DR WOLFGANG DONEUS, PRESIDENT OF THE COUNCIL OF EUROPEAN DENTISTS, DISCUSSES THE COUNCIL'S ROLE IN ADVISING THE EU ON THE CONTINENT'S ORAL HEALTH AND THE PROBLEMS CAUSED BY DENTAL TOURISM

A lasting smile

The Council of European Dentists (CED) is a not-for-profit association which represents over 340,000 dentists across Europe. It is composed of national dental associations and chambers from 30 European countries. Its key objectives are to promote high standards of oral healthcare and effective patient-safety centred professional practice across Europe, including regular contacts with other European organisations and the EU institutions.

CED president, Dr Wolfgang Doneus, explains the role the association plays in advising the European Commission in dentistry-related issues, and how they are hoping to tackle such challenges as tooth whitening and dental tourism.

While the Council of European Dentists advises the European Commission on policy and legislation, there is no commissioner, or directorate general, directly responsible for dentistry in the EC. Do you feel under-represented because of this?

No, and I think this needs to be looked at in a wider context: no specific profession has its own commissioner, and while some professions may have cabinet members who are responsible for certain areas within their field, there is a sense that an increase in administration in EU institutions could have a negative and restrictive effect. As experts in our field, moreover, the CED is affected by the internal market, healthcare, education and environment policy and we therefore work closely with several commissioners and directorates general, and this works well.

The most important thing for dentistry, however, is that the patient remains the focus, because, in the end, it is the patient-doctor relationship which guarantees success; if there is no proper relationship here, it is the patient who suffers.

What are your views on tooth whitening, and how is the CED using its knowledge and experience to advise the EC on this topic?

The CED called repeatedly for appropriate regulation of tooth whitening products at EU level in line with the advice from the European Scientific Committee on Consumer Safety which stressed that higher concentration products can be safe when used after a clinical examination and under the supervision of a dentist.

Following the Council of the European Union's adoption of the council directive amending Directive 76/768/EEC, concerning cosmetic products, tooth whitening products containing up to 0.1% of hydrogen peroxide will continue to be freely available to the consumers on the market. For products containing between 0.1% and 6% of hydrogen peroxide, clinical examination and first treatment by a dentist will be required, to ensure the absence of risk factors or oral pathologies, after which the patient will be able to continue the treatment by him or herself.

This directive is refreshing because it recognises the unique role of the dental practitioner, enabling the bleaching process to be controlled properly and to ensure patient safety.

With regard to both the treatment and the cosmetic side of dentistry, is dental tourism a particular problem in Europe?

Dental tourism is indeed a problem in Europe, as any tourism is when it is linked to health issues. However, the main problem with dental tourism is that people travel, sometimes significant distances, for price rather than quality, and while one cannot blame someone for what is effectively 'shopping around' for the best deal, dentistry should be viewed as an on-going treatment, not something that can be done and then forgotten about.

While it is not always the case that dentists who offer 'cheaper' services in certain countries are working to lower standards or ignoring codes of practice, the issues surrounding dental tourism stem from problems that can arise after any dental treatment, and that, when the dentist who has carried out this work is hundreds, if not thousands, of miles away from the patient's home, their regular dentist must now fix the problem.

To reiterate, this highlights absolutely that dentistry, and indeed oral health in general, is a concept and not a tooth-by-tooth treatment that can be obtained for the cheapest price possible and then forgotten. On-going contact between the patient and the dentist is of paramount importance to the success of the treatment, and, therefore, while dental tourism consisting of just a few miles – perhaps by people who live close to a country's borders and who find treatment is cheaper in their neighbouring nation - is less problematic, the kind of dental tourism that requires the patient to travel great distances (such as those that feature a week-long spa-like holiday during which the patient/tourist can have extensive dental procedures carried out) should be avoided at all costs because it is inevitably the patient who suffers, and not the dentist.

What are your hopes for the future of both the CED and European dentistry more generally?

My fundamental hope for the future of the CED, and thus for European dentistry, is to remain heading in the same direction as we have been going for the last year.


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John Dalli, the European Commissioner for Health and Consumer Policy

As Dr Doneus has highlighted, dental tourism is a topic of increasing concern in Europe. As such, it has also been the focus of a recent speech by John Dalli, the European Commissioner for Health and Consumer Policy.

On 12 October 2011, in Brussels, Dalli delivered a speech entitled "Health tourism – establishing a new culture in Europe". Here, the Commissioner explained that while, for many, health tourism may have negative connotations, it is not without benefits.

"Health tourism is about fostering well-being. It brings together the idea of promoting tourist services and facilities, with promoting health and well-being," he said, before revealing his view that health tourism is also a "dynamic and still-emerging sector which can contribute to the Union's economy, and help tourist destinations overcome challenges such as overreliance on a short season."

While Doneus' view of long-distance health tourism is certainly valid – in that, if a patient visits a dentist hundreds or even thousands of miles away for treatment, then this professional is unable to provide continuing aftercare – for Dalli, "Promoting wellness, and fostering an environment where citizens can enjoy wellness centres across Europe, needs to be part of our efforts to promote good health."

He went on: "Today, we see a wide range of 'health tourism' offers including classical spas; wellness centres in tourist destinations; and specialised centres which combine treatment with wellness and tourist elements.

"The availability of a health and wellness infrastructure might be an important criterion for choosing a holiday destination. Think, for example, of the peace of mind a wellness centre could offer to older travellers who might be suffering from a chronic condition."

Indeed, for the Commissioner, this type of tourism may even offer a way to promote health and to prevent chronic diseases across Europe.

This is particularly relevant to oral health, as smokers, for instance, are much more likely to develop oral infections and cancers of the mouth and throat, and so the promotion of healthy lifestyles and smoking cessation that health tourism can offer could act as a preventative measure.

However, there is a fine line that needs to be drawn, as Dalli himself acknowledged: "I have said it many times and will repeat it again: I do not want to make nomads out of our patients."

There can be an expectation of increased health tourism in the coming decades – the need to make sure any such health tourism industry is properly regulated has been identified. It is now up to the European Commission to make sure the right safeguards are implemented.

I have been the president of the CED from 2000-2006 and then again from 2009 to the present, so I have a good overview of the dental politics of Europe. The CED works with a lot of member organisations and national delegates within our organisation, while the work is done through working groups or in task forces. We have found that this is an effective way of running the organisation, and that the expertise of the various members is invaluable.

The CED board consists of eight people, half of whom are replaced every three years. This means that the ground is always fertile for new ideas; it is very much a living structure, with new members taking new responsibilities, which results in the CED being very well positioned to take stock of the situation and advise the EC on areas of particular importance. The CED further benefits from its Brussels office, which acts as an international secretariat, and whose full-time staff of three ensures permanent representation of the CED's interests in contacts with the EU institutions and with other Brussels-based stakeholders.

Dr Wolfgang Doneus

Nevertheless, not everything is regulated in Brussels or, indeed, by European authorities. Thus, especially with regard to health care in general, and oral health care in particular, there are many issues which are governed on a national level. Because of this, the CED must also continue to analyse what is occurring at a national level throughout Europe, and communicate this effectively in order to discover and implement solutions at both the European and national levels.

Yet, while some areas of dentistry will require continued attention and improvement, on the whole dentistry in Europe is progressing well, and it is the role of the CED to ensure that this success is continued.

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