

THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

# *Ireland's* Dental

NOVEMBER 2019



## *It's agreed*

Northern Ireland's focus on children and the elderly

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# Oral health strategy – the case for rapid research

**I**n the Long Gallery of the Parliament Buildings at Stormont last month, the mood among those who had gathered to explain, learn more about, and debate the issue of oral health in Northern Ireland was collegiate and positive. However, it could be argued that there were good reasons why this should not have been the case.

The 'Oral Health Matters' summit had been organised by the British Dental Association (BDA), when perhaps it should have been the Executive or the Department of Health taking the lead – with the BDA, and other interested groups, acting as consultees and sources of expert advice. In addition, when an initiative such as this is taken, there is usually a goal; in this case - it could reasonably be expected - that would be to deliver a new oral health strategy (or, at least, a refresh). The last strategy was published in 2007.

Why it was the BDA taking the lead, and not politicians or public health officials, was not raised. But in a sense, it does not matter now; the key people and organisations were in the room and there appeared to be broad agreement about what progress had been made in the past 12 years, what challenges remained, and a willingness to work together on actions that will help improve the population's oral health. One delegate, however, did raise the issue of the strategy age. He argued that while there might be consensus on the problems, and potential solutions, the lack of a 'new' strategy left nothing tangible for everyone involved to rally round.

Simon Reid, the Chief Dental Officer, did not completely disagree on that point, but he did express concern about the length of time that devising a new strategy might take and the delay in taking action this would cause. The 2007

strategy took two years to write, he said, and – if my ears served me correctly – he recalled it had had the input of a health department trainee at the time, who happened now to be sitting to his left; one Michael Donaldson, today's Head of Dental Services at the Health and Social Care Board.

In his presentation earlier, Reid had acknowledged the strategy's vintage, but argued that it was a "significant piece of work", whose key principles – prevention, complimentary health promotion, partnerships, and reducing inequalities – hadn't changed. The recommendations were still valid, and targets had been met, said Reid.

He did say that within partnerships, there should be more "embedding" of oral health in wider public health. In addition, he said there should be consideration of new targets.

This may all be true. But, still. The delegate's point about there being nothing to rally round holds. Reid's announcement of two 'options groups' – focused on the oral health of children and the elderly – was welcomed. Their work and outcomes will be observed with interest. It might be an idea, though, to reconsider the notion of producing a new strategy. An internal deadline for delivery in the first half of the new year could be set, allowing for '2020 – and beyond' to be incorporated in its title.

We're not advocating the adoption of a 'Design Sprint', as developed by Google Ventures ([www.gv.com/sprint](http://www.gv.com/sprint)). "Working together in a sprint, you can shortcut the endless-debate cycle and compress months of time into a single week". No, clearly not in this context. But, perhaps look to the work of the Nuffield Trust on rapid research.

"Many health care organisations use research to make decisions around management and organising care," says Dr Cecilia Vindrola-Padros, a member of its Rapid Service Evaluation Team. "This evidence might come in different forms, but one of the conditions for its use is that it will need to be available at a time when it can still inform decision-making processes."

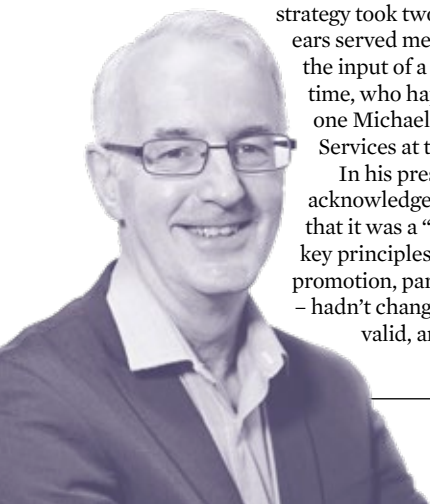
She adds: "The changing climate and priorities of many health care organisations means that many important decisions are made quickly. As a consequence, any research hoping to inform these decisions must be flexible enough to deliver findings within reduced timeframes or on an ongoing basis, in the form of emerging findings."\*

Dr Vindrola-Padros's own work in this field suggests the definition of rapid research can extend from five days to six months.\*\*

The launch of a new oral health policy for Northern Ireland in the spring of 2020 ought to be do-able.

\*<https://tinyurl.com/y57kkvr7>

\*\* *Quick and dirty? A systematic review of the use of rapid ethnographies in healthcare organisation and delivery.* Vindrola-Padros C, Vindrola-Padros B. *BMJ Quality & Safety* 2018; 27:321-330.



## Promoting leadership and international co-operation within the profession

**A**t a gathering in the Dublin Dental Hospital in Trinity College over the summer, Professor Brian O'Connell was awarded Fellowship of the Pierre Fauchard Academy (PFA). Professor O'Connell, Dean of Dental Studies, was being recognised by the PFA for his longstanding leadership within the profession and his sustained contributions to professional education. The incoming President of the PFA, Dr Terry Brunwick, bestowed this honour in person on behalf of the Academy. Dr Brewick travelled from the USA with key staff from the Pierre Fauchard Academy (PFA) – whose headquarters are in Logan, Utah.

The Pierre Fauchard Academy is an honorary dental service organisation that was founded in 1936 by Dr Elmer S. Best, a Minnesota dentist. Dr Best wished to help the profession and guide it, particularly in the area of scientific literature. His passionate concern for the search for knowledge and the raising of professional standards laid the ground work for the beginning of the Academy. This attracted outstanding dental researchers and teachers to its ranks, and led to a continuing role in fostering dental science.

The Academy is named after Pierre Fauchard of France (1678-1761), who is recognised as the "Father of Modern Dentistry" for raising dentistry to a profession. He compiled a book entitled *Le Chirurgien Dentiste, ou Traité des Dents* which is widely considered to be the first published textbook of dentistry. The Constitution of the Pierre Fauchard Academy laid out a series of objectives, honouring Dr Best's focus on integrity and ethics.

A primary objective at the time of its founding, was a focus on peer-reviewed scientific literature – looking at all aspects of dentistry.

Fellowship in the Academy is by nomination and is designed to honour past accomplishments in the field of dentistry and inspire future productivity. Professional leaders select fellows based on contributions to dental literature, service to the profession of dentistry, and service to the general community, thereby bringing credit to dentistry. These are among some of the criteria sought in recruiting new members. The Academy has its own publication programme with *Dental World* and *Dental Abstracts*, and has always encouraged its fellow members to contribute to dental education and dental literature. Through its Foundation, it offers financial support to

various dental projects that increase access to care for underserved populations and scholarships to dental student both in the USA and around the world. Among the current projects supported by the Pierre Fauchard Academy include many humanitarian projects – such as "Missions of Mercy" in the USA – known as MOMs.

Mission of Mercy events across America have been providing free dental services for the underserved since 2000. Each year, more state organisations have joined the effort to make a difference. Mission of Mercy events have helped more than 135,000 patients and provided \$76 million in free services since 2000. Further afield, the PFA supports "Australian Rescue Days" and also "Donate a Smile – Dental Relief Project: Central Africa Republic" among others. At the undergraduate level, the PFA supports a "White Coat Ceremony" – akin to the "Clinical Pledge" ceremony in UCC – which marks that important transition from classroom to clinic.

The Pierre Fauchard Academy is currently comprised of nearly 11,000 Fellows divided into 142 sections, 55 in the United States and another 87 in many other parts of the world, including South America, Europe, Asia, Africa and Australia.

The Academy is administered by a Board of Trustees consisting of four Officers and ten Trustees from around the world. Section organisation includes a Chairperson and such other officers or committee members as the Section may elect. The administrative office of the Academy is located in Logan, Utah.

I have been involved with the PFA for over a decade. Recently I was nominated Section Head for Ireland, following on from the trojan work of Professor Robin O'Sullivan (RCSI) and Professor Christopher Lynch (UCC). I am eager to expand the goals and objectives established by this charitable organisation. To that end, along with our committee, we plan to host a day of lectures covering aspects affecting day to day provision of general practice. It will also showcase the Academy's mission and charitable endeavours and goals. In talking with Incoming President, Dr Brewick, the PFA is eager to identify new and emerging leaders within the profession and help foster this spirit of leadership and collegiality that has is the hallmark of PFA worldwide.

My thanks to the PFA Headquarters staff who made the trip from Utah – and congratulations once more to Professor O'Connell on the fellowship. We marked the occasion with a celebratory event in Dublin, graciously sponsored by Dental Care Ireland.





# Action groups are ‘a significant step forward’, says BDA

The BDA's Caroline Lappin speaking at the Oral Health Matters summit last month

*Northern Ireland's Department of Health unveils focus on oral health for children and the elderly*

**THE** British Dental Association has welcomed an announcement by the Department of Health to establish two groups focusing on the oral health of children and the elderly in Northern Ireland.

The BDA said, however, that “any action will need to be accompanied by adequate investment and a commitment to address the needs of the dental workforce if it is to be successful.” Simon Reid, the Chief Dental Officer, made the announcement at the Oral Health Matters summit held at Stormont last month, organised by the BDA as a rallying call for a new vision for oral health in Northern Ireland.

The event was attended by more than 80 key stakeholders, including health spokespersons of the main political parties, the Older Person's Commissioner, policymakers, advocates, leading public health organisations, and charities.

“These new focus groups give dentists an opportunity to work collaboratively with

Department of Health and HSCB colleagues to generate ideas to deliver much needed advances in the population's oral health,” said Caroline Lappin, chair of the BDA NI Council.

Lappin added: “Whatever options are generated, additional investment to bolster oral health in Northern Ireland will be necessary. Going forward, improving oral health must be viewed as integral to embedding the prevention agenda, and delivering wider public health benefits to the population.”

Paula Bradshaw, the Alliance Party's health spokesperson and co-sponsor of the event, commented: “Despite some improvements, Northern Ireland has the worst oral health in the UK, and this has a detrimental impact on general levels of health and wellbeing.

“Particularly, only 19% of under-15s have ‘good oral health’ and screening in care homes is proving difficult, showing the challenges which exist across all age groups.

“This means there are many actions which need to be taken urgently to address issues ranging from the sugar epidemic to addressing gaps in dental provision. We also need to ensure this is not treated as some kind of optional extra – gum disease alone can be linked to diabetes, heart disease, dementia and arthritis.

