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## **Mental treatment acts 1945 to 1961: statutory provisions: regulations and explanatory notes regarding the reception, detention and discharge of mentally ill patients.**

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The ICSTD is a standing committee of the Faculty of Dentistry but with a wide membership across the dental spectrum that includes the three recognised training bodies in the State (the two dental schools in Dublin and Cork and the RCSI), the Irish Dental Association, representatives of the relevant specialist and consultant groups in both Oral Surgery and Orthodontics, the Chief Dental Officer and the Chairman of the ICSTD. Each of the membership categories is required to decide upon its own nominee(s). **It is important to note that within the specialist and consultant groups nominations, provision has been made to cover each of the relevant categories – i.e. one academic consultant, one regional consultant and one registered specialist and these are elected from within their own subgroups.**

Within the ICSTD, two new Advisory Committees have been established to provide a similar role to that of the SACs of the Joint Committee. From now on, any training facilities which are to be established in Ireland in either Oral Surgery or Orthodontics, must be inspected by these Advisory Committees and obtain approval through the ICSTD. Postgraduate programmes which do not have the approval of the ICSTD will not be recognised and the dentists who participate in such programmes will not gain entitlement to have their names entered in Register of Dental Specialists.

The provision of recognised training will ensure not only that our graduates will be trained to the highest level but it will also allow our patients to receive the highest standards of care. This is, after all, what everyone would wish to achieve.

### **Orthodontics:**

It is a requirement under the European Union Dental Directives that our specialists in Orthodontics are trained to at least the agreed minimum European standard. The European Union Advisory Committee on the training of Dental Practitioners has issued guidelines on specialist training and the Directive requires specialist training to be of a minimum of 3 years duration. The Dental Council has adopted the European model for specialist training in Ireland. Therefore, the curriculum for training and the regulations for examinations as laid down by the Council follow this format in this country.

### Training:

1. The entry point into specialist training which has been agreed by the three training bodies is:

- 2 years general professional training post-qualification and possession of the Membership of the Faculty of Dentistry, RCSI diploma (MFDRC SI) or equivalent

2. The course content broadly corresponds to the 'guidelines for the UK training programmes in Orthodontics for specialist registrars and other trainees' (April 1999) and fulfils the requirements of the relevant EU Directive

3. The course location has also been agreed in that more than 60% of the training time must be spent in a Dental school under the **direct supervision** of the Consultant trainer.

4. The training time will be 3 years after which an exit qualification will be taken at specialist level

5. If trainees wish to continue to Consultant level, a further 2 years training is required following which the Intercollegiate Specialist Fellowship will be necessary. The requirements for consultant appointments have already been drawn up and agreed between the CDO at the Department of Health and Children and the Faculty

The training described above mirrors the situation as it stands at present in the UK. The Faculty considers these standards to be essential for the trainee who will be recognised as an equal among his/her European colleagues, for the patient who will receive the best treatment and for the profession which reflects the standard of healthcare in this country.

Mr. Chairman, I would conclude this short presentation by saying that the Faculty of Dentistry would see itself as having no direct role in issues relating to manpower in this country but rather as a postgraduate body involved in the maintenance of the highest standards in postgraduate training in Dentistry in Ireland along with the Dental Council and the Universities.

**Dr. Peter Cowan**  
**Dean, Faculty of Dentistry, RCSI**



**Submission by the Dublin Dental  
School & Hospital to the  
Joint Committee on Health &  
Children of the Oireachtas  
in relation to Orthodontics**

**Professor John Clarkson, Dean  
Mr. Brian Murray, Chief Executive Officer  
Dr. Therese Garvey, Senior Lecturer/Consultant in Orthodontics  
Dr. Paul Dowling, Senior Lecturer/Consultant in Orthodontics**

**6<sup>th</sup> December 2001**

# Dublin Dental School & Hospital submission to the Joint Committee on Health & Children of the Oireachtas in relation to Orthodontics

## Mission

The provision of an environment where quality education, research and service programmes are integrated in a balanced way, appropriate to the resources available and the needs of the Community.

### **Goals**

Educate and train students to become highly competent, critically thinking, life long learning, ethical and socially responsible members of the dental team comprising dentists, dental hygienists, dental nurses and dental technicians.

Educate and train dentists in specialist and consultant postgraduate programmes to meet the needs of the community.

Provide continuing education opportunities for all members of the dental team.

Conduct research in education, basic and clinical sciences which builds on our strengths and individual talents at national and international level.

Provide clinical services at reasonable fees appropriate to the needs of the community in ways which ensure that the requirements of high quality teaching and research are met.

Provide a referral and consultation resource to healthcare providers and also provide appropriate clinical services at secondary care level focusing on multidisciplinary care and the development of centres of excellence.

Provide an environment that aids the retention and development of high quality staff.

The School and Hospital's mission and activities must operate in accordance with the Hospital's Establishment Order (S.I. 129 of 1963), be subject to the regulations of the Dental Council and international accreditation bodies and be carried out in collaboration with the University of Dublin, Trinity College.

The School and Hospital currently has 205 full time and 73 part time staff.

To achieve these objectives the School and Hospital carries out the following activities:

## Teaching

### **Undergraduate Teaching**

The undergraduate dental programme is a five year course leading to the award of a Bachelor in Dental Science (B.Dent.Sc.) degree of the University of Dublin. The teaching methodology is student self-directed learning (problem-based learning). Forty students are admitted to the course each year, of whom 8 are from outside the

European Union. The award of the degree permits, following registration, the carrying out of independent practice by dentists.

### **Postgraduate Teaching**

The Hospital provides a range of graduate programmes and courses:

#### Higher/Consultant

The Hospital is the only training centre in the country capable of providing programmes across the full range of specialities at consultant level.

#### Specialist

The Hospital provides three-year full-time training in a range of specialities. All graduates of these programmes are eligible for a certificate of specialist training for use in member states of the EU and satisfy the criteria set out on behalf of the Dental Council by the Irish Committee for Specialist Training in Dentistry of the Royal College of Surgeons.

#### Pre-Fellowship and Pre-Membership

Those who require to undertake specialist and higher training are required to have work experience in a dental hospital for at least one year or to have undertaken a course in vocational training. The School and Hospital provides courses for staff preparing for these programmes.

#### Higher University Degrees

The School and Hospital provides the resource to accommodate graduates undertaking scientific Masters and Doctoral programmes

### **Continuing Education for Dental Practitioners**

The School and Hospital provides formal programmes to practitioners in the form of both lecture based and clinical practice programmes. In addition, staff provide lectures to regional centres where scientific meetings are held. Also, staff members present lectures throughout the country on a regular basis.

Lecture Programme:- A monthly evening continuing education lecture programme is organised for dentists from around the country.

Clinical Practice Programme:- A weekly continuing education clinical practice course is organised. Dentists undertake to complete 6 practice modules over a 3 year period.

### **Dental Auxiliaries**

The School and Hospital provides formal training programmes in dental hygiene, dental nursing and dental technology.

Dental Hygiene:- A full time two year programme provides training for an intake of 8 students each year. The course meets the requirements of the Dental Council and includes training in infiltration local anaesthesia and dental radiography.

Dental Technology:- A full time three year programme provides training for an intake of up to 6 students each year.

Dental Nursing:- A full time two year programme provides training for an intake of 20 each year. The course became a full time two year programme in 1999 in order to address perceived deficiencies in the clinical experience of those qualifying. The course is aimed at school leavers.

A part time (evening) two year programme is provided for those working in dental surgeries who have no formal qualifications. In cooperation with the Dental Council, the Hospital is anxious to expand the numbers in dental nurse training at a regional level in order to address a shortage of trained personnel.

### **Staff Development**

The School and Hospital continues to train and develop all staff both clinical and non-clinical through a comprehensive training and development programme.

The School and Hospital provides support and encouragement for staff through the payment of fees and release for study leave to undertake courses leading to the award of Certificates, Diplomas, Degrees, Masters and Doctorates in a variety of disciplines.

The School and Hospital also provides support to staff through access to training in areas such as computer skills, manual handling, clinical skill development and management skills, etc.

### **External Academic Activity**

As an academic unit within the University of Dublin and in the European and international context of dentistry the Hospital provides significant input including leadership roles in the following activities which are essential for a dental teaching school and hospital:

University membership of Academic Council, College Officers and the Faculty of Health Sciences, Trinity College  
Royal Colleges of Surgeons in Dublin, Edinburgh, Glasgow and London  
International Association for Dental Research  
Irish Dental Association  
Dental Council  
EU Advisory Committee on the Training of Dental Practitioners  
International Federation of Dental Education Associations  
Postgraduate Medical and Dental Board  
Association for Dental Education in Europe  
16 international specialist associations  
European Association of Dental Public Health  
US National Institute for Dental and Cranio-Facial Research  
Health Research Board

In addition, as an academic clinical unit the School and Hospital provides an independent and hopefully informed opinion in all matters of oral health, disease and their treatment in this society.

Education and Training Programmes - numbers undergoing training

	Actual 1999	Actual 2000	Actual 2001
Dental Undergraduates (full-time) * 6 year programme until 1998	196	195	200
Higher Training (full-time)			
Orthodontics	1	0	0
Restorative Dentistry	2	0	0
Dental Radiology	1	1	0
Specialist Trainees: M Dent Ch			
Orthodontics	4	6	10
Oral Surgery	4	4	3
Prosthodontics	2	2	4
Periodontology	2	4	4
Paediatric Dentistry	2	2	0
Periodontology/Restorative	3	1	0
Oral Medicine			1
Pre-Fellowship and Pre-Membership Courses	12	13	11
Higher University Degrees			
Ph.D.	5	4	7
M.Sc.	1	2	7
MD	1	1	0
Dental Auxiliary Training			
Dental Nurse (full-time)	22	15	36
Dental Nurse (part-time)	36	70	66
Dental Hygiene (full-time)	16	14	16
Dental Technology (full-time)	9	5	5
Continuing Dental Education			
Monthly Lecture Course	76	75	96
Weekly Hands-on Course	40	40	40
Dental nurse courses	20	146	126
Dental hygienist courses	62	0	32
<b>Total:</b>	<b>517</b>	<b>600</b>	<b>664</b>

## Research

High quality research has been identified as a major priority for the School of Dental Science and the Dublin Dental Hospital. There has been a very significant increase in the quality and quantity of research papers published by the School's staff in international peer-reviewed journals of good standing over the last decade. The development of the new Dental Hospital & School complex on the Trinity College campus has provided a fresh impetus for clinical and basic research and the majority of staff are committed to developing and enhancing the School's research output over the next five year period.

There are currently several main areas of research undertaken or under development within the School and Hospital.

### Current research areas within the Dublin Dental Hospital & School

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- Oral Fungal Diseases
- Periodontology
- Oral Diseases and Oral Medicine
- Dental Education
- Public Dental Health
- Saliva and Salivary Gland Research
- Oral Pathology
- Restorative Dentistry & Materials Science
- Oral Clinical Research

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The research output is measured by reference to papers published in peer-review international journals, invited oral presentations from School & Hospital staff at prestigious international conferences and research grants. The overall research output of the School and Hospital compare favourably with similar institutions in the United Kingdom and in Europe.

