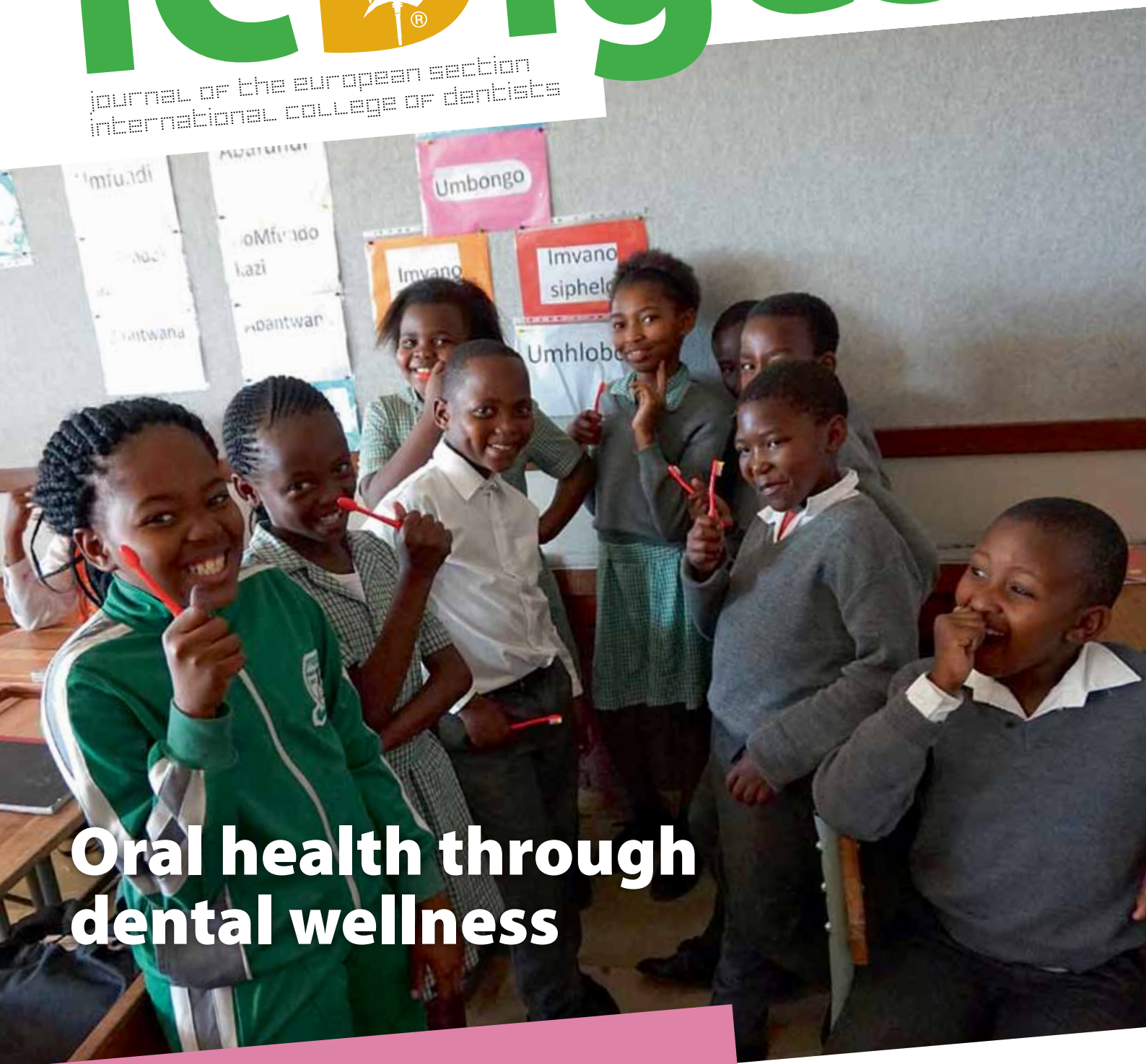
2018

ICDigest

journal of the european section
international college of dentists



Oral health through dental wellness

London 2017

Science, Fellowship, Recognising Service, Europe and Humanitarianism

Interview Christian Robin

President 2017-2018

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The International College of Dentists is a leading honorary dental organisation dedicated to the recognition of outstanding professional achievement and meritorious service and the continued progress of the profession of dentistry for the benefit of all mankind.

Motto
Recognising service as well as the opportunity to serve.

Core Values
Leadership Uphold the highest standard of professional competence and personal ethics.

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Education Contribute to the advancement of the profession of dentistry by fostering the growth and diffusion of dental knowledge worldwide.

Professional Relations Provide a universal forum for the cultivation of cordial relations within the profession and to assist in preserving the highest perception of the profession.

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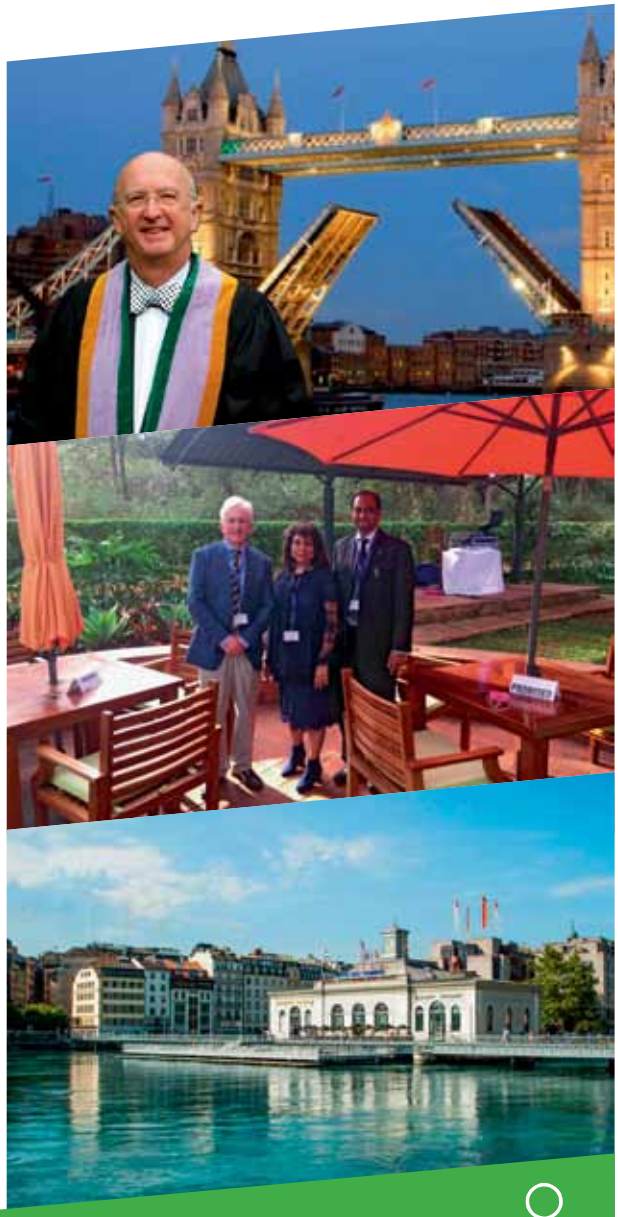

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Building on the past

As the new Editor of the ICDigest, I must, first and foremost, thank and pay tribute to my predecessor Walter van Driel. Supported by the Editorial Board and the production team, Walter took the ICDigest to a new level, requiring a huge commitment and unswerving service to the Section. I have inherited an attractive journal, the style and format of which I intend to preserve. I am delighted that Walter has agreed to continue to serve the Section as Webmaster.

The expectations of readers of journals are ever increasing. Editors must, therefore, be committed to continuous quality improvement, while anticipating topics which will interest and engage the readership at the time of going to print - nothing worse than 'old news' and a journal which provides no new knowledge or understanding. Also, publications such as ICDigest form an important archive which, in addition to documentation of detail, must capture the spirit of the time. During my term of office as Editor of the ICDigest, I will endeavour to meet these expectations, mindful that increasing numbers of new readers (i.e., new Fellows in the European Section of the Academy) will be 'e-skilled' millennials who may not greatly value journals.

In going forward, I will need the help and support of the Editorial Board and the Fellows of the Section. The existing, long-serving members of the Editorial Board, who must be thanked for their many, different contributions to the Digest, have agreed to stand-down, creating opportunity for me to refresh the Editorial Board, hopefully with more recent inductees who will help me keep the ICDigest contemporary and relevant. I will be most pleased to receive expressions of interest in joining the Editorial Board. To facilitate communications with the production team based in The Netherlands, Frans Kroon has kindly agreed to continue supporting the ICIDigest as Production Team Liaison.

In the meantime, I very much hope that you enjoy this Issue of the ICDigest; hopefully something for everybody, whether that be news, useful information or new knowledge.

As I work towards completing this issue of the ICDigest, I am already beginning to think about the content of the next issue. If you wish to contribute an article, a report of a meeting, or submit a letter or other short communication for consideration for publication in the 2019 ICDigest, please do not hesitate to contact me. Ideally, the ICDigest should be by the Fellows for the Fellows, reinforcing the core values of the College: leadership, recognition, humanitarianism, education and professional relationships.

Nairn Wilson, Editor in Chief

The ICDigest should be by the Fellows for the Fellows, reinforcing the core values of the College: leadership, recognition, humanitarianism, education and professional relationships.

The 62nd Annual Meeting of the European Section

London Memories

Between 14th –18th June 2017 London hosted the 62nd Annual Meeting of the European Section of the International College of Dentists.

Mark Wright

Dr Shelagh Farrell our European President and myself as Regent for England, Scotland and Wales, welcomed over 265 Fellows and guests to experience London at its best over the Queen's birthday weekend. Delegates were able to enjoy the Trooping of the Colour just a few minutes walk from the conference hotel, The Royal Horseguards in Whitehall, as well as attending the wonderful programme of events. This culminated with the Induction Ceremony for new Fellows and a Gala Dinner held at The Royal College of Physicians.

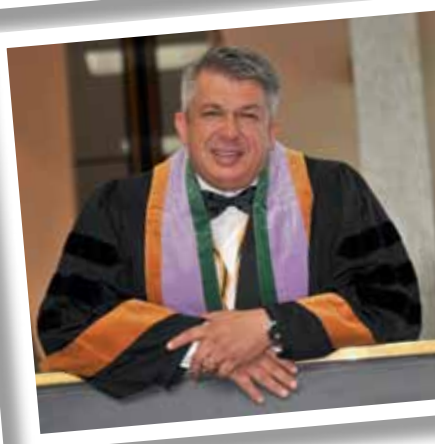
Seventy-three Fellows and guests from England, Scotland and Wales attended, and I was able to present 15 new Fellows for induction into the European section.

The meeting commenced with a golf tournament held at the oldest golf club in the world – The Royal Blackheath Golf Club followed by a three-course meal. This year the competition had joint winners with both Ole Staehr-Jakobsen and TC Patel gaining 37 points. Third place was awarded to Marion Lujbo with 30 points. The nearest to the pins at hole 8th and 16th was won by TC Patel and Kunju Patel respectively. TC Patel and Kunju Patel won the nearest to the pin at holes 8 and 16 respectively.

On Wednesday evening we were fortunate to be able to host a dinner, courtesy of Lord Colwyn CBE in the Cholmondely Room and Terrace at the House of Lords, to welcome all the European Regents and Vice Regents along with other dignitaries. A perfect summer's evening depicted London at its best.

The Board of Regents' meeting was held all day Thursday at the Oxford and Cambridge Club. During the evening we welcomed all our European Fellows and their partners with Pimms' on the lawns of Middle Temple followed by dinner at Middle Temple Hall.

Friday began with our scientific meeting. During the morning we were captivated with lectures by two outstanding speakers Dr Craig Gershater and Professor Iain Chapple.



Dr Gershater, who specialises in microbial biochemistry and biotechnology, commenced with his lecture on 'The microbial world and 'Life' as defined by cellular communication'. He began with an overview of applied microbiology, the 'multifactorial paradigm' and the 'oral ecosystem', describing clearly how biofilms develop, how microorganisms communicate with each other along how they react according to their environment, all of which can influence cell growth.

Professor Chapple then gave an enlightening lecture entitled 'The response of the body to commensal organisms, invaders and associated biofilm imbalances'.

He clearly explained dysbiosis, when things start to go awry, and how with the buildup of colonies of bacteria the environment is changed, which in turn leads to an alteration in microorganisms leading to disease. He looked at the immunology and metagenomics and how DNA sequencing allows microbial ecology to be investigated at a much greater scale and detail than before. By clearly identifying the plethora of 'bugs' present in the oral environment and understanding what they are all doing, one can then begin to understand their functions compatible with health or disease.
In his second lecture 'Time to put the mouth back into the body – the truth about periodontal –systemic links' Professor Chapple described how 54% of the population have some periodontal disease (60% over 65yrs olds). He described the relationship of periodontal inflammatory disease and co-morbidity with a long list of ailments including rheumatoid arthritis, obesity, type 2 diabetes, cardiovascular disease,

metabolic syndrome, cancer, male infertility etc. etc. He described how HbA1C is now used as an indicator of type 2 diabetes and has shown to be a more accurate indicator than blood glucose testing. Treatment of periodontal disease in these patients can reduce the HbA1C by the same percentage as placing patients on medications such as metformin.

