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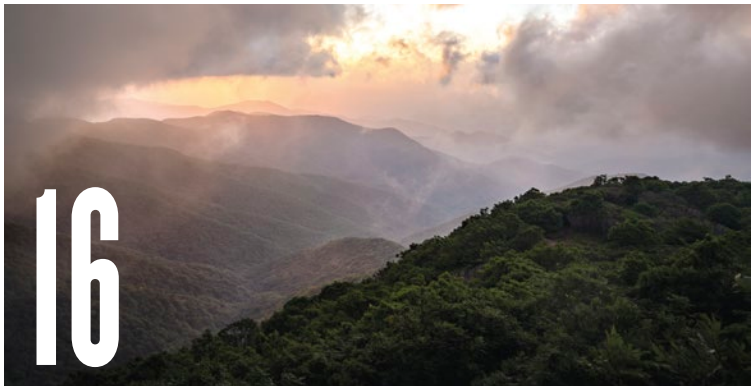

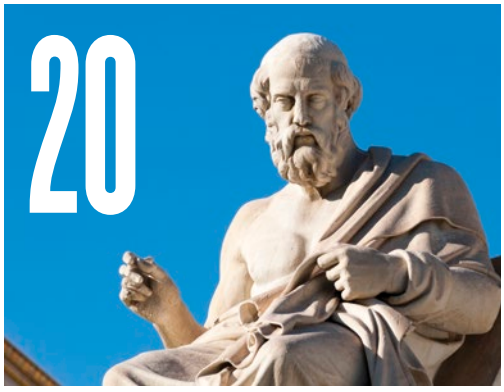

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A sense of community

Governments both side of the border must recognise the importance of public dentistry – and resource it accordingly.

The letter does not pull any punches. It speaks of a "dysfunctional and convoluted process". It says that: "The goodwill of the CDS [Community Dentist Service] has been decimated. They have been treated despicably...". And it concludes: "The mass withdrawal of CDS involvement in UDCs [Urgent Dental Care centres] is a direct response to the wholly unsatisfactory process". The observations are those of Grainne Quinn, Chair of the Northern Ireland Salaried Dentists Committee. They are contained in a letter sent to Robin Swann, Minister for Health in Northern Ireland's Department of Health, at the beginning of December. It was written after the department published its temporary regional rate for additional hours, which was significantly below what had been proposed, at the department's invitation, by the British Dental Association (BDA).

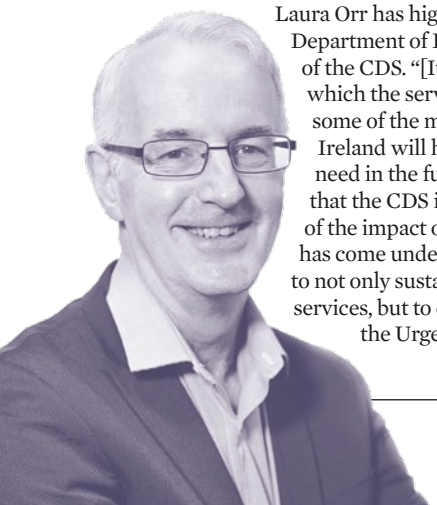
Quinn wrote: "The determination was unilaterally issued without prior engagement or agreement, as a fait accompli and without sufficient cognisance of BDA Northern Ireland Salaried Dentists Committee as the authorised negotiating body. This is the most recent chapter in a disappointing history of engagement by Department of Health and Department of Finance with the CDS in Northern Ireland."

The letter is symptomatic of a wider challenge to the CDS in Northern Ireland. As Quinn's BDA colleague Laura Orr has highlighted, the Department of Health needs to look to the future of the CDS. "[It] must tackle the systemic issues which the service faces, if they wish to ensure that some of the most vulnerable patients in Northern Ireland will have access to the treatment they need in the future," she says. Orr acknowledges that the CDS is far from alone in feeling the effects of the impact of the COVID-19 pandemic, but "it has come under unique and unrelenting pressure to not only sustain and rebuild their valuable core services, but to coordinate and deliver the work of the Urgent Dental Care centres. For almost nine months of the pandemic, CDS practitioners worked to provide additional care over evenings, weekends, and bank holidays with no indication of what, whether or when they might be paid."

> "REPEATED BLOWS AND DISAPPOINTMENTS HAVE CONTRIBUTED TO A GRAVE LACK OF CONFIDENCE AND TRUST"

Orr echoed the concern around the lower-than-expected enhanced rate for additional hours which, she says, "has done little to boost morale and fails to recognise the work already delivered by our weary practitioners." She adds: "This is reminiscent of my experience of the CDS contract process with the Department of Health. Protracted negotiations, communication issues and a complex approval system resulted in the process taking a full decade to conclude. Repeated blows and disappointments have contributed to a grave lack of confidence and trust in the capabilities of the Department of Health". CDS practitioners are being urged to complete the 2020 CDS survey they will have been emailed. It will be "essential in making [the] case for the service and providing evidence on morale, motivation and the future of the service for this year's submission to the Doctor and Dentist Review Body."

In the Republic, the incoming President of the Irish Dental Association (IDA) has warned that public service dentistry is facing a resourcing crisis as a result of the impact of COVID-19. Dr Anne O'Neill said: "Before the emergence of COVID-19, the provision of public service dentistry in Ireland was a cause for concern – now our resourcing levels have become a full-blown crisis." Between 25 per cent and 40 per cent of the HSE Community Dental Service staff had been assigned to assist in testing and contract trace for COVID-19, and not been replaced. As a result, the oral health care of vulnerable people and children is being neglected. A detailed resourcing plan is need from the Government "urgently", says O'Neill. Before the pandemic, the public dental service had seen a 20 per cent reduction in the number of practitioners at the same time as the number of patients eligible for treatment had risen by the same amount. "Oral health is a crucial part of a person's overall health," O'Neill reminded policymakers. "Our current resourcing levels mean that we are missing early-stage issues in both children and patients with special needs which could have major long-term health effects."



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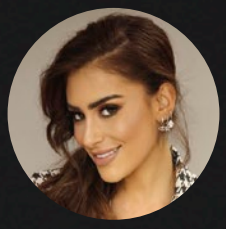

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Should a vaccine mean a return to life 'before-COVID'?

2020 is a year that will live in infamy. The calamity of COVID-19 and its effects – both from a public health perspective and an economic perspective – will linger for years to come. Almost every aspect of our society has been touched by the pandemic – from the way we purchase goods, undertake study, or even meet one another; all have been radically changed. A simple shaking of hands seems destined to be retired from our habits forever. From an oral health viewpoint, what long lasting changes will we see here in Ireland? And how will these changes unfold against the backdrop of Brexit, high unemployment, and continued uncertainty of public health?

To predict the future is always foolhardy, and 2020 handed us a refresher course! However, as COVID-19 research brings news of vaccines, successful clinical trials and high degrees of efficacy, the hope is that a vaccination is just a matter of time. At the beginning of December, the UK approved the use of the Pfizer-BioNTech vaccine. European Union member states are coordinating through the European Medicines Agency, whose scientific committee for human medicines will publish its assessment by 29 December.

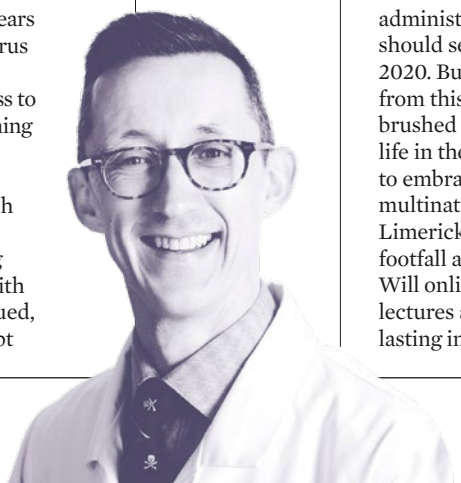
EU countries had the same option as the UK; so-called 'batch approval', as opposed to the more overarching 'market authorisation' the EU has chosen to pursue - and eyebrows were raised among European regulators at the UK's jingoistic celebrations (Pfizer is a US company and BioNTech was founded by a German couple of Turkish descent). But, politics aside, long-term immunity, always the goal, appears within our reach – just nine months after this virus wreaked havoc throughout Europe. In thinking about general dental practice in particular, access to dental services, the role of the dentist, and reaching a nearly normal phase seem worth exploration.

With the restrictions and protocols in place, attendance at the dentist has become very much tied to appointment times. Reduced space in waiting rooms, increased disinfection/cleaning times, augmented cross-infection measures (with PPE) have meant that routine dentistry continued, albeit with lower patient numbers. This concept of 'block treatment', where an increased number of scheduled procedures are performed in one sitting has lead to higher productivity per patient visit. The downside here is that patients face a higher per visit spend which, for many, is challenging, particularly as the economy is still very fragile. Despite this, the methodology of higher spend per visit is both financially and clinically prudent. Many dentists plan to continue this practice even when restrictions lift.

The role of the dentist is one which is also worth examining. Do we have a role to play in charting the COVID-19 course? And, in the roll out of any proposed vaccination programme, will private dentists be sequestered to help in the effort? Given the long standing success of pharmacists in administering the routine winter flu vaccine, there is merit in exploring this option – particularly if rapid deployment is of the essence. The meaning of the phrase 'role of the dentist' can also be thought of in its broader sense too. We are all data processors, cross-infection policymakers and radiological undertakings, to name but a few of the many hats we wear in general practice. We somehow are meant to extract the odd tooth, place a filling and fit a denture along the way too!

In some respects, if this era of COVID-19 is being seen as some kind of reset, then perhaps thought should be given to re-examining these roles also. Each aspect mentioned above, is critical to safe patient care and treatment delivery. Isn't it time we closely examined how we are absorbing or passing on the associated costs with this critical aspect of treatment provision?

And finally, the nearly normal phase is worth looking at too. All things going well, a safe, dependable vaccine administered to the vast majority of the population should see things return to how life was before March 2020. But will it really? Will the lessons we learned from this dark chapter of our recent history be quickly brushed aside or will we embrace a modified version of life in the years BC (Before-COVID)? Will we continue to embrace Zoom or Microsoft Teams? Will large multinationals abandon office space in Dublin/Cork/Limerick/Galway forever? How will this affect urban footfall and patient numbers in larger towns and cities? Will online CPD learning replace the usual face-to-face lectures and workshops? Only time will tell the long-lasting impacts and legacy of this pandemic.



