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September 2026

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Dentistry

Remembering Nigel Carter OBE:

the public voice of oral health p13



James Frith appointed as dental minister

James Frith will take on responsibility for dentistry as under-secretary of state for health and social care.

The government made the announcement three weeks into Prime Minister Andy Burnham's term. A reshuffle of the Department of Health and Social Care saw Yvette Cooper announced as health secretary and several ministers and under-secretaries introduced on 22 July. While it was not clear at this time who would take on the dentistry brief, it has now been announced that Frith, MP for Bury North, will be responsible for dentistry as well as:

- NHS data and technology
- Medtech (medical technology)
- Medicines
- Research and innovation
- Rare diseases
- Major and long-term conditions
- International and devolved governments
- Men's health
- Eyecare.

When first elected as MP in 2017, Frith sat on the Education Select Committee and chaired the All-Party Parliamentary Group for Hospice and End of Life Care. During his next term starting in 2024, he then served on the Culture, Media and Sport Select Committee.

In March 2026, Frith became a parliamentary under-secretary of state in the Department for

Science, Innovation and Technology. He was largely responsible for the government's work to develop a digital identity system for the UK.

Response from the profession

Prominent members of the dental profession have welcomed Frith to the post, calling for him to follow through on the government's previous pledges of large-scale dental reform.

Neil Carmichael, executive chair of the Association of Dental Groups (ADG), said: 'We warmly welcome James Frith and look forward to working with him. Under Stephen Kinnock's term, the ADG made considerable progress in addressing the massive workforce gap, and we now look to him to ensure the implementation of the interventions he announced.'

'In addition, NHS contract revisions remain essential if we are to secure long term access for patients. Meaningful reform of the GDC must also be addressed during his tenure.'

British Society of Paediatric Dentistry (BSPD) president Oosh Devalia said: 'The BSPD warmly welcomes you to your new role which includes overseeing dentistry. As the UK's leading charity advocating for children and young people's oral health, our clinicians and academics are the expert voice of paediatric dentistry and are ready to support you as you take forward national dental reform.'



Dentistry Top 50 announced

The Dentistry Top 50 has been unveiled for 2026, celebrating the individuals whose influence, ideas and achievements are helping to shape the future of the profession.

This year's list brings together 50 people making an impact across UK dentistry – from clinicians and educators to researchers, campaigners, business leaders and those helping to shape the profession at a national level. Among them are 19 new entries, reflecting a year of change and fresh thinking across dentistry, alongside familiar faces whose influence and contribution continue to grow.

Delivered in partnership with Denplan, part of Simplyhealth, this year's list offers a snapshot of the individuals helping to move UK dentistry forward.

Turn to page 32 to find out who made this year's Dentistry Top 50.

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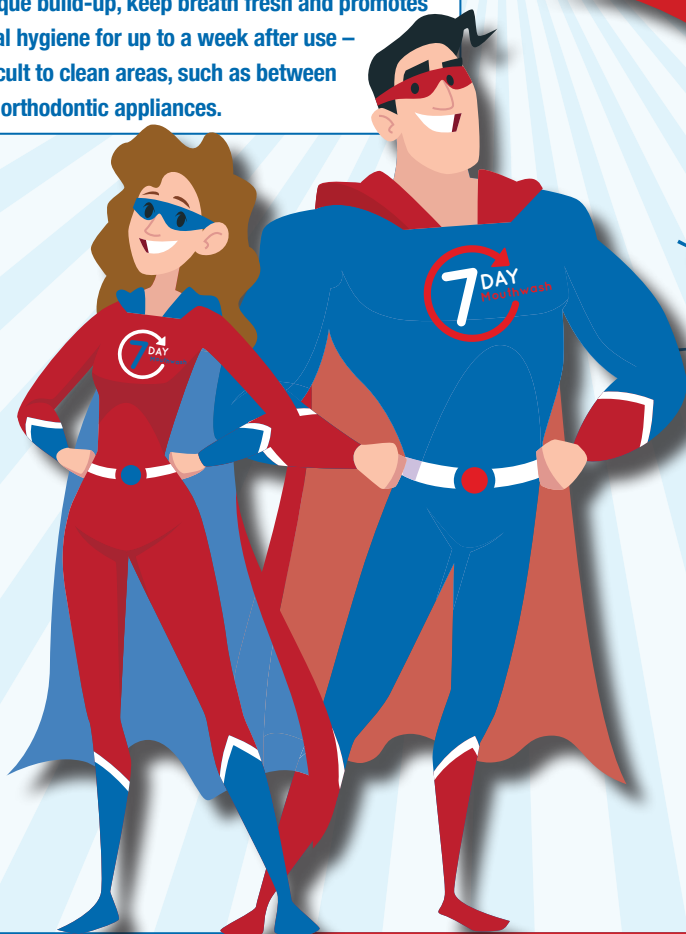
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For further information, and advice on when to recommend or offer ChloroStay 7-Day Mouthwash to your patients, please call Schottlander on freephone 0800 97 000 79, visit schottlander.com or chlorostay.com

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Mission statement

Dentistry magazine's unparalleled coverage of current affairs, new developments and the latest thinking keeps the dental sector on top of the issues that matter. For further information and to get in touch, email siobhan.hiscott@fmc.co.uk.

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Back with a bang!



Siobhan Hiscott
Editor's view

question: who is really moving dentistry forward?

The answer is never straightforward. Influence in this profession does not come in one form. It can be found in the clinician changing the way patients experience care, the educator shaping the next generation, the researcher asking better questions, the campaigner refusing to accept the status quo, or the leader making difficult decisions on behalf of others.

That is what the Dentistry Top 50 is designed to recognise. It is not a popularity contest, nor is it a ranking from one to 50. The 2026 list was shaped through nominations, discussion and deliberation, with the final selection reflecting professional achievement, leadership, education, campaigning and contribution to dentistry. Nineteen new names appear this year, alongside established figures whose influence continues to be felt.

That turnover matters. Dentistry is a profession in constant motion. The pressures facing practices, teams and patients change; technology changes; expectations change. So, too, must our understanding of who is leading the profession and what leadership looks like.

The Dentistry Top 50 therefore should not simply celebrate those with the loudest voices or the most recognisable names. Its value lies in recognising impact wherever it happens, often quietly and without expectation that anyone will notice it: in practices and universities, in representative bodies and charities, in research, policy, education and innovation. It reminds us that there is no single model of success in dentistry.

But recognition is only part of its purpose. A list such as this should also prompt us to look beyond the names and consider what they represent. Collectively, the Dentistry Top 50 tells us something about the direction of the profession: what we value, where momentum is building and

This issue sees the return of one of the profession's most talked about events. I am, of course, referring to the Dentistry Top 50! Every year, the Dentistry Top 50 asks a deceptively simple



‘Collectively, the Dentistry Top 50 tells us something about the direction of the profession: what we value, where momentum is building and who is prepared to challenge accepted ways of doing things’

who is prepared to challenge accepted ways of doing things.

At a time when dentistry faces difficult questions about access, sustainability and its future shape, that matters. Progress rarely arrives fully formed from a policy document or a boardroom. More often, it begins with an individual deciding that something could be done better – and then doing the work to prove it.

So, congratulations to everyone recognised in this year's Dentistry Top 50. But perhaps the most important message is for everyone who is not on it.

Influence is not a title bestowed once a year. It is what happens when people choose to make dentistry better than they found it.

Progress has stalled on children's oral health, report warns

The UK is at risk of raising 'one of the unhealthiest generations of children in decades' as roughly one quarter present with obvious tooth decay, a report into children's oral health has said.

Released on 14 July, the *State of Child Health 2026* report measures progress on children's health according to 12 key indicators. As part of this research, the Royal College of Paediatrics and Child Health (RCPCH) published an extensive report on children's oral health. As of 2024, Scotland and Wales had the highest proportion of childhood decay, at 27%, while England's levels sat at 22%. Northern Ireland had not collected oral health data since 2018 so was not included in the report.

While children's oral health had improved over previous decades, there has been little reduction in tooth decay between 2020 and 2024.

Childhood tooth extractions remain a significant burden on the NHS, persisting as the leading cause of hospital admissions in five-to nine-year-olds in England. In Wales, more than 3,500 children underwent tooth extractions under general anaesthetic in 2023-24.

Risk factors in children's oral health

Deprivation was a significant predictor of poor oral health across the UK. In Scotland, children in the most deprived areas had a 40% rate of tooth decay, falling to 16% in the most affluent areas. England showed a similar disparity, with a 32% decay rate in the poorest areas compared to 14% in the richest.

The report also revealed significant ethnic inequalities. In England, Asian or Asian British children and those from other minority ethnic groups were the most likely to have tooth decay, at 37.7% and 45.4% respectively.

According to the report, potential factors behind the high decay levels may include:

- Limited access to NHS preventive dental services, particularly in deprived areas
- High sugar consumption, especially among children from lower-income households
- Commercial baby foods and drinks often contain more sugar than recommended
- Lack of early oral health habits, including regular supervised toothbrushing
- Unequal access to the benefits of water fluoridation, which has been shown to reduce tooth decay and hospital admissions.

The consequences of poor oral health

The RCPCH also emphasised the widespread impact of oral health on children's lives. It cautioned that children with tooth decay may experience:

- Pain and infection
- Difficulty eating, sleeping and speaking
- Reduced ability to play and socialise
- More time off school
- Risk of serious complications, including dental abscesses and sepsis if left untreated.

In addition to affecting individual children's lives, poor oral health comes at significant cost to the government. The report estimates that tooth extractions in children aged zero to 19 in England cost the NHS £74.8 million in 2024.