“We need to see the Department of Health take a lead on this, engaging with healthcare professionals to ensure that there is adequate investment to fill the gaps and recognise the need for preventative action, entirely in line with the general Bengoa proposals. I commend the BDA NI on making these issues so prominent and on bringing so many people from so many sectors together to address them. There are significant challenges ahead, but we must work to meet them immediately.”

*Summit report, see p18*



SmileDirectClub has launched in Dublin, Cork and Belfast

## ‘Direct to consumer’ comes to Ireland

*Irish and British orthodontic societies issue guidance*

**THE** Irish Orthodontic Society has issued guidance in the wake of the launch in Ireland and the UK of SmileDirectClub, a US start-up offering a ‘direct-to-consumer’ aligner service.

SmileDirectClub has opened in 16 cities across the UK, including Belfast, and last month it announced branches in Dublin and Cork. The company is investing \$380m in its UK operations and plans to employ more than 300 people, including dentists, orthodontists, and dental nurses.

SmileDirectClub has “pioneered a unique teledentistry platform to connect customers with an affiliated network of registered dentists or orthodontists who direct all aspects of clinical care using SmileDirectClub’s platform,” it said.

However, the Irish Orthodontic

Association said: “Specialist orthodontists believe that the best short-term price and long-term value in orthodontics is achieved by minimising the risks and maximising the benefits. We believe this is best achieved by working directly with patients face to face before, during and after treatment, to support them in achieving the best outcome.”

Speaking at a press conference during the British Orthodontic Society’s annual conference in Glasgow earlier this year, its president, Jonathan Sandler, said: “In my professional opinion, if you embark on any orthodontic treatment without a suitably trained clinician taking the time to examine you and make appropriate recommendations, you could be in danger of having serious conditions missed, as well

as inappropriate and dangerous treatment carried out.”

In the US, the American Association of Orthodontists has lodged complaints about SmileDirectClub with dental boards and regulatory authorities in 36 US states. In contrast, SmileDirectClub has filed a lawsuit against the Dental Board of California, alleging harassment and intimidation of its employees and customers.

A spokesperson for SmileDirectClub said the services it offers are not ‘do-it-yourself’ or ‘over the counter’ and referred to a page on its website ([smiledirectclub.com/doctors](http://smiledirectclub.com/doctors)) that details the standards adhered to by its products and its network of professionals.

*BOC 2019 report, see p24*

## Irish Government’s policy ‘flawed’

**THE IRISH** Government’s new oral health policy is “fundamentally flawed” and cannot work in the absence of changes to the way dentists are trained, the State’s main postgraduate dental training body has warned.

The policy, published last April, needs to be reviewed and legislative changes made to ensure dentists are sufficiently educated, according to the RCSI’s Faculty of Dentistry.

Last month, the Government announced that free dental

treatment for under-sixes will come into effect next September as part of Budget 2020. But Fintan Hourihan, Chief Executive of the Irish Dental Association, said: “Moving from a risk-based, targeted public dental service model to a system where children are seen if they attend in private dental practices is very problematic.”

The Faculty said that the policy fails to make provision for the ongoing post-graduate education and training of dentists, and that the proposed

network of advanced oral healthcare centres requires skilled dental specialists who currently are not available.

Faculty dean Dr John Marley wrote to Minister for Health Simon Harris reiterating its concerns. Dr Marley said there should be a mandatory system of continuing professional development for dentists, as well as the introduction of further specialist lists beyond the existing ones in orthodontics and oral surgery.

Dr Marley said the

Department could not “simply race ahead” with the policy without putting in place the foundations needed to make it a success. “Enacting the legislative changes now to ensure that our dentists are sufficiently trained and educated must be the immediate priority for the Department,” he said. “Unfortunately, we see no evidence of this promised legislative change being actioned.”

*Oral health policy, p18*

# Dr Jennifer Collins joins Northumberland Dental Care as lead

**NORTHUMBERLAND** Dental Care in Dublin 4, formerly The Northumberland Institute of Dental Medicine, has appointed Dr Jennifer Collins as lead general dentist. In her new role, Dr Collins will provide a full range of general dental treatments for patients, as well as specialising in facial aesthetics.

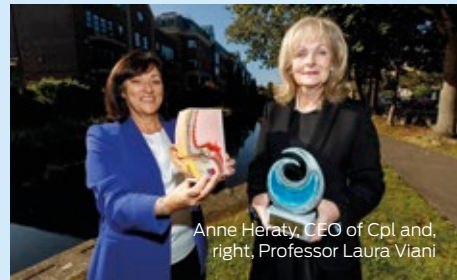
A graduate of University of Wales College of Medicine (2004), Dr Collins brings a wealth of experience to the practice, having previously trained and worked as a dentist in both Ireland and the UK.

For more than a decade, she has worked in private practice in the Dublin 2 area. Prior to this, she spent two years working in maxillofacial surgery

across two hospitals in Brighton and Eastbourne, UK.

Dr Collins has a special interest in cosmetic, restorative and implant dentistry and is fully trained in facial aesthetics. She is a member of the Royal College of Surgeons in Ireland, sits on the Irish Dental Association's GP Committee, and has volunteered with a number of charities including Operation Smile.

Now part of the Dental Care Ireland group, Northumberland Dental Care was established over 25 years ago in Ballsbridge, Dublin 4. Led by a multi-disciplinary team of experts, the practice offers a full range of general, cosmetic and specialist dental treatments.



Anne Heraty, CEO of Cpl and, right, Professor Laura Viani

## Hear, hear for Professor

Professor Laura Viani, a neurotological surgeon who led the development of the National Hearing Implant and Research Centre (NHIRC) in Dublin, has been awarded the Cpl World-Class Talent award for her pioneering work in the field of cochlear implants. Prof Viani, a fellow of RCSI and a member of the RCSI Council, opened Ireland's first implant clinic in Dublin in 1994 and completed the country's first implant surgery in March 1995. In the last 25 years, Prof Viani has built a RCSI-based clinic of two into a team of 30 specialists and clinical support experts across Irish hospitals, whose knowledge and skills put Ireland's cochlear implant programme on an international footing.

## Earnings collapse a 'risk'

A decade-long collapse in dentists' earnings risks the sustainability of Health Service dentistry, BDA Northern Ireland has said in response to a report from NHS Digital. It said since 2008/09, dentists' earnings have fallen in real terms by 30% for practice owners, while associates have seen their pay cut by 39%. Richard Graham, Chair of the BDA NI Dental Practice Committee, said: "It's time the Department of Health addresses the unsustainable financial burden on dentists, as they struggle to provide Health Service dentistry to the population at fees that simply don't pay."

## New rep for Castellini

HDMS ([www.hdms.ie](http://www.hdms.ie)), the Galway-based supplier of dental services, has been appointed as agent in Ireland for Italian medical devices firm Castellini.

## Complaints revealed

More than 760 complaints have been made against dentists in Ireland over the past five years, most of them relating to treatment issues, figures show. Last year, the Dental Council was contacted by 126 patients with issues regarding treatment (76%), "behaviour" (36%), and fees (12%).

## Dr Bell's sudden passing

Seapoint Clinic announced the "sudden and unexpected passing of our dear friend and colleague Dr David Bell" (right).

A spokesperson said: "Dr Bell's caring approach, witty outlook and dedication to his work made him loved and respected by patients and colleagues alike."



## Baltinglass Dental Joins Dental Care Ireland in the heart of Carlow

**DENTAL** Care Ireland, an Irish-owned practice network, has announced its acquisition of Baltinglass Dental, the Wicklow practice led by Dr Lotte Ramsden.

As a result of the acquisition, Baltinglass Dental will relocate from Baltinglass to the recently refurbished Dental Care Ireland practice on Tullow Street in Carlow. Dr Ramsden will work alongside Dr Richard Gillman, Dr Colm Traynor and Dr Róisín Brady to provide a full range of dental treatments.

Commenting on the merger,

Dr Ramsden said: "We can greatly enhance our overall patient offering. The practice on Tullow Street has been upgraded to the highest possible standards, and it is an ideal opportunity to consolidate many years of experience under the one roof."

Dental Care Ireland employs more than 200 people in 14 practices, comprising 80 general and specialist dentists, dental hygienists, dental nurses and practice managers, as well as operations, finance and marketing support staff.

# RCSI appoints innovation director

**ROYAL** College of Surgeons Ireland has appointed Professor Fergal O'Brien as its new Director of Research and Innovation. Under Professor O'Brien's leadership, RCSI's research community will advance its efforts to deliver scientific breakthroughs, innovations and insights that enhance patient treatment and care globally.

Professor O'Brien's appointment follows a period of significant growth in RCSI's research capability, competitiveness and impact. RCSI's field-weighted citation impact is the highest in Ireland and twice the world average, indicating the growing impact of RCSI researchers on the international health sciences landscape.

Welcoming the appointment, Professor Cathal Kelly, RCSI CEO, said: "Professor O'Brien brings proven leadership and management experience from his role as Deputy Director of Research and Innovation at RCSI since 2013, which included responsibility for research strategy across the

entire institution. This experience, coupled with his track record as a highly cited researcher and spin-out company founder, places him in a unique position to transform research operations and further develop a culture of innovation and impact in RCSI."

Following a degree in mechanical engineering and a PhD in bone bioengineering, Professor O'Brien was a Fulbright Scholar in tissue engineering at Massachusetts Institute of Technology and Harvard Medical School. He is currently Professor of Bioengineering and Regenerative Medicine and is the founding head of the Tissue Engineering Research Group in RCSI. He is also Deputy Director of the SFI Research Centre for advanced materials and bioengineering.

Since his faculty appointment in 2003, he has published more than 200 journal articles in leading peer-reviewed international journals and filed numerous patents, resulting in the successful translation



of technologies from his labs to the clinic. He is dedicated to postgraduate training and has supervised 40 doctoral students to completion as well as mentoring more than 50 postdoctoral fellows during his career to date. Professor O'Brien commented: "Our small size and sole focus on health sciences, together with our overseas campuses ensures a unique dynamic environment for interdisciplinary translational research. Our ties with our clinicians and hospitals present the opportunity to deepen engagement between basic scientists, clinicians and our industry partners, which, as well as leading to high-impact research, helps facilitate translation of scientific breakthroughs for the benefit of human health."