Foundation launches new research grants

Key research areas address minimum intervention dentistry and oral health in ageing populations among others


Mrs Makiko Nakao, President of the Foundation Board and Mr Makoto Nakao

DENTAL academics and clinicians have been invited to apply for research grants from Foundation Nakao. This is the second round of funding made available by this prestigious foundation since its launch in 2018, supporting clinical trials and research into important subjects such as minimum intervention dentistry and oral health of the elderly.

Successful applications will receive fully funded projects of CHF 50,000 per project in addition to wide exposure among dental professionals, the dental industry as well as the general public of each study's outcomes and achievements.

Advancing oral health research

The Foundation's first round of grant applications took place in September 2019 and six studies were awarded the honour of being accepted out of a huge number of submissions. Applicants represented the categories: government organisation, non-government organisation, university, research institution or other.

Foundation Nakao supports academic research and clinical studies contributing to its founding goal, which is the improvement of oral health and subsequent raised quality of life of all people around the world. Key oral health research areas address minimum intervention dentistry, oral health in ageing populations and the 8020 movement, tooth function, the prevention of oral frailty and dental IQ.

"The inspiration for the Foundation came from a topic that is very close to our hearts: the impact of oral health on quality of life. My husband and I believe that dentistry has a fundamental role to play in the health and longevity of people around the world. We look forward to seeing this becoming a reality through the activities of the Foundation," said Makiko Nakao, President of Foundation Nakao for Worldwide Oral Health at its official launch in 2018.

The award of grants from the latest round of applications will be announced in the first half of 2021.

About Foundation Nakao

Foundation Nakao for Worldwide Oral Health was launched on 21 September 2018 in Luzern, Switzerland. It was made possible by Mr Makoto Nakao, former Chairman of the GC Corporation, who after 42 years at the helm of the company donated his privately-owned company shares to support this noble initiative.

The Foundation's management board comprises a team of distinguished dental professional from four continents: Europe, America, Australia and Asia. They are Professor Reinhart Hickel, Professor Clark Stanford, Professor Macro Ferrari, Professor Eric Reynolds, Professor Keiichi Sasaki and Dr Kiyotaka Nakao.

www.foundation-nakao.com
info@foundation-nakao.com

Caries risk assessment joins 21st century

THERE are many factors that affect how likely a patient is to develop caries, and during this time when dental practitioners are trying to minimise aerosol generating procedures (AGPs), the ability to identify the risk and prevent the development of caries is paramount.

Products which enable dental professionals to minimise the invasiveness of restorative procedures are also in demand at the moment as they endeavour to reduce the requirement for AGPs in dental treatment. Now, GC has launched its latest MI Dentistry Caries Risk Assessment app.

The app guides you through a caries risk assessment with your patients. Based on age group and accounting for additional factors such as pregnancy, it asks a series of questions regarding oral health and the risk factors linked to caries and then suggests suitable prevention measures, as well as restorative solutions if required.

This could link into a dental practice retail strategy for selling prevention therapy OTC and offering an at-home treatment solution.

Download the MI Dentistry CRA app from the Google Play Store. For more information about GC UK Ltd call 01908 218999, email info.uk@gc.dental or visit www.gceurope.com.

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‘Be Proud of Your Mouth’ campaign unveiled by FDI

Time to organise low-risk, impactful campaign events for March 2021, says federation

REPRESENTING more than one million dentists worldwide, the FDI World Dental Federation (FDI) has unveiled a three-year ‘Be Proud of Your Mouth’ campaign that will be launched on World Oral Health Day (WOHD).

The campaign was unveiled as new data showed that mouth cancer referrals in Northern Ireland had fallen by more than a third since the start of the pandemic.

WOHD is celebrated every year on 20 March. Its purpose, says the FDI, is to “empower people with the tools and knowledge to prevent and control oral diseases, which affect nearly 3.5 billion people worldwide. The celebration encourages people to look after their oral health by adopting a good oral hygiene routine and managing risk factors. Preserving oral health can help keep the mind and body healthy too, as well as protect against the spread of infections.”

For the next three years, the overarching theme for the WOHD campaign is ‘Be Proud of Your Mouth’. “With this empowering call to action,” the FDI said it “hopes to motivate people to value and take care of their mouths and understand that by doing so, they can also help protect their general health and well-being.

People can show their support for the campaign by using the online #MouthProud custom poster tool* to place an ornate art frame over their mouths-as a symbol that they recognise just how significant and important the mouth is-and make a personal commitment to prioritise their oral health.

“This can be safely done from home, and everyone can show their solidarity with the campaign and contribute to the global movement by sharing their images on the ‘Mouth Proud Wall’,” said the FDI.

Each year, FDI records hundreds of WOHD events that reach millions of people worldwide, organised by its member dental associations and specialist groups, as well as the wider healthcare community. In 2021, FDI is working to ensure that every in-person celebration will respect local public health guidelines.

“The most important thing is that our World Oral Health Day** celebrations be conducted safely,” said Dr Gerhard K. Seeberger, the FDI President. “The COVID-19 pandemic has changed the nature and scale of in-person events, but with today’s technology, so much more is possible.

“Today, we have more time to organise low-risk, impactful campaign events for March 2021. I encourage everyone to visit worldoralhealthday.org and use the wealth of resources that are freely available.”

The campaign was unveiled as new data showed that mouth cancer referrals in Northern Ireland had fallen by more than a third since the start of the pandemic.

** www.worldoralhealthday.org/custom-poster*
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BE PROUD OF YOUR MOUTH
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World Oral Health Day
20 March

Dentists increasingly complaining about colleagues

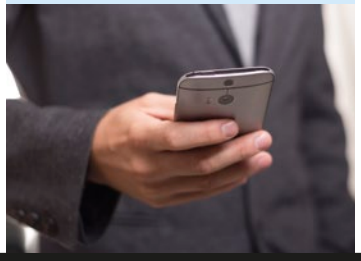
THE General Dental Council (GDC) has published a series of reports* which provide statistics and examples of fitness to practise case handling undertaken during 2019.

The statistical report provides a quantitative picture of fitness to practise in 2019. In addition, the regulator has also published six short insight reports covering decisions at the initial assessment stage for quarters three and four of 2019, including spotlight reports on concerns relating to consent and record keeping.

The reports show that of all the concerns received in 2019, only 36 per cent made it to a case examiner – the first stage at which a sanction may be imposed on a dental professional. They also reveal a further year-on-year increase in concerns raised by dental professionals, from 10 per cent to 13 per cent of the total, including ‘blue on blue’ cases – separate to those which are categorised as ‘whistleblowing’ by professionals.

John Cullinane, Executive Director of Fitness to Practise Transition at the GDC, said: “What is clear from these reports is that the large majority of concerns received by the GDC are assessed and completed without sanction, but they also highlight that early engagement in the process will typically end in a smoother resolution to any concern that’s raised, which ultimately must be in everyone’s interests.

“There’s some really useful insights to be gained here for dental professionals, particularly from the case examples in the short reports, so I’d encourage everyone to take a look.””
*www.gdc-uk.org/education-cpd/fitness-to-practise-learning



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Six-month check-ups 'not necessary for healthy adults'

Review 'provides reassurance' to patients who have missed routine check-ups during pandemic

A NEW review provides reassurance to patients who have missed routine dental check-ups due to COVID-19 restrictions by showing that six-monthly check-up appointments do not improve oral health.

A Dundee University team in collaboration with Manchester University and Cochrane Oral Health, has conducted a systematic review to identify the best time interval between dental check-ups for maintaining good oral health.

Traditionally, dentists recommend their patients visit for a check-up twice per year, even though the risk of developing dental disease is different for each individual.

A personalised risk-based recall interval between check-ups – where time between check-ups depends on an individual's risk of developing dental disease – varying between three and 24 months, has been recommended by the National Institute for Health and Care Excellence since 2004. Despite this, most practices continue to encourage adults to schedule appointments at regular intervals of six months.

To investigate the issue, the review group looked at the most current and robust evidence available, including two randomised controlled trials involving 1,736 patients which looked at how different intervals between check-ups affected: how many people had tooth decay, how many tooth surfaces were affected by decay, gum disease, and wellbeing.

"The review shows that current practice of scheduling six-monthly check-up appointments for all patients does not improve oral health compared to a personalised risk-based check-up approach or compared to check-ups every two years where patients are at low risk of dental disease," said Patrick Fee, the review lead. "The absence of any difference between check-up frequency indicates a risk-based check-up frequency can be supported, as it is not detrimental to oral health and is acceptable to patients. But it should be emphasised this is about adults having routine check-ups, not those who need to seek emergency treatment or children.

"Current practice of six-monthly check-ups could be considered an inefficient use of NHS resources, adding unnecessary patient and health service costs for no gain in dental health outcomes. This research is also valuable when considering the significant impact of the Covid-19 global pandemic and its effect on dental services worldwide, limiting patient access to dental treatment. Patient access to dental care may remain limited for some time, however the results of this review provide reassurance to those providing and seeking dental treatment that intervals between check-ups can be extended beyond six months without detriment to the oral health of patients."

One of the clinical trials the review looks at, the INTERVAL Dental Recalls Trial*, was sponsored by the university and conducted to add to existing evidence to help answer the research question.

The review, Recall intervals for oral health in primary care patients**, concludes that in adults, there was little to no difference between six-monthly and risk-based check-ups for a number of tooth surfaces with decay, gum disease and well-being after four years, and probably little to no difference in how many people had moderate-to-extensive tooth decay.

See page 28

** discovery.dundee.ac.uk/en/publications/interval-investigation-of-nice-technologies-for-enabling-risk-var*

***www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004346.pub5/full*

GDC faces legal challenge over lay chair

A LEGAL challenge could be mounted against the General Dental Council (GDC) if it appoints a lay person as its new Chair, the British Association of Private Dentistry (BAPD) has warned.

The GDC is led by a council of 12 members, comprising six lay "including the Chair", according to council documents, and six dental professionals. Its current Chair, Dr William Moyes has been in post for seven years and will be demitting office at the end of September 2021.

According to the BAPD: "This unambiguously states that the Chair of Council is one of six lay members. This is not predicated on the currency of your Council and its Chair, but is a general statement purported to be fact, immaterial of the current constitution of both. It is materially evident, that executive search agencies tendering for this process and the subsequently successful candidate, will position their effective advertising, search and selection processes to target lay candidates for the role of Chair of Council."

The BAPD has written to Ian Brack, Chief Executive and Registrar, welcoming his previous statement that applications for the role of Chair will be welcomed from both registrants and lay candidates and that core characteristics of the successful candidate would include substantial skills, experience and leadership authority, but it added: "We venture that you have missed one that is central to optimal performance as chair of the regulatory body of the dental profession, and that is having direct experience of that profession as a dental professional.