The RCPCH made several demands for the government to improve preventive action on children's oral health:

- Increase NHS dental capacity so every child can have a dental visit by age one
- Expand community water fluoridation in England
- Extend supervised toothbrushing programmes, particularly through Scotland's Childsmile programme
- Reduce sugar in commercial baby foods and drinks through regulation
- Invest in preventive dental services and tackle inequalities in access to care.

It also recommended that dental professionals encourage every child to see a dentist by their first birthday, promote early adoption of good oral hygiene habits and advise families to limit sugary foods and drinks.

News in brief

GDC appoints Dr Urshla Devalia as council member

The General Dental Council (GDC) has appointed Dr Urshla (Oosh) Devalia OBE as its new registrant council member. Oosh is a consultant paediatric dentist at the Royal National ENT and Eastman Dental Hospitals, president of the British Society of Paediatric Dentistry and a former clinical policy lead within the Office of the Chief Dental Officer for England.

She is expected to take office on 1 October 2026, replacing Simon Morrow, who will conclude his term after eight years.

Charity padel day raises money for Wells on Wheels

A charity padel event has raised £1,737 for Wells on Wheels, a charity that aims to break the wheel of poverty by the use of its water wheels freeing up time for young girls to now attend school.

The event, hosted by Frank Taylor & Associates and The Principals Club, took place at Rocket Padel in Beckton, and saw dental practice owners – 12 teams of two – enter the tournament with all entry fees donated to charity.

mydentist appoints new chief operating officer

mydentist has appointed Rob McCoy as its new chief operating officer.

Rob will join from Starbucks, where he spent eight years and most recently served as general manager of the UK business. He previously held senior leadership roles at Pizza Express and John Lewis Partnership, following nine years as a commissioned officer in the British Army.

He will report to mydentist chief executive Nilesh Pandya and is expected to join the mydentist board when he takes up the role on 5 October 2026.

BSPD travel award recognises innovative trauma management case

The British Society of Paediatric Dentistry (BSPD) has named Lisa Clarke, of the University Dental Hospital of Manchester, as the winner of its 2026 Max Horsnell Travel Award for an innovative approach to managing dental trauma in a young patient.

Lisa received the award for her clinical case report, *Preserving a growing smile: A splinting challenge in the mixed dentition*, which describes the treatment of a six-year-old boy who presented two weeks after suffering severe extrusion of his incisors.

Denplan appoints new managing director

Denplan, part of Simplyhealth, has appointed Nick Tait as managing director to lead its next phase of growth and innovation.

Nick brings more than 25 years' healthcare experience across dental, primary care, veterinary and wider healthcare markets. He joins Denplan from NVS Group, the UK's largest veterinary supplier.

In his new role, Nick will focus on evolving Denplan's support for dentists, practices and patients.



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New photoimmunotherapy technique targets periodontitis while preserving good bacteria

A near-infrared photoimmunotherapy technique first developed for cancer treatment has been adapted to selectively target periodontitis without a detrimental impact on the oral microbiome.

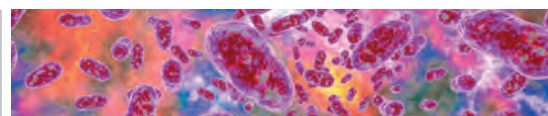
The method uses an antibody-dye compound that binds to target cells, activated by near-infrared light. In experiments, it bound to *Porphyromonas gingivalis* – a key pathogen that triggers periodontitis inflammation – while having no effect on human cells and harmless bacteria.

Researchers from Nagoya University have published an exploration of the potential of photoimmunotherapy for periodontitis treatment in the *Journal of Translational Medicine*. When tested on mice, the technique significantly reduced alveolar bone loss and improved the oral microbiome.

What benefits does photoimmunotherapy have over existing periodontitis treatments?

Existing treatments for periodontitis such as antibiotics and antimicrobial photodynamic therapy (aPDT) are not selective in the microorganisms they destroy. This means they often eliminate beneficial oral bacteria alongside harmful pathogens.

Kazuhide Sato, lecturer at Nagoya University and one of the paper's corresponding authors, said: 'These approaches often disrupt the entire oral microbial ecosystem and can also release lipopolysaccharide (LPS), an endotoxin that may exacerbate inflammation.'



'Results demonstrated that, unlike antibiotics or standard light therapy, this approach selectively removes the primary pathogenic species while preserving the remainder of the oral bacterial community.'

What's next?

The researchers note that periodontitis can be caused by many different pathogens, so targeting

one may not be enough. In future research, they hope to use artificial intelligence to identify other important bacteria in inflammatory processes and develop more precise treatments.

As periodontitis has been linked with systemic health problems such as diabetes, the paper's authors also hope their research could help identify patients who are the most likely to benefit from targeted treatments.

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International partnership empowers local professionals to improve oral health for more than 115,000 children

A community oral health education programme has been launched in Tanzania's Sengerema District, with the initiative expected to reach approximately 115,000 schoolchildren.

The programme brings together Tanzanian health organisation THEDI, oral health charity Bridge2Aid, GC Europe, Colgate-Palmolive Tanzania and local government authorities, with a focus on prevention, education and community engagement.

Sengerema District has a population of approximately 500,000 but is served by just two dentists and three dental therapists, placing greater

emphasis on preventive oral health measures and community-based education.

Representatives from 60 schools and 44 villages took part in the programme, with oral health messages being delivered through schools, healthcare facilities and local communities. Organisers hope the initiative will also reach thousands of families through information shared by participating children and community leaders.

Training was led predominantly by Tanzanian District Dental Officers, THEDI representatives and dental therapists who had previously taken part in professional development programmes supported by Bridge2Aid.

Seven members of GC Europe's team also travelled to Mwanza and Sengerema to support training and practical workshops. Toothbrushes donated by GC's dealer partners were distributed to participating schools and villages to support daily oral hygiene.

Committed to improving oral health

The programme also addressed infant oral mutilation (IOM), a harmful traditional practice involving the removal of developing tooth buds in young children. Discussions with local professionals focused on the role of education and trusted community figures in challenging the beliefs associated with the practice.

Katrin Langer is vice president of sales at GC Europe. She said: 'Working with dental professionals who want to help their communities improve oral health is inspiring. We came as strangers and left as allies in the fight against infant oral mutilation.'

Dental experts celebrate energy drink ban as official timeline set

The government has confirmed that new laws banning the sale of high-caffeine energy drinks to under-16s will come into force by April 2027. The announcement follows a public consultation launched in September 2025 and renewed pressure from dental and health organisations calling for action on children's oral and general health. Nine in 10 consultation respondents agreed with the government's proposal for an age-based energy drink ban.

BDA chair Eddie Crouch described the ban as a 'victory for common sense'. He said: 'Packed with sugar and highly acidic, dentists have seen the damage energy drinks do every day. The result is children struggling to eat, to sleep and to learn.' In June, the British Dental Association noted that it had been 700 days since the government first pledged to end the sale of energy drinks to children in July 2024. A coalition of leading health organisations, academics, youth campaigners and celebrities came together to urge the government to take action.

Previous research has found extensive harm caused to young people who consume energy drinks. For example, they were more likely to engage in binge drinking, smoking and other substance abuse, and other unsafe behaviours. They also had a higher risk of heart disease, allergies, insulin resistance and mental health problems.

Barbara Crowther, children's food campaigner, said: 'The decision to ban sales of high caffeine energy drinks to children is absolutely right, given strong evidence of their harmful effects on their physical, mental and dental health, and overwhelming public support including parents, young people, health professionals, teachers and food retailers.'



Dentist erased after 'Hollywood smile' patient harmed

A dentist has been erased after a patient seeking 'Hollywood smile' treatment was left with failing crowns and bridges, poorly restored teeth, gingivitis caused by ill-fitting restorations, retained roots, a fractured root, periapical pathology and bone loss.

The General Dental Council's (GDC) Professional Conduct Committee found that the registrant failed to provide an adequate standard of care between August 2020 and August 2023, including failures in pre-treatment investigations, treatment planning, radiographic

practice, discussing risks and diagnosing the need for further treatment.

It also found that the dentist provided a poor standard of treatment and care, failed to obtain informed consent, and failed to cooperate with GDC investigations by not providing sufficient evidence of indemnity and employment information.

The determination said the patient's evidence was that they did not know they would receive full crowns rather than overlays and were not informed about the risks of the treatment. The committee said actual and ongoing serious harm had been caused to the patient.

'Lack of insight'

The registrant did not attend or have representation at the hearing. The committee noted that they had requested to be erased on multiple occasions, including a few days before the hearing.

The committee heard that the dentist was a director and registered manager of the practice. It found that the dentist knowingly permitted an unregistered and erased former

dentist to practise dentistry at the practice and that clinical notes and treatment plans were signed in the dentist's name.

The GDC's expert witness said the dentist's conduct fell 'far below the standard expected' of a registered dentist.

The committee said there was no evidence of insight, remorse or remediation. It also found a high risk of repetition and said the conduct suggested an attitudinal problem.

In its sanction decision, the committee said conditions would not protect the public or satisfy the public interest

because the registrant was unlikely to comply with them.

It also said suspension would not be sufficient because there was no evidence that any period of suspension would change the dentist's behaviour.

The committee said erasure was the only appropriate and proportionate sanction. It also imposed an immediate suspension order to cover the appeal period. The dentist's existing interim suspension orders were revoked because the substantive erasure and immediate suspension order had been imposed.