Dr Geshater completed the morning session by discussing the impact of synthetic biology on our understanding of microbiology, discussing the Fourth Industrial Revolution, parallel biology and microbiology as a mathematical problem, describing clearly mathematical models and how mathematics now leads microbiological research.

The afternoon session commenced by looking at several of the humanitarian aid projects that the International College of Dentists supports. Richard and Mihaela Losfeld from 'Dentists San Frontieres' described the incredible work they have achieved in Uruguay.

This was followed by Dr Miguel Pavão an ICD Fellow from Portugal, who started his own non-governmental organization (NGO) called 'Smiling World' a few years ago, reported on the on-going oral health campaign in Sao Tome at schools for underprivileged children using a bus kitted out for dental examinations. The project 'Oral Health on Wheels', targeted for children, draws attention to the importance of Oral Health using the Dental Bus and a mascot (Tooth Fairy). Since 2007, 18,300 dental screenings have been carried out as well as talks to 60,000 children. This is an on-going project. Subsequent to becoming an ICD Fellow, Dr Pavão has applied successfully to the Philip Dear Fund via the P&F Committee for funding. The European Section set up the Philip Dear Foundation, named after the Section's inaugural President, aimed at providing funding for educational and humanitarian aid. All projects are presently funded through the auspices of this fund that is supported by a levy charged to each European Section Fellow.

The remainder of the afternoon was devoted to looking at and comparing the provision of oral health care in various regions of Europe. Dr Paula Vassallo discussed Southern Europe, Professor Elmar Reich the Bismarckian countries, Professor Roxana Oancea Central and Eastern Europe and Professor Ken Eaton the Nordic countries and the UK. The afternoon culminated with a questions and answers session and an introduction to next year's meeting in Geneva 21st – 24th June 2018.

For those not attending the scientific meeting, organised guided tours took the participants to the Tower of London and Westminster Abbey, including a traditional 'fish and chip' lunch.

Everyone met up in the evening for a sunny river cruise to see the sights of London refreshed by a glass of prosecco followed by a dinner at the outstanding Skylon restaurant, culminating with a magnificent firework display over the river Thames.

Saturday morning was again sunny with cloudless skies and we were free to explore London with the highlight of the Trooping of the Colour and the Red Arrows flypast.

The afternoon was the highlight of our meeting, commencing with our Induction Ceremony. We were privileged to welcome the Worldwide president Dr Rajesh Chandna to join us and inducted 56 new Fellows into the College from all over Europe.

Dr Dov Sidney was awarded the highest accolade for services to the College at large and received his Master Fellowship.

Following the ceremony, we were treated to a champagne reception in the Physic Garden followed by our Gala Dinner and dancing.

The post-meeting tour on Sunday, for those with the stamina to continue, went to Windsor Castle and the Saville Gardens. This year we have received tremendous feedback from many of the delegates. It appears that a good time was had by all.

I would like to thank Shelagh Farrell and all her committee for the hard work and organisation of this outstanding meeting, and I look forward to welcoming as many of you as possible in Geneva. ■

Increasing demand for aesthetic outcomes

Minimally invasive dentistry in the aesthetic zone

There is an increase in the demand for aesthetic outcomes in dental care. Alongside the popularity of 'cosmetic' dento-facial surgery, 'smile makeovers' and related procedures have become high revenue generators for dental practices. The British press (The Mail on Sunday online, 7th May 2017) claimed "Dentists' £1Billion boom", stating: "Amount Britons spend on cosmetic dental treatment up by a fifth in four years". This boom in British public interest in an aesthetic smile was reported also by the Guardian newspaper.

Subir Banerji

Subir Banerji, Private Practitioner, London and Programme Director MSc Aesthetic Dentistry King's College London Dental Institute.

Aesthetic dentistry is a rapidly growing aspect of oral healthcare provision worldwide. According to survey data obtained by the American Academy of Cosmetic Dentistry (AACD), the mean revenue generated by dental practices in the USA from cosmetic procedures grew to $495,000.00 in 2007, representing a sizeable 15% increase from the previous year. Notwithstanding subsequent growth in the aesthetic dentistry market, there is the prospect of further growth well into the future. It is important also to take note of data reported by a major, multinational indemnity group (Dental Protection Limited, UK), indicating that in 2011 that there had been a 50% increase in the number of complaints involving smile make-over procedures since 2006, with cases having been reported to have been settled for five figure sums, excluding legal costs. Aesthetic dentistry may be lucrative, but relatively high risk in terms of patient complaints.

Medico-legal issues often arise because of incomplete or inadequate pre-operative patient assessment and examination. In such circumstances practitioners tend to have failed to appreciate, let alone fully understand the patient's aesthetic values, concerns and perceptions, and

taken it upon themselves to impose their interpretation of the smile best suited to the patient. As discussed below, the patient must always be involved in smile design decisions with the changes proposed presented to the patient in a reversible, pre-treatment format for approval.

Although an aesthetic outcome following, for example, restoration of grossly carious or broken-down teeth, would be what most clinicians would strive to deliver, often there is a demand for aesthetic treatment where there is no disease present and the procedure is not a requirement for optimal oral health.

Presenting complaints and concerns

The goals of aesthetic dental care include the need to:

- meet the realistic expectations of the patient,
- attain long term functional and aesthetic stability and
- achieve the desired outcome through the application of minimal intervention approaches.

To begin to fulfil these goals, a comprehensive and contemporaneous patient history must be carefully obtained and appropriately documented. Above all else, it is of paramount importance that the practitioner listens attentively to the complaints and concerns of the patient, and compliments the history and examination procedure, as necessary, to fully investigate all the issues raised by the patient.

Treatment planning should not be commenced until such times as all investigations and related enquiries have been completed.

In general, there are three categories of 'dental aesthetic imperfections' which encourage patients to seek aesthetic intervention. These relate to anomalies in tooth:

- colour
- position
- shape

Aesthetic imperfections in colour may be caused by, amongst other factors, the presence of stains, craze lines, dentine exposure, discoloration of residual tooth tissue by pre-existing and existing restorations, alterations in the optical properties of the remaining tooth tissue, stained, dental caries, and tooth discoloration associated with loss of vitality of the tooth.

Positional concerns may be associated with the presence of dental diastema, rotations and tipping of teeth, crowding, supra-eruption or intrusion, anomalies in arch shape and size and, of course, loss or absence of teeth from the dental arch. Unilateral positional anomalies, which adversely affect symmetry tend to give rise to more aesthetic concerns than bilateral anomalies, in particular, if the bilateral anomalies are symmetrical.

Morphological anomalies which may be associated with aesthetic concerns include the presence of fractures, cracks, tooth wear - abrasion, abfraction, attrition and erosion, dental caries, surface defects such as hypoplasia, and variations in surface texture which may vary from limited to severe, as may be seen with in patients with congenital conditions such as amelogenesis imperfecta. Other congenital anomalies which may contribute to aesthetic concerns, include unusual crown dimensions -macrodontia and microdontia, and variations in root diameter dimensions. Congenital malformations of the teeth including peg-shaped teeth, dilacerations, fusions and germination are further examples of morphological anomalies which may give rise to aesthetic concerns.

In addition, as patients become more conscious and educated about facial enhancement treatments, which dental practitioners are increasingly providing, it is not uncommon for a patient to present with aesthetic concerns including concerns about facial aesthetics.

It is often very helpful to initially present the patient seeking aesthetic treatment with an aesthetic evaluation form designed to gain information and insight into the patient's personal perceptions of their dental and facial aesthetics.

Patient expectations

There is considerable diversity in perceptions as to what the ideal appearance of the anterior aesthetic zone (comprising the hard and soft tissues visible when the patient makes a broad smile) should be.

Certain concepts, including:

- the elimination or oral disease,
- the need for appropriate dental symmetry, proportion and harmony,
- an appreciation of tooth position, form and morphology, and
- an understanding of the variations that exist in tooth colour and shade can be considered to be 'universal concepts' in dental aesthetics. These concepts are considered to be generally 'acceptable' amongst dental professionals, patients and the public alike.

A patient seeking an alteration of their anterior aesthetic zone (often with the aim of enhancing the attractiveness of their physical features), requires careful evaluation and it is imperative that the treating clinician carefully 'listens' to the patient's concerns, and adopts a systematic and meticulous approach towards the undertaking of any clinical assessments and evaluations. A clear understanding of the universal concepts in dental aesthetics, as detailed above, is important along with knowledge in the application and limitations of the various materials and techniques available. All treatment must be underpinned by the principles of 'beneficence' – i.e. doing good and acting in the patient's best interest and 'non-maleficence' – i.e. doing no harm. There is evidence to show marked variations in expectations of the outcome with gender, ethnicity, peer/media pressure and age. An interesting and, as yet, unexplored area of such expectations is whether country

of origin and culture play a more dominant role, especially amongst immigrant populations.

Planning

Before any smile enhancement treatment is commenced and irreversible changes made, intra-oral diagnostic mock-up's, diagnostic wax up's and, more recently, digital smile design techniques either solely or in conjunction, as appropriate, need to be applied to ascertain the expectations of the patient and confirm that they are both realistic and achievable. This forms an important element of obtaining valid informed consent for the proposed treatment. Discussions should be structured, adopting a clear, accurate, balanced, logical, comprehensive and, where possible, evidence- based approach. In considering the possible treatment options (weighed against the option of no treatment) with the patient, all risks and benefits must be identified.

When minor adjustments are anticipated then a simple intra-oral "dry it and see" approach can be adopted where the teeth are air dried and a suitable composite is applied without the preparation of the enamel for bonding. However, in more complex cases where perhaps orthodontic tooth movement is being considered along with subsequent restorative options for space filling, then mounted study casts with the anticipated final tooth positions can be invaluable. The functional occlusal prescription can also be evaluated on such a set up (figures 1 a-e).

As mentioned previously, most patient complaints in aesthetic dentistry stem from the discrepancy between what the patient expected and the outcome of treatment. Therefore, it is time well spent to discuss in the detail with the patient the intended outcome, utilising reversible, preferably intra-oral techniques. The aim is for the dentist and patient to share the same anticipated outcome.

Figure 1(a): Patient unhappy with their smile.

Figure 1(b): Mounted study casts on a semi-adjustable articulator with the diagnostic wax up of the intended outcome.

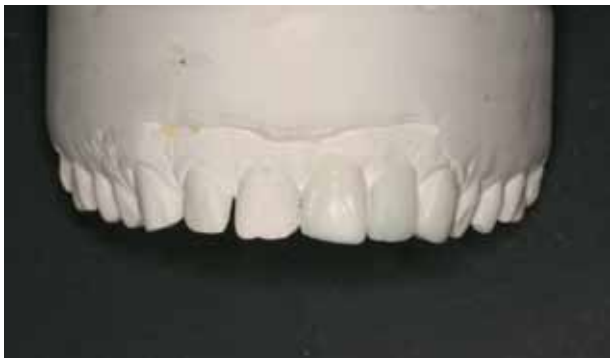


Figure 1(c): Upper study cast with diagnostic wax up.

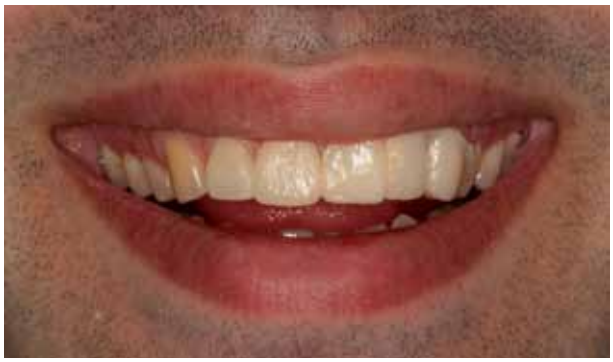


Figure 1(d): Using provisional crown and bridge material and direct composite resin the intended outcome from the diagnostic wax up is transferred onto the patients dentition without and tooth preparation. This allows the patient to make the aesthetic evaluation and the clinician to evaluate both the aesthetic and the functional outcome.

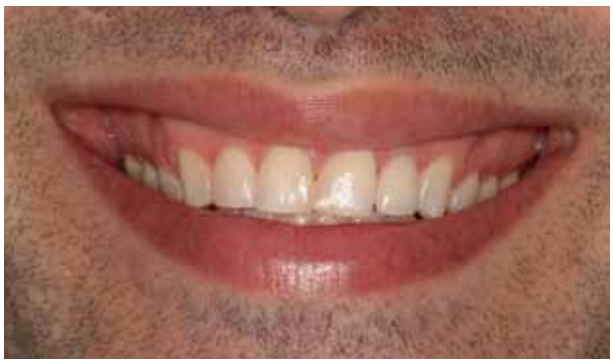


Figure 1(e): The completed case showing the patient at a review appointment approximately two years later. Treatment involved orthodontics, implant replacement of the missing upper left lateral incisor and direct composite bonding on the upper central and lateral incisors and canine teeth.

