
- Awareness of need for IT support: The majority of ROI respondents (n=98; 80%) were unaware of any IT supports for wiping or 'cleaning' BYODs at the point of trading in, trading up or abandoning devices. A similarly high percentage of UK respondents reported a lack of awareness of such IT support (n=54; 70%).
- Value of IT support: Respondents in the ROI (n=114; 92.6%) agreed that IT support when trading in devices would be useful (UK, n=74; 96%). The highest levels of value for such IT support were observed in the ROI private and UK public sectors.

Discussion

This study used an online questionnaire distributed to a convenient sample of dental care professionals in the ROI and UK, and demonstrates that smartphone and mobile technology use is widespread. No attempt was made to match the

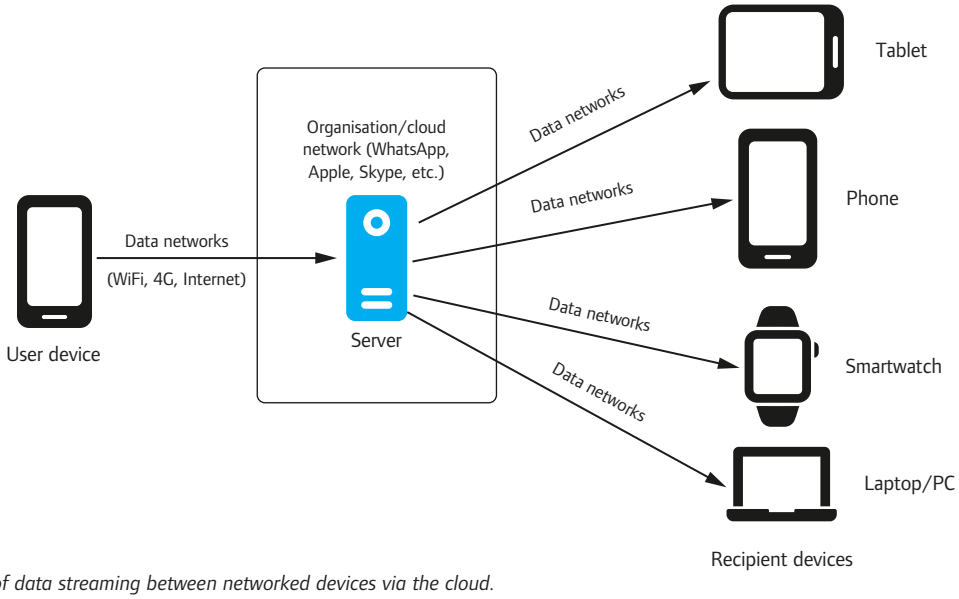


FIGURE 1: Illustration of data streaming between networked devices via the cloud.

demographics of ROI respondents with those of the UK; rather, the data was collated for trend comparison. Respondents confirmed that their smart devices are useful for the meaningful exchange of clinical information to assist patient management. However, while dental professionals may allow the exchange with a positive intention, the results confirm the use of inappropriate and insecure messaging apps[7] and video conferencing channels (e.g., WhatsApp and Zoom)[8] for the communication of sensitive patient data. Dental professionals currently practising within the EU (and UK) are obliged to work within the requirements of the GDPR. A minority of clinicians use SMS to communicate patient clinical information, contravening their GDPR obligations.[7] Accepting the limitations of the study, clinicians are mainly unaware of the potential for sensitive data to be obtained and exploited,[2] and yet clinicians ignoring GDPR may threaten patient confidentiality and bring the profession into disrepute. For the avoidance of doubt, the use of instant messaging and commercial apps such as WhatsApp for clinical communications is insecure and not GDPR compliant.[7]

With regard to level of perceived risk, a large majority of dental professionals in the ROI confirmed that they had the appropriate level of technological skill to use a smartphone. Given the number of respondents confirming the streaming and storage of confidential patient data to additional networked devices (laptops, smartwatches, iPads, etc.), this confidence seems misplaced. This study raises information governance concerns regarding the potential for numerous insecure locations where sensitive patient data is being stored and points to an unmet need for further clinician training in this area.

A larger proportion of ROI dental professionals who practise privately responded to the questionnaire than in the UK sample, and report sending clinical images insecurely and storing patient information on insecure devices in concerning numbers. This may be a consequence of a lack of access to enterprise/institutional technology supports that might be available in the public sector (e.g., the HSE) and also suggests a requirement for private sector training. Only half of the ROI cohort were confident to confirm that their BYODs were not streaming work-related data to their associated non-institutional clouds, further highlighting the potential for sensitive patient data breaches. It appears to be poorly understood that the likes of the Apple iCloud are hosted in unregulated servers outside the European Economic Area (EEA), and therefore are not GDPR compliant. **Figure 1** illustrates the potential for smart devices to stream data between networked devices via potentially non-GDPR-compliant and insecure cloud servers, an issue that is poorly acknowledged in the literature.[3]

The professional, ethical, security and legal concerns posed by popular messaging apps are established.[2,7,9] However, the wider functionalities associated with these modalities, including the selection of secure channels to communicate patient data, the data security issues posed by information streaming between networked devices, the streaming of sensitive patient data to insecure cloud servers, and the cleaning of devices before they are abandoned, traded in, or traded up, provide further areas for concern. Poor awareness regarding phone stewardship (protecting and being responsible for the data held on a mobile phone)[10] also evidences a requirement for digital professionalism and technical training for even the most experienced dental professionals. Despite lack of insight with regard to data security, there is a high level of recognition among professionals that supports the requirement for tasks such as wiping devices of patient-identifying data in the public and private sectors.

Conclusions

App, smartphone, and mobile device ownership among dental professionals for clinical communications is widespread in the ROI (and UK), with this study demonstrating that dental professionals are using their devices to send images (photos and radiographs) to one another. The risks associated with these activities are only partly acknowledged, with many dental professionals evidencing a lack of insight into data security. Dental professionals may benefit from mobile device management software to remove data when required, online portals to securely store and manage clinical images, and digital professionalism training. Some of these solutions are emerging in the UK's National Health Service (NHS), and could be included as part of professionalism and ethics training provided to clinicians through their indemnity organisation, which has flagged concerns in professional publications.[11]

We conclude that there is an unmet need for technical solutions, technical support, and digital professionalism training to facilitate the appropriate use of

smartphone technology for dental clinicians practising in the ROI. Until these supports are in place, it is essential for dental professionals to engage in the use of smartphone and mobile technology for the dissemination of clinical data with caution as they try to best serve their patients.

References

1. Rimmer A. Can I receive and store images sent from patients during remote consultations? *BMJ*. 2020;370:m2675.
2. John B, McCreary C, Roberts A. Smartphone technology for clinical communication in the Covid-19 era: a commentary on the concerning trends in data compliance. *Front Digit Health*. 2022;4:816604.
3. John B, McCreary C, Roberts A. Smartphone technology for communications between clinicians – a scoping review. *J Dent*. 2022;122:104122.
4. The EU Parliament TCotE. Regulation (EU) 2016/679 of the European Parliament and The Council of the European Union of April 27, 2016, on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Official Journal of the European Union. Union OJotE, (ed.). L119/1. Brussels: For the European Parliament, The President M. Schulz, for the Council of the European Union, The President J.A. Hennis-Plasschaert, 2016, p. 88. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0679.
5. O'Connor P, Byrne D, Butt M, *et al*. Interns and their smartphones: use for clinical practice. *Postgrad Med J*. 2014;90(1060):75-79.
6. Mobasheri MH, King D, Johnston M, *et al*. The ownership and clinical use of smartphones by doctors and nurses in the UK: a multicentre survey study. *BMJ Innovations*. 2015;1:174-181.
7. Masoni M, Guelfi MR. WhatsApp and other messaging apps in medicine: opportunities and risks. *Intern Emerg Med*. 2020;15(92):171-173.
8. Chen B. Zoom is easy to use, and easy to bomb. *New York Times*, April 9, 2020.
9. Mars M, Morris C, Scott R. WhatsApp guidelines – what guidelines? A literature review. *J Telemed Telecare*. 2019;25(9):524-529.
10. Mars M, Morris C, Scott R. Selfie telemedicine – what are the legal and regulatory issues? In: Ginige JA, Maeder AJ (eds.). *Transforming Healthcare Through Innovation in Digital Health: Selected Papers from Global Telehealth*. Amsterdam: IOS Press, 2018, pp.53-62.
11. Johnstone P. The device in your pocket. RiskWise, Risk management from Dental Protection 2018:6-7.

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. What is the name of the EU regulation that was implemented across the EU in 2018 concerning data protection and privacy?

- ○ Copyright and Patient Privacy Directive (CPPD)
- ○ General Data Protection Regulation (GDPR)
- ○ Privacy and Data Processing Regulation (PDPR)
- ○ General Data Privacy Rule (GDPR)

2. The majority of dental professionals stated that they had the clinical skills to use a smartphone to communicate patient data:

- ○ and on further questioning they demonstrated that they knew how to keep patient data secure.
- ○ thus confirming that they require no further training, support or policy regarding the issue of data privacy.
- ○ so patients should rest assured that their privacy is protected when sharing private information with dental professionals
- ○ yet they agreed in large numbers that they currently had patient information stored on their smartphones and streaming to their associated clouds.

3. Digital professionalism was outlined as an area of required competence for graduating dentists in Europe in 2017 under the domain of professionalism. This concerns:

- ○ the use of workplace technology to improve patient care.
- ○ the protection of patient data through the appropriate use of digital communications and was explicitly highlighted in an effort to avoid damage to the wider profession by bringing it into disrepute, undermining the trust that the public hold in dental professionals.
- ○ undergraduate training only and is not an issue for clinicians who have been in practice for a number of years.
- ○ the GDPR and concerns awareness for newly graduating clinicians so that they work within practice guidelines.