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**BDA NI: AGM**

Malone Lodge Hotel,  
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[bda.org](http://bda.org)

**12 NOVEMBER**

**BDA NI: How to get published and how the BDJ Portfolio can help**

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[tinyurl.com/y2aljux3](http://tinyurl.com/y2aljux3)

**14 NOVEMBER**

**RCSI: Diploma, Masters and Doctorate Conferring Ceremony**

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[tinyurl.com/yy8eb6kp](http://tinyurl.com/yy8eb6kp)

**15 NOVEMBER**

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**22-23 NOVEMBER**

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Convention Centre, Kilkenny  
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# Important and achievable

*Good oral health will require commitment from professionals – and the political will to make it happen*

WORDS  
WILL  
PEAKIN

**A**s the division between the dental profession and the Irish Government over the state's new oral health policy deepened last month, their counterparts in Northern Ireland gathered at Stormont to find common ground.

At an event organised by the British Dental Association (BDA), more than 80 stakeholders, including dentists, public health representatives, health spokespersons from the main political parties, policymakers, and representatives of charities, heard from BDA Northern Ireland representatives, the Chief Dental Officer, the Head of Dental Services at the Health and Social Care Board (HSCB), and experts involved in delivering care to vulnerable children and the elderly.

Tristen Kelso, BDA Northern Ireland's National Director, commented: "Ultimately our aim for today is that it marks the start of a fresh, ambitious and renewed vision that reconnects oral health to general health, that achieves better outcomes for our population, that is based in collaboration within the profession and beyond. He added: "It would be remiss not to acknowledge the dedication and commitment of local dentists to provide the best care possible to their patients – often in spite of difficult working conditions, including growing workforce pressures in the community dental service and what has become a very challenging financial context for GPs to provide health service dentistry. A strategic approach towards addressing these workforce realities will have to be factored into any new oral health policy process for it to succeed."

The Oral Health Matters summit in Belfast came in the wake of a statement by the Faculty of Dentistry in Dublin that the Irish Government's *Smile agus Sláinte* policy, published last April, was "fundamentally flawed". Dr John Marley, faculty dean at the Royal College of Surgeons Ireland, wrote to Simon Harris, Ireland's Minister for Health, reiterating its concerns about the policy. Dr Marley said it should be changed to provide for a mandatory system of continuing professional development for dentists, as well as introducing further specialist lists beyond the existing ones in orthodontics and oral surgery."

Dr Marley said the Department could not "simply race ahead" with the policy without putting in place the foundations needed to make it a success. "Enacting the legislative changes now to ensure that our dentists are sufficiently trained and educated must be the immediate priority for the Department. Unfortunately, we see no evidence of this promised legislative change being actioned."

At Stormont, however, there was an air of consensus. Not

on everything – including whether, fundamentally, there was a need for a new oral health strategy in Northern Ireland – but certainly on where new effort should be focussed; that is, on young people and the elderly. Simon Reid, the Chief Dental Officer (CDO), was nonetheless pressed by a delegate on the strategy. It had been raised earlier by one of Reid's fellow speakers; the fact that it dates from 2007. In response, the CDO questioned whether spending two years on writing a new strategy was a good use of scarce resources when there was already broad agreement on current priorities.

It had been a "significant piece of work," he said. However, the key principles – prevention, complimentary health promotion programmes, partnerships, and reducing inequalities – hadn't changed. The recommendations were still valid, and targets originally set had been met, said Reid. He did say that, regarding partnerships, there should be more "embedding" of oral health in wider public health. In addition, he recommended consideration of new targets. The outcome of this thinking, as Reid revealed at the summit, is the establishment of two 'oral health options' groups, focussing on the oral health of children and the elderly in Northern Ireland. Caroline Lappin, chair of BDA Northern Ireland's Council, said the announcement was "welcome news".

She added: "The pressing needs of the local dental workforce will have to be factored in if this work is to ultimately succeed. Our Community Dental Service is already unable to meet the existing demand for oral health care – while General Dental Practitioners are increasingly struggling to make health service dentistry a financially viable proposition. Whatever options are generated, additional investment to bolster oral health in Northern Ireland will be necessary. Going forward, improving oral health must be viewed as integral to embedding the prevention agenda, and delivering wider public health benefits to the population."

Oral health in Northern Ireland has, for many years, been considered the worst in the whole of the UK. Despite recognised progress, considerable challenges continue to be faced in 2019, not least affecting the youngest and oldest cohorts of the population. According to the latest Child Dental Health Survey, published in 2015, just 19% of 15 year olds here were considered to have 'good oral health'. In 2017/18 almost 5,000 (4,724) children faced tooth extraction under general anaesthetic in Northern Ireland (pro-rata, three times more than in England). BDA Northern Ireland has also highlighted the mounting pressures on dentists to meet the increased challenges from a growing ageing population that is increasingly retaining some natural teeth into old age.

In their presentations at the summit, Caroline Lappin and Dr Gerry McKenna, Specialist in Restorative Dentistry and Prosthodontics at Belfast HSC Trust, outlined the detail of





Roz McMullan, BDA, Simon Reid, CDO, Caroline Lappin, BDA Northern Ireland, Michael Donaldson, Health & Social Care Board

**ORAL HEALTH SUMMIT**



the scale of the problem facing Northern Ireland’s young and elderly populations. McKenna outlined the demographic trends leading to more people living to old age and their increasing life expectancy at that stage in life.

This age group is also keeping more of their teeth. But, he said, managing natural teeth in older people is challenging, with increased incidences of chronic dental disease. A 2019 Care Quality Commission report found the majority of care homes had no policy to promote and protect people’s oral health, almost half of homes did not provide staff training to support people’s daily oral healthcare, and 73% of residents’ care plans covered oral health partially or not at all.

McKenna outlined the National Institute for Health and Care Excellence guideline for improving the oral health of adults in care homes, a National Institute for Health Research-funded study designed to test the guideline, and the development of a ‘core outcome set’ specifically for older patients, supported by the BDA, in partnership with the Patient and Client Council, Age Sector Platform, Public Health England, and the Regulation and Quality Improvement Authority.

Caroline Lappin noted that she had been fortunate to study as a post-graduate under Aubrey Sheiham, Professor of Dental Public Health at University College London Medical School. “He was a man ahead of his time,” she said. In 2005, Professor Sheiham wrote: “The compartmentalisation involved in viewing the mouth separately from the rest of the body must cease.” She also highlighted the Faculty of Dental Surgery’s position statement, published this year, on how dentists could play a broader role in supporting their patients’ general health to deliver a “more holistic model of care”.

Lappin said there had been improvements in children’s oral health in recent years but, “sadly there is still a huge level of dental disease amongst children in Northern Ireland; the most recent survey, in 2013, revealing that obvious dental decay experience was present in the primary teeth of 40% of five year olds, rising to more than 70% by the age of 15. The Global Burden of Disease study from 2010 found that most disability amongst five to nine year olds in the UK was caused by poor oral health, and that it was the most common

reason for a child to be admitted to hospital. “This situation is almost entirely preventable,” added Lappin.

In the year 2017-18, 23,035 teeth were removed under general anaesthesia – of which 20,566 were baby teeth.

“My day job is working in the community dental service in the South Eastern Health and Social Care Trust. So, less than a mile down the road in the Ulster Hospital, you will find me on a Monday morning doing just this,” said Lappin, pointing to a photograph of a child under general anaesthetic surrounded by clinicians. “However, more worrying is the weekly occurrence for me and my colleagues in trusts across Northern Ireland who carry out these roles, that we are taking 12, 14 teeth out of one child on the list due to dental decay, which is an almost an entirely preventable disease.”

Lappin acknowledged the efforts of colleagues in the Department of Health and the Health and Social Care Board to reduce dental disease, through the ‘Happy Smiles’ programme for children and the fluoride varnish programme for children and the elderly. “Those projects ran extremely well last year,” she said, “unfortunately, in this financial year, the money was not available to continue the fluoride programme.” Lappin said there was a “clear need” to link oral health policy to over-arching health policy. She urged everyone in the room to confront this. “The case for change is clear, but we need support from each of you to bring it forward. We in the BDA are asking for a new vision for oral health care in Northern Ireland. Training more dentists, building more clinics is not realistic; it is also not the way forward. We in the BDA, along with colleagues in the Department of Health, the Board, the Public Health Agency, the regulators, our charity and third sectors, and our population; we need to work together to make change happen.

“Twenty years ago, the mantra was very much ‘prevention, prevention, prevention’. It’s still true today and even more relevant. Other regions have demonstrated that cost-effective and evidence-based programmes do work. However, we need commitment from professionals and the political will to make this happen.” Quoting from a 2019 Lancet report, Lappin concluded: “Preventing oral disease is important and achievable. Good oral health should be everybody’s business.”

# Painting a bright future

WORDS  
WILL  
PEAKIN

*In a first for Ireland, the Faculty of Dentistry is partnering with the three dental schools to host a post-primary careers day*

**I**n the context of the negative response to the Irish Government's new oral health policy, Smile agus Sláinte, promoting a career in dentistry might seem like a hard sell.

But the Faculty of Dentistry, of the Royal College of Surgeons in Ireland, FoDRCSI is determined to paint a bright picture for the profession's next generation.

In a first for Ireland, the Faculty is partnering with the island's three dental schools of Queens University Belfast, Trinity College Dublin and University College Cork to host a post-primary careers day at St Stephen's Green, Dublin, on 18 January.

The FoDRCSI is responsible for the accreditation of postgraduate dentists through examination, as well as providing postgraduate education to more than 2,000 members worldwide.

While the Royal College of Surgeons in Ireland (RCSI) does not have a dental school, the FoDRCSI recognises its responsibility for public engagement to attract and retain a new generation of dentists to manage the future needs of our patients in Ireland and beyond.

Consequently, the FoDRCSI sees this unique event as an extremely important opportunity to raise the awareness of dentistry both at undergraduate and postgraduate levels and is pitching it at transition year students, along with those in 5th and 6th year.

Dr John Marley, Dean of the Faculty of Dentistry, said the event's roots lay in a strategy meeting held when he took up the deanship, part of which recognised the real need to increase public engagement. “

“Although we are a postgraduate



organisation, it is these young people who will become the next generation of dentists and it makes sense to be involved at an early stage in the recruitment process and engage with enthusiastic young individuals.

“We want to present a positive view of the profession to this cohort of bright young people, bringing the Faculty and the dental schools together under one roof.”

Those students who travel to the FoDRCSI on the day can expect fantastic presentations by senior academic staff from each dental school, describing what's on offer if they study dentistry in Ireland.

In addition, there will be speakers from different sectors of dentistry along with undergraduate students and graduates to provide their experience of dentistry.

