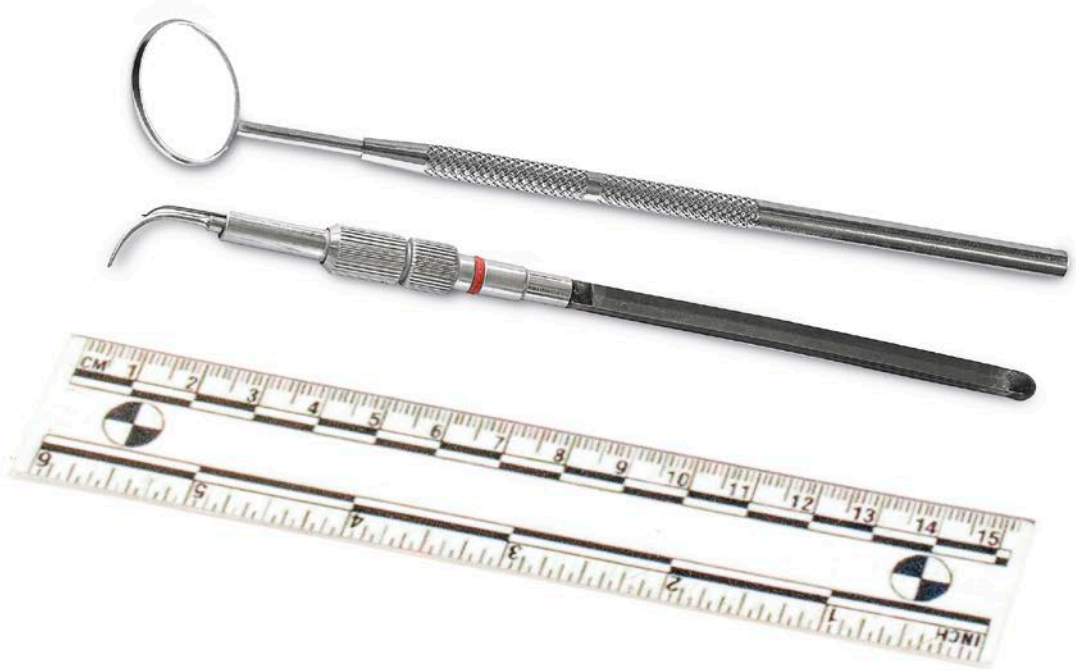
THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

# Ireland's Dental

JULY 2019


## Where's the *evidence?*

Reflecting on 20 years of landmark studies



RCSI FACULTY OF DENTISTRY

**Special Pre-Annual Scientific Meeting Hands-on Course***


The Faculty of Dentistry, RCSI presents a

# Hands-on Course in Minor Oral Surgery

A one day hands-on course in minor oral surgery will be held in the Royal College of Surgeons in Ireland, Dublin on **Thursday October 31st 2019**. The course will be held in RCSI's new state-of-the-art academic and education building, located at No. 26 York Street, Dublin 2.

**This course will be held by Consultant and Specialist staff from RCSI, Queens University Belfast and Belfast Hospital Trust.**

**After attending this hands-on course, delegates should:**

- Have knowledge of the assessment of the patient and surgical task including wisdom teeth removal
- Be able to identify and manage the "at risk" patient
- Have knowledge of the risks and complications of minor oral surgical techniques
- Have practical experience on porcine mandibles of:
  1. Sharps control
  2. Flap design and elevation
  3. Bone removal with drills
  4. Delivery of retained roots
  5. Soft tissue handling including repair and biopsy techniques

Fellows, Members & Diplomates of the Faculty:
Early bird rate of €600 is available until July 31st.
Normal price is €650.

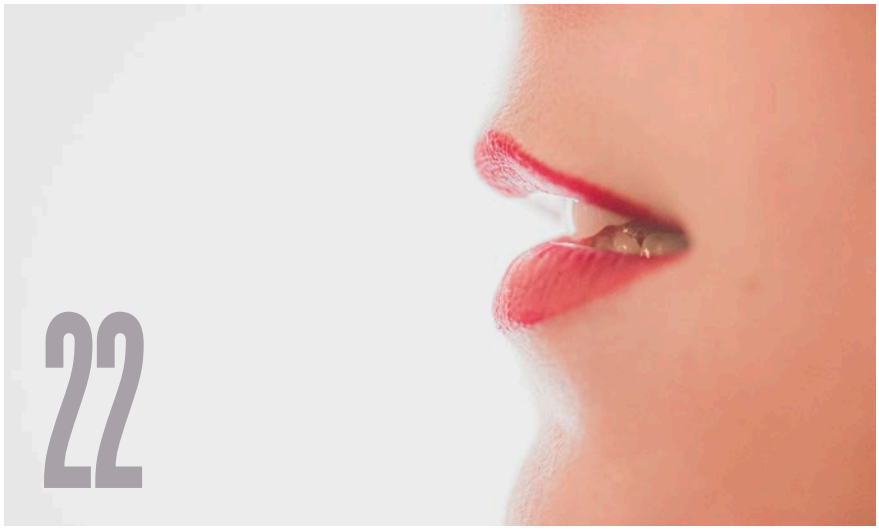
Non-Fellows, Members & Diplomates:
Early bird rate of €700 is available until July 31st.
Normal price is €750.

Online registration: www.facultyofdentistry.ie
For enquiries, email: facdentistry@rcsi.ie

***This hands-on course will be held a day prior to the Annual Scientific Meeting of the Faculty of Dentistry, which will take place on November 1st & 2nd, 2019. More info: asm2019.ie**

JULY 2019

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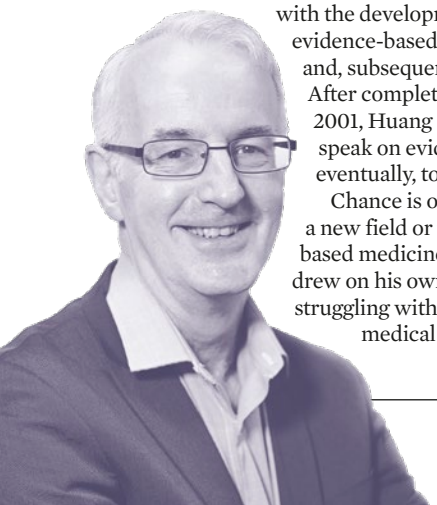
# From EBM, to EBD, EBO and ... EBP

*Evidence underpins medicine, dentistry and most recently orthodontics, but what about dentistry practice?*

There is nothing mysterious or magical about evidence-based care, according to Professor Greg Huang, of the University of Washington's Dental School. It just means, he says, that we need to have a good understanding of the principles of clinical research, and then "integrate the evidence with our education/experience and the patient's preferences/condition".

Huang is co-author of the book *Evidence-Based Orthodontics* and will be in the UK this autumn to deliver the Northcroft memorial lecture at the British Orthodontic Society's annual conference in Glasgow. He will describe the findings from a large, prospective, practice-based network study conducted in the United States. The aims of the study were to assess the practitioner recommendations, patient acceptance, treatment outcomes, patient satisfaction, and long-term stability.

Ahead of his visit, Professor Huang answered questions from *Ireland's Dental* (p34-35). His entry into the field was completely by chance, he reveals. When he began his academic career, he had decided to pursue a degree in epidemiology in order to improve his knowledge of clinical research. It happened to coincide with the development of evidence-based medicine and, subsequently, evidence-based dentistry. After completing his epidemiology degree in 2001, Huang started to receive invitations to speak on evidence-based orthodontics and, eventually, to write a text book on the subject.



Chance is often a factor in the development of a new field or technology. The father of evidence-based medicine, Professor Archibald Cochrane, drew on his own experience as a young man struggling with a medical condition and later, after medical training, on his time as a prisoner of war in Greece and Germany tending to fellow inmates, to undertake the primitive clinical trials which ultimately resulted in his watershed book *Effectiveness and Efficiency: Random Reflections on Health Services*, with its memorable declaration: "You should randomise until it hurts".

> "WHILE CHANCE IS AN IMPORTANT FACTOR IN MEDICAL BREAKTHROUGHS, IT IS THE ANTITHESIS OF GOOD MEDICAL CARE"

But while chance is an important factor in medical breakthroughs, it is the antithesis of good medical care. It is an issue which another subject of this edition, Derek Richards, has made a point of in his 20-year tenure as editor of the *Evidence-Based Dentistry* journal. His highlights from 20 years of reviews are featured on p37-38. Looking back, says Richards, there has been a steady increase in both the number of trials and the number of systematic reviews available in dentistry. The Cochrane Oral Health Group has been at the forefront in producing high quality systematic reviews. However, says Richards, many of these reviews continue to highlight in their findings that there is a lack of high-quality studies to answer the questions that are being asked.

Another challenge, he argues, is the broad range of outcomes measured by researchers. The lack of common or core outcomes measures continues to present challenges to systematic reviewers, argues Richards. The Core Outcome Measures in Effectiveness Trials Initiative aims to bring interested parties together, and there is some ongoing work in a number of dental areas including caries, periodontal disease, and cleft lip and palate. "Improving the quality of conducting and reporting research should facilitate the production of good quality reviews to drive and inform practice," says Richards. "However, even where we have good evidence, the translation of research into practice and policy continues to present challenges, as evidence of good practice is not readily adopted and where ineffective interventions are not stopped. So, while the past 20 years have seen progress in developing the evidence base of dentistry there is still much to be done in developing evidence-based practice (EBP) in the profession."

# Word of mouth

**Dr Paul O D'wyer** BDS MSc (Healthcare Mgmt)

# Make sure you hear the feedback

Patient satisfaction is at the centre of what we do as a profession – and it can be the most challenging aspect of our remit. Patient satisfaction (according to a recent paper by Campbell Tickle, BDJ, 2013) is a tricky parameter. Patients, in the main, have three strong criteria for choosing a dentist: trust, access and cost. In thinking about those three criteria, where does your clinic score best?

In thinking back through our undergraduate years, how often have we heard the phrase: "If your brother/sister/cousin/parent was attending you, what level of patient care would you provide?" (or some version of same). I certainly recall back in UCC, we were strongly chided if we did not provide the highest clinical standards at all times. In fact, anything less than perfection was almost considered substandard. Such worthy goals extract a heavy toll when trying to meet them in the "real world" – both from a financial and physical view point.

For example, how many of us have ducked down the aisle way of a supermarket to avoid meeting patient X, who you know will hold forth on the wonders of Polygrip for at least 15 minutes? (usually in a loud voice so even the till operators are aware of it).

Or how many of us have sailed past a petrol station, when we spot patient Y's distinctive car at pump number one – knowing that he will continue to grouse about his molar crown fee – now snugly in place for the past 10 years?

The financial toll can be seen in the climbing cost of regulatory compliance (without any assistance from government). The physical toll can be seen in number of "bad backs" I hear of (and see!) in the profession – usually due to years of contortion taking out that troublesome upper wisdom tooth or tricky/stubborn lower premolar. (A timely reminder to read up on correct posture!)

All of that said though, it is a great question to ask yourself in practice: Is my clinic the clinic my brother/sister/cousin/parent would choose to visit? How can we be sure?

The summer time provides a good opportunity to test this theory. Almost every practice in the country over the summer months, will have at least a handful of "summer casuals" (as my old boss in Nottingham used to call them). These are the patients who will attend once (maybe twice) with a specific issue – usually an abscess or lost crown. Aside from treatment, they provide a great testing subject for the question above: Is this a practice I would choose to visit?

Patient satisfaction surveys are an important aspect of patient care – which are all too often forgotten, neglected or not even considered. How do we know we are meeting our goals if we have no way of measuring them?

Have you organised a patient satisfaction survey – either paper-based in the practice or online via email? The out-of-town patient may well be grateful to be seen, but also will be a most reliable sounding board for constructive criticism, as they will probably never be seen in the practice again.

Satisfaction surveys come in all shapes and sizes. Many of us are familiar with Survey Monkey – an easy tool (and free!) which we can send to patients via email (in line with GDPR guidelines, of course). If however, you are a "low-tech" practitioner, a very simple RAG system, Red/Amber/Green can suffice.