The appointment of new key staff members during the last two years has allowed the expansion of the range of research activities undertaken in the School & Hospital to include community dental health, research, salivary gland and saliva research and gene therapy. Furthermore, an important new area of research into the microbiological quality of water in dental chair units, biofilm formation and environmental risk factors associated with dental equipment and the potential for the transmission of disease has been developed. This research program is essential because of increased awareness of potential biohazards in the dental clinic and concern about increasing numbers of dental patients with diminished resistance to overt and opportunistic microbial pathogens.

The School continues to co-ordinate a major EU Socrates Thematic Network (DentEd) to develop an EU system of quality assurance and application of best practice in dental education throughout Europe. All EU countries are represented by seventy different schools/institutions/national associations. This network is funded by DG XXII of the Commission.

**Table 2. Research Activities**

	1996	1997	1998	1999	2000
Publications in international peer reviewed journals	26	26	32	33	37
Invited oral presentations at international conferences	16	18	19	20	15
Theses published	6	8	2	3	6
Grants awarded to staff	£141,000	£142,000	£152,000	£154,000	£486,100
Presentations at international conferences	30	35	28	33	16
Presentations to learned societies and universities	52	60	54	50	54

## **Clinical Services**

### **Introduction**

The School and Hospital's oral services are broadly divided into three categories: emergency care, specialist services and general dental services carried out by students under supervision.

### **Emergency Services**

The Hospital provides a walk-in service for people in pain from Monday to Friday, 9.00 a.m. - 5.00 p.m. Patients are primarily self-referred and in pain. General hospitals and general dental practitioners also refer patients in pain for whom they cannot provide a service.

In addition, the Hospital provides an out of hours emergency service for the public and general hospitals accessed by telephoning the Hospital switchboard. This service operates until 01.00 hours and includes all day Saturdays, Sundays and Bank Holidays. Hospital staff are present in the Hospital for 2 hours every evening and for 3 hours every Saturday and Sunday to deal with emergencies. A review is currently taking place of the after hours service to determine whether it is necessary to continue with an after hours on site service during week days.

Hospital consultants are also on call from 01.00 hours until 09.00 hours each night to deal with emergencies from general hospitals with which the Dental Hospital has a service arrangement.

Last year 9507 emergency treatments were provided.

### **General Dental Services**

As a training centre the Hospital provides primary dental care to a cohort of patients who are treated by students under supervision, so that they can gain the requisite clinical experiences for the recognition of their courses. The students are required to gain experience across the full range of services provided by general practitioners in public and private practice.

Patients are sourced from a range of places including self-referral, the emergency service, referral from public and private practitioners who regard patients as being suitable for treatment in the Hospital, for social or economic reasons. Patients are assessed by staff as to their compatibility with student training needs and then assigned to student clinics.

### **Specialist Services**

The Hospital acts as a national resource for health board and general practice dentists for the referral of patients who require specialist treatments which dentists cannot provide. The principal referral specialities are:

Oral Medicine, Oral Pathology and Oral Radiology where the Hospital is the only reference centre in the country.

Orthodontics. Last year 11,304 treatments were provided.

Oral Surgery, covering maxillo-facial trauma, intermediate surgery and minor oral surgery. Last year 7,197 treatments were provided.

Restorative Dentistry, where the major treatment disciplines are fixed prosthodontics, removable prosthodontics, endodontics, full dentures, crowns, implants, occlusion, periodontology and general restorative treatments. Last year 20,067 treatments were provided.

Paediatric Dentistry. Last year 4,896 treatments were provided.

X-Ray Services. Last year 21,578 x-rays were provided.

The Hospital's X-Ray department has 2.5 full time equivalent radiographers who provide services for the Hospital's patients and for patients referred from other hospitals and dental practitioners for x-rays.

#### Laboratory Services

The Hospital operates an Oral Mycology laboratory and provides services as follows:

- Consultant and clinical diagnostic microbiology service for infectious fungi and yeasts to the Hospital's Clinics, the Prison Service, the National Haemophilic Centre at St. James's Hospital, and for clinicians in general practice. The laboratory comprises the only such dedicated mycology laboratory in the country.
- Antifungal drug susceptibility testing service for oral yeast species.
- Sterility testing service for Dental Hospital, Prison Service and St. Mary's Hospital Dental Theatre autoclaves.
- International reference and referral centre for clinical isolates of the recently identified pathogenic yeast species *Candida dubliniensis*, which was discovered by Dental Hospital researchers in 1995. The laboratory now receives a large volume of isolates for investigation each year from clinical laboratories all over the world.
- The laboratory also provides a unique molecular epidemiological service for investigating recurrent oral fungal infections.

The Hospital's Oral Pathologist operates in both the School and Hospital and the Central Pathology Laboratory (CPL) in St. James's Hospital. All oral pathology specimens are processed through the CPL.

#### External Services

The School and Hospital has service agreements with a range of agencies to provide specialist care services. These services play an important role in specialist/consultant training programmes as well as delivering specialist care for patients.

#### Mater Hospital:

The School and Hospital provides a maxillo-facial surgery unit at the Mater for the management of acute facial trauma, orthognathic (including TMJ) surgery and minor oral surgery.

#### St Vincent's Hospital:

The School and Hospital provides a consultant service for 2 sessions a week for inpatient consultations to the liver transplant, cardiac, haematology and respiration units of St. Vincent's Hospital.

#### St Luke's Hospital:

The School and Hospital provides oral care services for patients from St. Luke's Hospital undergoing radiotherapy treatment.

#### St Mary's Hospital:

The Hospital undertakes 5 theatre sessions each week for general anaesthetic and LA sedation cases in Oral Surgery.

#### St Columcille's Hospital:

A weekly theatre session is scheduled for the treatment of disabled patients and to undertake dental implant surgery. Very few of the scheduled sessions can be held because of the unavailability of beds. Where possible patients have been treated as day surgery cases in the Dental Hospital.

#### Hume Street:

One consultant session each week is provided for a joint clinic in Hume Street for patients with skin and oral mucosal pathologies.

#### Tallaght Hospital:

Two consultant sessions per week are provided for the treatment of children with bleeding disorders in the National Paediatric Haemophilia Centre and for children who are candidates for bone marrow and heart/lung transplants.

#### St James's Hospital:

A full dental service is provided by a consultant, house officer and dental nurse, for two sessions each week to the Haematology Department, which includes the Oncology and Bone Marrow Treatment Units and the National Haemophilia Centre.

One consultant session each week of Oral health care service is provided to the GUM clinic for care of patients with oral complications associated with HIV infection and sexually transmitted diseases.

#### Our Lady's Hospital for Sick Children, Crumlin:

The Hospital shares a paediatric consultant with Crumlin, together with non consultant dentists and dental nurses.

#### Prison Service:

A full oral/dental trauma service to Mountjoy Gaol, St Patrick's Training Unit, Arbour Hill Prison and Wheatfield Prison. This service is funded by the Department of Justice, Equality and Law Reform and provides for 19 clinical sessions each week.

#### Voluntary Health Insurance Board:

For the past 10 years the Dental Hospital has provided an advisory service to the VHI in respect of oral/dental surgery claims. This has had a significant influence in directing benefits towards more efficacious treatments. When first introduced this process reversed an escalating increase in oral/dental claims, the containment of which has been maintained since with significant cost savings to the VHI.

#### BUPA

An advisory service, similar to that provided for VHI, is provided for BUPA.

#### Emergency Services:

A 24 hour, 7 day on-call service for emergencies involving pain, bleeding, trauma and serious oral/dental infections is provided to Mater, St. Vincent's, St. Lukes, St. Columille's, Our Lady's Hospitals and to the Prison Service

## **Specialist Orthodontic Teaching**

Since the School & Hospital commenced orthodontic postgraduate training in 1989, we have graduated 14 specialist orthodontists and at the same time provided training for 7 orthodontists to consultant level.

There are currently 10 orthodontic postgraduate students in the School. This year we unsuccessfully advertised for the recruitment of a senior register to commence consultant training.

The Joint Committee should note that this is a high output of orthodontic specialists and consultants given the staff and resources available in comparison with Schools in other countries.

### **1989-1999**

The School & Hospital commenced the training of specialist orthodontists in October 1989. We recognised the future need for specialists and the increasing pressure which was evident in demand for orthodontic treatment in the public service.

The Joint Committee will be aware that in 1989 the Dental Hospital was in a building which was condemned by the Dublin Fire Service and there was no prospect of a new building in sight. At the same time, the School had to ensure that whatever programmes it offered met with accepted international standards, particularly as graduates of the specialist orthodontic course would have an automatic right to register as specialists in other EU countries under European law. The European Erasmus guidelines provide for orthodontic specialists to be in full time training with an academic institution for at least three years. The recognised training bodies here are the University of Dublin, University College Cork and the Royal College of Surgeons.

The University requires that all courses are externally examined as part of its quality assurance and improvement programme. In addition, the School and Hospital sought approval of its course from the Specialist Advisory Committee of the Joint Committee for Higher Training in Dentistry of the Royal College of Surgeons.

The Specialist Advisory Committee (SAC) guidelines limited the number of orthodontic postgraduates who could be accommodated within the Dental School so as to ensure adequate and appropriate training.

Because of a shortage of consultant staff both in the Dental School and in the Health Boards during the period 1989-1999, the School & Hospital was only able to graduate 10 orthodontic specialists and train 5 specialists to consultant level.

### **1999-2004**

In 1998 the Department of Health & Children, arising from the Moran Report and its consideration of the establishment of a specialist register in Orthodontics, requested the SAC to visit training facilities in the country. The SAC Report, published in 1999, permitted an increase in the number of trainees from a maximum of 6 at any one time to a maximum of 10 or 12 (depending on the involvement of the Regional Orthodontic Units).

At the time of the SAC visit in 1999 we had discussions with the Eastern and Western Health Boards to involve their regional consultant orthodontists in postgraduate training so as to widen the training base. Agreement was reached with the Western Health Board and two of their staff commenced our orthodontic postgraduate programme in October 1999. Two other students also commenced training that year.

When new consultants were appointed in the Eastern Regional Health Authority in 2000, it was possible to agree a training programme for 4 orthodontic postgraduates in the School working with Dr. Brian Bourke and Dr. Marielle Blake. In addition, working with Dr. Jane Davis in the South Eastern Health Board and Dr. Pat McSherry in the North Eastern Health Board, it was possible to accommodate a further 2 postgraduates.

There are currently 4 postgraduates in training who will graduate in 2002 and a further 6 who will graduate in 2004. For the next ten years, given the current training approval and resources, we anticipate being able to graduate a further 20-30 specialists.

Since the introduction of the Specialist Register in Orthodontics, the responsibility for recommending approval of specialist training programmes has shifted from the SAC to the Dental Council through the Irish Committee for Specialist Training in Dentistry. That Committee has just appointed a Director of Specialist Training and will be in a position to revisit training centres in the next couple of years. Although this may alter the approval for numbers in training, it is unlikely to move very far beyond the existing guidelines, which fall within international norms.