Following formal presentations, delegates will be able to meet the admissions teams from each dental school, along with student representatives.

There will also be interactive stations which will give students the opportunity to try their hand at some dentistry techniques and

ask questions of dentists who practise in various fields.

For those who cannot make it on the day, the organisers aim to stream the event on Facebook.

“Although this will not afford the opportunity to meet and question the dental teams [it] will, I hope, give a great flavour of what a career in dentistry is like,” said Dr Marley.

“It would be great if our dental colleagues could promote this event within their practices.”

Full details including registration information has been sent to all schools on the island of Ireland. For those who are interested, further details can be obtained by contacting the Faculty of Dentistry office: [facdentistry@rcsi.ie](mailto:facdentistry@rcsi.ie)

“

IT MAKES SENSE TO BE INVOLVED AT AN EARLY STAGE IN THE RECRUITMENT PROCESS AND ENGAGE WITH ENTHUSIASTIC YOUNG INDIVIDUALS”

DR JOHN MARLEY

# Disrupted

BY DIRECT-TO-CONSUMER ORTHO

British Orthodontic Society and Oral Health Foundation launch joint campaign at annual conference

BOC 2019: CAMPAIGN



Lord Winston explored how science may help us be happier

WORDS  
WILL  
PEAKIN

**B**etween a conference-eve dinner for keynote speakers at The Clydeside Distillery in Glasgow and a gala reception for delegates the following evening, there was plenty to absorb on the first day of the British Orthodontic Society's 2019 Conference this autumn.

Lord Winston, the IVF pioneer – and Professor of Science and Society and Emeritus Professor of Fertility Studies at Imperial College London – began proceedings by examining the role of brain imaging, hormone study, sexuality, child development, pharmacology, and psychological research in understanding how science may help us be happier.

It was a typically insightful and thought-provoking start to the three-day international gathering.

The conference featured, among others, Professor Greg Huang, who delivered the Northcroft Lecture (see *Ireland's Dental*, July 2019), in which he presented the results from an adult anterior open bite study conducted by the National Dental Practice-Based Research Network, and former MP Lembit Öpik, who joined Dr Michael

Millwaters, the oral and maxillofacial surgeon, to discuss his own orthognathic treatment and experience.

Dr Jay Bowman, the clinician and orthodontic device inventor from Michigan,

spoke about improving the predictability of clear aligners and treatments involving the use of mini-screw anchorage.

It was Dr Bowman who led the presentation of what the British Orthodontic Society (BOS) intends to be a campaign engaging the wider dental profession and, ultimately, the public. At the conference, the BOS and the Oral Health Foundation announced their plans for a national campaign to warn patients about potential risks of direct to consumer orthodontics, also known as DIY orthodontics.

The joint campaign, supported by a dedicated website launching in December, will advise patients in all circumstances to visit a trained clinician ensuring that they have the various options open to them explained so they can make an informed decision. The campaign comes as statistics from BOS reveal adult orthodontics continues to rise with three quarters (75 per cent) of orthodontists reporting an increase in adult private patients.

The BOS leadership said it was delighted to announce their partnership with the Oral Health Foundation. Both organisations provide patients with expert information that relates to their oral, orthodontic and overall health. By bringing the expertise of the two organisations together on this issue it will empower patients to make the right choices, they said.

"In my professional opinion," said Jonathan Sandler, BOS President, "if you embark on any orthodontic treatment without a suitably trained clinician taking the time to examine you and make appropriate recommendations, you could be in danger of having serious conditions missed, as well as inappropriate and dangerous treatment carried out.

"For me, one of the issues with 'DIY orthodontics' is that it offers just one narrow solution when there may be a more appropriate one for the patient. The value of informed choice cannot be over-estimated." Dr Nigel

Delegates being piped across the Clyde to the conference's gala reception





Carter, Chief Executive of the Oral Health Foundation, added: “As the demand for adult orthodontics increases, so do the options for patients. We are seeing a growth in online companies offering orthodontic treatments at significantly reduced prices. For many patients, it will feel like a sensible consumer-savvy choice. But this may not be the case.

“My clinical view is that orthodontics should always involve face-to-face contact with a trained clinical professional. This is to ensure patient safety and the most effective treatment. When carried out correctly, orthodontic treatment can give patients the straight and confident smile they have always dreamed about.

“We want to make sure that patients are given the very best advice about the safest and most effective way to have orthodontic treatment. This new campaign will make sure patients have a trusted space where they can see the most independent and impartial information available.”

The American Association of Orthodontics’ long-held position mirrors that of the BOS and the Oral Health Foundation. It states that orthodontic treatment is a complex medical process and that it is in the best, and safest, interest of the public to have that treatment conducted under the direct and ongoing supervision of a licensed orthodontist.

At BOC 2019, Dr Bowman briefed the media on the prevalence of DIY orthodontics in the US. He said: “I share many of the same concerns about direct-to-consumer treatments as have been voiced by the American Association of Orthodontists, the American Dental Association, and many US state dental boards and legislators.”

Dr Bowman added: “It is my opinion that comprehensive diagnostic records and an in-person examination should be performed prior to embarking upon treatment. I am also not convinced that orthodontic



## **ASK YOURSELF, WHAT OTHER TRANSFORMING DENTAL OR MEDICAL TREATMENT WOULD YOU UNDERGO WITHOUT AN IN-PERSON EVALUATION OR SUPERVISION BY A MEDICAL PROFESSIONAL?”**

**DR JAY BOWMAN**

progress follow-up and resolution of patient concerns can be handled only by so-called teledentistry.

“In other words, ask yourself, what other transforming dental or medical treatment would you undergo without an in-person evaluation or supervision by a medical professional?”

The BOS and the Oral Health Foundation will jointly develop the website aimed at anyone seeking information about orthodontic treatment. The site will be updated regularly and will be designed to be engaging and informative, said the organisations. It will include testimonials from various experts alongside patients who will talk about their experiences to “bring the issues to life,” said a spokesperson.

In addition to the campaign, the BOS is exploring regulatory options and it said it hopes that the appropriate bodies will take a “patient safety-led approach” to decision-making.

# Plagiarism

## AND HOW TO AVOID BEING *accused*

*A GDC FTP case involving five dentists has highlighted an issue regarding audits and significant event analysis*

**D**ental Protection has occasionally come across a request for advice from a member regarding whether or not an article or other piece of written work can be used as part of a postgraduate thesis or dissertation. Recent activity in suggests that it is vitally important to understand what constitutes plagiarism and what steps are taken by universities and other organisations to detect it.

A recent General Dental Council (GDC) fitness to practise case saw five dentists found to be dishonest, and they were subsequently suspended from the dental register for varying periods of time after sharing their own or copying another individual's Significant Event Analysis Reports (SEAs). We also know of other dentists who are receiving letters from their health board asking questions about their audit reports and SEAs which they submitted a number of years ago.

There is no doubt that plagiarism is considered to be a dishonest conduct and one to be avoided.

### What is plagiarism?

Plagiarism is defined by the Online Oxford Dictionaries as "the practice of taking someone else's work or ideas and passing them off as one's own". It is considered a very serious matter and further research reveals that "to plagiarise" means:

- to steal and pass off (the ideas or words of another) as one's own
- to use (another's production) without crediting the source
- to commit literary theft
- to present as new and original an idea or product derived from an existing source.

In other words, plagiarism is an act of fraud. It involves both stealing someone else's work and lying about it afterward.

The University of Glasgow states: "The incorporation of material without formal and proper acknowledgment (even with no deliberate attempt to cheat) can constitute plagiarism. Work may be considered to be plagiarised if it consists of: a direct quotation; a close paraphrase; an unacknowledged summary of a source; direct copying or transcription."

In academia, universities use anti-plagiarism software

to check the students' coursework to determine if the coursework truly belongs to them. Academics regard plagiarism as dishonest and fraudulent and it can result in the ending of someone's career. Although plagiarism is a clear danger to anyone's reputation and regarded as dishonest, some dentists are failing to understand the seriousness of the issue – in the UK, for example, NHS Education for Scotland (NES) makes thorough checks on works submitted to fulfil the QI requirements of the Terms of Service for dentists working in the NHS. The same anti-plagiarism software that has been used by universities for some years has recently been used by NES to check the validity of QI project reports and SEAs being submitted via the portal.

### Students and teachers

The most common form of plagiarism is using another's words or work without appropriate referencing. However, what readers might not be aware of is that in the case of co-authored work, if one of the authors has plagiarised any of the chapters or sections, both authors of the document will be considered to have acted dishonestly and could be accused of plagiarism.

For academic staff trying to prevent plagiarism, there are a variety of resources now available online to check the content of submitted work, which means that the chances of being discovered, if tempted, are high.

Students are not exempt from a GDC Fitness to Practise hearing. In October 2016, the GDC produced

WORDS  
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### Helen Kanney BDS LLB Dip LP MBA FFGDP (UK) FFLM

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 matters 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.





two new guidance documents on this topic – one for student dental professionals, which applies to all student dental care professionals and not just to dental students.

The other guidance document produced is aimed at all providers delivering training programmes which lead to registration with the GDC. This latter guidance provides help for academic institutions in running fitness to practise hearings against students, the most serious sanction following such a hearing being expulsion from the course, depending on the severity of the offence.

Plagiarism is included in the list of issues which could indicate that a student's fitness to practise may be impaired and may be considered as a threshold matter for implementation of an institution's fitness to practise procedures.

### Academic staff

For academic staff tempted to take short cuts, the message is: please don't. While there may be readily available guidance for students on the subject, regulations for academic staff apply on an institution by institution basis. The concept of peer review before submission of papers to journals is intended to highlight and prevent the problem, although this may not necessarily be completely effective.

The risks to academic staff tempted to take shortcuts are loss of professional credibility and indeed loss of employment. Plagiarism is not a crime as we understand that word in common parlance. Instead it is a civil law matter. However, that does not prevent the General Medical Council (GMC) or General Dental Council (GDC) from bringing charges of plagiarism or dishonesty against a clinician.

### Dentists, clinical audit, SAEs and dishonesty

Dentists, in some parts of the UK, on a health board dental list are required to do at least 15 hours of QI activity during each three-year period. Several dentists have recently contacted Dental Protection for advice in relation to concerns raised about the sharing of clinical audits and final audit reports with other clinicians. In some cases, the sharing of the audits has resulted in other dentists claiming the audits as their own work. Such a situation can, as explained above, result in allegations of dishonest conduct against all parties.