Body dysmorphic disorder

Body dysmorphic disorder (BDD) is a psychiatric condition characterised by the pre-occupation with an imagined defect in appearance, which causes marked distress to the affected person. Pre-occupation with the defect may cause clinically significant distress or impairment in social, occupation or other important areas of functioning, with the pre-occupation not being related to any other form of mental illness. Whilst BDD has been reported to have an incidence rate of approximately 3% amongst the general population, it would appear to be more common amongst patients seeking cosmetic and aesthetic dental treatments. Features of patients suffering from BDD include:

- onset in late adolescence,
- equally prevalent amongst males and females, although unmarried individuals appear to be more susceptible,
- a reluctance by patients to disclose their symptoms,
- social phobia's and obsessive-compulsive disorders (OCD's) are common amongst sufferers,
- a tendency towards alcohol dependency,
- a tendency to become housebound and
- suicidal tendencies.

Patients suffering from BDD tend to be most pre-occupied with aesthetic impairments relating to their skin, hair and nose. Indeed, a high proportion of sufferers reportedly seek cosmetic surgery involving their chins and noses. Details of such surgical intervention should be recorded as part of the medical history, which may ultimately help with the diagnosis of the condition.
Clearly patients suffering from BDD may be profoundly challenging to treat. When the dental practitioner observes behaviour, which may be suggestive of BDD, referral of the patient to their medical practitioner is advisable prior to considering any form of aesthetic dental care, in particular any form of invasive, irreversible treatment.

Aesthetic zone

The aesthetic zone, also known as the 'smile zone', includes all the hard and soft tissues that are visible when the patient makes a broad smile. The examination and assessment of the aesthetic zone should include evaluation of the:

- lips and adjacent soft tissues,
- dento-labial relationship,
- dental midlines,
- tooth size, shape, proportions, symmetry, position and axial inclination,
- tooth shade(s) and surface texture,
- contact areas and embrasures and
- gingival aesthetics.

Six smile zone shapes are commonly described in the literature. These are straight, curved, elliptical, bow shaped, rectangular and inverted. Smile zone analysis should start with determining the smile zone shape.

There is considerable variation in tooth exposure during smiling, both by and between individuals.
The term 'lip line' or 'smile line' is used to describe the relationship that exists between the inferior border of the upper lip, the maxillary teeth and gingival soft tissues on smiling, or when a patient is asked to make the sound 'E', commonly referred to as the 'E test'. Three types of lip line have been described:

- Low smile line – when the maxillary anterior teeth are exposed by no more than 75%, with no display of gingival tissue on smiling.
- Medium smile line where 75 % to all of the clinical crowns of the maxillary anterior teeth, and the associated interdental gingival papillae are exposed on smiling.
- High smile line where all of the clinical crowns of the maxillary anterior teeth and the adjacent gingival tissues, beyond the gingival margins, are exposed on smiling.

Low smile lines are the most forgiving; for example, when there is be an exposed cervical margin to a restoration, or a ridge defect in the anterior region, necessitating the placement of an artificial tooth with an abnormal inciso-gingival dimension and associated asymmetrical gingival profile.

The dental midline (DM) should, ideally, coincide with the facial midline (FM). The maxillary midline is best assessed against the midpoint of the philtrum. The labial frenum and facial midline are co-incident in approximately 70% of the population. A discrepancy of <2mm between the maxillary midline and facial midline is generally considered to be aesthetically acceptable. A variation > 4mm is associated with a suboptimal aesthetic appearance, and perfect coincidence of the DM and FM may result in an artificial appearance.

The colour of teeth should be evaluated according to:

- Hue – base colour
- Chroma – saturation of the base colour
- Value – brightness

There are many shade analysis systems available in the dental marketplace. The base shade should be recorded using a preferred shade guide. Colour variations within and between different teeth in each arch, in particular the maxillary canines, should be assessed and noted. The colour of a tooth may be influenced by many different factors including the presence of restorations, loss of vitality, discoloration following trauma and endodontic treatment, caries, areas of hypomineralisation and hypocalcification, staining-extrinsic and intrinsic, cracks and corrosion products from metallic restorations.

Tooth surface texture and lustre should also be documented, particularly when planning indirect restorations. A good quality study cast provides an excellent record of, amongst other features, surface texture.

Three common tooth forms have been described in the dental literature These forms relate primarily to the form of the maxillary central incisor teeth - the most dominant teeth in the smile. The three forms are:

- ovoid – egg shaped

• square – quadrangular
• triangular – tapering.

Variations in these forms have been described and may change with age, because of tooth wear.

Consensus opinion suggests that the size, shape and arrangement of the maxillary anterior teeth are the most influential factors in characterising the anterior dentition.
The morphology and positioning of the maxillary canine tooth has an important role in determining the progression of the patients smile from the anterior to posterior regions.

The shape of the mandibular anterior teeth should be assessed, with special attention to the profile and appearance of the incisal edges.

It is widely accepted that a key determinant for a smile to be considered pleasing is symmetry of the central incisor teeth. However, some asymmetry between the maxillary central incisors is common. It has been suggested that differences > 0.3 - 0.4mm in the dimensions or positioning of these teeth may be readily noticed. The aesthetics of asymmetric central incisors may be enhanced if the disto-incisal line angles of the teeth appear symmetrical.

For optimum aesthetics, the gingival levels of the anterior maxillary segment should be symmetrical, with the gingival margins on the central incisor - and canine teeth being slightly (<1mm) higher than on the lateral incisors. Disparities in gingival symmetry are frequently observed in association with localised dento-alveolar compensation, severe crowding, ankylosis, periodontal disease and the substitution of a canine for a maxillary lateral incisor

Minimally invasive dentistry

Minimally invasive dentistry (MID) is the application of "a systematic respect for the original tissue" and is a concept that can embrace all aspects of clinical practice. The common delineator is tissue preservation. The introduction of predictable adhesive technologies has led to a giant leap in interest in MID. In the context of aesthetic dentistry where there is no disease present a minimally invasive approach whereby the healthy tooth tissue is preserved has significant benefits and with current materials and adhesive protocols, can have the potential to satisfy both patient and the clinician's requirements to achieve an aesthetic smile with long term predictability.

MID in the aesthetic zone

Often the presence of disease is the cause for the chief complaint from the patient who is unhappy with the appearance of their smile and, the effective control and management of disease can produce a satisfactory long-term aesthetic outcome (figures 2 a and b). In addition to an improved appearance there is also a feeling of oral wellbeing which can contribute positively towards the general health of the patient, along with their confidence to interact with peers and in society.

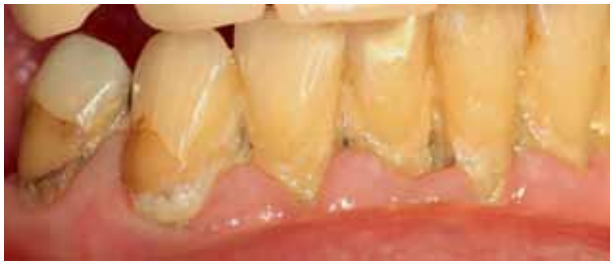


Figure 2(a): Adult female patient unhappy with the appearance of her anterior teeth.

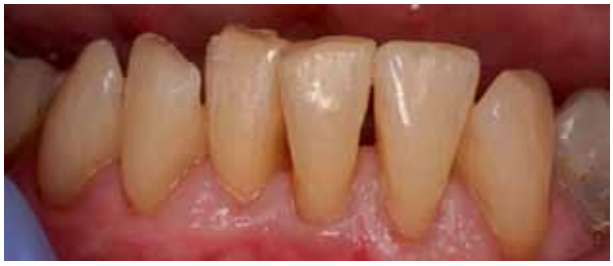


Figure 2(b): Patient at 7-year recall. The periodontal disease and caries control was all that was required to satisfy the patients aesthetic requirements and concerns.

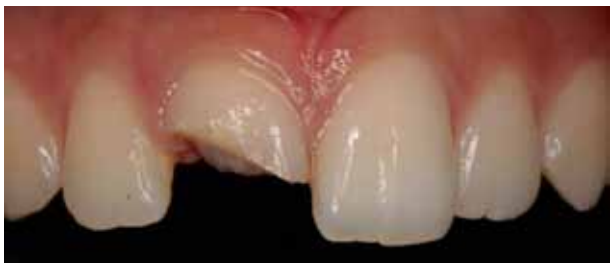


Figure 3(a): Adult female patient, upper right central incisor fractured following trauma with exposed pulpal tissue in an otherwise intact dentition.

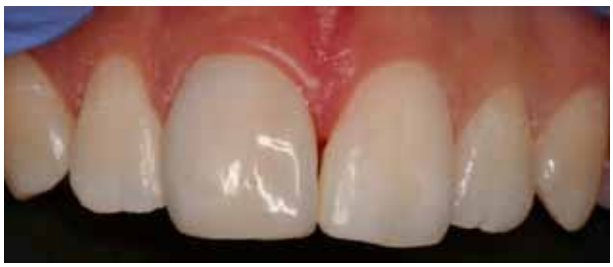


Figure 3(b): Patient at 4-year recall. The upper right central was endodontically treated and built up with a direct composite Restoration.

Previously when full coverage crowns or post crowns were considered for the restoration of grossly broken-down tooth, current adhesive options have the potential to eliminate the necessity for further healthy tooth removal in order to provide a satisfactory outcome. There is growing evidence on the longevity of adhesive restorations and the facility to provide a compromised tooth with another option in the 'restorative cycle' which therefore prolongs the longevity of the tooth. This approach also enables the option for repair should the existing restoration wear or fracture further contributing to the prolonged expectancy of the tooth (figures 3 a and b, and figures 4 a en

Figure 4(a): The upper left first premolar was previously endodontically treated and the existing amalgam restoration had failed with the fracture of the buccal wall.

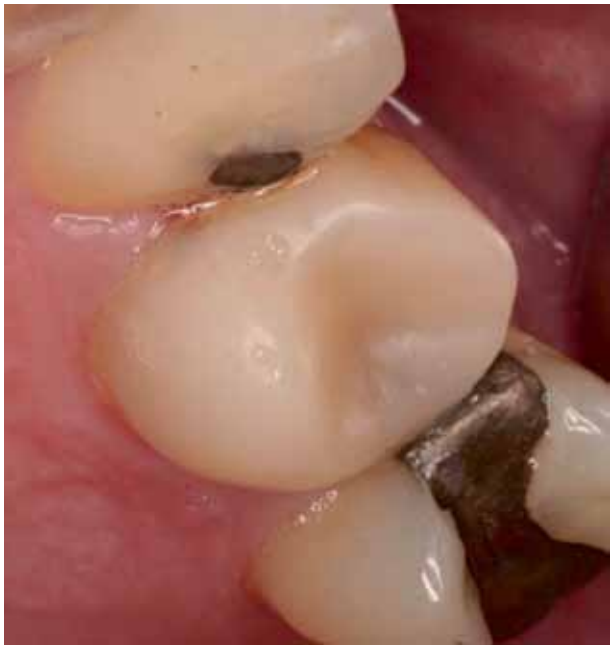


Figure 4(b): The upper left first premolar tooth at 9-year recall. This tooth was restored with a direct composite restoration. No further tooth tissue was removed or post placed in the root canal space.

b). An additional benefit is the possibility of shade, shape colour change in the future should it be required as the adjacent teeth change with time. This allows for the dynamic characteristic of aesthetic changes to be addressed and accommodated with the passage of time particularly in single unit restorations in the aesthetic zone.

Tooth whitening

Tooth whitening procedures have become well established and can produce an acceptable aesthetic result. It is an oxidative process/reaction that takes place following the application of a product to the tooth that alters the light absorbing or light reflecting nature of the tooth structure - thereby enhancing the perception of its 'whiteness'. The process invariably involves the use of peroxide-based products (hydrogen peroxide/carbamide peroxide) applied either chairside or using a home-based system requiring the fabrication of customised trays. This procedure requires regular replenishing for maintenance and the patient needs to be informed of this requirement. In certain instances, as in the case of severe tetracycline staining tooth whitening alone is not able to provide an adequate result. With the availability of composite tints, it has become possible to further mask discolouration using a minimally invasive technique (figures 5 a-d). In certain instances when a metal based onlay provides the best possible outcome for the restoration of a broken-down tooth which requires cuspal support, the appearance of the metal within the aesthetic zone can prove objectionable for the patient. With the use of masking tints and adhesive technology involving alloy primers and enamel bonding, the visible metal can be satisfactorily masked (figures 6 a-d).

Orthodontics

Orthodontic alignment with subsequent direct composite bonding enables an effective way to achieve a minimally invasive aesthetic result. With the exponential increase of orthodontic systems for anterior tooth alignment with considerably shorter treatment times careful evaluation is required to improve success and outcome of the long-term stability of the final tooth positions.

If it has been decided that orthodontic treatment is not indicated, and the presenting stable occlusion is to be maintained - a common approach in adult patients, then it is possible to use direct composite additions to the teeth in the aesthetic zone in a minimally invasive manner to deliver an acceptable aesthetic result (figures 7 a and b). Careful consideration to the distribution of the occlusal forces extends the longevity of the restorations.

