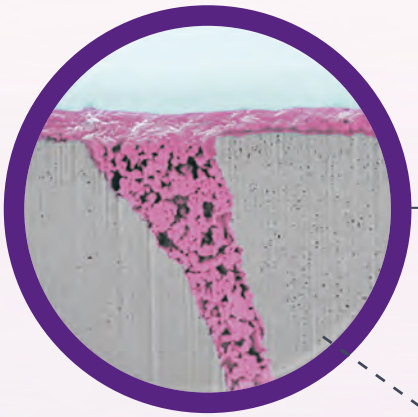
April 2026
FMC CONNECTING DENTISTRY

Dentistry

PRO-ARGIN is the mo
desensitising occlu



PRO-ARGIN technology
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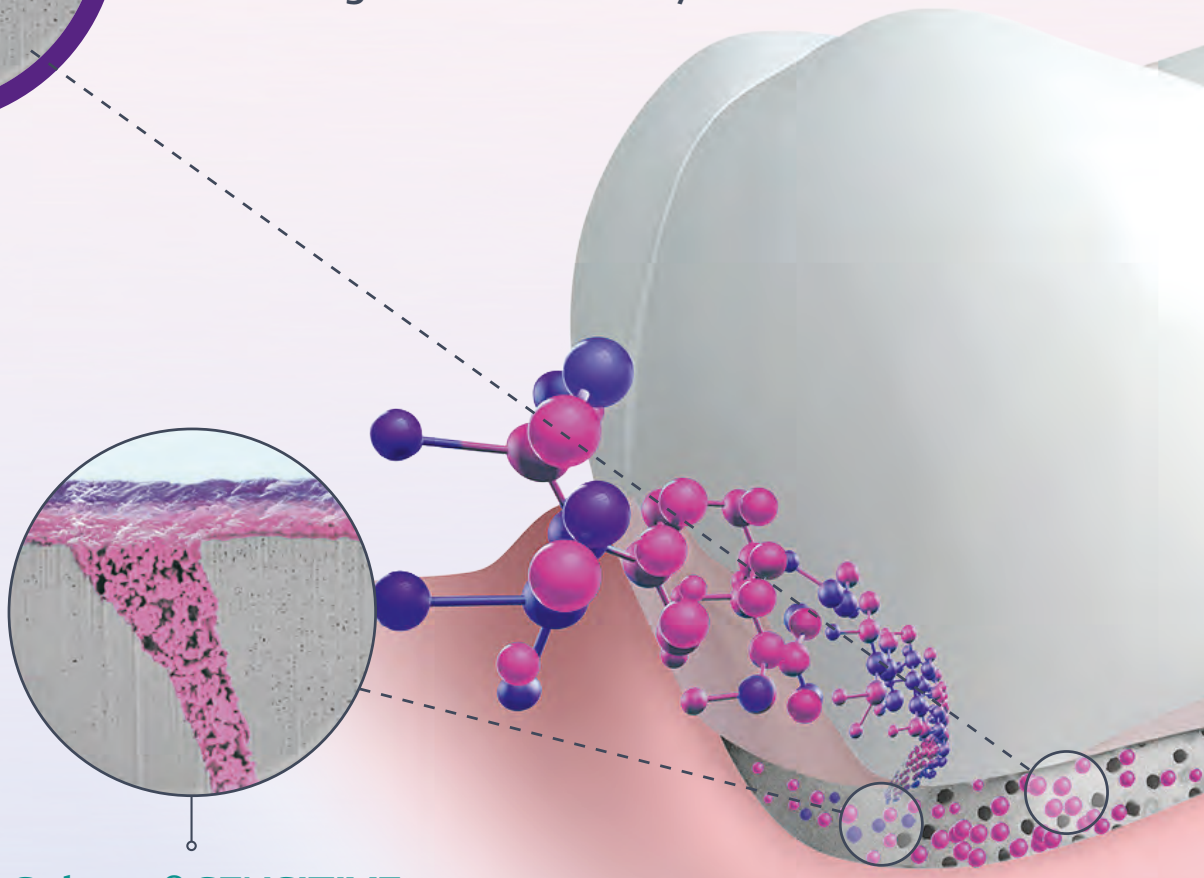

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Switch on

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#Versus previous formula, in vitro acid resistance after 5 brushings. †With continuous use.

References: 1. Liu Y, et al. J Dent Res. 2022;101(Spec Iss B):80. **2.** Data on File. Hines D. Colgate-Palmolive Techn

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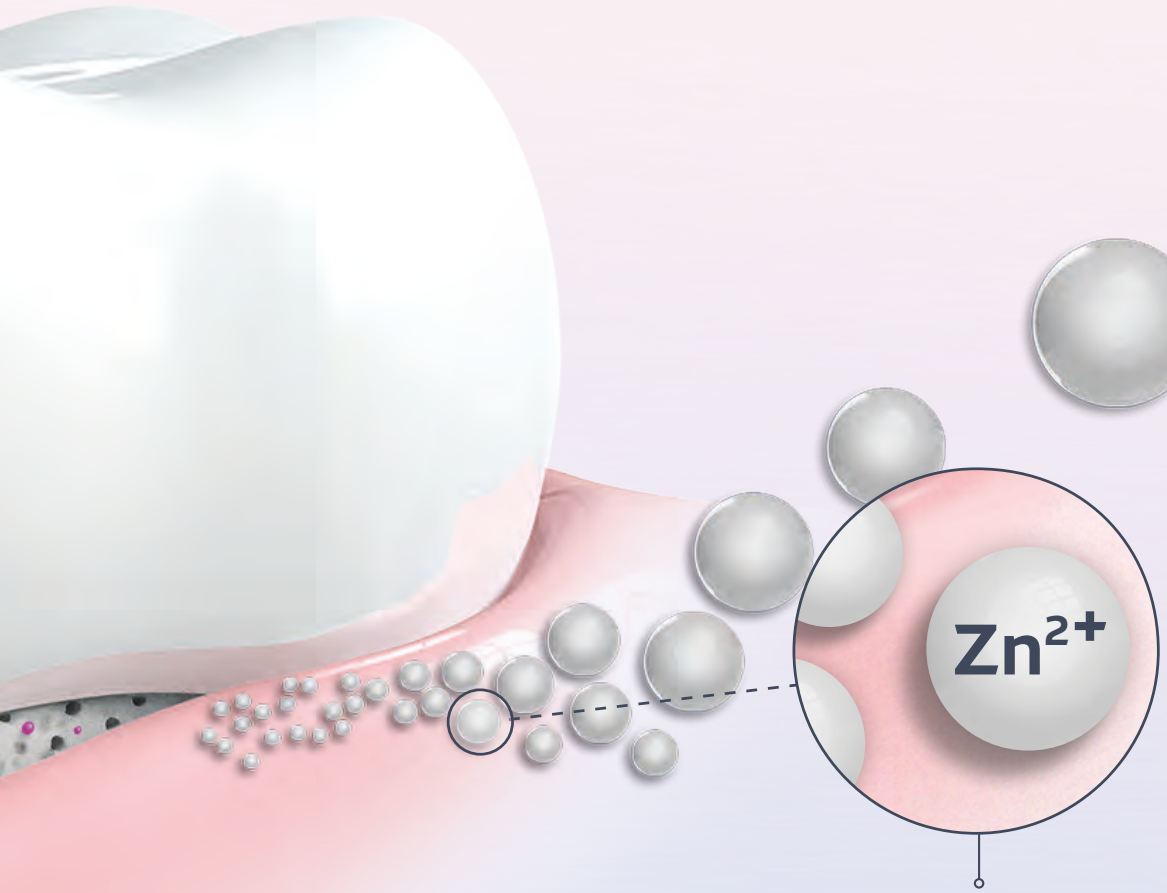

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only (Pollard et al. J of Dent. 130 (2023) 10443: 1-13). §Versus previous formula, in vitro occlusion after 3 brushings.

ology Center, 2021. **3.** Lai HY, et al. J Clin Periodontol. 2015;42:S17.

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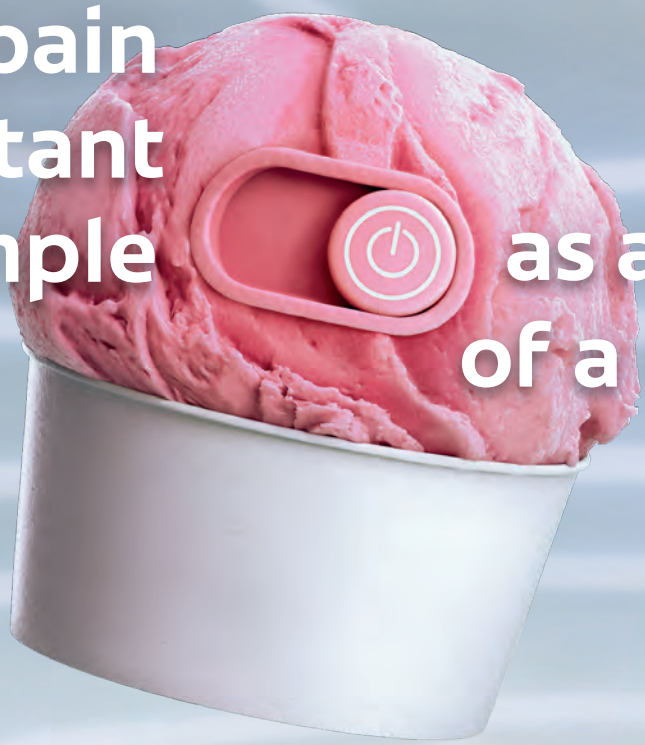

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References:

1. Subanalysis of Nathoo S, et al 2009. Nathoo S, et al. J Clin Dent. 2009;20(4):123-30).
2. Subanalysis of Docimo R, et al. J Clin Dent. 2009;20 (Spec Iss):17-22.
3. Lai HY, et al. J Clin Periodontol. 2015;42:S17.

PROFESSIONAL
ORAL HEALTH

April 2026
FMC CONNECTING DENTISTRY

Dentistry

HR built 'from the ground up' for dentistry

Life in practice is challenging enough without team management adding to the burden. See how Dentistry can help you make sense of HR from page 25.

Dentistry must focus on 'prevention, inequalities and patient outcomes' – not just activity

Deputy Chief Dental Officer Rakhee Patel (pictured) told audiences at the GDC's Dental Leadership Network last month that dentistry must stop simply measuring activity.

She said: 'We focus on how many patients came in... but success isn't just activity – patient experience and outcomes are just as important.'

She added that there is no 'one size fits all' solution to tackling health inequalities, saying: 'No service will look the same; no patient group will look the same. Success might look very different in different places.'

A 'slap in the face': patient fee rise under fire

Patient fees for NHS dentistry in England will increase by an average of 1.71% from April 2026.

Dental leaders have criticised the move as a 'substitute for state investment'.

Under the new pricing structure announced by the government:

- Band 1 treatment – covering examinations, diagnosis and advice – will cost £27.90, up from £27.40
- Band 2 treatments – including fillings, root canals and extractions – will increase from £75.30 to £76.60
- Band 3 treatments – such as crowns, bridges and dentures – will rise from £326.70 to £332.10.

Growing trend

The British Dental Association (BDA) noted that while the increase remains below the current level of inflation, it follows a trend of using patient fees to offset a lack of direct government funding. The BDA estimated that if state contributions had kept pace with patient charge increases since 2010, there would be enough resources to address the unmet dental needs of approximately 14 million adults in England. Shiv Pabary, chair of the BDA's General Dental Practice Committee, described the announcement as a 'kick in the teeth' for the profession and the public.

'This hike is a slap in the face to millions on modest incomes,' Pabary stated.

'It won't put a penny into a service on its knees.

'Patients will pay more, simply so ministers can pay less.'

'Put money back in your pocket'

The increase comes despite Prime Minister Keir Starmer's recent decision to freeze prescription charges to 'put money back in your pocket'.

Pabary highlighted this contradiction, noting: 'The prime minister... needs to explain these choices to the pensioners who will pay extra fiver towards their next set of dentures'.

The BDA further criticised the government for failing to apply the same logic to oral health as it does to general medication affordability.

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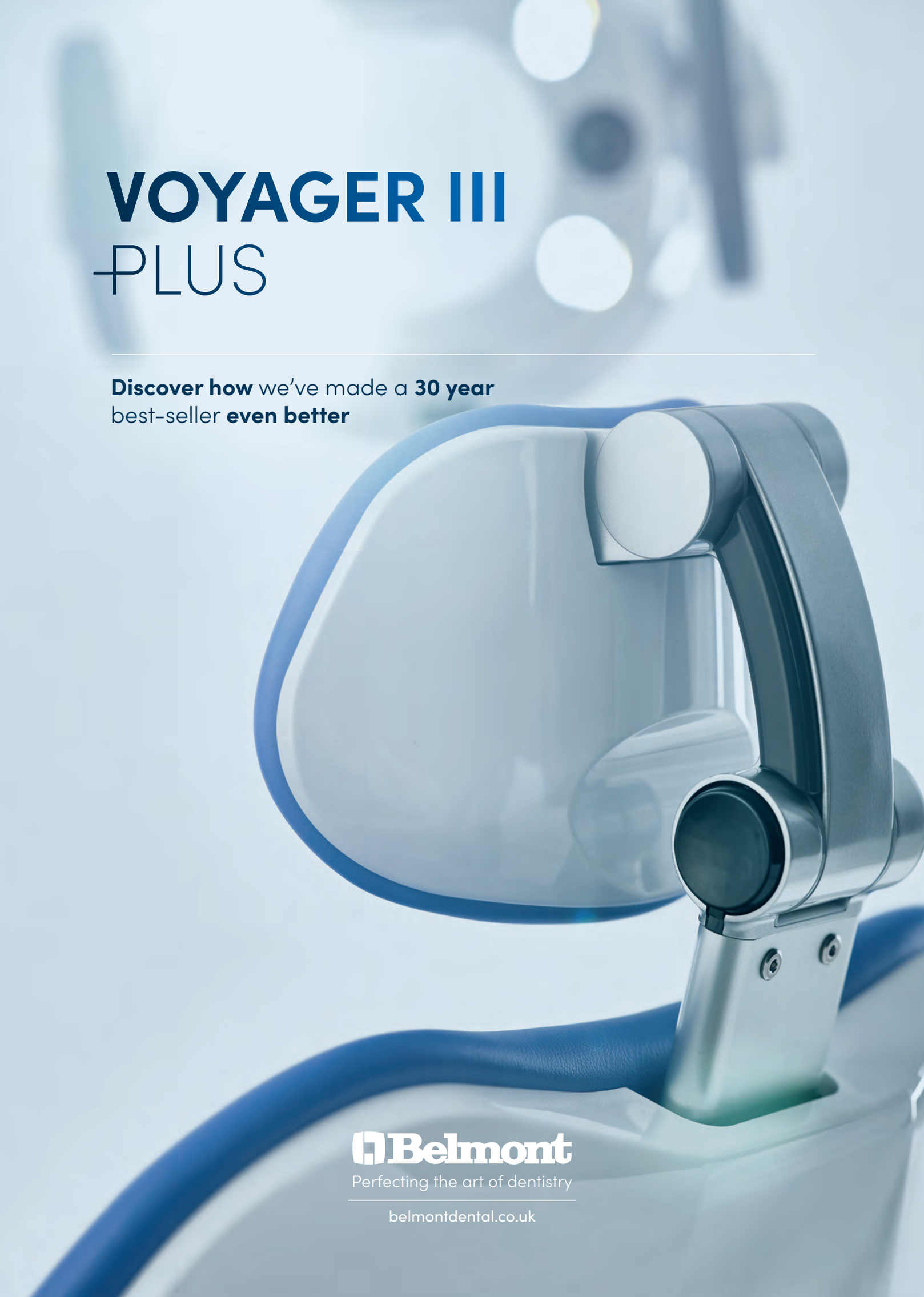

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TV soundbites are damaging dentistry

Seb Evans
Editor's view

Another morning, another television chat panel, and another wave of misinformation directed at the dental profession.

This time, the stage was Channel 5's Jeremy Vine on 5, where Matt Allwright and an ex-dental practice manager took aim at the cost of private dental treatment.

The claim – a dental implant costs just £200 to produce, yet 'greedy' dentists charge £2,000! Cue the collective gasps from the studio audience.

As someone who spends a lot of time speaking to the teams running these practices, this level of discussion is so frustrating, but also fundamentally dangerous.

It reveals a deep-seated misunderstanding of how clinical care, business and our society actually functions.

'£2,000 is undervaluing the amount that goes into a dental implant'

The myth of the £200 implant

Let's look at that £200 figure. What exactly does that cover?

In the world of soundbites, it presumably covers the physical screw and the crown. But a dental practice isn't a vending machine. When a patient pays for an implant, they aren't just buying a piece of titanium; they are paying for:

- Highly skilled time – the hours spent by the dentist, dental nurses and hygienists to ensure the patient's oral health is stable enough for surgery
- The invisible costs – lab bills, digital scanning equipment, sterile surgical environments, electricity, heating and marketing
- Expertise – five years of initial university training, followed by years of expensive postgraduate education specifically in dental implants
- Security – the cost of indemnity insurance and the clinical responsibility for a procedure that must last for years to come.

When you factor in the going rate for a professional's experience and the risk involved in surgery, £2,000 starts to look less like profit and more like a fair reflection of modern clinical overheads.

For an ex-practice manager to undermine her former colleagues by ignoring these basics is, frankly, disappointing.

In fact, the more I look at the above, the more I think £2,000 is undervaluing the amount of expertise and time that goes into a dental implant.

A flawed solution the the NHS

To be fair to Matt Allwright, he didn't weigh in with his thoughts at this point, perhaps because he wasn't aware of the economics of running a dental practice.

However, he did have one suggestion: shouldn't private fees be used to subsidise the failing NHS dental sector?

I hate to break it to you, but that's already the case. Thousands of practices across the UK only stay afloat because their private work covers the losses many make on NHS contracts.

But beyond that, is this truly the world we want to live in?

Should we have a system where the government promises a service, fails to fund it, and then expects private business owners to pay for it out of goodwill?

If we apply that logic elsewhere, should TV hosts chip in their own salary to fund the BBC or Channel 5's licensing?

Why should dentists be the only ones expected to risk their livelihoods to plug a hole left by decades of government underfunding?

The need for education

This whole segment highlights a desperate need for education.

We have a public that doesn't understand why they can't get free treatment, presenters who think profit is a dirty word and even former staff who don't understand the balance sheet of the rooms they worked in.

Dentistry is a profession, but it is also a business. If we want high-quality, safe and innovative care, we have to pay for the expertise required to deliver it. Until we start having honest conversations about the true cost of care – instead of chasing money-grabbing headlines – the crisis in UK dentistry will only deepen.

ORE overhaul could deliver 'five-fold' rise in overseas dentist registrations

The General Dental Council (GDC) has announced a significant overhaul of the Overseas Registration Examination (ORE).

It promises to quintuple the number of internationally qualified dentists joining the UK register.

With new arrangements set to begin in September 2026, the regulator aims to expand capacity to 1,500 successful candidates annually once the system reaches full maturity.

Breaking the bottleneck

For years, the ORE has been a point of frustration amongst many in the dental profession.

Limited sittings left thousands of overseas-qualified clinicians in professional limbo.

The new contract with UCL Consultants (UCLC) marks a shift toward a 'consistent and predictable framework'.

The numbers are ambitious:

- Part 1 places will increase from 1,800 in 2025 to 2,400 per year
- Part 2 places will rise from 720 to 944 in the first year, eventually hitting 1,500 by year three.

In 2024, only 354 dentists joined the register via this route.

If these projections hold, the GDC is attempting to industrialise a process that has historically been a trickle.

The workforce pipeline

With roughly a third of the UK register currently consisting of overseas-qualified dentists, international recruitment is no longer a temporary fix – it is a vital pillar of the workforce pipeline.

'In 2024, only 354 dentists joined the register via this route'

GDC chief executive, Tom Whiting, framed the move as part of a 'long-term plan' to support the wider dental workforce strategy.

However, while increased exam capacity is a welcome 'scale-up', the profession will watch closely to see if the quality of the assessment remains robust and if the clinical infrastructure exists to support this sudden influx of new registrants.

For practice owners struggling with recruitment, these figures offer a glimmer of hope, provided the GDC can deliver on this promised 'sustainable change'.

Dental graduate NHS tie-in proposed

Scottish dental, medical and nursing graduates would have to work in the NHS for five years or repay tuition support under a new Scottish Labour Party tie-in proposal.

Scottish Labour leader Anas Sarwar said he would implement the 'train here, stay here' policy if elected as first minister in this year's Holyrood election.

It would see graduates in dentistry, medicine or nursing from a publicly funded university required to work in Scotland's NHS or care system for a minimum of five years or repay tuition support and bursaries.

'Anas Sarwar said he would implement the "train here, stay here" policy'

He said: 'If Scotland pays for your training, Scotland should benefit from your skills.