It is important to understand that any allegation that a dental registrant has acted in a way that would be considered to be misleading or dishonest is taken very seriously by the GDC. The recent case of Ivey v Genting Casinos (UK) Ltd has changed the legal test for dishonesty that is applicable before the regulators. In this case, the UK Supreme Court confirmed that the previously used two-stage 'Ghosh' test is no longer applicable. The Ghosh test had both an objective and a subjective part to the two-stage test, which the courts and regulators used when considering whether conduct was dishonest. The Ivey case arguably makes it easier for dishonesty to be established as "it will no longer be necessary to prove that a professional subjectively understood that he or she was acting dishonestly".

### Regulatory bodies – GMC and GDC

In 2008, a well-known UK psychiatrist admitted inadvertent plagiarism in a hearing before the

GMC, resulting in a three-month suspension and his resignation as an NHS consultant. The individual concerned apparently explained at the time that a 'copy and paste error' meant that references had not been included in his work. That is how easily plagiarism can happen.

All students and members of the dental team are aware of the GDC's Standards for the Dental Team. Principal nine sets out the guiding principle that would cover an allegation of plagiarism, particularly the requirement that registrants should "ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession".

### Summary

Plagiarism poses a great risk to a clinician's career and professional reputation. It is essential to make sure that all work submitted, whatever the type and in whatever capacity, is your own and properly referenced. Not even one sentence should be copied from another person's work without the required references. In sharing your work with others, you are taking a risk that some of your exact wording will be used, which also carries the risk of an allegation of dishonest conduct.



**IT IS ESSENTIAL TO MAKE SURE THAT ALL WORK SUBMITTED, WHATEVER THE TYPE AND IN WHATEVER CAPACITY, IS YOUR OWN AND PROPERLY REFERENCED"**

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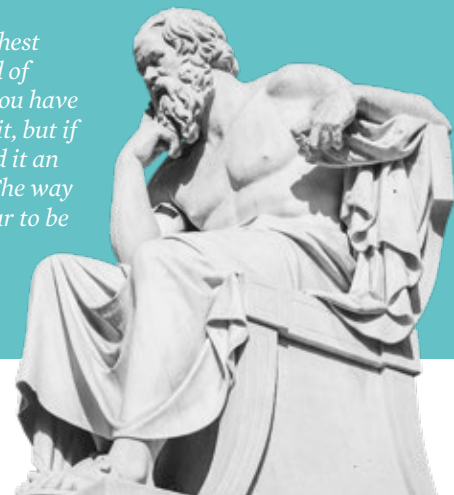
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*"Regard your good name as the richest jewel you can possibly be possessed of – for credit is like fire; when once you have kindled it you may easily preserve it, but if you once extinguish it, you will find it an arduous task to rekindle it again. The way to a good reputation is to endeavour to be what you desire to appear."*

Socrates



# Pivotal learning experience

## From initial examination to maintenance and recall

Robbie McLeish, BDS (Glas)

### Introduction

My vocational training year served as an excellent opportunity for honing my clinical, communication and team working skills, as well as providing my first real insight and experience of working in a system that sometimes presents challenges to providing the best available care. The case I am about to recall was by far the most memorable and rewarding one that I've had the opportunity to work on in my, currently, short career spent in general practice.

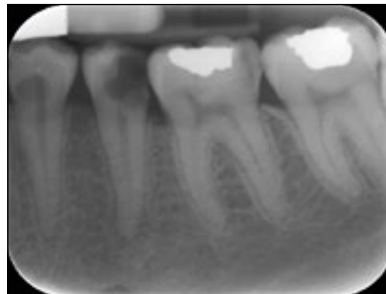
### Background and reasons for selecting the case

As a newly qualified and fresh-faced dentist, this patient presented early in my vocational training year and had struck a certain resonance with me, as they had attended university during the same time period as myself, having also moved there from a small town. As well as this they presented with one of the worst maintained dentitions – particularly for their age – I had seen, which would require a multidisciplinary approach to restore. For these reasons, I thought this patient would be an excellent example to discuss for my vocational training year case presentation, as well as providing an insight into what could be achieved and the limitations of supplying dental treatment on the NHS.

### Presenting complaint and examination

The 23-year-old male presented in August 2018 for an emergency appointment as a new patient to the practice. His chief complaint was of pain from a tooth on the lower left. Pain had developed two weeks prior, occurred when food or the tongue was pushed into the tooth, no spontaneous pain, no associated tenderness to pressure and resulted in no disturbance of sleep. Medically, he suffered from migraines; taking Pizotifen and Sumatriptan when required. He was otherwise fit and well and a non-smoker. Clinical and radiographic (*Figure 1*) examination revealed tooth 35 had deep caries in close proximity to the pulp with no associated peri-radicular pathology. A diagnosis of caries and reversible pulpitis was established, gross caries were hand-excavated and a Kalzinol dressing was placed, with a plan for the patient to return for a full examination and appropriate special investigations.

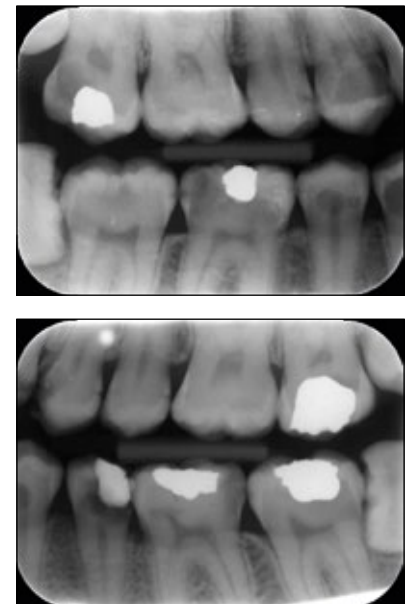
Figure 1



He returned several weeks later – with pain from 35 having settled – when a full examination, bitewings, anterior periapicals (*Figure 2*), clinical photography (*Figure 3*), sensibility testing and plaque and gingival indices were completed, giving the following findings:

- Fully dentate with mesially impacted 38 and 48
- Gross caries, affecting all teeth with the exception of 31, 41, 42
- All teeth positive to ethyl chloride sensibility testing
- Generalised plaque deposits and bleeding on probing; Bleeding Score: 100% Plaque Score: 76%
- BPE: 1, 2, 3 / 1, 2, 3
- Class 3 edge to edge incisal relation with moderate lower arch crowding and 12 and 22 in crossbite

Figure 2





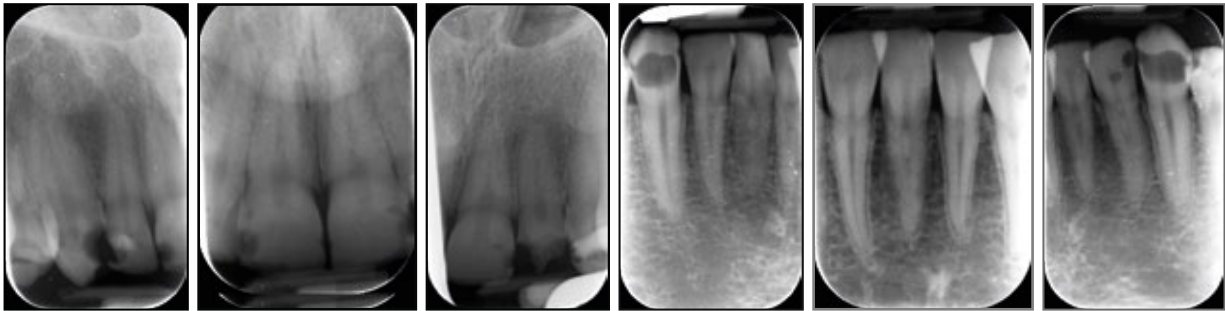


Figure 3: pre-operative



The dental and social history revealed that during his five years spent at university the patient almost never brushed his teeth and consumed one-to-two litres of full sugar carbonated drinks per day. Since moving back home and starting work in the family business, his reported hygiene and diet habits had improved, brushing usually once daily and drinking less than one litre of fizzy drinks per day. From all these findings, diagnoses were established and a treatment plan was formulated.





These findings lead to the following diagnoses:

- Caries: 18 - 11, 21 - 28, 38 - 32 43 - 48
- Generalised gingivitis
- Generalised chronic periodontitis (Stage I, Grade A, currently unstable, no risk factors)

**Treatment options discussed and plan agreed**

Clinical and radiographic examination showed that all teeth – excluding the 8s – were restorable, although some to a greater degree than others. Because of this we agreed upon a restorative approach including surgical removal of all 8s under a general anaesthetic. The general anaesthetic was chosen by the patient to minimise time off work. The plan included:

- Oral hygiene instruction and diet advice
- Periodontal Treatment: Supra and subgingival scaling
- Caries Management: 17 - 11, 21 - 27, 37 - 32, 43 - 47
- Root Canal Treatment: 12, 13, 22, 33, 35, 43, 44
- Cast Post/core: 22
- Metal Ceramic Crowns: 22, 24, 35, 12, 13

On discussion with the patient, it was decided all treatment would be provided on the NHS and the plan was submitted for prior approval. All anterior and buccal lesions were to be restored with composite resin, but with the option of using a resin modified glass ionomer should moisture control not be amenable to composite placement. The root canal treatments were charted on teeth where caries removal was likely to result in pulpal exposure and/or loss of vitality. The crowns were charted with the plan to use direct restorations if there was sufficient tooth tissue remaining after caries removal.

This being the first large case I had ever sent for prior approval, it served as

a steep learning curve in understanding the inner workings of the SDR and prior approval system, made even steeper by the change to a computerised approval system midway through. Because of this change and the extensive nature of the treatment plan, the time between initial submission and first approval was around four months.

**Treatment carried out**

The first phase of treatment included caries management, periodontal treatment, and oral hygiene and diet advice. The latter was also covered at the examination appointment and a marked improvement in gingival health and plaque control could be noted on the patient's return for treatment. Caries management represented the bulk of the treatment required, this included: the use of glass ionomer as an intermediate restoration in multiple buccal lesions where composite wasn't viable as an immediate restorative material, two pulpal exposures on teeth 24 and 46 – both rinsed with chlorohexidine and dressed with direct pulp caps of calcium hydroxide and resin modified glass ionomer cores – and most notably, no teeth showing indication for root canal treatment.