Direct composite veneers

Direct composite veneers can be used in the following instances:

- In the management of fractured, discoloured and rotated teeth.
- In the treatment of tooth malformations (e.g. peg shaped lateral incisors), or malpositions.
- Closure/narrowing of diastemata.

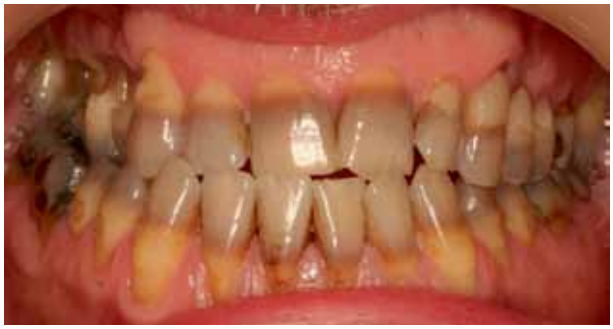


Figure 5(a): Adult male patient presenting with severe tetraclycline staining.

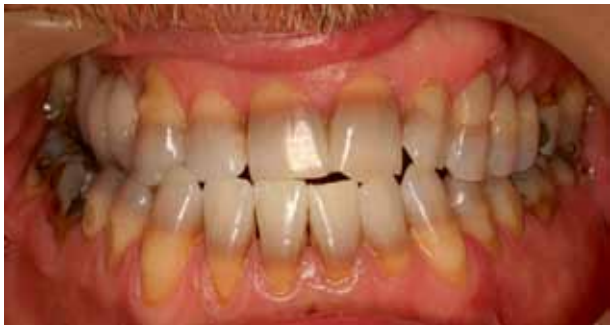


Figure 5(b): The appearance of the teeth after prolonged tooth whitening.

Figure 5(c): Review at 2 years. Further colour modifications have been achieved with the use of composite tints and direct composite application with no tooth tissue removal.

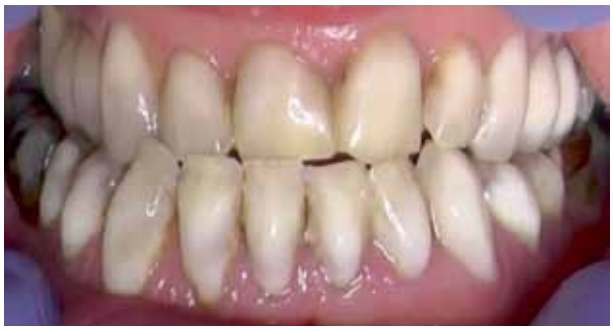


Figure 5(d): Review at 6 years. There has been some staining due to the patients habit of smoking occasional cigars however this can be addressed with polishing and composite enhancements techniques if required.

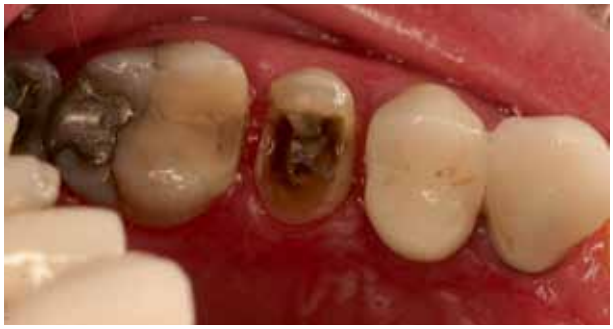


Figure 6(a): A broken down vital upper right second premolar tooth.

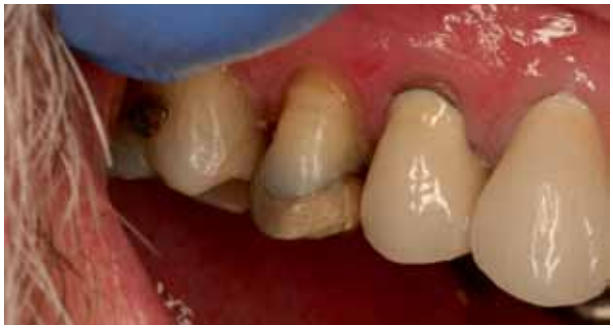


Figure 6(b): A indirect gold alloy onlay cemented with buccal cusp support.

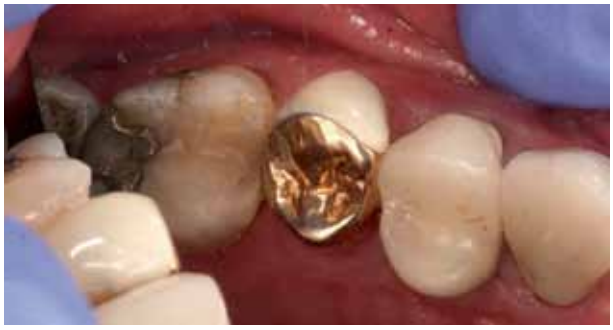


Figure 6(c): Occlusal view at 7-year review. A direct composite was placed buccally to mask the metal alloy.

Figure 6(d): Buccal view at 7-year review to show the direct composite masking of the metal alloy.

- In the management of congenital or acquired defects.
- The treatment of the worn anterior dentition.
- As a prelude to the use of indirect techniques to gain consent and verify acceptance/ tolerance.

Composites require maintenance and periodic polishing to maintain their aesthetic qualities. The placement of these restorations in complex cases can be time consuming and requires considerable operator skill for a suc-

Figure 7(a): Patient unhappy with the appearance of her front teeth.

Figure 7(b): Review at 5 years. Direct composite restorations were placed without any removal of healthy tooth tissue following aesthetic confirmation with a intra oral mock up. Care was taken to distribute the occlusal loading equally anteriorly to give even contact on anterior on mandibular excursions and have posterior disclusion.

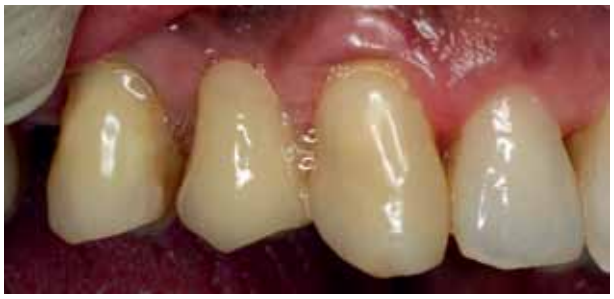


Figure 8 (a) & (b) show an adhesive bridge replacing the missing upper right first premolar at a 12-year review.

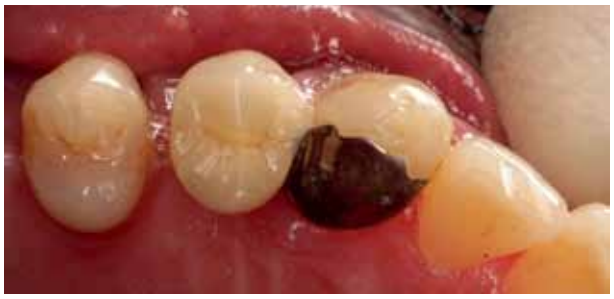


Figure 8(b)

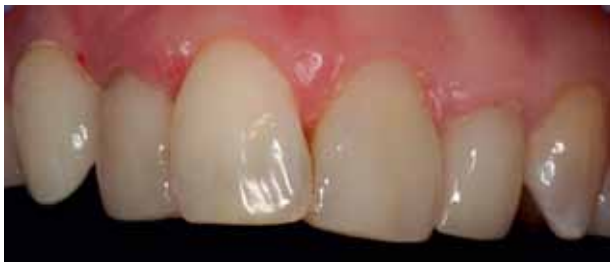


Figure 9 (a): Patient has a high lip line and is unhappy with the discolouration visible at the margins of the ceramic veneers placed on the upper left central and lateral and the upper right lateral incisors.

Figure 9 (b): Three-year recall. Rather than replacing the veneers the margins of the discoloured veneers have been repaired with direct composite restorations bonding to both the ceramic and the tooth.

cessful long-term outcome. Various researchers have indicated that operator skill, training and experience are the most important factors in the success of direct composite restorations long term.

Adhesive bridgework

Often a minimally invasive adhesive bridge can be provided as an alternative to a partial denture or an implant retained prosthesis. Careful planning, adhesion to good quality enamel and a carefully planned occlusal prescription contribute towards the long-term survival of these indirect restorations (figures 8 a and b).

Ceramics

There may be issues which arise in the long term with ceramic restorations. Margins become visible and stained, and the match of ceramic restorations may deteriorate as adjacent natural teeth undergo age-related changes. Despite aesthetic compromises long-serving ceramic restorations are often functionally adequate and removal of the restorations for replacement can be destructive. With modern adhesive technology and the use of silane coupling agents and direct composite resins a minimally invasive repair option may be applied (figures 9 a and b).

Conclusion

Patients will increasingly demand pleasing aesthetic outcomes in the rehabilitation and enhancement of their smiles. Minimally invasive treatment options in the aesthetic zone offer satisfactory, biologically acceptable alternatives to traditional approaches and have the potential to meet patient expectations in an increasing number and range of cases.

Consideration and the application of minimally invasive options extends the longevity of teeth in patients of all ages. ■

References available on request.

Introducing the Platform for Better Oral Health in Europe

Even though there have been enormous, positive advances over the last few decades in the state of oral health in Europe, it is a sad fact that having damaged, missing or filled teeth is still very much the norm and not an exception. Oral disease continues to be one of the biggest health burdens across the region.

Nigel Carter

Nigel Carter OBE, Chairman of the Platform for Better Oral Health in Europe

It is due to this that the Platform for Better Oral Health in Europe was created, with the singular aim of improving oral health and enhancing cost-effective prevention of oral disease across Europe.

Oral diseases not only impact on the individual through pain and discomfort, and the broader impact on their general health and quality of life, but also on the wider community, through the health system and associated economic costs.

The Platform for Better Oral Health in Europe is a joint initiative of the Oral Health Foundation, the Association for Dental Education in Europe (ADEE), the Council of European Chief Dental Officers (CECDO), the European Association of Dental Public Health (EADPH) and the pan-European region of the International Association for Dental Research. Its work is supported by the Wrigley Oral Healthcare Program and GlaxoSmithKline.

Need for Action

The Platform was created following the 'Call to Action for Better Oral Health in Europe', handed over to then Health Commissioner John Dalli by several Members of the European Parliament, in 2010.

Two years later, the platform commissioned an in-depth report to understand the level of oral health, in terms of both health and provision, in Europe. This allowed the Platform to establish a baseline in which to help improve both elements and measure, as well as future improvement.

The report titled 'The State of Oral Health in Europe' outlined the following trends of oral diseases in EU Member States:

- Despite a global decline in caries, the disease remains a problem for many groups of people in Eastern Europe, and for those socio-economically deprived groups in all Europe Union Member States.
- Over 50% of the European population may suffer from

platform for better oral health in europe

- some form of periodontitis and over 10% have severe disease, with prevalence increasing to 70-85% of the populations ages 60-65 years of age.
- In the EU, lip and oral cavity cancer is the 12th most common cancer in men. In 2008, there were approximately 132,000 cases of head and neck cancer across Europe, resulting in 62,800 deaths.

The 2012 report also discovered that current EU spending on all aspects of curative dental care and treatment was close to €79 billion, with future estimates that this figure could be as high as €93 billion by 2020.
Demographic changes also posed a formidable challenge, with an ageing population within the EU requiring challenging and ongoing oral health needs.
Inequalities across member states were also an ongoing problem, as low-income populations most in need of dental care faced higher hurdles compared to wealthier citizens.
In brief, the report outlined that there were significant oral health problems spread across EU states and within these there were profound disparities between states related to socio-economic status, age, gender, and general health status.
The Platform was therefore set up to address these problems and ensure that access to oral healthcare and education was improved across the region.

Mission

The Platform holds true to the belief that good oral health is an integral part of general health and wellbeing. It should not be considered in isolation from systemic health and, as many of the key factors that lead to poor oral health are risk factors for other diseases.
The mission of the Platform has therefore been defined as "to improve oral health and enhance cost-effective prevention of oral diseases in Europe."
To achieve this the goal of the Platform is to create a common European approach towards improved oral health education, promotion, and access to care in Europe.
They aim to deliver this by implementing four key elements:

1. **Encourage** oral health and the prevention of oral diseases as a fundamental to good general health.
2. **Enhance** the EU's oral health policy, including incorporating oral health in to relevant policies.
3. **Secure** EU action on oral health.
4. **Address** oral health inequalities and challenges, especially among vulnerable populations like children and adolescents, the elderly, and those with special needs.

Through the combined efforts on the Platform's five core members and 15 associate members, together with the valuable support of the Platform's sponsors, they can influence these areas to try and improve oral health across Europe.

Policy

The publication of the State of Oral Health in Europe report, provides a set of key policy recommendations to help drive the aims of the Platform towards their ultimate objective.

These five policy recommendations are:

1. Develop a coherent European strategy to improve oral health with commitments to quantifiable targets by 2020.
2. Improve the data and knowledge base by developing common methodologies and bridging the research gap in oral health promotion.
3. Support the development of cross-sectoral approaches with health and social care professions and support the development of the dental workforce.
4. Address increasing oral health inequalities and knowledge of prevention/oral hygiene practices of the public and guarantee availability and access to high quality and affordable oral health care.
5. Encourage best practice sharing across countries.