'This is about fairness to taxpayers, fairness to patients, and fairness to NHS staff who are too often stretched because the workforce simply is not there.'

The MSP also proposed a new 10-year health plan 'designed with the professions to align university places, training posts and long-term workforce need'.

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NHS contract clawback at £900 million in past two years

A BBC investigation has highlighted a £900 million of clawback because 'dentists instead prioritise private work'.

The BBC found that one pound in every seven that NHS dentists were paid over the past two years was returned as clawback, amounting to a total of £900 million.

It said that these findings 'explain why despite record sums being set aside for NHS dentistry, so many patients are struggling to get [a dental appointment]'.

Clawback levels peaked in 2024 at £479 million, reducing slightly to £457 million in 2025.

The levels remain much higher than previous levels, which stood at £169 million in 2021 and £139 million in 2020.

The British Dental Association (BDA) stressed that the returned budget was due to 'the broken contract dentists are working within'.

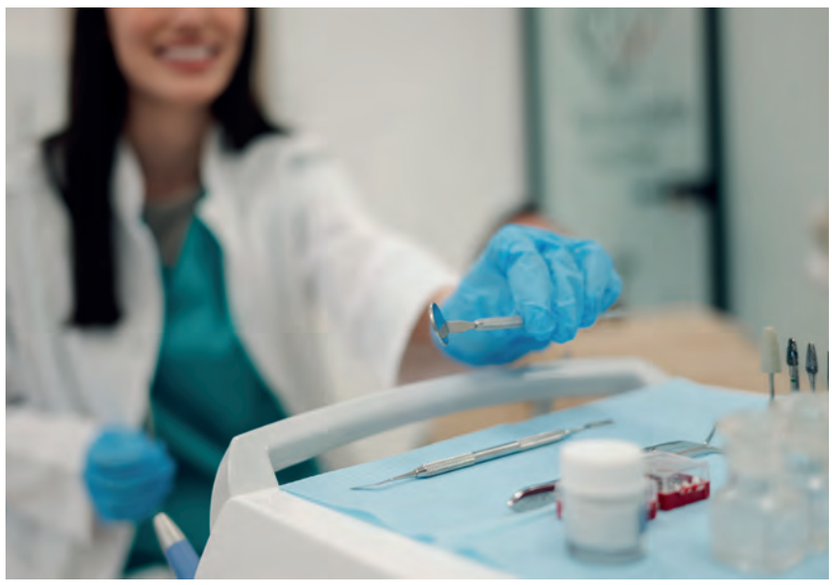
It said: 'These unused funds have long been the traditional excuse from successive governments for not funding NHS dentistry appropriately.

'This clawback is the result of chronic underfunding, with dentists now losing money delivering NHS care, and unable to fill vacancies.'

Where does the money returned through clawback go?

In addition to its criticism, the BDA commended the fact that the unused dental budget resulting from clawback is now being invested into recovery programmes.

The association urged the government to come to a sustainable funding settlement that 'covers dentists' costs and addresses sizeable unmet need for NHS care'.



Without this, it said 'pledged reform of the NHS contract may be doomed from the outset'.

BDA chair Eddie Crouch said: 'The fact dentists couldn't even spend their budget has always been cited by ministers as the reason they won't invest in dentistry.

'This was never about lack of demand. It was about underfunded practices struggling to meet punishing targets and fill vacancies.

'It's the simple fact we now have dentists losing money delivering NHS care.

'It might suit the treasury, but no healthcare professional can be expected to work this way.

'These underspends have all but vanished, but the access crisis is still with us.

'The last excuse for austerity in NHS dentistry has left the building.'

Seven in 10 elite athletes have periodontal disease

Elite athletes have significantly worse dental health than their peers, a study has found – with 70% presenting with periodontal disease and 46% with active caries.

Despite continuous access to dental and medical support, researchers have found that elite athletes have significantly worse oral health than expected.

Study authors Fernando Mata and Cristina López de la Torre discovered a very high prevalence of dental caries, dental erosion, and periodontal disease in athletes.

Why is the oral health of athletes worse?

The researchers suggested that one contributing factor could be the athletes' diets. Excessive consumption of sports drinks, gels and supplements could contribute to a diet high in sugars and acids.

This would worsen oral health through repeated exposure of the tooth enamel.

Meanwhile, frequent training and competition may lead to dehydration and oxidative stress.

Dehydration is known to reduce salivary flow and diminish the protective capacity of saliva.

Frequent use of dental devices such as mouthguards may also negatively impact the oral microbiome if not properly cleaned.

'The time commitment required for elite sport could lead to insufficient or irregular oral hygiene habits'

Finally, the authors suggest that the time commitment required for elite sport could lead to insufficient or irregular oral hygiene habits.

Though dental care might be more accessible for professional athletes, dental attendance may also be affected by a lack of spare time.

Demographic skews

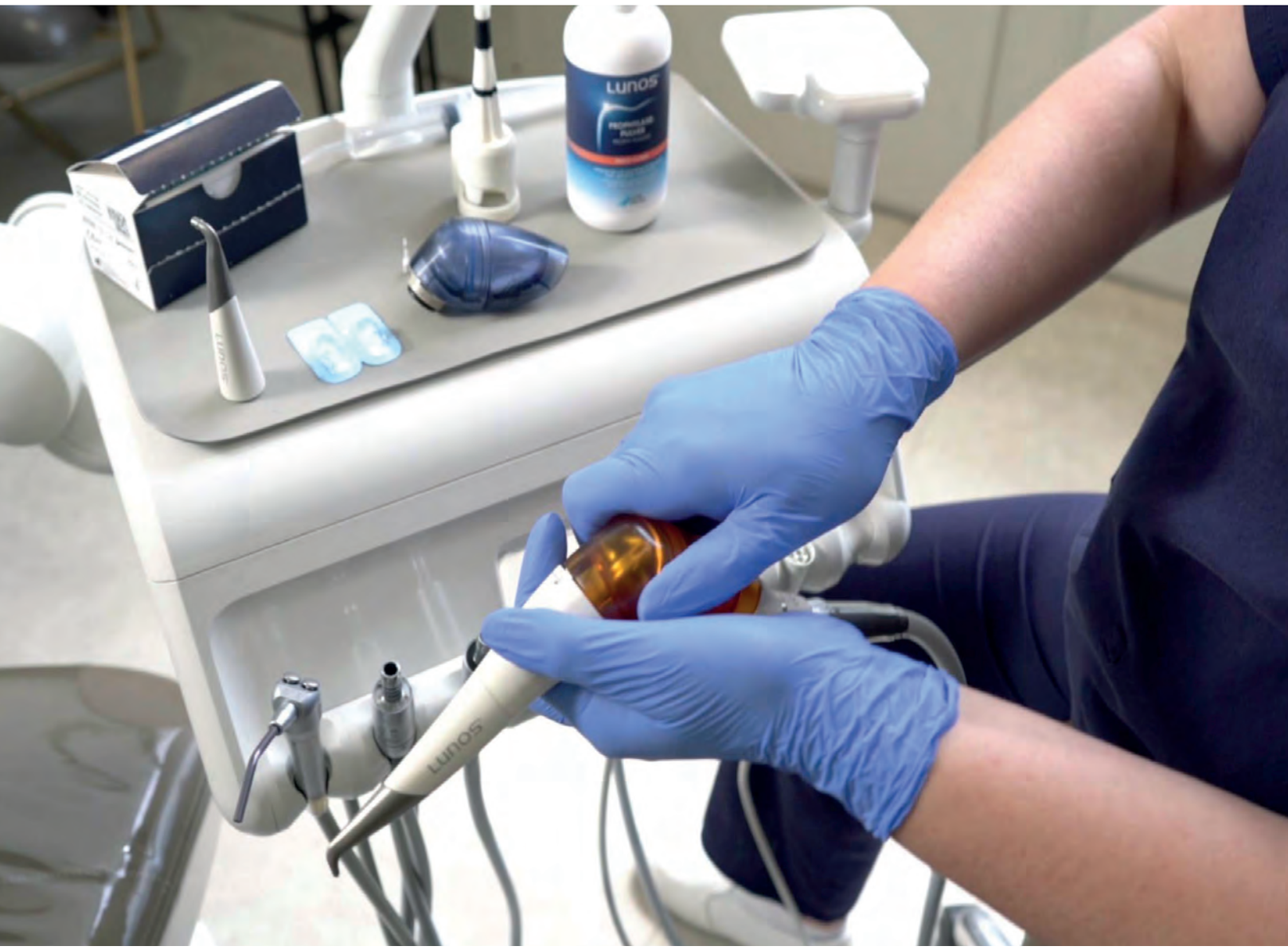
Another factor identified in the study is overrepresentation of particular demographics in sport.

For example, poor oral health has been found to be more frequent and severe in men, both in the general population and among athletes.

Additionally, the highest prevalence of dental disease is seen in young adults between 20 and 35 years, coinciding with peak athletic performance.

The researchers note that this is especially relevant as it is generally considered to be the age of peak general health.

This indicates that factors associated with sport accelerate oral deterioration.



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Review of private dentistry announced to 'make sure it is working well for customers'

A review of the private dentistry sector has been launched by the Competition and Markets Authority (CMA).

In November, chancellor Rachel Reeves ordered an investigation into the costs and practices of private dentistry in the UK.

Reeves said 'hidden costs, lack of transparency and overtreatment' had impacted families in need, and that she wanted to see 'urgent action' to reduce prices.

The CMA is now seeking feedback from both dental professionals and consumers on subjects ranging from finding a dentist and understanding prices to knowing where to go if something goes wrong.

The scope of the study will include:

- Access to private dentistry
- Consumer choice and experience
- Treatment prices
- Business tactics and behaviour
- Competition between private dentists
- Complaint and redress mechanisms
- Sector regulation.

Depending on the responses received, possible outcomes of the investigation could include recommendations to governments to change regulation of the sector, direct action from the CMA, or new guidance to ensure businesses understand their obligations.

'Utterly perverse'

CMA chief executive Sarah Cardell said: 'Going to the dentist is an important part of health and wellbeing.

'Yet we're concerned many may be uncertain about costs, availability, treatment options and what they're entitled to.

'For some, turning to private dentistry is a choice – but for many, it's a necessity.

'People need clear, accessible information at the right time so they can make the right decisions for themselves and their families.

'We want to hear directly from people across the UK about their experiences – good or bad – to help us build a clear picture of how this market is working in practice.'

The CMA said it 'recognises the dedication and professionalism of dental professionals' and that the investigation 'is not a criticism of clinicians or the care they provide'.

However, British Dental Association (BDA) chair Eddie Crouch described the inquiry as 'utterly perverse', as 'profits from private care are all that are keeping NHS dentistry afloat'.

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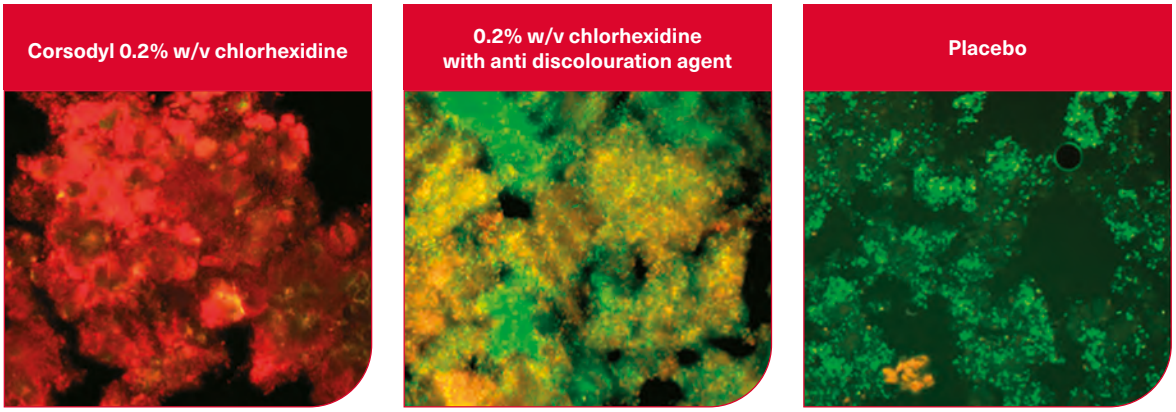

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* Mean values and statistical comparison between placebo and two chlorhexidine solutions in terms of plaque index, plaque area and biofilm vitality

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References: 1. Poppolo Deus F & Ouanounou A. International Dental Journal. 2022; 72: 269-277. **2.** Denton G. Chlorhexidine. Chapter 15. pp. 321-336. **3.** Guerra F, *et al.* Int J Dent Hyg. 2019 Aug;17(3):229-236. **4.** Haleon Data On File. **5.** Arweiler NB *et al.* J Clin Periodontol 2006; 33; 334-339.

Product Information: Corsodyl 0.2% Mouthwash (Alcohol Free) Active Ingredient: Chlorhexidine digluconate. **Indications:** Plaque inhibition; gingivitis; maintenance of oral hygiene; post periodontal surgery or treatment; aphthous ulceration; oral candida. **Legal category:** GSL. **Licence Holder:** Haleon UK Trading Limited, Weybridge, KT13 0NY, U.K. Information about this product, including adverse reactions, precautions, contra-indications and method of use can be found at: https://www.medicines.org.uk/emc/medicine/23034

Private dentistry and the CMA inquiry – it's all a matter of trust

Could the CMA inquiry into private dentistry provoke the return of 'greedy dentists' headlines, Nigel Jones questions

Nigel Jones
Director, Practice Plan

The media coverage of both the launch of the CMA inquiry into private dentistry and NHS money being handed back has prompted concern about potential reputational damage for the profession.

The threat is a reappearance of headlines featuring the label 'greedy dentists'.

In this context, I think it is important to acknowledge that the BDA and Eddie Crouch in particular have done some excellent work in recent years at ensuring the public receive a more balanced view of the dental profession.

This is not always easy when the media have an agenda that might be supported by telling the truth but not necessarily the whole truth.

Without doubt building and maintaining the general public's trust in the profession is vital when it comes to negotiations with the various governments and contractual frameworks and funding.

A public that is suspicious of the motives of those in the business of dentistry could embolden the powers that be, who wish to tighten rather than loosen the purse strings. However, it should also be remembered that the trust patients place in their own dentist nearly always seems to outweigh any misgivings they may have about the profession. In some ways, the start of my career was based on that premise.

In 1990, when I first began working in dentistry, the papers were still carrying stories of over treatment as a legacy of the Australian trenches of the 1970s and the 1986 Schanschieff Review (formerly the Committee of Enquiry into Unnecessary Dental Treatment).

At the same time, NHS dentistry was widely available to anyone that wanted it, accounting for over 85% of dental provision. The public were being given reasons to be suspicious and had plenty of choice of clinicians if they became unsure of the motives of 'their' dentist.

The trust equation

However, despite these factors, trailblazing dentists and practices still managed to switch to private very successfully. Many were rewarded for their bravery with massive improvements to their professional and, often, personal lives. More than enough patients were prepared to pay more to continue receiving care from a dentist in whom they had built up significant trust rather than change to an unknown quantity and pay less.

It's helpful to unpack that by referring to the trust equation, which first appeared in 2000 in the book The Trusted Advisor by Maister, Greene and Galford.

The trust equation is a framework to help explain how trustworthiness is built through a combination of credibility (trusting what someone says), reliability (trusting what someone does) and intimacy (entrusting someone with something) and can be diluted by self-orientation (is your focus primarily on yourself rather than others). When it comes to credibility, a dental qualification is enough for most patients and only in certain circumstances does this become a differentiator. However, perceptions of reliability generally build with time.

Connecting at an emotional human level rarely happens immediately. Especially in the stressful environment of a new dental surgery.

An assessment of self-orientation is potentially made more quickly. But for many, backing out of an arrangement once you have crossed the threshold is an uncomfortable thought. It's no wonder therefore, that the majority of patients who are in a financial position to do so, choose to stay with a tried and tested dentist going private rather than change to an unknown quantity.

It also helps explain why, when it comes to general dentistry, successful practices grow by referral.

If someone you already trust feels a dentist offers them enough credibility, reliability and intimacy to be deserving of their trust, it improves the odds.

Cosmetic dentistry a different matter

What about cosmetic dentistry? I have to admit to being as perplexed as many dentists at the number of incidents where a regularly attending patient reappears for their routine recall having gone to an unknown quantity for cosmetic treatment.

Indeed, the extreme example of 'Turkey teeth' seemingly challenges the whole basis of the trust equation.

The only way I can rationalise it is to think there is something about the psychology of elective care that seems to turn patients into consumers.

It may be that patients feel more empowered due to their ability to self-diagnose and visualise the outcome they want. Whatever lies behind it, that consumer-like behaviour potentially makes them more open to sophisticated marketing that almost certainly taps into the elements of the trust equation when they are making their choices. That and the poor internal marketing skills of their existing trusted general dentist!

Regardless of that exception, the point is that it will take a lot more than a fleeting headline and a CMA inquiry to undo the good work of the BDA, or damage the relationship patients have with their own dentist.

Applying the trust equation to the profession's relationship with government though, is an entirely different matter.

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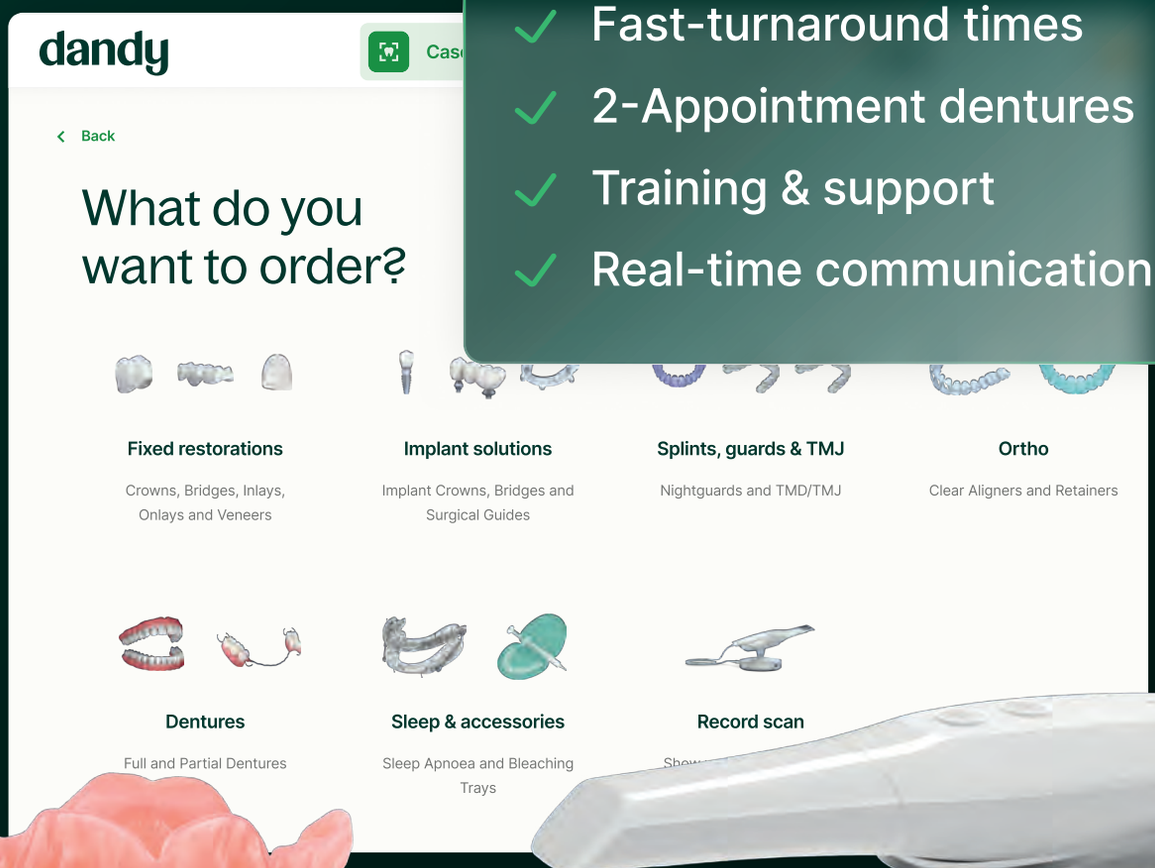

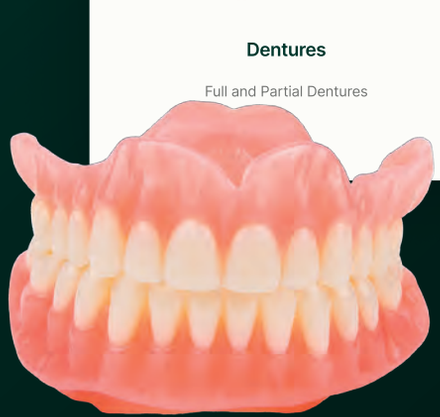

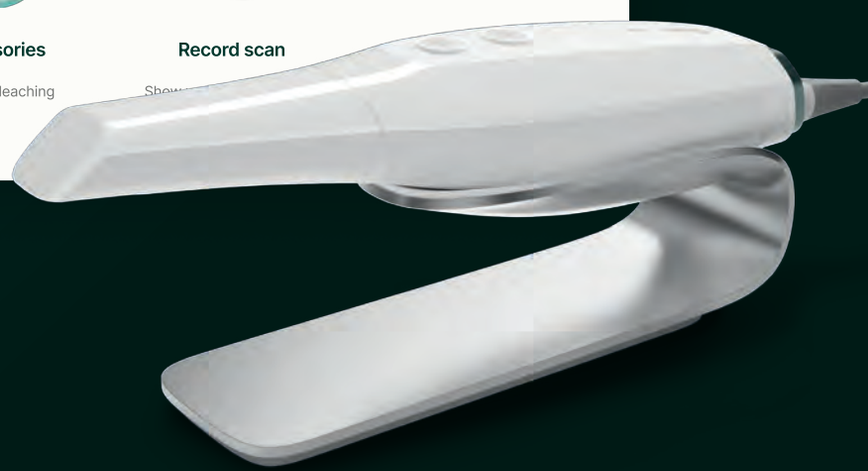

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Immediate implant placement versus socket preservation

Choosing between immediate implant placement (IIP) and socket preservation represents one of the more common dilemmas in modern dentistry, says Cemal Ucer

Cemal Ucer
Oral surgeon

On one hand, IIP often means fewer surgeries and a reduced treatment time, while alveolar ridge preservation (ARP) – grafting the site of tooth extraction with bone substitute materials – provides a predictable foundation for future procedures, but can defer implant placement by more than six months as the patient heals adequately (Udeabor and colleagues, 2023). Both choices have their practical applications, with success heavily dependent on case-by-case specifics.