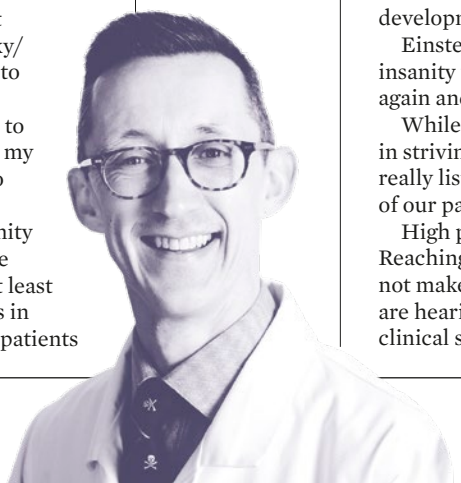
It's a simple matter of having some simple A4 sheets, with a satisfaction rating lined up. Keep the categories simple, e.g. Room for Improvement/ Satisfactory/ Excellent. The invited comments at the end can often be a treasure trove of ways to improve. A box sitting in a prominent place in the waiting room should encourage uptake. Instruct front desk reception and nursing staff to encourage patients to partake. Admittedly, for the days where we are running behind, the inevitable grumble of waiting will occur – but that too can be instructive in scheduling/zoning of the book.

In thinking about your practice as a business, it is a strong indicator for patients to see a willingness to bring on board their views. It underlines communication, strengthens trust and indicates development.

Einstein is famously accredited with a definition of insanity which is: "Doing the same thing over and over again and expecting different results!"

While general practice can sometimes feel that way, in striving to improve our clinic's performance, have we really listened to and heeded the words and comments of our patients?

High patient standards are the aim of us all. Reaching them takes effort, time and resources. So why not make sure you are doing just that, by ensuring you are hearing the feedback of those who use your clinical service.



# Reflective practice gains traction

*Regulators across healthcare unite to support assessment of professional experiences*

**THE** leaders of nine healthcare regulators have joined forces to stress the benefits and importance of good reflective practice among professionals in the healthcare sector. The chief executives have signed a joint statement* which outlines the processes and advantages of good reflective practice for individuals and teams.

Reflection is the process whereby healthcare professionals assess their professional experiences – both positive and where improvements may be needed – recording and documenting insight to aid their learning and identify opportunities to improve. Reflective practice allows an individual to continually improve the quality of care they provide and gives multi-disciplinary teams the opportunity to reflect and discuss openly and honestly.

The statement makes clear that teams should be encouraged to make time for reflection, as a way of aiding development, improving wellbeing and deepening professional commitment. Chief executives of nine regulators – the General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, the Nursing and Midwifery Council and the Pharmaceutical Society of Northern Ireland – have all signed the statement.

"Reflection plays an important role in healthcare," said Ian Brack, chief executive and registrar of the General Dental Council. "It brings significant benefits to patients by fostering improvements in practices and assures the public that professionals are learning from the challenges they encounter – and seeking to improve.

"Our recent research on CPD highlighted the importance of multi-professional teams coming together regularly to reflect when things go wrong and when things go right, and this is one of the things that we are going to be seeking views about when we consult on the future of lifelong learning for dental professionals in the early part of this summer."

The statement reinforces that reflection is a key element of development. It also makes clear that patient confidentiality is vital, and that registrants will never be asked to provide their personal reflective notes to investigate a concern about them.

Guidance is given on how to get the most out of reflective practice, including having a systematic and structured approach with proactive and willing participants. It makes clear that any experience, positive or negative and however small – perhaps a conversation with a colleague – can generate meaningful insight and learning. Multi-disciplinary and professional team reflection is viewed as an excellent way to develop ideas and improve practice.

The statement also reinforces the regulators' continued commitments to reflective practice across their own organisations and highlights the pivotal role it plays in changing and improving their work.

**www.gdc-uk.org/professionals/cpd/reflective-practice*

# Amalgam withdrawal cost highlighted

*Conference calls on government to fund phasing down*

**THE** slow pace of contract reform and the lack of support for dentists experiencing stress were among the 34 motions raised at the recent Local Dental Committees' (LDCs) annual conference in Birmingham.

The motion calling for a minimum UDA value of £25 was passed unanimously. During the debate, delegates heard that those involved in the contract reform pilots in Wales were already receiving this rate and their counterparts in England were seeking parity. Delegates also voted unanimously for greater mental health support for dentists to be made available now and funded by all the health services across the UK.

Many representatives expressed concerns in a debate about the costs associated with the gradual phasing down and withdrawal of amalgam, which are expected to be borne by dentists. There was unanimous support for a motion calling on Department of Health and Social Care to fund in full all the additional costs incurred with in this process, both in the short and long-term.

Conference also supported a motion calling for equity between the CQC rates paid by corporates and general dental practitioners on the high street. They voted unanimously for an end to the single owner subsidy. Delegates rejected calls from Cornwall LDC that the General Dental Practice Committee (GDPC) should adopt a view that NHS dentistry should only be funded for community and hospital services.

The escalation of dental charges in England, relative to Wales, was also raised amid concerns that these were masking cuts in state funding, as well as unjust. Delegates heard that band 1 charges are 58 per cent more for patients in England than in Wales and there was a variance of £70 in band 3 charges between the two nations.

There was unanimous support for a motion calling on the National Audit Office to investigate the disproportionate rise in charges in England.

Leading health economist, Stephen Tidman held delegates' attention during a presentation on the consequences the cash-limited dental budget in England that has not only radically reduced access for patients but also the numbers of dentists that provide NHS care. Marco Mazevet, of the French Dental Association, provided an insight into the way dentistry works in France, by contrast to the UK, while Paul Batchelor spoke about the different models of state-funded dentistry across Europe.

"It was great to see such a diversity of opinions at this year's conference, and our guest speakers gave us lots to think about," said Vijay Sudra, chair of LDC Conference 2019. "I'm now handing over the reins of LDC Conference chair to Leah Farrell, who is already leading on the organising of next year's event."

> "IT WAS GREAT TO SEE SUCH A DIVERSITY OF OPINIONS AT THIS YEAR'S CONFERENCE"

# Ballynahinch woman named Young Dentist of the Year

**A NORTHERN** Ireland dentist now living in Scotland, who also volunteers on a lifeboat crew, has been awarded a major accolade by her profession.

Jane Paterson, who is originally from Ballynahinch, has been named Scotland's Young Dentist of the Year.

Since graduating in 2012, Ms Patterson has worked at the Torwood practice, operated by Clyde Munro Dental Group, in Inverness. The practice location means patients come from afar; one patient from Inverness who moved to Oxfordshire even combines dental visits to Jane with a holiday in their former home area.

She collected the Young Clinician of The Year award at the Scottish Dental Awards held in Glasgow. "It was such a lovely surprise to be nominated and then shortlisted," said the Co Down native.

"On the night I couldn't believe I'd won. I knew some of the other people in the category – they were all very strong contenders and I thought I had little chance."


Jane Paterson with Kerra McKinnie of the Scottish Building Society, sponsor of the Young Dentist of the Year award

Ms Paterson, who is studying for a master's degree in restorative dentistry, also finds time to volunteer on the RNLI's Kessock Lifeboat as part of a 16-strong volunteer crew, supported by 10 onshore volunteers.

# Facing 21st century challenges at events programme in Dublin

*Scientific meeting will address oral surgery across all patient ages*

**THIS** year's Faculty of Dentistry RCSI Annual Scientific Meeting is a conjoint meeting with Association of British Academic Oral & Maxillofacial Surgeons (ANBAOMS), The British Association of Oral Surgeons (BAOS) and the Irish Association of Oral Surgeons (IAOS).

The meeting will take place over two days at the state-of-the-art RCSI College building in the city of Dublin from 1 to 2 November. The programme aims to address the challenges faced by oral surgery practice in the 21st century across all patient ages, 'from the cradle to the grave'.

"For the child patient we will tackle subjects as diverse as the future of oral surgery delivery post-Brexit, appropriate CBCT use in paediatric patients, and tomorrow's antibiotics for today's children," said Dr John Marley, Dean of the Faculty of Dentistry.

"For the young adult we will explore early identification and implications of dependency, resilience in the young surgeon and managing the increasing demands and expectations of the younger generation of patients for oro-facial cosmetic surgery as well as the dispelling the myths around the rationale for orthognathic surgery.

"In the adult, we will explore what is new in TMD management, managing risk in oral surgery practice and we hope to have a debate on adoption of augmentative surgery versus alternate methods of enhancing bone and soft tissues prior to dental implants.

"We will be looking at how and why head and neck cancer patients frequently develop debilitating pain and how to manage it in our surgeries and the new evidence base for prophylactic dental extractions in patients about to receive or receiving radio/chemotherapy, the results of which might surprise you.

"With the ageing patient we will look at the challenges of identification and consent of patients with dementia, polypharmacy in the elderly and its implications for oral surgery and cutting-edge science of managing impaired wound repair in the older patient."

Dr Marley added: "I hope you can join us here in Dublin for what will be a stellar line-up of speakers and wide range of subjects in a fantastic setting."

*More information: www.asm2019.ie*



# RCSI profiles talented, distinguished graduate

**PROFESSOR** Dr Mohammed Rafik Gardee, MBE (Medicine, 1966) has dedicated 40 years to the compassionate practice of medicine in primary healthcare, across continents and countries, and highlighted the inequality and lack of opportunities for ethnic minorities working in the NHS.

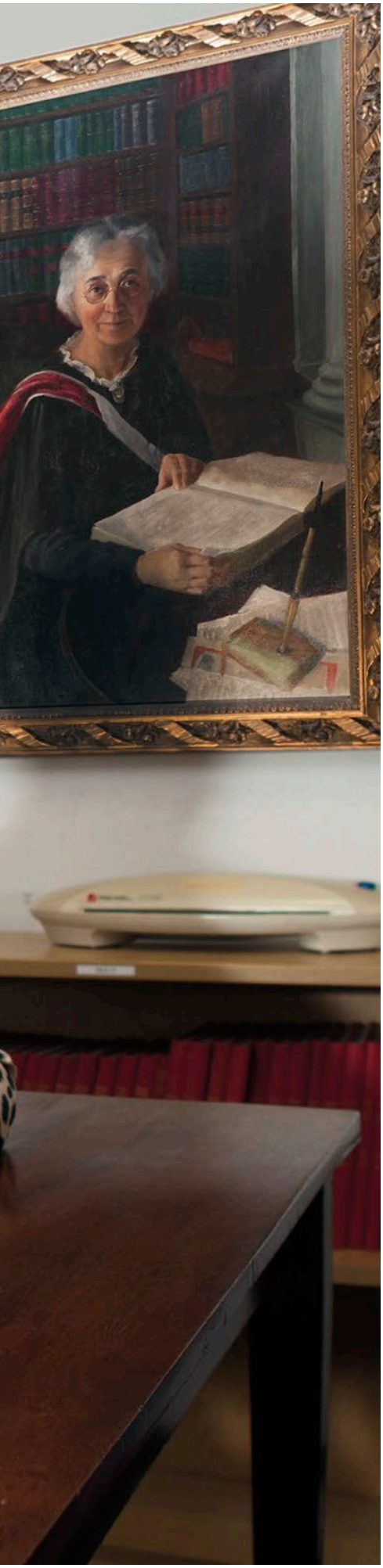
Rafik grew up in South Africa under the apartheid regime. After high school in Johannesburg, he went on to study at RCSI in Dublin where he became President of the Student Council. After his graduation from RCSI, Rafik worked in Ireland for four years, then returned to work in South Africa in 1970 where he set up a series of well-equipped clinics, at his own cost, and soon had five separate premises, with nurses he had trained as medical assistants, seeing 80-100 patients a day.

But his work in impoverished and disenfranchised communities in rural areas, prioritising the provision of health care for the underserved non-white community, brought him to the attention of the authorities and in 1977 the regime forced him to leave the country. Rafik settled in Glasgow where he spent 30 years in the NHS transforming care for ethnic minority populations, supporting the reception of Bosnian refugees, and taught and mentored thousands of undergraduates and postgraduates.

"My father remains an inspiration for all those that have had the pleasure to know him," said his son Dr Jameel Gardee, a partner at the Glasgow Smile Clinic. "It's great to see that a lifetime selflessly helping people continues to be appreciated and valued and he has set the bar very high for us as a family to try and follow in his footsteps! Thanks again to the community in Ireland at the RCSI who played such great effect in moulding the role models we have today."

*Read the profile of Professor Gardee in full here: www.tinyurl.com/y68crdep*


BDA President Roz McMullan's goal is to bring the expertise of all the nations and regions together



# Raise a glass to the President

*Working alongside pioneering surgeons and dedicated nurses has shaped Roz McMullan's approach to her life's work*

WORDS
WILL PEAKIN

A bottle of Bushmills 12-Year-Old Single Malt Distillery Reserve sits on a shelf in Roz McMullan's flat in London; a reminder of the moment when she found out that she had been made President of the British Dental Association (BDA).

After a 40-year career, Roz had been reconciled to retirement; enjoying her family and tending her garden, though still dedicating some time to the Probing Stress in Dentistry project she had championed as chair of the NI Council of the BDA.