Dental technician workforce continues decline while overall DCP numbers rise by 5%

The number of dental technicians on the UK register has fallen for the sixth consecutive year, despite the overall dental care professional register growing by almost 5%.

Annual renewal statistics from the General Dental Council (GDC) showed that 84,746 dental care professionals (DCPs) were registered in 2026, an increase of 3,746 compared with the equivalent point last year.

However, dental technician numbers fell from 4,895 to 4,824, continuing a decline that has prompted concerns about training and the future capacity of UK dental laboratories. Matt Everatt is the *Laboratory* editor-in-chief. He has suggested that the decline in the dental technology workforce was due to a number of factors including training programmes under financial pressure, unregulated manufacturing, and the impact of new technology.

A total of 3,769 DCPs were removed from the register following the annual renewal period. Due to ongoing problems with the MyGDC portal during this renewal period, the GDC said that DCPs who were having technical issues would not be removed from the register provided they contacted the regulator before the deadline.

Dental workforce demographics

Dental nurses remain by far the largest DCP group, with 69,824 registered – up from 65,797 in 2025. Additionally, the number of dental hygienists increased to 11,407 from 11,065 in 2025.

The dental therapy profession has seen significant growth since 2023. In three years, the number of dental therapists has increased from 5,558 to 8,824. Many of these were from internationally qualified dentists who joined the register with DCP titles, a route that the GDC has now closed.

First Budding Black Dentists conference raises awareness of specialist careers

Around 100 aspiring dentists, dental students, early-career clinicians, specialists and educators gathered at the Royal College of Surgeons in July for the first Budding Black Dentists conference, a sold-out event designed to make specialist careers more visible and accessible to Black dental professionals.



The conference comes at a time when Black, Black British, Caribbean and African dentists account for just 2.1% of the UK dental register, according to the GDC's latest registration statistics. While representation has improved slightly in recent years, it remains low, particularly within dental academia, where Black clinical academics continue to be significantly underrepresented.

For Budding Black Dentists CEO and founder Simisola Fynn-Famodun, the aim was to make specialist careers feel tangible. The conference programme combined specialist panel discussions with hands-on workshops in implant dentistry, suturing and intravenous cannulation, allowing delegates to experience skills associated with specialist practice rather than simply hearing about them. Budding Black Dentists social media manager Dara said the conference, which was supported by Bupa Dental Care, addressed a gap that many young professionals experience.



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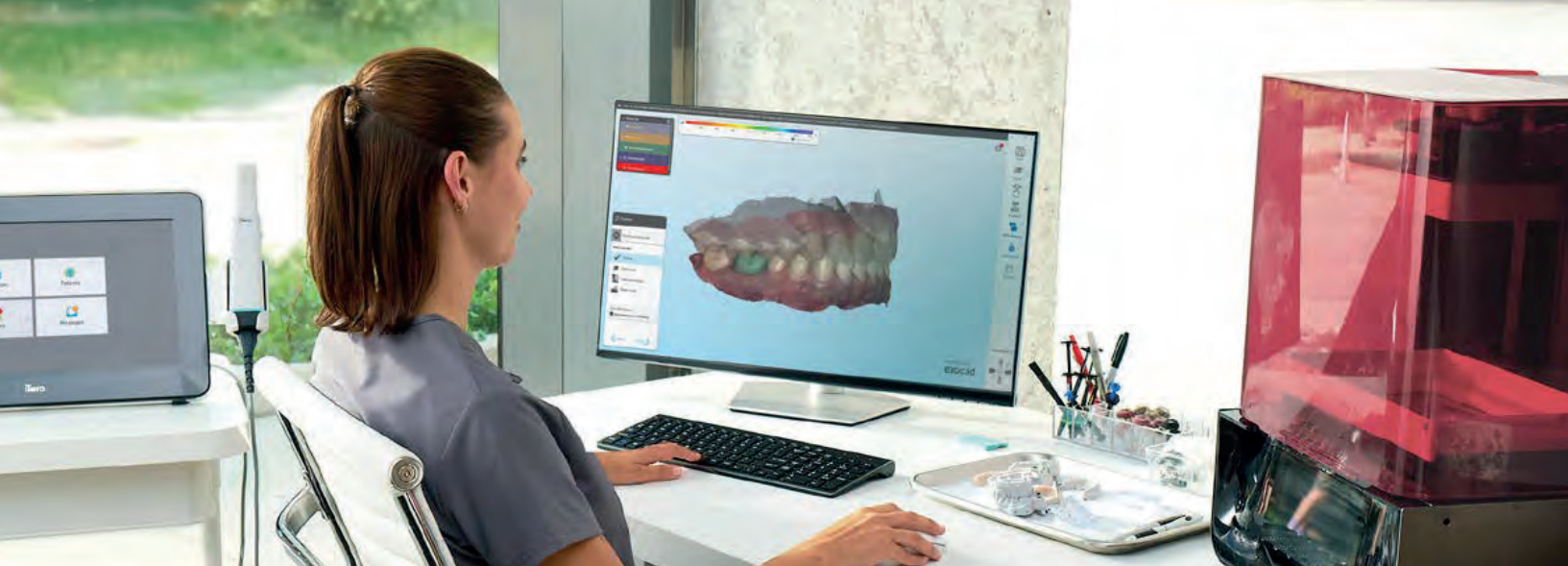
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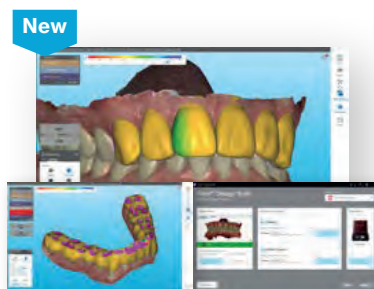
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S W I S S  M A D E



Remembering Nigel Carter OBE

Nigel Carter OBE, former chief executive of the Oral Health Foundation and one of UK dentistry's most prominent public health advocates, has died

Across nearly three decades leading the Oral Health Foundation – and more than 50 years connected to its work – Dr Nigel Carter OBE became one of the profession's clearest and most recognisable voices outside the surgery. His career was defined by a simple but powerful belief: that oral health mattered far beyond dentistry, and that better public understanding could change lives.

For many, his name will be inseparable from the Oral Health Foundation. But his larger contribution was to help move oral health into a wider public conversation – about prevention, inequality, cancer awareness, diet, smoking, access, education and the relationship between the mouth and the rest of the body.

He understood that if dentistry was serious about prevention, it could not speak only to itself. It had to reach patients, parents, schools, workplaces, policymakers, journalists and the wider health system. Over many decades, Nigel helped give that mission a structure, a platform and a public voice.

A career rooted in public health

Nigel qualified from the University of Birmingham in 1975, also gaining the LDS from the Royal College of Surgeons of Edinburgh. He began his career in mixed NHS and private general practice in Birmingham, establishing himself first as a practising dentist before his work widened into education, training, public health and charity leadership.

Alongside practice, he was closely involved in training dental nurses, dental technicians and other members of the wider healthcare workforce. That interest in education would become one of the consistent themes of his professional life. Whether speaking to patients, professionals, policymakers or the media, his work returned again and again to the same essential point: information only matters if it is understood, trusted and put to use.

His defining work came through the Oral Health Foundation, formerly the British Dental Health Foundation. Nigel's involvement with the charity stretched back to the late 1970s. He served as a council member, trustee and chair of the board before becoming chief executive in 1997.

It was in that role that his impact on UK dentistry truly took off. Under his leadership, the foundation grew in reach, profile and influence, becoming one of the most established independent voices for oral health education and public awareness. The charity's campaigns, resources

and media activity helped take oral health messages to audiences that dentistry alone would have struggled to reach.

National Smile Month became one of the clearest expressions of that work.

His campaigning on mouth cancer was especially important, repeatedly making the case for better awareness of symptoms, risk factors and the importance of early detection.

Nigel understood that the dental profession had a vital role to play, but also that late diagnosis could not be addressed by dentistry alone. The public needed to know what to look for. Government needed to recognise the scale of the problem. Access to regular dental care had to be understood not only as a matter of oral health, but potentially of life and death.

Connecting dentistry to wider health

That ability to connect dentistry to wider health was one of Nigel's strengths. He was never content for oral health to sit at the edge of healthcare policy. His work with public health organisations, government groups, advisory committees and European oral health bodies reflected a much broader view of the profession's responsibilities.



He served in roles linked to the Royal Society for Public Health, the General Dental Council Oral Health Committee, NHS Direct Online, the Department of Health Dental Smoking Cessation Group, the Oral and Dental Research Trust and the Platform for Better Oral Health in Europe.

Giving dentistry a public voice

Nigel also became one of dentistry's most experienced media voices. Through television, radio, print and online interviews, he helped translate oral health messages for the public without losing their clinical importance.

His work was recognised in 2012 when he was awarded an OBE for services to dentistry and dental health. It was a fitting acknowledgement not only of one individual's career, but of the cause he had done so much to advance: the idea that oral health education, prevention and public awareness deserve national attention.

The same broader direction was reflected in the charity's evolution from the British Dental Health Foundation to the Oral Health Foundation. That change spoke to an organisation with a widening purpose – national and international, professional and public, dental and health-focused. Nigel's leadership helped shape that transition.

Early in 2026, he announced his retirement as chief executive after 29 years in post. In marking that moment, the foundation described more than four decades of service to the charity as trustee, chair and chief executive.

A lasting legacy

For colleagues at the Oral Health Foundation, and for many across dentistry, his death will be felt deeply. But the professional legacy is also clear. Nigel helped build the systems, campaigns and language through which oral health could speak to the public.