The case for IP

Perhaps the clearest benefit to immediate implant placement is the efficiency, reducing the number of surgeries needed as well as overall time in the chair for the patient, making it a potentially better choice in terms of patient convenience and budget.

Biologically, the immediate placement of an implant helps to prevent resorption of the alveolar bone following tooth removal, which has long-term aesthetic benefits (Dyakova and colleagues, 2020).

Immediate provisionalisation, in addition, can have the added benefit of optimising the emergence profile, further supporting improved aesthetics.

Implant survival rate is very positive, statistically no better or worse for immediate implants than for delayed implants, at a reported rate of 98.4% versus 98.6% (Chatzopoulos and Wolff, 2025).

However, IIP is not without its limitations. Primary stability can be difficult to properly achieve in an area that has reduced bone density or quality.

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the increased technical demand and difficulty of inserting an implant into a fresh extraction socket when compared with placement in healed bone (Lee, 2021), due to a more unstable bone anatomy and increased possibility of complications.

The case for socket preservation/ARP

One of the notable advantages to socket preservation is its relative predictability.

In allowing for complete healing to take place before the placement of the implants, clinicians are able to gain a more accurate picture of the final ridge dimensions (Araújo and colleagues, 2005), as well as more precise treatment planning.

This approach is especially valuable when extractions face complications that could lead to infection or substantial bone loss.

Studies demonstrate that grafted extraction sockets maintain a greater ridge width and height compared with ungrafted extraction sites.

This preservation of the surrounding structural bone translates into easier implant placement, as well as a reduced need for subsequent corrective surgeries (Majzoub and colleagues, 2019).

In terms of treatment planning, socket preservation can provide more flexibility than immediate placement, which provides a limited period of time for patient education and financial planning.

In situations where immediate placement may be questionable – such as the presence of infection or thin buccal plates – socket preservation can present a more predictable option (Yankov, 2023).

Time for decision making

Despite negligible differences in implant survival between the two approaches, there are notable distinctions to be found when it comes to specific outcomes.

Aesthetic results are varied. While studies report that immediate placement leads directly to superior soft tissue aesthetics (Lee, 2021), other research indicates that an ARP approach delivers more predictable aesthetic outcomes when it comes to a thin or compromised buccal plate (Fok and colleagues, 2024).

Patient-reported outcomes tend to be close between the two approaches, with surveyed satisfaction remaining consistently comparable.

However, studies did show that, though patients preferred the reduced surgical time of the IIP approach, the likelihood of post-surgical complaints tended to be higher with this surgical technique (Fan and colleagues, 2025).

‘... the success of implant practitioners is based on the flexibility of their approach combined with their knowledge of procedures and their relative appropriateness’

How can you advance your implant skills?

Clinicians must have the requisite knowledge to make the choice between immediate and delayed placement options on a case-by-case basis, and this requires structured training.

For dental practitioners who wish to enhance or update their skill and education in the ever-evolving world of implant dentistry, the ICE Postgraduate Dental Institute & Hospital provides thorough and extensive courses, spearheaded by eminent specialist oral surgeon Professor Cemal Ucer.

The ‘Advanced certification in management of tooth loss: immediate implants vs socket preservation’ offers comprehensive teaching on the management of tooth loss with evidence-based techniques.

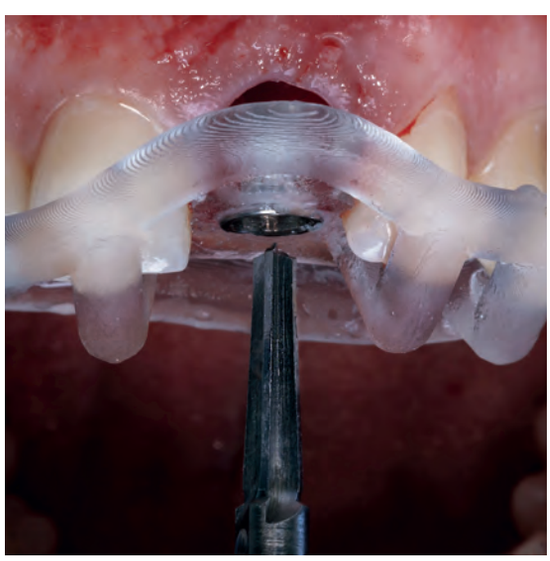
It also provides a clear roadmap for reliable decision-making, with theoretical and hands-on training designed to expand clinical, digital, and patient communication skills among practitioners.

Conclusion

Immediate implant placement and socket preservation are both evidence-supported approaches to post-extraction site management and smile restoration.

As the foundation of evidence and research continues to grow, the success of implant practitioners will be based on the flexibility of their approach combined with their knowledge of procedures and their relative appropriateness.

Understanding the strengths and limitations of different surgical approaches enables clinicians to optimise outcomes and prioritise patient satisfaction at all times.



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The evolution of endodontic irrigants – sequential versus continuous chelation

Nikita Jiwan examines current evidence to ascertain whether continuous chelation advances current clinical practice

Nikita Jiwan
Dentist

Irrigation remains crucial in endodontic disinfection, yet the core chemistry we rely on has remained relatively unchanged since sodium hypochlorite (NaOCl) and ethylenediamine tetraacetic acid (EDTA) became standard practice during the mid-20th century (Hülsmann and colleagues, 2003).

While the sequential use of NaOCl followed by EDTA is effective, its well-documented drawbacks, such as chemical incompatibility, dentine erosion and workflow inefficiency, have led to renewed interest in alternative chelators (Zehnder, 2006).

Continuous chelation, achieved by integrating NaOCl with a mild chelator such as 1-hydroxyethylidene-1,1-bisphosphonate, commonly referred to as etidronic acid (HEDP), is emerging as a feasible substitute for conventional irrigation (Zehnder, 2006).

This article seeks to study current evidence to ascertain whether continuous chelation advances current clinical practice.

A brief history and science of endodontic irrigants

The earliest reference of NaOCl dates back to World War I, when it was used to disinfect wounds and necrotic tissue (Zehnder, 2006).

Its broad-spectrum antimicrobial activity and unique capacity to dissolve necrotic pulp tissue firmly established NaOCl as the gold-standard root canal irrigant (Pandya and colleagues, 2025).

It reduces virulence factors such as lipopolysaccharides (endotoxins) while also acting as a lubricant during instrumentation (Boutsioukis and Arias-Moliz, 2022).

‘Continuous chelation results in cleaner canal walls and more uniform debris removal while reducing the risk of dentine erosion’

Its widespread availability, affordability and long shelf life have further contributed to its universal adoption in clinical practice.

Although NaOCl remains the primary endodontic irrigant, it has inherent limitations:

Inability to dissolve the inorganic component of the smear layer

Ineffectiveness in calcified canals (Zehnder, 2006).

Thus, chelation was introduced in 1957 when Nygaard-Østby proposed EDTA for smear layer removal and to facilitate canal negotiation (Hülsmann and colleagues, 2003).

Despite advances in irrigant delivery and activation, the basic principles of endodontic irrigation have remained rooted in the traditional NaOCl–EDTA sequence.

An alternative adjunct, chlorhexidine (CHX), although apt for antimicrobial activity, falls short in its tissue-dissolving ability and hence cannot substitute NaOCl as the primary irrigant (Zehnder, 2006).

The limitations of sequential chelation

Chemical incompatibility and workflow

When NaOCl and EDTA are used sequentially, chemical incompatibility is the main limitation. EDTA immediately deactivates NaOCl by consuming the free available chlorine, disabling its antimicrobial and tissue-dissolving effects; a reaction clinically visible as effervescence (Zehnder, 2006).

A saline rinse between irrigants is therefore recommended (Hülsmann and colleagues, 2003), but in practise, this step may be rushed or missed, reducing disinfection efficacy.

Smear layer removal at a cost

The sequential use of NaOCl and EDTA has also been associated with dentine erosion.

NaOCl deproteinises the collagen matrix, weakening dentine and permitting deeper EDTA penetration.

Subsequently, EDTA demineralises the collagen-depleted substrate, causing structural collapse and allowing further NaOCl ingress, producing characteristic ‘tunnelling’ erosion (Rath and colleagues, 2020).

The severity depends on exposure time: it is reported that 60 minutes of NaOCl contact before EDTA significantly reduces dentine flexural strength and creates erosive channels up to 20 µm, increasing the risk of vertical root fracture (Mai and colleagues, 2010).

Although such exposure times exceed typical practice, even standard protocols can remove the smear layer at the cost of cumulative dentine erosion.

These drawbacks make it necessary to explore alternative irrigation methods.

Continuous chelation: concept and advantages

To overcome these limitations, the concept of continuous chelation was proposed.

This streamlined protocol involves combining NaOCl with a weak chelator, such as HEDP, allowing simultaneous smear layer removal and disinfection throughout instrumentation (Zehnder, 2006).

The advantage is compatibility; HEDP does not significantly reduce available chlorine, thus preserving NaOCl’s antimicrobial activity.

This single irrigation solution has been shown to be superior in preventing the accumulation of hard tissue debris while simplifying the clinical procedure (Pandya and colleagues, 2025).

Laboratory studies consistently show continuous chelation

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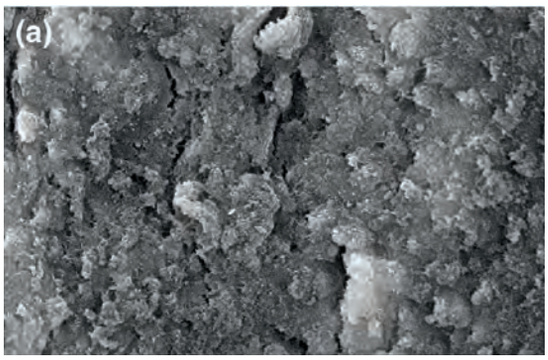

Figure A: A thick contaminated smear layer evident when distilled water was used as the irrigant

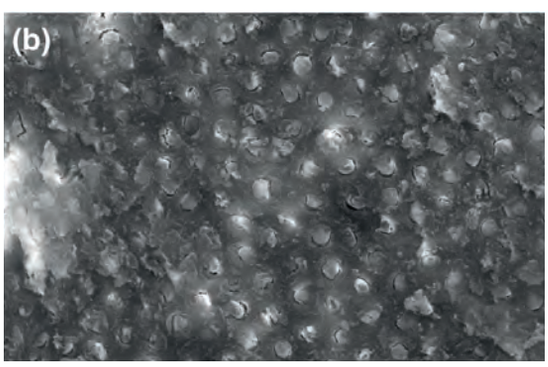

Figure B: Irrigation with 2.5% NaOCl during preparation resulted only in partial removal of the smear layer

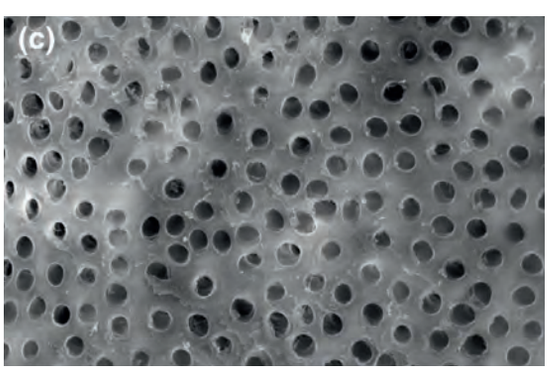

Figure C: An additional final rinse with 17% disodium EDTA

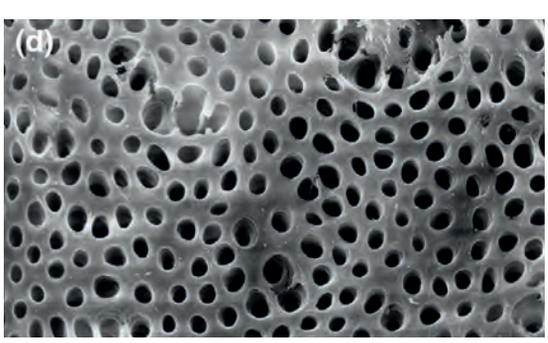

Figure D: Continuous chelation, containing 2.5% NaOCl and 9% HEDP throughout preparation resulted in near-complete removal (Boutsioukis and Arias-Moliz, 2022)

performs just as well as or shows improved results compared with sequential irrigation.

HEDP produces significantly less demineralisation and erosion than EDTA (La Rosa and colleagues, 2024).

Micro-CT analyses further support that continuous chelation results in cleaner canal walls and more uniform debris removal (La Rosa and colleagues, 2024).

Although it has been suggested that HEDP requires a longer contact time to achieve similar smear layer removal, this is not a drawback because HEDP is present throughout instrumentation (Álvarez-Sagües and colleagues, 2021).

Clinically, the evidence is emerging. A study of simulated double-curved canals concluded that combining HEDP with NaOCl reduced instrumentation time by approximately 13% compared with NaOCl alone, resulting in a simplified workflow by eliminating the separate EDTA step (Hofpeter and colleagues, 2025).

A recent double-blind randomised controlled clinical trial by Pandya and colleagues (2025) compared continuous chelation versus sequential irrigation in patients previously treated for symptomatic apical periodontitis.

The patients treated by continuous chelation produced a significantly greater reduction in intracanal endotoxins than those treated by sequential irrigation.

This suggests that continuous chelation might enhance disinfection, potentially by maintaining the potency of NaOCl throughout. However, the study was limited to single-canal teeth with small periapical lesion.

Conclusion and future direction

Despite the longstanding success of the NaOCl–EDTA sequence, recent evidence shows that adding HEDP to NaOCl maintains antimicrobial function, reduces dentine damage and streamlines the workflow.

Although EDTA remains valuable, continuous chelation represents a meaningful evolution in irrigant science and a promising direction for modern endodontic practice (Boutsioukis and Arias-Moliz, 2022).

Research into alternative weak chelators such as tetrasodium EDTA and clodronate are also under investigation (Boutsioukis and Arias-Moliz, 2022).

Ultimately, larger, long-term clinical studies involving more complex cases are necessary to establish whether continuous chelation improves patient outcomes. This will set the tone for further irrigant options in endodontics.

For more information about the British Endodontic Society, visit www.britishendodonticsociety.org.uk

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The silent HR pressure inside modern dental practices

HR is becoming an increasingly time-consuming burden – but it's one that practices can't ignore, explains Lara Brewood-Green

Lara Brewood-Green
Director, Dentistry HR

There is a quiet pressure building inside many dental practices.

It rarely appears in a single dramatic moment. Instead, it surfaces gradually: staff turnover that feels difficult to stabilise, uncertainty around associate agreements, performance conversations delayed for too long, compliance folders updated reactively rather than proactively.

For many practice owners, HR begins to feel like a constant background weight.

But the issue is rarely a lack of effort. More often, it is a mismatch between the way HR systems are designed and the reality of how dental practices operate.

Dentistry is not a corporate workplace

Most HR frameworks are built around large organisations.

They assume clear hierarchies, dedicated HR departments, and teams that operate at a distance from senior leadership.

Policies can be developed centrally and applied consistently across hundreds or thousands of employees.

Dental practices operate very differently.

They are small, highly visible environments where relationships matter enormously.

Owners work alongside their teams. Conflicts are personal and immediate. Associates may not be employees in the traditional sense. Clinical regulation shapes day-to-day operations in ways most corporate HR models never encounter.

When corporate HR is applied to dental practices

When HR systems designed for large organisations are applied to dental practices, the result can feel cumbersome rather than supportive.

Practice owners often encounter:

- Overly complex processes that are difficult to apply in small teams
- Generic documentation that doesn't reflect clinical realities
- Advice that lacks understanding of associate relationships
- Compliance systems that prioritise paperwork over practical management.

The result is that HR begins to feel reactive rather than supportive.

Compliance is maintained, but confidence is not.

The reality for practice owners

Most dental practice owners did not train to become HR managers.

They trained to provide clinical care, lead teams and build practices that deliver good dentistry.

Yet the moment a practice begins to grow, people management becomes unavoidable. Recruitment, performance conversations, contracts, compliance requirements and team development all become part of daily leadership.

Without a framework that reflects how dental practices actually function, these responsibilities can quickly feel overwhelming.

What should effective HR in dentistry actually look like?

When HR is designed specifically for dentistry, the experience looks very different.

Instead of feeling heavy or reactive, it becomes a framework that supports confident leadership.

Moving from reactive to proactive

The most successful practices increasingly treat HR as a strategic function rather than an administrative burden.

Done well, it provides stability for teams, clarity for owners, and a structure that allows practices to grow without constant friction around people management.

The challenge is not whether HR matters in dentistry. It clearly does.

The challenge is ensuring that the model being used actually fits the environment in which dental teams work every day.

Why dentistry feels different

- Teams are small and tightly connected
- Roles often overlap between clinical and non-clinical staff
- Personal dynamics influence daily workflow
- Patients are present during much of the working day
- Regulation is embedded into clinical delivery.

This environment requires a different approach to people management.

Key hallmarks of dental practice-ready HR:

- Clarity in associate and employee relationships
- Simple systems that work within small teams
- Guidance aligned with dental regulation and CQC expectations
- Practical support for difficult conversations and team management
- Documentation that reflects real practice scenarios.

Five hidden HR risks quietly building in dental practices

Dental practices aren't lacking in commitment to their teams, but HR is now carrying greater reputational and operational risk, Lara Brewood-Green says

Lara Brewood-Green
Director, Dentistry HR

For many years, HR in dental practices has often been handled informally.

Relationships are close: teams are small, and practice owners work alongside their staff every day.

Because of that, trust, common sense and experience have traditionally carried much of the responsibility for managing people.

In many cases, that approach worked well.

But dentistry is changing. Practices are growing, regulation is increasing, and employment expectations are evolving.

What once felt manageable through informal systems now carries greater legal, reputational and operational risk.

There are five key areas where that pressure is starting to show:

1. Associate agreements that no longer reflect reality

Associate contracts are one of the most complex areas of HR in dentistry.

Many agreements were written years ago and quietly carried forward as practices evolved.

Over time, however, the way associates work within a practice can shift – responsibilities change, financial arrangements adapt, or expectations around facilities and support evolve.

When agreements no longer reflect the practical reality of how a practice operates, misunderstandings can develop – sometimes only becoming visible when a dispute arises.

2. Performance concerns left unaddressed

Discussing poor performance is never an easy conversation.

Because practice owners work closely alongside their staff, it can be tempting to delay addressing concerns about behaviour, performance or team dynamics.

In the short term, this often feels like the easier option.

But when concerns are not addressed early, small issues can grow into larger problems – affecting team morale, patient experience and ultimately the stability of the practice.

3. Inconsistent documentation across the team

Many practices hold documentation for policies, contracts and team procedures.

The challenge is not always the absence of documents – it is consistency.

Over time, documents can become outdated, versions multiply and different team members may operate under slightly different arrangements.

This creates uncertainty for both staff and practice owners when questions arise.

In a regulated environment like dentistry, clarity and consistency are essential.

4. Unclear processes for difficult situations

Every practice eventually faces challenging situations: a grievance between colleagues, concerns about conduct, a request for flexible working, or a disciplinary matter.