Caries and the older patient

Learning outcomes

- Readers will learn that Irish population demographics are rapidly changing. Dental practitioners will be expected to maintain ageing, heavily restored and compromised dentitions for longer, in the context of a population with a high caries index, compared to our European counterparts.
- Skilful management of dental caries in the older adult starts with accurate caries diagnosis using tools such as Cariogram, CAMBRA and ICDAS. A focus on non-operative caries management strategies is the cornerstone of successful treatment.
- When operative caries management is required, the most minimally invasive excavation techniques are recommended, while repair and refurbishment of existing restorations is advised when managing secondary caries. Readers will see step-by-step clinical photography illustrating contemporary evidence-based, minimally invasive excavation techniques.

Introduction

Population ageing is global and pervasive in Ireland. We can expect to see the proportion of the population aged over 65 grow to nearly 30% in the next 30 years. Along with this, we have seen a reduction in tooth loss; therefore, we will be managing increasing numbers of partially and fully dentate older adults in dental practice. Older adults in Ireland have high levels of past caries experience, and root caries is almost exclusively a disease seen in this particular cohort. Preventing and managing caries in older adults with heavily restored dentitions will bring both treatment planning and operative challenges to the dental profession.

Background

Projections by the Central Statistics Office (CSO) for the Pensions Board indicate that life expectancy at age 65 years is expected to increase for both males and females, and the proportion of the population aged over 65 years is projected to rise to 17% by 2026. This is increased from 11% of the population aged over 65 in 2005. This trend is set to continue through to 2056, by which time it is estimated that those aged over 65 years will comprise 29% of the Irish population.[1] This projected pattern of Irish population ageing will have profound consequences for Irish dentistry. Older adults in Ireland have a high caries experience. The most recent National Oral Health Survey (NOHS) reported the mean Decayed Missing Filled Teeth (DMFT) score of those aged 65 or older as 25.9.[2] This was higher than other European countries at the time but, most alarmingly, the proportion of total DMFT score attributable to tooth loss was substantially higher at 88%. By comparison, the UK and Germany were approximately 50% around the same time period.[3]

We have not had an NOHS conducted since 2002; however, there have been some recent studies on the oral health of older adults in Ireland. Inclusion of an oral health exam in the TILDA study captured data on 1,286 older adults and reported a mean DMFT of 24.4 and a mean Root Caries Index (RCI) of 9.1.[4] Similarly, a study into root caries in older adults conducted in Cork reported a mean DMFT of 23.5 and a mean RCI of 9.5.[5] It is important to note that both of these studies recruited community-dwelling older adults, and they do not reflect oral disease levels among those in residential care, which may be far higher. From these studies it is clear that older adults in Ireland have a high level of caries experience. In addition to this, the World Health Organisation (WHO) has predicted that existing oral health inequalities are likely to widen as a result of the Covid-19 pandemic, which caused widespread disruption in public-funded oral healthcare delivery.[6] Even without data, it is reasonable to assume that nursing homes in particular were likely to have been affected particularly badly.

Risk assessment

As caries is not randomly distributed within the older population, many researchers have attempted to identify factors that may predispose an individual to the disease. Caries is a preventable disease; however, access to care, compliance issues, and cost may preclude the use of a preventive intervention on the entire population. As an example, it is known that one-third of the older adult population bears most of the root caries burden.[7] Therefore, if these individuals could be identified prior to developing the disease, targeted prevention measures could be delivered. Two caries risk assessment tools have been validated in a number of older adult populations. The first of these is the Cariogram, which is an interactive computer-based risk assessment model developed in Sweden.[8] The programme contains an algorithm that is expressed in a pie chart, explaining the extent to which different aetiological factors of caries affect the individual's caries risk, and can guide strategies for prevention.

The Cariogram was evaluated in an Irish setting on a group of older adults and was shown to be clinically useful in identifying individuals who would develop caries over a two-year period. Patients categorised as high risk, on average, developed two new root carious lesions, compared to those in the lowest risk group, who had a mean root caries increment of 0.04.[9]

The benefits of the Cariogram are that it is free (the software and manual are free to download to your computer) and the pie chart that is generated can be used as an effective patient education tool to show the impact that dietary or oral hygiene routine changes could have on caries risk. The disadvantages are that it can be time consuming to complete, and involves saliva testing kits, although the model has

Dr David E. McReynolds BA BDentSc MFDS RCSEd DChDent (Pros) FFD RCSI (Pros)
Academic Prosthodontist and Assistant Professor in Restorative Dentistry
Dublin Dental University Hospital
Trinity College Dublin

Dr Martina Hayes PhD FDS (Rest Dent) RCSI PgDip TLHE BDS NUI
Associate Professor/Consultant in Restorative Dentistry
Dublin Dental University Hospital
Trinity College Dublin

been shown to be a good predictor even when these saliva tests are not entered into the model.[9]

Caries Management by Risk Assessment (CAMBRA) is another well-known caries risk assessment tool. This was developed in the early 2000s in San Francisco, and is a paper-based assessment form, which categorises patient caries risk and suggests a caries management strategy based on that information.[10] CAMBRA includes risk factors that are particularly relevant to older adults including medications with xerostomic potential, removable dental appliances, and exposed root surfaces. However, CAMBRA has not been validated among older populations as frequently as the Cariogram.

Prevention

Caries is a lifelong, progressive, and cumulative disease that undermines the mechanical integrity of the affected dentition and leads to tooth loss. Thus, non-operative measures aimed at delaying, curtailing, and preventing carious lesion formation are at the heart of caries management strategies. Non-operative measures should be focused towards dietary changes, fluoride exposures, and improvements in oral hygiene.

Dietary free sugar intake is the principal risk factor in carious lesion formation. The evidence base suggests that carious lesion formation follows a dose-response curve, whereby, as free sugar intake increases, so does carious lesion incidence. Therefore, any measures that can be taken at patient level to reduce or restrict both the sugar frequency and sugar quantity consumed can result in effective arrest of carious lesions. To achieve total arrest, sugar intake should ideally be less than 5% of total dietary energy intake. However, diets are habitual and tend to be emotionally comforting; therefore, achieving sustained, patient-level dietary behavioural change can be very difficult. Positively framed and personalised dietary counselling is likely to be the most helpful approach in changing patients' dietary habits.[11] Good dental dietary advice should align with good general health dietary advice. With this in mind, patients should be guided towards diets that are rich in protein, fruits, and vegetables, as well as starchy staple foods, such as wholemeal bread, rice, pasta, potatoes, and unsweetened wholemeal cereals (porridge, Shredded Wheat, or Weetabix). Sugar-laden, fat-laden, and highly processed foods should be minimised. It is not enough to guide patients away from problematic foods; personalised, healthy substitutes should be recommended to patients. Similarly, dietary counselling should occur repeatedly and patient engagement is required for the process to be effective.

Fluorides reduce caries risk but do not eliminate risk completely.[12] Nevertheless, fluorides are one of the most effective tools at a dentist's disposal, which can be used to shift the balance of carious lesion formation from demineralisation towards remineralisation. As with dietary sugar intake, fluoride's effectiveness follows a dose-response curve, whereby increases in fluoride concentration and application frequency result in reduced DMFS scores.[13] Vehicles for fluoride delivery include water, toothpaste, mouth rinses, and professionally applied varnishes. It is sensible to intensify fluoride application in high-risk patients until their caries risk stabilises. Dentists should consider prescribing products such as Duraphat 5,000ppm fluoride toothpaste, where one tube should last the patient one month. Such pastes replace over-the-counter toothpastes and their effect is entirely topical. So long as patients are instructed to expectorate excess paste following use, systemic side effects are negligible. Professionally applied fluoride varnishes reach concentrations of 22,600ppm and are very effective at reducing caries rates when applied at three-month and six-month intervals. The best time to apply such varnishes is during dental examination, as their effect is optimised when applied to clean, dry, and isolated teeth, which concordantly represents the best circumstances to assess a dentition for carious lesions.

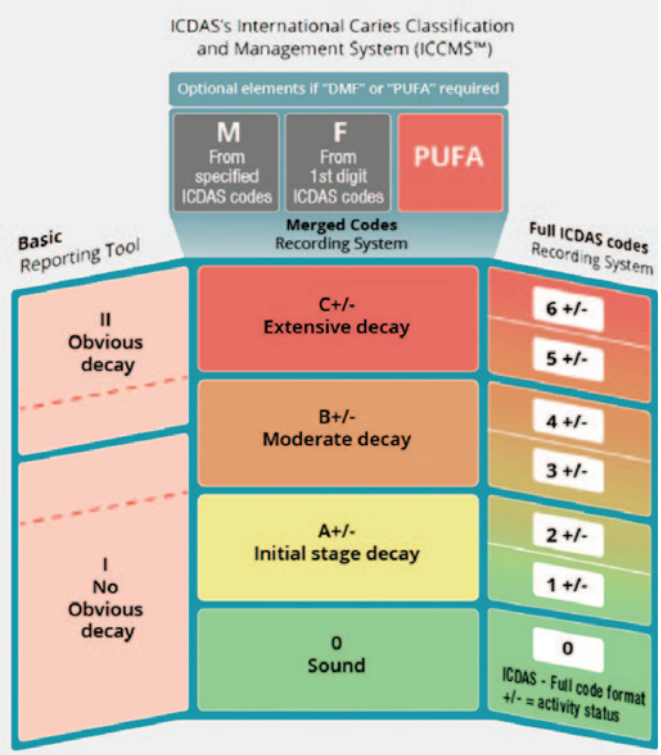


FIGURE 1: At present the majority of dentists are using a Basic Reporting Tool for dental caries diagnosis (left column), which is dichotomous in nature. It would be sensible for clinicians to adopt the ICDAS Merged Codes Recording System (middle column). This means that clinicians will fundamentally have to work harder in their diagnosis of dental caries but, in doing so, will tend towards more conservative management strategies for dental caries, which will ultimately improve patient outcomes.