The Dental School & Hospital will co-operate fully with that Committee insofar as we have the staffing and resources.

### **Training Impediments**

The Committee should be advised that training is critically dependent on the number of consultant staff in the Schools and in the regional units. I would like to pay tribute to all those involved in our postgraduate programme, particularly my colleagues present, Dr. Garvey and Dr. Dowling, and Drs B. Bourke, M. Blake, N. McGuinness, J. Davis and P. McSherry in the regional orthodontic units and also Professor Lagerström who continues to provide some teaching support. Our staff are, however, under pressure to maintain the standard and quality of the specialist postgraduate programmes whilst at the same time providing undergraduate teaching primarily to dental students and also to dental hygienists and dental nurses.

Members of the Committee will, I am sure, be aware that it is extremely difficult to recruit dental nurses in Dublin and virtually impossible to recruit radiographers. This places serious difficulties in the way of maintaining teaching and service and is affecting our ability to provide the range of training and care we would wish.

The present teaching and seminar space is inadequate for our existing postgraduate specialist trainees in the various disciplines and causes concern with respect to increasing numbers further. A request has been made to the Department of Health & Children recently to purchase adjoining buildings to accommodate and expand our postgraduates training facilities. (The Committee's support for this would be very welcome)

## Future Training

### Existing Resources

Given existing staffing and facilities and with the active involvement of the regional consultant orthodontists it will be possible for the School to train 10-12 specialists at any one time provided dental nursing staffing, radiographer staffing and physical facilities be improved.

In addition we are also very anxious to train additional consultants to meet present and future needs and we expect to have a number of applicants in 2002.

We are also keen to train the proposed dental auxiliary therapists proposed by the Dental Council at the request of the Minister for Health & Children.

We would like to take this opportunity to thank the Department of Health & Children, in particular Mr. Tom Mooney and Dr. Gerard Gavin for all their assistance.

### Additional Resources

With additional resources, including a full time consultant orthodontist, dental nurses, radiographer, patient manager and space together with the vital involvement of our regional consultant colleagues, it would be possible to increase the number of postgraduates, consultants and therapists in training.

If we are to meet the level of demand for orthodontic services in the public sector, it will require the active participation of regional orthodontic units with both schools to make in roads on the projected manpower requirements.

As a School and Hospital, we continue to play our part in achieving that objective in so far as our resources permit, bearing in mind that orthodontics is one of the range of dental specialties for which we need to provide.

## **Presentation by the Cork Dental School and Hospital to the Joint Oireachtas Committee on Health and Children**

**6<sup>th</sup> December 2001**

Thank you Chairman and members of the committee for your invitation to make a presentation to you on the provision of orthodontic services in Ireland. Our presentation today will clarify the role of the Cork Dental School and Hospital in dental education and training, at both undergraduate and postgraduate level, and I hope that it will be of assistance to you in your deliberations.

### **Status and Function of Cork Dental School and Hospital**

The Cork University Dental School and Hospital evolved from the original dental hospital that had been established in 1913 by the North Charitable Infirmary. In 1968, University College Cork took over the administration and control of the dental hospital and a new Dental School and Hospital, built on a site adjacent to the Cork University Hospital in Wilton, was opened in 1982. The facility functions primarily as a teaching institution under the direction of University College Cork and it receives approximately 75 per cent of its funding from the Department of Education and Science. Teaching is delivered to students of dentistry, dental hygiene and dental nursing and approximately 150 students are enrolled at any one time.

## **Undergraduate Training**

The Cork Dental School and Hospital provides undergraduate dental education and training leading to the award of the degree of Bachelor of Dental Surgery by the National University of Ireland. This is one of the two qualifications awarded in the State that confer entitlement to registration in the Register of Dentists and the subsequent right to practise dentistry here. The main function of the Dental School and Hospital is to provide education and training to students of dentistry so that on graduation they have the requisite knowledge and competence to provide treatment at primary care level and the diagnostic skills to refer patients for specialist treatment. In order to train undergraduates to this level, both primary and specialist dental care must be provided within the school and hospital and to this end staff and students provide a wide range of dental treatments for patients from the Southern, South Eastern and Mid Western Health Board areas.

## **Specialist Services currently provided to Health Boards**

The senior staff of Cork Dental School and Hospital is comprised of specialists in paediatric dentistry, oral and maxillofacial surgery, oral surgery, restorative dentistry and orthodontics. These staff, in addition to their academic duties, provide an important consultant service within their areas of specialisation. An example of this service is the treatment of orthognathic surgical cases in the region. This means that all patients with orthodontic problems requiring surgical intervention, for example patients whose jaws need to be repositioned, can have their treatment provided by consultant staff of the Dental School and Hospital.

## **Specialist Training**

A secondary, but very important, function of the Cork Dental School and Hospital is to provide post-graduate clinical training to specialist and consultant level. Prior to the development of the Health Board orthodontic services and laterally the setting up of the Register of Dental Specialists, postgraduate clinical training in orthodontics was provided largely on a demand basis. The bulk of orthodontic treatment was provided through private practices and dentists sought training with a view to setting up such practices.

Specialist training was overseen by the UK based Joint Committee for Specialist Training in Dentistry but this function is now the responsibility of the Irish Committee for Specialist Training in Dentistry.

One of the current requirements for specialist training programmes is that trainees are supervised and trained by at least two consultants. At present the Dental School and Hospital employs just one consultant in orthodontics and consequently cannot at this time apply for recognition of a training programme.

Senior academic consultant orthodontic staff are in short supply world-wide and a number of efforts by the School to recruit staff at this level in the recent past have unfortunately proved to be unsuccessful.

In 1998 the Dental School offered an appointment as a visiting professor of orthodontics to a orthodontist from New Zealand. However, due to personal reasons, he unfortunately could not take up the appointment and our proposals to commence a programme of specialist training in the discipline had to be abandoned.

In 1999 an application to the Department of Health and Children for assistance with the funding of a permanent Professorship in Orthodontics was approved and the post was advertised. There were two applicants but neither was deemed to be suitable for appointment at this level. The post has again been advertised this year and interviews are scheduled to take place in mid February. From the number of inquiries made to date I am confident that the post will be filled in 2002 and we should be in a position to re-commence specialist training in orthodontics before the end of the year.

### **Facilities and Funding**

Training to specialist or consultant level involves the acquisition of diagnostic and clinical skills as well as the gaining of experience in research and audit. It is important that future directors of the delivery of health care are not alone fully experienced in all aspects of their own specialty but also knowledgeable about related specialties. They must work closely with other specialties within dentistry and medicine, and such a facility is available in a multidisciplinary dental school sited next to a major general hospital. The Department of Health and Children acknowledged that other requirements, such as clinical and computing facilities were required for postgraduate learning and in 1999 provided the necessary funding to have these put in place.

## **Plans for 2002**

The Cork Dental School and Hospital understands and accepts its remit to provide specialist training. The Dental School would welcome the opportunity of working closely with the local health board in the development of specialist training in orthodontics. The Dental School is currently unable to provide appropriate training in orthodontics because it does not have a second orthodontic consultant in post.

### **In 2002 the Cork Dental School and Hospital expects to:**

- Employ a specialist orthodontist.
- Appoint a Professor of Orthodontics.
- Begin a specialist training programme for 2-4 orthodontic trainees.
- With co-operation from Regional Consultants, and with the approval of the ICSTD, the number of trainees could increase to perhaps 6-8 per annum commencing in 2003.

**Presentation to Joint Oireachtas Committee on Health and Children  
regarding Public Health Orthodontics 24/1/02  
Ian O'Dowling, Consultant Orthodontist.**

Good morning

The National Orthodontic Service is disintegrating. The waiting lists for treatment are increasing, the waiting time for orthodontic treatment, that is the time from being placed on the list and receiving treatment has increased to such an extent that some patients now require surgery in order to achieve the same standard of result that could have been achieved if they were treated at an earlier age. We find ourselves in this position because of the incompetence of the Department of Health and Children and the greed of the Dental Schools of Cork and Dublin. There are four problems facing the service: -

- 1. Determination of Eligibility for treatment.**
- 2. Treatment of Patients.**
- 3. Training.**
- 4. The after effects of the SAC visit in 1999.**

**Determination of Eligibility for treatment**

In 1985 the Department of Health issued guidelines based on the severity of a child's problem. The guidelines are vague and the Moran Report, which looked at the future development of orthodontic services, recommended a specific index, the IOTN. This recommendation has not been implemented by the Department and in June 2000 and October 2001; two further sets of guidelines were issued by the Department. There is now such confusion, that as Consultant I do not know what guidelines are to be used when assessing children to determine their eligibility for treatment. The recent guidelines issued by the Department are so severe that I firmly believe Children will be damaged by exclusion from the service if I am forced to implement them.

**Treatment of Patients**

The only way we can significantly increase the number of patients under treatment, is to employ more staff: -

- Consultants
- Specialist Orthodontist
- Non-Specialist Dental Surgeons
- Private Orthodontists
- Axillaries

Due to the lack of trained personnel our ability to attract Consultants or Specialist Orthodontists to the service are extremely limited. The vast majority of treatment is provided by non-specialist Dental Surgeons trained by the Consultants. The Private Orthodontist's where I work are unwilling to accept patients from the boards existing waiting lists. Orthodontic Therapists will not reduce waiting lists.

### **Training**

The future of the service depends on our ability to train our staff to become Specialists in orthodontics. In most Countries it is recognised that training programmes are organised through Dental Schools. We have two Schools in this State, one in Dublin, one in Cork. The school in Dublin is the only school within the state recognised for post-graduate training in Orthodontics. It has been particularly unhelpful in developing training programmes for those working within the public health system and contrary to statements made by John Clarkson, is specifically unwilling to accept trainees from Cork. The school in Cork lost its recognition in 1996 and despite the appointment of a new Dean has been unable to regain its recognition. The letter of 1999, whereby the Consultant Orthodontist within the school stated that they were ready willing and able to provide post-graduate training for my staff was particularly unacceptable. In 1999, fed up at the lack of support from the Dental Schools, the Regional Consultants set a post-graduate training programme of their own. This training programme was due to be assessed in 1999 by an SAC visitation from the Royal College of Surgeons in London. Recognition of a training programme is necessary if one is to be allowed sit the specialist examination of membership of Orthodontics of one of the Royal Colleges. At the request of the Department and through the interference of the Dental Schools the training programme was refused recognition and collapsed in May '99.

### **The after effects of the SAC visit in 1999**

#### **A. Effect on Staff.**

- Resignation of Staff
- Dissatisfaction with status, job description etc.
- Reduction in numbers of new patients commencing treatment

## **B. The Attempted removal of certain Consultants.**

Since 1999 the public orthodontic service has been very much under the control of the Dental Schools and the Department. You will have heard John Clarkson and Robert McConnell refer to three specific Consultants. It is almost as if the Dental Schools have targeted three particular Consultants as being in some way unsupportive of their actions. We know that Triona McNamara was harassed and bullied by management within the Eastern Health Board, and that she was prevented from doing her job properly. We know that complaints to senior management and indeed to the Minister were a waste of time. It is clear that an attempt was made to force the resignation of Triona McNamara as Consultant to the Eastern Health Board.