"The branch had put my name forward; I thought that was a great honour, but aside from filling out the form I had not thought much about it," Roz recalled. On the day the BDA's Principal Executive Committee met to ratify the nominations for future honours and awards, she happened to be hosting some visitors from Australia. It was raining, and where better to take guests on a wet day than the Old Bushmills Distillery.

"Because of the 'angels' share' and the risk from a spark, mobile phones have to be turned off – so I had been uncontactable," said Roz. "At the end of the tour, traditionally you have a wee nip. It was then I noticed that I had a missed a call, so I said to my guests: 'Enjoy your nip, I'll go outside and see who's looking for me.' Well, on hearing the news I turned a whiter shade of pale. I went back, but my hands were shaking, and I couldn't even raise the glass to my lips."

Roz told her guests and went outside again to call her brother and tell him the news. Looking on, the distillery staff had thought something was wrong – but the guests let them know, and a second nip was placed on the bar. When Roz returned after a short while, she was also greeted by members of staff with the bottle of 12-year-old bearing a label customised to celebrate her appointment.

"It was a whirlwind moment," she said, adding with a laugh, "one day I'll crack it open!"

Roz McMullan owes an early childhood habit of sucking her fingers for her distinguished career in dentistry; a deep commitment to the profession which continues formally into 2020 with the year-long BDA Presidency. At the age of five, she had been enrolled in one of two UK growth studies in Belfast (the other was in London). Each year, for the next decade, the craniofacial development of hundreds of children was tracked with radiographs, impressions, and photographs.

"Today's ethics committees would not allow yearly radiographs to be taken, let alone in a child from five to 15 years," commented Roz. "These growth studies are invaluable and will never be repeated."

Professor C Philip Adams was leading the Belfast study and, realising that Roz's mother was anxious about her daughter's increasingly

prominent front teeth, assured her that when the time was right clinically, he would oversee their straightening.

As a teenager, maths was Roz's favourite subject, but the culture of the time meant that women were not considered for a career in financial services. "I remember telling my orthodontist how terrible this was. He was a lovely man and he listened patiently. Then he said: 'Why don't you become a dentist?' And he walked me round the dental school, and it just such a transformative moment. It was the interaction with the patient, the multidisciplinary nature of the job, the sense of being able to make a difference in people's lives."

Roz went on to graduate from Queen's University Belfast and spent a year in general practice in Edinburgh, at two practices – in Stockbridge and West Calder – which illustrated the stark contrast in fortunes that can exist between communities in close proximity.

"I learned a lot about real life and the importance of caring for individual patients," she said.

Back at dental school in Belfast, Roz trained as an orthodontist and was planning to become a senior registrar. At the time, a pivotal and revered figure in orthodontics in Northern Ireland was a Scot, Professor Andrew Richardson, who one day called Roz into his office and offered her the opportunity to work with the pioneer of corrective cleft palate surgery, Professor Olav Bergland, in Oslo.

"When I returned to Northern Ireland, I said: 'We really need to develop alveolar bone grafting here'. Colleagues, including Professor Gunvor Semb and another Scot, Professor Bill Shaw, were incredibly supportive; we were only the second unit in the UK, after Great Ormond Street, to routinely offer the procedure."

Roz completed her senior registrar training and in 1991 was appointed consultant orthodontist in the Western Health and Services Board (later the Western Trust) where she stayed until her retirement in 2016. "I was enthused by this wonderful training – and then, suddenly, you are out their 'on your own'," said Roz of her first months in the role.

"But the Trust was tremendously supportive of innovation. I wanted to de-medicalise the care that we gave to some of our babies, and so we developed the cleft liaison nurse role. I'm a clinician; I make diagnostic decisions. Working with nurses and midwives exposed me to a completely new skillset; developing care pathways and working with people in an empathetic way."

Throughout her career, Roz has been involved in supporting dentists and dental teams in difficulty. In 2016, she worked with NIMDTA, the Northern Ireland Medical and Dental Training Agency, and Northern Ireland's Public Health Agency to establish 'Probing Stress in Dentistry', which works to raise the awareness of mental wellbeing in the dental workforce, and to establish a network of mental health first-aiders to support and signpost dentists, dental students, and dental teams who are experiencing difficulty.

It's clearly sensitive work and, in itself, counselling people who are feeling overwhelmed can in turn create mental pressures on the counsellors themselves, hence the creation of a 'buddy' system to maintain a mutual awareness of their own wellbeing. As I interviewed Roz, she presaged her comments with a question to me about whether I had direct experience of the issue. It was a telling insight into how discussion of suicide is best approached, whatever the context. In her presidential address, Roz said this: "These are certainly difficult times in the profession with a massive reduction in practice income and increase in expenses that most small businesses would struggle to cope with. Associate contracts have come under similar pressures over the last 10 years. Young dentists are coming out of university with large debts. Our community, hospital and academic colleagues are also affected by funding pressures, trying to maintain high standards of care, teaching and research, with reducing budgets alongside demanding performance targets and often concerned they are not valued by the organisation they work for.

"This, in addition to the burden of regulation and fear of complaints, has produced a profession that is anxious and constantly looking over its shoulder. For some, the stress can be overwhelming."

During her presidency, Roz is determined to take the lessons from the Probing Stress in Dentistry project, and others such as Stress in the Dental Workplace Working Group in Scotland, and make them UK-wide. Public Health England has expressed a strong interest. Roz's goal is to bring the experience and expertise of people in all nations and regions together, to create a template that can be easily adapted depending on geography and profession.

"We should measure success not by activity, but by outcomes; by what we achieve," she said.

> "WE SHOULD MEASURE SUCCESS NOT BY ACTIVITY, BUT BY OUTCOMES; BY WHAT WE ACHIEVE"
>
> ROZ McMULLAN

**If you are feeling overwhelmed, please reach out for support:**
**Dentists' Health Support Programme - 0207 224 4671**
**Samaritans - 116123 (calls will not appear on your phone bill)**
**Lifeline (Northern Ireland) - 0808 808 8000**

## Confidence is a key issue

"The General Dental Council must regain trust by championing the profession of dentistry and acting wisely and proportionately when dealing with complaints. They must demonstrate to the profession that they accumulate and use our money frugally.

"All those who commission and regulate dentistry must not ignore the systemic failures, rather than taking the easy route of focusing blame on the individual practitioner.

"We must be confident that our government understands and values dentistry and recognises that prevention of dental disease is key, ensuring oral health remains integral to the population's overall wellbeing.

"We must be able to trust the dental leaders in all four nations to deliver a system of NHS dental care that is respected, valued, properly funded, and supports dentists, no matter in what area they work, to aim for good dental health from cradle to grave.

"We can be confident that the BDA will put dentists at the heart of everything we do, no matter what stage they are in their career or where they work. The BDA is run by dentists for dentists and has the expertise to deliver practical and timely support and effectively represent you in all your diversity.

"Above all, we must have confidence in ourselves, celebrate our successes and learn from our mistakes."

***An extract from Roz McMullan's Presidential Address.***

# New thinking to combat oral cancer

*International speakers, expert panellists, and delegates selected from around the world are to share the issues they face in the fight against the disease*

WORDS
NIALL MCGOLDRICK

Oral cancer continues to claim lives throughout the world without much progress been made in tackling the disease. In the UK, incidence has increased by 86 per cent since the 1970s. Globally, there are around 300,000 new cases each year. Prognosis remains poor. Surgery continues to be the mainstay of treatment with around 50 per cent of patients living to five years post diagnosis. Furthermore, nine out of 10 of these cancers can be attributed to a modifiable risk factor.

The problem is clear to those working in the area and to most dental professionals, but if we are to make a real difference to the figures above then some new thinking is required. We need the attention of world governments, research bodies, and healthcare providers to shine a light on the issues at hand and give oral cancer research and preventive policy a space at the funding table.

The Global Oral Cancer Forum hopes to begin that journey. We are bringing together an interdisciplinary delegation from around the world that will include dentists and doctors from many specialities, public health practitioners, NGOs, charities, data scientists, survivors and patients to establish new frontiers in the fight against oral cancer.

The inaugural Global Oral Cancer Forum took place in New York City in 2016. Some 250 people from around the world took part and contributed to the meeting. This was the first step in building partnerships and

**Dr Niall McGoldrick is a member of the GOFC organising committee and convenor of Let's Talk About Mouth Cancer www.ltamc.org**

> "WE NEED THE ATTENTION OF WORLD GOVERNMENTS, RESEARCH BODIES, AND HEALTHCARE PROVIDERS"
>
> NIALL MCGOLDRICK

networks capable of making a real change across the oral cancer continuum and improve approaches to prevention, detection and treatment. It was clear from the forum that there was an appetite to continue momentum. A series of white papers with outputs from each of the sessions were published and are available to view here: www.globaloralcancerforum.org/white-papers

The next step is to bring together an even wider, more diverse group at the Global Oral Cancer Forum 2020 (GOCF'20) taking place in Edinburgh on March 6 and 7 2020. The new theme for GOCF'20 is "reducing risk, prevention, early diagnosis and innovative treatments." We will highlight risk reduction across the entire oral cancer continuum from prevention to initial diagnosis and treatment. International speakers, expert panellists and delegates selected from various world regions will convene to share the issues they face in the fight against oral cancer.

The Global Café session on day one aims to harvest and harness ideas from the international assembly focused on building awareness of gaps in prevention, patient care, technology and services. This session will be key to developing a strong global network and form a new social leadership within the oral cancer action community. By building these partnerships, the forum will promote the changes required for a substantial impact on incidence, morbidity and mortality of oral cancer worldwide.

GOCF'20 will also act as a spring board for early career researchers to get involved and mix with some of the old power that have contributed to the oral cancer work stream, bridging the gap between old and new. The agenda is available to view on our website www.gocf20.com

We want to extend an open invitation to any non-profit organisation that supports the GOCF'20 mission, to come onboard as an intellectual sponsor of the forum without financial commitment. Be part of the change and join the conversation on March 6 and 7 2020 in Edinburgh.

# Indemnity and beyond

*UK Government Consultation on Indemnity – a view from Helen Kaney, Lead Dento-legal Consultant and Head of Dental Services, Scotland, Dental Protection*

Helen Kaney BDS LLB Dip LP MBA FFGDP (UK) FFFLM
Lead Dento-legal Consultant and Head of Dental Services, Scotland, Dental Protection.
Helen spent many years in general dental practice before training as a solicitor and working for law firms that acted for commercial insurers and the UK indemnity organisations, acting for both doctors and dentists in various situations including clinical negligence claims and regulatory matters.
She also worked as a dentolegal adviser for a commercial insurer which provided claims-made insurance for clinicians. Helen has worked for Dental Protection for the last 10 years where she is a Lead Dento-legal Consultant and Head of Dental Services, Scotland and advises and assists Dental Protection members throughout the UK and internationally.

The UK Government has finished consulting on proposals that would reform how general dental practitioners and other healthcare professionals purchase their indemnity[1].

This consultation was launched just before the state-backed indemnity scheme began for medical GPs in England and Wales for clinical negligence claims that relate to their NHS contracted work. A state-backed indemnity scheme for UK dentists, however, seems very unlikely and would be very challenging given that many patients will receive private and NHS treatment from their dentist and often during the same course of treatment.

It is therefore unlikely that a state-backed scheme would be introduced given the complexity of managing this scenario. UK dentists will therefore continue to arrange their own indemnity cover for the foreseeable future.

So, what do dentists need to know and what are the factors that dentists need to take into account in their indemnity decision-making?

The first is to check whether the protection provided is claims-made or occurrence-based. The second is

to establish whether the provider is a discretionary mutual organisation or an insurance company.

## Occurrence-based vs claims-made cover

Most clinical indemnity cover over the last 100 years in the UK has been provided by three main medical and dental defence organisations. In the last few years, however, there has been a rise in the number of insurers that have started to offer indemnity insurance in the UK market. Much has been written over the years about all of these issues and a recent BDJ article[2] covered these points.

The key difference between occurrence-based and claims-made protection is in relation to how the protection is structured. It is important to understand that claims are rarely made immediately after an adverse incident or course of treatment occurs. It is well known that cases in dentistry, and clinical negligence claims in particular, can have a very long "tail", which means that it can take several years from the moment the incident happened or course of treatment was provided until a complaint or claim arises.

Dental Protection statistics indicate that only 14 per cent of claims are reported in the same year that the incident occurred. When a clinician is protected by occurrence-based indemnity, that clinician can be assured that if they leave clinical practice for any reason they have indemnity in place for all incidents arising out of that clinical practice, no matter when a case relating to that incident, whether it be a complaint, claim or regulatory matter, comes to light.