It is impossible to eliminate dental plaque completely; however, optimised oral hygiene practices aimed towards the repeated mechanical disruption of polymicrobial biofilm, such that the biofilm remains immature, results in the curtailment of carious lesion formation. Meticulous toothbrushing with a manual or powered brush, and the use of interdental brushes, such as TePe brushes, remain the most effective measures for dental plaque control.[14] High-caries-risk patients may benefit from supportive periodontal therapy at increased intervals where plaque control can be reviewed and tailored, professional tooth and root surface debridement can be implemented, and professional fluorides can be applied to the dentition. Such approaches have been reported to be effective at controlling caries rate in addition to controlling periodontal disease.[15] The highest risk patients may benefit from such professional interventions as often as every three months.

Operative management of coronal carious lesions

Prior to operatively managing a coronal carious lesion, it is sensible to precisely diagnose the extent of the carious lesion and to consider if operative intervention is even necessary. At present, the majority of dentists are using a Basic Reporting Tool for dental caries diagnosis, which is dichotomous in nature and surprisingly vague compared to more precise diagnostic algorithms (**Figure 1**). The International Caries Detection and Assessment System (ICDAS) offers precision

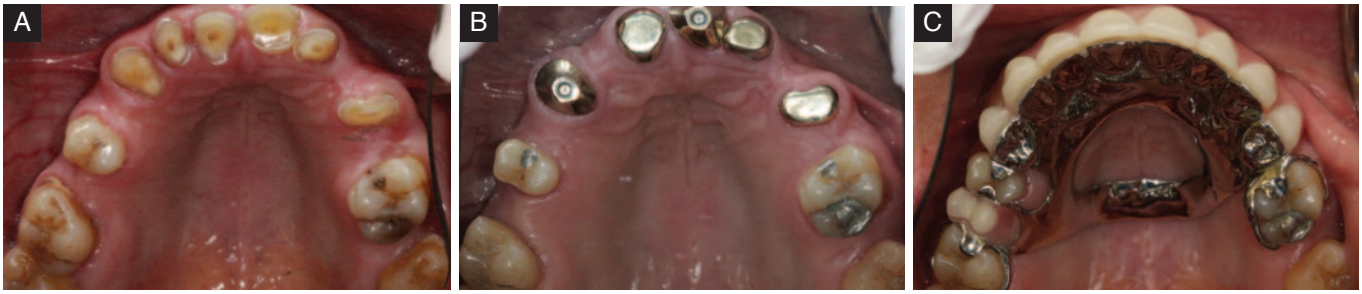


FIGURE 2 : In Figure 2A, the pre-operative presentation of the UR5 and UL6 illustrates ICDAS II Code 04 inactive carious lesions. A very common clinical presentation in routine general dental practice, it is questionable whether such inactive, non-cavitated carious lesions require direct filling at all, even when the carious lesion breaches dentine. However, as these teeth were to act as partial overdenture abutments (Figures 2B and 2C), a clinical decision was made to conservatively restore these carious lesions (Figure 2B) in order to create predictable foundation conditions for a partial overdenture. (Treatment completed prior to the Minamata Convention on mercury.)

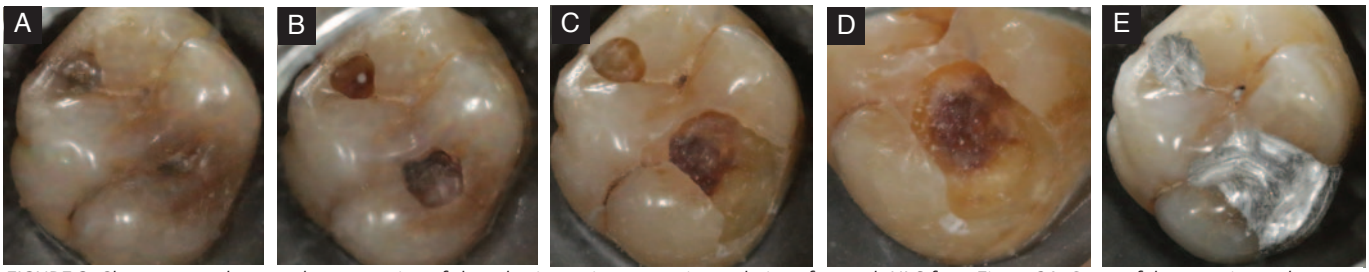


FIGURE 3: Close-up step-by-step documentation of the selective caries excavation technique for tooth UL6 from Figure 2A. Successful restorations rely upon the development of sound enamel and dentine margins at the amelodentine junction, which subsequently create conditions for a hermetic seal. Importantly, so-called caries-infected and caries-affected dentine may be left behind at the pulpal wall without fear of caries progression, pulpitis or pulpal obliteration.

when both diagnosing and understanding the extent of a carious lesion. Where carious lesions remain non-cavitated, as is the case in ICDAS II codes 01-04, or initial to moderate stage decay, there may be little value to operative management strategies (**Figures 2A-2C**). That is; operative intervention is mainly useful in cavitated situations where the purpose of a direct filling is to simply facilitate oral biofilm control through effective patient-level toothbrushing.

It is important to understand that operative interventions such as direct fillings do not prevent future tooth decay. If anything, direct fillings tend to mechanically weaken teeth and predispose teeth to fractures, which tend to be complicated, time-consuming, expensive, and unpredictable to manage.[16] Unless it is absolutely necessary for facilitating oral biofilm control, for foundation restoration, or to aesthetically improve an unacceptable appearance, the best filling is no filling at all. While this has been well known in the literature for many years, translating such an approach to clinical practice has remained elusive.[17]

When direct fillings are deemed clinically necessary, practitioners should use the most minimally invasive, selective caries excavation techniques, with a view towards preserving pulpal health, as much natural tooth structure as possible, and optimising restoration performance.[18] With this in mind, rubber dam isolation creates ideal moisture control conditions and facilitates aseptic technique, which is beneficial even when the pulp is not directly exposed (**Figure 3A**). Carious and undermined enamel should be excavated with a diamond fissure-type bur in a high-speed handpiece under copious water coolant (**Figure 3B**). The peripheral amelodentinal junction should be cleared to hard, sound dentine, using the largest sterile rosehead bur that will fit into the carious cavity at slow speed with copious water coolant (**Figure 3C**). Subsequent caries excavation should be completed using a sequence of sterile rosehead burs, from largest to smallest. A small bur can seem more conservative, but in fact tends to be more destructive when excavating soft caries, as such instruments tend to gouge into demineralised dentine, risking iatrogenic pulpal exposure. Unsupported enamel may be removed with a diamond fissure bur. Most importantly, caries at the pulpal walls need not be excavated at all, providing there is sufficient cavity depth to retain a restoration with mechanical integrity (**Figure 3D**).[19] Indeed, even so-called caries-infected dentine can be left behind if advantageous in preventing pulpal exposure, so long as a hermetic seal is achieved from a well-placed and well-fitted restoration to sound enamel and dentine margins (**Figure 3E**).

Similarly, when managing secondary coronal carious lesions, practitioners should consider using methods that preserve tooth structure, such as filling repair techniques rather than total filling replacement (**Figures 4A-D**).[20] Such procedures recognise that it is no longer deemed necessary to entirely remove an existing restoration from a tooth when managing secondary caries. Such procedures only result in an iatrogenic loss of tooth structure to the detriment of the long-term prognosis of the tooth. It is now recognised that so long as sound enamel and dentine margins are developed, such that a peripheral hermetic seal can be created and a restoration with good mechanical integrity can be placed, no further removal of tooth structure or existing filling material need occur.

Operative management of root carious lesions

Restoration of a cavity that extends onto the root surface is challenging as they may exhibit mixed cavity margins positioned in enamel as well as dentine, and there are few if any restorative materials that bond equally well to both dental tissues. Furthermore, there is a constant flow of gingival crevicular fluid to battle, as well as frequently inflamed gingiva in the area of the cavity, which bleeds easily on probing and manipulation. The cavities themselves tend to be broad, shallow, and saucer shaped, travelling around the circumference of the root. This results in a cavity form with little to no mechanical retention compared to Class I or Class II cavities (**Figure 5**).

With all this considered, it is unsurprising that restorations placed in root carious lesions perform poorly compared to coronal restorations. A systematic review

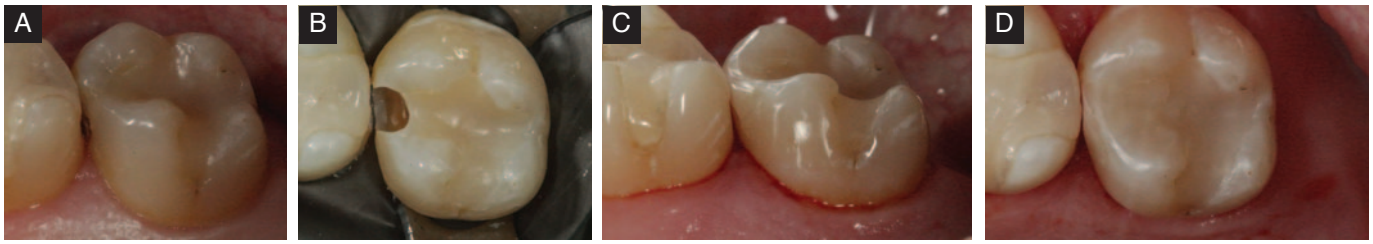


FIGURE 4: Close-up step-by-step documentation of a filling repair. Class II cavitated caries (ICDAS II 06/extensive stage decay) is visible in Figure 4A. It is no longer deemed necessary to remove an entire existing restoration in order to treat secondary caries. Rather, the filling repair procedure again relies upon the development of sound restorative margins (Figure 4B) and a hermetic seal in the subsequent restoration (Figure 4C-4D).