Through the implementation of these policies, the Platform hopes to address the huge impact that oral diseases have across Europe and close the gap on oral health inequalities across the region.

Achievements

Since its inception, the Platform for Better Oral Health in Europe has already achieved great progress towards its mission.

Previous work demonstrated a range of effective population-based preventive initiatives that have already been implemented across Europe. The Platform published an initial collection of best practices in oral health prevention and promotion from across Europe. It is currently working to identify further examples of best practice which meet the newly published EU Commission guidelines for quality

The aim of this exercise is to explore summarise and publicise some of the existing programmes and examine what is necessary to ensure that these are supported by decision makers, sustainably financed, and rolled out between Member States where relevant.

The Platform also developed and launched its 2020 targets, to highlight three key areas where oral health policy improvement is urgently needed.

These are data collection systems, preventive policies and education and awareness.

To assess the situation in more detail, the Platform for Better Oral Health in Europe sent a questionnaire on some of the indicators to leading dentists from the 28 Member States of the EU.

Respondents from 25 EU Member States completed the questionnaire. The responses to the questionnaire have been analysed and consolidated to form the first edition of the European Oral Health Report Card: (http://www.oralhealthplatform.eu/wp-content/uploads/2015/09/European-Oral-Health-Report-Card.pdf).

Targets

The Platform believes that a large part of the disparity across Europe can be remedied through better oral health prevention programmes.

Oral diseases are easily preventable through healthy diet, regular dental check-ups and routine personal oral hygiene practices, including frequent dental check-ups, the use of fluoride containing toothpaste and mouthwashes, and interdental cleaning.

The Platform believes that European decision-makers could take further steps to improve the oral health of their citizens in a cost-effective way by focusing more on the promotion of good oral health and the prevention of oral diseases.

Of particular importance is the need to improve the collection of data and to consider oral health as an integral part of general health and wellbeing. There is a need to address risk factors common to many other chronic conditions, which include diet, smoking and alcohol use.

The Platform has two major short-term objectives at this time.

In November 2015 the EU Commission in association with OECD published a report entitled Europe Health at a Glance. We were shocked, but perhaps not surprised to find that there was no mention of oral health in this at all.

We are currently working to put forward a case for the inclusion of oral health data in future editions of this report by emphasising oral health's links to and importance for general health.

To this end the Platform is also participating as a collaborating partner in several EU Joint Actions on Chronic Diseases, Frailty, Inequalities and Health Information.

The Platform is also an active member of the European Health Policy Platform and has supported the output of several Thematic Networks on health issues.

At the present time, we are also embarking on a programme of outreach to other health NGOs and stakeholders operating at a European level with a view to sharing best practice, looking at areas of common interest and raiding the profile of oral health on their agendas.

The second major strand of work continues the previous work of the Platform on Best Practices. As part of the CHRODIS Joint action -implementing good practices for chronic diseases across the EU, very detailed criteria were established for best practices and these have not been taken up by the Commission to launch a repository of healthcare best practices that can be taken up by Member States for implementation in their own countries. We have been working to tailor the various criteria developed for use specifically in relation to oral health projects and are now at the final stages of this process. We are now launching an appeal to anyone involved in oral health promotion and prevention across Europe to submit their best practices using the developed criteria and we will then arrange for those meeting the European standards to be placed on the Commission Platform.

The Platform has come a very long way in the seven years since it was formed. We have a better understanding of the triggers to influence policy makers to include oral health on their agenda and look forward to seeing progress towards better oral health in the years and decades to come.

For further information regarding the Platform for Better Oral Health in Europe, its aims, objective and achievements please visit www.oralhealthplatform.eu ■

20-20 vision: Leading dental education into the next decade

Against a backdrop of societal and cultural changes, let alone advances in the understanding of molecular biology and technological developments of increasing sophistication, the challenge for dental school leaders to form the next generation of dental healthcare professionals is daunting, but offers potential to effect profound change. It is a sobering thought that the cohort of dental students entering dental school in 2020 will continue to practice dentistry well into the mid-2060s and beyond. The aim of this article is to reflect on some challenges and opportunities facing those who lead our dental schools as we move into the next decade.

Chris Lynch

Professor Chris Lynch, Professor of Restorative Dentistry, University Dental School & Hospital, University College Cork, Wilton, Cork, Ireland.

The same but better?

One of the challenges facing dental students of today is that they are often considered "not as good as they used be". Such criticisms are leveled with the accusation that dental students do not gain as much clinical experience as graduates of yester-year. Yet such criticisms are often flawed as the claimed, much-missed experience often relates to treatments which are increasingly regarded dated, such as rendering significant numbers of patients edentulous, linked with the provision of immediate dentures, or the inappropriate destruction of otherwise healthy teeth when providing aggressive, interventive treatments such as conventional crowns and bridges, many of which now have effective, minimal intervention alternatives. The 'things aren't what they used to be' claims also fail to recognize that current dental students have demonstrated significant academic and scholastic achievement as part of the selection process for dental school - in part recognized by the critics, who are often heard to say, "not sure if I would get into dental schools today". Our students really are "the brightest and the best"who, if given appropriate encouragement, will provide future leadership in the profession, while driving advances in treatment and patient care.

Our dental school programs need to ensure our graduating students are competent and have achieved sufficient clinical experience to qualify as 'safe beginners'. In addition, contemporary dental school programmes should aim to include appropriate research-led teaching. An important example of this relates to molecular oral biology, where an increased awareness and understanding can drive the development of new techniques and treatment. For example, one's conceptual migration from the perception of dentine as network of tubules, to the further understanding that is a reservoir of bioactive molecules such as the TGF-beta family, can drive new treatments in dentine auto-repair. Understanding the complex interaction of cellular-signaling during tooth development will, in the future, lead to predictable tooth regeneration techniques. These developments cannot happen, or will not happen as quickly, if we do not recognize the potential of, and guide, our students. A careful and judicious balance is required within the dental school curriculum to ensure our students are emerging clinician-scientists.

Further understanding of the behaviours and learning styles of current generations of students is also important in nurturing and facilitating their development. Existing students interact with each other, and learn in different ways to anyone who completed their own dental school education more than 10 years ago. Use of social media platforms, with resources which are often readily updatable in real time, offer a different approach to delivery of teaching via course handbooks and even textbooks, which will be outdated as soon as they are published. Virtual learning spaces, and communication and co-operation between students can be achieved using appropriately resourced and protected social media programs. Contemporary lecture capture and/or podcasting of lectures and tutorials allow students to review important lectures at a time of their own choosing and in keeping with the demands of their personal lifestyles. The author recently examined a fascinating PhD thesis on student progression which included consideration of this point: focus group interviews of students compared their perception of recorded lectures based on their attendance during its scheduled time, and their subsequent use of the recorded lecture in their personal study. A common pattern emerged: students who found the lecture to be "boring" or "dense" while attending during its scheduled time, found the recording of the lecture to be invaluable during revision time, with some students reporting that the lecture contained all the relevant material they required for their revision. We need to recognize the need, and adapt our teaching styles and programs to enhance the learning experience for our students.

The dentist as a professional person

"Ethics are what we do when no one else is looking! For heaven's sake, I learned that from you!"
Dr Fraiser Crane speaking to his father, Martin Crane (Fraiser, Season 6, Episode 15).

Increasing emphasis is placed in dental school programs on the professional and personal development of students as a professional. Moving away from staid teaching on 'laws and rules', which are 'learned' and 'recited' at examination time, we should instead foster our students as ethical, socially conscious, and thoughtful members of the dental team, with appropriate and necessary self-awareness and insight into their own actions and behaviours. Such considerations should also include probity, honesty, and effective and appropriately empathetic communication skills and behaviours. There is much benefit in intertwining such teaching as a vertical thread through each of the years of the dental school programme, allowing opportunity to monitor the development of individual students, while underlining the importance of this subject. Challenges in this domain exist for our students in today's world in a way that they did not exist before, such as an increased awareness of mental health issues, substance abuse, and social transgressions or even illegal actions on social media. As current leaders in dental schools we must help and guide our students deal with such challenges – simply ignoring these, or claiming they are not part of the program is not enough: we have to equip our students with the tools to deal with such challenges if we want to help them develop appropriately as professional people. We should also encourage students to have a responsibility to "look out for" classmates and colleagues, engendering collegiality and professional networks, which could provide simple but effective support for those who are struggling with difficulties. Leadership begins with the individual – in so many ways our students look to us as role models – and we can introduce apparently simple, yet effective changes in the student milieu.

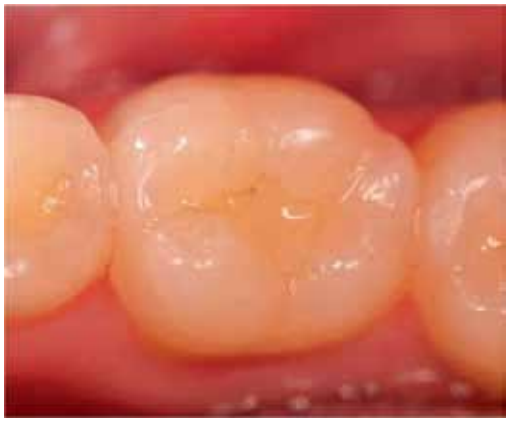


Fig. 1. Resin composite offers predictable and superior results to amalgam when placed in posterior teeth, while offering a minimally invasive approach to treatment.

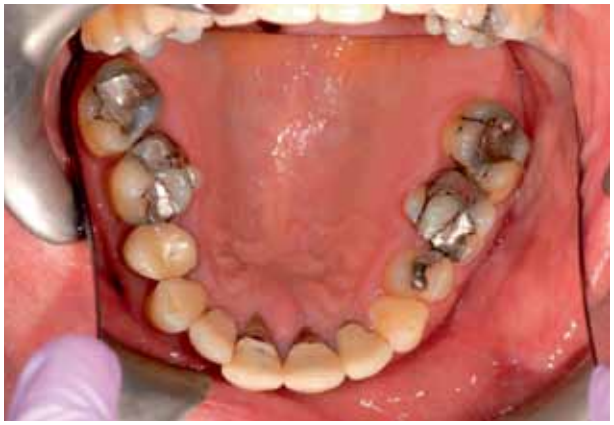


Fig. 3. A heavily restored dentition: more and more patients are presenting in need of "replacement dentistry" – i.e. managing failing restorations – greater emphasis should be placed on teaching students how and when to intervene in managing such restorations.

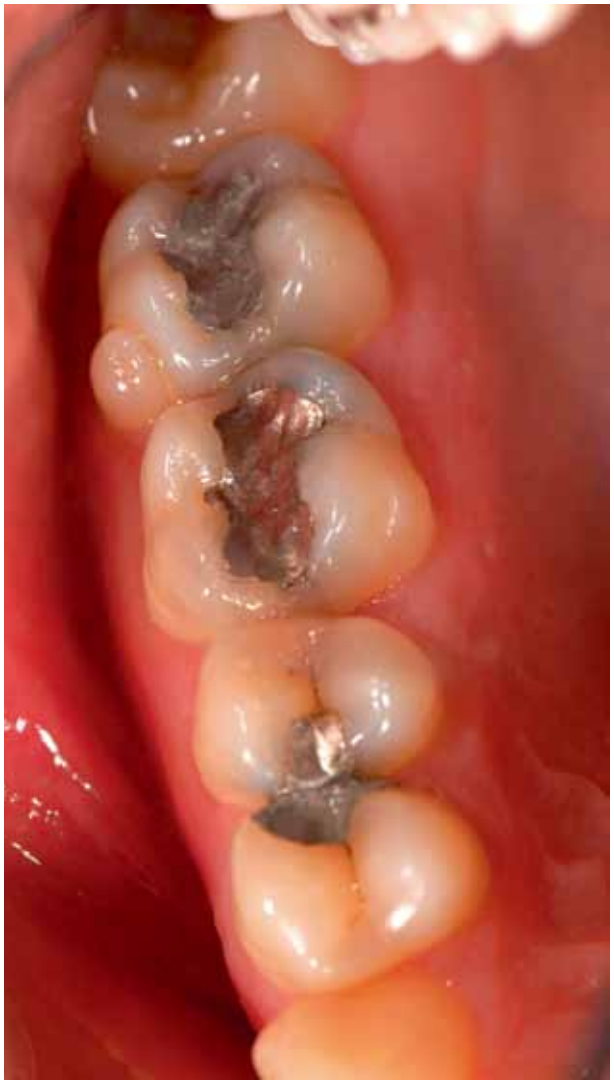


Fig. 2. This image shows posterior teeth that have been restored with amalgam. Resin composite would have offered a more predictable approach to treatment in this situation.

Clinical teaching: where are we going?

Within the busy curriculum it is always difficult to decide which clinical treatments and techniques to include. However, some important developments have taken place in recent years, while others fast approach us.