Once caries management was complete and all intermediate glass ionomer restorations were changed for composites, the treatment plan was reassessed. Ethyl chloride sensibility testing was repeated on teeth that had been approved for pre-emptive root canal treatments; all of which were found to be positive. From this the following changes were made to the treatment plan and re-approval was applied for:

- All RCTs and 22 cast post/core were removed
- 46 amalgam restoration changes to a metal shell crown due to more extensive caries than anticipated
- 12 and 13 metal ceramic crowns were changes to direct composite restorations

- 47mo amalgam changed to 47mob amalgam
- 27do amalgam changed to 26dob amalgam

Then began phase two of the treatment, which included crown preparation and cementation for teeth: 22, 24, 35, and 46. For 24 and 46, after pulpal exposures, there was three month waiting period to ensure neither became symptomatic or non-vital.

The final phase of treatment included periodontal re-evaluation, clinical photographs (*Figure 4*) and consideration of long-term maintenance. Post-treatment plaque and gingival indices showed a plaque score of 24% and bleeding of 35%, with only one pocket greater than 4mm in the six-point pocket chart. The patient showed great motivation from the start which made for ideal conditions for placement of composite restorations close to the gingival margin at the caries management phase. His motivation wavered past this initial phase; however, the need for long term maintenance was enforced throughout the treatment. This resulted in a marked improvement which can be observed in the final clinical photographs. There were still some areas of marginal gingival inflammation that can be noted; this was partly due to some rough eqi-gingival restoration margins that were corrected. The patient's fizzy drink consumption had also dropped dramatically, reporting only drinking two glasses per week, having changed to mostly water. He was placed on a three-month recall interval to ensure periodontal health was being maintained, with the plan of being moved to a six-month recall once stable.

**Benefits to the patient**

The patient noted a considerable aesthetic improvement to his smile as well as a functional benefit, feeling

Figure 4: Post-operative





confident to eat without risk of damage to decayed teeth. He also described feeling less lethargic with much more energy since cutting down his high sugar diet, as well as a cleaner feeling mouth through brushing two times per day and use of interdental brushes almost every day.

### Conclusions and learning from the case

This case proved to be an invaluable learning experience for me, both in improving my clinical skills, as well as gaining a more complete understanding of providing dental care within NHS Scotland.

The latter included learning to work within the SDR, the prior approval process and the limitations of treatment that can be provided on the NHS. It was also very rewarding to see the patient's change in attitude to oral hygiene have a positive effect on his life as a whole, not just limited to the mouth.

It helped me realise the importance of treating every patient with a holistic approach, to ensure they can achieve the maximum benefit from the treatment you provide.

There were some areas that on reflection of the case could have been improved upon. I feel these can be broken down quite well into limitations of my own ability/knowledge and limitations of treatment provided on the NHS.

#### Limitations of my own treatment:

- Upper left posterior periapical more appropriate radiograph than left bitewing
- 35 shade not great match; patient not concerned or interested in remake



- Periodontal health; ultimately patient driven but hoped to see better resolution by end of treatment
- Consider veneer technique for more seamless margins on anterior composites
- A longer waiting period of six to twelve months may have been more appropriate before reassessing vitality of 24 and 46 pulp exposure and placing crowns.

#### Limitations of NHS:

- Direct composite less destructive method than metal shell crown for 46
- Four months wait between applying for prior approval and it being passed
- Intermediate glass ionomer restorations not financially feasible if working as an associate

- Large anterior direct composite restorations time consuming and not remunerated well; likely to result in placement of crowns when less destructive option available.

Overall, I thoroughly enjoyed working on this case and found it a pivotal learning experience in my vocational training year, showing what could be achieved on the NHS and that my initial scepticism wasn't completely founded.

It was also rewarding to be able to see the treatment all the way through, from initial examination to maintenance and recall; giving the opportunity to thoroughly reflect on the treatment as a whole, a luxury not always afforded at an undergraduate level.



ADVANCED DENTAL AESTHETICS  
DENTAL LABORATORY

# ADVANCED DENTAL AESTHETICS AND THE FAIRYTALE OF 3D PRINTING

**T**he world is changing faster than ever, fuelled by rapid technological advances. One of the most dynamic fields is 3D printing. NextDent by 3D Systems is leading in this exciting new 3D printing innovation, for dental technology and dental care industries.

We are thrilled to work with a company like 3D systems and their 3D Printer, which is currently setting the standard in 3D printing in terms of speed and accuracy.

## EXPERIENCE YOU CAN COUNT ON

3D Systems has leveraged its 30 years of 3D printing experience in for the development of a number of dental 3D printers that offer high precision and detail resolution. They are used for the processing of different dental materials, from metal (CoCrMo alloy) to biocompatible resins. Our dental solutions are designed for use in dental laboratories, making production methods faster, easier and more effective. This complete solution represents industry-defining materials and print innovation, dental domain expertise, and regulatory compliance in all major markets to revolutionise the workflow.

## CERTIFIED AND BIOCOMPATIBLE MATERIALS

Combined with a portfolio of 30 unique NextDent biocompatible materials – the largest number available from any material supplier – the NextDent 5100 addresses multiple dental applications. These materials are offered in a variety of aesthetic colours to closely match patients' teeth and gums. All NextDent materials are biocompatible and CE-certified, FDA listed and classified in accordance with the international medical device regulations.

## TRUSTED END-TO-END WORKFLOW

Fully compatible with industry-standard intra-oral scanning and software solutions, the NextDent 5100 3D printer delivers precise results every single time with minimal human intervention. Combined with other 3D Systems dental solution components it creates a comprehensive and trusted workflow. This includes the NextDent LC-3DMixer for optimal stirring of materials, and the NextDent LC-3DPrint Box for UV post-curing. This makes it the only system on the market to have a complete fully validated workflow from start to finish.

## BENEFITS

- Part of a complete workflow with NextDent biocompatible materials, 3D Sprint software and post-processing
- Accuracy, repeatability, unmatched productivity and low total cost of operations
- Flexibility to address multiple indications with range of NextDent biocompatible materials
- This complete solution represents industry-defining materials and print innovation, dental domain expertise, and regulatory compliance in all major markets to revolutionise the workflow.

## APPLICATIONS

- Complete digital dentistry solution for a range of 30 biocompatible materials
- Orthodontic models
- Crown and bridge models
- Long-term temporaries (provisionals)
- Pressable wax restorations
- Surgical guides
- Splints/night guards
- Try-In dentures
- Long-term dentures.



The more digital things become, and the more 3D printing becomes more mainstream, Advanced Dental Aesthetics offers all the expertise the clinicians or other dental labs need to move forward confidently into this fast-developing field.

Our dental laboratory has a reputation for excellence based on experience, expertise and innovation. We provide products to dentists across Ireland and the UK and pride ourselves in putting our clients and their patients' requirements first with full traceability from start to finish. ADA uses cutting-edge technology to ensure we continue to offer the highest-quality dental restorations which also includes 3D printing.

If you'd like to learn more about how our services can help improve your business, get in touch today: [www.adadentallab.ie](http://www.adadentallab.ie)  
Call 0871498809 or email us at [info@adadentallab.ie](mailto:info@adadentallab.ie)



# CHALLENGES RAISED BY RISE OF TELEDENTISTRY

## THE ANNOUNCEMENT THAT THE

“teledentistry pioneer”, SmileDirectClub, is opening ‘SmileShops’ in locations in the UK and Ireland cannot have by passed any thinking dentist.

A slick, well-written press release made it easy for sub-editors to cut and paste. The tone and content shifts the focus from those boring places where people can obtain specialised dental advice and treatment; commonly known as dental practices. That these businesses comply with regulations and educational standards is neither here nor there.

The release states that SmileDirectClub’s mission is “to democratise access to safe, affordable and convenient teeth straightening solutions through doctor-directed remote clear aligner therapy”.

“We believe everyone deserves a smile they love,” says Alex Fenkell, co-founder of SmileDirectClub. Of course every dental health professional has been struggling for years wondering how they should help their patients.

The evangelising feel continues: “Our mission is to help people unleash the power of their smile and positively impact their place in the world. The confidence that comes from having a great smile is transformative to every aspect of your life. The time is right to expand our mission to the UK to give more Britons the confidence that comes from a straighter, brighter smile.”

So, another company helping the dentally challenged

general public to get just the treatment they need to improve their appearance on Instagram...and all for just £1499...

*“...licensed dentists and orthodontists customise each patient’s treatment plan and manage their patients’ care from initial diagnosis through [to] the conclusion of treatment, monitoring care along the way with remote check-ins every 90 days to allow patients to avoid the hassle of scheduling frequent visits to a doctor’s office...”*

Heaven forbid that people might have to visit a trained and registered dentist to ensure no harm was being done.

## WHAT SHOULD YOU DO IN THE FACE OF THIS CHALLENGE?

**Be aware.** This is a logical extension of the spread of aligner therapy which has removed the near monopoly for “tooth straightening” from control of specialists and into general practice. If you have a practice which depends upon a regular throughput of aligner patients not only for jam, but also bread and butter, then be prepared to fight back. Take a long hard look at your marketing and ensure that you are perceived as an expert, who is going to be around in another decade, is experienced and can offer a broad range of skills.

**Focus on relationships.** SmileDirect appeals to transactional customers. Success in dentistry, as in all good businesses, is built on relationships. Ensure that you understand the difference between the two.

Transactional patients are primarily interested in price; if they can find something cheaper, they will move. They exhibit little or no loyalty, and believe that the internet or a catalogue will give them all the information they need. Easy marketing hits appeal to them.

They provide little profit, so be prepared to pile high and sell cheaply if you go into this market. Always seeking a deal, they will watch your business go bust because you weren’t cheap enough.

Relationship patients seek trust, they become lifetime patients and supporters. They want the familiar and the reliable in people and products. They will pay more because they value the relationship, they find it emotionally tiring to shop around. Long and medium term they are highly profitable and are the core of a professional business.

[ WORDS: ALUN K REES ]

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](http://www.thedentalbusinesscoach.com)





**Know your patients.** Those three little words are the difference between success and failure, and between happiness and misery in dentistry. Ensure that they wouldn't dream of going anywhere else by knowing not only what they need but also what they want. The market has changed profoundly – if it hadn't, we wouldn't be talking about SmileDirect. For generations dentists

“

**HEAVEN FORBID THAT PEOPLE MIGHT HAVE TO VISIT A TRAINED AND REGISTERED DENTIST TO ENSURE NO HARM WAS BEING DONE”**

reacted to disease. Bad tooth? Fill or remove. Too many gaps? Fill the spaces. Over a generation we have become more proactive. Dentists and their teams help their patients to keep their teeth, to maintain them and to have greater expectations. By raising our patients' 'dental IQ' we encourage them to have and to share their aspirations.