"We hereby give notice that the BAPD will challenge this process should advertising not be equitably positioned within dental profession specific press, recruitment companies and online resources, as well as those more usually favoured for general executive recruitment."

According to the GDC, the successful candidate will be "responsible for ensuring that the GDC fulfils its full range of statutory duties, of which protecting public safety, maintaining confidence in the profession, and professional standards are of central importance."

The BAPD wrote in its letter: "We submit to you that a fourth duty is also of central importance; maintaining confidence of the profession. It is a fact that the GDC currently does not inspire the confidence of the profession. Indeed, your own recent surveys attest to that fact. As we stated in our letter of 8 October, an essential first step to reestablishing confidence within the dental profession is to appoint a dental registrant as Chair of the Council. We will continue to scrutinise the processes and procedures of the GDC and we look forward to your response in due course."

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[1] Inoue K, Song YX, Kamiunte NO, Oku J, Terao T, Fujil K. Effect of mixing method on rheological properties of alginate impression materials. Journal of Oral Rehabilitation, 2002; 29: 615-619.
[2] McDaniel TF, Kramer RT, Im F, Snow D. Effects of mixing technique on bubble formation in alginate impression material. General Dentistry, 2013; 61(6): 35-39.
[3] Internal test
[4] Presley S, Morgan J. The Selection, Use and Accuracy of Alginate Impression Materials. Dental Learning – a peer reviewed publication, 2015; 3(3): 23-30.

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www.worldoralhealthday.org

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www.rdpduk2020.eventbritestudio.com

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Those who suffer from both periodontitis and cardiovascular disease may have a higher risk of cardiovascular complications and should carefully follow recommended dental regimes of prevention, treatment, and maintenance. These are among the key messages of the Perio & Cardio educational campaign launched by the European Federation of Periodontology (EFP) and the World Heart Federation (WHF). This global initiative is centred on the perioandcardio.efp.org site, which has recommendation documents, infographics, an animated film, and other educational materials – all aimed at bringing this knowledge to the dental team, cardiologists, medical professionals, pharmacists and the public.

Perio & Cardio is based on a new evidence-based scientific consensus on the links between periodontal and cardiovascular diseases and expert recommendations on prevention and therapy for both types of disease. All the material in the campaign derives from the consensus report 'Periodontitis and cardiovascular disease' – published in February by the EFP's Journal of Clinical Periodontology – which expressed the findings of the Perio-Cardio Workshop, held in Madrid in 2019, which brought together 20 experts in periodontology and cardiology.

www.efp.org/gum-disease-general-health/perio-cardio

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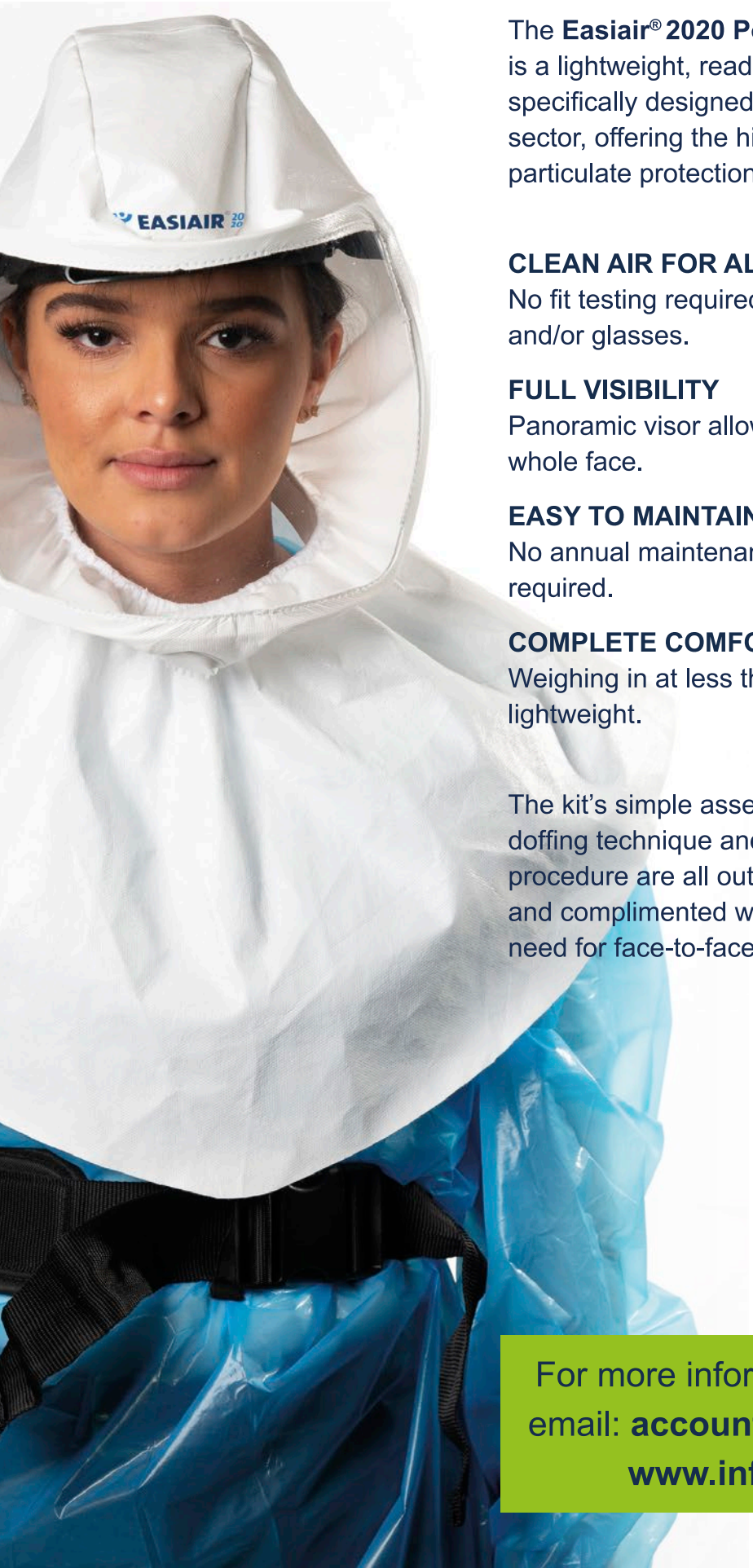

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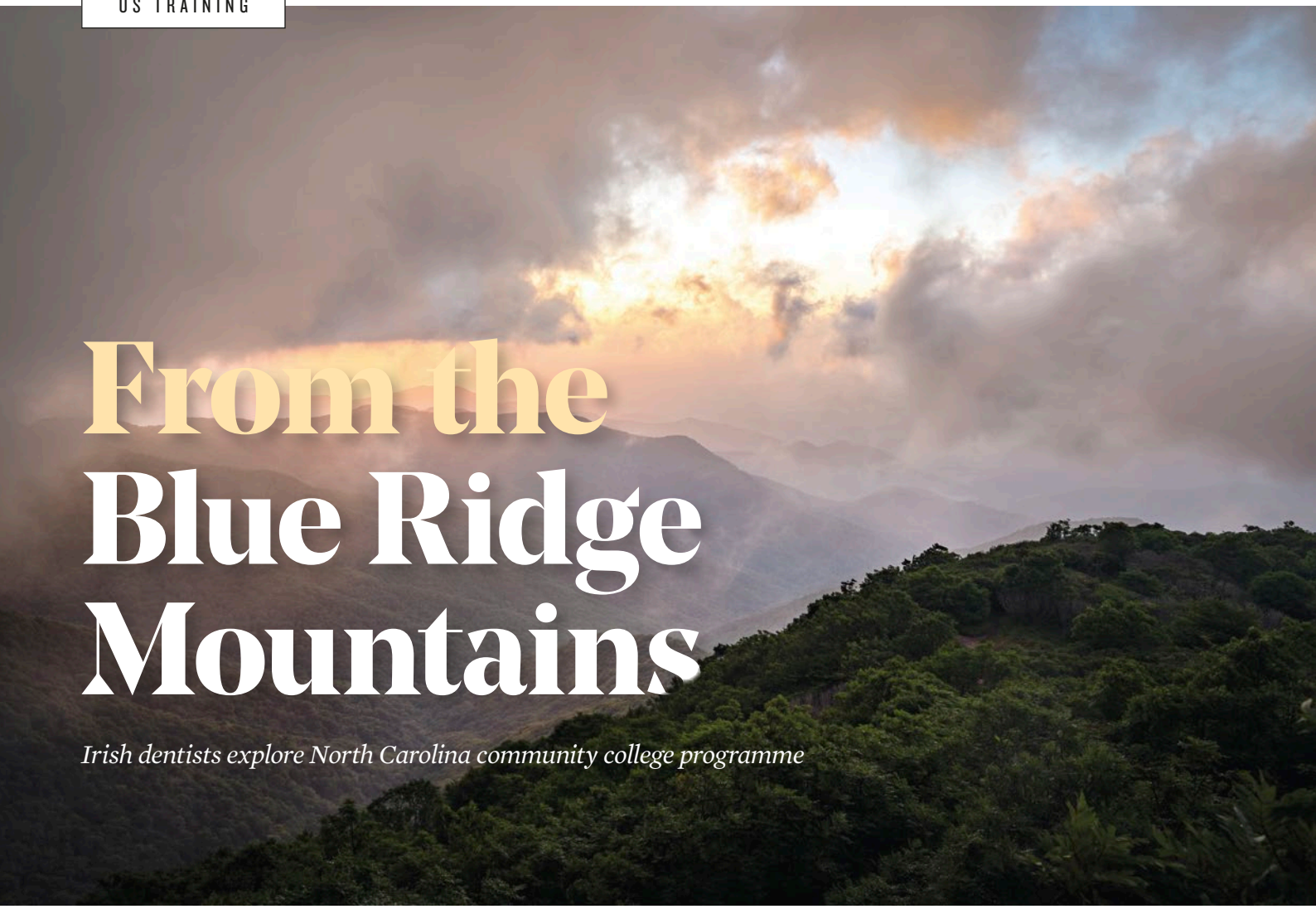

From the Blue Ridge Mountains

Irish dentists explore North Carolina community college programme

Blude Ridge Mountains
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A small college at the foot of the Blue Ridge Mountains in North Carolina has created a course that, as one student remarked, "opened up a new way of looking at my local community." That student is Dr Siobhan Murray, a dentist in Ireland, who along with her friend and fellow Irish dentist, Dr Nuala Carney, enrolled in Catawba Valley Community College's Community Dental Health Coordinator course to see how the successful ADA-founded programme could improve the oral health of patients back on the Emerald Isle.