## **C. Appointment of Pro-Dental Hospital Consultants.**

When the LAC interviewed for further Consultant posts in the Eastern Health Board, astonishingly Triona McNamara was not on the interview board. However both Consultants on the board represented the Dublin Dental School. Clearly the Dublin Dental School was now in a position to provide a strangle hold on Consultant appointments in the Eastern Health Board.

### **Solutions**

#### **1. Guidelines.**

There is a simple solution to the problems regarding guidelines. If the Consultants working within the Service could meet with the Minister for Health and his officials in the Department then very quickly consensus can be agreed on what guidelines are to be used. This will mean that the same set of criteria interpreted in the same manner is used in all health boards. However, I do not believe that the presence of the Chief Dental Officer would not be conducive to getting agreement.

#### **2. Training**

The issue regarding training is more complex. However if the Minister uses the EU directives, then he can decide what training programmes are recognised, if for example this afternoon he writes to the CEO's of all the Health Boards advising them to contact teaching institutions in the U.K and Northern Ireland, then I believe that training programmes can be set up. In

the mean time the Dublin School can reassess its commitment towards training and the school in Cork need not be forced into appointing unacceptable candidates to the post of Professor of Orthodontics.

There are problems and there are solutions, but unless the Department change and discover the courage to support the Public Health Service in contrast to supporting two Dental Schools, then there will not be solutions to the problems.

Thank you,

**Southern Health Board Orthodontic Service Jan '01-Dec '01**

<b>Ass/Op</b>	<b>New Pat</b>	<b>Treatment Complete</b>	<b>Recall</b>	<b>Other Appt</b>
2249	1332	947	3135	20427

Regional Orthodontic Department,  
St. James's Hospital,  
Dublin 8.

**Joint Oireachtas Committee on Health and Children  
January 24<sup>th</sup>, 2002**

**Oral Submission**

**Orthodontic Services Nationally.**

**Summary:**

- It is possible to deliver a good quality cost effective orthodontic service.
- It has been done and it can be done again.
- It is recognised by everyone that money is not the problem.
- There is a solution. It is simple and has no cost implications.

**Recommendation and Solution:**

- ◆ That orthodontic services, within the Department of Health, are moved from the Community Care section to the Hospital Care section.

Triona McNamara  
Consultant Orthodontist

## **Background:**

The Department of Health's policy is that orthodontic services are consultant-led.

The Department achieved much success with this policy from 1985 to 1999, when it gave into pressure groups and created the current crisis.

During this 14-year period improvements occurred in orthodontic services, nationally, every year.

- The number of children getting quality orthodontic treatment with fixed appliances increased.
- Waiting lists and waiting times improved every year.
- Health Boards recruited consultants, orthodontic units were built, staff were trained.
- At the same time as staff were trained, they were willing to deal with orthodontic waiting lists in an effective and efficient manner, resulting in thousands of children getting treatment throughout the country.
- Satellite orthodontic services were created in order to improve local access for patients.
- Public money began to be spent more efficiently and the squandering of public money on orthodontics, which was appalling in some Health Boards, was on the decline.
- While not ideal there was general recognition that orthodontic services were improving nationally, and that the system was fair.

Problems did exist, much more needed to be done but in the overall context we were going in the right direction, nationally, with orthodontic services.

Consultant-led services were introduced by the Department of Health to replace specialist orthodontists' services, which they recognised as having failed.

- There is nothing 'new' about specialist orthodontists' services.
- The claim by the Department, that the specialist orthodontists' services per se will solve our problems is wrong.
- There is nothing 'new' about the current training programme.
- This type of training programme has failed us in the past nationally and will fail us again.
- In reality it prevents patients' services.
- It ensures the thousands of children we could be treating now will not get treatment over the next five years.
- Most significantly it removes our only mechanism of dealing with our large waiting lists and it will delay recovery, to what we had back in 1999, by 15 to 20 years.
- There is nothing 'new' about the suggestion of sending patients into the private sector.
- All these so-called 'new' systems have been tried by the Department in the past and have failed us and there is evidence everywhere that they will fail us again.
- My colleagues and I welcome the introduction of orthodontic auxiliaries, but are alarmed at the lack of understanding by the Department of their needs.
- Should auxiliaries, as it appears, be introduced in the same unstructured way as has befallen clinicians, even more chaos is inevitable.
- The Department's suggestion that the specialist register might help is wrong.
- This register restricts orthodontic practice.

### **Track Record with Orthodontic Services:**

Personally I have provided quality efficient orthodontic services in both the Western Health Board and Eastern Health Board when supported by the Department of Health. (1992-1999)

### **Western Health Board & Eastern Health Board: 1992 - 1999**

For the Western Health Board, I reduced waiting times from over 6 years to 2 years. I trained four dentists and supervised a workload of over 3,000 patients in fixed appliances annually. I established and ran a central unit in Merlin Park Hospital, Galway and satellite services in Castlebar, Roscommon, Claremorris, with review clinics in Clifden and Ballina.

With the support of University College Galway, I succeeded in having the Medical Faculty open up their Masters' of Medical Science programme, which was then restricted to medical graduates only.

Not alone is this postgraduate programme now open to dentists but it is also open to pharmacists and other medically related post-graduates.

I began work for the Eastern Health Board in 1996. Within 2 years I reduced waiting lists from over 18,000 to 6,600 and at a time when the annual referral rate onto these lists was 2,000 patients.

All Category I lists were dealt with and I established a successful system whereby all Category I patients for the Region were seen immediately and started treatment within six weeks of their assessment. I reduced waiting times for Category II patients by 3.5 years and provided assessment services to all Category III patients. I trained 8 dentists and had over 4,000 patients in fixed appliance treatment.

As well as establishing the central orthodontic service in St. James's, I established and ran satellite services for patients in Wicklow town, Ballinteer, Coolock, Wellmount and Ballygal in Finglas, Roselawn, Kilbarrack, Larkhill, Crumlin, Athy, Naas and Newbridge.

As in the Western Health Board, my staff and I interacted with our community dental colleagues and held calibration clinics to help referring dentists who put patients on lists.

The service was not without difficulties. Problems existed but in the overall context the service worked well. I saw the achievements as a good start that could be built upon in the Region.

**When the consultant-led service was supported everyone was a winner: the Department of Health, the community, management, the trainees, myself. It was a very happy and productive time in the E.H.B., just as it had been in the W.H.B. It was also fair to everyone.**

Support staff were very much part of this successful process. Nurses, radiographers, clerical staff, all, were provided with opportunities for training and staff development. Nurses I trained have gone on to do formal MSc's and one was the first Irish orthodontic nurse to obtain a prize at a British Orthodontic Conference.

All staff, both clinical and non-clinical, were encouraged to attend courses and conferences. In addition I guided clinical staff to do some research work and they published and presented material at Scientific Conferences both nationally and internationally.

At no extra cost management and the Department of Health got a fine quality service for thousands of patients in the EHB/ERHA Region. At the same time as services were provided, my trainees received expert skills and the opportunity to develop their careers and increase their earning capacity. The trainees also benefited since it can cost over £200,000 to obtain orthodontic training and qualification. As consultant I benefited by being involved in training and interacting with young, keen, motivated dentists.

**The Department of Health abandoned its successful policy in 1999. This 'political whim' has caused chaos and confusion for everyone: patients, parents, politicians, managers, and consultants alike. It has also caused tremendous unfairness to be re-introduced for everyone.**

All the systems that had been tried and failed in the past are now re-introduced; training with no service commitment, fee-per-item. The unaccountable specialist services that had been eliminated, in every Health Board but the E.R.H.A., are now being re-introduced nation-wide.

Despite all the extra money, extra consultants, extra specialists, extra managers, extra money to the private sector, extra trainees, etc. etc. **fewer children are getting orthodontic treatment now throughout the country, than back in 1999.**

**Conclusions:**

- ◆ Change is needed within the Department of Health. All the difficulties experienced by orthodontics can be traced back to the Department of Health.
- ◆ The first breakthrough for orthodontic services happened back in the 1980's, when regionally, orthodontics in Health Boards was separated and moved from the community care programme to the Hospital programme.
- ◆ The Department of Health is the only place where this separation has not taken place.
- ◆ It is time to complete this process and separate orthodontics from the Community section of the Department of Health and move it to the Hospital section.

Thank you for giving me the opportunity to make this presentation. I wish you success in bringing normality back to orthodontics.



**Triona McNamara**  
**Consultant Orthodontist**

**Submission to:**

**Joint Oireachtas Committee on Health and Children.  
Thursday 24<sup>th</sup> January 2002.**

I wish to state I am here in a personal capacity and not representing the Western Health Board.

I have been working with the Western Health Board for twenty-four years. I am Principal Dental Surgeon in Mayo. I have always been interested in orthodontics and from 1993 have been actively involved with the Regional Orthodontic Department in Galway. My clinical time is confined to orthodontics. In 1998 I was awarded a Master of Medical Science on a study of the orthodontic and other dental needs of cleft lip and palate children in the West of Ireland.

Until 1993 there were basically no orthodontic services in the Western Health Board except what was undertaken by individual dentists in primary care. They did their best, but a lot of cases were too severe to be treated with removable appliances. Children in the West with extreme and handicapping malocclusions were placed on a large orthodontic waiting list. From this in the fullness of time (approximately six years), if they were lucky they might receive treatment through the private sector on a fee per item basis, but only if the Board had funds available and the private practitioner could facilitate the patients within his practice. It was an ad hoc unsatisfactory arrangement.

One of my first duties after taking over as principal dental surgeon in December 1989 was to review our orthodontic waiting list in Mayo and ensure the children on it fulfilled the Department of Health 1985 eligibility criteria. In Mayo we had upwards of a thousand children on our waiting list and the waiting time for treatment was almost six years, but in reality a significant proportion of these children never received orthodontic treatment.

In November 1992 Dr. Triona McNamara was appointed consultant orthodontist to the Western Health Board and she set about setting up and developing a Regional Orthodontic Service for the three counties Mayo, Galway and Roscommon. She used the same model as the MidWestern Health Board, which was devised and developed by her brother Mr. Ted McNamara. I am not aware that it has ever been acknowledged that Mr. Ted McNamara stands alone in his service to public orthodontics and orthodontic education. It was he who conceptualised and worked tirelessly to establish consultant led Regional Orthodontic Departments for the purpose of providing a top quality highly productive and efficient service to public patients. He is also exceptionally well qualified and is the only Irish graduate ever to be appointed Senior Registrar at the world-renowned Eastman Dental Institute in London. In the field of education he has been equally generous, having trained or assisted in the training of most of the consultant fraternity and many of the specialists trained in this country. All this was achieved while still continuing to deliver a first class public orthodontic service.