Occurrence-based indemnity is considered to be the 'gold standard'. Practitioners often value the long-term peace of mind that it offers, because they do not need to make any further financial arrangements if they leave membership of their provider or cease practice in order to protect them for the future. Although the cost of claims-made protection is often lower in the first few years than it is for an occurrence-based protection, there can be additional costs incurred on ending the policy (such as at retirement, if the clinician ceases practise or if they switch to another indemnity provider).

When all additional costs are considered, the overall cost for both claims-made and occurrence-based protection is likely to be broadly similar over the course of a clinician's career. There is a need with claims-made insurance that "incidents" are reported within specific time frames, but what constitutes an "incident" can be open to interpretation in dental claims. Recent

member research by Dental Protection showed that the requirement to report incidents for claims made policies was of particular concern.

## Discretionary indemnity vs insurance

Much has been written over the years about discretionary indemnity and concerns about the value of such indemnity are regularly raised in several platforms, including on social media. There appears to be a belief that discretionary assistance can be withdrawn on a whim, which is absolutely not the case in my experience. In fact, discretionary indemnifiers must follow the law around how discretion is exercised, to ensure that it is fair and consistent and not arbitrary, capricious or irrational. Medical and dental defence organisations are also governed by their Articles of Association, which form a contract between the defence organisation and the member. If the articles are breached, members have recourse to the courts[3].

Proponents of discretionary indemnity cite its flexibility as a positive aspect, in that it can allow the provider to respond to changes in the dentolegal environment and assist members with emerging risks that may not have been foreseen at the time membership was taken out.

Decisions to assist members are made every day. In situations where the analysis of the case and the member reveals a potential issue, the matter is considered extremely carefully to assess whether assistance can be provided.

There also appears to be a belief that assistance can be withdrawn mid-case, unjustifiably. In my experience, this would only occur if, for whatever reason, the member had decided not to co-operate with their defence team. Legal teams require instructions and cooperation from the member and when this isn't happening, the member is advised that if they are unable to work cohesively with their defence team, assistance may be withdrawn. Such situations are rare, but when they do occur, the member is given several chances to consider the implications of disengaging with their defence organisation. Some individuals then elect to deal with the matter themselves. It is also important to be aware that not all indemnity providers assist with personal conduct matters before the regulator, which is why some individuals are unrepresented at the GDC.

Both discretionary indemnity and insurance policies have their pros and cons. A contract of insurance brings a certain level of contractual certainty that assistance will be provided as long as the claim being made, i.e. the assistance being requested by the insured individual, falls within the contractual terms of the policy. But precisely one of the benefits of discretionary indemnity is that it is not bound by policy wording. Discretion can be exercised to widen the scope of the assistance usually provided for the benefit of the individual or the profession as a whole, which means that discretionary indemnity is usually considered to be more flexible.

It is very important to fully understand what has been purchased, whether it is discretionary or insurance-based cover and whether it is claims made or occurrence based. Policies provided by commercial insurers have differing caps and exclusions, so it is vital to understand what has been purchased and what the policy covers. It is also important to be aware that medical and dental defence organisations are "not for profit" member-owned organisations and do not need to charge insurance premium tax.

> "THE UNINTENDED CONSEQUENCES OF REQUIRING ALL DENTISTS TO HOLD AN INSURANCE PRODUCT NEED TO BE CONSIDERED"

## UK Government Consultation and what happens next?

The three main UK medical defence organisations (MDOs) have now all responded formally to the Government's consultation. All indicate that there is little evidence that patients are unable to access appropriate compensation and explain that requiring dentists to hold insurance will mean that dentists have to pay extra costs to protect themselves from claims, including insurance premium tax of 12 per cent and other costs of regulation.

Discretionary indemnity continues to be the principle that underpins how compensation is made available in the UK – not just by the MDOs, but by the new state-backed scheme for GPs, the scheme run for NHS Trusts and also the indemnity provided to nurses by the RCN. There is very little evidence or concern regarding the current arrangements.

The unintended consequences of requiring all dentists to hold an insurance product need to be properly considered if the Government proceeds with these proposals, and the types of insurance available considered and recommendations made regarding what would be considered to be an acceptable form to ensure protection of both the patient and the clinician. Dental Protection is very aware of the number of dentists who appear before the GDC without any support or assistance from their indemnity provider, which is certainly not in the interests of those individuals or even the profession as a whole. Whilst it seems likely that the Government will proceed with the reform of how indemnity in the UK is regulated, another option is to require a mandatory Code of Conduct for the discretionary providers. Among other measures, this could establish an independent complaints process to adjudicate on member complaints.

The final decision of the UK Government remains to be seen, i.e. whether that is to maintain the status quo or to dictate that all clinicians without a state-backed indemnity scheme need to hold regulated cover. Time will tell.

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# Collaboration is the Key

*Professor Albert Leung, Dean Elect of the Faculty of Dentistry, Royal College of Surgeons in Ireland, is looking forward to taking office in 2020*

Professor Albert Leung

Albert Leung's career pathway to Dean Elect of the Faculty of Dentistry, Royal College of Surgeons in Ireland (RCSI) and Professor of Dental Education, Head of Continuing Professional Development and programme Director of the MSc in Restorative Dental Practice at University College London Eastman Dental Institute has not followed a traditional academic dentistry route.

After qualifying as a dentist from Dundee University in 1985 – "It was great, and I received some excellent teaching and made a lot of friends; though the accent and the haggis took some getting used to, as well as phrases: like 'a wee bit here, a wee bit there'!" – it would have been the norm for newly qualified dentists then to embark on and stick to one of three distinct career pathways; primary care dentistry, postgraduate training with hospital services, or academic research.

Professor Leung, however, took a blended approach: "To keep me motivated and interested, I looked for opportunities to combine a career in primary care dentistry, academic dentistry as well as to pursue my other academic interests, and this was neither easy nor fashionable", he said. "I was very fortunate to have met some great mentors, who guided me through the primary care pathway at the Royal College of Surgeons of England, but most importantly the MGDS career pathway at the Faculty of Dentistry, Royal College of Surgeons in Ireland which made all the differences in the end. "These opportunities allowed my career to be developed over many years in primary care dentistry as well as in academic teaching at King's College London Dental Institute where I had fifteen very happy years".

He has gained Fellowships from the Faculty of General Dental Practice, Royal College of Surgeons of England, the Faculty of Dentistry, Royal College of Surgeons in Ireland, as well as qualifications in music, law, and education.

Professor Leung has chaired the Examination Committee at the Faculty of Dentistry, RCSI and has recently completed his term as Vice Dean. He also has an extensive postgraduate teaching, assessment and curriculum development profile in the UK, Ireland, Bahrain, Jordan, Kuwait, Qatar, Sudan, the United Arab Emirates and Sweden. He received the Association of Dental Education (ADEE) Excellence in Dental Education Mature Career Educator Award in 2017, the same year he was appointed Professor of Dental Education at the Eastman Dental Institute at University College London (UCL).

After being elected as the next Dean of the Faculty, he will take office in February 2020. "I really look forward to working with my colleagues collaboratively, because they all have vital roles in moving the Faculty forwards and upwards" he said, adding, "I am so fortunate to benefit from the inspiration and guidance of the current and former Deans, the Faculty Board, Fellows and Members of the Faculty, and many other colleagues outside RCSI. Together we shall try to break new ground in dental education in Ireland, the UK and much further afield."

"Dental education has come on leaps and bounds," he observed, "With contemporary pedagogic approaches, contextualised guidance, defined leaning outcomes, and effective feedback loops, it is now much clearer as to the mechanisms for clinicians to improve their knowledge base and clinical approaches, both in undergraduate and post-graduate training, for the benefit of the patients and beyond."

"I immensely look forward to my new role as from February 2020, and to work collaboratively with colleagues within and outside RCSI to move training and education forwards and upwards for the benefit of our patients and the dental profession."

## Careers Day 2020

The Faculty of Dentistry RCSI will host a Post-Primary Careers Day event on Saturday 18 January 2020. This event is aimed at transition year students, along with 5th & 6th years, who are interested in a career in dentistry.

Whilst the Royal College of Surgeons in Ireland does not presently have a Dental School, the Faculty recognises its responsibility for public engagement to attract and retain a new generation of dentists. Consequently, the Faculty sees this event as an extremely important opportunity to raise the awareness of dentistry both at undergraduate and postgraduate levels.

For those students that travel to the RCSI on the day, they can expect fantastic presentations from senior academic staff from all three Dental Schools on the island of Ireland (Trinity College Dublin, University College Cork and Queens University Belfast) describing what their dental schools can offer students if they choose to study dentistry. In addition, there will be speakers from different sectors of dentistry along with undergraduate student and graduate student presentations on their experience of dentistry.

Following the formal presentations, delegates will be able to meet the admissions teams from each dental school, along with dental student representatives. There will also be interactive stations and students will be able to meet and ask questions of dentists who practice in various fields.

*Interested pupils should speak to their career guidance counsellor or teacher regarding registration. Further details can also be obtained by contacting the Faculty of Dentistry office: facdentistry@rcsi.ie*

> "I AM REALLY LOOKING FORWARD TO WORKING WITH COLLEAGUES; TOGETHER WE WILL HAVE A VITAL ROLE IN MOVING THE FACULTY FORWARDS AND UPWARDS FOR THE 2020S"
>
> PROFESSOR ALBERT LEUNG


Emear O'Connell

# Aiming *to unite*

*President-elect of the ADI wants to increase access to education and inspire more women to get involved*

Thinking about a career as she grew up, Eimear O'Connell was torn between teaching PE, engineering, and dentistry. "I thought about becoming a dentist because I woke up in bed when my granny hadn't got her full dentures in place. It gave me a worse nightmare than the one I had had to make me seek solace beside her in the first place! It made me never want to end up in such a situation with my own mouth."

After school in Coleraine, Eimear graduated from Edinburgh University in 1992. "Edinburgh was chosen primarily for the beauty of the city," she recalled. "It had a good reputation for dentistry, but I fell in love with the city – Belfast, Newcastle and Manchester didn't stand a chance after that!

"My first job was as a house officer, in conservative dentistry. I learned so much, but realised hospital work involved losing control of what happened in the long-term to patients, which didn't suit my psyche. I then worked as an associate in an NHS practice in the city until 1995, when I set up my own practice, Bite Dentistry.

"At that point I realised how little I knew about running a business! In the early years it was very challenging," she said. "But when you have great staff, the running the business part becomes easier – allowing me to focus on providing dentistry," she said. The practice became fully private two years later, and Eimear has been working in the city ever since.

"My focus as a dentist has been primarily based on preventing people from losing their own teeth by educating them on how to properly maintain their teeth through oral hygiene and diet," she said.

She has worked with the same group of support staff for 10 years and they have all completed advanced training in implant dentistry, radiography and sedation. In 2014, to celebrate 20 years in practice, Eimear took her team to New York for five days where they attended the Greater New York Dental Meeting and saw the sites.

Around five years ago, Eimear also became Scotland representative for the Association of Dental Implantology (ADI). "After spending 20 years managing my practice and bringing up my family, I decided I had to take a step forward to help women in dentistry and to show it is possible to manage both," she said.

Like most representative organisations, there is a core membership who see real value; the challenge, said Eimear, is to motivate the rest to realise the benefits. The dental profession faces challenges and opportunities.

"One of the main challenges is litigation against dentists," she said. "The main opportunity comes with an ageing population, and people needing implants; with only 4 per cent marketing penetration this allows more scope for practice." Increasing use of digital technologies will also support improved patient outcomes.

Eimear is leading the way for women in dentistry. She is the first woman to be president-elect of the ADI and works hard to promote women in dentistry. She received her MFGDP in and FFGDP from the Royal College of Surgeons London and her Diploma of Implant Dentistry from the Royal College of Surgeons Edinburgh; she was the first female dentist in the UK to gain an implant diploma from the RCSE.

Outside of dentistry, Eimear coaches and plays hockey and she loves sailing and skiing. She has three daughters, another reason why she is so passionate about helping women in dentistry.

Looking forward to presidency of the ADI, Eimear said: "The main aim is to try to unite our profession, increase access to education and inspire more women to get involved." What more can the profession and wider society do to support more girls and young women into the profession?

"There is actually a 50/50 split between men and women at university level, so there isn't necessarily a need for more women entering our profession," observed Eimear. "The more important thing is to keep them engaged and work out what challenges they face to advancing on a career pathway."