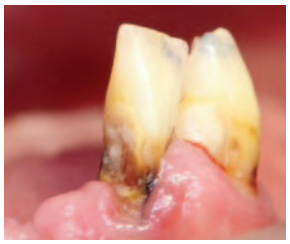


FIGURE 5. A typical root carious lesion with margins in both enamel and dentine and a shallow saucer-shaped form, lacking mechanical retention, with adjacent inflamed gingiva. Restorations placed in such conditions tend to fail mechanically or by debond. It may be better to attempt to arrest certain root carious lesions using non-operative strategies.

reported failure rates of between 17% and 36% at 12 months for restorations placed in carious class V lesions.[21] In fact, only one study had high success rates at the two-year follow up, but this study used amalgam as the restorative material, which is not a long-term option for dentists following the Minamata Convention on Mercury. Overall, the aforementioned systematic review showed that glass-ionomer cements or resin-modified glass-ionomer cements tend to fail mechanically but may confer a protective effect against recurrent caries. Conversely, resin-composite restorations tended to remain present but had a very high incidence of recurrent caries. This is likely reflective of the less predictable bond to dentine and the challenges in isolation when a cavity extends to or beyond the gingival margin level.

Atraumatic restorative technique (ART) may be a particularly useful and attractive approach in the management of root caries lesions. It allows for conservative spoon excavation of any caries-infected dentine, followed by the placement of a high-viscosity glass-ionomer cement and a protective coating or varnish. ART generally does not require local anaesthesia or conventional drilling, and can be performed in a domiciliary setting for patients who cannot attend the general dental practice. The limited data we have in this area has shown that ART restorations may be at a higher risk of failure than conventional restorations of root caries lesions in older adults.[22] We need to balance this, however, against the potential for this approach to deliver dental care to older adults who may not otherwise be able to access it.

Conclusions

Caries levels among older Irish adults are high. Ideally, we should use a minimal intervention approach of risk assessing our patients and implementing appropriate caries prevention regimes. When operative intervention is deemed necessary, we should consider the use of the most minimally invasive, selective caries excavation techniques, as well as repairing and preserving existing restorations where possible.

References

1. Connell P, Pringle D. Population ageing in Ireland: projections 2002-2021. National Council on Ageing and Older People. 2004.
2. Whelton H, Crowley E, O'Mullane D, *et al.* Oral Health of Irish Adults. 2000-2002.
3. Carvalho JC, Schiffner U. Dental caries in European adults and senior citizens 1996-2016. *Caries Res*. 2019;53(3):242-252.
4. Naseer A, McLoughlin J, Donoghue OA, Kenny RA, O'Connell B. Dental health status of community-dwelling adults aged 50 years and over in Ireland. A cross-sectional analysis of the Wave 3 TILDA cohort. *HRB Open Res*. 2022;1:26.
5. Hayes M, Da Mata C, Cole M, McKenna G, Burke F, Allen PF. Risk indicators associated with root caries in independently living older adults. *J Dent*. 2016;51(1):8-14.
6. Wen PY, Chen MX, Zhong YJ, Dong QQ, Wong HM. Global burden and inequality of dental caries, 1990 to 2019. *J Dent Res*. 2022;101(4):392-399.
7. Griffin SO, Griffin PM, Swann JL, Zlobin N. Estimating rates of new root caries in older adults. *J Dent Res*. 2004;83(8):634-638.
8. Bratthall D, Hänsel Petersson G. Cariogram – a multifactorial risk assessment model for a multifactorial disease. *Community Dent Oral Epidemiol.* 2005;33(4):256-264.
9. Hayes M, Da Mata C, McKenna G, Burke FM, Allen PF. Evaluation of the Cariogram for root caries prediction. *J Dent*. 2017;1(62):25-30.
10. Featherstone JD. The caries balance: contributing factors and early detection. *J Calif Dent Assoc*. 2003;31(2):129-134.
11. Moynihan PJ. Dietary advice in dental practice. *Br Dent J.* 2002;193(10):563-568.
12. Moynihan P. Sugars and dental caries: evidence for setting a recommended threshold for intake. *Adv Nutr*. 2016;7(1):149-156.
13. Walsh T, Worthington HV, Glenny AM, Marinho VC, Jeroncic A. Fluoride toothpastes of different concentrations for preventing dental caries. *Cochrane Database Syst Rev.* 2019;3(3):CD007868.
14. Worthington HV, MacDonald L, Poklepovic Pericic T, *et al.* Home use of interdental cleaning devices, in addition to toothbrushing, for preventing and controlling periodontal diseases and dental caries. *Cochrane Database Syst Rev*. 2019;4(4):CD012018.
15. Renvert S, Persson GR. Supportive periodontal therapy. *Periodontol 2000.* 2004;36(1):179-195.
16. Henry, DB. The consequences of restorative cycles. *Oper Dent.* 2009;34(1):759-760.
17. Innes NP, Frencken JE, Schwendicke F. Don't know, can't do, won't change: barriers to moving knowledge to action in managing the carious lesion. *J Dent Res.* 2016;95(5):485-486.
18. Lim ZE, Duncan HF, Moorthy A, McReynolds D. Minimally invasive selective caries removal: a clinical guide. *Br Dent J.* 2023;234(4):233-240.
19. Kidd EA. How 'clean' must a cavity be before restoration? *Caries Res.* 2004;38(3):305-313.
20. Green D, Mackenzie L, Banerjee A. Minimally invasive long-term management of direct restorations: the '5 Rs'. *Dent Update.* 2015;42(5):413-426.
21. Hayes M, Brady P, Burke FM, Allen PF. Failure rates of class V restorations in the management of root caries in adults – a systematic review. *Gerodontology*. 2016;33(3):299-307.
22. Göstemeyer G, da Mata C, McKenna G, Schwendicke F. Atraumatic vs conventional restorative treatment for root caries lesions in older patients: meta-and trial sequential analysis. *Gerodontology*. 2019;36(3):285-293.

Dental care for older adults

Leung KC, Chu CH.

Abstract

There is a global increase in the older population. Unfortunately, dental conditions in the older population can sometimes be poor as a result of worsened physical conditions and the cumulative damage caused by dental diseases in the past. Many suffer from oral diseases such as dental caries and periodontal disease but receive no regular dental care. Oral conditions and systemic problems are interrelated. Chronic medical problems and polypharmacy are common among them. These conditions may lead to xerostomia with or without a decrease in saliva output. Additionally, many older adults have deteriorated masticatory function associated with physical health issues such as frailty. Preventive measures are crucial to stop oral diseases from progressing, and the replacement of missing teeth is needed when masticatory function is impaired. Older adults also suffer a higher risk of oral cancer because of their less resilient but more permeable oral mucosa. With the increasing need for elderly dental care, dentists should equip themselves with knowledge and skills in geriatric dentistry. They should help older adults to develop and maintain the functional ability that enables well-being in older age. This communication article aims to discuss the relevant medical conditions, common dental diseases, and dental care for older adults.

Int J Environ Res Public Health. 2022;20(1):214.

Deep margin elevation: a literature review

Samartzi TK, Papalexopoulos D, Ntovas P, Rahiotis C, Blatz MB.

Abstract

A conservative approach for restoring deep proximal lesions is to apply an increment of composite resin over the pre-existing cervical margin to relocate it coronally, the so-called 'deep margin elevation' (DME). A literature search for research articles referring to DME published from January 1998 until November 2021 was conducted using MEDLINE (PubMed), Ovid, Scopus, Cochrane Library, and Semantic Scholar databases applying preset inclusion and exclusion criteria. Elevation material and adhesive system employed for luting seem to be significant factors concerning the marginal adaptation of the restoration. This technique does not affect bond strength, fatigue behaviour, fracture resistance, failure pattern, or repairability. DME and subgingival restorations are compatible with periodontal health, given that they are well polished and refined. The available literature is limited mainly to in-vitro studies. Therefore, randomised clinical trials with extended follow-up periods are necessary to clarify all aspects of the technique and ascertain its validity in clinical practice. For the time being, DME should be applied with caution respecting three criteria: capability of field isolation; the perfect seal of the cervical margin provided by the matrix; and, no invasion of the connective compartment of biological width.

Dent J. 2022;10(3):48.

Tricalcium silicate cement sealers: do the potential benefits of bioactivity justify the drawbacks?

Aminoshariae A, Primus C, Kulild JC.

Background: Grossman described the ideal properties of root canal sealers. The International Organization for Standardization and American National Standards Institute and American Dental Association have codified some of his requirements in ISO 6876 and ANSI/ADA 57, respectively. In this narrative review, the authors combined the ideal Grossman properties and requirements of these standards, emphasising the newer tricalcium silicate cement sealers. This chemical matrix for such sealers was developed on the basis of the success of bioactive mineral trioxide aggregate-type (tricalcium silicate cement) materials for enhanced sealing and bioactivity.
Methods: The authors searched the internet and databases using Medical Subject Heading terms, and then conducted a narrative review of those articles involving the tricalcium silicate cement endodontic sealers.
Results: Ninety-four articles were identified that discussed tricalcium silicate cement sealers. Tricalcium silicate cement sealers are partially antimicrobial and have bio-activity, which may presage improved biological sealing of the root canal system. Most other properties of tricalcium silicate cement sealers are comparable with traditional root canal sealers.
Conclusions: Within the limitations of this review, tricalcium silicate cement endodontic sealers met many of the criteria for ideal properties, such as placement, antimicrobial properties, and bio-activity, but limitations were noted in solubility, dimensional stability (shrinkage and expansion), and retrievability.
Practical implications: Tricalcium silicate-based cements have been commercialised as bio-active, bioceramic endodontic sealers. Warm, cold, and single-cone obturation techniques are usable depending on the commercial product. Some sealers can cause discolouration and are not easily retrievable, particularly when used to completely obturate a canal.

J Am Dent Assoc. 2022;153(8):750-760.