The very fine Regional Orthodontic Department in Galway was officially opened in 1994. The effect on the service in the region was revolutionary. Waiting time for treatment dropped significantly and a highly productive efficient service of the highest quality was provided. In the years 1994 to 1996, a total of 4,355 children started treatment. The high quality of this treatment was confirmed by independent audit (Burden et al, Belfast 1997). At the time of her departure in June 1996 waiting time for treatment was at two years and heading for eighteen months. Mr. William Moran the then General Manager for Galway Regional Hospitals wrote of Dr. McNamara "You have developed a service which is the envy of all and you have moulded a most dedicated, skilled and enthusiastic team". He further wrote "It has been a great pleasure for myself and all in the Management Team to have worked with you and experienced the quality of work which you have achieved".

The fine fully functional department with a highly trained and committed staff worked to a new consultant from 1997. The department continued to function satisfactorily until towards the end of 1999. Then problems began to arise. Children in the West with severe malocclusions who were deserving of treatment and who would have been deemed eligible for treatment prior to 1999 were now being denied treatment. The waiting time for treatment also began to increase and now stands at over four years.

This has caused immense distress for children and parents and also for colleagues like myself who have been involved in providing orthodontic treatment in the region in times when chronic lack of funding was the problem. It is inexplicable in these times of unprecedented prosperity that children in the West of Ireland are finding it harder to receive essential orthodontic treatment.

The disintegration and collapse of the fine orthodontic service we had has been very difficult to witness. As previously stated I have been twenty-four years with the Western Health Board and have seen a range of efforts to deal with orthodontics. I have experienced the private fee per item. It is not cost effective for a Health Board. An independent analysis of the cost of the two systems was carried out in the Western Health Board. For every one child treated in the private sector up to three children could be treated through the consultant led service we had. The consultant led service has been without doubt the most effective, when not interfered with.

In conclusion, the West, for the first time had a fine top quality regional orthodontic service for children. The West has been marginalised enough. It is wrong that genuinely deserving children in the West of Ireland are being unfairly denied essential orthodontic treatment because of politicking by powerful lobbies in Dublin. I am disappointed that the Department of Health allowed this happen.

Signed:   
Antonia R. Hewson,  
Principal Dental Surgeon.

**PRESENTATION BY**  
**THE ORTHODONTIC SOCIETY OF IRELAND**  
**TO**  
**THE JOINT OIREACTHAS COMMITTEE ON HEALTH**  
**AND CHILDREN**

**24<sup>TH</sup> JANUARY 2002**

## INTRODUCTION

The Orthodontic Society of Ireland is the only professional body which represents Irish orthodontists in all areas of clinical practice – academic and regional consultants, specialists in private practice and the public service, and graduate students on formal training pathways. The OSI is affiliated to the World Federation of Orthodontists and is a member of the society of the European Federation of Orthodontic Specialist Associations. The OSI organises continuing professional development for its members by way of lectures courses which attract the world's most eminent speakers to its scientific meetings.

It is an inclusive clinical and scientific society whose membership includes over 90% of registered specialists in Ireland. Across the whole spectrum of our membership, there is support for the co-ordinated, planned development of orthodontic services to deliver high quality treatment in an equitable and affordable system. The OSI endorses the current policy of the Department of Health and Children, with regard to the consultant-led delivery of service and the training of specialist personnel.

Orthodontics is the branch of dentistry concerned with the growth and development of the face and jaws, and the diagnosis and treatment of occlusal anomalies. Orthodontic treatment is a highly sophisticated health care service which results in excellent treatment of malocclusion and facial deformity, based on the premise that treatment is provided by well educated, skilled, and experienced specialists.

Orthodontics is a recognized specialist branch of dentistry as defined by European Directive 78/687, in accordance with which the Dental Council in Ireland holds the Register of Specialists (Orthodontics). Registration depends on successful completion of approved training courses in academic institutions, which comply with international guidelines and are subject to approval by The Irish Committee for Specialist Training in Dentistry (ICSTD). Arising from the European Directive, the Erasmus Project has outlined strict criteria for a 3-year university-based postgraduate academic and clinical

training, entry to which must be by open competition between applicants who have achieved the basic entry requirements. Under EU law, graduates of such courses have automatic right of specialist registration in other EU countries.

The OSI fully endorses a planned programme of training under the auspices of the ICSTD. "Training" courses which do not meet the Erasmus regulations or receive ICSTD approval cannot result in specialist status or registration, and have no place in the future development of orthodontic services in Ireland. "Great harm can be done by incompetent orthodontic treatment" (Houston, Tully and Stephens) and it is no longer acceptable for children in the public sector to receive compromised orthodontic treatment.

The Dental Protection Society in a recent publication to members, 'Riskwise Ireland', advised that dentolegal problems are more likely to arise where a general dental practitioner with no formal training in orthodontics is undertaking the treatment.

#### **CURRENT DELIVERY OF SERVICE:** History of service and current problems

Current problems arise due to the inability of the hospital orthodontic service to meet the extraordinary demand for orthodontics from the increasingly dentally aware population of this well developed Western society.

No society has ever successfully delivered high quality free orthodontic treatment on demand, and in Ireland, the hospital service has signally failed to do so. The service, as structured, was doomed to fail since the problem of inexhaustible demand was compounded by both the limitations on productivity and the high costs inherent in the system.

There has been no universal system for the delivery of orthodontic treatment in the public sector but, as demand for orthodontic treatment increased, there was an ad hoc response in a localized and fragmented way. Following the appointment of the first Regional

Consultant in 1985, a model of service delivery was adopted based on consultant supervision of public service dentists. This arose in circumstances where manpower constraints were severe, but it has been adhered to since, and expanded to apply to many Health Boards in the country, in spite of increased availability of specialist manpower in both the private and public sectors. It was adopted as the preferred model in the then EHB region as lately as 1996, with the recruitment of general dentists from the community service to the newly established Regional Unit, despite the fact that qualified specialist orthodontists who were then in the full time salaried employment of the EHB were excluded from the Unit.

This model of consultant-led and dentist-delivered service had the following deficiencies

Low Productivity:

Since key clinical decisions must be made by the competent clinician, in this case the consultant, the productivity of this one individual limits the productivity of the whole system. Productivity is further reduced where consultants avail of their contractual entitlement to fulfill their public service hours in four working days per week. It might be noted also that the entire functioning of the system depends on a single individual, as was demonstrated recently with catastrophic results in the ERHA.

Consultants' clinical time is necessarily further reduced due to their commitments in other areas- administration, assessment clinics, research/audit and teaching. Indeed, the planned development of a graduate training programme within Health Boards will further reduce the amount of consultant time available for service supervision.

Although exact figures are not available to this Society, a review of the published statistics from Health Board Annual reports, seems to confirm the that productivity of the system is low. The published national figures for the productivity of the public orthodontic service shows that total annual completed treatments do not exceed 5000 and this is despite a massive programme of capital spending to establish new treatment units,

and expenditure on pay and non-pay budgets which is high relative to all other dental budget spending.

Specifically, for instance, in 1998, the Regional Orthodontic Department in the Eastern region, which was established in 1996 with a clinical staff of 7, reported:

Finished cases	289 (41 per staff)
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This was in the year that the Moran Report based its assumptions on productivity within the system of 350-400 completed cases per practitioner per year.

#### High Costs

Salaries of dental staff properly reflect their professional training and qualifications but this model of service delivery under-utilises these clinical skills and essentially uses qualified professional staff in the role of auxiliaries.

These professionals are then lost to the understaffed general dental service where they would be a valuable resource in the delivery of both primary dental care and interceptive orthodontics. An effective secondary service depends on an efficient primary care service, with adequate monitoring of occlusal development, diagnosis of abnormalities, appropriate primary interventions and timely referrals to the hospital service. It was always entirely self-defeating to have a secondary service which acted as a drain on primary care professional staff.

Precise figures are not available to this Society, but we estimate that direct professional and non-professional salary costs alone would amount to over £800 per case, if productivity could be maintained at 200 completed cases per specialist annually.

This would seem to be confirmed also by the figures put forward to this Society by Mr. Michael Walsh, Assistant Chief Executive of the Northern Area Health Board, in our recent negotiations on the proposed public/private mix pilot scheme. The proposal to fund Medical Card Holders in the private sector with a grant of £2,000 was based on Board estimated costs per case in the St. James Hospital Unit of approximately £2,000.

In summary, the model of the hospital orthodontic service, consultant-led and dentist-delivered, although conceived as a mechanism for delivering high volume/low cost treatment has in fact proved to be the opposite. The system, since 1985, has been enormously and increasingly expensive and has failed to meet demand resulting in the current waiting list crises in most Health Board areas.

It is apparent that provision of service directly by registered specialists, with a full time clinical commitment, would allow for greatly increased productivity, by removing the dependence of the service on a single clinician whose other duties necessarily reduce his/her availability for clinical supervision. It is the position of the OSI that this system would also reduce total costs per case. Consideration should be given to the use of orthodontic auxiliaries to support the specialist staff, to further increase productivity.

## **DEMOGRAPHICS AND MANPOWER**

Studies on manpower levels are relatively few and there is no recognized ideal orthodontist:population ratio. Extrapolation from the most recent published figures for Ireland suggests that there are currently 79 specialists eligible for specialist registration in Ireland. (Blake, Garvey and Healy, 2001)

TABLE 1

## Orthodontic Specialist Manpower

SOURCE	NUMBER
Private Sector	47
Public Sector	17
Regional Consultants	10
Academic Consultants	4
Tertiary Care Consultant	1

The total number of orthodontists in the country has increased over the last twenty years so that the orthodontist:dentist ratio has almost doubled and the ratio of orthodontist:12 year olds has improved almost threefold.

TABLE 2

## Orthodontist : Dentist

YEAR	No. Dentists	No. Orthodontists	RATIO
1980	1033	22	1:47
1998	1713	69	1:25

TABLE 3

## Orthodontist : 12-year old

Year	No of 12-year olds	No of orthodontists	Ratio
1980	61,004	22	1:2773
1998	61,425	69	1:890

The age profile of Irish orthodontists is young with 60% having over 20 years to retirement. Studies suggest that natural wastage will require 29 replacement orthodontists to maintain the current orthodontist: 12-year old ratio over the next 20 years. Relative to other European countries, levels of orthodontic manpower in Ireland are quite high and the manpower 'crisis' is not one of absolute numbers but rather one of access, with uneven distribution between public and private sectors, and uneven spread geographically.

## TRAINING

The Dublin Dental School is currently the only recognized centre for training of orthodontic specialists in Ireland. An approved programme of specialist training was established in 1989 by Dr Bryan Jones which produced 12 specialists and 5 consultants over the next twelve years, in circumstances of poor resources and low staffing levels. More recently, with the involvement of Regional Consultants from 5 Health Board areas, it has been possible to expand this programme so that 10 postgraduate students are currently in training. This programme which is capable of expansion in the coming years with the involvement of other regional consultants, particularly if funding is made available to expand the Cork Dental school facilities.

This is in marked contrast to the productivity of regional departments as 'training units' independent of the academic institutions in Ireland. Over the 17 years since the first centre was opened, only 5 specialists have been trained.

Of the 10 graduate students currently in approved training, 8 are sponsored by Health Boards and are committed to the service for three years post-qualification. Of the 12 specialists trained prior to 2001, 7 were sponsored by Boards and are currently employed in the public sector.