> "I WOKE UP IN BED WHEN MY GRANNY HADN'T GOT HER FULL DENTURES IN PLACE. IT MADE ME NEVER WANT TO END UP IN SUCH A SITUATION WITH MY OWN MOUTH."

# Show me the evidence

At this year's British Orthodontic Conference, Professor Greg Huang from Washington State University will deliver the prestigious Northcroft memorial lecture. Here, *Ireland's Dental* asks Dr Huang about his career and his focus on evidence-based dentistry.

## Why did you study dentistry?

My father was a pediatrician, and I always admired him for taking care of kids. However, there were two things about being a pediatrician that concerned me – there were lots of after-hours emergencies, and your patients were typically ill. When I considered careers that might allow me to work with healthy kids while minimising emergencies, dentistry, and in particular, orthodontics, seemed to be a perfect fit.

## What were the highlights of private practice?

When I completed my orthodontic training, I started a practice in my hometown in Florida. I really enjoyed treating patients who were the kids of my friends and neighbours, and many of my patients and their parents had been patients of my father. To me, that sense of belonging to a community is the most special part of being a health care provider. I had a great time practising in that setting for 10 years.

## Why the move into academia?

After about eight years in practice, I wondered if I might be able to contribute more to our profession. I had been teaching one day a month at the University of Florida, and I decided to consider a five-year stint in full-time academia. Naively, I thought my job would mainly be clinical teaching, as I had primarily been a clinician. However, now I realise that to be successful in academia, scholarship and service are equally important. Five years went by quickly, and as I became more immersed in research and administration, the original five years has quickly turned into 21 years.

## What have been some of the most satisfying investigations?

I have had a very fulfilling career in clinical research, but in particular, the investigations into third molar removal, remineralisation of white spots, vibration, and currently, the adult anterior open bite study stand out. Also, I feel that the systematic reviews we have conducted on periodontal health, open bite, deep bite, self-ligating brackets, and vibration have been real contributions to the orthodontic literature.

> "THE ALIGNER REVOLUTION, COUPLED WITH 3D TECHNOLOGY, ARE THE LATEST EXAMPLES OF TECHNICAL ADVANCES IN OUR FIELD THAT ARE BOTH EXCITING AND A LITTLE SCARY"
>
> PROFESSOR GREG HUANG

## Describe your motivation to develop the field of evidence-based orthodontics?

Believe it or not, my entry into this field was completely by chance. When I began my academic career, I decided to pursue a degree in epidemiology in order to improve my knowledge of clinical research. This just happened to coincide with the push towards evidence-based medicine and evidence-based dentistry. After completing my epidemiology degree in 2001, I started getting invitations to speak on evidence-based orthodontics. There is nothing mysterious or magical about evidence-based care. It just means we need to have to have a good understanding of the principles of clinical research, and then integrate the evidence with our education/experience and the patient's preferences/condition. I was approached by Wiley around 2008 to write a textbook on evidence-based orthodontics. This text is now in its second edition, and I think an evidence-based

approach to orthodontic care is well entrenched in most graduate programmes.

### And what has been the impact?

Things don't change overnight, and the impact of EBO continues to grow. However, I do believe that the systematic reviews and meta-analysis that have been published in recent years have produced changes in our profession. For example, systematic reviews have changed our views on specific techniques, like early treatment for Class II patients or the advantages of self-ligating brackets. Also, the lack of evidence is important, as it reminds us that we do need better evidence for many of our treatments. In the US, the American Board of Orthodontics is emphasising an evidence-based approach to their exams. Finally, many manufacturers are tempering their advertising claims based on the evidence-based findings reported in the literature.

### Describe the work of the practice-based network study?*

This seven-year project, funded by the National Institute of Dental and Craniofacial Research (NIDCR), has allowed us to investigate some very interesting and important questions in the field of dentistry and orthodontics. The advantages of network research include good generalisability, as well as the ability to enrol many patients in a relatively short period of time. In the case of the anterior open bite study, we had participation from more than 90 clinicians and almost 350 patients from all over the United States. NIDCR has just decided to renew the network for another seven-year cycle.

### Are you embarking on new studies and/or projects?

I hope to follow the subjects in the anterior open bite study for the next three to five years. I am also interested in real-time 3D imaging of the tongue, to assess differences in tongue posture and function in normal versus open bite subjects. Over my 30-year career in orthodontics, I have always found it interesting that orthodontists can achieve successful results with many different techniques and treatment plans. If this is true, then we should also be investigating other aspects of care, like efficiency, predictability, safety, cost, and of course, stability.

### What do you consider to be some of the challenges and opportunities for the profession?

Over many decades, our profession has faced both opportunities and challenges from technical advances. For example, straight wire appliances, bondable brackets, and niti wires have all improved orthodontics, but they have made it easier for non-orthodontists to provide orthodontic care. The aligner revolution, coupled with 3D technology (particularly, the advances that are possible with 3D scanning and printing), are the latest example of technical advances in our field that are both exciting and a little scary, due to their potential impact on the delivery of orthodontic care. In the United States, a large pharmacy chain is placing intra-oral scanners in their stores as a gateway for aligner treatment, with no dental professional on site.**

> "OVER MY 30-YEAR CAREER IN ORTHODONTICS, I HAVE ALWAYS FOUND IT INTERESTING THAT ORTHODONTISTS CAN ACHIEVE SUCCESSFUL RESULTS WITH MANY DIFFERENT TECHNIQUES"

### What are your interests outside the profession?

I am a husband and also father to two teenagers, so that occupies quite a bit of my time outside of work. Hobbies include racquetball, hiking, photography and piano.

**Dr Huang will describe findings from the large, prospective, practice-based network study conducted in the United States at the British Orthodontics Conference taking place in Glasgow from 19 to 21 September. www.bos.org.uk/news-and-events/events/boc-glasgow-2019*

*** www.cvs.com/shop/content/smile-direct-club*

# EBD where's the evidence?

*Preparing to step down after 20 years, the editor of the journal of Evidence-based Dentistry looks back at watershed studies*

Derek Richards qualified from Cardiff Dental School in 1977 and came to public health dentistry after working in hospital, general and community practice. While undertaking his dental public health training in the Anglia and Oxford region he developed an interest in evidence-based health care and in 1995 helped to establish the Centre for Evidence-based Dentistry in Dundee.

He was also instrumental in founding the *Evidence-based Dentistry Journal*, which he currently edits. Derek is a specialist advisor to the Scottish Dental Clinical Effectiveness Programme and led the development of the Scottishdental.org website and completed the development of on online training programme for the National Dental Epidemiology programme (www.ndip.scottishdental.org).

Derek was involved in the York Review of water fluoridation and the NICE dental recall guideline and chaired a selective update of the SIGN guideline on the prevention of caries in children, which was published in March 2014. He has been involved with teaching evidence-based dentistry and a wide range of evidence-based initiatives both nationally and internationally since 1995. He is also a co-author of the book *Evidence-based Dentistry: Managing Information for Better Practice (Quintessential of Dental Practice)*.

"As I [was preparing] to step down as editor after 20 years with the journal it was suggested that I might like to select 20 topics we have summarised that I felt were important," he said. "Given that new evidence is emerging all the time and that some Cochrane reviews have had two or three updates since the journal started this was a bit of a challenge. As it is also a very personal choice, it comes with my personal biases, so be warned!"

Most of the studies selected by Derek have been Cochrane reviews. "The development of the Cochrane Oral Health Group and the number of reviews have to me been one of the important drivers of evidence-based dentistry over the past 20 years," he said. "Over that period, we have also seen significant growth in the number of non-Cochrane systematic reviews conducted. This, together with increased teaching of evidence-based dentistry at under and postgraduate level, has helped its development.

"However, there is still much to do to develop dentistry's evidence-base, and many of the reviews we are doing are highlighting the need to improve the quality of our primary research. We need to rapidly adopt and implement the best research practices. There is plenty of guidance out there in resources such as the EQUATOR Network*.

"We also need to build on the work that some dental groups are doing with common outcome sets**. Using common outcome sets helps compare outcomes in similar studies and assists systematic reviewers to aggregate data which should help us to build a more robust evidence base, answering important questions more quickly. As the volume of published research continues to grow, I feel there will be more than enough for my successor to digest and summarise."

Professor Elizabeth Kay has been appointed as the new editor. Elizabeth, who qualified from Edinburgh Dental School in 1982, has a long and distinguished career in dental public health and dental research and is a long-standing member of the BDJ editorial board. She is the author of 200 research and professional papers, six books and two book chapters, and has previously been Scientific Advisor to the BDA. In 2017, she was awarded an MBE in recognition of her services to dental education and is currently the Foundation Dean at the Peninsula Dental School at Plymouth University and Faculty Associate Dean for Equality and Inclusion. She will take over the position from the current editor with the June 2019 issue.

"I'm really excited about the new post and to have the privilege of working with some excellent people," said Elizabeth. "I have spent quite a long career trying to do research and translate it so that it's relevant to practitioners who are delivering good dental care to the population. I've been a great proponent of evidence-based practice and the evidence base being used properly ever since I did my PhD."

**www.equator-network.org*
***www.comet-initiative.org*

> "THERE IS STILL MUCH TO DO TO DEVELOP DENTISTRY'S EVIDENCE-BASE, AND MANY OF THE REVIEWS ARE HIGHLIGHTING THE NEED TO IMPROVE THE QUALITY OF OUR PRIMARY RESEARCH"
>
> DEREK RICHARDS

**Derek Richards' highlights from 20 years**

- The review of the prophylactic extraction of

The development of the Cochrane Oral Health Group and the number of reviews have been one of the important drivers of evidence-based dentistry

third molar teeth by Song et al., helped inform the NICE guidance on third molars and an announcement is awaited as to whether an update will go ahead.

• The York review of water fluoridation was an extensive and unique review in that it was overseen by a steering group involving both pro- and anti-fluoridation.

• The first publication of the Cochrane review on powered versus manual toothbrushes, summarised by Rick Niederman, coincided with an evidence-based dental meeting in Boston, and received a significant amount of media coverage with different interpretations of published evidence on whether powered or manual brushes performed better. Subsequent updates of the review are now clearer that powered toothbrushes reduce plaque and gingivitis more than manual toothbrushing in the short and long term.

• Summaries by Hannu Hausen of just two of the Cochrane reviews undertaken by Valeria Marinho on topical fluorides was very helpful in clarifying the effect size of a range of topical fluoride interventions.

• The summary by Sergio Uribe of the Cochrane review of pit and fissure sealants, the latter providing evidence of the effectiveness of sealants, with the most recent update of the review demonstrating caries reductions in occlusal surfaces of between 11-51 per cent at two years, an effective preventive intervention.

• Jim Bader's summary of the NICE guideline on dental recall. The key recommendation of the guidance was a move away from fixed six-monthly recall intervals to a variable risk-based interval for both children and adults. While there has been some change within the profession, this still seen by some as controversial and later this year the results of a UK-based trial will be available, which will add another contribution to the debate.

• Orthodontic retention regimes are also a topic of much debate and Chung How Kau summarised the Cochrane review by Littlewood et al., that looked into the evidence for this which at the time found insufficient data. The review was updated in 2016 and while more evidence was included in the review there is still not enough high-quality evidence to make recommendations.

• The only randomised controlled trial on Derek's list is a large trial of the Hall technique for restoring primary molars summarised by Aronita Rosenblatt. A simple and effective approach for managing carious molars that has been supported by several other trials and is now considered as one of a number of biological options for managing carious primary molars.

• In 2008 Toru Naito summarised a Cochrane review addressing the issue of whether single or multiple visits were the best approach for root canal treatment in permanent teeth, a topic of some debate. However, the review found no evidence of a difference in effectiveness between the two approaches, with the latest update to the review also finding no apparent difference.

• For many years the early extraction of primary canines had been recommended to facilitate the eruption of the palatal ectopic permanent canines. Carlos Flores-Mir summarised a 2009 Cochrane review which found no evidence to support this and there is now a new expanded Cochrane protocol in development.

• Toothpastes of different concentrations was, Derek believes, the Cochrane Oral Health Group's first published network meta-analysis. Published in 2010 and summarised by Graciella Racines, it confirms the benefits of using fluoridated toothpaste to prevent caries and provides information on the relative effects of the different concentrations of fluoride.

• Debra Ferraiolo and Analia Veitz-Keenan summarised a Cochrane review that compares paracetamol and ibuprofen for pain relief following third molar removal, finding high quality evidence to show that ibuprofen was superior to paracetamol.

• Sugar consumption is an important risk factor for caries and Ruth Freeman summarised the systematic review by Paula Moynihan that underpinned the 2015 WHO guidance on sugar intake.