It can be very easy to presume what your patient wants; like any relationship it needs work.

**Know yourself.** The phrase “low hanging fruit” when applied to business means those goals that are easier to achieve than others. However, it has been used to encourage dentists to get involved in ‘easy sales’. It doesn't necessarily apply to treatments that are relatively expensive but can be very profitable.

Quality of care cannot be measured on a spreadsheet and most dentists, no matter how closely they watch their Key Performance Indicators, will always want to be able to look themselves in the mirror at the end of the day.

# FEEL 'STUCK' AND DON'T KNOW WHAT TO DO? HAVE NO-ONE TO DISCUSS CHALLENGES WITH?



*Should you use a business consultant at your practice? If you decide to, here are some suggestions on how to get real benefit*

[WORDS: RICHARD PEARCE]

“  
**BUSINESS CONSULTANCY IN DENTISTRY IS COMMONPLACE, BUT LIKE ALL THE SERVICES YOU BUY, HAVE A CLEAR IDEA OF THE OUTCOMES YOU ARE AIMING FOR AND IN WHAT TIMEFRAME”**

## **IT HAS OFTEN BEEN SAID THAT**

management consultants just use your watch, to tell you the time and then charge you for the privilege! There may be some truth in this so, therefore, the buyer – i.e. practice owner – needs to be clear on the short/long term benefits which they want from any consultancy engagement.

This article will look at the history of consulting, the position of management consultants in business generally, consultants in dentistry and how you as an owner might work with a consultant.

Management consultancy really began in the late 19th century as an interest in the process of management developed. It slowly developed with industrialisation and really expanded in the 1960s and 70s as larger companies looked for process improvements and to quickly get an outside perspective from consultants who had global exposure to the problems which they faced. Today, it is a multi-billion-pound industry, so you are definitely not alone when you hire a consultant!

It was only as dental practices began to increase in size and complexity and owners realised the need to market their services, that a very few individuals noticed an opportunity to provide advice. Historically, the main source of advice for a practice owner was their accountant. If the accountant had a few dental clients they could quite easily compare these practices,



by looking at the Profit & Loss statements they were creating and extract some useful benchmarks. Notably on costs – accountants haven't picked up the slightly derogatory moniker as 'bean counters', for nothing!

Clearly, the practice owner should ensure that their accountant provides the desired level of commentary on the performance of their business in a timely way, but furthermore advises on the funding (for growth), tax planning, compliance and exiting (selling) assistance, that is also needed. So, why seek the services of a dental business consultant? The reasons will probably fall into the following categories:

- Want to grow (want more profitability) but not sure how
- Feel 'stuck' and don't know what to do
- Feel lonely/have no-one to discuss the challenges with, within the practice
- Have a 'difficult' manager who is an obstacle to development but don't know what to do about it (and so want someone to help 'remove' them without contravening employment law).

If any of the above apply to you, or even if you have a different reason, try to write down what you want a consultant to help you achieve and how long you think it might take. Ideally, make your objectives SMART (Specific, Measurable, Achievable, Realistic, Time-bound). So often, a consultant engagement becomes open-ended and the initial objectives get forgotten and never

referred to. You should be very clear on the costs involved and how long the engagement will last. There are dental practice owners paying many thousands of euros a month for a consultant's input yet the amount of time they work 'for you' can be hugely variable. Duration-wise, it's difficult to make real change in less than a year, three years should be more than enough time to make fundamental changes.

Some owners become totally dependent on their consultant and they assume every word they utter or write is business 'gold'! Unfortunately, not every initiative they suggest will be right for you or will work in the context of your practice. It is possible that the implementation may not deliver as expected; perhaps a key staff member (who is part of the implementation) might leave, or you might not invest appropriately.

It always surprises me that an owner doesn't ask for a six-month or a one-year 'break' in the consultancy engagement while they consolidate. It is natural, if a consultant is paid by the month that they will keep pushing the pace. It is very easy for them to keep suggesting/insisting what needs to happen next, because they feel they are justifying their fee. Often what is needed is stability, consolidation and consistent growth. Take control and say what you believe is right for you.

When meeting your consultant, put aside the appropriate time: have the meeting at

an appropriate location and don't let it be shortened/interrupted. This is a constant bugbear for business consultants and can be an indicator of the importance you attribute to business development. (Once, I was in a client meeting in an office which was too small for two staff and yet there were four of us in there! Seriously, go to Starbucks or pay the £100-£200 for a hotel meeting room, for the morning/day.

Business consultancy in dentistry is now commonplace, but like all the services you buy, you should have a clear idea of the outcomes you are aiming for and in what timeframe. Every business situation is unique, but it can be useful to look at trends and developments across the industry: ultimately the right course of action for your practice can only be decided by you.

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](http://www.smartpractices.co.uk)





Development on site of a former toy shop in New Street was completed in June this year

# BACK HOME TO KILLARNEY

After 25 years of successful practice in the UK, periodontist and implantologist Tomas Allen has returned to Ireland – to open Kingdom Clinic

**P**eriodontist and dental implantologist Tomas Allen has returned to Ireland after 25 years in the United Kingdom to open an ultra-modern, high-tech dental referral practice in Killarney.

Kingdom Clinic is a specialist clinic accepting referrals for implantology, periodontology, oral surgery, and dental sedation. Tomas said the aim of the clinic was to be a reliable referral partner to local clinicians. "We will only provide the treatment prescribed by our referrers and all patients will be returned once this work has been completed," he said. "We will not be operating as a general dental practice"

The 4000sq ft premises were completely

redesigned and rebuilt internally to accommodate five modern surgeries, cone beam CT scanning suite, two waiting rooms, and a conference room – all fully air-conditioned throughout. "Our aim is to provide an excellent level of service to referring clinicians and to positively change patients' view of dentistry – though the clinic's design, the quality and training of the staff, and the significant investment in technology," said Tomas.

The brief given to specialist dental architect Farahbod Nakhaei, of Glasgow-based NVDC, was to create a 'feel-good', non-dental environment for patients. Farahbod has achieved this through extensive use of glass, clean lines, and

Tomas has recently enrolled on a mastership in laser dentistry programme

wide corridors. The surgeries are designed so that no equipment is on show (apart from the chair) and patients are distracted by centrally controlled relaxing music and calming landscape visuals on widescreen monitors. Additionally, the surgeries have 'virtual ceilings' by Newry-based LED Sky Ceilings.

"It has been a significant expense," said Tomas, "but I am confident it will reap rewards in the long term. It makes for a very nice working environment for the staff and the initial response from patients has been very encouraging!

"We offer appointments from 7am to 7pm and we do not close for lunch. The main reception area is designed to





resemble a small hotel lobby, with minimal references to dentistry. There is a second large waiting area on the first floor, with floor to ceiling glazing and a large screen TV only playing relaxing landscape images.

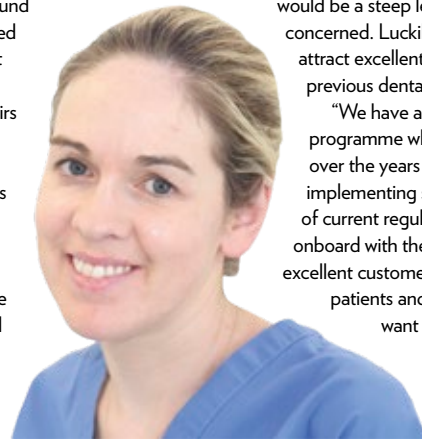
“The public areas are all furnished with sofas and chairs from a hotel furniture specialist and are all disability access compliant without appearing clinical. The walls are decorated with high quality artwork and photography depicting images from the local area. Even the toilet walls have large scale HD vinyl wraps of Kerry scenery!”

Built in 2001, the building had a sound structure, but the internal layout was suited to retail rather than dentistry. The biggest construction expense was to remove the original, poorly located, cast-concrete stairs and install a new concrete stairwell, spanning three floors. With the work led by main contractor, Milltown-based Evans & Kelliher, this created a lot more space and made all the floors regulatory compliant.

“Ike and Bev at DentalSaver (UK) were a great help,” said Tomas. “They provided us with, and installed, most of the dental equipment, including five Belmont Clesta chairs. They have a very

(Left) Surgeries are designed so that no equipment is on show, apart from the chair, and patients are distracted by calming visuals

(Below) Specialist oral surgeon Dr Norma O’Connor



streamlined service, from advice on purchases, liaising with our architect and building contractors to installation and testing of equipment. Ike, being a former dentist, was able to foresee some issues with the design and layout meaning expensive alterations were avoided. I would certainly recommend their services.”

It didn’t take too long to settle into their new surroundings. “We were new to the area with a newly created clinic which had a lot of new systems,” said Tomas. “Into this mix we had to add new staff. We knew that there would be a steep learning curve for all concerned. Luckily, we have managed to attract excellent staff, all of which have previous dental experience.

“We have an in-house training programme which we have developed over the years and we are now implementing so that all staff are aware of current regulations but are also be onboard with the practice ethos of excellent customer service and care of patients and referring colleagues. We want to be a strong partner.”

The team at Kingdom includes specialist oral surgeon Dr Norma



## LED Sky Ceilings for Dental Surgeries



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(Left)  
The main reception area resembles a boutique hotel lobby

(Below)  
Dental sedationist Dr Margaret O'Connor

O'Connor, who has held the position of oral surgeon in hospitals in Ireland and the UK, including consultant in oral surgery at the Edinburgh Dental Institute. Her qualifications include a master's degree in oral surgery, membership of the Royal College of Surgeons and she is a Fellow of the Royal College of Surgeons. Norma provides a full range of oral surgery services including tooth/root removal, diagnosis and management of oral soft tissue problems, jaw joint pain, facial pains, and dental implant therapy. Dental sedationist Dr Margaret

O'Connor has 19 years' experience of working in general dentistry. She has a keen interest in treating nervous patients and has worked in the dental sedation department at King's College London, where she gained a Postgraduate Diploma in Dental Sedation. Margaret has also passed membership examinations to both the Faculty of Dental Surgery at the Royal College of Surgeons in England and Faculty of Dental Surgery at the Royal College of Surgeons in Edinburgh. She has also undertaken extensive



postgraduate study in the field of facial aesthetics. As per the practice ethos, Margaret wishes to reassure referring clinicians that her practice is limited to sedation dentistry and all her patients will be returned to the referring dentists after the prescribed treatment has been completed.