He championed prevention before it became a familiar policy phrase. He kept mouth cancer in the public conversation. He argued for oral health as part of general health – and he helped show that dentistry's responsibility did not end at the surgery door.

Nigel's career is measured by the steady rewriting of the entire conversation around oral health.

He leaves a profession more aware of its public voice, and a charity whose work continues to reflect the belief that guided so much of his life: that better oral health should be understood, valued and within reach for everyone.

John Chope (1948-2026)

A dedicated dentist, teacher, mentor and public servant, John Chope made a lasting contribution to the profession over a remarkable 50-year career

Dr John Chope passed away peacefully in his sleep at home on 1 August 2026, after a five-month illness with pancreatic cancer.

He graduated from Bristol University Dental School in 1972 after six years of study, which included an intercalating physiology degree. During this period, he studied taste receptors, reflecting an early interest in the scientific foundations of dentistry and medicine.

In 1973, he was employed by the University of Khartoum, where he worked as a senior lecturer in physiology in the Faculty of Medicine. His role involved both teaching and examining medical students. During his time in Sudan, John also became a co-founder of Khartoum Dental School. He assisted with the establishment and design of the first dental course in Sudan and contributed to its teaching, combining his academic work in physiology with the development of dental education.

On returning to Bristol, John became a senior house officer (SHO) in the oral surgery department. He subsequently worked in general practice in Bristol and Shepton Mallet before opening his own practice in Holsworthy, a small market town in Devon.

Running his own practice required skills that went far beyond clinical dentistry. Out of necessity, John developed not only as a dentist and employer, but also as an engineer, electrician, plumber and builder. These practical abilities became another important part of a working life characterised by wide-ranging interests and skills.

He remained an enthusiastic and dedicated dentist for 50 years, working in his own practices in Holsworthy, Okehampton and Hartland in Devon, and Bude in Cornwall.

Beyond the practice

John's commitment to dentistry extended well beyond his own practices and communities. Teaching and supporting other members of the profession remained a significant part of his life.

His involvement in education, which had begun during his time in Khartoum, continued throughout much of his professional career, establishing postgraduate teaching for young dentists and mentoring right up until his retirement in 2024.

John also gave many years of service to the wider dental profession. He served on the General Dental Council (GDC) for 17 years and worked for 15 years as an independent medicolegal expert.

He was a National Council member for 16 years, including nine years as chair of the Confederation of Dental Employers (CODE). He was also a National Council member of the Dental Practitioners' Association (DPA) for six years.

His professional responsibilities extended beyond these organisations. John was an expert professional panel member of the Family Health Services Appeal Authority and the Health, Education and Social Care Chamber of the First-Tier Tribunal of the Ministry of Justice for 18 years.

Alongside this extensive professional service, he also served as a magistrate for 25 years, adding another long-standing commitment to public life.

In 2005, John became a member of the external advisory board for the successful Peninsula Medical School dental school bid in national competition, contributing once again to the development of dental education.

His commitment to dentistry also took him overseas later in his career. In 2018, John volunteered as a dentist and dental team leader with a small multidisciplinary clinical



team working for the International Health Service charity in remote Honduras.

As well as providing dental care, he took on responsibility as the dental team leader. The majority of the treatment provided during the trip was oral surgery.

Sharing wisdom

John was committed to sharing the knowledge and experience he had accumulated throughout his career.

He gave more than 50 professional talks to dental groups on a wide variety of subjects, with titles ranging from 'Hypnosis in dentistry' to 'That's a fine mess you got us in! Understanding current GDS crisis'. The breadth of these subjects reflected the wide range of issues that interested him within dentistry.

Writing was another important part of John's contribution to the profession. Over the years, he wrote more than 150 dental articles, the majority of them for *Dentistry* magazine and CODE. Together with his lectures and professional talks, his writing provided another means through which he shared his knowledge and views with colleagues.

John's interests, however, went far beyond dentistry. They included farming, architecture, building, structural design, inventing and sketching.

These interests often had a distinctly practical and creative dimension. He produced his own technical drawings, designed dental and agricultural equipment, and even illustrated his professional talks himself.

John will be remembered for his remarkable contribution to dentistry, his commitment to teaching and mentoring, his many years of professional and public service, and the breadth of interests that accompanied his working life.

Across five decades in dentistry, he remained closely involved with the profession through clinical practice, education, writing, mentoring and service.

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Patients do not always talk about oral health in the language of periodontal risk, systemic links or long-term prevention. Often, they talk about confidence. They talk about breath, appearance, embarrassment, pain, missing teeth, social pressure and whether they feel able to smile.

For dentistry, that creates a communication challenge. The profession is rightly focused on disease, prevention and clinical stability. But for many patients, the value of oral health is felt most immediately in everyday life: speaking at work, going for an interview, appearing in a photograph, socialising without anxiety or helping a child feel less self-conscious.

A question of value

That gap and the difference between clinical importance and lived experience was a focal point at Bupa Dental Care's second annual 'Dental Health Is... Live' conference.

Held at the International Convention Centre in Birmingham over 8 and 9 June 2026, the two-day event brought together more than 1,200 clinicians, practice managers, receptionists and practice teams from across its UK network.

While the main exhibition spaces buzzed with continuing professional development (CPD) workshops on genomics, diagnostics and connected healthcare, an exclusive roundtable gathered to look at several different topics, including how do people actually value their teeth?

Mark Allan, general manager for Bupa Dental Care, chaired the session. While personalised

prevention and the future of oral health understandably led the way, it quickly anchored to the real-world perspective of patients and the businesses that employ them.

Wellbeing at work

Matt Sayers, director of international benefits at CME Group, brought a crucial employer's perspective to the table. For businesses, he explained, corporate wellbeing is traditionally understood through three distinct pillars: financial, physical and emotional.

Dental care is particularly valuable because it sits squarely across all three.

Unexpected treatment costs can severely affect financial wellbeing. Regular attendance and preventive care support physical wellbeing. Meanwhile, breath, appearance and personal confidence heavily influence emotional wellbeing in the workplace.

'Employees love benefits they can use,' Sayers said of the practical value of dental cover.

He compared dental care with two very different workplace benefits: pensions and gym subsidies. Employers may spend heavily on pensions, but staff do not experience them day to day. Gym subsidies, by contrast, are popular because employees can use them regularly.

'We spend most of our cost on pension, but people don't get to use that pension, so it's kind of high cost, lowish perception,' Sayers said. 'But our most popular benefit is gym.'

Sayers suggested dental cover sits closer to that second category.

'Employees love it, because they get to use it,' he said.



The mouth-mind connection

Patrick Johnston explores how confidence, wellbeing and prevention shaped discussion at this year's Bupa Dental Care's 'Dental Health Is... Live' conference

'And that's where this dental one definitely helps with that, because you definitely will go to the dentist regardless of whether you're sick or not.'

For employers, that accessibility makes oral health a practical, visible part of everyday corporate wellbeing rather than an abstract human resources promise.

Confidence and clinical care

One of the most compelling parts of the discussion came when the panel turned to patient psychology.

Professor Iain Chapple MBE, professor of periodontology and consultant in restorative dentistry at the University of Birmingham and Birmingham Community

Health NHS Foundation Trust, had already set the tone on the conference main stage during his keynote presentation.

There, he warned delegates that oral health cannot be viewed in isolation. He noted established connections between periodontal disease and systemic conditions such as diabetes, cardiovascular disease,

chronic kidney disease, rheumatoid arthritis and Alzheimer's disease. For the profession, he argued, those links underline the need for more integrated healthcare.

Reflecting further during the roundtable on the tension many clinicians feel around purely aesthetic or cosmetic patient demands, Professor Chapple was clear that clinical health must always come first.

Patients seeking whiter teeth or aesthetic improvements still fundamentally need healthy gums, prevention and long-term clinical stability. But he also acknowledged that modern dentistry cannot simply dismiss the intense emotional force behind those cosmetic requests.

'We have to recognise that mental health and self-confidence are incredibly powerful, particularly in the younger generation,' Professor Chapple said.

That sentence carried significant weight because it came from a periodontologist speaking with deep clinical caution. It recognised something patients already know but clinicians, may sometimes, overlook. Teeth affect how people speak, smile, work and feel around others.

Allan picked up the same theme, describing what he called the 'mouth mind connection'.

'There is something in that, whether that's teenagers needing orthodontic treatment, who are struggling to get treatment, and they're being bullied or on social media for their appearance,' he said.

He also pointed to the more severe impact of tooth loss, including people whose missing teeth affected their confidence and ability to return to work.



From motivation to prevention

Ela Sarwar, a dental hygienist currently studying towards a master's in neuropsychology, brought that point back to behaviour change. She said patients are more likely to act when advice connects with something personal and achievable.

'Behaviour change doesn't happen with the information I'm going to share with them,' she said. 'It actually starts with

something that relates to them.'

For one patient, that may be future disease risk. For another, it may be feeling confident in front of colleagues, avoiding bleeding gums or no longer worrying about breath.

The point was not that confidence should replace clinical priorities. However, confidence may be one of the clearest ways patients understand why oral health matters. If dentistry can connect that motivation

with prevention, regular attendance and periodontal stability, the wellbeing message becomes a route into better care rather than a distraction from it.

That also speaks to a wider public perception gap. Many people still see dentistry as something they access when they are in pain or when something visible has changed.

Framing oral health as part of confidence, work and daily participation could help make prevention

feel more relevant before problems escalate.