Treatment outcome with orthodontic aligners and fixed appliances: a systematic review with meta-analyses

Papageorgiou SN, Koletsi D, Iliadi A, Peltomaki T, Eliades T.

Background: The use of orthodontic aligners to treat a variety of malocclusions has seen considerable increase in the last years, yet evidence about their efficacy and adverse effects relative to conventional fixed orthodontic appliances remains unclear.
Objective: This systematic review assesses the efficacy of aligners and fixed appliances for comprehensive orthodontic treatment.
Search methods: Eight databases were searched without limitations in April, 2019. Selection criteria: randomised or matched non-randomised studies.
Data collection and analysis: Study selection, data extraction, and risk of bias assessment were done independently in triplicate. Random-effects meta-analyses of mean differences (MDs) or relative risks (RRs) with their 95% confidence intervals (CIs) were conducted, followed by sensitivity

analyses, and the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) analysis of the evidence quality.

Results: A total of 11 studies (four randomised, seven non-randomised) were included comparing aligners with braces (887 patients, mean age 28.0 years, 33% male). Moderate quality evidence indicated that treatment with orthodontic aligners is associated with worse occlusal outcome with the American Board of Orthodontics Objective Grading System (three studies; MD = 9.9; 95% CI = 3.6-16.2) and more patients with unacceptable results (three studies; RR = 1.6; 95% CI = 1.2-2.0). No significant differences were seen for treatment duration. The main limitations of existing evidence pertained to risk of bias, inconsistency, and imprecision of included studies.

Conclusions: Orthodontic treatment with aligners is associated with worse treatment outcome compared to fixed appliances in adult patients. Current evidence does not support the clinical use of aligners as a treatment modality that is equally effective as the gold standard of braces.

Eur J Orthod. 2020;42(3), 331-343.

Quiz answers

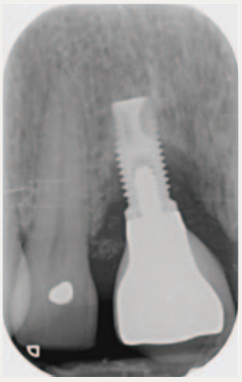
Questions on page 146.

1. Dental implants should be examined for signs of inflammation (erythema, bleeding on probing, swelling and suppuration) through visual inspection, probing and digital palpation. Attachment loss can be assessed with probing and radiographs.

2. Patients with a history of periodontitis, poor plaque control, lack of regular maintenance, smoking and diabetes.

3. Peri-implant diseases and conditions can be classified as peri-implant health, peri-implant mucositis, peri-implantitis, or peri-implant soft and/or hard tissue deficiencies.

4 Oral hygiene instruction, non-surgical debridement and smoking cessation advice. Surgical intervention to be considered once oral hygiene is satisfactory. Referral to a periodontist should be offered for specialist care.



SITUATIONS WANTED

Practice manager available with 20 years of experience in running a practice. Qualified DSA, diary optimisation, chairtime value, HR, contracts, stock control, compliance, leadership skills. Contact Pauline@dentalconsultancy.ie.

SITUATIONS VACANT

Associates

Kerry: Part-time/full-time associate for the opportunity to join a young, vibrant, and dynamic team. Fully private, modern practice. Full book guaranteed. Must be motivated and have a specialism/special interest in orthodontics, implants, endodontics, oral surgery. Contact info@creandental.ie.

Begley Dental is seeking a part/full-time associate for new state-of-the-art surgery. Fully computerised with digital X-ray and OPG. Excellent remuneration. Contact fergalbegley@outlook.ie.

Cork City: Dental associate required. Full-time and two part-time positions. Also, part-time locum post for four weeks. Full book in excellent, established practice. Contact 086-8584774 or gwalsh3000@gmail.com.

Cork City: Multi-surgery practice requires an associate. Flexible hours, full support, computerised, scanner, and on-site lab. Contact corkcityassociate@gmail.com.

Dr Paul O'Boyle is seeking a talented dental associate for an established book of private patients. Biomimetic interest an advantage. June 23 start. Riverside Dental, Celbridge. Contact poboyleriverside@gmail.com.

Experienced dental associate required in Carlow town. Full/part-time position in a private, well-established clinic. Be part of a great multidisciplinary team with many visiting specialists. Excellent backroom support. Cerec, in-house laboratory, digital scanner, CBCT. Please send CV to bbarrett@pembrokedental.ie.

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, July 14, 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	€123	€246
26 to 40 words	€147	€295

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.

Dublin 15: Hard-working and motivated dental associate required. Full time. Guaranteed full books. Great atmosphere. Supportive staff. Mentoring by a senior dentist if required. Please reply with CV by email to bodekerpeter@gmail.com.

Dental associate required for a full- or part-time position in a busy fully private practice, 15 minutes from Dublin city centre. Great atmosphere and experienced support staff. Mentoring available. Digital scanner and OPG available. Endodontist, periodontist, and hygienist present. Contact dublindentistrecruitment@gmail.com.

South-east Galway: Unique opportunity to 'try before you buy' or work as an associate with control over days and hours, and scheduling and fees without the HR and admin hassle. Long-established practice, excellent support staff, private/PRSI. Contact drrothwelldental@gmail.com.

Experienced dental associate required in busy modern practice in Dublin 14. Private/PRSI, free parking, hygienist, full support from our friendly team. Contact dublin14dentist@gmail.com.

Orthodontic associate required, Midleton, Cork. Two days per week. Large six-chair general, orthodontic, and implant practice occupying three floors and established 20 years. Large, bright orthodontic wing, on-site lab and qualified technician, OPG, CBCT, six months waiting list. Well-managed diary, holiday cover, parking. Contact vacancies@corabbeyortho.ie.

Part-time associate dentist required in Cork City suburb. Busy, expanding, modern, and spacious surgery with experienced, friendly support staff. Hygienist, visiting oral surgeon. Private/PRSI. Contact toothdr10@gmail.com.

Associate required to replace a departing colleague in busy west Limerick practice. The practice has an in-house prosthodontist, orthodontist, and hygienists. Mentorship available for the correct candidate. Experienced support staff. Friendly working environment. Please reply with CV to info@mullanedental.ie.

Part-time experienced dental associate with IDC registration for modern, friendly, computerised practice in Kilkenny. Fully digitised, OPG, implant, oral surgery, hygienist, excellent remuneration. Contact dentistkilk22@gmail.com.

Bowe Dental Clinics is recruiting associate dentist(s) to join expanding clinics in Limerick and Tipperary. Fully digital practices, OPG, CBCT, 3Shape. More than 20 years established patient list. Private, PRSI, GMS. Monday to Saturday days available. Contact eamonn@bowedentalclinic.ie.

Malahide, north Dublin: Experienced dental associate required in a well-established private/PRSI clinic. Flexible hours, full or part-time arrangements considered. Great team and excellent support. An interest in sedation (IV and NO) an advantage but not essential. Please email CV to cirociao4@gmail.com.

South Dublin: Experienced associate required in a busy, well-established, computerised general practice in a lovely location. Initially part-time (two to three days), likely to be full-time. Great team providing clinical and clerical back-up in a friendly environment. Contact dentalassoc993@gmail.com.

Experienced part-time associate required for a well-established, modern practice in Dublin 4. Fantastic opportunity to be part of a multidisciplinary team. CEREC, Prime Scan, Itero 5D, full digital workflow, OPG. Experience with digital dentistry preferable. Two to three days initially. Contact office@pembrokedentist.ie.

Associate required for full-time position in busy Tipperary practice three days a week. Great working atmosphere, very helpful staff, and fully-computerised practice. Immediate start date available, but all options considered. Please leave in a CV or email to dentalpost1@gmail.com.

Associate dentist with good skill set and experience for a part/full-time position required in modern, busy, Cork City suburban practice. Contact ob1kob2@gmail.com.

Ratoath Dental and Implant Centre requires an experienced and excellent associate. Very busy, well-equipped, five-surgery practice. Exceptional team. 30 minutes from Dublin city centre/airport. Part-time with potential to become full-time. High-quality, private dentistry. See website for details. Contact: conor.irwin@ratoathdental.ie.

Experienced dental associate with IDC registration required part time, Thursday and Friday, for modern, mixed practice in Dublin 2. 3Shape IOS, CBCT, implant, oral surgery, and prosthodontics. Friendly and enthusiastic team player required. Contact john@dentalhouse.ie.

Associate required for full/part-time position in busy private practice in New Ross, Co. Wexford. Great team, excellent support, mentoring available. Fully computerised, OPG, IO scanner, hygienists, endodontist. Excellent remuneration. Please email CV to info@rogersdental.ie.

Midleton, Cork: Unique opportunity for an experienced dentist replacing a departing colleague. Mainly private/PRSI. Self-employed associate position. Five days a week, including Saturday mornings. Excellent earnings (50% split). Exact software, digital X-rays/OPG. Email CV to npdent22@gmail.com.

Associate required for busy private/PRSI practice in Portumna, Galway. Digital, visiting endodontist, hygienist, experienced support staff, and great working environment. Full book. Flexible days/hours. Excellent remuneration. Contact drrothwelldental@gmail.com.

Meath: Associate dentist required to join fast-growing, busy clinic in new medical centre. Modern, digital radiographs and scanner, computerised. Great team support and wonderful working environment. 50% remuneration. Private/PRSI/GMS. Contact fiacloirnua@gmail.com.

Dentist associate required for a busy expanding practice. 50% remuneration for the right candidate. Support and mentorship provided by long-term existing staff. Fully digital, OPG, hygienist, CDT, orthodontics, and implantology on site. Flexible working days/hours. Contact Kingscourtdentalpractice@gmail.com.

Associate required 9.30am-5.00pm, Monday and Tuesday. Busy private practice in Midleton, Cork. Five chairs, excellent support, OPG, CBCT, full book, in house technician. Contact: carmel@corabbeydentalclinic.ie.