Irish challenges

"Ireland doesn't have a specific training programme like the CDHC programme at present," said Dr Carney, who has worked as a general dentist in Dublin on and off for the past 30 years, and also taught dental undergraduates at Trinity College Dublin. "The CDHC training seems to be more practical and hands-on in not only educating patients, but also actively encouraging and supporting them as they seek to access and undergo treatment.

"There is definitely a practical emphasis on reaching out to vulnerable or marginalised members of communities, helping patients find a dental home and removing whatever barriers exist to them undergoing treatment if possible. The statistics showing the significant uptake in attendances at clinics following projects carried out by CDHCs is a powerful testament of this."

In 2006, the ADA set up a task force to determine how to best meet the needs of dentally underserved rural, urban and American Indian communities. Later, in 2009, the ADA established the Community Dental Health Coordinator pilot programme as one component in the effort to break through the barriers that prevent people from receiving regular dental care and enjoying optimal oral health.

In October 2010, the first class of 10 CDHC students completed training in Tempe, Arizona, and Norman, Oklahoma, and began working in tribal clinics, urban and rural Federally Qualified Health Centers, Indian Health Service facilities and other settings. The ADA is currently providing technical assistance to 18 educational institutions with more than 600 graduates over the years, and 43 states have either a CDHC school programme, a graduate of the programme or a student in the programme.

'Across the pond'

Dr Carney first heard about the CDHC programme when she attended the ADA FDI World Dental Congress in San Francisco in 2019, as a representative of the Irish Dental Association.

"I was able to attend the Oral Health Forum at the very end of the conference and heard Dr Jane Grover of the ADA speak about the CDHC training programme, amongst other things," Dr Carney said. "I was really impressed by what a simple, novel and practical idea it was, and particularly by the statistics showing how effective the training programme had been to date. We spoke briefly after the session and again a few weeks later

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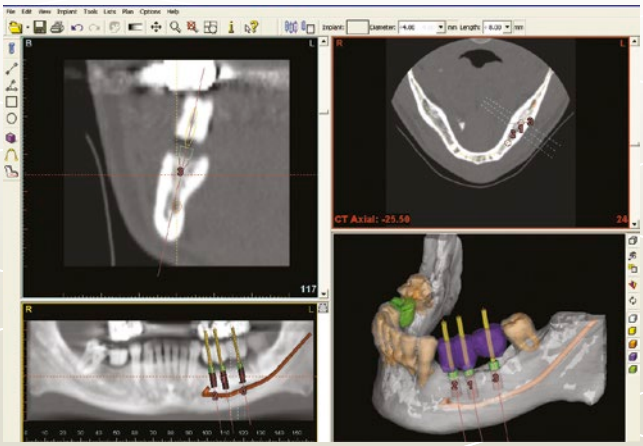

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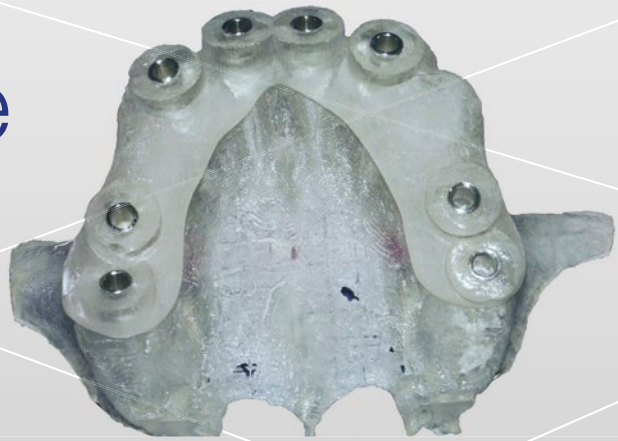

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online, at which point Dr Grover very kindly suggested the possibility for an Irish dental health worker to participate in a future training programme."

Dr Carney brought up the topic to her local dental society, where it was decided that it might be best for one or two dentists to participate to see if the training might be transferable to an Irish environment. She recruited her friend, Dr Murray, the owner of two general dental practices in Donegal Town and Letterkenny, both in County Donegal. Dr Murray jumped at the chance. The two met decades ago on a month-long mission in the Himalayas, educating and treating villagers with no access to oral health or hygiene.

"I also spent three months, subsequently, carrying out similar work in Georgetown, Guyana," D. Murray said. "These experiences made me aware of the benefits of bringing oral health education and dentistry to the community. Oral health education and support availability is minimal in our country, which means that vulnerable groups such as children, the hospitalised and the elderly are unsupported."

Building bridges

Although the 32-week course was online, Catawba Valley Community College's Community Dental Health Coordinator programme – first established in 2019 – immersed the two Irish dentists in how to implement a programme from the ground up. They studied and learned alongside US dental providers who impressed them with their zeal during Zoom meetings and other online discussion forums.

"I am so impressed by the enthusiasm, dedication and determination of the other CDHC participants to really get involved in so many different aspects of helping patients of all ages, cultures and backgrounds improve their access to dental care and oral health education in their communities," said Dr Carney. Kay Sitterson, an adjunct faculty member at the college, said the American students learned a great deal from their Irish counterparts: "I think the takeaway for our students is that their systems, their problems and issues sounded like ours," she said.

Dr Carney aims to introduce the programme back home, excited to see how lessons learned in North Carolina can be applied in her area. "Seeking out this cohort of patients and actively encouraging and supporting them to seek and undergo treatment as required will be a key challenge – and this is where I would see this CDHC training as being hugely beneficial both to patients and dental practices alike," she said.

"Giving hygienists and dental nurses the opportunity and training to liaise directly and effectively with patients and facilitating their access to dental care in a new environment and system could make an enormous difference to the success of this scheme and improve acceptance of the scheme by the profession."

Dr Murray looks back at the programme fondly, hoping that more dentists from Eire can collaborate with American dental providers more in the future, if given the opportunity. "I could see the potential for us, here in Ireland, to build a working relationship with our American colleagues," Dr Murray said. "[We can] learn from their experiences and share our community problems with them in order to find solutions to improve delivery of a much-needed service."

David Burger is a Senior Editor at the American Dental Association. This article first appeared in the August edition of ADA News / tinyurl.com/yyfcxawz

> "I COULD SEE THE POTENTIAL FOR US, HERE IN IRELAND, TO BUILD A WORKING RELATIONSHIP WITH OUR AMERICAN COLLEAGUES"

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Dentistry in the new decade

The first virtual Annual Scientific Meeting (ASM) of the Faculty of Dentistry RCSI featured speakers from around the world

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ASM 2020 was chaired by Professor Albert Leung, Dean of the Faculty of Dentistry, RCSI, and delegates were welcomed by Professor Cathal Kelly, CEO/Registrar at the RCSI.

Speakers included Dr Martin Foster of Dental Protection, Professor Anthony Roberts, of University College Cork, Professor Alastair Sloan, of Cardiff University, Dr Radi Masri, of the University of Maryland's School of Dentistry, Dr Saorise O'Toole, of King's College London, Professor Paul Coulthard, of Queen Mary University London, Dr Suk Ng, of King's College London, Professor Jo Frencken, of Radboud University, Nijmegen, Professor Sam McConkey, of the Royal College of Surgeons in Ireland, Yangfang Ren, Professor in the Department of Dentistry at the University of Rochester Medical Center, Dr Paul Quinlan, an examiner for the Royal College of Surgeons in Ireland and Professor Nicola Innes, of Cardiff University.

The Edward Leo Sheridan Lecture 2020, 'Dentistry in the New Decade: The Impact of COVID-19 Upon Oral Health Care', was delivered by Stephen Porter, Director and Professor of Oral Medicine at UCL Eastman Dental Institute. Professor Porter set his lecture in the wider context of the challenges facing society; poverty, inequality, hunger and global warming. But he focused on the implications of COVID-19 on oral health.

As he spoke, there had been more than 58,000 infections in Ireland and more than 895,000 in the UK. Deaths stood at 1,885 and 45,000, respectively. Across the world, the figures were 43.5m and 1.16m, respectively. It does not just cause pulmonary disease, he said, but can affect any part of the body with both short and, potentially, long-term consequences, some of which may impact on oral health.

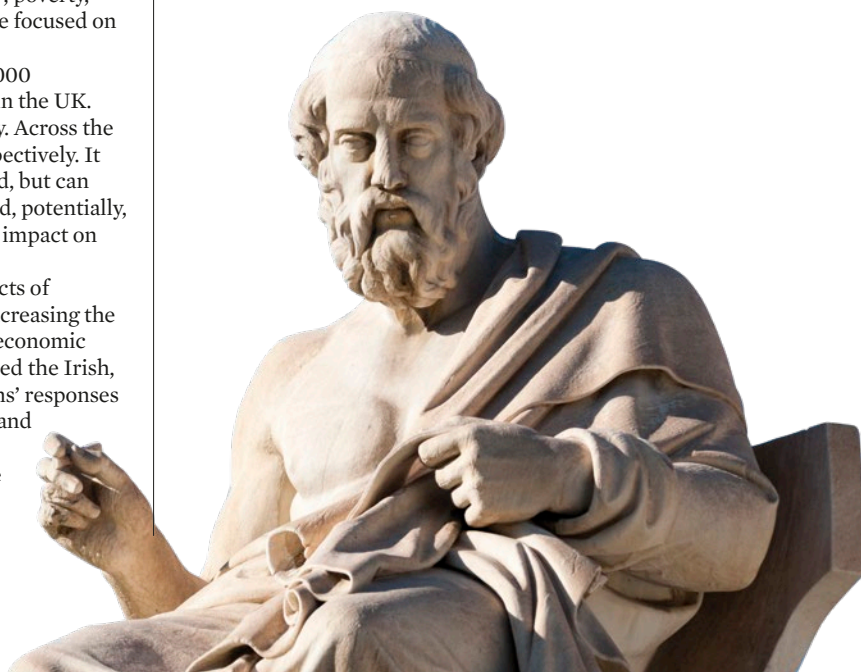
Professor Porter detailed the potential effects of COVID-19 on the body, the medical factors increasing the risk of death, as well as the ethnic and socio-economic factors that should be considered. He described the Irish, UK Government and devolved administrations' responses to the pandemic, the economic implications, and the impact on the healthcare system. Health workers who previously provided dental care had been reassigned. Public health services previously provided by the NHS have shifted to the private sector. All of these will have an effect on oral health, said Professor Porter. Before considering this in detail, he described the potential of vaccines and the challenges in making them effective, as well as the role of drugs in mitigating the disease.