Without clear processes in place, these situations can feel highly personal and emotionally charged.

Because of this, it's easy for decisions to be made reactively rather than through a structured framework.

That can leave practice owners feeling exposed and unsure whether they are handling the situation correctly.

5. Being reactive instead of proactive

Many practices only engage with HR support once a problem has already emerged: when a dispute arises, a grievance is raised or a difficult situation escalates.

By that point, the options available are often narrower and the situation more complex to resolve.

Effective HR works best when it supports practices proactively – providing clear frameworks, documentation and guidance before issues arise, rather than only responding once something has gone wrong.

For practice owners, moving from reactive to proactive HR can reduce risk, strengthen team relationships and create greater confidence in how people management is handled day to day.

From trust to structure

None of these risks arise because practice owners lack commitment to their teams.

In fact, the opposite is often true. Dental practices tend to be highly collaborative environments built on strong relationships.

But as practices grow and expectations evolve, informal approaches can begin to show strain.

The challenge is not replacing trust – it is supporting it with systems that bring clarity, confidence and consistency to how teams are managed.

'The challenge is not replacing trust – it is supporting it with systems that bring clarity, confidence and consistency to how teams are managed'

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Running a dental practice comes with a level of complexity that isn't always visible from the outside.

Alongside clinical care, there is a constant stream of decisions around rotas, team dynamics, compliance and day-to-day changes. Most of it happens quietly, in the background, but it builds over time.

As Craig Welling, CEO of FMC, explains: 'There's a lot of issues that are complex within the running of a dental practice... rotas, communication, last-minute changes... it all adds up.'

For many practice owners, that pressure is not about capability or effort. It comes from trying to manage people within systems that were never designed for the way dental practices actually operate.

What we kept hearing

In conversations across the profession, a similar picture kept emerging.

Practices had documentation. They had contracts. They had processes of some kind.

But they were often spread across different places, handled in different ways, and updated at different times. Lara Brewood-Green, lead people consultant at FMC, describes it simply: 'If you're a dental practice manager or clinician... there's often a lot of separate documents and paperwork... and a lot of the time that is a very manual process.'

Nothing on its own felt unmanageable. It was the accumulation that created the strain.

Questions took longer to answer than they should. Situations were handled slightly differently each time. Small uncertainties started to sit in the background.

And in a close-knit team, those things rarely stay contained.

'People issues can be time consuming and really sensitive for practices.'

Where the difficulty comes from

Dentistry doesn't follow a standard workplace model.

Teams are small and visible. Practice owners work alongside their staff. Associates sit somewhere between independence and integration. Regulation is part of everyday clinical work.

As Lara explains: 'It's not a one size fits all.

'It's very much dependent on the dental practice itself and the dynamics.'

Most HR systems, however, are built with very different environments in mind.

They assume clear structures, dedicated HR support and distance between leadership and teams.

When those assumptions don't hold, the systems can feel awkward to apply.

That is often where the difficulty comes from.

Not the absence of HR, but the lack of something that properly fits.

What we wanted to do differently

Dentistry HR was developed with that in mind.

The intention was not to introduce more process, but to make existing responsibilities easier to manage and more consistent across the practice.

That meant creating a clearer structure around the areas that tend to cause uncertainty, and making sure that structure reflects how dental practices actually work day to day.

It also meant recognising that documentation alone is not enough.

'We are there to be a listening ear. We understand dentistry... and we want to make things more simplistic for you', Lara explains.

Having access to people who understand the context can make a meaningful difference when situations are not straightforward.

What changes when things feel clearer

When people management is more consistent, the impact is often gradual but noticeable.

Decisions take less time. Conversations happen earlier. Situations feel easier to approach.

For practice managers in particular, that can create space to focus on the areas of the business that matter most.

Lara continues: 'It enables the practice manager... to get some time back... to focus on servicing patients and growing the business.'

A more practical way to manage people

Dentistry HR has been shaped around the realities of practice life.

The aim is not to add another system to manage, but to bring a greater sense of clarity to something that can often feel uncertain.

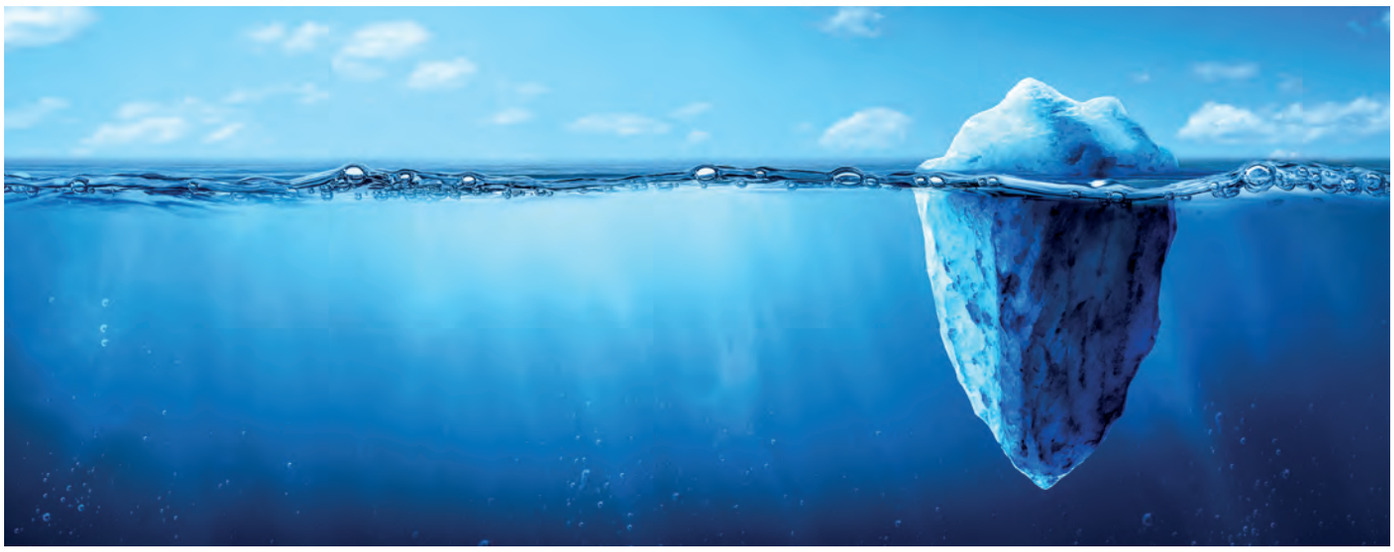
That shift is what many practices have been missing – and it is where a more tailored approach to HR in dentistry begins to make a difference.

What changes when HR becomes clearer

- Decisions feel more consistent
- Situations are easier to handle
- Less time spent second guessing
- More focus on the practice and patients.

Dentistry HR

Bring more clarity to how you manage your team
Scan to explore Dentistry HR



Associates, employees – and the contracts practices misunderstand

Associates are not employees in the traditional sense, and that can leave a number of HR issues lurking out of sight, Lara Brewood-Green explains

Lara Brewood-Green
Director, Dentistry HR

Few areas of HR create more uncertainty in dental practices than associate relationships.

Associates are not employees in the traditional sense. They operate as self-employed clinicians, often with significant professional autonomy.

Yet they are also embedded within the daily life of the practice – sharing facilities, working within practice systems, and interacting closely with the wider team.

This unique position makes the associate relationship one of the most complex aspects of practice management.

Why associates sit in a grey area

In most workplaces, HR frameworks are designed around a clear employer-employee relationship.

Dentistry does not always fit that model.

Associates are typically self-employed contractors, responsible for their own tax arrangements and professional indemnity.

At the same time, their work takes place within the structure of a dental practice, under shared governance, and often using practice resources.

This creates a natural tension between independence and integration.

Practice owners must respect the associate's status as a self-employed clinician, while also ensuring the practice operates safely, efficiently and in line with regulatory expectations.

Where confusion most often arises

In many practices, associate agreements are created at the point of recruitment and then left largely untouched for years.

As practices evolve, expectations can shift – sometimes subtly.

Common areas of misunderstanding include:

- Facilities and equipment expectations
- Responsibility for materials and lab costs
- Working patterns and diary management
- Patient allocation and treatment planning autonomy
- Notice periods and exit arrangements.

When these issues are not clearly defined in agreements or consistently applied, tensions can emerge.

Regulation and responsibility

Associate relationships also exist within a wider regulatory framework.

Practice owners must ensure the practice meets obligations around governance, patient safety and regulatory compliance.

Associates, meanwhile, remain individually accountable for the care they provide.

Balancing these responsibilities requires clarity, transparency and mutual understanding.

Without that structure, misunderstandings can quickly escalate into disputes that are difficult for both sides to resolve.

Why this matters more today

As dentistry becomes more sophisticated – with growing practices, corporate groups and increasingly complex regulatory oversight – the associate relationship is under greater scrutiny than ever before.

For practice owners, this means the associate agreement is no longer simply a contractual formality. It is a critical framework for how the clinical team functions.

Handled well, it provides clarity, fairness and stability for both parties.

Handled poorly, it can become one of the most significant sources of conflict within a practice.

Five practical rules for managing associates professionally

While associates are not employees, HR principles still play an important role in how practices function day to day.

The most effective practices recognise this and put simple frameworks in place that support both autonomy and accountability.

1. Set clear expectations from the start

Professional expectations should never sit in the grey space of 'assumed behaviour'.

Associates should understand how the practice expects clinicians to work with patients, nurses and reception teams, as well as standards around record keeping, clinical governance and communication.

These expectations are best established during onboarding and reinforced through the culture of the practice.

Clarity early on prevents misunderstandings later.

2. Address concerns early and professionally

Difficult conversations can feel uncomfortable in small teams, particularly where associates are self-employed.

But avoiding these conversations rarely solves the problem.

If concerns arise around communication, professionalism or teamwork, they should be raised early and discussed constructively.

The focus should remain on shared standards within the practice rather than personal criticism.

Handled well, these conversations reinforce expectations and protect the culture of the team.

3. Recognise and reinforce positive behaviours

HR is not only about managing problems.

Associates who contribute positively to the culture of the practice – supporting colleagues, communicating well with patients or helping improve systems – should be recognised.

Simple acknowledgement can strengthen professional relationships and reinforce the behaviours that help a practice run smoothly.

4. Apply expectations consistently across the team

One of the quickest ways to create tension within a practice is inconsistent expectations.

If some associates follow certain processes while others operate differently, the wider team can quickly feel the imbalance. Consistency helps ensure everyone understands how the practice operates and what is expected of them.

5. Make sure the contract reflects the way the practice actually works

Ultimately, the associate agreement should support the real operating model of the practice.

Over time, however, many agreements drift away from reality as practices evolve. Working patterns change, facilities develop, financial arrangements adapt and team structures shift.

Periodic review of agreements helps ensure they remain aligned with how the practice actually functions.

Clarity of language also matters. Because associates are typically self-employed rather than employees, the terminology used within agreements and day-to-day practice documentation should reflect that status.

wFor example, references to 'holiday' or 'annual leave' may be more appropriately framed as 'agreed absence' or 'planned leave'.

These distinctions may seem small, but they help maintain clarity around the nature of the relationship.

A well-constructed agreement cannot prevent every disagreement – but it can provide clarity and structure if questions arise.

Structure supports autonomy

Dentistry depends on professional autonomy.

Associates must retain the clinical independence that allows them to make appropriate decisions for their patients.

But autonomy works best when supported by clear expectations and well-understood boundaries.

When practices get this balance right, associate relationships become one of the profession's greatest strengths – combining entrepreneurial flexibility with collaborative team care.

For practice owners, the aim is not to introduce unnecessary bureaucracy.

It is simply to ensure that the frameworks guiding these relationships are clear, fair and aligned with the realities of modern dental practice.

Introducing Dentistry HR

Struggling with people management? Meet Dentistry HR – a new way forwards for dental practices

In this issue, we've explored a reality many dental practices recognise – that managing people in dentistry is rarely straightforward.

Small teams, close working relationships, complex associate arrangements and increasing regulatory expectations mean that HR in dental practices operates very differently from most other workplaces.

Yet for many years, the tools available to support practice owners have largely been adapted from corporate environments that were never designed for the realities of chairside care.

The result is familiar to many practice leaders. HR can feel reactive, overly complex or disconnected from the day-to-day realities of running a practice.

Why dentistry needs its own HR approach

Dentistry sits in a unique position. Practice owners are not only business leaders – they are clinicians working alongside their teams.

Associates operate within structures that do not fit neatly into traditional employment frameworks. Regulation intersects with both clinical care and team management.

These dynamics require an approach to HR that understands the environment in which dental teams actually work.

Over the past three decades, Dentistry has been at the centre of the profession's conversations – working with practice owners, associates, regulators and industry leaders to understand the challenges shaping dental practice.

One theme has surfaced consistently: practices need clearer, more practical support when it comes to managing their teams.

From insight to solution

Dentistry HR has been developed in response to that need.

Rather than adapting corporate HR models to dentistry, the aim has been to build a system designed specifically around the realities of dental practice.

Drawing on more than 30 years of sector insight, Dentistry HR provides a framework that combines practical documentation, structured processes and expert guidance tailored to the profession.

The goal is simple: to bring clarity where practices have experienced confusion, and confidence where they have felt uncertainty.

What Dentistry HR provides

Dentistry HR is designed to support practice owners with the key areas of people management that commonly create pressure within practices.

Rather than acting as a generic HR subscription, the service has been designed as practice-ready support built specifically for dentistry.

Supporting confident leadership in practice

For many practice owners, HR responsibilities have grown steadily alongside the profession itself.

As practices expand, teams diversify and regulation increases, people management becomes a more visible part of running a successful dental business.

Dentistry HR aims to support practice leaders in navigating that complexity with clarity and confidence.

When HR systems are aligned with the realities of dental practice, they can strengthen teams, support compliance and allow clinicians to focus on delivering excellent care.

Be among the first to explore Dentistry HR

To mark the launch of Dentistry HR, a limited number of practices will be invited to take part in the initial rollout.

This includes opportunities to:

- Join a launch webinar exploring the challenges and solutions around HR in dentistry
- Book a discovery call or HR surgery to discuss their practice's needs
- Access early implementation support.

For practices looking to bring greater structure and confidence to their people management, Dentistry HR represents a new approach built specifically for the profession.

Demystify your HR.

Lead with confidence.

Build a practice where teams feel aligned, supported and ready to deliver exceptional care.

Dentistry HR

Dentistry HR includes:

- Sector-specific contracts and documentation designed for dental practice environments
- Structured people management processes that support consistent decision-making
- Expert advisory support from professionals who understand the profession
- Clear alignment with regulatory expectations relevant to dental practices
- Ongoing guidance when issues arise within teams.

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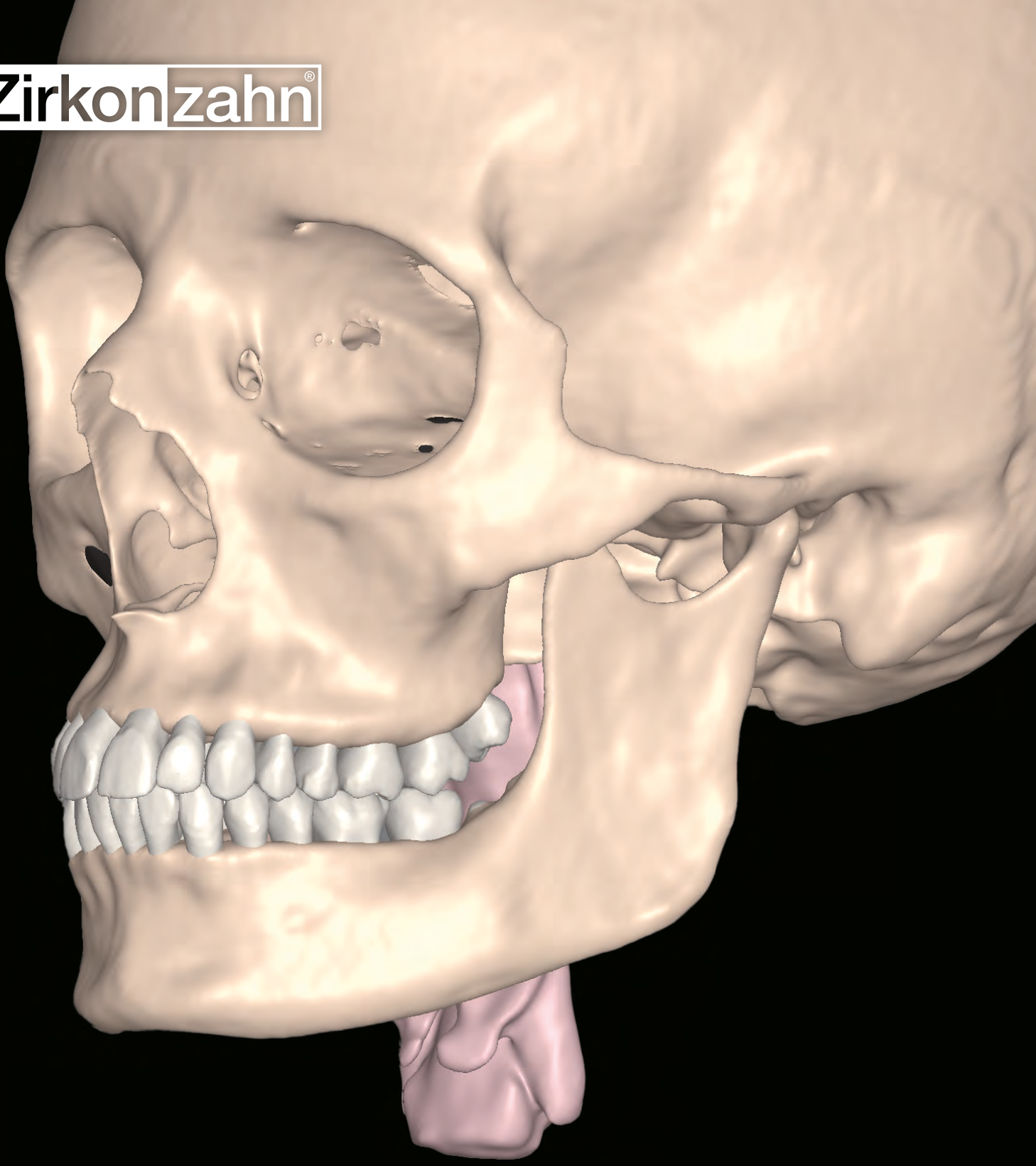

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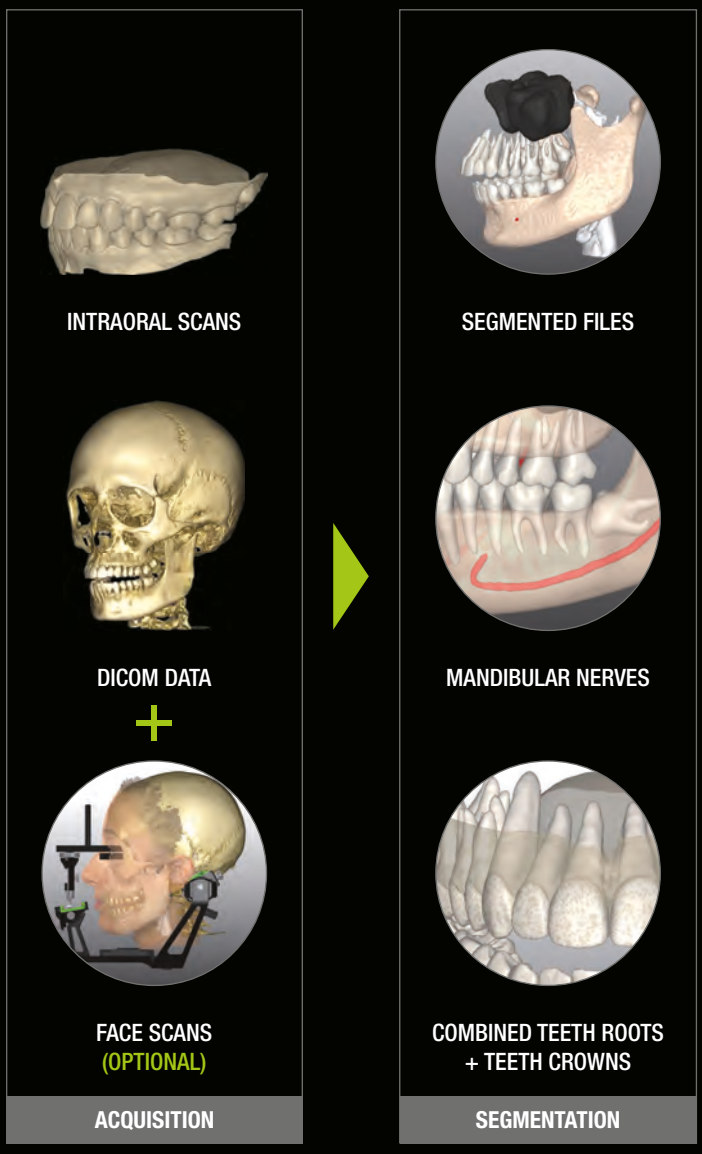

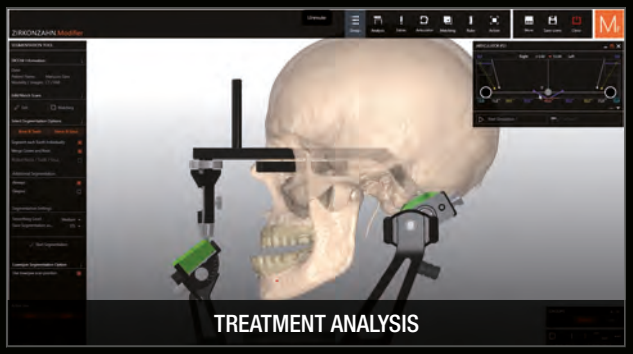

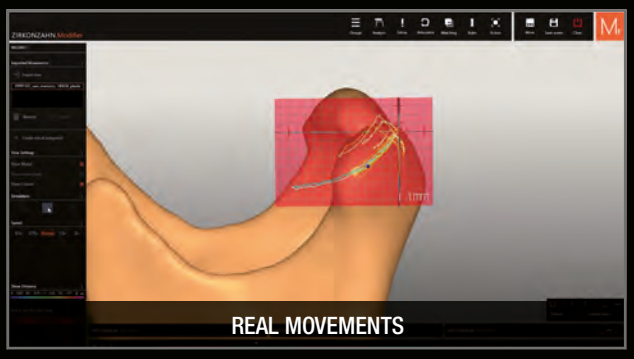

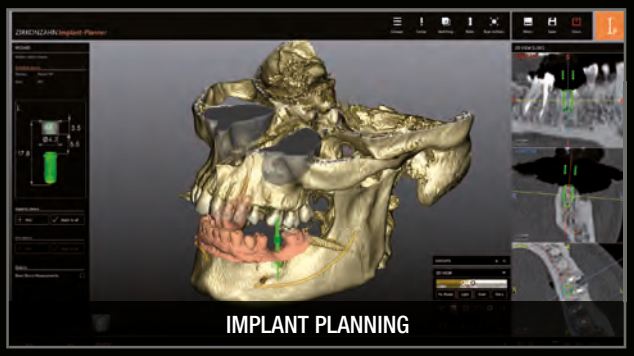

Bone Doctor is Zirkonzahn's new software module that significantly simplifies the digital analysis of the bone situation: by importing the patient's DICOM data, the module allows users to analyse the different cranial bones and generate the corresponding 3D files. The software is capable of autonomously segmenting any part of the skull. The extracted maxilla can be combined with the patient's Real Movement data to analyse the condylar movements and extracted teeth can also be used to perform orthodontic movements based on their actual root and crown morphology.