• Periodontal disease remains a significant public health problem and Shalini and Neeraj Gugnani examined a Cochrane review on whether interdental brushing in addition to toothbrushing compared with toothbrushing alone was better for periodontal health with the review finding low quality evidence of a benefit.

• Three authors, Caitlin Stone, Andrew Hannah and Nathan Nagar, summarised a review of the long-implicated link between occlusion and temporomandibular disease (TMD). The Manfredini review summarised found very little clinically relevant evidence supporting an occlusal cause for TMD.

• Another summary by Debra Ferraiolo and Analia Veitz-Keenan looked at a Cochrane review comparing surgical versus non-surgical approaches for endodontic re-treatment, another area where there are differing views on the best approach. The review found evidence that surgical approaches lead to better outcomes, but the available evidence was of low quality.

• A number of studies have suggested links between periodontal disease and a range of medical conditions. One of these, adverse birth outcomes in pregnant women, was assessed in a 2017 Cochrane review, summarised by Silvia Spivakovsky. It found it was unclear if periodontal treatment during pregnancy has an impact on preterm birth (low-quality evidence). However, there was low-quality evidence that periodontal treatment may reduce low birth weight (< 2500 g).

• A summary by Parthasarathy Madurantakam of another Cochrane review which looked at the question of whether open or closed surgical exposure of palatally displaced crowns had the best outcomes, again a topic where there are different views. The review found no evidence to suggest that one approach was better, but the available evidence was of low quality.

*'20 years – 20 highlights', by Derek Richards: www.nature.com/articles/s41432-019-0003-z*

# Oral syphilis – A case report

Dr Maria Taheny[1], Dr Rebecca Lees[2], Mr Roger Currie[3], University Hospital Crosshouse

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## Introduction

Syphilis is a sexually transmitted infection caused by the spirochaete Treponema pallidum. Oral manifestations are usually in the form of a painless ulcer, known as a chancre, at the site of entry of the infection. This is a case report of a patient who was referred to the OMFS clinic with suspected oral cancer, but following investigation was diagnosed with syphilis. This report highlights the importance of considering syphilis in the provisional diagnoses of white/red patches and ulcerative lesions of the oral mucosa.

## Case

A 38-year-old man was referred to the oral and maxillofacial surgery clinic by his GMP with regards to a non-healing ulcer on his right lower lip. The GMP had prescribed a course of Nystatin, followed by Fluconazole with no improvement. At this point the patient was referred to the OMFS unit due to clinical suspicion of oral malignancy.

The patient attended the clinic complaining of an ulcer on his lower lip which he originally thought was a cold sore but grew suspicious when it increased in size and did not heal over a four-week period. He also mentioned being aware of a persistent white patch under his tongue and recurrent oral ulceration for three months.

Medically, the patient was diagnosed with HIV and subsequent Hepatitis C co-infection five years previously and was receiving the antiretroviral drugs Dolutegravir and Rezolsta. He was a smoker of 20 cigarettes per day and drank 18 units of alcohol per week. He worked as a hotel manager.

Clinical examination revealed a large ulcer on the right lower lip which measured approximately 1.5cm x 1cm. It was a mixed red and white ulcer which appeared indurated. (Figure 1). There was also a red and white patch on the left ventral tongue (Figure 2) and some small ulcers on the posterior hard palate. Urgent incisional biopsies of the lip and tongue lesions were carried out.

The results showed both biopsies to be in keeping with the clinical impression of syphilis. The key diagnostic feature from the histopathology was "numerous corkscrew-like spirochaetal organisms especially prominent within the surface epithelium" which were visible after staining for Treponema pallidum (Figure 3).

The patient's blood tests were also positive for Syphilis IgM and Treponema pallidum antibodies. Liaison with the Infectious Diseases team resulted in the patient receiving intra-muscular benzathine penicillin treatment.

## Discussion

Syphilis can be congenital or acquired. Acquired syphilis is sexually transmitted and has three clinical stages: primary, secondary and tertiary.[2] It can present as various oral manifestations, mainly at the secondary stage[2]. Oral manifestations are, in many cases, one of the first signs of the disease and can guide the correct and early diagnosis, which is of great importance for the treatment of the condition[3].

These manifestations include ulcerated lesions, white plaques, verrucous lesions, or other atypical lesions [1]. The lip represents the most common site of involvement, followed by the tongue and the tonsils. [2,4,5]

In this case, the patient had sexually transmitted HIV and had already undergone serology investigation for syphilis, therefore secondary syphilis was in the provisional diagnoses. However, if the patient did not present with this history, the suspicion of syphilis would not have been as obvious. The other provisional diagnoses were aphthous ulcers secondary to immunocompromise, lichenoid reaction, dysplasia or SCC.

The analysis of a suspected patient's clinical history, combined with physical examination and serological assays normally allows a conclusive diagnosis of the disease to be reached, and biopsy is not normally required as an initial diagnostic resource[2]. In this case, biopsy was performed to rule out oral malignancy or dysplasia, particularly given the fact that the patient had risk factors for oral cancer, including smoking and immunocompromise and both the tongue and lip lesions had been present for more than three weeks.

The therapy of choice for syphilis is benzathine penicillin[2], which is delivered intra-muscularly[1]. For patients hypersensitive to penicillin, oral administration of doxycycline 100mg twice a day for 14 days or tetracycline 500mg four times a day for 14 days is indicated, with similar efficacy[2].

## Conclusion

This case highlights that syphilis can present intra-orally and represent a diagnostic challenge because of the broad spectrum of clinical appearances, which can be similar to other oral mucosal lesions. A thorough medical and social history is vital in reaching a definitive diagnosis so the appropriate treatment can be provided.

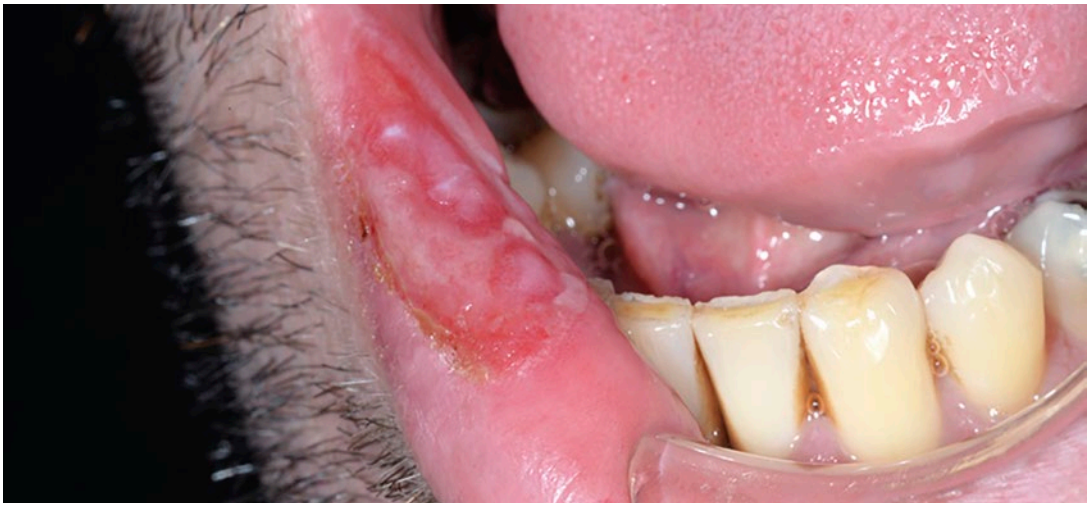

**Figure 1:** Lip lesion

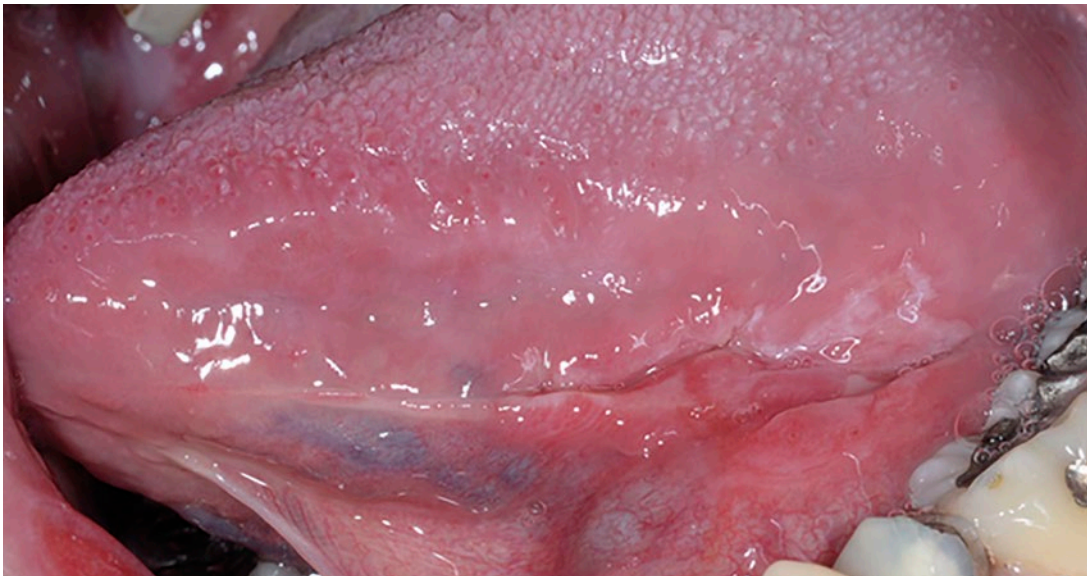

**Figure 2:** Tongue lesion

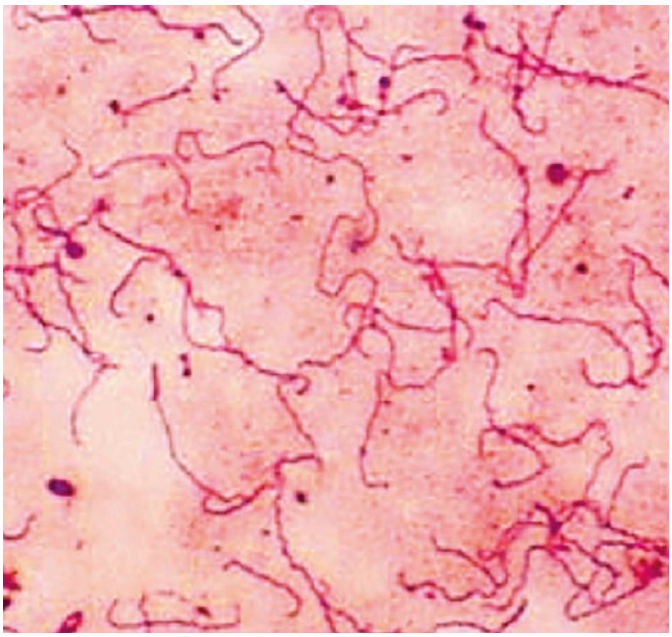

**Figure 3:** Treponema pallidum slide [6]

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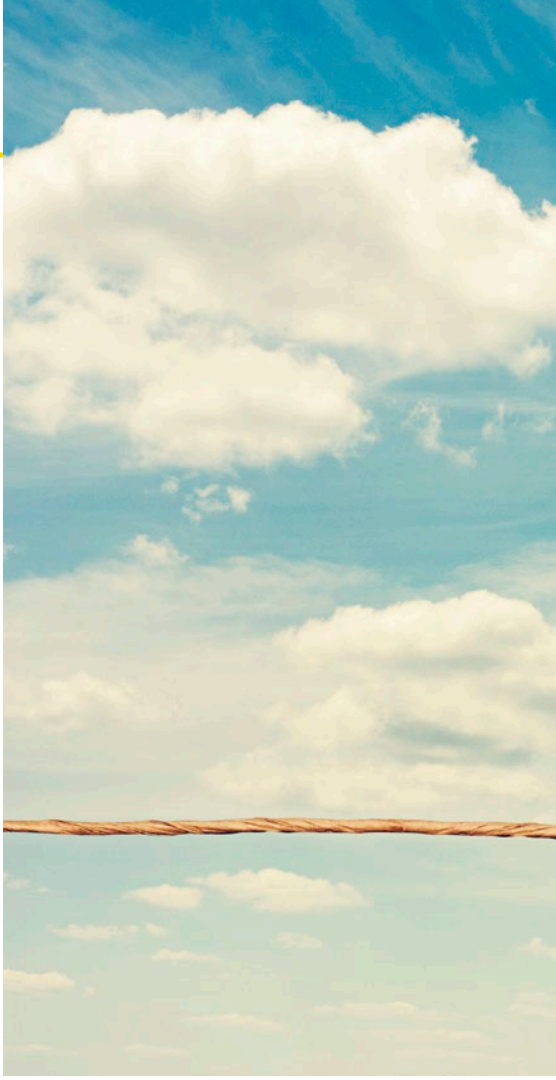


# THE PERILS OF WILFUL BLINDNESS

*Open your eyes, practice a bit of self-honesty and self-awareness to re-energise yourself and your practising career*

[ WORDS: ALUN K REES ]

**WILFUL BLINDNESS IS DEFINED AS,** "a term used in law to describe a situation in which a person seeks to avoid civil or criminal liability for a wrongful act by intentionally keeping himself or herself unaware of facts that would render him or her liable". I am going to stretch the definition to include wilful ignorance which includes situations where people deliberately turn their attention away from ethical, business and other problems because the effort of facing up to making a decision is too much for them.