The impact on oral health

Professor Porter detailed the cessation of dental practice across primary, secondary and tertiary care, the transfer of patients to telephone triage, and the establishment or urgent dental care centres for the management of significant issues. There was some realignment of secondary and tertiary care, but they worked to guidelines that were "not notably evidence-based," he said. Guidelines were developed to provide symptomatic relief and to identify life-threatening illness. Similarly, guidelines for this were not based on strong evidence and relied heavily on the use of analgesia and anti-microbials. PPE supply was an issue, and the regulatory responses were "not notably fast". Clinical care suffered, said Professor Porter.

In terms of the impact on clinical staff, practices were closed - and, in some instances, employees were able to

In his lecture, Professor Stephen Porter invoked Plato



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be furloughed. But the support from Governments for practices and clinical staff was limited. Some staff were able to transfer to provide support for hospital intensive care and theatre teams. "In the hospital I work in, we had a consultant orthodontist assisting in the delivery of babies," said Professor Porter. "They found it remarkably interesting. The obstetricians, initially, found it a little bit challenging, but then remarkably rewarding. And the babies and families were happy. Everything went well."

Professor Porter said it was difficult at that point to ascertain the effects on oral health; there was not enough epidemiological data. But he added: "It is estimated that there were around 15 million check-up and treatment sessions lost in the UK and many thousands of exodontia procedures on children were postponed." His lecture reflected the concern at the time among dentists about their ability to return to practice at anywhere near a pre-COVID-19 level of activity and the associated implications in terms of delayed treatment and missed disease. The financial sustainability of practices, and the livelihoods of dental professionals, was also a concern, he added.

While prescribing analgesics and anti-microbials provided short-term comfort to patients, there was the long-term risk of them developing anti-microbial resistance. Tele-dentistry had allowed some contact between practitioners and patients, but every speciality had encountered challenges, said Professor Porter, because of the concern around aerosol generating procedures (AGPs). The incidence of oral disease progression was likely to increase. In oral medicine, where AGPs are not used, Professor Porter said that patients were presenting with facial pain or burning mouth syndrome because, he suggested, of anxiety caused by the pandemic. "What you can conclude is that all aspects of healthcare have been compromised and it is likely to be for some time," he said.

Professor Porter described the concern around AGPs as a "major roadblock", but that there was no strong evidence that aerosol spread of COVID-19 was likely to be common in a dental setting. The publication by the Scottish Dental Clinical Effectiveness Programme (SDCEP) of its 'rapid review' on AGPs had provided "some hope". Now there were some more manageable clinical guidelines, he said, based on a number of principles – on the use of three-in-one syringes, high-velocity suction and rubber dams, for example – along with the possibility of reducing fallow time to 10 minutes, which will allow more patients to be seen. A resurgence of COVID-19 and renewed restrictions around social distancing could still have an impact, however. Faltering moral and rising anxiety among staff could see them lost permanently to the profession. There also remained the question of who would pay for the additional measures necessary for practices to see patients in-person.

The professor also highlighted the continued risks to the most vulnerable in society and those who suffer inequality. "If anything has been made clear in all of this it is that the COVID-19 pandemic has exacerbated socio-economic and ethnic inequalities and it will undoubtedly worsen oral healthcare," he said. "Therefore, we need to quickly work out how we can establish good oral health care and prevent oral disease for as many people as possible, particularly those who suffer inequality."

> "THE PANDEMIC HAS EXACERBATED INEQUALITIES AND AND IT WILL UNDOUBTEDLY WORSEN ORAL HEALTH CARE"

> "WE HAD A CONSULTANT ORTHODINTIST ASSISTING IN THE DELIVERY OF BABIES – EVERYTHING WENT WELL"

Education and research

Teaching in university and clinical education stopped with lockdown, said Professor Porter, though institutions did switch to online learning and there has been a gradual return to clinical teaching, but only in some dental schools around the world. There was limited or no graduation of dental students in 2020. In the UK, Brexit and the morale-sapping effect of COVID-19 combined to have a "choking" effect on people entering the profession, said Professor Porter. Nonetheless, the delivery of online dental education has been advanced in a matter of months, as opposed to years; a phenomenon experienced in other sectors, also.

In terms of research, the bulk is carried out by universities and – as it was with teaching – it ground to halt with lockdown (aside from that associated with COVID-19). Clinical trials stopped. Research has restarted, but there are delays in outputs and additional costs associated in restarting. Research income from charities will fall because their income has suffered as a result of the pandemic. Is there an upside, however, Professor Porter asked: "Without doubt, university research has significantly influenced our understanding of COVID-19 and helped improve the return of oral healthcare – for example, the work undertaken in Scotland was all undertaken by university staff."

Professor Porter said that the pandemic had encouraged cross-sector and trans-national cooperation and had raised the profile of oral health care professionals through their appearance on webinars and in the media. There may be future research opportunities in terms of how COVID-19 has changed oral health care, he added. Though he was critical of the variation in national responses, the messaging from public bodies on dental practice, and the lack of forward-thinking around dentistry in discussion papers published in response to COVID-19.

The future of oral health

In conclusion, Professor Porter said: "While COVID-19 may disappear, or become manageable, other pandemics may come along. So, anything we learn now may have value for the future. Oral health care is important - for life and for general wellbeing. It must be protected. The burden of oral disease lies in people who are low income, who are marginalised and who are in vulnerable groups.

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Paediatric dentistry - looking ahead

Dr Dympna Daly qualified from Trinity College Dublin in 1982. She completed a master's degree in paediatric dentistry at the University of Minnesota in 1989 and was the recipient of the Hatton Award for her thesis on prenatal fluoride. On her return to Ireland, Dr Daly worked part-time teaching at Dublin Dental Hospital and established her private practice in Galway City. Some brief extracts from Dr Daly's ASM 2020 presentation:

› "One of the nicest aspects of working in paediatric dentistry is that we get the opportunity to look after the oral health of babies and young children as they move through quite dramatic stages of growth and development. And it really is at this young age that we have the best opportunity to instill in them the best of oral health and primary prevention."

› "We know that for good oral health, we have to begin early - by six to 12 months of age. We can't depend on the babies to ring up and make an appointment. So, our focus is on parents and caregivers to try and ensure that they're aware and know to bring their children to see us around the time that the first primary tooth erupts. Preventive interventions in the first year of life are critical."

› "The Childsmile programme in Scotland has resulted in a saving of millions of pounds for the NHS. It takes only a fraction of the savings to run the entire programme."

› "A large part of our prevention treatment is the appropriate use of fissure sealants, both for primary and for permanent teeth. We know that these are extremely successful."

Dr Dympna Daly

› "The use of nano particles, nano devices and nano robots - there's some interesting work being done. We're now seeing applications of these nano materials across all aspects of dentistry. I think we're going to see some very interesting developments in years to come."

› "No matter how great our materials, our techniques, or our interventions, we're really not going to get a handle on this until we have a structured programme allowing us to see [patients] from birth and [for them] to have ongoing access to ongoing oral health care."

Therefore, there is a need to target those groups. And lastly, while the load of oral disease might lessen over time, the nature of oral disease will continue to change as people live longer, and disease prevention gets better and new medicines come along, which may impact upon the mouth or upon the delivery of oral health care.

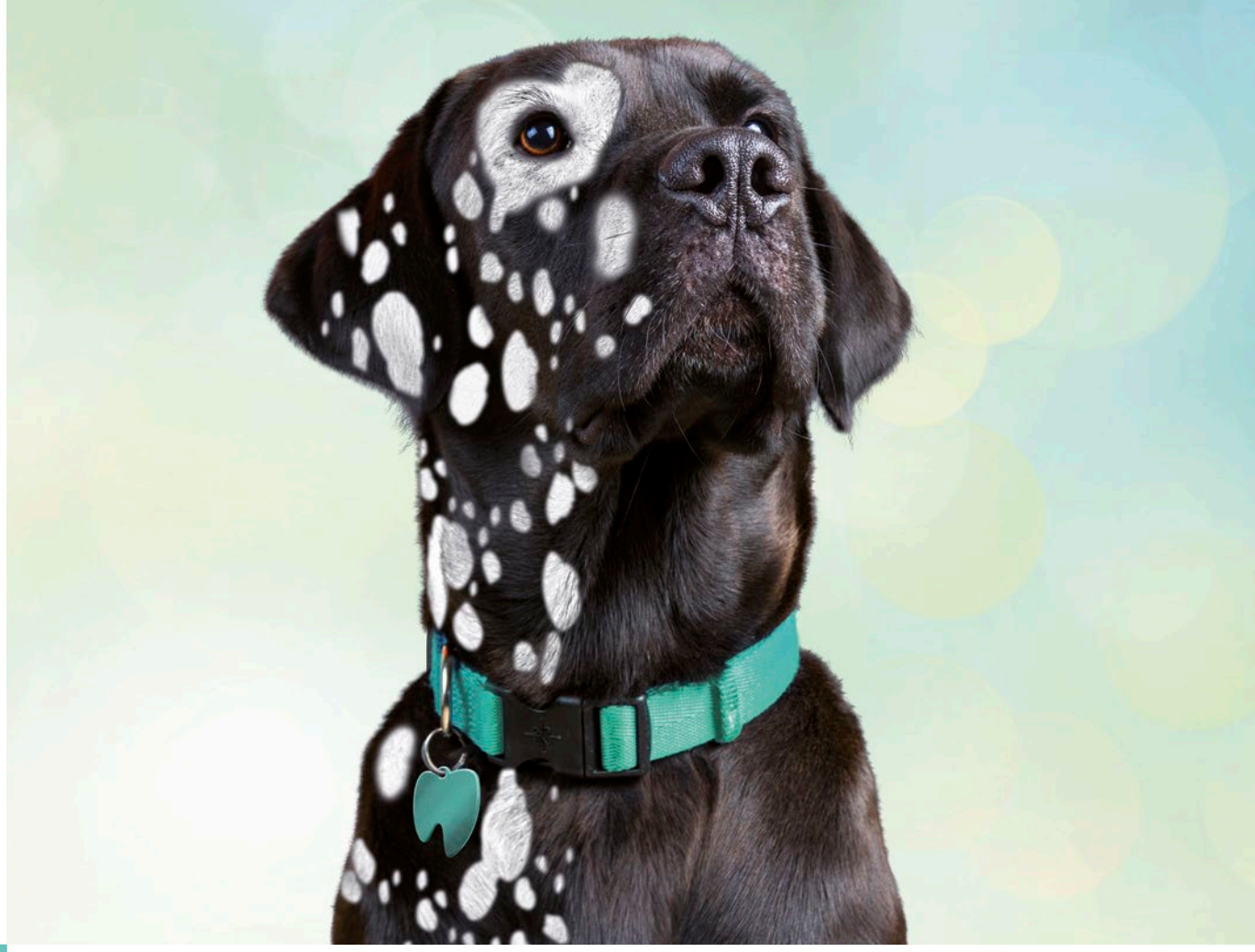
"What should we do? What are the actions that need to be considered? We do need to look back carefully to learn and influence our leaders; we need to provide them with accurate, relevant information, telling them what has gone wrong, telling them what will work for the future. Leaders need to engage with policymakers in a timely fashion that places people at the centre, particularly placing the people who are vulnerable to ensure they receive effective preventative care and good care of active oral disease.