Know more about Bone Doctor and Zirkonzahn.Modifier at Zirkonzahn's new 2026 lecture tour:
The Full Power of Zirkonzahn.Modifier – Digital Design Advantages | Edinburgh, 28 April 2026

For more information and registration, scan the code or contact:
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AI-SEO explained – what dentists actually need to do in 2026

If SEO, GEO, AEO, AI-SEO, LLM optimisation confuses you, you're not alone! David Nelkin clarifies what you should be focusing on

David Nelkin
CEO and founder of Xcelerator Dental

If you've been anywhere near a marketing conversation recently, you'll have noticed the acronyms multiplying at an alarming rate. SEO, GEO, AEO, AI-SEO, LLM optimisation – it can feel like the landscape is shifting under your feet every five minutes. And if you're a busy practice owner trying to actually run a dental practice, that is understandably overwhelming.

So let me cut through it for you. The reality is simpler than the noise suggests and there are some genuinely important things you need to be doing right now that most practices simply aren't.

Let's start with what hasn't changed

SEO (Search engine optimisation) is still the foundation. That hasn't gone away and it won't.

Three questions are still at the heart of it all. Is your practice discoverable? Is the information about you understandable? And are you trustworthy?

Get those foundations right and everything else flows from them.

Think of the new acronyms as different outputs of the same foundations rather than entirely separate disciplines.

AEO – answer engine optimisation – is about appearing in direct answers rather than just a list of links. Featured snippets, AI overviews, 'People also ask' sections, voice search results – these are all AEO placements, and the goal is to be the answer, not just a result.

GEO – generative engine optimisation – takes this further. It's about being cited inside AI-generated responses, whether that's in Google's AI overview, in Chatgpt or in Perplexity. Strong, well-structured SEO is what powers your ability to appear in all of these places.

Search didn't die - it expanded

One of the most pers istent myths doing the rounds is that search is dying. It absolutely isn't.

People are now finding businesses through traditional search results, through maps, through their Google Business Profile, through social content, and through AI-generated answers.

The pie is bigger, and you need a presence across more of it.

Here's a stat that should make you sit up: in 2025, around 60% of Google searches ended without anyone clicking through to a website.

If people are getting answers directly from Google without ever visiting your site, you need to be the source of those answers.

Your Google Business Profile, your reviews and your Q&A content matter enormously; in many cases, they're the only thing a potential patient sees before deciding whether to call you.

Google still dominates with over 93% search market share in the UK, so don't let anyone tell you to abandon it.

But Chatgpt has become the fifth most visited website in the world as of January 2026.

These AI tools are mainstream now, and your visibility within them is increasingly important.

Why your practice is already feeling the shift

Your rankings might look stable, but your website traffic is changing and the nature of your enquiries feels different. That's not a coincidence.

Decisions are happening earlier in the patient journey now.

A potential patient might encounter your practice in an AI overview, check your Google Business Profile, read reviews across a couple of platforms and watch a short video – all before they ever visit your website.

The modern patient journey runs something like this: social media sparks curiosity, video does the research, reviews form opinions, Google validates the decision, and AI provides a summary.

You need to show up at multiple points along that path.

The three new things you must be doing

The SEO fundamentals we've always talked about still matter – your website, your local SEO, your Google Business Profile.

But there are now three additional activities that have a direct and proven correlation to your search visibility. And most practices are either not doing them at all or not doing them consistently enough.

1. Organice social media posts

Google now indexes social content directly. Your Instagram posts, in particular, are being pulled into search results – and Google appears to treat recent social activity as a freshness signal, factoring it into its algorithm.

An active, regularly updated social presence is no longer just about brand awareness; it is now part of your SEO strategy.

Post consistently, make your captions descriptive and relevant, and think about what questions your posts are answering for potential patients.

2. Video shorts across Youtube, Instagram and Tiktok

Short-form video has its own dedicated tab in Google search results now, sitting ahead of traditional video results.

Google has also introduced a 'What people are saying' video carousel that surfaces user-generated video content alongside business content.

In 2016, visual content occupied just 2% of mobile search results – by 2024 that figure was 30%.

The direction of travel is clear. Short videos answering common patient questions, showcasing treatment outcomes or introducing your team are now appearing directly in Google searches.

You do not need a film crew or a big production budget – you need consistency and relevance.

3. Online reviews across multiple platforms

Reviews are now a live, active signal that directly influences where you appear, including in AI-generated responses.

Fresh, recent reviews across multiple platforms – Google, Trustpilot and Facebook at a minimum – tell AI and search engines that your practice is active, trusted and worth recommending.

A practice with reviews spread consistently across the last 12 months will outperform one with a larger but older bank of reviews.

Respond to every single one, positive and negative. And treat review generation as an ongoing system rather than something you push occasionally.

Write for conversations, not keywords

Alongside those three new priorities, the way you approach your website content needs to shift.

People and AI tools are now asking questions rather than typing keyword strings.

That means your content needs to answer real questions about cost, suitability, fear, outcomes and recovery – the things your team answers on the phone every single day.

Add FAQ sections to your key treatment pages, use subheadings phrased as questions, and write the way your patients actually talk.

Build a content ecosystem

The smart approach to all of this is to create once and distribute everywhere.

Write a strong blog post or film a strong video, then repurpose it across social, email, your Google Business Profile and beyond.

This is also what helps AI platforms build a consistent picture of your practice, making you more likely to be cited and recommended.

Stop obsessing with being number one

Chasing a number one Google ranking is not your goal in 2026 – and honestly, the concept is becoming increasingly meaningless.

Think about it: if a patient finds you through an AI-generated recommendation, where exactly does 'number one' fit into that?

If they discover you through your Google Business Profile, or a short video, or a review on Trustpilot, what does your organic ranking position even mean?

With so many different touchpoints now driving patient decisions – AI overviews, map packs, social content, reviews, featured snippets – the idea of a single number one position is an oversimplification that could actively distract you from what matters. And for what it's worth, being position three with content that genuinely answers what someone is looking for will outperform a number one ranking on a page nobody's engaging with.

Nearly 60% of searches end without a single click to any website.

The metrics that matter are enquiries, bookings, treatment starts and review momentum – not where you sit in a list.

Behaviour signals matter too

The signals Google and other platforms use to determine trust are increasingly behavioural.

How quickly you respond to enquiries, the recency and spread of your reviews, how fresh your content is, the engagement your posts receive – all of these matter.

There is also credible evidence that Google is now monitoring the sentiment and outcome of phone calls to businesses listed on Google Business Profile.

How your team handles inbound calls could directly influence your search visibility and needs to be taken seriously.

Bringing it all together

Good SEO in 2026 comes down to three things: be findable, be understandable, be trustworthy.

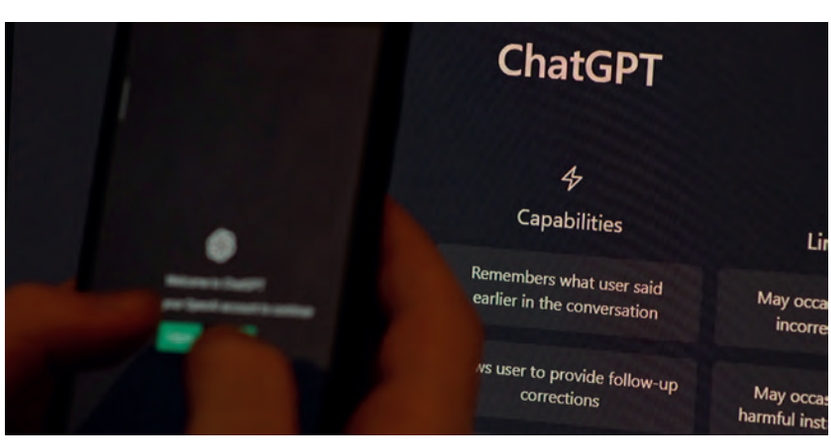
Your Google Business Profile, your reviews, your conversational content, your short-form video, your social presence and the way your team handles incoming enquiries all feed into those pillars.

At Xcelerator Dental, our whole approach is built around simplifying this for practices and taking the complexity of marketing off your plate, so you can focus on delivering exceptional patient care.

Our promote, convert, grow model is designed to make sure your practice is visible in the right places, that your website converts the traffic you generate, and that your team has the tools to turn enquiries into treatment starts.If you'd like to talk through where your practice currently sits with any of this, I'm always happy to have a conversation.

There are no quick fixes here – but there is a clear path, and the practices that start walking it now will be in a significantly stronger position by the end of the year.

'Good SEO in 2026 comes down to three things: be findable, be understandable, be trustworthy'



Why income protection is essential for dentists

Income protection is so important for peace of mind and maintaining the stability of your practice, Iain Stevenson says

Iain Stevenson
Head of dental, Wesleyan Financial Services

Dentistry is a physically and financially demanding profession. Yet many dentists underestimate the importance of income protection.

While you focus on patient care, it's easy to overlook the risk of being unable to work due to illness or injury.

At Wesleyan Financial Services, we've seen firsthand how vital this cover can be.

Over the past five years, 99% of all claims were paid out. In 2025, it reached 100%.

For dentists, the most common claims involve musculoskeletal issues, accounting for 33% of claims in the past five years and 38% in 2025.

This highlights the physical toll of dentistry and the real risk it poses to your livelihood.

If illness or injury stopped you from working, would you still be able to cover your mortgage? Household bills? Family expenses?

'The statistics are clear: the likelihood of needing to make a claim is higher than many expect'

Peace of mind

An income protection policy ensures that your regular expenses would continue without disruption.

It's not just about safeguarding your income. It's about maintaining the stability of your practice and your peace of mind.

The statistics are clear: the likelihood of needing to make a claim is higher than many expect.

With nearly all claims paid, income protection isn't just a safety net. It's a practical investment in the longevity of your career.

Dentists dedicate their working lives to caring for others.

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For more information about Wesleyan Financial Services, visit **wesleyan.co.uk/dental**.

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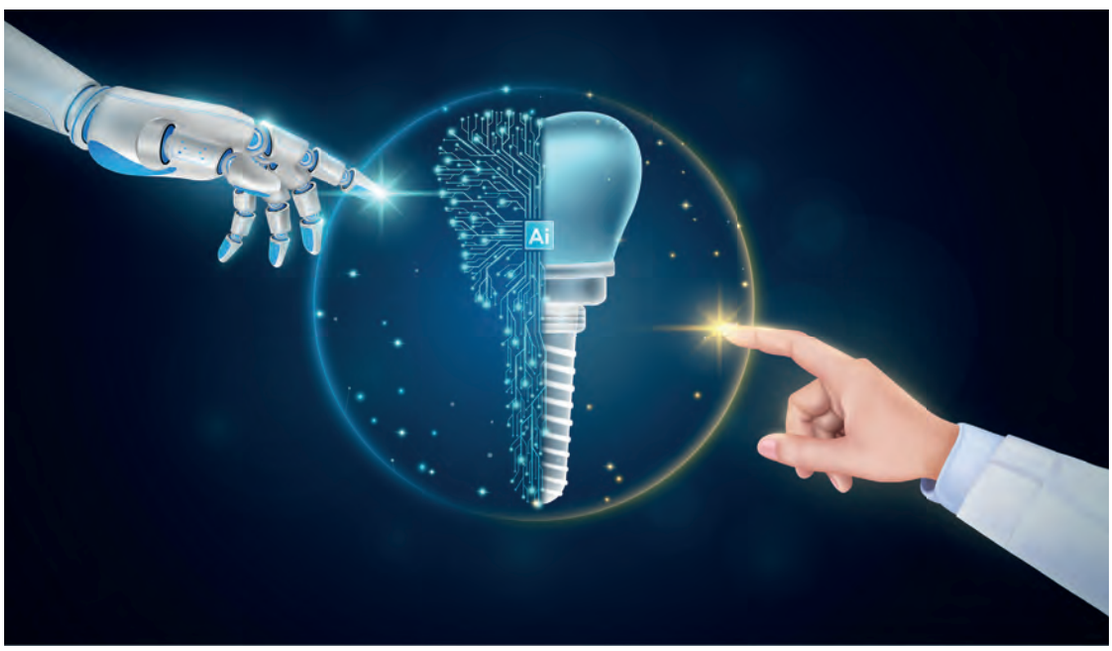
The evolution of laboratory communication

Communication must be consciously owned because when it belongs to everyone, it often belongs to no one, says Joanna Mekshi

Joanna Mekshi
Dental lab operations leader at Rahnama Dental Lab



Around 80% of the work we receive in our laboratory is digital.

It is faster and more streamlined, but speed does not always mean completeness.

We still receive scans without opposing arches, prescriptions without materials specified, shades missing, implant systems unconfirmed, or cases submitted with a patient already booked before a return date has been agreed.

That is not a technology problem. It is an ownership problem.

Digital systems move information quickly, but they do not question whether that information is complete or realistic. Someone still has to notice the gap and address it early.

The clientele manager role

The clientele manager role exists in that space. It ensures prescriptions are complete before they reach the bench, confirms return dates against patient bookings, and clarifies ambiguity immediately rather than the day before dispatch.

Communication is logged so technicians are not interrupted mid-case. If technicians are chasing information, they are not producing work, and that affects quality and morale.

Client satisfaction is essential, but not at the expense of the technical team.

A laboratory runs well when technicians feel protected from unnecessary disruption and dentists feel supported rather than challenged.Much of what clients experience as excellent service is structured communication happening consistently in the background.

I am also fortunate to work within a laboratory led by a director who remains deeply involved in cases and gives significant care and attention to the clinical outcome, not just the commercial side of the business.

That level of leadership sets the tone. It creates a culture where quality is prioritised and communication is taken seriously.

Equally, the technical team I work alongside demonstrates exceptional dedication and precision. Their focus and craftsmanship are the foundation of everything we deliver.

My role only functions because it supports professionals who take genuine pride in their work.

The requirement for ownership

Importantly, this position does not require clinical qualification. It can be developed.

It requires attention to detail, confidence to ask questions, and genuine respect for both sides of the workflow, the time pressures in a practice and the precision required in a laboratory.

I entered the role without a dental background. It evolved over time through mentorship and experience.

I was fortunate to be given the opportunity to learn how cases move through production, how implant systems differ, and where communication breakdowns typically occur.

That experience reinforced that structured communication within a lab can be built deliberately. It does not rely solely on technical credentials.

Deliberate communication

For smaller laboratories, this does not necessarily require an additional employee.

However, communication must be consciously owned. When it belongs to everyone, it often belongs to no one.

Similarly, practices benefit from designating a clear case owner responsible for ensuring prescriptions are complete, photographs attached and queries answered promptly.

When communication sits with a named individual rather than a general inbox, predictability improves on both sides.

Good communication in dentistry does not need to be louder or more complex. It needs to be deliberate.

When someone takes responsibility for the relationship, not just the case, technicians can focus, dentists feel supported, and patients ultimately benefit.

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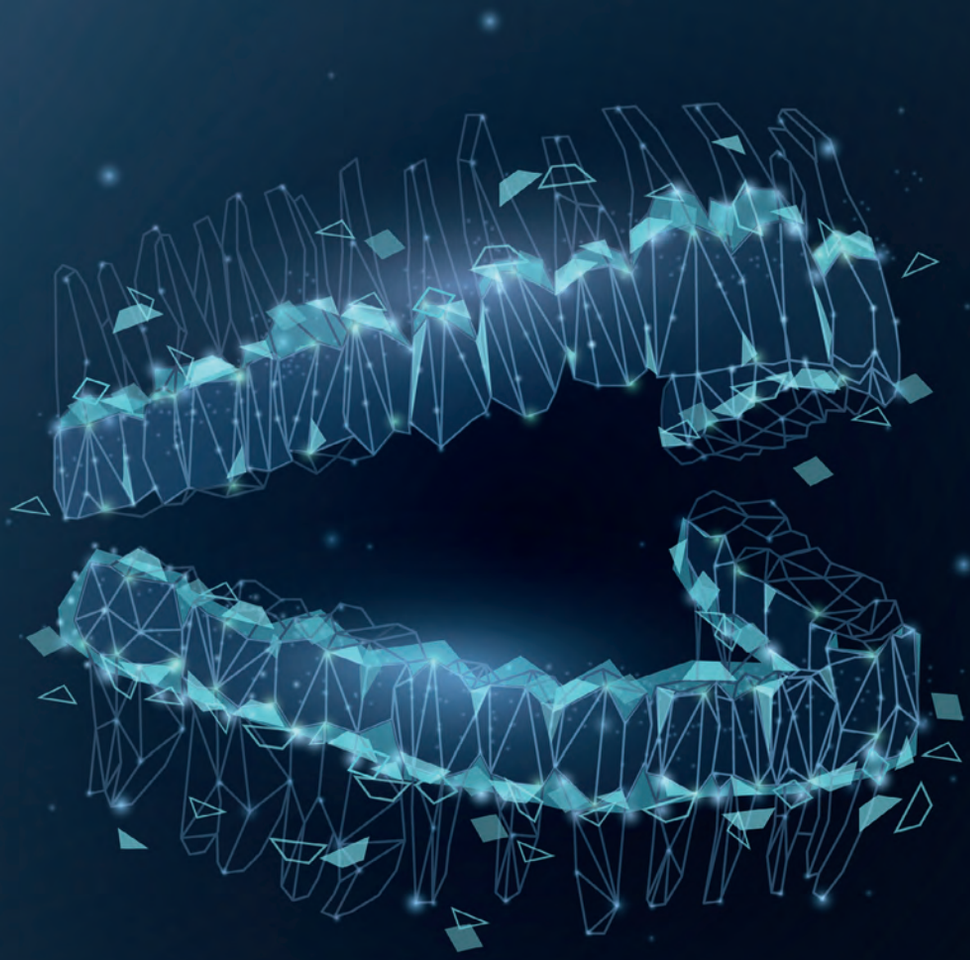
The Dentistry Show



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AI isn't just for clinicians

By cutting admin with digital tools, leaders can focus on people, patients and results, while protecting their own mindset to stay proactive, says Patrycja Galonzka

Patrycja Galonzka
Award wining practice manager

Speaking to healthcare leaders across the UK, I hear the same question: 'How do I stay relevant when AI is changing everything?'