It has also been described as Nelsonian Knowledge, because of Admiral Nelson's reaction to signals suggesting that he end an action and retreat during the Battle of Copenhagen. Famously, he held a telescope to his blind eye and said, "I see no ships", continued the action and won the battle.

More recent examples include the Catholic Church, and the banks involved in the sub-prime mortgage business. We are all familiar with procrastinating politicians "kicking the can down the road" or "into the long grass".

In dentistry and other businesses, 'wilful blindness' can manifest itself as a reluctance to change even in the face of evidence. We know what worked in the past will not always work in the future but often people and organisations seem to persist. A favourite saying is, "People will not make changes until the pain of not making a change is greater than the pain of changing."

Examples often quoted are the manufacturers involved in the wagon and carriage industry as the age of the motor car blossomed. The carriage makers suffered but the carriage parts makers often transitioned successfully. The Timken Company made roller bearings and adapted their products easily. On the other hand, of the 40 or so manufacturers of whips, tools and carriage parts in the town of Westfield, only one survived.

Often, because teaching reflects older experiences and the status quo, students are given a potentially outdated view of the world of work they are joining. Occasionally, I am aware that the opposite can be the case, in some subjects cutting edge techniques might be taught which have not been adopted by the mainstream.

The Gaussian distribution curve of people's adoption of new ideas shows that the innovators are 2.5 per cent, the early adopters 13.5 per cent and the early majority 34 per cent of a population (dentists included). The remaining 50 per cent comprises the late adopters and the laggards. In more simple terms, as Jim Lovell of Apollo 13 fame said, "There are people who make things happen, people who watch things happen and people who wonder, 'what happened?'"

The real and potential applications of digital technology in dentistry have already seen the innovators and early adopters stretch away from the rest. The early majority will soon join in, but the other

50 per cent risk being left far behind as the changes are rapid and the required investment of both time and money is considerable. Stay in the rear and you run the risk of being dropped from the race.

Success will come to those who not only deliver what their existing patients want, but also anticipate what they can offer to their patients that is not currently available. Look at the success of removable aligners, facial aesthetics and minimal intervention techniques. It would have taken a brave man or woman to have backed those just a decade or two ago.

Writing in **The Journal of mHealth*, Dr Aalok Y Shukla says that modern dentistry has two parts:

Psychosocial dimension: Feeling happy with your smile – orthodontics, prosthodontics and cosmetic dentistry.

Health dimension: No disease in the mouth, gum disease, tooth decay, endodontics, jaw pain, oral cancer.

He anticipates that the future solution will have three elements:

- Continuous digital monitoring of oral health for early detection of disease.
- Preventive, interceptive and reparative home solutions.
- Clinical minimally invasive reparative, regenerative and enhancing solutions.

As Bob Dylan sang, "The times they are a'changin'."

The usual excuses of dentists including, "My patients won't pay", "I'm too close to retirement", and "I'll wait a few years for the price to come down" no longer wash. With the growth of practices and more aggressive marketing, patient expectations are increasing rapidly and the consumerist genie is out of the bottle. If you don't provide the service then expect your patients to vote with their feet and find someone who will cater for their needs.

The patrician era of "doctor knows best" is long gone and has been replaced by one where the patient does their homework and expects the best.

Wilfully blind behaviour will lead to your practising life becoming stifled, stagnant and stultified. Open your eyes, practice a bit of self-honesty and self-awareness to re-energise yourself and your practising career.

**www.thejournalofmhealth.com/disruptive-technology-in-dentistry-rethinking-the-model*


Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

www.thedentalbusinesscoach.com


> "THERE ARE PEOPLE WHO MAKE THINGS HAPPEN, PEOPLE WHO WATCH THINGS HAPPEN AND PEOPLE WHO WONDER, 'WHAT HAPPENED?'"
>
> JIM LOVELL, NASA ASTRONAUT

# RECRUIT, INDUCT, DEVELOP

*Assembling an effective team is vital for both a growing practice and building a group*

[ WORDS: RICHARD PEARCE ]

**FOLLOWING ON FROM MAY'S** article, where we looked at recruitment, this month we will consider how we can help our new employee to make an effective contribution as quickly as possible. We will assume that you had a clear person specification for the job description (JD) you were aiming to fill. Your marketing of the vacancy generated at least 10 applications. You asked them to complete some online screening, perhaps an Excel and Word assessment and you shortlisted three for interview.

Based on a scoring system, you interviewed the candidates on the shortlist and there was one stand-out candidate. Within 12 hours of the interview, you rang the candidate you wished to appoint and offered them the job and they immediately accepted. Straight away you sent them a well-written offer letter, confirming salary, start date and their contract. Now the hard work starts.

Having checked references and agreed a start date, you prepare for their first day. Easily overlooked is communication to all your current team of the new employee. An announcement of their name, the start date and a small bit of background on their experience may be useful. You don't want them arriving and nobody knowing who they are, this would not demonstrate that you are organised and effectively communicate with your team. The first month is crucial, both parties are deciding if they made the right decision. You will need an induction plan that covers at least the first two weeks. It will need to include:

- Who they will meet and when.
- Software they will use (and their training on it).
- Documentation they will need to read.
- Specific training, the learning outcomes and how their understanding might be tested.

Don't forget regular reviews with them (at the end of the first day, first week and first month). Give them a chance to express their concerns so you can immediately address them. Make sure they have their job description at each review (the JD will have been crucial in designing their induction).

Each induction of a new staff member is a chance to improve it for the next new recruit. Therefore, ask them at each review what part of the induction could have been better and how it could be improved. Could you use videos to enhance their understanding? It's possible they have come from a non-dental background and so they will need to understand the treatments that you provide.

Your new staff member is obviously on probation. There is a reason for the probationary period. You can't possibly be completely sure that a person is right for a role and so probation allows you to fairly assess them and if need be, they can fail their probation and leave.

Once they are operating in their new role, whether it's as a nurse, receptionist or dentist, after induction you will want to consider ongoing training and development. After only a few weeks you can start to congratulate yourself on your skill in seeing potential, or alternatively start to question your choice.

So, a word about what to do if you find yourself in the latter camp. This is why regular reviews, which are documented, are so crucial. If you have areas of concern, then you need to highlight them with the new employee early on. Be clear on where their behaviours need to alter. But always remember, "Fire, fast!" If you start to have doubts, take immediate steps to assuage those doubts, or fail the probation. So much time can be wasted persuading yourself that an employee will work out, when they almost certainly won't.

Many times, I have been into a practice to assess their operation and find that one employee can be the 'obstacle' to progress. Often it can be the manager who has been in place for a long time and just 'gravitated' to the manager position. This is always a difficult problem to fix and is usually time-consuming and often expensive. But, if you

consider the recruitment and induction process that has been suggested above, it was almost certainly not followed when you evaluate a 'problem' employee. Often there was no clear JD for the position (and probably still isn't), no interview and evaluation process and certainly no effective ongoing reviews.

The recruitment and development of an effective team is vital if you want a growing practice and even more important if you have aspirations to build a group. Staff are your biggest cost and will be the source of your biggest headaches if you don't develop skills to recruit, induct and develop them.


Richard Pearce lives in Northern Ireland. Following a business career in various sectors and an MBA, he joined his dentist wife in dentistry. Richard combines his wide commercial experience with being attuned to what it is like for an associate dentist, a practice owner and a practice manager. His unique perspective ensures he can assist a practice owner with every area of the practice to create a more profitable practice and to achieve their smart objectives.

**www.smartpractices.co.uk**

# CHOOSE AN AGENT BASED ON PROFESSIONAL RECOMMENDATIONS

Ted Johnston, Practice Consultant Scotland and Ireland of Dental Elite, hears from Dr Chhaya Chauhan about her buying experience

When it comes to acquiring or selling a dental practice, it's important to get the right professional support in order to encourage a smooth and effective process. The team you work with can make a huge difference to your experience and the success of a transaction, so choosing wisely is a must.

Seeking out advice from other individuals who have been through similar situations can be a great help, as you can glean valuable insight into what to expect and how to avoid common pitfalls associated with the process. Preparation is often key when it comes to practice sales and acquisitions. In addition, looking for personal recommendations for the agents that colleagues have liaised with will help to point you in the right direction when it comes to selecting an effective agent for you.

**For more information on Dental Elite visit www.dentalelite.co.uk, email info@dentalelite.co.uk or call 01788 545 900**

Dr Chhaya Chauhan

Dr Chhaya Chauhan recently bought Tru Smile Dental Practice with the support of Dental Elite. Here she shares her experience and discusses how she found working with the team.

### WHICH CONSULTANT(S) AT DENTAL ELITE DID YOU WORK WITH?

I worked with Sue Humphrey and Helen Craine.

### WERE THEY IN REGULAR CONTACT AND WERE THEY APPROACHABLE IF YOU HAD ANY QUERIES?

They were both brilliant for staying in contact regularly. They were very approachable and really made me feel very comfortable to ask any questions that I had throughout the process.

### WERE YOU COMFORTABLE THAT YOU HAD ALL THE INFORMATION YOU NEEDED THROUGHOUT THE PROCESS?

Yes. They always gave me the best information and kept me up-to-date with everything that was happening during the transaction.

### HOW DID YOU FIND THE AGENT BUFFER BETWEEN SOLICITORS, BUYER AND SELLER?

It was amazing to have the agent round up all the latest information – this was very useful with so much going on. I also liked that I had a single point of contact. It was easy to get updates from Sue as she was the person dealing with all aspects of my traction and I didn't have to explain the situation to a new person every time.

### WOULD YOU RECOMMEND DENTAL ELITE TO OTHERS?

Yes, 100%. I would say they provide the best service by far. They were one of the only agents in the dental market to include CQC support, which is a massive benefit.

### ANYTHING ELSE YOU WOULD LIKE TO SAY?

Thank you so much to the whole team for being so wonderful in this process! They really do hold your hand through the whole thing and get you to the finish line as efficiently as possible.

If you're looking for advice or support with buying or selling a dental practice, find out what the experienced team at Dental Elite could do for you by contacting them today.

> "IT WAS AMAZING TO HAVE THE AGENT ROUND UP ALL THE LATEST INFORMATION – THIS WAS VERY USEFUL WITH SO MUCH GOING ON. I ALSO LIKED THAT I HAD A SINGLE POINT OF CONTACT"

# CELEBRATING 10 YEARS AS ONE OF IRELAND'S LEADING SPECIALIST SUPPLIERS

Based in Galway City, Hogan Dental and Medical Services (HDMS) is an independent company dedicated to providing customers in Ireland with modern, reliable dental equipment at competitive prices. HDMS specialises in surgery design and planning, dental equipment sales, equipment installation and repairs and maintenance.

This year, HDMS celebrates 10 years in business; a fantastic achievement in a competitive market place within Ireland. Paul Hogan established HDMS back in the downturn of 2009 and it has grown steadily through reputation into one of Ireland's leading specialist companies involved in the supply, service, and maintenance of all essential dental equipment used in today's modern dental practices all over Ireland.

Through expertise and experience, the product offering from HDMS is carefully chosen from a range of established and selected leading brands which are highly recognised throughout the dental industry for their quality, reliability and performance.

Paul spoke of his delight at securing the Anthos and Castellini dealerships for Ireland which has really catapulted his business in the last number of years. "We are delighted to be able to offer the Anthos and Castellini range, which includes dental chairs, sterilisation, radiology and imaging, multimedia and instruments," he said.

"Anthos and Castellini are a perfect fit to incorporate with our current range, and with the different chair options and high-class technology, we feel these chairs will make a big impact in the Irish market."


Paul added that not only do Anthos and Castellini manufacture dental chairs, but they also design and manufacture a high-class range of vacuum B Class autoclaves and X-ray units. Italy's leading producer of dental units, Anthos and Castelllini provides products designed to ensure all dentists have a model that suits their individual working style.