Perhaps one of the most significant changes over recent years is the drive towards preventatively-orientated, minimally invasive dentistry, with increased placement of posterior resin composites in preference to dental amalgam (figures 1and 2). Dental schools have provided worthwhile and important leadership in driving this shift, often against resistance from established practitioners. From a time, almost 20 years ago, when as few as 1-in-10 dental students gained clinical experience in the placement of posterior resin composites, the most recent round of surveys of UK and Ireland dental schools reveals that the proportion of posterior resin composites: amalgam placed clinically by dental student is, on average, 2:1. A majority of schools estimate that by 2020, amalgam will account for less than 10% of restorations placed by students in posterior teeth. Such developments, now

Fig. 4. The upper right first molar has suffered restoration fracture: Is a localised repair preferable to restoration replacement in this situation?

history in dental schools in countries which no longer use dental amalgam, are to be encouraged, especially when one considers the beneficial effects of such techniques in avoiding the needless sacrifice of otherwise healthy tooth substance required for mechanical retention of amalgam. Further consideration on this point arises from the Minamata Treaty on mercury elimination, which at the time of writing has been signed by 128 countries and ratified by 91 of these countries. Within Europe, the recommendations of the Minamata Treaty are being implemented via an EU directive which at its initial steps prohibits placement of amalgam in children under 15 years of age and in pregnant or breast-feeding mothers from July 1 2018. Further milestones will involve enhanced environmental control of mercury within the dental surgery, with an eventual trend towards the elimination of amalgam within the EU by 2030. With this in mind the author recommends, as he has done before with other colleagues, that the time has come to stop teaching amalgam placement within dental schools. Instead students should be given further, more advanced teaching in posterior resin composite placement, along with enhanced teaching in other relevant, related areas, such as caries diagnosis and the maintenance and repair/refurbishment of existing restorations which, while remaining clinically serviceable, feature some form of deterioration (figures 3 and 4).

Another important development and dilemma for dental schools is the teaching of technological advances, such as prosthodontic digital techniques and endodontic instrumentation. The author, who leads teaching in prosthodontics within his dental school, has been asked if there is a need to teach traditional techniques, involving "wax and plaster"? There is no doubt that novel digital technologies are the future of dentistry. However, in schools which train students for the international setting, great challenges exist in managing the tensions between traditional and developing technological advances. Should students be trained to use manual endodontic instruments in addition to rotary instrumentation? Should students be taught to record principally digital impressions to generate digital models, which can be stored electronically, thereby reducing the problems and costs associated with the production and storage of poured models? The author's response to the questions posed is, for now, that both traditional and novel technologies should be taught: globally mobile graduates may go to work in areas of social affluence or deprivation, and we are not serving the best interest of our students or their patients should they find themselves in circumstances where they are incompetent in the use of 'local' techniques. However, the situation needs to be monitored, with the scope to increase the amount of teaching of novel technologies in the coming years, with leadership to be encouraged within clinical practice to support these new technologies.

Future global leaders in oral health care

As well as leadership within the dental practice, dentists should offer leadership within their profession and in society. Dentists need to be advocates for patients, for example in addressing inequalities in (oral) health and health care delivery in their society at large. More subtly, the practice and concepts in dentistry are global and universal. In a world where political developments are pointing towards insular and inward-looking developments, dentistry offers opportunities in the global setting. While there are considerations in the practice of dentistry which are peculiar to individual countries or regions, the nature and consequence of dental disease and tooth loss are universal. Reflecting on leadership qualities discussed previously, we should educate and train our students for delivery of oral healthcare systems within the modern global society, which is sensitive to, and respects cultural differences.

Further scope for development exists amongst dental professionals to become as much 'physicians' as surgeons. The author's comments in this regard relate to enhanced teaching of human diseases for dental students, and the interface with oral medicine. This will allow dentists to treat patients with certain medical conditions with confidence, thereby increasing access to care. As well as this, dentists should become skilled in recognizing oral changes consistent with early systemic disease, allowing early referral and management. There is also much to be achieved in the concept of the dentist becoming a full member of the primary care team – being capable of delivering relevant healthcare interventions in their surgery such as smoking cessation, alcohol reduction or anti-obesity advice. Dental schools should look to modify their programs to include these changes.

Concluding remarks

The challenge for dental schools and their leaders is to not only provide high-quality dental professionals for the betterment of society, but also to foster and nurture the leaders of the future. Future advances in the understanding and treatment of dental disease, as well as technological advances in treatments, will come from an increased scientific awareness and knowledge, which can be supported through an appropriate balancing of the dental school program. In a modern, global society we need dentists with open and questioning minds, who are professional people and capable to responding to the needs of diverse cultures and populations. We will need to meet this challenge now, in the 2020s and beyond… ■

References on request

The role of the ICD Global Director of Development

As Fellows of the ICD, we tend to live our College lives within the confines and framework of the Section in which we were inducted, in our case the European Section.

Phillip Dowell

Phillip Dowell, ICD Director of Global Development, Past International President

As International President the theme of my year was 'Internationalism'. The message behind the theme was to feel and experience the joys and Fellowship of visiting other Sections and to be more aware of the international nature of the College.

In travelling around the Sections, it soon became apparent to me that much work needed to be done on the structure and recruiting and retention methods of some of the Sections to follow best practice. Moreover, I appreciated that implementing my recommendations would be time consuming and difficult to achieve because of changes in Section leadership and lack of continuity in the running of certain Sections. This is an area of potential development and one that may eventually become part of my remit as the College's Global Director of Development.

The splitting of the College Secretariat from the USA Section, only a few years ago, brought with it significant advantages, not least of which was an increase in the time available to be spent on international matters. An important development, especially when the College was faced with getting new premises and staff, which inevitably created a strain on the budgetary purse!

The dues collected by the Sections were not sufficient to support increased staffing levels. Recognition of the funding situation led to the establishment of the Diamond Sponsorship Program. This program has recently had Gold and Silver levels of sponsorship added, and is now known as the ICD Corporate Partnership Program. This program

Lecturing in Kenya

With hosts in Kenya, Dr and Mrs Pankay Patel.

generates the only source of non-dues revenue to support the functions of the College office.

Increasing the College budget allows time and resources to be allocated for College office staff to help with the administration of educational and humanitarian projects globally. However, the College office is always working at a frenetic pace, with more and more work coming in, and not enough hands to cope. As a consequence, volunteers have given their time to help in areas where they feel they can provide the most benefit. A prime example of this is Past International President, Dr. Garry Lunn from Canada. Garry is the College's Facebook guru, devoting a lot of his time in helping the College have a greater media presence.

The role of Director of Development of the College was founded at the 2016 International Council meeting in Denver. The initial remit was to help the College with funding issues. The role is, however, in its infancy and subject to annual review, and may grow into areas of need identified by the Secretary General in association with the College Executive Committee. Initiatives have included attending the International Dental Show (IDS) in Cologne, Germany - the world's largest dental trade show, where we were able to secure three new Silver College Partners: EMS, Dentsply/Sirona and Hu-Friedy.

As Director of Development, I contact all our corporate partners on a quarterly basis to sustain good communication and confirm that they are receiving all relevant information on the College via the College Today newsletter, the Globe and social media postings. It is also important to make sure that the needs of corporate partners are taken into account and ensure that the partnership with the College is truly symbiotic.

More recently, in a push to strengthen the College presence in Africa, I gave a presentation on the role of the ICD in social inclusion at a Kenya Dental Association meeting in Nairobi (figures 1 and 2). This also paved the way for an Africa-wide ICD meeting, with delegates from Southern Africa, Egypt and Sudan and Eastern African countries to take place later this year. Two International Councilors will be speaking at this meeting, including our own Professor Mauro Labanca.

It is an irony that the role of Director of Development is still developing. It is one that I thoroughly enjoy doing and gives me a great deal of satisfaction, especially when we get another corporate partner on board! I consider myself most fortunate to have been given this great opportunity to serve the College that means so much to all of us. ■

The Dental Wellness Trust

Linda Greenwall

I established the Dental Wellness Trust in 2011 with the aim, as an ICD Fellow, of giving back to less fortunate communities. I am a Specialist in Restorative Dentistry and Prosthodontics with a multidisciplinary specialist practice in Hampstead London. I undertake aesthetic dentistry cases and complex tooth whitening, and am author of several textbooks on tooth whitening.

To start the trust, I established a Board of trustees and advisors and investigated the best ways to making a meaningful difference in oral health. Doing good is one thing, but doing the right good is essential. I consulted with Professor Aubrey Sheiham, Consultant in Public Health. He advised that the focus should be on establishing toothbrushing programmes in areas of high need, complimenting successful oral health programmes running in many countries throughout the world. I consulted also with Dr Lorna McPherson and Professor Ivor Chestnutt who established the Child Smile and Designed to Smile Programmes in Scotland and Wales respectively.

I was born in Cape Town, South Africa and so initially focussed on the poorest townships in Cape Town, namely Khayalitcha, Mfuleni and Blue Downs. I connected and consulted with Professor Neil Myburgh at the Department of Community Dentistry, University of the Western Cape to establish a task force and a research base.

Oral Health through dental wellness is the mission

What we have achieved so far and where do we work?

We have provided toothbrushes, toothpaste and oral health education in the following countries:

UK

- Homeless, Crisis at Christmas -for the last four years we have donated over 12,000 toothbrushes to this programme.
- North London Schools and care homes - oral health education for children and care home residents and their carers.
- Luton, Bedfordshire - oral health education for over 1,000 children over the past three years - Megamolars and the Saving Kids Teeth Campaign.
- We have commenced a toothbrushing programme for the children in schools in Luton. The children are enjoying the programme and we are currently devising a song to learn all the parts of the teeth to clean.

Linda Greenwall, Specialist Practitioner, London, and Founder of the Dental Wellness Trust

South Africa

- More than 10,000 children in schools in the poorest townships, including 2,000 children participating in the Trust's evening LiveSmart Oral Health programme.
- We have provided oral health education for carers in an elderly care facility in which we have undertaken screening programmes.
- Johannesburg - our newest programme, focussing on children in the poorest township of Johannesburg in Soweto, Alexandra and Doornfontein, where we will introduce our innovative oral health programmes Educares into nurseries and Schools.

We have created a group of 33 'Toothbrush Mamas' (figure 1) who help to sustain our programmes in 370 schools in the Cape Town townships. They visit our schools to ensure a regular supply of soap and toothpaste and that the programme remains sustainable. The toothbrushes are kept on a toothbrush board (figure 2) that the Mamas make themselves. The toothbrush board is kept at school with a cover. Each toothbrush is named and is separated to ensure that none of the toothbrushes touches each other. The Toothbrush Mamas continue to innovate the oral health programme with songs, rhymes and dances. Our song "We brighten the corner where we are" is popular with the kids and teachers.

Fig.1 Training the 'Mama's' in South Africa in brushing teeth.

Fig.2 A toothbrush board.

Uganda

We have worked with Chayli Fehler who has helped 500 Southern Sudan refugees in Uganda. Chayli gave the children their first Good Deed toothbrush (see below) and toothpaste. The toothpaste was very popular, and the children were delighted to receive instruction on how to brush their teeth. The toothpaste was a special luxury and a prized treasure. Chayli has made two trips in the past year, one at Christmas time and another in August 2017 to help 150 new refugees.

Other countries have included Kenya-Rwanda orphanages in Kigali, Ethiopia, Ghana, where the work of the Trust has been supported by students from King's College London Dental Institute, Ukraine and Croatia, reaching out to children in orphanages, and Israel-West Bank Toothbrushes organised by Dr Tariq Bashir.

The Dental Wellness Trust has also helped refugees in Calais and Greece, working with the Refugee Crisis Foundation.

Good Deed toothbrushes

We have continued to give away and sell our Good Deed toothbrushes. To date we have given over 16,000 toothbrushes to children and adults in many countries, including 10,000 toothbrushes for the homeless during Crisis at Christmas over the last four years.

Mitzvah Day 2015-2017

We have participated in Mitzvah Day (Good Deed Day) when over 200 children in London pack up Good Deed toothbrushes for children in townships, together with a special personalised note to each child. The children in London enjoy this activity, increasing their awareness of the importance of kindness and charity and doing good deeds. This activity has helped introduce oral health programmes into the poorest township in South Africa.

Live Smart Teachers Conferences

In February 2017 and 2018 we held training conferences for 160 teachers participating in our schools programme. We taught the teachers how to brush their own teeth first. We then introduced the LiveSmart programme and taught the teachers our handwashing and tooth brushing songs. We started off the morning expressing gratitude to each participating teacher, followed by a women's empowerment and enrichment lecture to help the teachers induct and conduct the oral health programme in their schools. The mornings included a jive session which everyone enthusiastically participated in. This energised the group making it ready for action. Each teacher received the LiveSmart oral health manual to help them implement the programme in their school. We also provided toothpaste plates (figure 3) for each teacher, together with Dental Wellness Trust soap bottles. The key to our programmes is sustainability. This is done through daily monitoring of our programmes in schools and our evening health programmes with our Toothbrush Mamas.