"Research must be focused upon the questions which are burning, which are rate-determining for COVID-19, not the superfluous ones. With regard to education, we need to maximise the use of technology. But we also need to realise that learners are not fools; that if we are going to generate webinars they need to be of high quality. We need to ensure that the information we pass to oral health care providers ensures that patients are better treated. We need to maximise technology to enable people themselves to change their oral health. The prevention of common oral disease should remain a priority. If plaque related caries, gingivitis and periodontitis is prevented, then there's less of a need for a patient to acquire an invasive dental procedure.

"Governments must address the issues of deprivation and inequality. Dentists cannot do that. Medical people cannot do it either. They can make representation to governments, but only governments can truly change deprivation and inequality. The research we do should be targeted to key issues with respect to COVID-19 or anything else that is of major oral health need. Education must provide knowledge to ensure appropriate action by health care providers. We must remember that oral health care has changed because of COVID-19. But we must ensure that going forward, oral health care is better than the past.

"Finally, here are some phrases from Plato which, for me, summarise what is happening and what we should do. 'Wise men speak because they have something to say; Fools because they have to say something'. Be careful of webinars and be careful of poor reviews. They need to say something positive that helps you and in turn helps your patients. 'The measure of a man is what he does with power'. The leaders of dentistry need to ensure that they tell the policymakers that change is needed. 'Necessity is the mother of all invention'. You, as an oral health care provider, as a patient, as a member of the public may have a solution to a problem; ensure that you tell others about it. It is important to realise that COVID-19 is a pandemic. We have had pandemics in the past. And we will probably have pandemics of the future. The changes we make now will benefit others in the future. Let us make the most of that opportunity."

> "CHANGES WE MAKE NOW WILL BENEFIT OTHERS IN THE FUTURE – LET'S MAKE THE MOST OF THAT OPPORTUNITY"



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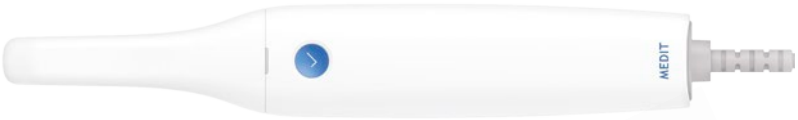

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Getting personal with the dental check-up: are risk-based recalls risky?

Patrick Fee[1], Derek Richards[1], Jan Clarkson[1]
[1] School of Dentistry, University of Dundee

How often to recall our patients is perhaps the most common decision dentists make. Traditionally most adult patients are used to having a check-up every six months, regardless of an individual's risk of oral disease. The most recent Adult Dental Health Survey reported that 61 per cent of dentate adults said the usual reason they attend the dentist is for a regular check-up [1].

The dental check-up can be considered to have a dual function in primary and secondary prevention. Early signs and symptoms of oral disease can be detected, in particular dental caries and periodontal disease, as well as a systematic examination of the oral mucosa [2–5].

Preventive advice can also be provided where appropriate and may incorporate oral hygiene instruction, dietary advice, and smoking cessation or alcohol-related health advice if appropriate [6,7].

Extending intervals between dental check-ups from six months to 18 months was proposed by Aubrey Sheiham in 1977, who concluded: "No evidence was found to support six-monthly dental checks" [8]. Recall intervals between check-ups based on patient risk assessment have been endorsed by professional expert bodies, dental health service reform initiatives and clinical practice guidelines in several countries [9–11].

The 2004 National Institute for Health and Care Excellence (NICE) guidance recommends that the interval between check-ups "should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease" [12]. Based on the NICE guidance the Scottish Dental Clinical Effectiveness Programme (SDCEP) published their Oral Health Assessment and Review guidance in 2011[13].

However, until now the evidence to support these recommendations was of low-quality. October 2020 saw the publication of an updated Cochrane review recall intervals for oral health in primary care patients [14]; its aim to identify the best time interval between dental check-ups. The review included randomised controlled trials conducted in general dental practices and is, therefore, of direct relevance to this setting. This review found two clinical trials investigating the effect of different check-up frequencies – including one recently completed trial – the INTERVAL Dental Recalls Trial [15].

This trial assessed patients attending the dentist either every six months, every 24 months, or attending for a check-up based on their likely risk of disease on a personalised risk-based recall interval. Recruiting dentists considered if each individual was suitable to be seen on a 24-month recall interval prior to random allocation to a recall strategy. Those patients where a 24-month interval was considered appropriate were randomised to one of three groups – six-monthly, 24-monthly or risk-based recall. Those patients where a 24-month recall was not considered appropriate were randomised to either a six-monthly or risk-based recall.

The clinical effectiveness and cost-effectiveness of these different recall strategies were assessed after a four year follow-up period across a broad range of clinical and patient-reported outcome measures: gingival bleeding on probing, periodontal disease, dental caries, calculus, patient well-being and patient satisfaction with treatment. Of the 51 dental practices and 2,372 recruited patient participants, 24 dental practices and 1,188 participants were from Scotland.

Consequently, the Cochrane review concluded that "there is high-certainty evidence that there is little to no difference in oral health outcomes when comparing six-month recall interval with a risk-based recall interval. In addition, there is moderate to high-certainty evidence that there is little to no difference in oral health outcomes when comparing a 24-month recall interval with either six-month or risk-based intervals". The comparison with the 24-month recall interval reinforces the value of the risk-based interval as all participants on a 24-month recall had been risk assessed and considered eligible for this interval.

The results of this review question whether a universal six-month check-up is the best frequency for check-ups when those attending based on risk or those low risk patients attending every two years had similar oral health after four years. The results also provide a positive message that dentists can accurately assess patients' risk of oral health problems and allocate an appropriate recall interval based on this risk assessment.

NICE guidance recommends a recall interval based on an assessment of an individual's risk of dental disease, varying between three months to two years between check-ups in adults, reserving the longest interval for patients "who have repeatedly demonstrated that they can maintain oral health" [12].

The guidance recommends the longest interval of 12 months between check-ups in those younger than 18 years old. The guidance also outlines the various steps dentists can take to decide on an appropriate recall interval and is summarised in Figure 1.

Details on oral hygiene habits and timing, dietary habits – including amount and frequency of sugar intake, fluoride use, and tobacco and alcohol intake can be collected in a comprehensive history. A medical history can be assessed to identify factors that may impact on oral health. Further important information is assimilated from a thorough clinical examination, where signs of active disease can be identified, plaque control and potential retentive factors evaluated, and quantity and quality of saliva assessed.

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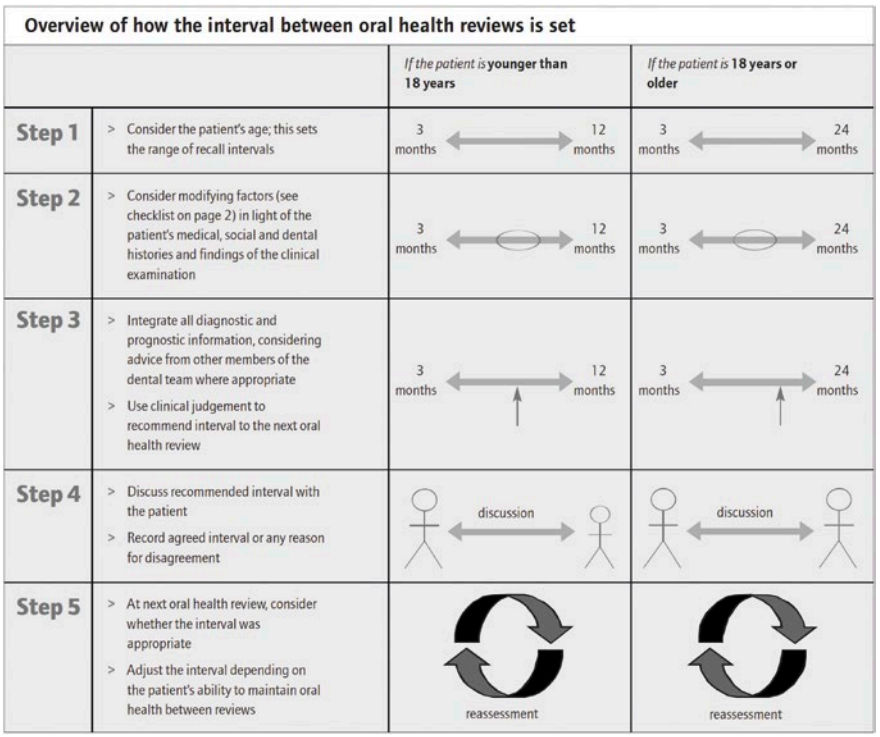
Figure 1
'Overview of how the interval between oral health reviews is set' + Table to the right-hand side: 'Risk factor variables from the NICE dental recall checklist'



Overview of how the interval between oral health reviews is set

		If the patient is **younger than 18 years**	*If the patient is* **18 years or older**
Step 1	> Consider the patient's age; this sets the range of recall intervals	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 2	> Consider modifying factors (see checklist on page 2) in light of the patient's medical, social and dental histories and findings of the clinical examination	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 3	> Integrate all diagnostic and prognostic information, considering advice from other members of the dental team where appropriate > Use clinical judgement to recommend interval to the next oral health review	3 months ⟷ 12 months	3 months ⟷ 24 months
Step 4	> Discuss recommended interval with the patient > Record agreed interval or any reason for disagreement	discussion	discussion
Step 5	> At next oral health review, consider whether the interval was appropriate > Adjust the interval depending on the patient's ability to maintain oral health between reviews	reassessment	reassessment

Risk factor variables from the NICE dental recall checklist

- Medical history
- Social history
- Dietary habits
- Exposure to fluoride
- Clinical evidence and dental history
- Recent and previous caries experience
- Recent and previous periodontal disease
- Mucosal lesion
- Plaque
- Saliva
- Erosion and tooth surface loss

Past disease experience can also be assessed through the number of restored and missing teeth. This can be a difficult component to integrate into the risk profile of new or recent patients where uncertainty around the timing of restorations or extractions remains following history and examination. A number of supporting tools have been developed and supplied with the SDCEP guidance to assist practitioners in the collection of appropriate information to aid risk assessment [13].