The real challenge: it's not about the tech. AI won't replace leaders, but leaders who embrace AI will leave the rest behind.

Recent headlines focus on scanners, digital workflows, and reception automation – innovations that are shaping the future of dentistry.

But before any of these tools can make a real impact, the groundwork is laid behind the scenes: in strategic planning, in team meetings, training sessions and those quiet moments when leaders wonder: 'How do we lead through this?'

At the same time, those expected to lead this change must also learn about the AI era, not just to help others, but to improve their own performance.

By cutting admin with digital tools, leaders can focus on people, patients and results, while protecting their own mindset to stay proactive and truly enjoy their work.

On social forums, I see managers overwhelmed by workload, people's challenges, and lack of systems.

They are asking for checklists and support. Many say they are relieved not to be managers anymore.

Others offer support, but the sense of burnout is real.

Modern leadership foundations

Today's dental leaders need more than clinical expertise, they need a digital mindset rooted in:

- Openness to change: welcoming new tools as opportunities, not threats
- Empathy: listening to team concerns and supporting their growth
- Clarity: building simple, repeatable systems for digital workflows
- Empowerment: involving the whole team in adopting new tech.

Mindset: resetting the settings

Digital transformation isn't just about efficiency. It's about mindset.

In a recent Mel Robbins podcast, the discussion focused on how mindset operates like the settings in our brains, filters we can adjust.

The leaders who thrive aren't the ones with the fanciest tools, but those willing to reset those settings and lead their teams with clarity and confidence.

This is where authentic authority comes in. Modern leaders don't pretend to have all the answers; they model growth, openness, and resilience.

Mindset is the foundation for adapting to change, supporting your team, and protecting your own energy.

A framework for leading now

The CESAR framework is designed to help dental leaders thrive in the AI era: build high-performing teams, create systems that work (and prevent firefighting), lead with calm authority, protect your own mindset, deliver an exceptional patient journey, and drive business results.

Culture first: building trust in change

At Aspire Smiles, our journey started with honest conversations.

We talked openly about what was changing, why it mattered, and how we would support each other.

That is the heart of CESAR; a people-first approach guiding every digital decision we have made.

We have been using Synthesia to create training videos for our team

Change can trigger resistance or curiosity; it is our job as leaders to turn anxiety into engagement.

We are also clear about our 'anti-values', what we won't accept, as much as what we stand for.

Empowerment: training as a journey

Empowerment is not a one-off event. It is a series of small, supported steps.

For us, that means digital handovers, practical checklists, and encouraging every team member to use digital tools safely and confidently.

Training is provided in manageable, regular sessions so everyone feels equipped to contribute and grow.

I have been using Synthesia to create training videos for our team.

This is not just about saving time (though it does that, too). It is about making training more accessible, consistent, and engaging for every team member, no matter their schedule or learning style.

Systems: simplicity and consistency

Systems keep the wheels turning. We document every workflow and review them regularly with the team.

Simple, repeatable systems replace firefighting and keep everyone aligned, even as things change.

Authentic authority: leading by example

I make a point of sharing my own learning curve, because authentic authority means admitting you don't have all the answers, but you are willing to figure them out together.

It is about transparency, calm presence, and honest feedback, especially when the path ahead isn't clear.

Results: more than efficiency

AI isn't here to replace practice managers. It is here to help us lead better if we are willing to adapt, empower, and build systems that work for people, not just processes.

If you're navigating the digital shift and want to talk frameworks, real-world challenges, or where to start, I'd love to connect.

Reach out on Linkedin, and let's move the conversation and our profession forward.

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New NHS dental contract for England – still more questions than answers

On a recent Practice Plan webinar hosted by Nigel Jones, Chris Groombridge and Simon Thackeray, were inundated with questions about the unscheduled care element of the new NHS dental contract for England

Nigel: There is a huge demand from practices for information about the new contract.

Chris, I suspect that you've looked very carefully at what the detail is so, could you explain how you see things, please.

Chris: What's happening in simplistic terms is, 8.2% of the contract that you currently have will become for urgent care and the remainder, 91.8% will be for routine care.

So, you'll have two targets and you will have to deliver a minimum of 96% on both. So, that is what fundamentally is going to change.

Obviously, routine care will be slightly reduced by 8.2% and urgent care will go.

Having said that, most practices deliver an element of urgent care. The Department of Health themselves believe that's about 7% nationally, so it's a slight increase for practices. It's not so much about the percentage. I think 8.2% is quite a fair, sensible figure.

It's the impact that the direction of travel is going forward and what that says to the profession and to patients.

Nigel: And the 8.2%, Simon, my understanding was that the government was pushing for a lot more than that.

Simon: Yes. I think the BDA has done a fantastic job to keep it down. I've been a critic of the BDA at times, but I sit on the GDPC (General Dental Practice Committee) and they've been the people who have negotiated via the executive.

I suspect that the government probably wanted something in the region of 25%, and I've even heard 20% mooted previously. Of course, it depends on how you define 'emergency care'. This is not just urgent care, the government's calling it 'unscheduled' care.

So again, this is going to be one of these things where the devil is in the detail.

'Unscheduled care' for me is the patient who came in today for a crown resub who was one of my regulars.

We've trained a lot of our patients quite well and when you look at that, I don't think 8.2% will be a difficult target for a lot of practices to reach.

In fact, you might find that they do more than that. Of course, when that happens effectively this is now going to eat into your normal or your second target, which is your routine care.

Chris: I'd like to point out you can overperform on the urgent care target, which in turn feeds into your routine, but you cannot do it in reverse.

This is targeted at your own patients, which you can focus on and 111, it's a combination.

The appointments can be slotted anywhere, which is far better than blocks. What they originally proposed was blocks.

If you work out what the DNA/FTA (did not attend/failed to attend) rate of £15 means, that £15 equates to roughly five minutes of surgery time.

So, if you'd done blocks, you'd end up with a £75 loss per DNA. It just doesn't make economic sense.

By allowing you to slot them in where you want, that makes the DNA rate suddenly a viable option.

Simon: It's going to be better than it has been. Although £15 pounds is still an insult.

One of the issues will be who has access to getting those patients in?

There has been talk about giving the Integrated Care Board (ICB) access to your appointment book and they can book this type of appointment.

This isn't on from a data protection point of view. Some people will be concerned that this might be the intention.

You know as well as I do, Chris, some of the ICBs aren't necessarily consistent in the way that they deal with things. So, it wouldn't surprise me if one ICB goes rogue and says: 'Right, we want access to your computer system so we can book those patients in.'

Chris: The gist of what will happen is the ICB will approach each practice, and they will agree some regular times to slot 111 patients in.

Equally, you can just focus on your own patients, and you might be able to deliver the target of 8.2%. A lot of practices will look to do that.

That means the slots will vary as it will be ad hoc to maximise appointment space and minimise DNA.

Inevitably that means where they put those patients will be varied for a lot of practices.

Nigel: In the press it says about providing 8.2% for urgent care. Is that going to be on patients registered at your practice or will you have to take on new patients for that part? So, if 111 phones up and says: 'We have a patient that needs to be seen', what will happen?

Chris: That will be a conversation between you and the ICB.

The Department of Health and Social Care is working out what 8.2% looks at with the ICBs at the moment. They will then in turn contact you, at which point you will know whether you're going to be able to achieve it on your own patients, or you're going to take a combination of 111 and your own patients, or solely 111.

It will be up to the practice to work out how it delivers that urgent care.

Simon: There isn't any registration in this contract. There hasn't been any registration since 2006, so theoretically you only have regular patients, you don't have any registered patients.

So, if you had capacity, then that capacity can be filled by an 'unscheduled' patient.

I don't think you'll be able to say: 'I'm reserving this slot because one of my regulars might ring up with a problem'. You have to achieve 8.2% and at the end of the year if you're struggling for those percentages, which you probably won't be, you're going to need to see all and sundry.

The intention of this contract is to increase access for those who currently can't get access.

That is evident in the fact that they're bringing in these new care pathways to get the more complex patients treated as well.

Nigel: The lack of notice for people to wrap their heads around the business implications feels wrong, if I'm honest. I also think the core competency seems to be more about contract management and fine print nowadays.

There seems to be a great need for more clarity on this aspect of the changes. Let's hope we get it. Thank you both.

Understanding your dental practice's true value

Henry Strevens explains what influences the true market value of your business, and how it may be more nuanced than you think

Henry Strevens
Director at Frank Taylor & Associates

There is a school of thought that an item's worth is solely based on what someone is willing to offer for it.

Its value is determined by the highest price a buyer is prepared to pay at any given time, rather than by cost, sentimental value or estimated worth.

However, this overlooks a key point: a sale cannot proceed without both the seller and the buyer agreeing on a price beforehand.

And this involves a collective evaluation of both tangible and intangible factors.

In a dental practice, value lies in the physical space and location it occupies, as well as the nurtured relationships and brand reputation it has built. Even in its potential for growth and goodwill.

And, while some areas can be improved through smart management and strategies, others remain beyond the sphere of influence.

1. Location

Location is crucial. Urban and suburban areas typically command higher prices due to greater demand, convenience and easier recruitment.

Areas with strong transport links or within commuting distance are preferred, as 95% of buyers are unwilling to move simply to acquire a practice.

Socio-economic status also plays its role. As a result, remote practices can take longer to sell.

However, post-Covid, more buyers are eyeing quieter places for that all-important better work-life balance.

Some believe outlying areas offer potential for healthier profits due to lower costs and less competition on their doorstep.

2. Income type

Understanding how a practice generates revenue is crucial for potential buyers, and the income mix (eg, NHS, private, plan-based, or mixed) is a key consideration.

Financial metrics such as gross fees, core expenses, net profit, EBITDA (earnings before interest, tax, depreciation, and amortisation, typically the bottom-line profit), and the reconstituted net profit are vital for evaluation.

Quality standards, cost efficiency and obligations related to existing NHS contracts may also influence these figures.

3. Type of dentistry

Service offerings and patient base are key considerations.

General dentistry is highly profitable and stable, commanding the largest market share.

By contrast, specialised fields such as orthodontics, endodontics and periodontics serve smaller patient bases, often resulting in lower valuations.

However, specialised practices are attracting specialised dentists. An orthodontic clinic can achieve higher profit margins and promises steady patient flow, especially if it has invested heavily in cutting-edge technology and enjoys strong referral networks.

4. Financial performance

A practice's financial performance, including income stability, profitability and clinician-generated fees, provides invaluable insight.

Evaluating core costs, such as wages, lab expenses, materials, property and marketing, is essential.

Strong financials reflect effective management, consistent revenue and diligent cost control, all of which enhance value.

Transparent, well-maintained accounts will foster confidence and trust among potential buyers.

5. Size of practice

Size matters. A practice with only one surgery may be less attractive due to limited expansion opportunities, whereas more than five surgeries can be perceived as overwhelming.

The optimal range is typically three to four surgeries, which balances growth potential with manageability.

Additionally, size can affect budget and is therefore a key driver of income, ultimately influencing valuation.

6. Property

The ownership structure is crucial. Owning both the business and the building outright may entail higher initial costs but offers greater security than leasehold arrangements, which are constrained by lease terms that can limit value and flexibility.

Lenders prefer freehold properties. Consider whether the business can finance the freehold without incurring high costs, and whether renewal on fair terms is feasible if the property is leasehold.

The potential to expand or convert part of the property from residential use can influence valuation.

Pre-emption rights, which give third parties first refusal, may also affect value.

7. And the rest

Peripherals that may seem unimportant, such as opening hours, parking and a strong brand, are in fact your key hidden assets that enhance accessibility and patient satisfaction – and attract more patients.

An active social media presence and a user-friendly website build recognition and loyalty, while growth signals expansion potential and long-term value.

These 'quiet' factors help shape your dental practice's overall worth.

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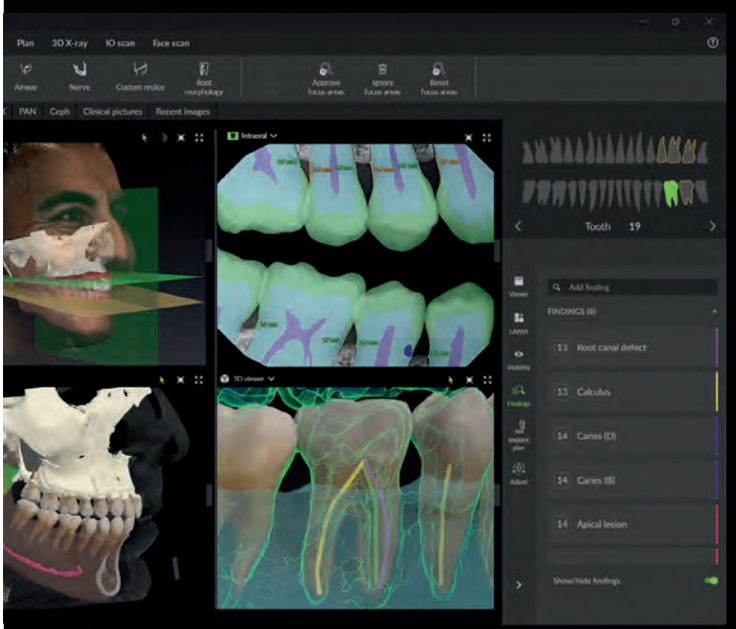

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Rhythm before rush: creating calm, predictable workflows

You cannot control 80% of what walks through the door, but you can control the rhythm, says Mark Topley

Mark Topley
Founder Great Boss Academy

Stop at a motorway services just before nine o'clock on a weekday morning and you will often see something worth noticing. The managers of each outlet in the building are standing together in a brief huddle.

No chairs. No laptops. Ten minutes, sometimes less. Then they are gone, back to their teams, and the day begins.

It is not glamorous. But it works. And it works precisely because it is predictable.

That small scene captures something that many dental practices are missing – the habit of deciding how the day is going to go, before the day decides for them.

The problem isn't the chaos

Ask any principal dentist or practice manager to describe a difficult week and the answer is usually the same.

Someone rings in sick. A patient runs late and throws the diary. Equipment fails. Team friction surfaces at the worst possible moment.

And in the middle of all of it, the person responsible for the practice is expected to lead calmly and make good decisions.

The chaos itself is not the real problem. A dental practice is a fast-moving, people-heavy environment and disruption is part of the territory.

The problem is what happens when leaders allow the day to happen to them, rather than deciding in advance how they are going to shape it.

You cannot control 80% of what walks through the door.

But there is 20% you can control and when you take deliberate ownership of that 20%, it changes the feel of everything else.

That 20% is your rhythm.

What rhythm looks like

Patrick Lencioni, in his work on meetings and organisational health, makes a great point that applies directly here: the problem in most organisations is not too many meetings. It is the wrong kind, happening at the wrong time, for the wrong reasons.

When leaders try to deal with everything in one unstructured conversation nothing gets resolved properly. People leave without clarity. The next conversation starts where the last one ended.

A simple rhythm prevents that. It does not need to be complicated. It needs to be consistent.

Start with a daily stand-up – the practice equivalent of what those motorway services managers are doing every morning.

Five to 10 minutes, on your feet, before the clinical day begins. The agenda is tight: what does the day look like, what are we watching for, is there anything we need to know now?

It is also worth building in 30 seconds to anchor the team to what good looks like.

A brief reminder of how you expect people to show up, and a specific call-out of something you have seen done well in the last day or two. Just a genuine, named example: 'Yesterday I noticed how Sarah handled that nervous patient, that's exactly the kind of care we are here to give.'

That habit, done consistently, does more for culture than any team away-day.

Issues that need more than 30 seconds get taken offline. The point is alignment, not analysis.

Back to those services. At some, the huddle is short and operational, just the day ahead. At others, it runs slightly longer and includes numbers from the previous day, target updates, anything strategic that needs flagging.

Both versions work, because both versions are deliberate. One is about running the day. The other is about running the week.

In a dental practice, that maps onto a Monday rhythm, a slightly longer team or leadership check-in that sets the tone for the week.

Diary pressures, staffing considerations, anything carrying over from last week. Give it a fixed end time and honour it.

Then protect your time throughout the week. Build in short, regular check-ins with key people rather than leaving your door open to whoever needs you most.

This is not about being unapproachable. It is about making sure that when people do have your attention, they get the best of it.

End the week with a brief review. What went well, what needs adjusting, what can be closed out now so it does not carry into Monday?

Five or 10 minutes. Simple.

Why people resist this

The pushback, from both principals and practice managers, is consistent: 'I've got enough to do. I don't have time for more structure.'

That feeling is real. But it is also the reason the rhythm matters.

The leaders who say they are too busy to build routine are usually the ones spending their days in reactive mode, managing problems that a bit of forward structure would have reduced.

They are not too busy for rhythm. They are too busy without it.

Structure does not add pressure. Done well, it absorbs it.

What changes when it works

The first thing people notice is not productivity. It is the chance to breathe. A sense that the week is something they are shaping, rather than something being done to them.

The team feels it too. That has a real effect on retention, on culture, and on how the practice handles genuine emergencies when they do arrive.

You will still have weeks where everything goes wrong. Rhythm does not prevent that.

What it does is give you a foundation to return to, so you are rebuilding from structure, not starting from scratch.

Control the 20% you can. Let the rhythm do the rest.

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Stress, anxiety, burnout – developing resilience

Lisa Devine and Hafeez Ahmed reflect on their personal experiences and how they achieve a measure of balance and peace

Lisa Devine
Sports and holistic massage therapist

Hafeez Ahmed
Specialist periodontist

Mental wellbeing is as personal as the individual.

It's best regarded as an ongoing conversation leaving mental health experts somewhere in the backdrop.

We say this not disrespectfully but because although the mental health experts have established standardised diagnostic labels to facilitate research and insurance, the field is characterised by deep, ongoing disagreements regarding almost every other aspect of mental health and mental health care.

In addition to this, conditions in the workplace have never been better than the present moment.

Eliminating undesirable behaviours from the workplace has been an ongoing process active since forever. Yet claims of coercion, bullying, stress, and burnout continue to rise and rise.

Burnout

Inspiration behind this article is a psychiatrist who specialises in burnout in doctors, dentists and vets.

The psychiatrist, contacted Dr Hafeez Ahmed shortly after she'd finished reading his book *The Philosophy Fridge*. She was concerned that having blown the whistle at work, endured the experience and published a book about it, it was inevitable that he'd be burnt out. That's the rule apparently.

Remarkably, much to his surprise, Dr Ahmed avoided burnout and considers that recalibration of childhood conditioning.

Holistic massage played a helpful role – although chronic back pain remains an issue.

The word burnout implies it's terminal and for some people this is true. However, it can be fluid and transient.

The main difference is one's mindset and ones' relationship with stress and anxiety.

How each of us associates with stress and anxiety is very subjective and based purely on conceptual theories.

To complicate matters further, most of us find it difficult to differentiate, within ourselves, emotional distress from mental distress from psychological distress.

Stress

Stress is relative. Its effect is perceptual.

The word describes a force, usually a tension. It often results from injustice and perceived injustice.

It's also often a mismatch between a person's reality and their expectation of how they would like their reality to be.

It results from many things like inequality in the workplace.

That said, often, some people enter the workplace pre-loaded with stress. Work is their escape from stress at home.

Survival requires an adjustment in expectations and a sense of relative perception.

Therapy and massage can be very helpful; it acts by releasing some of the tension from the muscles and joints.

'Some of the damage is irreversible, the imagination and faith required to tackle the recalibration of the conditioning is like taking a tiger by the tail – defeat feels inevitable'

Anxiety

Research shows numbers of people diagnosed with mental health disorders continue to rise and rise, with most of the disorders having an association with anxiety.

The website www.femh.net is one of many similar organisations typically set up by psychiatrists frustrated by the failings of traditional psychiatry.

Their opinion, broadly, is anxiety needs to be reconsidered. They argue that reconsidering what nature intended the natural purpose of anxiety to be, may hold clues to a potential solution.

One sign of the misconception is that people in general and professionals alike use the word anxiety and the phrase anxiety dysfunction to mean the same thing.

They are not the same, anxiety is natural, anxiety dysfunction isn't. Anxiety isn't the problem; anxiety dysfunction is.