Luton

We have started the toothbrushing programmes into an infant (4-5 year-old age group) school in Luton as a pilot study (figure 4). There are three classes of 30 children. After lunch each day the children wash their hands and brush their teeth. We continue to monitor the programme in the schools and provide them with the supplies they ▶

Fig.3 The Dental Wellness Trust, have come up with the idea of placing the toothpaste on a plate, this allows a clean and non-contaminated application of toothpaste onto the brush. This also prevents waste as only a small pea size amount is used.

Fig.4 Children from Whipperley Infant School in Luton participating in tooth brushing programme.

need. In the future we hope to train parents to become 'toothbrushing ambassadors' who will help sustain the programme. The children look forward to their daily brushing programme.

Going forward – our goal is that:

- Each child has their own toothbrush.
- Each child will know how to look after their own teeth, taking responsibility for their own oral health and, in turn, general health.

We are working with the Level Trust, a poverty charity based in Luton where there are 16,000 children living below the poverty line.

Saving Kids Teeth

We are asking questions…

- Why do 46,000 children in England need to be admitted to hospital each year to have teeth extracted under general anaesthesia?
- What are the methods and strategies that can be implemented to help more children attain dental wellness?
- How can we improve oral health to enhance general health in children?
- What is the relationship between sugar, dental health, obesity, diabetes and general health in children?
- What strategies are needed to help more children?

Saving Kids Teeth - a Dental Wellness Trust campaign, highlights the oral health plight of so many children in England. Over the last three years we have organised a conference to address our questions. The 2017 conference was attended by over 200 dentists. All the money raised has been invested in the Dental Wellness Trust LiveSmart toothbrushing programmes.

Research

We have undertaken four research projects to measure the impact of our programmes. These have included a toothbrushing programme, an elderly oral health assessment in Cape Town, a fissure sealant study and a fluoride varnish study. An abstract of the varnish study has been submitted to the 2018 IADR Conference in London. The fluoride varnish, supported by DMG Germany, has involved screening 400 children and the application of topical fluoride to their teeth. The children will be monitored and screened every three months over the course of the next 12-18 months. The research, which has involved training Toothbrush Mamas in the application of fluoride varnish, received ethical approval from the University of the Western Cape in Cape Town.

Dental Clinic in Mfuleni

In the townships of Cape Town there are nearly one million children with high levels of dental disease (<85% of 15-year olds with dental caries), but without access to dental care. Although there is a Government Dental Clinic, this is insufficient to meet needs - many children missing school because of dental pain. We are planning on establishing a Dental Clinic in Mfuleni to help address this problem. We are seeking funders and donors to make this dream a reality. We are planning to create an innovative health pod which will serve also as a community centre as well as a dental clinic. We are collaborating with, in addition to the University of Western Cape and Afrika Tikkun Organisation, Cape Town Architects Louis Karol and Associates and Arup Engineers, who have agreed to provide their services on a probono basis, to help progress this project.

Website

More information on The Dental Wellness Trust, including 'how to get involved' and 'how to donate' facilities may be found on the Trust website http://dentalwellnesstrust.org/

The International Council Meeting, November 2017

The International Council was hosted in Taipei, Taiwan by the Chinese-Taiwan Section (Section XII). Annual Sessions of the Council have traditionally been hosted by one of the Autonomous Sections. Recently, however, it was decided that the Council could choose any place in the world to hold its Annual Session, provided good access for international air travel and the venue.

Frans H.M. Kroon

Frans H.M. Kroon, International Councilor Section V, European Section

Introduction

As has become custom and practice, the Council meeting was incorporated in the Congress and Convocation of the host Section; the meeting was held in the same hotel (Howard Plaza Hotel) as in 2005.

The first day of the three-day meeting was used by the Executive Committee to finalise the agenda and the prepared motions. During its 'office-year' the Executive Committee has several meetings, either by telecom methods, or face-to-face in places suitable for the 'reigning crew' of the year.

Most Councilors arrive the day of the Executive Committee meeting. This give them the opportunity to meet each other as members of the several (sub)committees in advance of the Council Meeting. Saturday 11/11 and Sunday 11/12 were scheduled for meetings of the full Council. Until 2019, the European Section has three International Council positions, thereafter, given decisions taken a few years ago, Section representation will change. From 2019, each Section will have one Councilor, with an additional Councilor for every 500 Fellows over and above the first 500. The minimum number of Fellows per Autonomous Section is 120 Fellows. These measures were proposed and accepted to obtain a better balance in representation and to avoid the Council becoming too big.

Besides the Autonomous Sections, there is 'Section XX', including several mostly small Regions across the world. The recently formed Autonomous Section XV is composed of a substantial number of Regions, formerly included in Section XX, which has four International Councilors.

Council meeting

The International Council, the governing body of the College, comprises 38 Councilors representing Fellows in 122 countries.

It is the job of the international Council to determine the future direction of the College globally, and to ensure efficient and effective operation, providing the best value to its members.

The main items discussed and agreed in Taipei included:

1. The Constitution and Bylaws Committee received approval to begin work on modernising the College Bylaws, and create Standing Rules to better interpret and define the Bylaws.
2. Existing policies of the College will be reviewed and updated to reflect changes to the Constitution and Bylaws.
3. Guided and introduced by the incoming President, Dr Clive Ross, an interesting discussion was initiated on several topics of importance to the future direction and leadership of the College:
   - The role of the College Secretary General in a transitioning College Office structure.
   - The reorganisation of committees into smaller, task-specific working groups.
   - The position of Speaker of the International Council.
   - The use and need for College leader job titles and descriptions.
   - The consideration of two-year terms for the positions of the President, President Elect and Vice President.
   - The management of Section XX.
   - The need to improve communications between the College leadership, Sections and Fellows.
4. The Centennial Celebrations of the College. The International Council meeting in Taipei was the launch pad for the ICD Centennial Celebrations to be held in Japan in 2020. The College Centennial Committee and related sub-committee assignments were agreed. The Centennial theme, branding statement and logo were introduced to the Councilors. Sections will begin to receive Centennial information and instructions in 2018, as well as suggestions for the incorporation of Centennial celebrations into local activities. The highlight of the Centennial events in Japan will be an International Gala, which all ICD Fellows will be invited and encouraged to attend.
5. Thanks to an initiative of our (European) International Councilor Dr Mauro Labanca, a delegation from the ICD Italy District will have a private audience with Pope Franciscus who has graciously agreed to extend his blessings and congratulations to the College on reaching its centennial milestone and global activities.
6. ICD Sections and Fellows will be encouraged to engage organisations and personalities to acknowledge the College Centennial with endorsements, proclamations and other expressions of support.
7. ICD Global Projects is to ensure that the College motto "Recognizing Service and the Opportunity to Serve" is being well served through the countless number of humanitarian, educational, public health and leadership projects sustained by ICD Sections, Regions and individual Fellows across the globe. For several years, the Council has considered ways to share these projects with all ICD Fellows across the world. Thanks to the sterling work of Canadian International Councilor, Dr Donna Brode and her team, progress has been made in the development of an interactive projects map, which features data on all ICD projects. This user-friendly, world map is available on the ICD website. The Council unanimously approved the further development of this map, which provides viewers with all relevant project data by simply clicking on a pin over the project's location. The fully developed interactive projects map will be a huge break-through in displaying ICD projects digitally and coordinating office support. It will be vital, however, that Sections assist the College in regularly reviewing and updating data on the map. The College Projects Committee and College Office have created a review process system to be initiated prior to launch of the map.
8. An ICD Antibiotics Awareness video is to be created in collaboration with the US Centers for Disease Control and Prevention (CDCP). This video, once completed, will be made available to both all ICD Fellows and other dental professionals on the ICD website. In addition, the College has progressed two related educational initiatives, the Dental Safety Program and the Get Smart About Antibiotics program.
9. Many other topics were discussed and debated during the 2017 International Council Meeting, such as Section and Committee reporting, financial planning, membership development and communications.

The Taipei Tower

New to the International College meeting this year was the first-ever Executive Committee Q and A session, which allowed Councilors and guests an opportunity to raise questions, comments or concerns about any ICD-related matters. This session proved to be very popular.
The International Treasurer reported that the new dues schedule between the Sections and the College Office was working well.
Before the International Council Meeting was adjourned, it was decided that the 2019 meeting would take place in New York City, during the Greater New York Dental Meeting (GNYDM), providing opportunities for ICD Councilors and Fellows to mix and mingle with GNYDM delegates, attendees and other international dental leaders.
Finally, the awards ceremony and customary officer installation took place. The following retiring International Councilors were given Meritorious Awards for their dedicated services: Donna Brode (Canada), James Conrardy (USA), Henry Diversi (USA) and Curtis Johnson (USA).
Then, outgoing International President, Rajesh Chandna, was praised by the incoming President, Clive Ross, for his fine leadership and hard work as well as his extensive travels to visit so many Sections and attending so many Convocations during his term of office. The presidential gavel and chain of office were exchanged after Past President Phillip Dowell installed incoming International President Clive Ross and the other Officers.

The 2018-2019 Executive Committee of the International Council is constituted as follows:
President, Clive Ross (New Zealand)
President Elect, Bettie McKaig (USA)
Vice President, Akira Senda (Japan)
Treasurer, Richard Smith (USA)
Editor, Dov Sydney (Israel)
Secretary General, John Hinterman (USA)

Installation by Past President Phillip Dowell of the officers of the Council of the ICD (L- R):
Jack Hinterman, Secretary General; Richard Smith, Treasurer; Dove Sydney, Editor; Bettie McKaig, President-Elect; Clive Ross, President; Akira Senda, Vice President; Rajesh Chandna, Immediate Past President

Summarising remarks

In summary, the 2017 International Council Meeting in Taipei was highly productive. It was led with great skill by Speaker: Dr David Thomson. President Dr Clive Ross is clearly a President with purpose and vision.

Social events and Convocation Ceremony

The first evening guests and spouses were invited to attend a welcome reception in a Beer House. The venue was overwhelming big and could have easily accommodated ten times the size of our Council group; but we had the luxury of a private venue. A buffet dinner with fresh prepared fish and meat snacks was followed by an extensive variety of deserts. A jazz band played classic songs and tunes of the 20th century and succeeded in encouraging the President of the Taipei Section Dr Ying-Kwei Tseng to give a solo performance by singing the Frank Sinatra song 'My way'. Charming and spontaneous!
Late Saturday afternoon, the Council attended the Convocation Ceremony of the Inductees of the Taipei Section. After a short history of the College and a welcome speech by the International President, the new fellows were individually presented, receiving their Certificate and Key from the International President, Dr Rajesh Chandna, supported by the President of the Taipei Section, Dr Ying-Kwei Tseng. A short informative CV of each candidate was projected at the time of their presentation. The Convocation Ceremony was followed by a reception and Gala Dinner for all Chinese-Taipei Fellows and partners, together with the officers, members and partners of the International Council. The evening was excellent, with musical entertainment being provided by mainly a classic violin-quintet.

On the Sunday, the Council meeting was concluded with a Farewell Dinner. A pleasant coach-ride took us into the mountain area north-east of Taipei to Yilan's Silks Place. An elegant restaurant; superb Chinese food, even more special than the high-quality fare at the Gala Dinner, again combined with entertainment - this time a solo-saxophonist, supported by a drummer and a singer. The evening began with a dance and singing performance by young children from a local school; a musical performance about the effects of devastating deforestation of the mountain slopes. Most interesting and very well done. Overall an overwhelming gracious farewell by our hosts, highly appreciated by all Councilors and their partners.
International Councilor of Taipei Dr Yuh-Yan Shiau and his team can be proud of having organised a perfect meeting for the International Council.

Acknowledgments: For this report I freely, partially and thankfully used the initial summary of our meeting sent to all Councilors from Central Office by Chelsea White. Photography by Phillip Dowell. ■

Interview with the President – Christian Robin

Interviewed by the Editor - Nairn Wilson

What has been your career to date in dentistry?

I graduated as a Swiss dentist in 1981 at the Geneva School of Dentistry. I started working 50% as an assistant in a private practice and 50% as a school dentist in the dental school service in the Canton of Geneva.

In 1986, I joined the team of Professor Urs Belser as a half-time (50%) assistant to teach fixed prosthesis in his department at the Geneva School of Dentistry. That same year, I opened my own dental practice in Geneva. After five years, I obtained my doctorate in dentistry, having presented a thesis on adhesion to ceramics.

To date, I remain in the teaching team of the Fixed Prosthesis and Biomaterials Division of the University Clinic of Dental Medicine at the University of Geneva, led by Professor Irena Sailer, as a part time (20%) lecturer. It is a special feature of the Geneva school to entrust teaching to dentists in private practice to guarantee teaching close to the reality of a dental office.

I also teach fixed prosthesis at the School of Dental Hygienist in Geneva and am responsible for training dental assistants in the field of fixed and removable prostheses during their third year of training.

I became a specialist of the Swiss Society of Reconstructive Dentistry in 1995, and I am currently a member of the specialization commission that awards the title of specialist to young dentists. Each candidate presenting for assessment must successfully present eight completed, complex cases to obtain the federal designation of reconstructive dentistry specialist.