The Orthodontic Society of Ireland supports the Dental School training pathways. However, it is important to realize that training is costly in terms of financing and time. It involves:

- Investment in the teaching facilities of the dental schools- academic and support staff
- Uptake of the limited clinical time of the available regional consultants
- Treatment facilities and supporting staff of regional units devoted to trainees and therefore lost to service production.
- Salaries of trainees for 6 years –3 training and 3 post qualification
- Low productivity during training

Training is incompatible with the simultaneous delivery of an efficient service and if trained specialists are not retained in the service, massive public expenditure will have been wasted without producing any benefit to the service whatever.

## **RECRUITMENT**

Recruitment of trained specialists is obviously an attractive option since it removes the burden of training costs from the service.

There are currently 15 Irish postgraduate students training in UK/USA, some of whom may be expected to return to the state. Manpower studies in Britain suggest an overall shortage of orthodontists, so it is likely that most British trained specialists will find employment in UK. Recruitment from other European countries faces the problem that conditions of employment are generally less favourable in the Irish public sector than in European systems.

To date, there has been only limited success in recruiting trained specialists. Country wide, there have only ever been 10 specialists recruited to salaried dental service, 1 Irish, 4 UK, 2 US, and 3 European. Retention of recruited staff has been even more

unsuccessful with 4 of these specialists leaving the service after very brief periods, and only one of the remainder having taken up permanent employment with a Health Board.

The principal obstacle to the recruitment of specialists has been the absence of a grade of specialist, other than consultant, within the service. Retention was poor due to the lack of a career pathway and the relatively poor remuneration offered by Boards in a piecemeal way in different areas. The recent introduction of the specialist register has allowed progress to be made on the establishment of specialist grade, and negotiations have recently been completed with the HSEA to agree the responsibilities, duties, terms and conditions of the post. The grade provides for a full time clinical commitment of staff trained to treat all cases, at a salary approximately 75% of that of the consultant. It is to be hoped that these developments will prove sufficient to attract specialists in the future.

It should be noted however, that although the post has been approved by the HSEA, it has not yet been processed through the Department of Health and Children. The OSI would urge the Department to proceed forthwith with the establishment of these posts. Orthodontics is a clinical discipline with a protracted treatment time and continuity of care with one practitioner is critical to the success of treatment. Retention of staff is crucial for both the standards and efficiency of the service.

#### **TREATMENT NEED – Epidemiology of occlusion**

Orthodontics involves the treatment of dental anomalies which arise in almost 100% of cases as a result of individual variation and not as a result of disease. The extent to which poor alignment can affect dental health has been extensively researched and it is established that it is only at the very extremes of normal variation that orthodontics confers any health or functional benefit. (Shaw et al 1981)

The majority of orthodontic treatment is carried out for *aesthetic* reasons, and the extent to which this carries psychosocial health benefits is also extensively researched. (Shaw et

al 1980, 1981) Again, it is established that only extreme deviations from the norm carry any psychosocial handicap.

Thus treatment 'need' can be defined in terms of patients who will show a measurable health benefit from treatment, in contrast to 'demand' for treatment which is determined by a subjective desire for improved dental appearance, and is almost inexhaustible. Demand for treatment even when third party funded, is higher in higher socio-economic groups (Proffit and Fields, 2001), and may approach 60% of population where there is free access to services. International experience shows that demand for orthodontic treatment has the potential to overwhelm the capacity of any service to provide it, and that there would be minimal health benefit in establishing such a service.

It is necessary therefore to distinguish between need and demand, and much scientific research has led to the development of indices capable of identifying patients who will show a measurable health benefit from treatment - such as the IOTN (Shaw et al 1991) which incorporates both the functional and aesthetic components of treatment need. The OSI favours the use of an index such as IOTN in the public service, since it is internationally accepted as reliable and valid, is administratively simple to apply, and can be used with much greater objectivity than the current guidelines of the Department of Health and Children.

Eligibility under current Department guidelines probably extends to around 18-20% of 12-year old population, or 10,000-12,000 eligible cases per year; expansion of the scheme to include all IOTN Categories 4 & 5 may extend eligibility to 30-35% of 12 year olds, or 18,000 -20,000 cases per year. The actual uptake of treatments would be somewhat less. The cost to the state of providing orthodontic care to all patients in IOTN categories 4 and 5 would be in the region of £36,000,000.

In view of the limited health benefit to be gained from this level of service, and the costs involved, it may be appropriate to consider a rationalization of the eligibility criteria, to include an assessment of the patients' ability to pay. Such measures might require a review of the Health Act or the directive of 1985.

### Structure of services

The OSI considers that successful planning of future orthodontic services must involve two separate approaches:

1. Long term strategic planning.
2. Management of the existing localized acute problems created by current regional waiting lists-waiting list initiatives

#### **1. Long term strategic planning of services**

This Society believes that the structure of the public orthodontic service should be planned to cater for the level of service it ultimately intends to deliver and that current waiting lists should be addressed by separate measures.

Since there is no definitive clinical cut off point which determines a health or functional indication for treatment, the level to which free orthodontic treatment is to be provided is essentially a political or administrative decision.

Principal options for delivery of service are:

1. Exclusive provision of service within the salaried public service, which would require manpower based on productivity of 200 cases per year per specialist, or 300 per year where the specialist is supported by an auxiliary.
2. Partial provision of service within the private sector, possibly by the creation of a category of partial eligibility based on clinical criteria and/or ability to pay.

#### **2. Management of current Situation:**

The ongoing inability of the Hospital services to meet the demand for service has resulted in waiting lists in most Health Boards, with a total of 23,686 awaiting assessment and 11,995 awaiting treatment.

**Table 4****Orthodontic Waiting lists (November 2001)**

Health Board Area	Awaiting Assessment	Awaiting Treatment
Eastern	11,781	904
Southern	5,962	4,470
Midwest	3,380	1,392
Northwest	1,210	2,173
Western	719	1,479
Midlands	377	473
Southeast	257	462
Northeast	None	642

It is most interesting to note the geographic spread of the areas with highest waiting lists, with 89.2 % of the assessment waiting lists in the three areas where the model of consultant-led and dentist-delivered service has been long established, and where it is advocated that this model be continued. It is ethically unacceptable and indeed probably illegal to allow patients to remain on a waiting list for possibly over two years, only to deny them service by reason of non-eligibility. If clinical guidelines are to be used to target patients with maximum occlusal handicap, then the assessment must be provided within weeks or months of referral.

Treatment waiting times are absolutely unacceptable also, doing a great disservice to patients who have treatment delayed long beyond the ideal time clinically.

**Waiting List Initiatives****1. Assessment waiting lists**

The waiting list for assessment should be cleared in 2002 and in future, assessment waiting times should be kept below three months. Such assessments can only be carried out by consultant/specialist and should ideally be provided by 'in-house'

salaried staff, since there would be a perceived conflict of interest if specialists from the private sector conducted assessments.

This is not the impossible task that it might appear. In the East Coast Area Health Board, (ERHA) the newly established regional unit commenced service in September 2001, and by the end of January 2002, it will have successfully cleared an assessment waiting list of almost 2,500, without a full complement of specialist staff. In four other Health Board regions, the total assessment waiting list is only 2,563 and could presumably be cleared in a similar time frame.

## 2. Treatment waiting lists :

Possible strategies for immediate effect include :

- Increasing capacity of public service – along lines of scheme implemented recently by NAHB where salaried specialists are given use of public facilities on a fee per item basis out of hours. Such schemes might address some of the problems of recruitment and retention of specialist staff.
  
- Accessing treatment in the private sector- options:
  1. Full funding of private sector fees for eligible patients.
  2. Grant in aid for eligible patients – contrary to Health Act, but may be possible through Social Welfare system
  3. Reduced fee to private specialists providing treatments in Health Board facilities- reducing direct expenditure for Boards and maximizing the return on the capital investment of establishing the regional units.

Any proposals to involve the private sector should be introduced on a national basis and the Orthodontic Society of Ireland would be happy to engage in negotiations should any such scheme be considered.

## RECOMMENDATIONS:

1. The immediate national implementation of the agreed specialist posts and commitment to an exclusively specialist delivered service.
2. Training of further specialists through the approved academic training pathways, in conjunction with regional consultants.
3. Recruitment of European registered specialists.
4. Consider the introduction of orthodontic auxiliaries to increase the productivity of the specialist delivered service.
5. Strategic planning of service to deliver chosen level of service annually.
6. Waiting list initiatives to deal with the current problems:
  - a) Assessment waiting lists to be eliminated as a priority
  - b) Treatment waiting lists to be reduced by a combination of:
    - i) expanding the capacity of public service
    - ii) accessing private sector by nationally agreed schemes.

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PRESENTATION BY  
THE IRISH CONSULTANT ORTHODONTISTS'  
GROUP

TO

THE JOINT OIREACHTAS COMMITTEE ON  
HEALTH and CHILDREN

24<sup>th</sup> January 2002

## Introduction

Orthodontics is that branch of dentistry concerned with the alignment of the teeth, the growth of the jaws, and the treatment of facial abnormalities. Such abnormalities can range from cleft lip and palate, overgrowth or undergrowth of one or more jaws, and extreme variations of normal, to crowding of the teeth.

The general public see orthodontics mostly as "straight teeth". Crowding of the teeth is the most common orthodontic problem, and very few people have absolutely straight teeth. Variations from the ideal can range from very slight to extreme.

Studies in the field of social psychology show that a significant degree of *social* gain can be obtained from orthodontic treatment. Shaw et al (1980) in a study of schoolchildren has shown that teasing and nicknames about teeth are more hurtful than comments about other bodily features. Ramstad et al (1995), Shaw et al (1980, 1981), Speltz et al (1993) have found modest or varying degrees of improvement in self-esteem, social skills, and social interaction in patients who have had orthodontic treatment. Dann et al (1995) found that patients' self-concept does not improve during orthodontic treatment, while Albino et al (1994) found that while parent, peer, and self-evaluation of dental and facial attractiveness significantly improved after treatment, self-esteem was not affected.

The demand for all forms of free medical care is, in theory, limitless. Helm (1990) found that if all barriers to orthodontic care (financial, lack of specialist personnel, severity-indexed, etc) were removed, 60% of the population would demand it.

In the past, it was believed that tooth crowding resulted in dental decay and gum disease. Despite numerous scientific investigations in a number of countries in recent years, the evidence for such a link is very weak (Addy et al, 1988; Addy et al, 1990; Dummer et al, 1990a; Dummer et al, 1990b; Helm and Petersen, 1989a; Helm and Petersen, 1989b). Dental crowding, therefore, has little dental health implications. Extremely prominent upper front teeth ("buck teeth") are more prone to trauma (Burden, 1995; Holland et al, 1988; Hunter et al, 1990), and 1-2% of the population have impacted upper canines ("eye teeth"), of which 12% cause varying degrees of damage to the roots of the adjacent teeth (Ericson and Kurol, 1987a; Ericson and Kurol, 1987b). Extremely deep bites can cause trauma to the hard and soft tissues, but overall, the dental health implications of malocclusion are modest, to say the least (Shaw, et al, 1991)

The prevalence of crowding has increased due to the effect of fluoride in the drinking water supply, with consequent reduction in dental decay (O'Mullane, et al, 1996). Before the 1960's an intact dentition was a rarity in Irish patients, with tooth extractions being common. This tended to relieve crowding. Access to orthodontic care was minimal or non-existent for the vast majority of the population, firstly because of the lower patient expectations, secondly because there were so few orthodontists working in the country, and thirdly, because of the expense of treatment in the private sector. Since that time, however, awareness of orthodontics has increased exponentially, and demand for such treatment has increased in parallel with this.