Integration of this collected information allows the clinician to use their clinical judgement to predict the individual's likely future disease experience and recommend an appropriate tailored recall interval based on this risk assessment. This is a joint decision between clinician and patient and involves discussing the recommended interval, exploring patient preferences and expectations, and discussing any relevant financial implications.

An agreed interval should result and be recorded along with a record of patient views, particularly useful where these may differ from the clinician.

In circumstances where uncertainty regarding an individual's disease risk occurs, an initial conservative recall can be extended where maintenance of oral health is demonstrated over time. Consideration of the appropriateness of the previous recall interval in terms of health outcomes and patient views can inform clinician and patient joint decision making on the next interval between dental check-ups. The interval may be maintained at the same level if it is achieving its aims. Where disease activity is low, the recall interval can be gradually extended towards the 24-month maximum period.

Where disease activity progresses, a shorter recall interval and more intensive preventive care may be considered. Individual risk factors and therefore risk of dental disease change over time. Where exposure to new risk factors are identified at dental recall appointments, previously longer recall intervals can be adjusted to account for changes in likely future disease experience. Clinicians should continue to use dental recall appointments to provide advice on reducing the patient's risk factors and enhance protective factors.

Dentist confidence in their perceived ability to assess risk increased with their experience of conducting risk assessments over the four-year trial period. With experience, clinicians should be able to carry out a risk assessment quickly and intuitively as part of each recall appointment.

One of the persistent arguments in favour of maintaining six-monthly dental check-ups is that dentists may miss the opportunity to diagnose oral cancer lesions at an early stage in patients who attend at longer recall intervals. The incidence of oral cancer in the UK is highest in Scotland, at 10.0 per 100,000 males[16]. However, it has been reported that 53.7 per cent of patients diagnosed with oral cancer had not attended a dental check-up at all in the two years preceding diagnosis [17]. It is estimated that dentists in Scotland will see a case of oral cancer once every 10-20 years [17] – depending on the geographical location.

In addition, risk factors for oral cancer are similar to risk factors for dental caries and periodontal disease – smoking and alcohol intake and individuals from lower socioeconomic

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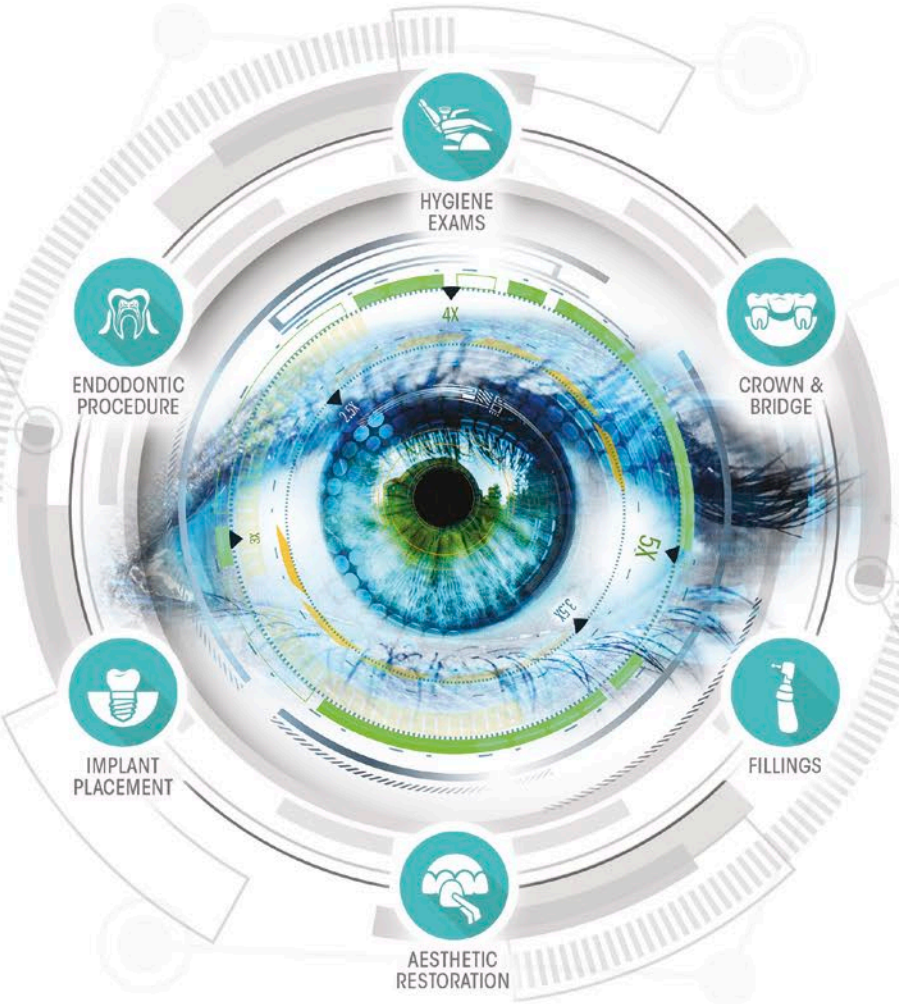

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status are at increased risk of all three diseases. A personalised risk-based recall would therefore allow those individuals at greater risk to be seen more frequently while healthy patients can be seen less frequently.

The UK National Screening Committee advises the NHS about screening programmes for all diseases and has considered oral cancer screening, rejecting it on several occasions[18]. Examination of the oral mucosa is still recommended at every recall, as is the recall of patients at high risk of dental disease and oral cancer more frequently than patients at low risk of these diseases.

A recent article in *The Lancet* commented on the opportunity afforded to dental services by the COVID-19 pandemic [19] – specifically re-orientation towards a less invasive and more preventive approach, prioritising care for high need groups and ceasing ineffective treatments that do not improve health outcomes.

Considering that the NHS in Scotland delivered 2.8 million dental check-ups in 2018-19, accounting for 15 per cent of all primary care dental spending [20], there would appear to be opportunities for cooperation between health care policy makers, clinicians and patients to ensure patients are receiving treatment supported by contemporary scientific evidence.

The results of this research are particularly valuable when considering the impact of the COVID-19 pandemic – dental practices have been closed, patient access for dental treatment has been limited, and access to dental care may remain limited for some time. But the results of this review provide reassurance to those seeking and providing dental treatment, that intervals between check-ups can be extended beyond six months without detriment to oral health. The enforced extended time between dental visits may also provide an opportunity for practitioners to identify patients at higher or lower risk of oral disease.

Figure 1: 'Overview of how the interval between oral health reviews is set' © NICE 2004 Dental Recall – Recall interval between routine dental examinations. Available https://www.nice.org.uk/guidance/cg19/evidence/full-guideline-appendices-f-g-pdf-193348913. All rights reserved. Subject to Notice of rights. Reproduced by kind permission from the National Institute for Health and Care Excellence (NICE). NICE guidance is prepared for the National Health Service in England. All NICE guidance is subject to regular review and may be updated or withdrawn. NICE accepts no responsibility for the use of its content in this product/publication.

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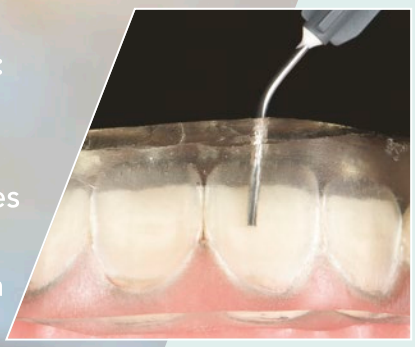

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Dr Emma Ravichandran

Dr Emma Ravichandran explains why she uses the new BELOTERO® Lips duo to create natural looking[1], predictable and harmonious results[2], that are tailored to her patients' individual needs.

What is so different about BELOTERO® Lips?

The true difference for me is the way in which BELOTERO® Lips and the full BELOTERO® range is manufactured. BELOTERO®'s patented technology is known as CPM® or Cohesive Polydensified Matrix® technology[2,3]. As practitioners in the UK and Ireland, we have a huge number of HAs available to us, BELOTERO® is the only cohesive polydensified matrix product on the market.

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Can you explain the Rheology of BELOTERO® Lips?

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Cohesivity

The cohesivity of a product is the ability of that product to stick together. Cohesivity of a hyaluronic acid within tissues is of paramount importance to minimise product migration, specifically when treating the vermilion border. This cohesivity combined with CPM® technology enables optimal tissue integration, and even distribution, reducing risks of bumps, lumps[1,4] and migration of the gel. In my opinion, the ideal product to treat the vermilion border is BELOTERO® Lips Contour or BELOTERO® Balance, this is because of its cohesivity.

Elasticity

Elasticity is the ability of a product to return to its original shape when placed under a stress. A HA with high levels of elasticity in the lips is crucial because of the constant functional movement of the lips. The elasticity of both BELOTERO® lips products is excellent, however the high elastic capacity of BELOTERO® Lips Shape makes it perfect for a natural-looking[1], long lasting[2] volumisation of the body of the lips.

The tailored rheological properties of the BELOTERO® Lips duo mean they can be used alone or in combination to define, project and volumise the lips[1], whilst giving a natural appearance at rest and on animation[1].

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  0.3 ml BELOTERO® Lips Shape
- **Lower Lip:**
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  0.2 ml BELOTERO® Lips Shape

BELOTERO® Lips Contour is a 0.6ml dermal filler with a cohesive polydensified matrix® of 22.5mg/ml Hyaluronic acid and is indicated for treatment of the vermilion border[5]. This product must be injected intradermally[5] to deliver the best and longest lasting results.

BELOTERO® Lips Shape is a 0.6ml dermal filler with a cohesive polydensified matrix® of 25.5/ml Hyaluronic acid and is indicated to volumise the body of the lip[6].

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BELOTERO® Balance Lidocaine is the same formulation as BELOTERO® Lips Contour. BELOTERO® Intense Lidocaine is the same formulation as BELOTERO® Lips Shape.