For more than 60 years now, an extensive product range, outstanding design, officially recognised quality and excellent performance have made this brand a popular choice with dentists worldwide. This year, each of the chair models have seen a new design and have evolved to ensure increased flexibility, ease-of-use and enhanced performance with some outstanding features.

The new range of chairs is for professionals looking not only for dental equipment, but also a functional instrument whose value fits well with the economic aspects of their business activity. All HDMS products are a sound point of reference for dentists, providing practical solutions and limitless opportunities.

HDMS are also agents for many more leading brands, such as Cattani suction and compressors, Dürr suction and compressors, Midmark sterilisation and decontamination and MyRay Imaging. HDMS plans to grow the business over the next few years and add to the current staff.

It's easy to see how ambitious Paul and his HDMS team are when you see the brand-new modern website they now have online at www.hdms.ie. Paul explained: "Currently we have a great customer base all over Ireland and really intend to grow this. The Irish dental industry is in a good place right now and we have had a lot of new business in the last three years, setting up new dental clinics and upgrading established dental clinics.

"We are able to provide a turn-key solution where we have professionals on board for sourcing a premises, planning, design and, of course, then fitting out the clinic with modern equipment all compliant to HSE standards and of a high quality which can be seen in the examples on the portfolio section of the website."

The HDMS team provides exemplary service, specialised experience and high-quality support to ensure every client is happy with their finished design.

**HDMS, Galway, Ireland , 087 8702619, 091 582608, info@hdms.ie, www.hdms.ie**

HDMS
HOGAN DENTAL & MEDICAL SERVICES

› DURR DENTAL

## PARLIAMENT TALKS DENTAL TECHNOLOGY


Sir Paul Beresford MP recently held an All-Party Parliamentary Group for Dentistry and Oral Health event at the Houses of Parliament. Visitors were encouraged to learn how modern dental technology is making fear of the dentist a thing of the past. The event was designed to be fun and fully interactive, with Members of Parliament invited to feel what it's like to perform dental procedures using a realistic virtual reality unit. Those wishing to step back in time could try their hand at pulling teeth with an 18th century tooth key to see if they could get a foot-powered Victorian treadle drill spinning fast enough to get to the top of a leader board.

One manufacturer invited to attend was Dürr Dental, who took along their VistaCam intra-oral camera. Ian Pope, Managing Director, said, "It was great to see what technology is currently available in UK dentistry. Having worked in the industry for more than 30 years, I have seen phenomenal advancements, but none more so than the pace of change in digital dentistry over the last five years. Technology is making dentistry less daunting to the public as it allows dentists to communicate more easily with patients and treat disease less invasively."

www.duerrdental.com

› DURR DENTAL

## SMART TECHNOLOGY FOR THE SURGERY

Chances are many of us are using smart technology within the home, to control our heating, lighting or alarm systems. Now the same pioneering technology is available to make your working life as simple. Dürr Dental has launched its new IoT (internet of things) solution called VistaSoft Monitor, to ensure that the practice runs smoothly and intuitively.

This cloud-based IoT service solution allows all connectable Dürr Dental systems to be integrated into VistaSoft Monitor, providing a clear overview of all products, including compressors, autoclaves and X-ray systems. The software is based on the following principle: monitor-transmit-analyse-act.

The units constantly monitor important operating parameters and transmit them in real time to VistaSoft Monitor, where they are analysed and then presented to the user in a clear format. Operation can be viewed centrally at a PC in the reception area, or decentralised in every treatment room or on a smartphone/ tablet via the corresponding app.

www.duerrdental.com

› JOHNSON & JOHNSON

## JOHNSON & JOHNSON LAUNCHES NEW CAMPAIGN TO HELP IMPROVE THE NATION'S ORAL HEALTH

This month sees the launch of a new campaign by Johnson & Johnson, offering more than 400,000 people up to £50 off a dental hygiene appointment.

Across England, Wales and Northern Ireland, 66 per cent of adults have visible plaque and 83 per cent show some evidence of gum disease (that is bleeding, calculus, periodontal pocketing of 4mm or more), suggesting that there is still more help needed for the population to achieve better levels of plaque control.

Johnson & Johnson has been dedicated to supporting dental professionals in improving their patients' oral health for more than 100 years, making full use of evidence-based clinical research and science to help deliver better outcomes through its range of LISTERINE® mouthwashes.

Building on this, the new campaign aims to offer greater support to dental hygienists, as Johnson & Johnson recognises the importance of regular dental and hygiene visits and is committed to helping reinforce that message among the public.

With only 17 per cent of adults in England, Wales and Northern Ireland stating that they had seen a dental hygienist at their last completed course of dental treatment, it seems that there remains a need for increased awareness and access.

Speaking about this extraordinary contribution to the nation's oral health, Mike Lynch, Global Scientific Engagement Director of Oral Health for Johnson & Johnson, commented, "Just like our dedicated dental professionals in the UK, we are committed to improving oral health for patients. To show our support, Johnson & Johnson is pleased to be able to remove the financial barrier for more than 400,000 individuals and demonstrate the value of our dental hygienists in the UK to ensure more people can understand the importance of good oral health."

To qualify, the individual must purchase two promotional bottles of LISTERINE®, available in Tesco stores from this month. They then visit their existing hygienist (if they have one) or make an appointment with any hygienist in the UK for a scale and polish and pay for the appointment in the usual way, applying to Johnson & Johnson for reimbursement up to a value of £50.

The only impact on dental hygienists may be an increase in patient numbers, especially where cost of treatment has previously been a barrier.

Johnson & Johnson

For further information, visit www.listerineprofessional.co.uk/dentalcheck

› DURR DENTAL

## CLEAN WATER WITHOUT CHEMICALS

Dental treatment systems offer ideal conditions under which biofilm can form and micro-organisms such as pseudomonas, legionella and cryptosporidium can flourish. These micro-organisms can be exposed to the patient via the cooling water, mouth rinsing water and aerosol exposure. Hygowater from Dürr Dental ensures the service water in your practice always meets the same stringent requirements as drinking water. This standard is consistent with the advice given by the Robert Koch Institute.

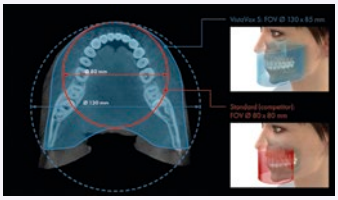
Water-carrying systems in treatment units can still, however, harbour various micro-organisms, which can colonise and form a biofilm which adheres to the inner walls of the unit. To ensure optimum safety, micro-organisms must be reduced to a minimum and biofilm permanently removed from hoses and pipes.

Hygowater is a system that promises safe and reliable service water processing. It fulfils all the legal requirements for water hygiene, as well as satisfying the meticulous standards demanded by the German Drinking Water Ordinance as well as meeting the requirements for a Class I medical device.

The compact unit is extremely easy to operate. The unique combination of filtration and electrolysis prevents biofilm formation and thus minimises infection risks to both patients and practitioners. As well as being good for the safety of the practice, it's also great for the environment, as long-term drinking water quality is ensured without the use of any chemical additives.


www.duerrdental.com

› DURR DENTAL



## ALL-IN-ONE DIAGNOSTICS

Dürr Dental has developed an extended version of its VistaVox S panoramic machine which contains six additional programs for time-saving cephalometric exposure with minimum radiation doses, called VistaVox S Ceph.

As you'd expect from Dürr, exceptional diagnostics and ease-of-use are guaranteed. Alongside the 17 panoramic programmes, the VistaVox S Ceph has several orthodontic applications, including 'Lateral Head', 'Full Lateral Head', 'PA Head' and 'Waters View'. The unit is as fast as it is smart – with a scan time of just 1.9 seconds, images are exceptionally sharp using the lowest possible radiation dose. This functionality is afforded by the high-sensitivity CSL sensors. The unit can effortlessly switch between the 3D X-Ray and the Ceph boom, a process that on some machines can be both cumbersome and risky.

Just like the VistaVox S it has a perfect 3D imaging volume of 130mm (compared to 80x80mm for most other systems). This means it completely covers the whole diagnostically relevant area, including the rear molars, an essential requirement for diagnosing an impacted wisdom tooth. Enhanced visibility does not require a higher radiation dose; in fact, the opposite is true. A special curved path, which rotates 540°, in combination with a tightly collimated fan beam and a highly sensitive CsI sensor, means that a particularly low radiation dose is used.

Similarly to the VistaVox S, this enhanced model offers Ø 50 x 50mm volumes, for indications that only require a certain part of the jaw region to be shown, e.g. for endodontic or implant treatments. The unit offers true all-in-one capabilities for a full range of diagnostics, making it ideal for dentists, orthodontists or those who work within larger practices offering a full range of specialist treatments.

www.duerrdental.com

› DURR DENTAL

## PRESERVING VALUE

Dürr Dental invented the modern day suction system, so has a wealth of experience to draw on when it comes to maintenance. To preserve the life of your unit they offer the following tips (based on more than 50 years of experience!):

1) Aspirate at least one glass of water through the spittoon and the suction hose after every patient to remove blood, saliva and dentine residue.

2) Use cold water to mix disinfectant, as hot water inactivates many disinfectant components and tends to create foam and cause coagulation when combined with blood.

3) Just as with household appliances, limescale can damage components. Depending on water hardness, use MD555 cleaner at least once a week.

4) Use only foam-free products intended for the job – never use household cleaning agents in the suction unit.

5) Never mix products as this can neutralise the disinfectants.

6) Do not use the suction unit to vacuum drawers!

7) Carry out the recommended maintenance.

Dürr Dental is the only supplier of suction systems who also manufactures cleaning solution. Its Orotol® range is the leading brand of suction disinfectant in the world. It boasts an extraordinary cleaning power and is foam-free, making it popular with nurses. The suction range is available as either a concentrated powder or as a liquid, both of which have an environmentally friendly composition and a pleasant odour.

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**NEODENT IRELAND are delighted to introduce 2 days you can't afford to miss**

# THE ART OF IMMEDIATE IMPLANT TREATMENT

Reduce treatment times, improve outcomes and open up a whole new world of implant dentistry

One Grand Morse® connection for all Grand Morse® implants



## DAY 1: IMMEDIATE PLACEMENT AND RESTORATION OF SINGLE UNITS

**Speaker:** James Hamill
**Date:** Friday 20th Sep
**Cost:** £600/€695

Learn how to place and restore immediate implants in the anterior and posterior of the mouth using the specially designed NEODENT GM implant. This one-day hands-on course will introduce and teach the concept of restoring immediately placed implants. Using models, the delegates with place an anterior and posterior implant and restore them using various techniques such as NEODENT 'Click', Peek abutments and the 'One abutment One time' philosophy.

## DAY 2: FULL ARCH IMMEDIATE LOAD 'NEOARCH'

**Speaker:** Pynadath George
**Date:** Saturday 21st Sep
**Cost:** £1,200/€1,380

During the day you will produce an upper or lower immediate full arch bridge on specially designed models. This course is for surgeons already involved with dental/oral implants and are interested in full mouth immediately loaded cases.

This one-day course is intended to guide and consolidate the theory, concept and management of full arch immediate loading as a treatment option for the terminal dentition. This will be covered by the use of interactive seminars and lectures and "hands-on" training via the use of plastic jaws. Participants will ALL be expected to extract teeth and convert a denture into a fixed acrylic bridge through a specially designed plastic jaw.

**Cost:** Come to both days for the reduced rate of £1,600/€1,850+Vat or attend your preferred day.

Day 1 £600/€695+Vat Day 2 £1,200/€1,380+Vat

**Venue:** Radisson Blu Hotel, Athlone

**For more details, contact the exclusive distributor of Neodent in Ireland, Quintess Denta on 01-6918870(Dublin) or 028-68628966(NI) or email ian@quintessdenta.com**

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## James Hamill

**BDS MFDS RCSEd Dip Imp Dent RCSEd**

James is the CEO of Quintess Denta and an active implant surgeon providing his clinical, mentoring and educational services throughout Ireland. James is an open, honest and engaging speaker who has a wealth of experience across the surgical and restorative aspects of conventional and immediate implant dentistry.

## Dr Pynadath George

**BDS, MFDS RCPS, MSc Rest Dent, MSc Imp Dent**

Pynadath is one of the most prolific Immediate Load Full Arch providers in the UK. He has provided these types of treatments for a long period of time and is passionate about educating others on how to achieve predictable, safe and life changing treatments for their patients. He is exceptionally qualified to explain the NEOARCH technique and is a talented presenter.

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Paul Tipton
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