Dental associate required for a busy dental practice in Dublin 5. Flexible days and hours. No weekends. Please email CV to northcitydental@gmail.com.

Part-time associate needed for a busy, mixed practice in south-west Dublin. Two days per week. Experience is a plus. Excellent work environment and high remuneration. Progression to full-time is a real possibility. Contact sbarnes@ballyfermotdental.ie.

Dentists

Motivated and experienced dentist required for a full/part-time position in south Dublin/north Wicklow. Excellent remuneration for dentist interested in aesthetics (bonding/Invisalign, etc.). Great atmosphere among a friendly team in a multidisciplinary clinic. Contact begleycaitriona@yahoo.ie.

Based in a great location with a fantastic team. Irish Dental Council registration required. Medical card patients and lots of private work. Contact melissa.graham@smartdentalcare.co.uk.

Dental Care Ireland, Greystones: Our modern and well-established digital practice has a high earning opportunity for an experienced dentist (orthodontist experience is an advantage). Full and part-time options, fully supported by our experienced team. Private and PRSI. Contact careers@dentalcareireland.ie.

Vacancies in HSE Dental Service Dublin south, Kildare, and west Wicklow. See more details at https://www.hse.ie/eng/staff/jobs/job-search/medical-dental/nrs13605.html. Contact siobhan.doherty1@hse.ie or catriona.roe@hse.ie.

Mayo: Full/part-time, experienced dentist required to join a very busy practice. Three surgeries, new equipment, fully computerised, digital scanner, excellent support team. High-earning potential. Contact reception@claremorrisdentalcentre.com.

Part-time dentist required initially two-three days including Saturdays for a busy, mixed, and modern dental practice in Dublin. Full book guaranteed. Opportunity to build an orthodontic career for incoming colleague along with general dental practice. Contact muhammad.aasif@hotmail.com.

Dentist required for a busy, modern, fully private practice in Enfield, Co. Meath. State-of-the-art equipment with Primescan, 3Shape scanners, and CBCT. The position suits an enthusiastic associate who wishes to develop with a progressive team. Excellent remuneration. Contact deirdre@thejamesclinic.com.

Part-time dentist required for a busy, private practice in north Dublin. Digital scanner and OPG on site. Hygienist, periodontist, and endodontist support on site. Experienced and friendly support staff. Mentoring available if needed. Excellent remuneration. Flexible days and times. Contact dublindentistrecruitment@gmail.com.

General dentist required to cover maternity leave two days a week from August in busy practice in Drumcondra, Dublin 9. Experience essential. Email CV to niamh@drumcondravillagedental.ie.

Dentist required: Full or part time. Modern, busy private practice. Mount Merrion, Dublin 4. Fully digital. iTero. OPG. Flexible hours. Must have a strong interest in cosmetic dentistry. Email CV to drerikawhitesmile@gmail.com.

Dental Care Ireland, Meath: Our established, modern practice has a high earning opportunity available due to company growth. Offering strong patient books and fully supported by our friendly and experienced clinical teams. Experience and IDC registration is required. Contact careers@dentalcareireland.ie.

Experienced dentist required for Saturday sessions. Friendly, well-organised, private, PRSI practice. Experienced, friendly support staff. Excellent remuneration and earning potential. Multidisciplinary practice. Potential for extra sessions. Located a few minutes off M50. Free parking. Contact info@woodstowndental.ie.

Experienced, enthusiastic, part-time dentist required to work in a busy, well-established, modern practice in north Co. Dublin. Private/PRSI. Contact info@rushdentalsurgery.ie.

Dentist required for a busy, award-winning practice in the north east, one hour from Dublin/Belfast. Full/part-time. Contact mbcar06@gmail.com.

Part-time dentist required in busy Cork orthodontic practice. Experience preferred but not essential. Flexible hours. Contact info@browneortho.ie.

Experienced, enthusiastic, part-time dentist required to work in a busy, computerised, family practice in Malahide, Co. Dublin. Private/PRSI.

Immediate start. Please leave in CV or email CV to dentistpostmalahide@gmail.com.

North Kerry dental practice seeking an experienced part-time dentist. Please email CV to info@ballybuniondental.ie.

Full/part-time dentist required for busy clinic in Swords. Fully digitised practice. Invisalign training provided, ongoing support from principal dentist. New graduates welcome. Flexible schedule. Car space. Annual leave. Large patient database. Close to Pavilions shopping centre/airport. Itero scanner. Contact: practicemanager@oneilldentalcare.ie.

Dentist required for private Athlone practice. Private and PRSI patients. OPG and CBT. Hygienist and full support staff. Excellent remuneration. Experience preferred. Part/full time. Contact reception@mearesdental.ie.

Established, independent, private practice in Kildare town. Practice income 95% private with PRSI. Implant, sedation, orthodontics, and oral surgery provided with free mentoring. Fully computerised with SOE digital X-rays, digital OPG and CBCT intra-oral scanner. Contact info@kildaredentalcentre.ie.

New graduate dentists: Smiles Dental is hiring! We have exciting opportunities available for 2023, 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.

Dentist required for Thursday, Friday, and Saturday position. Opportunity to go full-time from September. Two years minimum experience. Fully digitised practice/OPG. Private/PRSI. Contact dentistdublin10@gmail.com.

Dental Care Ireland: High earnings and strong patient books within our established modern practice. Flexible days/hours nationwide due to growth. Our friendly and experienced support team are in place. Flexible opportunity and great package on offer. Contact careers@dentalcareireland.ie.

Dental Care Ireland t/a Callan Dental: High earning opportunity in our established, modern practice. Flexible days/hours, strong patient book on offer, fully supported by our friendly, skilled, clinical team. Must be registered with the Irish Dental Council. Contact careers@dentalcareireland.ie.

Locums

Dublin: Locum dentist required May 3-15, option to stay on for two days a week, monthly gross achievable €40k. Must have cosmetic dentistry experience. Contact: orthosull@gmail.com.

Experienced locum dentist required to join a busy, private dental surgery with immediate start. Possibility of associate part-time position. Please email CV to: lucandentalcare@gmail.com.

Full or part-time. Modern, busy private practice. Mount Merrion, Dublin 4. Fully digital. ITRO. OPG. Flexible hours. Strong interest in cosmetic dentistry. Contact drerikawhitesmile@gmail.com.

Specialist/limited practice

Urgently required: Busy oral surgeon list in modern specialist clinic. Fantastic earning potential. Great facilities including CBCT, sedation, experienced support staff. Contact tomas.allen@kingdomclinic.ie.

Dental Care Ireland has nationwide opportunities for specialist orthodontists. Strong patient books, high-earning opportunities with flexible day/hours on offer. Established modern practices with state-of-the-art facilities. IDC registration and experience required. Contact: careers@dentalcareireland.ie.

Orthodontist required to join our established team in Dunboyne, Co. Meath. Flexible, part-time with potential for full-time. Email CV to dunboyneorthodontics@gmail.com.

Visiting periodontist required for busy, private practice in Limerick city centre. Steady stream of patients requiring specialist-level care. Orthodontics and advanced restorative treatments provided in house, requiring hard and soft tissue expertise, integrating with comprehensive treatment plans. Contact kevin.murphy@murphydentalcare.ie.

Limerick: We are looking for an enthusiastic, driven dental surgeon to join our well-established and busy private practice in Limerick. We will accept full and part-time applications, and can offer a full, well-managed diary. Contact sophie.collier@bupadentalcare.co.uk.

Woodquay, Galway: Excellent opportunity for an experienced, driven dental surgeon. Established list and great cosmetic and orthodontic treatment potential. Full and part-time applications are accepted. High earning potential. Contact sophie.collier@bupadentalcare.co.uk.

Enniscorthy: Modern practice seeks a patient-focused dental surgeon. Full or part-time options available, fully-equipped surgeries and busy patient book for excellent earning potential. Contact sophie.collier@bupadentalcare.co.uk.

Private general/specialist practice based in Skerries with highly equipped surgeries delivering quality service alongside an excellent support team. We are seeking a dentist with a masters qualification in restorative dentistry on a part-time basis. Contact yoursmile2612@gmail.com.

Specialist oral surgeon required for practices in south east. Flexible sessions/days within established practices with excellent facilities. CBCT onsite. Long waiting lists. Full support from our skilled and experienced admin and clinical staff. Contact bpm.gmedical@gmail.com.

Expression of interest sought from the following specialists and dentists with special interests: periodontist, oral surgeon, orthodontist, and endodontist in a new advanced dental clinic. Must show commitment to clinical excellence and multidisciplinary care. Close to Dublin. Contact spec1.dental@gmail.com.

New dental practice opening this summer in the ever-growing town of Celbridge, Co. Kildare. Looking for a specialist who would like to grow with this practice and to be part of something new and exciting. Contact shackletonclinic@gmail.com.

Dental Care Ireland: High earning opportunities due to exciting company growth. Orthodontists, implantologists, and endodontists required nationwide. Flexible hours within established practices with excellent facilities. Fully supported by our skilled and experienced support staff. IDC registration is essential. Contact careers@dentalcareireland.ie.

Begley Dental is seeking an oral surgeon and an orthodontist to work sessions in our new state-of-the-art surgery. Fully computerised with digital X-rays including OPG and lateral ceph. Contact fergalbegley@outlook.ie.

Kerry: Implantologist required for very busy, fully private practice one day per month. Contact info@creandental.ie.

Part-time position. Very busy periodontal practice. Flexible hours/days.

Modern facilities, CBCT, sedation, laser, X-Guide etc. Fantastic earning potential. Contact tomas.allen@kingdomclinic.ie

Dental technicians

Mayo dental surgery requires full-time technician. Mostly acrylic work, denture repairs and fabrications, special trays, bleaching trays, and Essix retainers. Cerec 3D CAD/CAM unit on site. Continuous training and professional development encouraged and provided by supportive principal dentist. Contact castlebardentalclinic@gmail.com.