As the conference concluded, Allan noted that the event gave teams the perfect opportunity to 'build skills and gain insight they need to help shape the future of dental care'.

By bridging the gap between clinical necessity, workplace funding models and the emotional realities of patients, the profession can better demonstrate that oral health is a vital component of feeling well.



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Dentist suspended over treatment of lip and tongue ties – what can we learn?

Lactation experts **Ashana Gupta** and **Sarah Oakley** analyse the case of a dentist suspended over consent failings in infant tongue tie treatment, while the registrant reflects on the wider lessons for dentistry

Ashana Gupta

Oral surgeon and lactation consultant

Sarah Oakley

Lactation specialist and tongue tie practitioner

The terms tongue and lip tie refer to congenital conditions whereby the frenulum connecting the lip or tongue to the mouth is too tight. In newborn babies, they can cause challenges with latch, milk transfer, maternal discomfort during breastfeeding, or prolonged feeding times.

While accusations of overdiagnosis have led lip and tongue ties to be the subject of controversy in recent times, it was not the procedure itself that caused the issue in this case. Instead, the dentist was found to have failed to obtain informed consent for some aspects of the treatment.

Ashana Gupta and Sarah Oakley explore what happened and the registrant also reflects on the consent issues raised and the impact of the fitness to practise process.

Communication and consent

Both experts stressed that the dentist was not criticised for their management of the patient's tongue

and lip tie. Ashana said: 'The key themes from this case relate less to whether tongue tie release itself is an appropriate treatment, and more to the importance of transparent communication, informed consent and shared decision making throughout the entire patient journey.'

The registrant told *Dentistry*: 'There was no finding of clinical harm arising from the treatment itself. The issues centred on consent, communication, documentation and process. Those are serious issues, and I have taken them seriously.'

The dentist was also found to have obtained valid consent for the initial tongue tie procedure, informing the parents of the potential risks and even sending them an information pack that they had to sign prior to treatment.

However, the General Dental Council (GDC) concluded that they did not gain sufficient consent to reopen the wounds at a follow-up appointment. The dentist said this was 'not just an issue for tongue-tie treatment' but for wider dentistry.

They said: 'As clinicians, we can sometimes assume that because a patient is

attending a planned review or continuation appointment, the consent remains understood. This case has reinforced for me that this assumption can create risk.'

What is adequate consent?

'My focus has always been to help families who are often exhausted, distressed and struggling to access joined-up care,' the dentist said. 'In this particular case, whatever the regulatory findings, my clinical intention was to support one family within what I understood to be an ongoing pathway of care.'

For Sarah, this raises an important debate around what adequate consent is and how it is understood by professionals, patients and parents.

She said: 'Parents frequently come to practitioners in a heightened state of stress, having experienced significant feeding difficulties for a sustained period of time. They are also often recovering from a traumatic birth experience. Most parents have little experience of surgical procedures, and many have accessed misleading information online and conflicting information and poor support from other healthcare professionals in relation to frenotomy and infant feeding.'

Addressing misconceptions can be very difficult, but is often key to managing expectations and ensuring patients fully understand their treatment.

What misconceptions surround tongue ties?

Sarah has found that many parents believe tongue tie treatment is a 'quick snip' that will result in instant improvement. In this case, reopening wounds caused the

patient to bleed, which they and their parents found distressing.

She said: 'Where practitioners are doing anything for which the evidence base is limited or conflicting, parents need to be made aware of that, along with the risks, benefits and alternatives prior to intervention.'

There is strong evidence that tongue tie can lead to reduced tongue mobility and feeding issues in young babies.

However, Ashana notes that the evidence is less straightforward surrounding other possible effects of tongue ties such as speech impediments.

She continued: 'Beyond infancy, a restricted tongue movement may, in some individuals, be associated with functional concerns such as difficulty producing certain speech sounds (for example, some "th" sounds), although the relationship between tongue tie and later speech difficulties is complex and not every child with a tongue tie will experience these problems.'

'This is why assessment should focus on function rather than appearance alone, and decisions should be made based on the individual child's needs.'

'Checking that patients or parents have understood the information provided and keeping detailed records are both central to proving that consent has been established'



How can consent for treatment of tongue ties be properly established?

Ashana believes that creating an environment that feels safe for the patient and their parents is crucial in tongue tie assessment and treatment. She said: 'Parents should feel supported with clear, balanced information so they understand the diagnosis, the available options, the potential benefits and risks, and are able to make an informed decision at every stage of care.'

Checking that patients or parents have understood the information provided and keeping detailed records are both central to proving that consent has been established. Ashana advised a thorough explanation of what is being proposed, why it is being considered, the risks and the alternatives – ensuring these conversations are clearly documented.

The registrant informed the patient's parents that they were going to 'apply some pressure to release the wound as it looked a bit tight', and received a nod by way of agreement. This was not considered sufficient by the GDC.

Sarah said: 'Practitioners offering division, or any surgical procedure, need to ascertain that the parents have fully understood the implications of proceeding with surgery, but this is not always straightforward and overwhelmed, sleep-deprived parents may not assimilate or recollect everything that is said to them.'

Ideally, parents would be given time to consider their options and do further research after an initial consultation. However, Sarah notes that many parents travel to access tongue tie treatment and may be reluctant to delay a procedure while coping with acute feeding issues.

Another crucial precursor to adequate consent is the practitioner's own understanding of current professional discussions around lip and tongue ties.

What do dental professionals need to know about tongue ties?

Appropriate training is essential for any dental professional undertaking assessment and treatment of oral ties in newborns. According to Ashana, this might include:

- Understanding infant feeding
- A strong grounding in neonatal oral anatomy
- Knowing the indications for intervention
- Appropriate consent processes
- Aftercare
- Recognising when referral or additional support is required.

There are a number of different techniques for treating tongue and lip ties, including sterile scissors and laser

therapy. Ashana said: 'Laser can provide a precise approach and may offer some haemostatic benefit by coagulating small blood vessels during treatment. As with any procedure, appropriate patient selection, clinical skill, consent and aftercare planning remain fundamental.'

The two experts agreed that the suspended dentist's approach to treatment went against current thinking at times. While Ashana cited the Association of Tongue Tie Practitioners' statement that releasing an upper lip tie is not supported for managing feeding difficulties to the same degree as with tongue ties, Sarah explained that reopening wounds after a tongue tie procedure is not a widespread practice as it could promote the formation of more scar tissue.

Sarah concluded: 'I think all practitioners involved in

tongue tie division – be they dentists, doctors, surgeons, nurses or midwives – can learn from this case and we can all take steps to improve our practice as a result.'

Overall, the specialists advised 'careful assessment and appropriate discussion of the evidence base' where tongue and lip tie management is concerned.

The dentist also acknowledged the effect of the fitness to practise process on their own life. They said: 'This case followed a GDC process lasting around three years, with a significant personal, professional and reputational impact. The process itself has a huge impact on a clinician's state of mind.'

'I fully understand that regulatory proceedings must be rigorous, but the experience can feel highly adversarial rather than constructive, especially when it continues for such a prolonged period.'



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The solution to ORE booking bottlenecks?

Online queueing experts **Miruna Strandberg** and **Matthew King** on what the General Dental Council can learn from commercial ticketing software to solve bottlenecks in the Overseas Registration Exam (ORE) booking process

Miruna Strandberg
Head of marketing, Queue-it

Matthew King
CEO, Queue-Fair

Prospective candidates for the ORE have reported payment issues, errors and overloaded servers since the GDC migrated the booking system to the myGDC portal. Many were unable to book a place to sit the exam, with some unsure if they had been successful despite payment having been taken.

A Part 2 booking was delayed by a week while the GDC carried out further testing, though candidates experienced the same malfunctions regardless.

But what exactly is causing these issues? Miruna Strandberg, head of marketing at Queue-it, and Matthew King, CEO of Queue-Fair, share their thoughts on why the ORE booking website is failing and how the bottlenecks can be managed. Both companies provide software that helps companies cope with high volumes of website traffic.

‘A queue system would assign candidates a random position’

Why does website traffic lead to bottlenecks?

According to Miruna, the problem is not simply the high volume of traffic on a website but the number of transactions attempted. She said: ‘Most websites can handle thousands of concurrent visitors browsing content or sitting on the homepage. It’s when those thousands of visitors start performing dynamic transactions that systems begin to struggle.’

This creates a bottleneck that fails under the transaction burden. In short, the ORE portal is not crashing due to the number of visitors on the site, but because they are all trying to book a place simultaneously.

Miruna compared this to a live event environment: ‘It’s like a stadium that can hold 100,000 people. Everything works fine while people are sitting in their seats. But if everyone wants to buy a drink or leave the venue at the same time, bottlenecks form quickly and the experience deteriorates.’

What is causing the ORE booking bottlenecks?

Miruna described a number of different transactions within the booking process with the potential for bottlenecks:

- Checking and updating available exam places
- Processing payments
- Communicating with third-party services that detect fraud or send confirmation emails.

Any of these processes could be responsible for the webpage malfunctioning.

To identify the problem, Miruna advised that the first step would be to ‘measure the system’s true capacity under realistic load conditions and understand where performance begins to degrade.’

How can bottlenecks be managed?

Miruna identified two primary ways that a bottleneck can be managed: increasing capacity or controlling traffic flow.

Capacity can be increased by ‘scaling infrastructure, re-architecting systems, redesigning business processes, or investing in additional technology’. However, she notes that this can be complex, expensive and, sometimes, impractical.

Matt therefore suggested that controlling visitor flow through a virtual waiting room would be the best solution. He said this ‘should hold the visitors away from the site in the minutes leading up to the sale, and then fairly add them to the online queue when it opens’.