*In summary therefore, social and psychological gain is more common with orthodontic treatment. The dental health implications of the vast number of orthodontic malocclusions are modest.*

### **Epidemiology of orthodontic treatment need.**

Studies by Burden and Holmes (1994) Burden et al (1995), and Burden (1995) in the UK show one-third of adolescents are in definite need of orthodontic treatment, one-third have borderline need for treatment, and one-third have little or no need for treatment, using the Index of Orthodontic Treatment Need (IOTN). This agrees with figures from the USA's Public Health Service (Kelly, 1977; Proffit, 2001).

In the Republic of Ireland, 53,000 children are born every year. Assuming that one-third are in need of orthodontic treatment, this would translate into 18,000 patients starting and finishing treatment every year. In total, the number of patients that would need to be under treatment at any particular time would be approximately 40,000. Current figures suggest that approximately 10,000 patients are under treatment around the country.

### **Orthodontic manpower**

Currently there are approximately 77 qualified specialists in orthodontics in Ireland. The majority of these (45) work in purely private practice. There are approximately 16-20 specialists working within the Health Board orthodontic services, with 10 consultants in regional hospitals, 1 consultant at tertiary care level, and 4 academics.

The distribution of orthodontic specialists is very uneven, with most concentrated on the East and south coasts.

	No. of specialists within the Health Board service	No. of Consultants
ERHA – Northern Area	2	0
ERHA – East Coast	3	1
ERHA – South Western	3	1
South-Eastern Health Board	3	1
Southern Health Board	0	1
Mid-Western Health Board	2	1
Western Health Board	1	1
North Western Health Board	3	1
Midlands Health Board	0	1
North-Eastern Health Board	3	1

### **The role of the consultant orthodontist**

The consultant orthodontist's role is to carry out orthodontic assessments of patients referred from the schools dental service and from other dentists; to supervise those under training for specialist qualifications; to carry out treatment for those patients with the most severe and extreme orthodontic problems; to do research and audit; to manage the service and plan its strategic development; and to ensure quality control.

### **Projected manpower needs**

Approximately 20,000 patients each year need treatment.

The maximum safe caseload for a specialist in full-time practice is approximately 400 patients.

The average length of treatment is approximately 18 – 24 months.

Assuming a two-year treatment cycle, this would equate to 200 patients per year finished by each specialist (and an equivalent number taken on for treatment). Dividing 20,000 by 200 results in a figure of 100.

Therefore, 100 specialists within the service would be needed to treat the one-third of the adolescent population in need of treatment.

### **Recruitment of specialists**

The difficulties in recruiting trained specialists to work within the Health Board orthodontic services has, up to now, been very marked. Pay and conditions have not compared favourably with those in private practice.

The use of untrained non-specialist dentists recruited from the schools dental service has been used in the past. However, while such a system may have been politically expedient, the long-term implications of this give rise to a number of concerns, viz:-

- (a) such dentists are being used as orthodontic auxiliaries, needing constant supervision by the consultant. Many such dentists may not wish to undergo specialist training due to lack of interest in acquiring such qualifications, or due to domestic commitments.
- (b) If such dentists decide to leave the service they would require retraining to allow them to return to general dentistry
- (c) When orthodontic auxiliaries are introduced, the cost implications of having two different grades of personnel, one much more highly paid than the other, carrying out the same work, will immediately become obvious to management.
- (d) Requiring non-specialist orthodontists or trainees to undertake a caseload of 500 patients is not only clinically unwise, it is unsafe. It does not allow a specialist trainee to learn properly from the consultant, and utilises the non-specialist as a mere auxiliary.

### **Training of specialists in orthodontics**

Currently the only dental school in the Republic that can offer a recognised postgraduate training programme in orthodontics is the Dublin Dental School. The Cork Dental School cannot offer such a programme because it does not have sufficient number of senior trained academic consultant orthodontic staff to do so (currently there is only one full-time orthodontic consultant in the Cork Dental School).

At present, ten graduate dentists are under specialist training in the Dublin Dental School. Two are under training in collaboration with the Western Health Board, two in collaboration with the SWAHB, two with the ECAHB, and one each with the NEHB and SEHB. Two are on the full-time dental school course. Four of these will complete their course in 2002 (including the two from the WHB). It is anticipated that further trainees will commence training in 2002.

The facilities and staff in the Dublin Dental School are currently stretched to the limit. New consultant academic staff need to be appointed, and extra clinical facilities made available to expand orthodontic specialist training. A number of the regional consultants teach and supervise on a part-time basis in the Dental School, but this is not a sufficient substitute for full-time academic staff. Senior staff appointments also need to be made in the Cork Dental School, in order to commence a specialist training programme.

In order for a dentist to become a registered specialist in orthodontics, European directives require a three-year postgraduate training programme. Entry to such programmes is competitive. The reason why such programmes have to comply with EU regulations is to allow mutual recognition of each member states' professional qualifications, and to allow free movement within the EU of qualified professionals.

Part of the time in training is spent in a regional unit, and part in a university dental school. Candidates enrol for a Master's degree and almost all will undertake a membership examination of one of the Royal Colleges of Surgeons of the UK and Ireland. In 2000, the Dental Council of Ireland opened its register of dental specialists with divisions of orthodontics and oral surgery. The entry of a candidates name on this register allows the public to identify those dentists who are bona fide specialists.

The Specialist Advisory Committee report to the Chief Dental Officer (1999) recommended a maximum of 10 training posts in the Dublin Dental School, with 4-8 in the Cork Dental School, assuming that sufficient staff were available. This would result in a maximum of 18 specialists being graduated every 3 years (or the equivalent of 6 every year). In view of the fact that 80 more specialists are needed for the orthodontic service, at the most optimistic forecast, it would take a minimum of 13 years to bring the numbers up to this level if such a scheme was fully operational, and assuming that all trainees were health board staff and remained within the service after achieving specialist status.

### **Recruitment of specialists from outside Ireland**

A number of Health Boards have attempted to recruit specialists in orthodontics from outside the state, but so far with limited success. Three orthodontists are currently working in the Health Board service (2 in the North Western Health Board: one from the Lebanon, one from Sweden) with 1 orthodontist from Denmark working the SWAHB of the ERHA.

Up to now, the UK has been the main location for recruiting medical and dental staff from outside the state. This is due to a number of reasons - geographical, historical, language, and common training pathways in medicine and dentistry. The British Orthodontic Society in a recent manpower report (2001) found that there is a severe shortage of orthodontists in the UK, and it proposes increasing the number under training.

With such a manpower shortage in the UK, it is unlikely that it would prove a major source of recruitment for orthodontic specialists.

### **Irish trainees in the UK and USA**

A number of Irish dentists are currently enrolled in courses in the UK. Many may continue to work in the UK, within practice or the NHS, which is well structured and organised.

A few Irish dentists are training on courses in the USA. It is likely that if they return to live and work in Ireland that they will set up their own private practices.

### **Infrastructure to service and supporting specialities**

In order for a comprehensive service to be delivered, the relevant number of dental nurses, secretaries, and laboratory support would be needed.

For each specialist, at least one dental nurse would be required to assist them. Each department would require secretarial staff, and the laboratory support for the construction of appliances would also be needed.

**Supporting specialities** – the main associated speciality that would be required to support the orthodontic service is the oral and maxillofacial surgery service. Since the introduction of the orthodontic service, the oral surgeons in both private practice and hospital departments report a major increase in the number of patients that they are receiving for treatment for impacted teeth, retained roots, buried wisdom teeth, and for the treatment of patients requiring major jaw surgery for the correction of facial deformity. Proffit (1994) estimates that up to 0.4% of the entire population require such corrective surgery – this would amount to approximately 250 new patients in the country every year (or 25 per health board).

The work of oral and maxillofacial surgeons also encompasses the treatment of patients with mouth and facial cancers, road traffic accidents and other trauma, and collaboration with the other head and neck surgical specialities such as neurosurgery, ophthalmic surgery, ENT surgery, and plastic surgery.

The ideal surgeon to population ratio is 1:150,000, based on recommendations from both the British and US Associations of Oral and Maxillofacial Surgeons. In Ireland, this would equate to 25 consultant oral and maxillofacial surgeons throughout the country. Currently, there are five such surgeons; 3 in Dublin, one in Cork and 1 in Limerick.

## SOLUTIONS

1. RECRUITMENT OF SPECIALISTS
2. TRAINING OF SPECIALISTS
3. RECRUITMENT OF AUXILIARIES
4. PRIORITISING PATIENTS FOR TREATMENT
5. UTILISING THE PRIVATE SECTOR
6. INSURANCE SCHEMES

### 1. RECRUITMENT OF SPECIALISTS

Long-term priority must be given to training sufficient numbers of orthodontists within Ireland. It is unlikely that significant numbers of orthodontists can be recruited from outside the State. Up to recently, salary, career structure, and conditions have not been attractive for orthodontists. Most European countries offer more attractive working conditions.

In the long term the majority of non-Irish orthodontists may not wish to remain here. As orthodontic treatment is a long-term modality, such continuity within departments is extremely important.

Without a good salary very few orthodontists will wish to take up such posts, especially in the more unpopular areas. A system whereby Health Boards would sponsor orthodontists' training in return for an equivalent number of years service should become the norm, as is already being done in some health boards.

### 2. TRAINING OF SPECIALISTS

The training capacity within the Republic is limited. Even with the projected numbers under training in both Dental Schools (assuming that sufficient academic staff are in place), it would take 13 years, at the most optimistic forecast, to train sufficient specialists for the public service, even assuming every single one entered the health service after training (see appendix 1)

### 3. RECRUITMENT OF AUXILIARIES

Orthodontic auxiliaries are extensively used in many European countries, and in the USA and Canada. These are recruited from the dental nursing grade and undergo a one-year training programme. They are then employed to undertake the main tasks of placing and adjusting appliances on patients' teeth, and work under the supervision of a specialist or consultant. They are not allowed to work independently and must be supervised at all times.

Currently orthodontic auxiliaries are not legal in Ireland, but the Dental Council has submitted a proposal to the Minister for Health for their introduction.

#### 4. PRIORITISING PATIENTS FOR TREATMENT

Up to recently, the only guidance that has been available in regard to which patients should receive treatment is in a letter from the Department of Health dated January 22<sup>nd</sup> 1985, signed by a Mr. Dewey. This sets out the original guidelines as to which patients are eligible for treatment. There are 3 categories – category A, which includes patients with cleft lip and palate, category B, which includes patients with 10mm overjets, and finally category C – which is vague and unsatisfactory, and which could allow almost any patient to be placed on the treatment waiting list.