Dental nurses/receptionists/managers

Exciting opportunity for part/full-time nurse to join our award-winning team in Meath. Experience is essential. Knowledge of Exact is desirable. Excellent working conditions with staff benefits. Car park available. Start date June, 2023. Contact dentaljobireland1@gmail.com.

Part-time dental nurse position available in our beautiful Malahide seaside clinic. Experience preferred, not essential. We are looking for a kind, enthusiastic, friendly team member who shares our commitment to providing exceptional patient care. Please email CV to info@bespokedental.ie.

North Dublin practice seeks kind, caring, and enthusiastic dental nurse. Full training provided. Experience preferred, not essential. Full/part-time considered. Contact pdsvacancy@gmail.com.

Part-time, permanent receptionist needed for a busy, private south Dublin clinic. At least three years' experience required. Please email CV to sandyfordhall.dentist@gmail.com.

Experienced dental nurse required to join a busy, modern dental surgery in west Dublin. Full/part-time role available with immediate start possible. Please leave CV in or email CV to lucandentalcare@gmail.com.

Experienced dental nurse is required full time in an expanding modern busy practice in Carlow town. Very friendly team. Contact maddendentalclinic@gmail.com.

South Dublin practice seeks energetic and enthusiastic dental nurse/receptionist. The successful candidate will be afforded all necessary training with the support of an experienced and supportive team. Full-time position but part-time considered. Excellent pay. Contact Laurasoshea@yahoo.co.uk.

Exciting opportunity. Experienced full-time secretary required for a busy private specialist clinic. Based in the Northbrook Clinic, Ranelagh. Working with Prof. Leo Stassen. A dental nurse qualification desirable but not essential. Good typing skills desirable but not essential. Please forward CVs to info@maxfax.ie or contact 087-215 3233.

Dental hygienists

Full or part-time dental hygienist position available at our busy private practice with full book. Excellent and friendly support staff. Flexible hours. Competitive hourly rate. Contact Jason@jmedental.com.

Part-time hygienist required for Dungloe Dental, Co. Donegal. Full book for two days/week in busy modern practice with friendly, support staff. Contact info@dungloedental.ie.

Dental hygienist needed three days a week for busy general practice in Tramore, Co. Waterford. Private and PRSI. Fully digital. Friendly support staff. Excellent remuneration. Contact sorchawhite@hotmail.com.

Hygienist position available in our busy, modern, private practice in north Dublin. Full patient books and flexible days/hours available. Experienced nursing support provided. Excellent remuneration and CPD provided. Contact dublindentistrecruitment@gmail.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.

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

Dental Care Ireland: Nationwide opportunities for graduating hygienists due to company growth. Our established, modern practices have strong patient books and flexible days/hours available. Supported by our friendly and experienced teams. Attractive packages on offer. Contact careers@dentalcareireland.ie.

Dental Care Ireland Galway, Mayo, Sligo have hygienist opportunities due to company growth. Our established, modern practices have strong patient books and flexible days/hours available. Supported by our friendly and experienced teams. Attractive packages on offer. Contact careers@dentalcareireland.ie.

Gentle, professional hygienist wanted to cover maternity leave in our lovely private practice, Dundrum Dental Surgery, from July 10, 2023. Three fully booked days per week. An earlier start date of June 10 is also feasible. Excellent remuneration. Contact sarahjane@dundrumdentalsurgery.ie.

Dental hygienist required for busy coastal practice part time with possibility of full time. Private/PRSI. Qualified, friendly, supportive staff. Contact niallmcrty@gmail.com.

Busy, award-winning north east practice seeks hygienist. Contact mbcar06@gmail.com.

Dublin practice, established in 2009, seeks hygienist to replace departing colleague for one day per week. Spacious surgery in lovely practice setting, detached sterilisation room, full office support. Happy patients. Private and PRSI. Generous terms. Contact 002thdoc@gmail.com.

Dental hygienist required for maternity cover for busy private practice in Thurles, Tipperary. One or two days a week. Friendly, supportive team. To start from August 2023. Contact aidanburkethurles@yahoo.ie.

Part-time dental hygienist required in our state-of-the-art city centre clinic. Two full days available. Friendly and welcoming team. Contact louise@clearbraces.ie.

Dental hygienist required for a private busy south Dublin dental practice. 15 hours per week with the possibility of more. Private practice/PRSI. Friendly

supportive dental team with very loyal friendly patients. Contact mayberrydentalcare@gmail.com.

Full or part-time dental hygienist positions are available in Galway City. Modern, private practice. Free parking. Excellent support staff provided. Friendly experienced team. Flexible hours. Contact alisonkavanagh1981@gmail.com.

Dental Care Ireland, Waterford: High earning opportunity for a hygienist to join our established modern practice, flexible part-time days on offer. Strong established patient book and great package. Friendly and experienced team. Contact careers@dentalcareireland.ie.

Dental Care Ireland, Carlow: Part-time hygienist role available with strong established patient books on offer. Our modern practice has a friendly, experienced team in place. Flexible hours and package on offer. Contact careers@dentalcareireland.ie.

Kerry: Motivated, full-time hygienist required. Very busy, fully private practice. Full book guaranteed. Contact info@creandental.ie.

Kerry: Dental hygienist required for maternity cover for busy private practice in Killarney, Co. Kerry. Two/three days a week, very flexible. No late evenings or weekends. Friendly, supportive team. Contact info@killarneydental.ie.

PRACTICES WANTED

Ortho specialist looking to buy a practice in south Dublin or Kildare. Available in Dublin May 14-20. Interim arrangements considered. Hoping to relocate October 2023. Contact: teddy001992@gmail.com.

PRACTICES FOR SALE/TO LET

Dublin 13: Premises to let for clinical dental technician. Contact brytesmile@gmail.com.

South Dublin: Long-established two-surgery, fully private/PRSI practice. Excellent location with room to expand. Low overheads. Plentiful parking next door. Very strong new patient numbers. Computerised/digital. Strong potential for growth. Principal available for transition. Contact niall@innovativedental.com.

Cork City: Two-surgery leasehold practice. Excellent location. Low overheads. Huge potential. Principal open to transition. Contact 087-283 5282.

Dental imaging centre with excellent turnover and potential to expand. Contact 087-207 1077.

Kilkenny City practice for sale. Low rent. Private/PRSI. Retirement planned. Principal available for transition. Priced to sell. Contact dentalpractice3.1415@gmail.com.

Donegal: Busy practice. Superbly equipped. OPG, computerised, no medical card. Large new patient numbers. Excellent staff. Low overheads. High profits. Long lease/freehold property. Principal happy to transition. Area wide open. Excellent expansion possible. Contact niall@innovativedental.com.

Cork City: Very busy, long-established, well-equipped, two-surgery practice. Room to expand. Area open. Digitalised/good recall system. Excellent location. Strong footfall. Low overheads including rent. Long-term associate in place. Priced to sell. Principal retiring. Contact niall@innovativedental.com.

Busy two-surgery practice with potential for three for sale in Ballina, Co. Mayo. Established 1997. Private/PRSI. Great growth potential. Principal available for transition period. Priced to sell for €200k. Contact lnoonan2@msn.com.

Fully equipped surgeries to rent in specialist suite in Oranmore, Galway. Contact paul@paulmccabe.ie.

South Munster: Very busy, long-established, well-equipped, computerised/digitalised, three-surgery practice. Decontam in place. Excellent location. Strong footfall freehold/leasehold options. Very good figures/profits. Long-term associate in place. Priced to sell. Principal retiring. Contact niall@innovativedental.com.

Kilkenny City. Very busy, two-surgery practice with room to expand. Prime location. Very low overheads, including rent. Strong new patient numbers. Computerised, digitalised, hygienist service. Potential for major speedy growth. Priced to sell. Flexible transition, negotiable. Contact niall@innovativedental.com.

Cork: Long-established, good footfall, very busy, walk-in dental practice. Ample room to expand. Strong, busy, and active hygienist. Excellent equipment including OPG. Low overheads. Computerised. Very good new patient numbers. Realistically priced. Contact niall@innovativedental.com.

Invisalign Smile Architect™

Transform the invasive procedures of the past into the minimally invasive treatments of tomorrow.

Invisalign Smile Architect™ is a first-of-its-kind smile design solution that combines alignment and restorative planning in a single platform, promoting lasting oral health.

align

invisalign®

Respect for dentistry

Dr Christine McCreary is an Emeritus Dean/Head of School and Dentist at Cork University Dental School and Hospital, who has led an interesting and varied career between dentistry and medicine, which led her to specialise in oral medicine. As she reflects on the dental profession as a whole, she worries that it is losing the respect it deserves.

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

I initially wanted to study medicine. I didn't get enough points to get in, but I did get enough to get into natural science in Trinity. In the February of that first year, I heard there were places available in the dental class, so I appealed, and I was able to transfer. I went through there, I did well in final year, and I got a job as a house surgeon. I qualified in 1983 as a dentist and went back in 1987 to study medicine.

Tell me more about your career and specialisms?

I qualified in 1991, worked through the junior doctor system and then came back in as a specialist registrar to the dental hospital in Dublin and my specialty was oral medicine; that's what I became a consultant in eventually. I worked in Dublin as a consultant from 1997 until 2002. When I qualified as a dentist, HIV was just coming over the horizon. There was so much general medicine, so many oral manifestations of HIV and AIDS, and it was a very scary time, particularly for patients, but it was a very good learning experience for me. And that was really, I suppose, when I decided I wanted to specialise in oral medicine.

In this edition, the focus is on women in dentistry. Can you tell me about your experience as a woman in the profession?