Miruna explained: ‘Rather than allowing thousands of visitors to overwhelm a vulnerable system at once, a virtual

waiting room receives incoming traffic, provides visitors with their position in line and estimated wait time, and admits them in a fair, first-in, first-out order at a rate the booking system can reliably handle.’

Neither company has examined the GDC’s systems directly, so their comments are based on general principles rather than a technical assessment of the ORE booking platform.

What are the benefits of a queue system?

A queue system would assign candidates a random position, which Matt suggests ‘eliminates unfair advantage due to [for instance] some visitors having faster internet connections than others’.

He continued: ‘People that arrive after the queue has opened are added in first-come, first-served order, but behind everyone from pre-sale so it’s all completely fair.’

According to Miruna, this would control the flow of site visitors to match capacity ‘rather than allowing demand spikes to overwhelm critical systems’.

Who already uses virtual waiting rooms?

Miruna also suggested monitoring traffic in real time and having contingency plans in place for unexpected demand, bot activity, or operational issues.

She said: ‘The most successful organisations combine capacity improvements with traffic orchestration strategies.’

These approaches are widely used for the sale of tickets at major events. Miruna said that ticket sellers ‘actively orchestrate online traffic by controlling visitor flow, filtering bots and other abusive traffic, monitoring events in real time, and managing session integrity throughout the purchase journey’.

However, queue systems have been used in educational contexts before. Queue-Fair has worked with educational establishments to manage registration day and/or results day, as well as government bodies, healthcare organisations, online retailers with busy product drops, and financial institutions.

Matt said: ‘The system is suitable for any website that gets too busy from time to time.’

Most notably, the software was used by the Royal College of Emergency Medicine for what it describes as ‘a very similar registration’ to the ORE.

The GDC has said it will implement a new candidate portal for exams taking place from 2027. It has not yet announced how the new system will manage periods of high demand.

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Convincing Andy NHS dentistry is vital

Nigel Jones asks whether Andy Burnham will recognise dentistry's potential to play a bigger role in improving the nation's health

Nigel Jones
Director, Practice Plan

Another summer, another prime minister, another list of priorities that dentistry is fighting to top.

Given the enormity of the challenges facing Andy Burnham, social care being just one of the many significant examples, I suspect we will see yet more frustration for the British Dental Association (BDA), the Association of Dental Groups (ADG) and the thousands of NHS dentists in England waiting for the oft promised fundamental reform of the NHS dental contract. The day-to-day battles being fought by so many in the profession to keep NHS dentistry alive and kicking must be exhausting and, at some point, something has got to give. Too often, that is the mental health of dental practitioners and can also be their physical health and their financial wealth. It is so unjust.

One of the most exasperating aspects of the current state of affairs is that, from my privileged position as a longtime observer of UK dentistry, there are so many reasons to be optimistic about how the dental market will develop over the next few decades.

Over the last couple of months, I have met and listened to so many people that fill me with hope

and excitement about the future role that the dental profession can play in one of those big challenges facing Andy Burnham – safeguarding and improving the health of the nation and the NHS.

Leading the way

The presentation at this year's ADG Conference by Professor Nora Colton of UCL Global Business School of Health was a fascinating endorsement of how dentistry has been leading the way for decades when it comes to a prevention focused approach to healthcare.

We can get so preoccupied with the 40-50% of the population that don't visit the dentist that we forget the majority are willingly turning up for a health screening, usually every six or 12 months. On top of that, it's a screening for which most of them pay!

Rather than applying NICE guidelines to reduce that frequency of attendance, shouldn't the focus be on how to harness it for wider prevention measures? Thankfully, that's exactly what more entrepreneurial thinkers in dentistry are starting to do.

Take Dr James Goolnik as an example. He starts his regular dental examinations by asking his patients: 'How did you feel when you woke up this morning?'

That simple question opens a window into the wider health of the patient and prompts the kind of discussion that can lead, for example, to addressing sleep apnoea that can damage sleep quality and hamper the patient's ability to make healthy lifestyle choices.

Or look at the growing number of practices that are taking advantage of their patients being in the surgery by extending their oral health examinations to include screens for cholesterol levels, diabetes and even blood pressure. Any issues that come to light prompt the recommendation for the patient to investigate further via their pharmacy or GP.

The wait for an NHS appointment with any GP let alone 'your' GP can be alarmingly long depending on your location. Which is why more dental practices are utilising spare rooms on their premises to offer access to private GPs who offer both speed of access and continuity of care.

Others are going further and are offering the private GP equivalent of dental membership plans that build in an annual health screen as well as, within fair usage terms and conditions, unlimited appointments. Some of these plans include discounts on any follow-

up treatment with physios and podiatrists housed in the same building.

With the rapidly expanding amount of research and evidence linking oral health to heart disease, strokes, dementia and cognitive decline to name but a few and the focus on the oral as well as gut microbiome, the importance of dental care is ever-growing.

Addressing the issue

I first came across Andy Burnham in 2006 when he was minister for delivery and reform at the Department of Health before he went on to become secretary of state for health in 2009.

Unlike many of his predecessors, this

experience must have given him a deep insight into the root causes of so many of the problems facing the NHS. In an ideal world, he will see NHS dentistry as an enabler to addressing some of those problems.

However, in the real world, I suspect we will witness a continuation of the PR management we've seen with successive governments of various hues and persuasions.

Thankfully, there are some very impressive individuals within dentistry leading the way to challenge the more conventional way of thinking about health and I, for one, am excited to be witnessing it.



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Introducing the 2026 Dentistry Top 50

Explore this year's **Dentistry Top 50** and discover the people whose work is helping to define the profession today

The wait is over. The Dentistry Top 50 2026 has arrived, celebrating the people whose work, leadership and ideas are helping to shape the future of UK dentistry.

Nineteen people join the Top 50 for the first time this year, alongside returning figures who continue to make their mark on the profession. The list spans every corner of dentistry, from clinicians transforming patient care and educators inspiring the next generation, to

researchers advancing knowledge, campaigners driving change and leaders shaping national policy.

Compiled after weeks of nominations, discussion and deliberation, the list reflects the many different ways influence is earned in modern dentistry. Some names will be familiar, having featured in previous years and continued to build on that impact. Others have emerged through new ideas, fresh leadership or achievements that have caught the profession's attention over the past 12 months.

There is no ranking involved. What unites everyone on this year's list is a shared commitment to improving dentistry for colleagues, for patients and for the wider profession.

Recognising excellence

Putting the list together is never straightforward. Nominations arrived from across the profession, each one making the case for someone whose work deserved recognition. Narrowing hundreds of names down to 50

meant weighing achievements that are often impossible to compare directly.

A campaigner's impact does not look like a researcher's, and a practice leader's contribution does not look like an educator's. The final list is an attempt to recognise excellence in all its different forms.

At the heart of the Top 50 selection process is the care and consideration that goes into every discussion. Every nomination represented someone making a genuine difference to the profession, which made every decision both rewarding and incredibly difficult. While not everyone could make the final 50, this year's list reflects the breadth of talent, leadership and innovation that continues to shape the future of UK dentistry.

This year's Dentistry Top 50 is delivered in partnership with Denplan.

'Having the opportunity to be part of the Top 50 campaign has been a real privilege,' said Matthew Nolan, head dental officer at Denplan.

He said: 'Reading through this year's list, I have been struck not only by the quality and breadth of talent across the profession, but by the commitment, energy and determination of so many individuals who are working to make a genuine difference.'

'These are people who are challenging thinking, supporting colleagues, inspiring the next generation and helping to shape a thriving future for UK dentistry. Congratulations to everyone that made the list.'



**Andrea Johnson**

Chair and CEO, Den-Tech

**Andy Evans**

CEO, Dentaaid The Dental Charity

**Anushika Brogan**

CEO, Damira Dental Studios

**Professor
Avijit Banerjee**Professor of cariology and operative dentistry,
King's College London**Ben Atkins**Past president and trustee,
Oral Health Foundation**Bill Sharpling**Associate dean (CPD), King's College London
and director, LonDEC**Carol Somerville
Roberts**President, British Academy of
Cosmetic Dentistry**Cat Edney**

Dental therapist and founder, The Modern Therapist

**Debbie Hemington**

President, British Association of Dental Therapists

**Deepa Bharakhda**

Co-founder, Nightshift



Eddie Crouch
Chair, British Dental Association



Farzeela Rupani
Group chief medical officer,
Colosseum Dental Group



Fiona Ellwood BEM
Executive director,
Society of British Dental Nurses



Gauri Pradhan
Co-founder and trustee,
International Dental Organisation



**Professor
Iain Chapple MBE**
Head of periodontal research,
University of Birmingham



James Goolnik
Founder and clinical director,
Optimal Dental Health



Jason Wong MBE
Chief Dental Officer for England



Jin Vaghela
Co-founder and CEO, Smile Clinic Group



Joanne Stevenson
President, Dental Technologists Association



Kaival Patel
Director, Kana Health Group and Kana Dental Academy



Karen Juggins MBE
Consultant orthodontist and founder,
Keep Smiling campaigns



Kev Chavda
Founder, Brush It Forward



Kish Patel
Co-founder and CEO, Smile Clinic Group



Kunal Patel
Founder, Love Teeth Dental



Linda Greenwall MBE
Founder, Dental Wellness Trust



Manrina Rhode
Founder and CEO, DRMR



Mark Allan
General manager, Bupa Dental Care



Matthew Nolan
Head dental officer, Denplan



Milad Shadrooh
Dentist and content creator



Nicola Z Gore
Vice-president, College of General Dentistry



Nilesh Pandya
CEO, mydentist



Nilesh Parmar
Implant surgeon, multi-practice owner and dental business commentator