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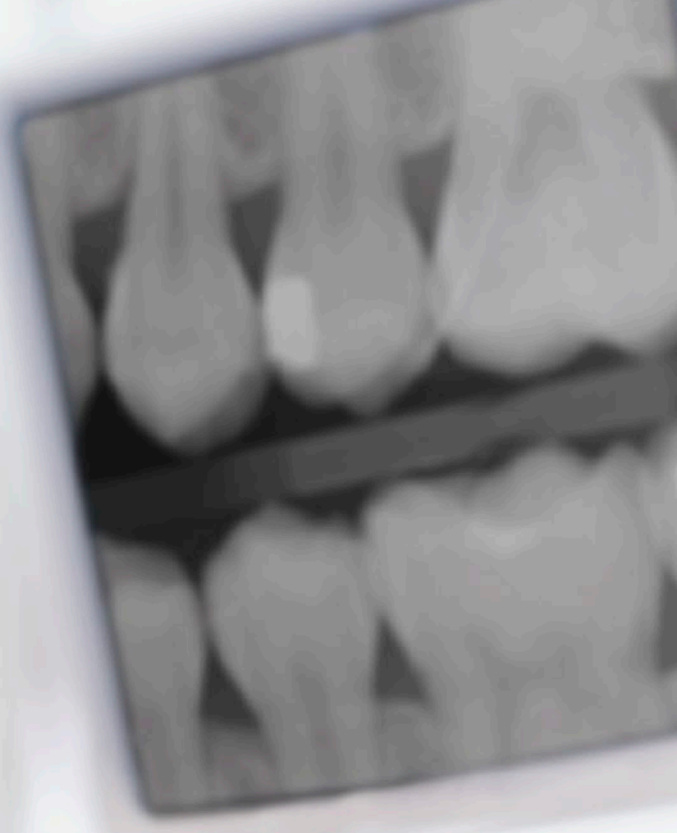

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'IF WE WINTER THIS ONE OUT...'

Ireland's Dental hears from Kulzer's Ryan Maguire about his thoughts for the future

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My career in dentistry began in 2001 with Henry Schein, where I held number of sales roles before initially joining the Kulzer team in 2006. I spent ten years at Kulzer as technical sales consultant for Ireland. I then assumed the role of Territory Manager with implant manufacturer Sweden & Martina and spent three years in the post. At the beginning of 2020, I re-joined the team at Kulzer.

HOW HAVE YOU FOUND YOUR RETURN AND WHAT ARE YOUR GOALS?

It has been challenging joining just as lockdown was implemented, but the team have been great welcoming me back. Dentistry in the south has restarted more rapidly than in the north. I've seen a rise in demand for our products so thankfully I have been kept busy. Normal service is yet to fully resume so I haven't managed to get around to see as many people as I would've hoped. That said, I am finding new ways to connect with clients; video conferencing is now much more commonplace for everyone. I've certainly adjusted the way I work somewhat.

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Going forward with Kulzer, my plan is to continue giving a hand to oral health, as is our company mission. I feel there is growing demand in the general public for high quality dental care. People are becoming better educated about what treatments available and therefore expectations are high. As a company, we have all the resources and expertise necessary to support Irish dentists to meet this high demand and deliver on patient expectations.

WHAT ARE THE COMPANY'S KEY STRENGTHS?

Our two USPs, in my opinion, are our people and our products.

In 2019 Kulzer UK & Ireland supported more than 130 hands-on restorative courses; this alone is quite a feat. Providing quality courses is extremely labour intensive and requires a massive effort logistically to ensure everything runs smoothly on the day for the delegates and speakers. The level of knowledge, experience and professionalism within the Kulzer team is the reason we are trusted to deliver so many world-class events. The Kulzer team, for me is truly unique and, I believe, second to none in the industry.

We are also fortunate to have many innovative market-leading products. Most notably, our range of composite materials. Venus Pearl, Venus Diamond and our recently launched Venus One are game-changers among restorative materials, all with our unique patented TCD-Urethane monomer. This innovation offers clinicians many significant benefits in terms of strength and aesthetics, to name just a few.

As a result, the fracture toughness of these materials is without equal in the market. The Venus range, like our team, is second to none in the industry.

FINALLY, YOUR THOUGHTS ON THE COMING MONTHS?

The coming months will no doubt bring challenges for our families and the profession as a whole, so please stay positive, stay safe and to quote the late great Seamus Heaney: "If we winter this one out, we can summer anywhere". If you would like to learn more about any Kulzer products, please get in touch with me. I am only too happy to assist in any way. I'm happy meet virtually or in-person, where it is safe to do so.

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JUST WHAT YOU'VE BEEN LOOKING FOR!

A new online dental jobs site is delivering what professionals and practices need. *Ireland's Dental* spoke to its founder, James Parish

CAN YOU TELL US A BIT ABOUT YOURSELF?

My career path really started in secondary school, where I was drawn to the sciences because I didn't enjoy having to write long answers to the questions in subjects such as English and History. Having grown up in a medical family I was naturally drawn to medical career pathways, and thanks to a natural aptitude for the sciences, I soon found myself with the grades needed to apply to medicine and dentistry. Like many dentists (I suspect!), I chose dentistry on the promise of a healthy income and Friday afternoons off! But in reality, dentistry has given me far more than I thought it ever could. It has proven to be a fantastic choice, one that I'm glad I made every day, even if I'm still working on Friday afternoons.

I graduated from Queen's University Belfast in 2013 and have since been working as a dentist in general dental practice. I really enjoyed my first few years in general practice, but I quickly became frustrated that there were clinical problems I couldn't solve, such as complex prosthodontic issues and dental implant cases. This prompted me to enrol for an MSc in Dental Implantology through the University of Bristol which I completed in 2019. This allowed me to broaden my scope of practice so that I could confidently treat most clinical problems. I now work in general and referral practice four days a week, and also work as a research supervisor for the University of Bristol on the implant course. This year has been an especially busy year as I have entered into the world of dental recruitment with Dental Jobs Online.

WHAT HAVE BEEN THE HIGHLIGHTS OF YOUR CAREER SO FAR?

One real highlight was winning the Leo Heslin medal from the Faculty of Dentistry at RCSI as a fourth-year student. I remember I was seated next to Patrick Palacci at lunch before he gave the Edward Leo Sheridan lecture, which was a fantastic experience, although I'd like to think I'd be able to contribute more to the implant conversation if we met these days. A huge recent highlight was when we received our first job advert on dentaljobsonline.ie – having worked on the site for months it was a really proud moment.

Dental Jobs Online.ie

James Parish
dentaljobsonline.ie
info@dentaljobsonline.ie

WHY DID YOU DECIDE TO LAUNCH A JOBS SITE?

After graduating, I moved to England and worked in Bristol and Cheltenham for a few years. When I returned to Ireland in 2015, I was looking for a job in Dublin, but it was nearly impossible to find one. I went through the traditional recruitment methods available but found it really hard to find out which practices were advertising, and incredibly difficult to contact them. I was really well qualified at that stage and not being able to find a suitable job was frustrating, but I also felt there must be a lot of practices who were missing out on recruiting other well qualified and experienced dentists like myself. That experience has always stuck with me, and so this year I decided to do something about it and so Dental Jobs Online was born.

HOW DID YOU GET IT OFF THE GROUND?

The process started when I commissioned our tech team to build a website. We looked at the existing recruitment options, both in Ireland and abroad, and worked out how we could improve on them. While I know a lot about the dental world, I knew very little about software engineering and one of the real challenges, and real successes, has been working with our tech team to deliver what dental practices need. One key feature of the site is our job alert emails. Once a dental professional signs-up, they can create a job alert so they will be emailed if a particular job is posted in their area of choice. For recruiting practices, this means they can now have their jobs emailed to dentists who may be interested, rather than having to wait for dentists to search through job sites to find them. The site is constantly being developed to make it more relevant and more useful for practices and jobseekers.

WHAT DOES THE SITE OFFER THAT OTHERS CANNOT?

Over the past few years there have been massive developments in recruitment in many industries, but these have been very slow to come into dentistry. Our site allows recruiters to create a practice profile, and to place jobs on our database. Once posted, jobs are publicised through our social media platforms on Facebook and Instagram. Dental professionals can 'save' their favourite recruiters to receive a notification when they advertise jobs and can also save job searches to be notified when jobs are posted in a particular location.

AND HOW DID THE LAUNCH GO?

Things have gone well so far! Since we started at the end of September, we've had 53 jobs posted with us and that number is always increasing. We are also launching in Northern Ireland over the next few weeks with a sister site (www.dentaljobsonline.co.uk). I hope that this will help border practices where recruitment has traditionally been difficult as they will be able to post their jobs on both sites – but only paying once – which should help them find the right people.

WHAT'S THE RESPONSE BEEN SO FAR?

The response has been very positive. I've had a few good chats with a lot of practice owners and managers who have been able to provide added direction for the site by telling me what they need.

AND YOUR PLANS FOR 2021?

We have big plans for where we are going to take the site. Our company aim is to make recruitment easy for dental practices, and dental professionals, and all of our future plans are aimed at achieving this. There is so much amazing technology available to take all the hassle out of recruitment. What we have achieved so far is to build a really useful recruitment site, but what we aim to do over the next few years is to take that to the next level.

DentalJobsOnline.ie Jobs Section

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- **Associate Dentist**
  Frazer Dental - Kingscourt, Co. Cavan
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- Northside Dental Surgery - Coolock, Dublin
- Crotty Orthodontics - Cork City
- Railway Dental Surgery - Cavan Town
- Renmore Dental Practice - Galway City
- Dublin Dental Clinic - Dublin City Centre
- Atlantic Dental Care - Strandhill, sLIGO
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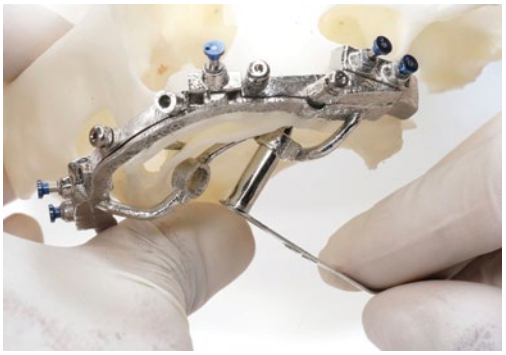
QUORIS3D APPOINTS NEW SALES MANAGER

Helping dental practices streamline workflow with CHROME guided surgery and 3D printing



Orla Sheehy will help practices use CHROME and 3D printing solutions

Quoris3D is delighted to welcome Orla Sheehy to the team as the new sales manager for Ireland and Scotland. Originally from Carlow, Orla has worked in the dental industry for more than 16 years. Prior to joining Quoris3D, she spent a number of years working for GSK before moving to the dental implant sector. Orla originally qualified as an engineer, then furthered her education by completing a Master's in Business in her spare time. This experience enables Orla to work with her clients to deliver real business benefits.

Speaking of her appointment, Orla said: "I look forward to helping dental practices streamline their workflow with CHROME guided surgery and our 3D printing solutions. We have a fantastic portfolio of products to offer along with the technical and surgical knowledge to support our customers."

Quoris3D is changing the face of dentistry with pioneering 3D print technologies. Its core business is CHROME guided surgery, which was developed for dentists who desire a pre-planned, predictable guided All-On-X style surgery. This service offers your patients a life-changing experience with virtually pre-planned dental implants and teeth in a one-day procedure.

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- **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'.

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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 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 a 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.

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