Tomas has a BDS degree (with honours) from University College Cork and a master's degree in Clinical Periodontology (with distinction) from Queen Mary University of London. He has qualifications from the Faculty of Dental Surgery at the Royal College of Surgeons in England and completed a diploma in Dental Implantology, organised by Perio-Implant Europe at the FAPI Dental Institute in Brazil and the University of Paris V.

He has recently enrolled on a mastership in laser dentistry programme, to fully explore the benefits of this exciting new field of dentistry. Tomas has a special interest in the new and exciting fields of digital dentistry because of the benefits it brings to the outcome of dental implant therapy.

"We expect our practice to have a wide catchment area, including Kerry and the border regions of the surrounding counties of Cork and Limerick," he



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**"We are delighted to have been the main contractor for this project and wish Tom and his team best wishes and every success in the future"**



said. “The nearest clinics that offer similar services necessitate a long commute for many patients. In time, we hope that we will attract patients for the quality of service that we offer, but our convenient location will be a major advantage for patients in Kerry.”

The practice offers IV and RA sedation, and a radiology referral service to local clinicians with acceptance of referrals for high definition OPG and CBCT scans. “We understand the urgent nature of these referrals and offer a same-day service, if required,” said Tomas. “The patient can be seen on the day the referral is received and the images can be made available to the clinician on that same day. In addition, we can also arrange a radiologist reporting service from US board certified radiologists. This also has a quick turn-around time of one to three days, with an optional express service.

“For dental implant referrals, we can provide many levels of service. From site development – grafting and socket preservation – to placement only or fully restored treatments. We are happy to work with a wide range of implant systems. Our preferred brand is Southern Implants. For clinicians referring to us for the first time, we will provide a free restorative kit, with hands-on instructions!”

Tomas also has years of experience in the provision of sinus lift procedures. Although the indemnity insurance for this procedure has increased dramatically, making it uneconomic for many practitioners, Tomas is fully insured to carry out this procedure and can provide this treatment for his referrers. “We use CBCT scans, Piezosurgery techniques, along with a sinus kit, to greatly increase the safety and predictability of sinus lifts,” he added.

Had he noticed any trends or changes in popularity to the services they provide?

“There is certainly a growing awareness among the population about periodontal disease and the effectiveness of therapy. We have seen a steady rise in patients self-referring for such therapy. Patients are less likely to accept tooth loss, and this is reflected in the demand for dental implant therapy. Many patients do a lot of their own research on the subject of dental implants. Not so long ago, patients generally focused on the price of implants; now the focus has shifted to value for money, which is not the same thing!

“At our consultations we take time to explain their treatment. Patients are particularly impressed when we can show them their 3D scans with virtual implant placement. This greatly improves treatment acceptance but also their understanding of treatment limitations. We also provide a copy of the plan images to the referring dentist, which has proved very popular and is great for effective communication.”

It’s all been quite a journey for Tomas. “This has been a huge commitment in terms of time and finance. Everything has gone into this practice, even the sale of our home. However, the project has exceeded my expectations and we are proud of the



The practice features modern and relaxed surroundings for patients and staff

achievement so far. Patients have given us very positive feedback about the clinic itself, but more importantly the positive feedback about the treatment received.

“It is early days, but I am very optimistic about the future of the practice. I know that we have to work hard to earn the trust of referring dentists and to attract new patients. It takes time to gain the trust and confidence of referrers, but ultimately, we want to be seen as a reliable referral partner. We also want to add other specialist dentists to our staff and are currently actively seeking an endodontist for example. This is the fourth – and final – practice that I have owned, and the third that I have set up from scratch. It is the type of practice I have always dreamed of owning; multi-surgery, excellent design, and technology driven. Over the years, I have learned a lot about the business of dentistry. Success comes, ultimately, from excellent service and patient care.”

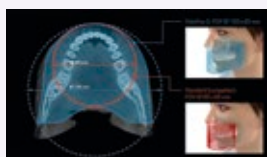
Kingdom Clinic, 43-44, New Street, Killarney, Co. Kerry, V93N802 / [kingdomclinic.ie](http://kingdomclinic.ie) / T: 064 776 3010 / E: [info@thekingdomclinic.ie](mailto:info@thekingdomclinic.ie)



**IT IS THE TYPE OF PRACTICE I HAVE ALWAYS DREAMED OF OWNING; MULTI-SURGERY, EXCELLENT DESIGN, AND TECHNOLOGY DRIVEN”**

TOMAS ALLEN

## &gt;DÜRR DENTAL

**ALL-IN-ONE  
DIAGNOSTICS**

Dürr Dental has developed an extended version of its VistaVox S panoramic machine with six additional programmes 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 – a scan time of just 1.9 seconds results in exceptionally sharp images using the lowest possible radiation dose due to the high-sensitivity CSL sensors. The unit can switch between 3D X-ray and Ceph boom, a process that, until now, was often cumbersome.

As with the VistaVox S, it has a perfect 3D imaging volume of 130mm (compared to 80x80mm for most), so covers the whole relevant area including rear molars, an essential requirement for diagnosing impacted wisdom teeth. Enhanced visibility does not require a higher radiation dose. Instead, a special curved path, rotating 540°, in combination with a tightly collimated fan beam and a highly sensitive CSL sensor, means a low dose is used.

Similarly to the VistaVox S, this enhanced model offers 50x50mm volumes, for indications that only require part of the jaw region to be shown, e.g. endodontic or implant treatments.

The VistaVox S Ceph offers true all-in-one capabilities for a full range of diagnostics.

## &gt;DÜRR DENTAL

**SMART TECH  
IN SURGERY**

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 reception area PC, or decentralised in every treatment room or on a smartphone/tablet via the corresponding app.

Potential problems are detected in advance, e.g. if the fill level of the amalgam collecting container nears its maximum an alert will be sent to ensure a replacement is ordered in plenty of time. The software also flags issues that require an external response, such as a filter change on a compressor or a routine service of equipment. Operational reliability is ensured as monitoring is done through IoT rather than human assessment, leaving staff free to focus on what's most important – patients.



## &gt;DÜRR 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 microorganisms 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 (consistent with advice given by the Robert Koch Institute).

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

The Hygowater system's safe and reliable processing fulfils all legal requirements for water hygiene, satisfies meticulous standards demanded by the German Drinking Water Ordinance and meets the requirements for a Class I medical device.

The compact unit is so easy to operate and its unique combination of filtration and electrolysis prevents biofilm formation. It's good for the safety of the practice and it's great for the environment, as long-term drinking water quality is ensured without the use of any chemical additives.

## &gt;DÜRR DENTAL

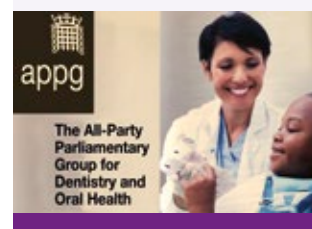
**PARLIAMENT  
TALKS DENTAL  
TECHNOLOGY**

Sir Paul Beresford MP recently held an all-party parliamentary group for dentistry and oral health 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, commented, "It was great to see what technology is currently available in UK dentistry. Having worked in the industry for over thirty 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".



# CHROME GUIDED SURGERY – THE WAY TO GO!

Procedure is changing lives for both patients and clinicians



**T**here was huge interest in Chrome Guided Surgery at the recent BDIA Dental Showcase in Birmingham. Dentists from all over Ireland, the UK and further afield learned about Chrome Guided Surgery and the many other exciting offerings from Quoris3D.

A sister company of the well-known Quintess Denta, Quoris3D specialises in giving dentists direct access to 3D printing, 3D design services and the ability to purchase some of the world's leading 3D printers in the market. Quoris3D are resellers for EXOCAD, Envisiontec 3D Printers, Medit and DOF scanners.

Another key offering from Quoris3D is CHROME Guided Surgery. This service offers your patients a life-changing experience with virtually-preplanned dental implants and teeth in a one-day procedure.

CHROME, the world's leading Full Arch Guided Surgery Solution is designed to simplify surgery, improve planning, predictability and results in the growing market of full arch immediate load treatments.

CHROME was developed for dentists who desire a preplanned, predictable

guided All-On-X style surgery. This amazing service delivers anchored bite verification, anchored bone reduction, anchored site drilling, accurate anchored provisionalisation, and a method of transferring all surgical and restorative information for the final restorative conversion phase. Most cases simply require a CT scan and traditional records.

## BENEFITS OF CHROME:

- No binding and bending of plastic
- CHROME Fixation Base create utilising SLM technology
- No more blind drilling
- CHROME allows visualisation of the drill as implants enter the bone
- No more lengthy conversions
- CHROME conversion takes just minutes to perform
- Complete confidence
- Digital workflow and guide expertise

The Quoris3D.com website has a CHROME 'case selection' service. Whether a clinician is unsure if a case is suitable, needs assistance in assessment or would just like an experienced clinician to give a second opinion before submitting a case for

payment, clients are encouraged to use this free service to help get your cases 'CHROME ready'.

## CHROME FULL ARCH GUIDED SMILE IS AVAILABLE FOR EDENTULOUS PATIENTS.

First, make sure to set the vertical, bite and aesthetic parameters in a pre-surgery temporary denture. Then follow the dual scan method to capture the DICOM. The case can then go live on the [www.quoris3d.com](http://www.quoris3d.com) website, an online planning meeting is arranged and then manufacture started. Quoris3D can help you with every step, digitise all your records and teach you how CHROME will improve, streamline and simplify your full arch work. A recent example of how Chrome Guided Surgery is changing lives for both patient and clinician is a recent full arch surgery that went from the usual six-and-a-half hours to just under two-and-half hours, thanks to the use of Chrome Guided Surgery. This is a much more positive experience for the patient and all the team members overall. Quoris3D will educate and support every client to implement this revolutionary technology.

(Above) There was huge interest in Chrome Guided Surgery at the recent BDIA Dental Showcase in Birmingham

(Below) Mark McGowan, Quoris3D, Thomas Kuun, Roe Dental Laboratories, James Hamill, Quoris3D

To learn more about Chrome Guided Surgery and all the amazing 3D printers and 3D printed products available from Quoris3D visit [www.quoris3d.com](http://www.quoris3d.com)