Between 1997 and 2010, I was a member of Executive Board of the Geneva Section of the SSO (Swiss Dental Association). I held the following positions: President of Conciliation Commission, and then President of the Geneva Chapter of the SSO (2001 to 2005), President of the Scientific Information Commission and Treasurer, and President of the Deontology Board.

Since June 2014, I have been chairman of the committee responsible for dental cases within the Geneva Supervisory Commission for all health professions.

Finally, since 2010, I have overseen forensic odontology in Geneva, together with the wife of one of our Swiss Fellows, Dresse Maud Virgillito. Our activity consists essentially of making age estimates and identifications under judicial mandate. This is an exciting field in which our expertise as dentists is greatly appreciated by our forensic doctor colleagues. We trained in Oslo at IOFOS (International Organization for Forensic Odonto-Stomatology) and we regularly conduct continuing education courses in Scandinavia (Iceland and Spitzberg).

What attracted you to Fellowship of the College?

I didn't know about the College until I was invited to join it in 1994, at an annual meeting in Jerusalem, by the then Swiss Regent, Dresse Nicole Vallotton. I immediately appreciated the opportunity to acquire very informative contacts with new colleagues from all over Europe. I remember that we had the opportunity to visit the dental schools in Jerusalem and Tel Aviv, which interested me very much, given my duties at the Geneva Dental School. Since then, we have had little opportunity to visit dental schools, except in Dublin in the late 1990s and in Vienna where we visited the Dentistry Museum, which was excellent. That's why I would like to give Fellows the opportunity to visit our new school in Geneva during the Scientific Day of the meeting in Geneva.

What roles have you had in the College?

I was an ordinary Fellow from 1994 to 2004, making it a point of honour to attend almost every meeting of the Section. Then, I became Vice Regent to support my predecessor Dr Philippe Hediger, whom I replaced in 2011. I was also a member of the Advisory Scientific Committee under the chairmanship of Cecil Lineham. It was a great pleasure to work with her.

What would you like to achieve during your year as President of the European Section?

The organization of the meeting in Geneva is presently

taking up almost all my time and energy. The success of this event is important to me, with my predecessors having set the bar very high. This raises the question of repetition of important arrangements every year: Would it not be wise to set up a structure that can be reused every year to simplify the organisation of the Section meeting?
What interests me at our annual meetings is the approach that each country has to dentistry. I would like to give our Fellows the opportunity to appreciate a reasoned approach to a subject of dentistry. It will not be possible to talk about all areas of our profession, but we will try to present a way of approaching our treatments to provoke a reflection that can extend to all other areas of our profession. This is why I wanted to open the Scientific Day with a paediatric cardiac surgeon, who will talk to us about the approach in his field. I'm all the more interested in this since Professor René Prêtre, in addition to intense hospital activity, devotes a large part of his free time to operating on sick children in Africa, through his foundation "Le Petit Cœur". The two aspects of his practice are aligned with the spirit of the College, namely high-level exchanges on different aspects of our profession and intense activity in humanitarian fields where there is still so much to be done.

What, in your opinion, are the major challenges facing dentistry and the College?

I believe that the introduction of large healthcare structures, in which management control has been gradually transferred to the hands of financiers, has significantly changed the supply of dental care. We must remain vigilant so that the care offered to the population remains as individualised and reasonable as possible.

Where do you think dentistry and the College will be in twenty years of time?

I think that the digitisation of our profession is only just beginning. I see it as a great way to improve the quality of care, reduce costs and also a great way to communicate with patients. Each step of the treatment can be presented and explained more easily. We also have a great opportunity to improve our teaching, while continuing to collaborate with our partners, such as dental technicians and dental hygienists. This will significantly improve the quality of care and patient information. The College will continue to be a wonderful platform for Fellows of the Section to exchange experiences with each other. I also hope that the College's commitment to humanitarian action will be strengthened, so that advancements in dentistry are shared with as many people as possible.

You will be hosting the Annual Meeting of the Section in Geneva this year. What would you like the meeting to be remembered for?

I spoke of the College as a wonderful organisation for exchange and dialogue, which is exactly what makes the city of Geneva so special. I hope that everyone feels the importance of maintaining and improving our communication, especially in a world where everyone tends to withdraw into themselves. This is what we have customarily called "The Spirit of Geneva" which was forged by three key figures: Jean Calvin, Jean-Jacques Rousseau and Henri Dunant, whose legacy helped to make Geneva a symbol of dialogue, peace and democracy. The City of Calvin already welcomed the oppressed of Europe driven out by the Reformation, making openness to the world its banner. The author of the Contrat Social, the philosopher Jean-Jacques Rousseau, proposed the creation of a Confederation of Peoples to guarantee perpetual peace, inspired by the Swiss model. One hundred years later, Henry Dunant finally laid the foundation stone for the International Committee of the Red Cross, born of the Geneva Convention of 1864, which gave life to the current pillars of international humanitarian law. May a little of this spirit continue to grow in each of us...

What message would you like to convey to present and future members of the Section?

Educate to integrate! More than 40% of the population of Geneva is of foreign origin. I believe that this makes my country so successful in that it offers everyone the same opportunities and possibilities to succeed in life, regardless of their origin. I live it every day in the students with whom I have the pleasure of working.

My Organising Committee and I look forward to welcoming you to Geneva. I hope the meeting will be well-attended. ■

International College of Dentists
European Section

63rd Annual Meeting European Section
Geneva, Switzerland
21 - 24 June 2018

WELCOME

It is a great honor and pleasure for me to welcome you to Geneva for the 63rd Annual Meeting of European Section of the International College of Dentists, to be held between 21-23 June 2018.

I was born, I work and I teach in this beautiful city.

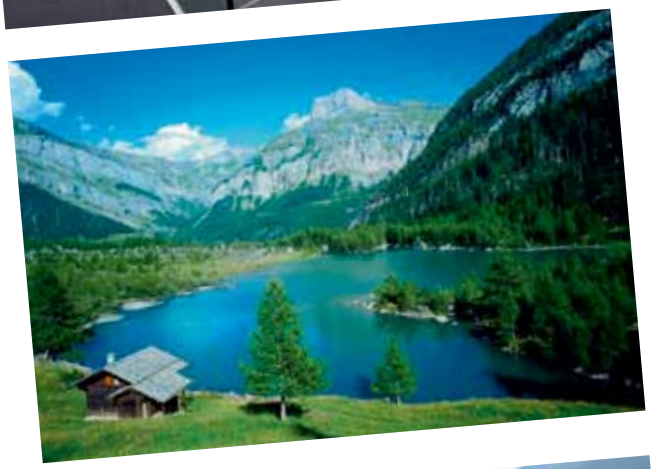
The city has an undeniable international character, as it is the home to many international organizations including the European Headquarters of the United Nations, the Headquarters of the Red Cross and the Headquarters of the World Health Organization.

We will do our very best to showcase the various aspects of the city during your stay.

Christian Robin, President ICD-Europe 2018

ICD European Section 2018

Complete overview of the programme on www.icd-europe.com



PROGRAMME

Wednesday, June 20th
- Pre congress golf tournament : Golf du Domaine Impérial • Regent's Dinner

Thursday, June 21st
- Board of Regent's board meeting
- Welcome Reception and Dinner at Cité du temps

Friday, June 22nd
- Scientific day at the University Medical Center
- Theme of the day: Mini invasive dentistry
- Accompanying persons tour to CERN, Red Cross museum, lake cruise, city tour, walk in the mountains.
- Dinner at Chateau des Bois

Saturday, June 23rd
- Visit of the Patek Philippe watch museum
- Induction ceremony at Maison de la Paix
- Cocktails and gala dinner at President Wilson hotel

Sunday, June 24th
- Post congress tour to Derborence for a fantastic day in the Swiss Alps

Induction Ceremony 2017

The ICD European Section Induction Ceremony was held at the Royal College of Physicians, Regents Park, London with Shelagh Farrell, President of the European Section, presiding. Dr Rajesh Chandra, International President, was in attendance.

The Platform Party

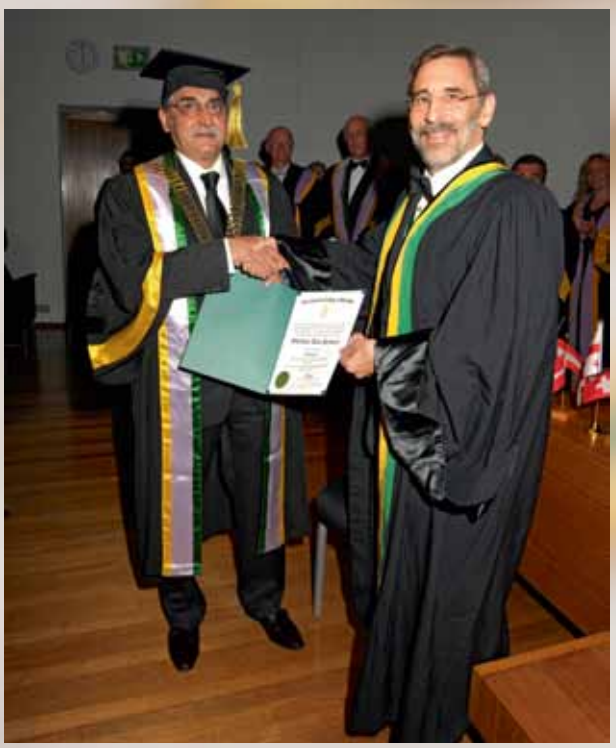
Front row, left to right: Phillip Dowell, Past International President, ICD Director of Global Development; Frans Kroon, International Councilor; Dov Sydney, International Editor; Rajesh Chandna, International President; Shelagh Farrell, Section V President; Jean-Louis Portugal, Regent France; Matthias Bimler, Regent Germany; Argirios Pissiotis, Section V Registrar, Section V Vice President; Ephraim Winocur, Regent, Israel and Malta.

Second row, left to right: Werner Lill, Regent Austria; Gil Alcoforado, Regent Portugal; Illia Roussou, Regent Greece and Cyprus; Mies Buisman, Regent Benelux; Maren de Wit, Section V Treasurer; Santiago Jane, Regent Spain.

Back row, left to right: Tomi Jukic, Regent Central and Eastern Europe; Christian Robin Section V President-Elect, Regent Switzerland; Ivar Hoff, Regent Scandinavia; Richard Graham, Regent Ireland.

Not in picture: Mauro Labanca, Section V Deputy Registrar, Regent Italy; Mark Wright, Regent United Kingdom and Walter van Driel, Section V Editor.

The inductees were addressed by Phillip Dowell, Past International President and ICD Director of Global Development who, in his address, stressed the Mission and Core



Dov Sydney accepting his Master Fellowship.

Values of the College, as set out in the first page of each issue of ICDigest. It was emphasised that the International College of Dentistry is an honorary organisation, recognised around the world as a preeminent international dental society. The College aims to have a membership composed of outstanding dentists from around the world who have demonstrated an abiding interest and concern for their profession and, in addition, have shown their value as citizens.

All new inductees were encouraged to maintain the highest professional standards and to commit themselves to advancing the art and science of dentistry for the health and welfare of the public, both in their home countries and internationally. It was noted that the limited number of Fellows in the College is a result of the high level of selectivity in the screening of candidates by Regents and then Members of the Board. In congratulating the new inductees on joining the world-wide ICD Fellowship, they were advised "embrace the College and it will embrace you".

Following the induction of the new Fellows, Dov Sydney was awarded the prestigious accolade of Master Fellow of the College by International President Rajesh Chandra, for extraordinarily conspicuous and outstanding service to the College at large.

The Induction Ceremony was followed by an elegent champagne reception and superb gala dinner. ■

The European Section 2017 Inductees


Sander Vogels


Torbjörn Lundström


Susanne Strömhielm


Robert Gottlander


Iain Chapple


Onkar Dhanoya


Serpil Djemal


Elaine Halley


Nigel Jones


Hew Mathewson


Shamir Mehta


Paroo Mistry


Tif Quershi


Yogesh Savani


Anil Shrestha


Patricia Thompson


Robert Thompson


Nairn Wilson


Huw Winstone


Jean-Cédric Durand


Estelle Genon


Jérome Lipôwicz


Martina Kuch


Elpida-Niki Emmanouil- Nikolousi


George Siavikis


Ioannis Vouros


William Cosgrave


Joseph McEnhill


Gerrald McKenna


Pessia Friedman-Rubin


Patricia Almeida Santos


Francisco Brändo Brito


Eunice Carrilho


Lúis Filipe Correia


Inês Faria


Helena Francisco


Rui Pereira da Costa


Adriana Quintas


Alexandre Santos


João Tondela

Antonio Castaño Séiquer

Luis Jane Noblom


Montserrat Puigrefagut


Carlos Jose Mas Bermejo


Ignacio de Urbiola


Robin Jaquet


Leila Galiotto


Jürg Willi


Marzena Dominiak


Janja Jan


Sanda Lah Kravanja


Lia Sanodze


Siniša Varga


Lyanda Musima

Future Annual Meetings of the European Section International College of Dentists

2018 Geneva, Switzerland • 21-23 June 2018

2019 Thessaloniki, Greece • 5-9 June 2019

2020 Porto, Portugal • 10-14 June 2020