In recent years, waiting lists in orthodontics around the country have given rise to concern. Some Health Board areas have waiting lists of a few months for assessment, and a waiting list for treatment of approximately one year, while others have a waiting list for treatment of 6,000 patients, with an assessment waiting time of up to two years.

Such long waiting lists are unsatisfactory and result in patients with very severe problems being kept waiting while those with lesser problems receive treatment. The Consultant Group have been advised by the Medical Protection Society that placing patients on a waiting list for treatment from which they are not likely to be called for treatment is unethical and wrong.

The assertion has been made that delaying treatment for some patients can result in them requiring major jaw surgery at a later date. No scientific evidence has ever shown that orthodontic treatment at an early age obviates the need for jaw surgery. Growth of the jaws is under close genetic control. Orthodontic treatment has never been shown to have any effect on the growth of the jaws. Orthodontic effects are confined to the teeth and the supporting bone, and not the skeletal bones of the jaws.

The 1985 guidelines have been revised and updated by the Irish Consultant Orthodontists' Group and the Dept. of Health and Children to reflect contemporary orthodontic opinion and to prioritise resources on those patients with the greatest need. It has been found that approximately 15-20% of referred patients would be placed on the waiting list using these guidelines. This would allow the system to cope with the present numbers.

Ideally, some internationally used and validated index (such as the Index of Orthodontic Treatment Need, IOTN) should be used, but this would overwhelm the system at the present time. Figures by Richmond et al (2001) show that up to 60% of all referrals would fall into the grades 4 and 5 (those in most need of treatment) using the IOTN. This has been confirmed by data from the Western Health Board (2000).

#### 5. UTILISING THE PRIVATE SECTOR

As it is unlikely that sufficient numbers of specialists can be recruited in the short to medium term, consideration should be given to utilising the resources of the private sector. This has been used in the past, most notably in the Midlands Health Board, where the waiting list is extremely low, and where, up to recently, there was no consultant service.

A number of possibilities exist to treat patients within the private sector:

- (a) full funding of treatment within the private sector
- (b) partial funding of treatment within the private sector
- (c) allowing private treatment within the health board service

(a) Full funding of treatment within the private sector.

This has already been used within a number of health boards, most notably within the Western Health Board to treat 250 patients from the treatment waiting list. The patients are given a letter of approval, which they can then take to the private specialist of their choice. The private specialist then invoices the Health Board with their fees.

The advantage of this system is that it is popular both with the patients and the private orthodontists. There is little difficulty in administration and the scheme has worked well so far.

The disadvantage is that it is expensive as full fees are paid.

(b) Partial funding of treatment within the private sector ("grant-in-aid")

Partial funding of treatment ("grant-in-aid") has recently been proposed within the Northern Area Health Board. However, the scheme was abandoned as it was found to be contrary to the Health Act, 1972.

Grant-in-aid was proposed as follows: £1000 (Euro 1270) would have been provided to non-medical cardholders, while £2000 (Euro 2540) would have been given to medical cardholders. The patient would then have attended the private orthodontist of their choice, paid the relevant fees to the orthodontist, and those who paid tax would have received tax relief on the balance of the fees that they would have had to pay.

Such a scheme would be more cost-effective than option (a). However, it would require a change in the Health Act to make it operational. It remains a possibility for the future.

A considerable number of EU countries have full or partial reimbursement by central government / social insurance for orthodontic treatment (e.g. Norway, Sweden, Denmark, Finland). Others fund orthodontic treatment purely through social insurance (as in Germany) or private insurance schemes (see appendix 2). All such countries have indexes of severity that determines the level of third-party funding for treatment.

(c) Allowing private treatment in Health Board premises

Specialist-trained staff would be allowed to undertake private treatment and to receive private fees from the Health Board for undertaking treatment for patients out of hours.

Such private fees would need to be at least 50% of that in private practice. Figures from the Orthodontic Society of Ireland (OSI) estimate that at least 50% of a private orthodontic practice's income goes in expenses (staff, supplies, heat, light, electricity, rent, rates, stationery etc), while the remainder is taxed at the maximum tax rate (currently 42%).

Therefore, a private orthodontist in solo practice will only receive approximately £600 (Euro 760) for two year's work for a patient that originally paid them fees of £2,500 (Euro 3170)

Private practice in Health Board clinics would be another cost-efficient way of treating more patients and would be an incentive to retain trained specialist staff.

## 6. INSURANCE SCHEMES

No insurance schemes currently exist in this country for the funding of orthodontic treatment (VHI / BUPA do not cover orthodontic treatment). Social insurance schemes exist in the Netherlands and Germany, which cover orthodontic treatment in whole or in part.

Prepayment / savings schemes are in place in the UK and other countries. These are started when the child is at a very young age and come to maturity at the age that orthodontic treatment is usually needed. If orthodontic treatment is not needed, then the funds can be used for something else.

Friendly societies and occupational medical aid schemes (St. Paul's, Garda medical aid, etc) offer grants to cover part of the cost of treatment. Tax relief is available for the remainder of the fees.

Currently, tax relief is available (up to 42%) for orthodontic treatment. It is estimated by the Orthodontic Society of Ireland that the cost of orthodontic treatment is £1.80 (Euro 2.30) per day for two years under this scheme.

## SUMMARY

- Orthodontic problems, in varying degrees of severity, affect between 30-50% of the entire adolescent population – this is unparalleled compared to any other medical or surgical discipline.
- The vast majority of orthodontic malocclusions have little dental or general health implications.
- The majority of patients seek treatment for cosmetic and /or social reasons.
- If no barriers to orthodontic treatment existed, up to 60% of the population would demand it.
- Currently in Ireland there are insufficient numbers of trained orthodontists working within the public health service to satisfy consumer demand.
- Approximately 100 trained specialists working within the health service (10 per health board area) would be needed to treat those patients who come within the most severe categories of treatment need.
- The training of dentists as specialists in orthodontics needs to be augmented with cooperation between the health boards and the dental schools. The appointment of new academic staff in orthodontics in both the Dublin and Cork Dental Schools is essential.
- Grading of patients according to the degree of severity is essential to ensure that those patients with the most severe clinical treatment need receive treatment.
- Given the limited resources available to the orthodontic service at the present time, blanket entitlement of the entire population for free orthodontic care is impracticable. The Dept. of Health and Children has to make this clear to all interested parties – patients, politicians and health professionals.
- The numbers of consultants in orthodontics in the country needs to be doubled, with at least two consultant orthodontists in each health board area.
- Infrastructure support to the service is severely lacking. There is a need for the appointment of up to 25 consultants in oral and maxillofacial surgery to deal with the surgical need generated by the orthodontic service and to treat patients with severe facial deformities. Such surgeons are also needed to treat patient with oral and facial cancers, trauma of the head and face, and severe dental problems, in collaboration with other surgical specialities.
- Utilisation of the private sector in the short to medium term to deal with waiting lists, needs active consideration, with either the payment of full fees or the use of grant-in-aid to patients. This latter, however, would require a change in the relevant Health Act.

- Insurance or prepayment schemes with tax relief should be introduced to allow those families with higher incomes to opt for private orthodontic treatment.
- The legalisation, training and recruitment of orthodontic auxiliaries would help to reduce the waiting lists significantly. It must be emphasised that such auxiliaries cannot work unsupervised and therefore the need for training of specialists cannot be downgraded. Also, the productivity of an auxiliary will not be the same as a trained specialist and an auxiliary should not be considered as a substitute for a specialist.

IN ALL PUBLIC HEALTH CARE SYSTEMS

**DEMAND** > **NEED** > **RESOURCES**

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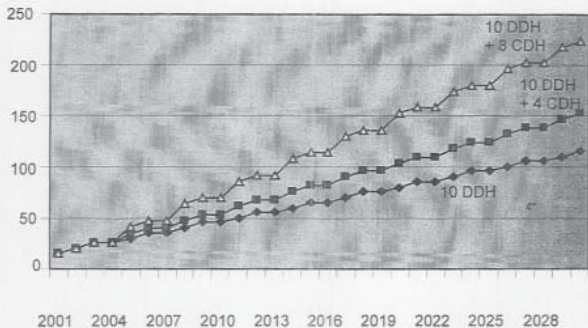
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**APPENDIX 1 – Projected number of specialist trainees in orthodontics 2002 – 2025 between the two dental schools (Dublin and Cork)**



This model makes a number of assumptions:

- that the Dublin Dental School will continue to train 10 specialists every 3 years
- that the Cork Dental School will start a specialist training programme in 2002 for the middle and upper lines
- that the graduates will go into the Health Board orthodontic service after training and will stay in the service

**APPENDIX 2 – EUROPEAN UNION COMPARISONS FOR ORTHODONTIC MANPOWER, TREATMENT NEED, ORTHODONTISTS' PLACE OF WORK, AND FINANCING OF TREATMENT**

Country	Population (millions)	Births / annum	Nos. in need of tx each year	No. of orthodontists	New patients / orthodontist each year
NORWAY	4.4	57000	19000	227	83
GERMANY	82	736000	245000	2643	93
SWEDEN	8.8	86000	29000	300	97
DENMARK	5.3	63000	21000	161	130
FINLAND	5.2	57000	19000	135	140
FRANCE	58	711000	237000	1500	158
NETHERLANDS	16	176000	59000	259	227
<b>IRELAND</b>	<b>3.8</b>	<b>53000</b>	<b>18000</b>	<b>77</b>	<b>233</b>
UNITED KINGDOM	60	680000	226000	779	290
SPAIN	40	358000	120000	376	319
GREECE	10	97000	33000	300	323
ITALY	57	508000	170000	300	567
PORTUGAL	9.8	102000	34000	50	680
BELGIUM	10	106000	35000	N/A	N/A

Country	Orthodontists' place of work				How treatment is financed		
	% private practice	% community service	% hospital	% academics	% of tx private	% insurance	% govt subsidy
NORWAY	75%	14%	1%	6%	10	0	90
GERMANY	95%	0%	0	5%	10	90	0
SWEDEN	5%	86%	0	8.3%	10	0	90
DENMARK	32%	57%	1.6%	8%	5	5	90
FINLAND	42%	42%	1.5%	13.3%	5	0	95
FRANCE	95%	3.3%	0	1.3%			25-100
NETHERLANDS	95%	0%	0	5%	50	50	0
<b>IRELAND</b>	<b>60%</b>	<b>0%</b>	<b>33%</b>	<b>7%</b>	<b>95</b>	<b>0</b>	<b>5</b>
UNITED KINGDOM	46%	20%	30%	10%	10	0	90
SPAIN	66%	7.5%	7.5%	18%	79	20	1
ITALY	78%	9.2%	0	12%	85	15	0
PORTUGAL	60%	8%	8%	24%	85	0	15
BELGIUM					75	25	0
GREECE					80	10	10

Sources: Moss (1993); UNICEF population statistics website [www.unicef.org/stats/](http://www.unicef.org/stats/); Federation Dentaire Internationale website [www.fdi.org.uk/](http://www.fdi.org.uk/)