Pynadath George
President, Association of Dental Implantology



Rachael England
Head of policy and advocacy, Oral Health Foundation



Professor Raj Rattan MBE
Global adviser, Medical Protection Society



Reena Wadia
Founder, RW Perio



Rhiannon Jones
President, British Society of Dental Hygiene and Therapy



Rhona Eskander
Owner, Chelsea Dental Clinic, and co-founder, PÄRLA Oral Care



Robbie Hughes
Founder, Dental Excellence and Avant Garde Dentistry



Roshni Karia
President, College of General Dentistry



Sandeep Kumar
Founder and CEO, MiSmile Network



Sarika Shah
Founder, Flourish as a Female in Dentistry



Simisola Fynn-Famodun
Founder, Budding Black Dentists Network



Simon Chard
Co-founder and CEO, PÄRLA Oral Care



Simon Thackeray
President, British Association of Private Dentistry



Stephen Kinnock MP
Secretary of State for Wales,
formerly Minister of State for Care



Professor Tim Newton
President, Oral Health Foundation



Urshla Devalia OBE
President, British Society of Paediatric Dentistry



Victoria Sampson
Founder, THS Labs and creator, Oralis1



Professor Zoe Marshman
Professor of Dental Public Health,
University of Sheffield

A guide to AI in dentistry

Looking for the latest information regarding artificial intelligence (AI) in dentistry? *Dentistry* examines how AI, in its various forms, is reshaping the dental sector



Artificial intelligence (AI) in dentistry is being used ever more frequently by dental practitioners. That should come as little surprise; AI is increasingly used in many aspects of our lives.

Older forms of AI involved a stimulus being processed by a set series of rules, which would generate a response. The first AI tools were used in healthcare back in the 1950s to analyse blood and urine samples. By the 1980s, AI was being used in medical image analysis.

However, today's AI systems learn for themselves using large data sets. This is known as machine learning.

A 2023 study by Dental.org found that more than a third of dentists have implemented AI in their practices and 77%

'AI is a powerful tool, streamlining the work of dental practices and providing dentists with valuable information about their patients at high speeds'



AI in dentistry: key takeaways

- AI is becoming mainstream in dentistry, supporting both clinical care and day-to-day practice management
- Image analysis is one of its most established uses, helping dentists assess radiographs and scans for caries, periodontal disease, endodontic problems and surgical planning
- AI can reduce administrative burden, assisting with scheduling, billing, patient communications, record-keeping and clinical documentation
- AI supports rather than replaces clinical judgement – diagnosis and treatment decisions must remain the responsibility of appropriately trained dental professionals
- Data privacy, cybersecurity and regulation are essential considerations as AI becomes more widely integrated into dental practice.

of them reported positive results after applying it.

Evidence suggests that patients appreciate the benefits of using AI in modern dentistry to reduce medical bias and improve accuracy.

Uses of AI in dentistry

AI has an increasingly prominent role across many aspects of dentistry. It can be used clinically, for example, to aid diagnoses. It can also be used to help with practices' day-to-day business operations.

Here are some of the main ways in which AI is currently reshaping dentistry.

Image analysis

Image analysis is the most prominent way in which AI is currently utilised in dentistry. Using images such as 2D radiographs and CBCT, MRI and intraoral scans, AI image analysis draws upon large datasets to predict anomalies, which the dentist can then investigate.

AI image analysis can therefore increase confidence in diagnosis and play a role in developing patient treatment plans. It can be used in different ways, including:

- Caries diagnosis: AI tools can be used to analyse X-rays to help dentists identify areas that require further examination
- Periodontal diagnosis: AI can help to measure bone levels and detect tartar
- Endodontic diagnosis: AI can be used to help identify periapical pathologies. This technology analyses high-resolution 3D images of the periapical region
- Surgical planning: AI can be used with CBCT images to assist in the planning of surgeries. It can identify anatomical landmarks and pathologies. This can be used to increase surgical accuracy and efficiency. It can also improve communications between clinicians and dentists, who can use visual aids when explaining surgical processes.

Practice management

AI can be used to automate or simplify administrative tasks, such as scheduling, billing, record-keeping, communications and sending reminders to patients. This can streamline practice management.



Clinical documentation

There are various ways in which AI can be used to assist with clinical documentation.

For example, AI speech recognition software can be used for electronic health records. Technologies like conversational workflow assistants and documentation companions offer secure and convenient support for maintaining clinical documentation.

Other uses include:

- **Data management:** AI can be used to aid clinical decision-making through the rapid interpretation of large datasets. This can range in scale from data from a small independent practice to global datasets. This has great potential in terms of coordination and collaboration between medical and dental practices, for example
- **Personalised medicine:** AI can be used to inform personalised patient treatment plans based on medical history and genetic makeup
- **Predictive analysis:** AI can help to predict diseases and patient outcomes using large datasets. These can include medical records and genetic information
- **Drug discovery:** AI can be used to help predict the potential efficacy of drugs and speed up the drug discovery process
- **Clinical decision-making:** AI can provide dentists with recommendations based on the latest clinical evidence and guidelines.

‘Nothing can replace the work of a skilled dental professional in treating their patients’

Ethical considerations of AI in dentistry

AI tools often carry with them a variety of ethical concerns, and those for use in dentistry are no different.

One of the most important issues relates to patient welfare. While AI can be used to assist with diagnoses, only an appropriately trained dental clinician can diagnose or decide on treatment. AI is one of many tools that clinicians can use to inform their decisions, but it cannot make diagnoses itself.

Cybersecurity is also vital when using AI. A key concern is how patient data will be collected and shared. Privacy and confidentiality must be maintained.

Of course, it is also vital that regulations are followed. As technological advances

continue at speed, it is important to follow updates to guidelines.

A powerful tool

AI is revolutionising the dental sector just as it is the wider world. From analysis of X-rays to practice management systems, AI integration is becoming standard.

Nothing can replace the work of a skilled dental professional in treating their patients. But AI is a powerful tool, streamlining the work of dental practices and providing dentists with valuable information about their patients at high speeds.

AI is set to become ever more powerful, and we can expect further innovative applications of the technology to the dental sector.

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Implementing AI in dentistry

Hannah Burrow shares the six questions to ask before bringing artificial intelligence into dental practice

Dr Hannah Burrow
CEO, co-founder and CSO,
Kiroku

Artificial intelligence (AI) is moving quickly from something we talked about in the abstract to something dental professionals are using every day, from radiograph interpretation and patient communication to administration and clinical record-keeping.

I am hugely optimistic about what this technology can do. But healthcare is not somewhere we should simply sign up for the latest AI tool and see how we get on.

‘Human review cannot be optional in a clinical setting’

The better question is not: ‘Is AI good or bad?’ It is: ‘Is this particular AI appropriate for this task, and what happens when it gets something wrong?’

That matters because the tolerance for error changes with the task.

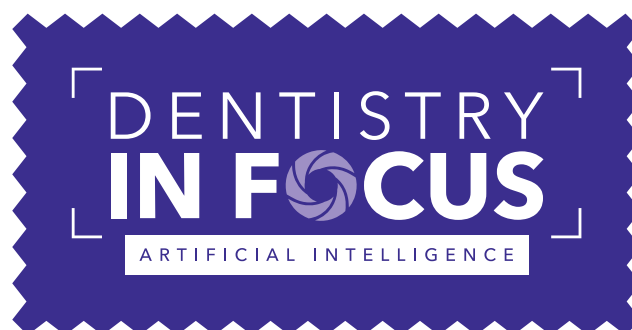
A poor music recommendation on Spotify is irritating, but an incorrect entry in a patient’s clinical record carries clinical, legal and patient safety implications.

Generative AI produces plausible outputs, not necessarily true ones. Something can sound convincing, be beautifully written and still be wrong. That is why human review cannot be optional in a clinical setting.

AI checklist for dental practices

Before introducing any AI tool, ask:

- Purpose: do we know exactly what it is, and is not, being used for?
- Data: do we know where patient data goes, how it is stored and whether it is used for training?
- Safety: can the supplier show evidence of appropriate security, clinical safety and regulatory compliance?
- Oversight: does a clinician review and approve anything that becomes part of the clinical record?
- Audit: can we see who created, changed and approved an output?
- Team: does everyone know how the tool should, and should not, be used?



The principle is simple: AI should reduce friction without reducing clinical control.

AI note-taking deserves particular attention

Record-keeping is repetitive and cognitively demanding, and a good system can help create more contemporaneous, complete and structured records.

AI can hallucinate, generating a plausible detail that was never said or done. It can omit information or lose context. And perhaps most importantly, it can create automation bias: a polished, well-structured note looks trustworthy, so we become less inclined to read it critically.

Review therefore cannot become a formality.

AI can capture, structure and draft, but the clinician remains responsible for diagnosis, consent, treatment decisions and the final clinical record.

When comparing AI products, I would encourage practices to spend time on the less glamorous parts of the technology: data protection, cybersecurity, clinical risk management, regulation and auditability.