Reading for self-directed personal development

Our book recommendations are:

1. ***Nosedive – An Unconventional Rescue*** it's published anonymously but we know both the authors. It's the kind of book we wish we'd been forced to read and discuss with our peers and teachers and, perhaps, even with our parents
2. ***The Chimp Paradox*** by Professor Steve Peters is an excellent book. It's reasonable and logical, it's well written. It changed my life and made me feel as if I understood myself better
3. ***An Intimate History of Humanity*** by Theodore Zeldin helps you realise that: 'There's nothing new under the sun', and it helps defeat the modern thought: 'I can't be right unless there's something wrong with me'
4. ***The Blank Slate*** by Professor Steven Pinker discusses parenting styles by looking at the nature-nurture debate and how it's been distorted
5. ***Evolutionary Psychiatry Current Perspectives on Evolution and Mental Health*** by The Royal College of Psychiatrists England
6. ***Good Reasons for Bad Feelings – Insights from the frontier of Evolutionary Psychiatry*** by Randolph M Nesse. The American physician who with the book Why We Get Sick, established the field of evolutionary medicine
7. ***What Mental Illness Really Is... (And What It Isn't)*** by psychologist Dr Lucy Foulkes talks about excessive labelling, over-diagnosing and reimagining anxiety.

From the day we are born, anxiety has to be cultivated carefully like a rare plant liable to become extinct at any moment.

The function of anxiety in its broadest sense is to protect us from danger. Anxiety dysfunction on the other hand develops from parents attempting to shield babies from uncomfortable feelings.

Fear

Anxiety is associated with fear, aversion and avoidance. Some of this may be genetic and biological but most of it is conditioned in.

Personal construct theory by the American psychologist Dr Geroge Kelly has long held that everyone constructs a mental framework from which they see the world.

Its premise is a simple one: when we are born, we have no experience of sensations, every sensation is new, and the meaning of each one has to be conditioned into us.

In the beginning, the conditioning happens through the eyes, by a baby looking into mum's eyes. The baby has no control over it.

The mum conditions the baby based on her ideology of discomfort, and her desire to use her privilege to help the baby avoid it.

This is where it gets complex, fast. The natural function of anxiety broadly speaking is to protect us from danger. When the mum overextends her natural desire to protect the baby, she conditions the baby to avoid discomfort, she conditions the baby to protect itself from uncomfortable feelings.

Anxiety is designed to protect a baby from danger – it's not designed to protect a baby from uncomfortable feelings.

This isn't true for everyone as there are many ways the conditioning process results in dysfunction. Some parents neglect their children, some abuse their children, these undesirable approaches can also result in anxiety dysfunction.

Sadly, balance is rare. Balance is not only rare, it's difficult to achieve due to what experts call 'transgenerational trauma'.

For his part, Dr Ahmed learnt that the clashes with his wife were less than ideal for his children's conditioning. He has since apologised and regrets it, deeply.

Some of the damage is irreversible, the imagination and faith required to tackle the recalibration of the conditioning is like taking a tiger by the tail – defeat feels inevitable.

Another reason is that memories are unforgettable. In Dr Ahmed's observations, anxiety dysfunction is the gateway to all mental health disorders. Except in a tiny number of people who are born with a true neurological defect.

Emotional distress

Emotions and eating go hand in hand. Emotions change how we experience food.

It's rare to meet anyone who hasn't at some stage in their life experienced a manner of eating which is undesirable. It can be a cry for help.

The key to the emotional enterprise is anxiety. Anxiety is the pre-emptive emotion that subsumes all other emotions, and it suffuses our every perception.

The gut is the canvas upon which anxiety instruments act out and the gut has often been called the second brain.

Each of us has our own emotional challenges, for his part Dr Ahmed was born into a particularly abusive environment, rich in physical, emotional, mental and psychological abuse.

Yet he believes all it did was tilt his attitude and ambition. It allowed him to develop more realistic expectations of reality. It was unfortunate and undesirable as it resulted in a psychotic episode.

It also left a legacy which makes him sensitive to his attention deficit hyperactivity disorder (ADHD) personality characteristics.

We are all born with all the ADHD characteristics. The characteristics aren't the problem, failing to live within the parameters of the characteristics is the problem. The smaller legacy is that under pressure some of his natural behavioural characteristics defy social constraints.

We are all born with behavioural characteristics which fall on a spectrum. Failing to get attuned to our own needs and failing to live within our natural behavioural characteristics often results in a misdiagnosis of autism.

Psychological distress

It's when you do something without even knowing you're doing it.

It's when your mind makes your body do something without you even knowing you're doing it. It's when your mind makes your body do something without you being able to see the link.

For Dr Ahmed, during the whistle blow experience, his gums went painfully crazy displaying ulcers, blotches, erosions, swellings.

It was far worse than pregnancy gums. It was an immunological glitch, a breakdown between the mind and endocrine glands.

He had a firsthand experience of what he coaches his patients to manage.

It helps to remember that however you look at it – top to bottom, front to back – it's the same tube, full of bacteria designed to break things down. Designed to destroy.

Dr Ahmed experienced problems with his stomach, gut and for good measure his bladder occasionally malfunctioned. He experienced rancid eyes, leaky gut, myalgic encephalitis, irritable bowel syndrome, and then, after the Covid-19 jab, a protracted episode of chronic fatigue syndrome.

In his opinion, it was the outcome of every moment of his life up to that point.

It helps to remember that most episodes of most emotional and psychological issues are situational. They are fluid and transient, they are a sign that adaptation is required.

Exercise, stretching and meditation

A common adage is 'move your arms and legs and forget to be'.

Exercise is great for circulation, it's great for the heart, it purges the toxins and maintains strong bones and supple muscles.

Unless you've been diagnosed with chronic fatigue syndrome – then it makes your hard stiff painful muscles even more painful.

Otherwise, exercise maintains health, it prevents diseases, it's beneficial to the body, the mind, and your sanity. All scientifically proven.

For dental professionals, it can help to do some light exercise and stretches between every patient.

Lisa has put a selection of exercises and stretches that can be done between patients in a blog on her website: www.therapyandfitness.co.uk.

During meditation is a good time to deploy jaw muscle relaxation techniques to limit the amount of jaw clenching and tooth grinding, both of which are an embodiment of stress.

To contact the authors, email lisa@therapyandfitness.co.uk and binswoodhousedentalpractice@btinternet.com.

Dealing with your first complaint

Unfortunately, complaints are commonplace, but it can still be daunting receiving your first one. Bryan Harvey explains how to manage them professionally and appropriately

Bryan Harvey
Senior dento-legal adviser at the Dental Defence Union

We know how upsetting it can be to receive a complaint at any stage of your career. But it can be even more distressing when you are a newly qualified dental professional starting your career.

While it is understandable that you may take a complaint to heart in the early stage of your career, talking it through with more experienced colleagues and getting the early support of your indemnity provider will be hugely helpful in keeping the matter in perspective.

Here's what you need to know after you have received a complaint.

What is a complaint?

The NHS complaint standards define a complaint as 'an expression of dissatisfaction, either spoken or written, that requires a response'.

Consequently, if a patient makes you or any other member of the team aware they are unhappy with any aspect of your service, you would be wise to treat it as a complaint.

Who can make a complaint?

The patient, the patient's parent or other person with parental responsibility if the patient is a child, or the patient's properly authorised representative can all legitimately make complaints.

If a third party is complaining on behalf of the patient it is especially important to establish their right to do so before responding, in order to preserve patient confidentiality.

Why might someone complain?

Dissatisfaction with the treatment or service, or a failure to meet patient expectations (which may or may not be reasonable) underlie just about all complaints.

Many complaints arise from misunderstandings due to difficulties with communication, such as not explaining what is involved in carrying out the treatment in a way the individual patient fully understands.

Additionally, a perception of a lack of courtesy and human empathy, of rudeness, indifference, callousness or aggression sometimes form part of a complaint, or can even be the sole issue.

How to deal with a complaint

Don't react defensively to complaints. They should be dealt with calmly, constructively and in line with the practice complaints procedure. In Standard 5.1.6 the GDC explains that a complaint can be an opportunity to improve your service.

We can all learn from patient feedback, be it positive or negative, as part of our ongoing learning and professional development.

Remember it is good practice to share lessons learnt with all team members and remember to keep a written record of all complaints, and file complaint correspondence and documentation separately from clinical records. Patients can complain verbally or in writing. If a patient makes a verbal complaint, then try to discuss it with them there and then, if possible.

Alternatively, arrange a follow-up conversation, to ensure the patient feels they are being listened to.

If you receive a verbal complaint, you should make a written record of the complaint rather than ask the patient to put it in writing themselves, as this can risk escalating the situation. As with any complaint, reassure the patient that whatever they say will be treated sensitively and in confidence, and will not prejudice their future care.

A carefully worded response to a written complaint can often help prevent the complaint progressing further.

Do contact your indemnity provider as soon as you are aware of any complaint for guidance on how to manage the situation for the best outcome.

A response should address all the significant points raised by the patient, and offer a suitable solution.

Also, consider what outcome the patient wants, and if in doubt, ask them to specify what they're seeking. Asking this does not commit you to providing anything they request.

Your complaints checklist

- Are your responses to complaints timely, professional, measured and sympathetic?
- Have you offered the patient an initial discussion to resolve the complaint?
- Have you provided a full, detailed response to the patient?
- Has the complaint been signed or overseen by the responsible person, or someone with delegated authority?
- Have you recorded what action has been taken in response to the complaint?

For more information on starting your career as a dentist, visit the DDU's student hub.

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The emotional burden of the hygiene appointment

Simone Ruzario explores why supporting dental hygienists and dental therapists wellbeing is essential for the future of prevention-led dentistry

Simone Ruzario
Dental hygienist and dental therapist, as well as president-elect of the British Society of Dental Hygiene and Therapy

At first glance, a dental hygiene or dental therapy appointment can appear routine. A patient arrives, clinical assessments are completed, preventive advice is shared and treatment delivered before the next patient is called in.

However, those working in these roles know that the reality is often far more complex.

Dental hygienists and dental therapists frequently move through tightly scheduled appointment lists, sometimes seeing patients back-to-back throughout the day.

Within each appointment there is a need for clinical precision plus reassurance, communication and encouragement.

Over time, this combination of physical concentration and emotional engagement can create a cumulative load that is rarely visible from the outside.

As a profession, we often talk about promoting health for our patients but supporting the wellbeing of the professionals delivering that care is just as important.

Hidden demands

Dental hygienists and dental therapists occupy a unique position within the team.

Prevention sits at the centre of their role, which means appointments frequently involve conversations about oral hygiene, lifestyle factors and long-term health.

While these discussions are fundamental to preventive care and often rewarding, they can also carry a significant emotional demand.

A cross-sectional survey of 1,507 members of the UK dental workforce, published in the *British Dental Journal*, found that 61% of respondents reported high levels of emotional exhaustion, a key component of burnout. More than one-third of respondents showed symptoms suggestive of depression, while 8% met criteria for occupational burnout (Knights et al, 2025).

Supporting wellbeing

Recognising these pressures brings the realities of modern clinical practice to the fore and reinforces the importance of supporting the wellbeing of dental teams.

This benefits not only clinicians themselves, but the entire practice environment, including patients.

Practical adjustments within the practice can make a meaningful difference.

Realistic appointment scheduling, protected breaks and appropriate treatment times help reduce the intensity of continuous clinical work. When clinicians feel they have adequate time to provide care properly, patient interactions often improve as well.

Dentistry has traditionally been a profession where individuals feel pressure to remain resilient at all times, which can make conversations about stress or wellbeing difficult to initiate. Open dialogue and supportive leadership can help normalise these discussions and ensure that team members know where support can be found.

Alongside such practice-wide changes, individual clinicians can also take practical steps to support their own wellbeing.

Taking proper breaks, including stepping away for lunch, allows clinicians to reset both physically and mentally during busy clinical days. Basic needs should not be overlooked either; skipping toilet breaks or remaining in static postures for prolonged periods can contribute to fatigue and discomfort.

Short moments to stretch, move or adjust posture between patients can help reduce physical strain. Even a brief walk outside during lunch can provide fresh perspective and mental space away from the surgery.

Simple breathing techniques may also help during particularly demanding sessions, allowing clinicians to release tension and refocus before welcoming the next patient.

Care begins with the team

Dental hygienists and dental therapists are central to prevention-led dentistry. Our work improves patient understanding, supports the wider dental team and contributes significantly to long-term oral health outcomes.

Ensuring that these professionals feel supported and able to maintain their own wellbeing is therefore not simply beneficial for the workforce. It is fundamental to the future of preventive care, because when clinicians are well, they are better able to help others stay well too.

For a list of references email seb.evans@fmc.co.uk.

The British Society of Dental Hygiene and Therapy (BSDHT) provides valuable opportunities for connection, education and peer support for dental hygienists and dental therapists throughout their careers. Visit bsdht.org.uk for more information.

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The power of giving

Carol Somerville Roberts explains why she has chosen Bridge2aid as her presidential charity for the year and how the organisation is transforming dental care across Tanzania

Carol Somerville Roberts
President of the British Academy of Cosmetic Dentistry

There are many dental charities doing exceptional things around the world.

As the President of the British Academy of Cosmetic Dentistry (BACD), I have selected Bridge2aid as my chosen charity this year; a wonderful organisation that aims to reduce the disparity in dental access for people in Tanzania.

Their work isn't just worth a read – it's worth our support. Bridge2aid first came to my attention many years ago through the BACD.

I know colleagues who participated in a fundraising climb of Mount Kilimanjaro for the charity, and then, last year, I found out about another Bridge2aid expedition: cycling 330km from Kilimanjaro to the Ngorongoro Crater.

I got involved and completed it earlier this year – our group of 20 raised £80,000, shattering our target, to fund a new dental clinic.

The challenge

Tanzania has approximately 600 dentists, most of whom are based in the cities, to provide care for nearly 70 million people.

The focal point of Bridge2aid is training dental therapists with more advanced skills; upscaling them so more rural communities can receive dental treatments.

This is done with the support of local agencies and the donations given to Bridge2aid.

Following the completion of the cycling challenge, I was able to visit the new dental clinic and see its success.

While basic in design, with extension cables and bits of tape scattered around to keep it going, the clinic had not compromised on effectiveness or sanitisation. Equipment donations from UK dental companies help to provide excellent treatments.

Able to treat patients quickly and efficiently, it was a fantastic feeling to see what happens when we put our minds together.

How dentists can make a difference

There are lots of ways in which we, as a profession, can help bridge the divide in international dental care. You just need to find the charity that resonates with you.

This could be supporting wider members of the dental team or suppliers, or finding organisations that enable you to become an educator and train others, or to visit areas and deliver life-changing treatments in-person. A lot of dentists are in a position to give. For Bridge2aid, becoming a Unity partner is an excellent way to bring more dental care opportunities to Tanzania.

This involves an annual commitment of £250 a month (£3,000 a year) and goes towards the training of a dental therapist.

Between 200-300,000 potential patients can be seen each year for every new dental therapist, so the impact is immediate and long-lasting.

Fundraising opportunities such as the cycling challenge are unforgettable experiences too, building a strong sense of community.

These aren't always abroad either – this June there will be a Bridge2aid charity bike ride in Glastonbury that you can get involved with!

Looking ahead, Bridge2aid will continue to expand outwards.

The focus will pivot from treatment to the importance of prevention and education; to stop problems before they present themselves.

Bridge2aid is a fantastic entry point for those wanting to give back. Afterall, the thrill of giving lasts a lifetime.

For more information, email shaenna@bridge2aid.org and to become a unity partner today.

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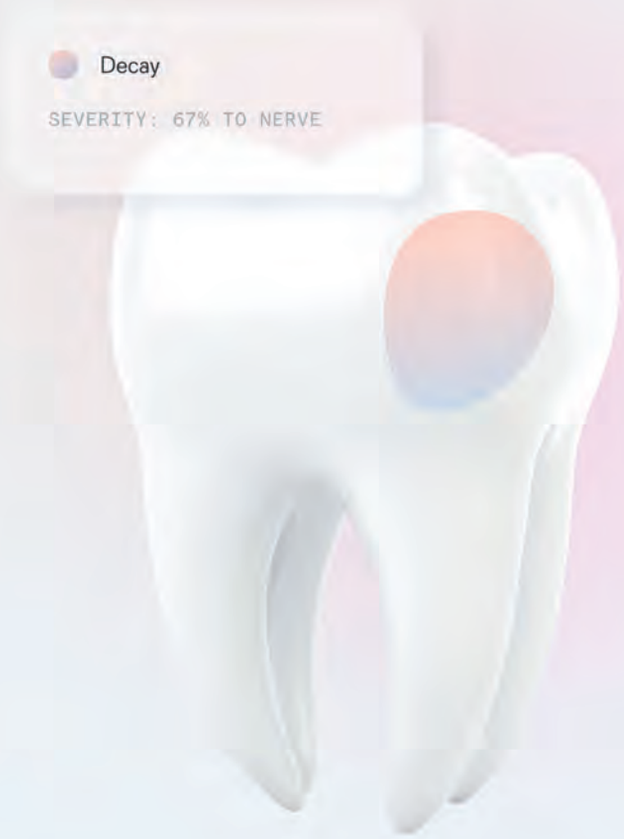
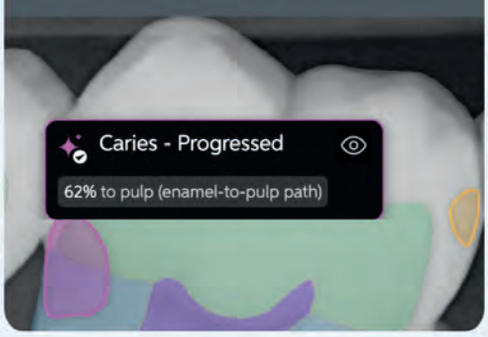


"With Second Opinion, my patients leave confident, not confused. We're all working from the same page, and that's the foundation of trust and quality care"

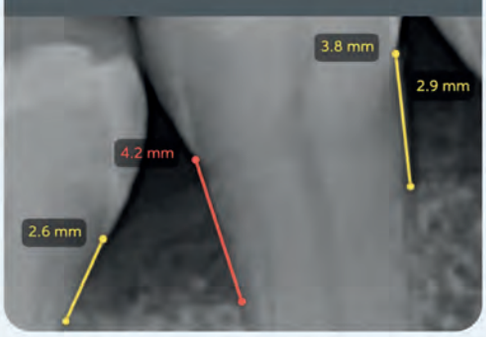
Dr. Kunal Rai, Meliora Dental

KEY FEATURES

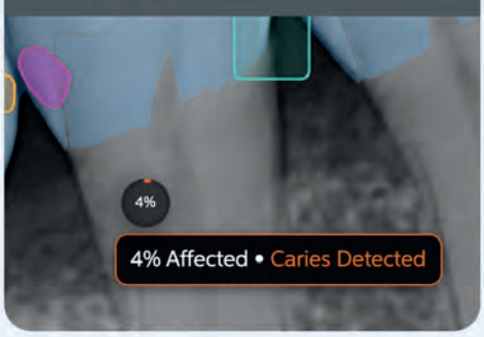
Decay Penetration %



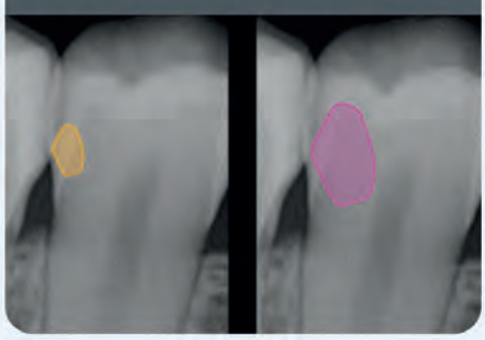
Bone Levels



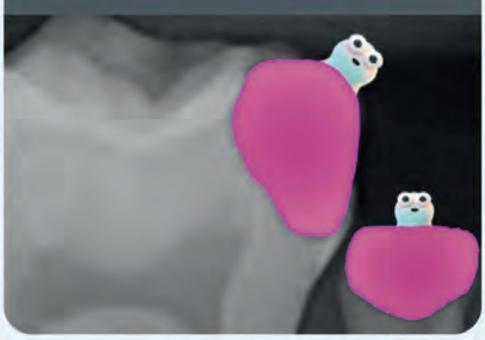
Affected Tooth %



Progression Viewer



Kid-Friendly Case Presentation



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Sexual safety in dentistry – what every practice needs to know and do now

Pat Langley outlines what compliance looks like in practice – and where practice owners, their teams and their patients are most at risk.

Pat Langley
Clinical director at Dentistry Practice Services

Dental practices with an NHS contract in England should sign up to the Sexual Safety Charter by 31 March 2026.

There is no equivalent 'sign-up' requirement in Wales, Scotland or Northern Ireland and no requirement for private practices.

It's important to note, however, that while some of the drivers originate in NHS policy, the expectations apply just as much to private dentistry and wherever your practice is located.

Regulators are increasingly focused on how practices prevent, identify and respond to inappropriate behaviour involving both patients and practice team members.

A unique risk environment

Dentistry presents particular challenges when it comes to sexual safety.

Care is delivered in close physical proximity, usually in enclosed surgeries, and frequently involves anxious or vulnerable patients.

At the same time, team hierarchies and small practice settings can make it harder for team members to raise concerns.

These dynamics mean that strong professional boundaries, clear safeguards and a culture of openness are essential – not optional. As expectations continue to evolve, many practices are still unclear on what compliance looks like in day-to-day dentistry.