I think in one way it's a great career for women, and I think women experience less of a glass ceiling in dentistry than they might even in medicine. But the one problem I see with it is the so-called phenomenon of the feminisation of the profession, and I do think that's an issue that we haven't really come to terms with. Any profession being wholly one gender I don't think is a good idea. We know the number of dentists in Ireland, and we're short of people in general dental practices in Ireland, so I think we would like to encourage our male colleagues to keep at it. And it's a great job for men as well, of course.

Have you had any involvement in the IDA?

I was a member of the IDA when I was actively working, and I've certainly had a very good relationship with them. While I haven't taken up a central role within the IDA organisation as such, I would have had a lot of links and people would have rung me and asked me for advice. I would have rung them to put things across their desks as well, to see what they thought about certain things.

What do you think are the big issues that the IDA needs to focus on?

I think the standard of care and the access to care now is probably not even as good as it was 40 years ago. It's a real sign of how sick our health system is generally. The other problems that I see are the relationship between private practice, the dental schools, and the HSE. There are pockets of really good work, but the HSE as such, and the dental service in the HSE, has been underfunded and ignored.

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

I think it focuses very much on general practitioners, but I think in some way we could combine all the talents and have a much more interactive experience. Apart from that, I think we need to really look seriously at how we want dentistry to be perceived. Do we want to be seen purely as people who you go to for tooth whitening, or do we want to be seen as people who are great at picking up serious diseases, oral cancers, etc? I think that's been lost a little bit. I think respect for the profession has decreased and I think we need to look at ways of trying to build that.

Christine has been enjoying her retirement for almost a year now, and says she has enjoyed having time for herself. She has taken up more exercise, such as walking and swimming, and has even done a bit of travelling around Europe.

Dental Protection

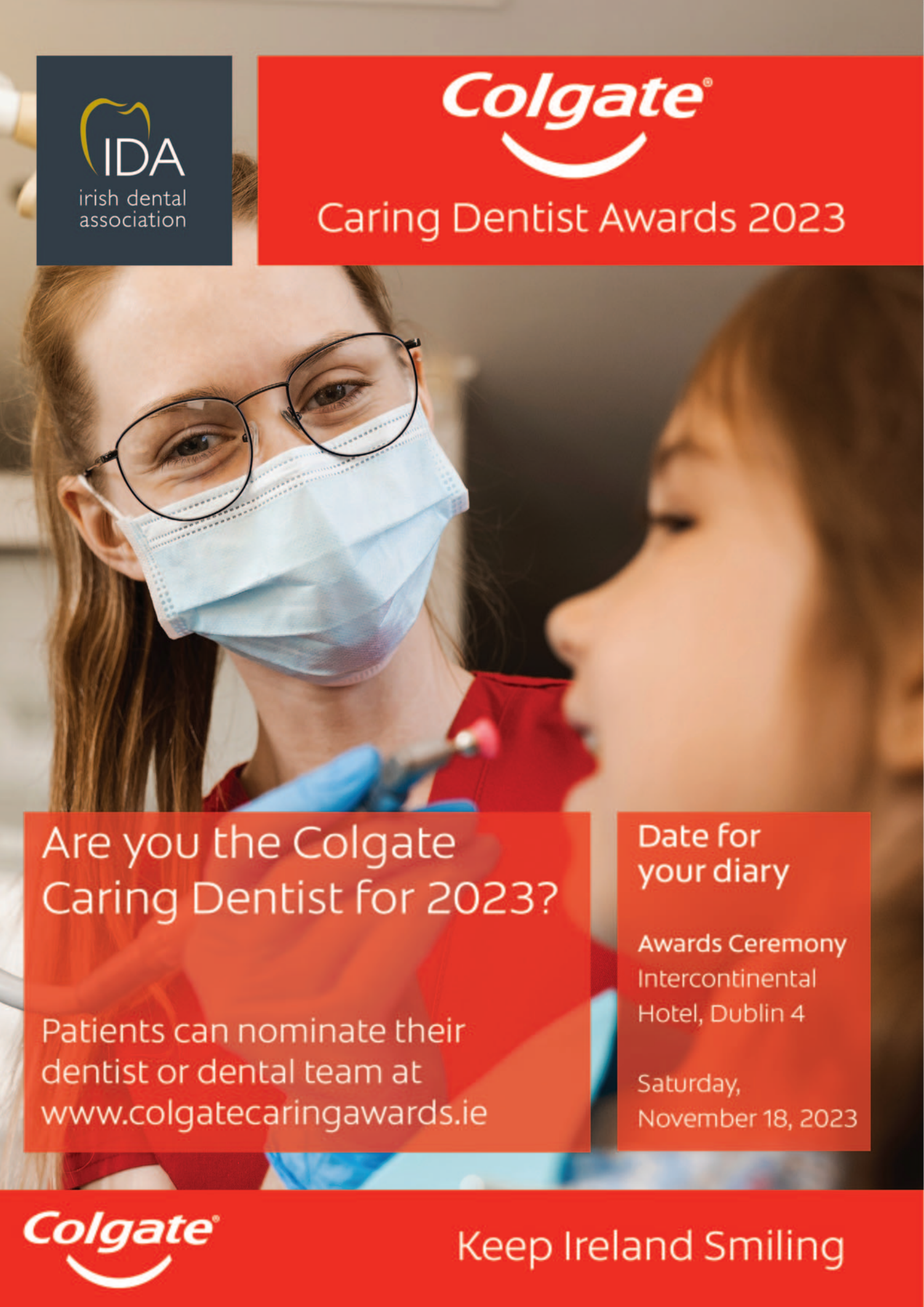
CUSTOMISED to your career

Professional dental indemnity from Dental Protection is designed and priced just for you. Safeguard your reputation with the world's leading protection organisation for dentists and healthcare professionals.

- 24/7 emergency dentolegal advice
- Professional development courses – at no extra cost
- Support for every stage in your career
- Experts who understand you

Always there for you

dentalprotection.org


IDA
irish dental association
Colgate
Caring Dentist Awards 2023
Are you the Colgate Caring Dentist for 2023?
Patients can nominate their dentist or dental team at www.colgatecaringawards.ie
Date for your diary
Awards Ceremony
Intercontinental Hotel, Dublin 4
Saturday, November 18, 2023
Colgate
Keep Ireland Smiling

Tristen Kelso
Director, BDA Northern Ireland

Health Service dentistry in NI facing collapse

The BDA has written to the Department and to politicians to warn about an imminent collapse in dental treatment services.

In an open letter to Peter May, Permanent Secretary at the Department of Health, Drs Peter Crooks, Roz McMullan, Ciara Gallagher, Ann McAreavey and Darren Johnston, representing all crafts of dentistry in Northern Ireland, stressed: "If the axe falls on dentistry – indeed if there is a failure to provide needed investment – this service faces collapse. The price will be paid by patients across Northern Ireland".

This is in response to a letter from Michael O'Neill, Head of General Dental & Ophthalmic Services in the Department, who wrote to dentists on May 3 last saying that work is ongoing to secure savings and raise revenue across health budgets.

On May 22, the Department of Health confirmed that £360m of cuts will be taken from the health budget, including an end to the Rebuilding Support Scheme (RSS) enhancement of IoS fees after Q1, and no current ability to make any pay award for 2023/24.

In the continuing absence of government, we are calling on MLAs to step up and protect the future of NHS dentistry across Northern Ireland. We have warned officials and politicians that planned cuts will devastate a service already on the brink. An urgent meeting with the Permanent Secretary has been requested.

Our BDA leaders say that Northern Ireland faces a three-tier system, where those who can't get registered for NHS care but can't afford to pay privately are left without routine access, short of accessing emergency services.

The letter cites bleak evidence from the frontline, with the crisis on the high street being felt acutely across community and secondary care:

- **oral cancers:** red flag referrals for suspected oral cancers from high street dentists to secondary care, set at two weeks, are currently running at eight-and-a-half weeks in some areas;
- **an access crisis in primary care:** last year the BBC found that 90% of practices were not accepting new adult patients and 88% were not accepting child patients. Activity levels have only recovered to approximately 80% of pre-Covid levels. A workforce crisis is fuelling this access crisis, combined with unviable fees to dentists for providing NHS care. Some 60% of dentists intend to increase their amount of private work, and 41% of practice owners intend to decrease their health service work. This picture is set to worsen;
- **multi-year waiting times:** we have five- to six-year waiting times for routine assessment for oral and maxillofacial services, 219- to 312-week hospital orthodontic waiting times for patients with facial deformities, and are currently reliant on a surgeon from Wales to come over every two months to treat children with cleft lip and palate. Cuts could mean waiting times increasing further, and some treatments no longer being available in Northern Ireland;
- **widening health inequalities:** NI residents are twice as likely to have filled teeth as their counterparts in England, and children are three times as likely to have multiple teeth extracted under general anaesthetic. Children in our most deprived communities are least likely to be even registered with a dentist (63% registered in the most deprived areas vs 80% in the least deprived). Health inequalities will widen further if, as a result of reduced funding, access to the full range of dental services is reduced;
- **plummeting morale:** Covid-19 has had an enormous impact on the dental profession. 63.6% of community dentists – treating the most vulnerable in society – say their morale is 'low/very low', with a key factor being the ongoing patient backlog. Existing difficulties accessing theatre space is having an impact on the vulnerable groups these dentists serve; and,
- **a growing pay gap:** additional in-year funding will, in effect, not be available for pay uplifts here, rather it will be prioritised to settle the £297m debt. Northern Ireland has a shameful track record of delivering late pay uplifts. The possibility of no uplift would have a devastating impact on recruitment and retention, and the financial sustainability of practices. In hospitals, dental core trainees (DCTs) have a pay gap of up to 25% compared to other UK nations. This is having a huge impact on recruitment, with nine of 22 DCT posts currently unfilled.

"If the axe falls on dentistry – indeed if there is a failure to provide needed investment – this service faces collapse. The price will be paid by patients across Northern Ireland."