What regulators are looking for

Caring about and being able to demonstrate that you care about sexual safety in your practice is not just about what the regulators require; it's about making sure that you have mechanisms in place to ensure your practice feels safe.

There may be some misconceptions that sexual misconduct and sexual harassment are an HR issue only. This is not the case; both are safeguarding concerns (in addition to HR issues). For this reason, inspectors look at how this issue is managed across safeguarding, governance, training and day-to-day care.

In practice, this means dental practices must be able to demonstrate that they:

- Prevent inappropriate behaviour
- Respond promptly, effectively and appropriately when concerns arise
- Learn from incidents, and put measures in place to reduce the chances of a recurrence.

Culture

Culture is everything in all organisations, including dental practices.

Policies alone are not enough; culture is about what it feels like to work in your practice or your organisation.

That doesn't mean policies are not required; they are, and they should lay out 'how we do things in our practice'. It's then up to every practice team member to 'live' your policies.

A strong approach to sexual safety includes:

- Having a clear, visible sexual safety policy
- A zero-tolerance stance on sexual harassment and sexual misconduct
- A shared understanding across your whole team on what is unacceptable behaviour
- Leaders who model professionalism and reinforce professional boundaries
- Having an open and honest culture in which team members feel confident to speak up without fear of repercussions.

Reporting

Underreporting is one of the biggest risks in healthcare – and dentistry is no exception. Every practice should ensure:

- All team members know how to raise a concern
- Concerns can be raised confidentially
- Patients have clear, accessible routes to complain or raise a concern
- They know when escalation outside the practice may be required.

Training

Training is key; all team members should receive induction and refresher training. Designated leads also should receive additional training on receiving disclosures, confidentiality, record-keeping, risk assessment, interim measures, investigations and support.

Clinical safeguards that matter

In a dental setting, practical safeguards are critical.

In addition to a robust Sexual Safety Policy, these include:

- A sexual safety risk assessment that identifies risks, current mitigations in place and additional measures that may be required, especially following an incident.
- Clear, consistent communication around consent and professional boundaries.
- A clear chaperone policy.
- A clear lone working policy and risk assessment with guidance on 'checking in' procedures.

Governance: the leadership test

Practice owners and managers should review incidents regularly, put measures in place to reduce the chances of a recurrence, discuss sexual safety at meetings and evidence learning and improvement.

And finally...

It's worth remembering that failures in this area carry significant regulatory, reputational and workforce risks.

The practices that succeed will embed sexual safety into everyday practice and build safer, stronger teams.

If you would value additional support in managing compliance across your practice, book a demo to find out how Dentistry Compliance can help: dentistry.co.uk/compliance.

Root canal treatment made global headlines: let's not waste the moment

Recent global media coverage highlights why we must view endodontic therapy as a critical systemic infection control measure, explains John Barclay

John Barclay
North Wales based dentist with a special interest in endodontics

Root canal treatment rarely trends internationally.

Yet in January 2026, a paper in the Journal of Translational Medicine triggered coverage in over 800 news outlets worldwide.

The headlines were irresistible: root canals could lower blood sugar; they might reduce heart disease risk.

Predictably, the reactions split in two. Some celebrated; some rolled their eyes. Both missed the point. Because this isn't about promising cardioprotection. It is about finally acknowledging what endodontics actually is.

Infection is not decorative

Apical periodontitis is not a radiolucency.

It is a chronic inflammatory lesion driven by microbial infection inside the root canal system.

For years we have framed root canal treatment defensively: it relieves pain; it saves the tooth.

True, but incomplete. It resolves infection, and chronic infection is not biologically quiet. It stimulates; it signals; it provokes.

Systematic reviews have demonstrated that individuals with apical periodontitis exhibit elevated circulating inflammatory markers compared with controls (Gomes and colleagues, 2013; Georgiou and colleagues, 2019).

More recent pooled analyses show that successful endodontic treatment is associated with reductions in high-sensitivity CRP at six months and at 12 months (Jakovljevic and colleagues, 2025).

The recent metabolomic study that sparked the headlines reported broader shifts in glucose- and lipid-associated metabolites following successful treatment, alongside reductions in branched-chain amino acids and correlations with inflammatory markers and metabolic syndrome indicators (Zhang and colleagues, 2025).

Different methods, different lenses, but the same direction: remove the infection and inflammatory and metabolic signals shift.

Myth busting

There is another uncomfortable truth. Apical periodontitis has been associated with episodes of bacteraemia and measurable systemic inflammatory changes (Georgiou and colleagues, 2019; Zhang and colleagues, 2025).

The recent longitudinal metabolomic work demonstrated strong correlations between serum metabolites, inflammatory mediators and both intracanal and blood microbiome profiles (Zhang and colleagues, 2025).

That does not mean bacteria are continuously flooding the bloodstream. It does not mean root canals prevent heart attacks. But it dismantles the myth that periapical infection is biologically isolated.

When we instrument, disinfect and obturate a canal, we are not performing carpentry. We are resolving a chronic microbial stimulus. And microbial stimuli do not respect anatomical boundaries.

Let's be precise

Reducing hs-CRP is not the same as preventing a myocardial infarction. Altering branched-chain amino acids is not the same as curing diabetes.

We do not have event-based cardiovascular outcome trials. We do not have randomised systemic disease data.

But we do have consistent evidence that apical periodontitis contributes to systemic inflammatory burden (Gomes and colleagues, 2013; Georgiou and colleagues, 2019; Jakovljevic and colleagues, 2025).

And we have emerging longitudinal evidence that successful treatment reduces part of that burden (Jakovljevic and colleagues, 2025; Zhang and colleagues, 2025). That matters.

What we must not say

Not: 'Root canals prevent heart disease.' Not: 'This treatment will fix your blood sugar.'

Instead: 'You have a chronic infection at the root of this tooth. Chronic infections contribute to inflammation in the body. Treating this removes that source of inflammation. While research continues, maintaining oral health supports overall health.'

That is accurate. That is defensible. And that is powerful.

The real shift

The headlines were not entirely wrong; they were incomplete. Root canal treatment is not a cardiology intervention. But it is infection control, and infection control is never trivial.

Perhaps the bigger story is this: endodontics is the management of chronic infection.

And when inflammation is understood as systemic and networked, even modest movement of the inflammatory dial toward health is justification enough.

For a list of references email seb.evans@fmc.co.uk.

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Zirkonzahn's lecture tour comes to Edinburgh on 28 April 2026

Free two-hour lecture exploring the digital design possibilities of Zirkonzahn.Modifier

Under the title 'The full power of Zirkonzahn. Modifier - digital design advantages', Zirkonzahn's lecture tour for 2026 continues with its next stop in Edinburgh on 28 April 2026. Presented by master dental technician Alexander Lichtmannegger, this year's lecture explores the company's advanced design software, Zirkonzahn. Modifier, illustrating its latest features and seamless integration within the treatment workflows.

Zirkonzahn.Modifier was developed specifically for digital dental technology: by presenting two real patient cases, the lecturer will highlight how the software opens up entirely new pathways for digital designs, offering an intuitive and modular workflow that does not bind dental technicians to rigid project structures, but leaves them maximum flexibility. The first patient case focuses on a complete implant-supported restoration consisting of zirconia suprastructures and substructures.

Participants will gain insight into the design process including the Die & Implant module, the passivity check step and final characterisation with the new Colour Liquids Prettau Aquarell Boost.

Mounting in the articulator using intraoral scans and segmented files generated from the 'Bone Doctor' software module

The second case presents the digital workflow for creating ultra-thin Prettau Skin veneers. From the Mock-up module and Bone Doctor to the Veneer & Inlay module, the session will also cover the use of the Partial Planner module for designing gingivectomy guides.

Following the cases step-by-step, participants will be able to observe, amongst others, how the software's cutting-edge algorithms offer exceptionally natural and functional tooth setups that go far beyond standard solutions. They will also gain insight into the high level of automation and flexibility in data processing and editing.

The lecturer will explain, for example, how intraoral and laboratory scans can be automatically positioned in digital articulators, allowing occlusion and function to be evaluated directly during the design process. He will also illustrate how changes can be applied immediately within the ongoing project, and how models, constructions and scan data can be edited and adjusted in real time.

Part of the lecture will also be dedicated to the new Zirkonzahn.Archiv module in combination with the Zirkonzahn.App, The Head Tracker digital facebow and the new Qlone Dental Pro 3D scanner app, for taking facial scans from smartphones.

Meets GDC outcome C criteria

The two-hour lecture is open to both dental technicians and dentists and meets the criteria for the General Dental Council's (GDC) development outcomes C. Participation is free, but registration is mandatory. Places are limited.

For more information and registration, scan the QR code or contact Carmen Ausserhofer and Jasmin Oberstaller: call +39 0474 066 662/+39 0474 066 735, or email carmen.ausserhofer@zirkonzahn.com/jasmin.oberstaller@zirkonzahn.com.

ADI Masterclass 2026 launches registration ADI

Registration is now open for the ADI Masterclass 'Full Arch' taking place on Saturday 30 May 2026 at the Royal College of Physicians, London.

This event marks a significant launch for clinicians looking to elevate their expertise in full arch implant rehabilitation. Designed as a full day deep dive, the programme brings together internationally recognised leaders in full arch surgery, biomechanics and digital workflows: Dr Dan Holtzclaw, Dr Costa Nicolopoulos, Dr Sam Omar, Dr Sausha Toghranegar and Dr Hubert Trzepatowski.

Join the Masterclass to explore full arch rehabilitation from every angle, from biologically driven treatment planning to advanced surgical approaches. Each session is focused on strengthening clinical decision making, improving long term outcomes, and translating evidence-based concepts into practical, efficient protocols.

www.adi.org.uk

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Give your practice more options for imaging and diagnosis with the CS 9600 CBCT Scanner from Carestream Dental.

The five-in-one system puts 2D panoramic and cephalometric imaging, CBCT imaging, 3D facial scanning and 3D model scanning into the hands of clinicians, through an intuitive operating system.

A wide selection of 14 fields of view also enables dental professionals to gain imaging for a variety of clinical needs, whilst minimising exposure to radiation where appropriate. For simple cases, a 4cm x 4cm scan may be all that is needed, but dental professionals can also stretch to 16cm x 17cm for specialised needs with ease.

The CS 9600 CBCT scanner uses razor-sharp panoramic images through the Tomosharp algorithm and a resolution up to 75 microns for detailed results. This ensures clinicians can approach their cases with greater confidence, and have a greater insight into the challenges that are presented to them.

www.carestreamdental.co.uk

Sensei scales with you Carestream Dental

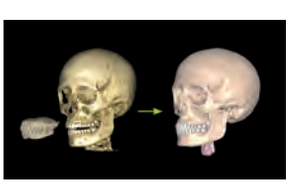
Practice management is no easy feat, and Sensei Cloud, the cloud-based practice management solution from Carestream Dental, makes tasks simple – no matter the size of your practice.

Whether you offer private care, NHS services, or a mix of the two, you can keep track of key information across performance, financing, and more.

Sensei Cloud also aids professionals who manage multiple sites, centralising data into accessible and understandable points. By operating as a cloud-based system, clinicians can make informed decisions no matter where they are in the world. All information is secured in line with GDPR requirements and is regularly backed up to ensure accessibility.

gosensei.co.uk

Bone Doctor – new software module for precise surgical planning Zirkonzahn



With Bone Doctor, Zirkonzahn has developed a new software module that significantly simplifies the digital analysis of the bone situation.

By importing the patient's DICOM data, the module allows users to analyse the different cranial bones and generate the corresponding 3D files.

The software is capable of autonomously segmenting the desired anatomical structures, saving the user a lot of time.

The segmentation can include any part of the skull, such as the lower jaw, mandibular nerves, individual teeth, maxillary sinuses and other anatomical parts.

The generated 3D objects can be used in Zirkonzahn.modifier, Zirkonzahn.implant-planner as well as in third-party designing and implant-planning software. Additionally, the extracted maxilla can be combined with the patient's 'real movement' data to analyse the condylar movements.

Extracted teeth can also be used to perform orthodontic movements based on their actual root and crown morphology.

www.zirkonzahn.com

W&H unveils the next chapter in its evolution W&H

After more than 135 years of engineering excellence, W&H is entering a new phase focused on innovation, design and connected digital workflows.

The company's latest development, the Seethrough imaging portfolio, reflects a renewed commitment to supporting modern dentistry with intuitive technology and integrated clinical solutions.

Designed as a connected imaging ecosystem, Seethrough brings together extraoral and intraoral imaging within a single digital environment.

The range includes Seethrough Flex, a compact high-performance imaging system suited to contemporary practices, and Seethrough Max, which offers the same advanced capabilities with a larger field of view.

Integrated with Implantmed Plus II through W&H's cloud-based Iodent platform, the system enables seamless data flow across diagnostics, planning and treatment.

Jon Bryant, managing director of W&H UK, said the launch represents a 'confident and connected' future for the brand, combining clarity, usability and design to support clinicians and enhance patient care in an increasingly digital dental landscape.

www.wh.com

Reliable Brilliant Bulk Flow Coltene

Brilliant Bulk Flow from Coltene is a bulk-fill composite designed to deliver a fast, reliable, and aesthetically pleasing solution for deep posterior fillings.

The product offers a 4mm reliable curing depth, achieving polymerisation in 20 seconds through high initial translucency that supports deeper light penetration – without compromising strength.

With One adaptive Multi Shade material, Brilliant Bulk Fill Flow is optimised to one shade that matches a vast range of tooth colours, ensuring that your patients are more than satisfied with the results.

Brilliant Bulk Fill Flow allows clinicians to reduce chair time and simplify restorative workflows, delivering consistently remarkable results with enhanced efficiency.

colteneuk.com/brilliant-bulk-fill-flow
info.uk@coltene.com
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Hyflex EDM nickel titanium files from Coltene hold absolute excellence at the forefront of their design.

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Manufactured using electrical discharge machining (EDM), the files adapt to canal anatomy with ease – with absolute strength and reliability.

Even with the most complex or curved canals, precision is never compromised when using the Hyflex EDM nickel titanium files with predictable shaping every time.

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Greater comfort and safety in wound care
Hager & Werken

Caring for wounds and sutures after dental procedures can present challenges for dental practices.

Moist or bleeding areas must be reliably protected while ensuring patient comfort and ease of use, as well as cost-effective handling.

This is where Reso-Pac (Hager & Werken) comes in – an odontological wound protection dressing in the form of an adhesive, cellulose-based wound protection paste that acts like a 'sticky plaster in the mouth'.

It adheres securely to mucous membranes, wounds and sutures, even on moist or bleeding surfaces, protecting the treated tissue throughout the entire healing phase.

Reso-Pac remains soft, is tasteless and odourless, effectively keeps bacteria at bay and supports the healing process.

It can also be used to carry applied medication.

Thanks to these properties, Reso-Pac is extremely versatile and can be used in implantology, periodontology, after extractions and in orthodontics and prosthetics.

It offers patients noticeable comfort, for example when protecting sore gum areas in brace wearers.

The hygienic single portions are now available in a new pack size of 20 × 2 g (previously 50 × 2 g), and Reso-Pac is also still available in the economical 25 g tube.

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Why now is the time to take control of dental decontamination

Aura Infection Control explains why a quiet summer period could provide a perfect opportunity to reassess and strengthen decontamination protocols

As dental practices prepare for the seasonal shift into spring and summer, the focus naturally turns to increased patient demand and team availability.

However, warmer temperatures and fluctuating chair usage also introduce heightened infection control risks – making this a critical time to strengthen decontamination protocols.

For dental professionals, a proactive seasonal approach is essential.

From dental unit waterlines (DUWLs) to autoclave performance, the actions taken now can significantly impact safety, compliance and efficiency in the months ahead.

A seasonal reset

Spring provides the ideal opportunity to carry out a full decontamination review.

Following the winter period, practices often face a build-up of dust, debris and microbial contamination.

A structured deep clean of treatment rooms, sterilisation areas and equipment ensures a solid foundation for the busy season ahead.

With patient numbers typically rising through spring and into summer, it is equally important to review stock levels of essential consumables.

Shortages during peak periods can disrupt workflows and compromise compliance.

At the same time, revisiting and updating infection control protocols ensures alignment with current guidance and reinforces a culture of safety across the team.

DUWLS: managing an ongoing risk

Dental unit waterlines remain one of the most persistent challenges in practice decontamination.

As temperatures increase, so too does the risk of biofilm formation – particularly during periods of inactivity such as overnight shutdowns, weekends and annual leave.

Without proper management, biofilm can rapidly develop within the tubing, compromising water quality and increasing contamination.

A best-practice approach begins with testing water quality, followed by targeted biofilm removal using systems such as Alpron.

Once a clean baseline is established, ongoing maintenance is essential – and this is where Bilpron offers a distinct advantage.

Designed specifically for periods of inactivity exceeding 48 hours, Bilpron provides long-term disinfection by remaining within the system and forming a protective barrier against microbial growth.

Its clinically tested formulation ensures waterlines remain protected even when chairs are not in use, giving practices confidence during holiday closures and quieter periods.

As Laura Edgar, managing director of Aura Infection Control, explains: 'Seasonal downtime can become a risk factor if not managed correctly.

'Planning ahead – particularly when it comes to waterline treatment – can prevent significant contamination issues and protect both patients and staff.'

Autoclaves: maintaining performance under pressure

While waterlines are a key focus, autoclaves should not be overlooked – especially during warmer months when heat and humidity accelerate microbial growth.

Over time, residue and biofilm can build up within autoclave chambers and internal components, potentially impacting performance and sterilisation efficacy.

Routine deep cleaning is therefore essential to maintain compliance and ensure reliable instrument processing.

Products such as Restore tabs provide an effective solution, designed to penetrate internal areas and remove hidden contamination.

Incorporating regular autoclave maintenance into seasonal protocols helps safeguard performance and reduces the risk of cross-contamination.

Turning downtime into opportunity

Although summer is a busy period, it often includes pockets of reduced activity due to annual leave.

These quieter moments present an opportunity for practices to take a more strategic approach to infection control.

Deep cleaning during downtime allows teams to work more thoroughly without disrupting clinical schedules.

It also provides an ideal setting for refresher training, ensuring staff remain confident in correct disinfectant use and protocol adherence.

A preventative approach

As environmental factors such as allergens and waterborne pathogens increase during spring and summer, maintaining a clean and well-managed practice environment becomes even more important.

Integrating proven solutions such as Alpron for biofilm removal, Bilpron for long-term waterline protection, and Restore tabs for autoclave maintenance supports a comprehensive and reliable infection control strategy.

Looking ahead

As the profession enters one of its busiest periods, the practices that prioritise preparation will be best positioned to deliver safe, efficient and compliant care.

Seasonal change shouldn't be seen as a challenge, but as an opportunity to reset and recommit to the highest standards of decontamination.

Because in modern dentistry, prevention isn't optional – it's essential.

To book a free dental decontamination review visit: www.aiconline.co.uk/dental-decontamination-review/ or contact Laura Edgar on 01833 630393 or email orders@aiconline.co.uk.

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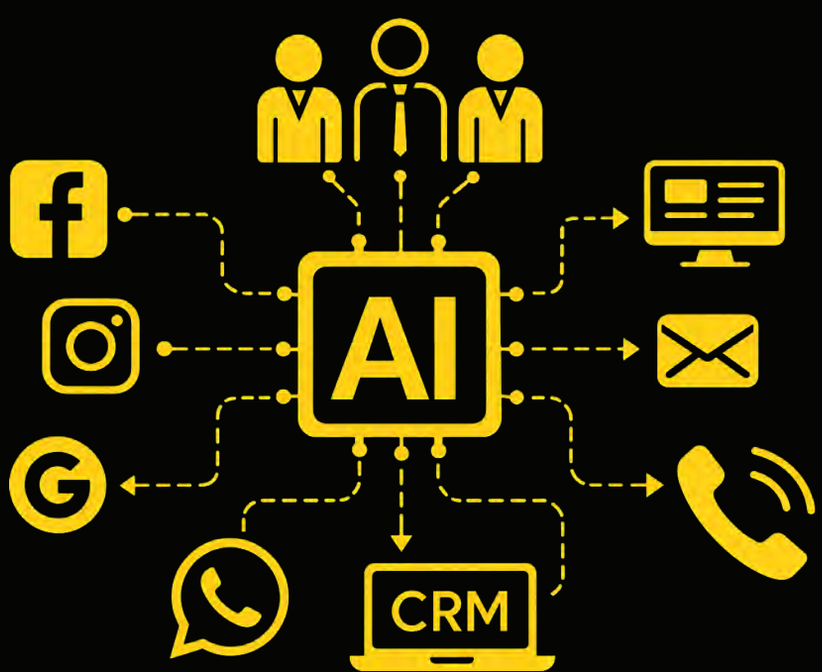

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