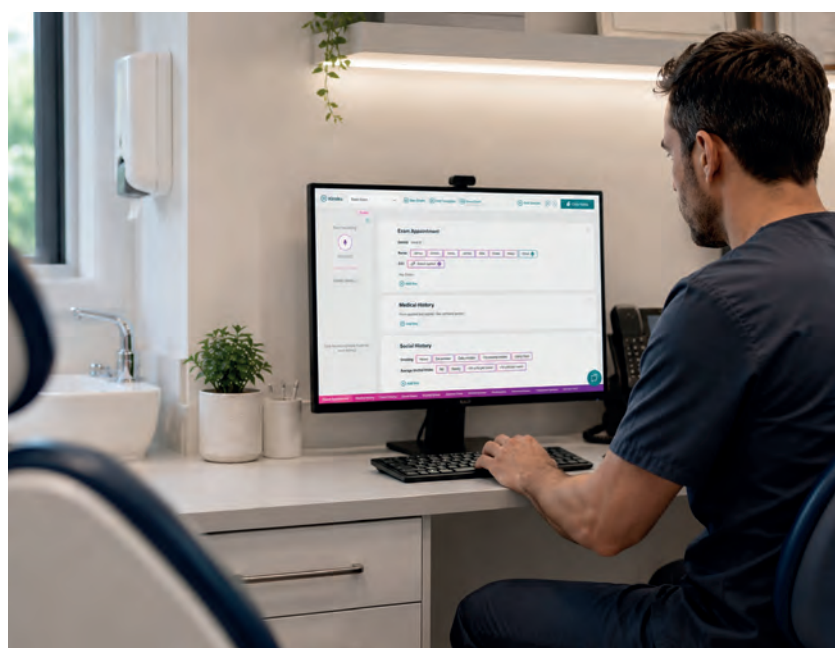
At Kiroku, we take this side just as seriously as the technology itself. We have built around DCB0129 clinical risk management, cyber essentials, NHS DSPT and MHRA registration as a class I medical device, and DTAC.

These will not be the exact requirements for every AI product, but suppliers handling clinical information should be able to show you their homework, not simply reassure you that their product is secure. Furthermore, they should be making this information extremely accessible, such as in the form of a trust centre on their website.

AI will become a normal part of dentistry, and I think that is positive. Used well, it can reduce administrative burden and give clinicians more time for the person sitting in front of them.

Dentists do not need to become AI engineers. We do need to ask sensible questions of companies asking us to trust their technology with our patients.

See Kiroku’s trust centre at trust.trykiroku.com.



ChatGPT dentistry

Bethany Rossington explains how to handle the AI-informed patient

Bethany Rossington
Dental surgeon and founder,
Renavé

Six months ago, Dr Bethany Rossington had never encountered a patient arriving with an AI-generated treatment plan. Now she finds that this ChatGPT dentistry is a weekly occurrence.

A search of social media shows the trend is accelerating across UK dental practices and raises questions for the profession. Namely, how do you handle a patient who arrives convinced that ChatGPT knows better than their clinician?

A framework that works

Bethany Rossington, who practises aesthetic medicine, has developed a practical consultation approach that other clinicians can learn from. Rather than challenging ChatGPT dentistry information head on, she starts from a position of curiosity.

'I will always start the discussion by asking what they are looking to achieve and if they have come across anything they are particularly interested in or that they feel may benefit them,' she says. 'I will thank them for doing so much research and reassure them that it helps me when my patients are keen to understand their treatment better.'

From there she explains AI's limitations without undermining the patient. 'I will usually explain that AI is an incredible tool but draws



information from many sources, some of which aren't the most up to date or reliable meaning there can be errors. In particular, I will stress that AI doesn't always know what weighting to put on different risks or patient specific factors, meaning something important is ignored or something less relevant is exaggerated.'

When a patient remains unconvinced, Bethany is clear about where the boundary lies. 'If a patient really won't listen to my advice, I will gently say that trust is an essential part of the clinician/patient relationship and if they do not feel my judgement is sufficient, we won't be able to progress with treatment.'

A profession underprepared

Beyond the consulting room, Bethany has wider concerns about how equipped the profession is to handle this shift.

'At present, I don't think the dental profession is fully prepared to manage the implications of AI-informed patients and there is a clear need for more structured guidance from regulatory bodies such as the General Dental Council (GDC) and professional organisations,' she says.

Her concern about access is particularly pointed. 'I anticipate this issue is likely to be amplified by ongoing difficulties in accessing NHS dental care. As access becomes more limited some patients may increasingly rely on AI tools for guidance.'

In a statement, the GDC said: 'All patients come with different levels of knowledge, ideas and expectations;

however, the central principle remains clear: dental professionals are responsible for the care they provide, and the use of AI tools cannot detract from that professional responsibility.

'This is reflected in our Standards for the Dental Team, which set out that dental professionals must work in partnership with their patients and keep their best interests at the heart of every clinical decision.

'As AI develops rapidly, we recognise the need for regulation to adapt to reflect this changing environment and have commissioned reviews of research into the use of AI in dental practice and in education to ensure that any future regulatory development has a strong evidential foundation.'

Where ChatGPT dentistry is heading

Despite her concerns, Bethany is not entirely dismissive about AI's long-term role. 'I do believe that AI will reach a point where it can reliably inform aspects of dental treatment planning and this development is likely to occur sooner than we think.'

The caveat is important. 'AI should enhance rather than replace clinical judgement, as treatment planning is complex and requires consideration of patient preferences, clinical experience and ethical reasoning that cannot be fully replicated by an algorithmic model.'

AI in prosthetic care

Is AI helping dental professionals personalise care or just producing generic advice in a more convincing font, asks [Anna Veli](#)

Anna Veli

Consultant maxillofacial prosthodontist, Engreco Healthcare

Artificial intelligence has quietly become part of clinical life, from drafting emails and tidying spreadsheets, to sitting somewhere in a patient's own research before they reach us.

In maxillofacial prosthetics, that raises a interesting question: is AI helping us personalise care, or producing generic advice in a more convincing font?

Information is not judgement

Patients researching a silicone ear, nose, eye or nipple prosthesis can arrive already familiar with retention magnets, adhesives, silicone grades or digital scanning. That's not necessary a bad thing. After all, an informed patient makes for a better conversation. The difficulty starts when general

information is mistaken for personalised advice.

The real clinical question is rarely: 'can this be made?' It's whether it will work for this patient's anatomy, lifestyle and expectations; weighing tissue condition, colour, function, retention, maintenance and priorities together, and occasionally concluding a prosthesis isn't the right answer at all.

No AI does that weighing up. A trained and certified prosthetist does.

Using AI in a prosthetics clinic and lab

At Engreco Healthcare, a maxillofacial prosthetics clinic and dental laboratory, AI is a tool, not a decision-maker.

The team uses it to draft and refine website content, review on page SEO and structured data, audit our website for usability gaps, and refine social media posts.

Behind the scenes, we've built our own repeatable skills within AI tools such as Claude, saved instructions and house style that let recurring jobs (including correspondence, spreadsheets, and report formatting) run automatically to a consistent standard, not reinvented each time. That frees a small team for work that needs a human.

We also use AI to spot patterns in patient questions when searching for our services, and shaping educational content based on that.

Most interestingly, we're exploring AI-assisted analysis of anatomy, colour and skin-tone against digital models, flagging areas needing closer attention or a more natural look.

Similar clinics and labs are likely to see AI move into digital

shade matching, CAD design assistance, automated quality checks between scan and print, business inventory forecasting, and clinician-reviewed transcription.

Patient-facing chatbots for booking are plausible too, provided they're clearly signposted as non-clinical and never used to triage symptoms unsupervised.

The legal boundary matters

Of course, none of this sits outside regulation. Where AI software is used for a medical purpose, it may fall within the UK's medical device framework overseen by the Medicines and Healthcare products Regulatory Agency (MHRA), depending on intended use. Where patient images or health data are processed, that's special category data under UK GDPR, and the Data Protection Act

2018 requires meaningful human involvement in decisions with significant effects on a patient.

For us, AI supports the workflow; it never replaces clinical judgement or accountability.

Human expertise, amplified

The most exciting future for this profession isn't AI versus the prosthetist. It's the prosthetist with better tools.

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Adopting AI note-taking

Why aren't dental practices adopting AI note-taking and what can they do about it, asks **Monika Morgan**



Monika Morgan

Communications consultant and trainer, The Comms Lab

In dental practice, three barriers consistently prevent AI note-taking from moving beyond initial curiosity:

1. Tools are judged too early
2. There is no shared standard for what good looks like
3. No one owns making it work.

The pattern is easy to recognise and it is one I see repeatedly in training sessions with NHS teams. A clinician tries an AI note-taking feature once or twice. The output is not quite right – too much captured, or nuance missed, for example. The tool is dismissed as inaccurate. But AI is only as good as the judgement behind it. Getting to a high-quality output requires upfront effort: testing, iteration and adjustment. It needs, in effect, to be trained.

Even when teams get past that stage, a second issue emerges: no shared definition of quality. What makes a good clinical note?

‘The challenge is closing the gap between initial curiosity and consistent use’

What needs to be captured, what can be left out, and how should AI-generated content be reviewed?

In many practices these questions are left to individual clinicians to decide. The result is inconsistency – and hesitation. When everyone is making their own judgement call, AI becomes a personal risk rather than a supported way of working.

This is where the third barrier becomes critical: ownership. In practices where no senior leader has clearly endorsed or guided the use of AI, adoption remains fragmented. Without clear direction, AI note-taking becomes something people experiment with privately rather than something the practice has chosen to do.

The data protection question

Alongside these internal barriers, there is a common external concern: data protection.

Clinicians are legally and ethically responsible for the content of their records, regardless of how they are produced. Introducing AI into that process raises important questions. Are consultations being recorded or simply transcribed? How is patient consent handled? Where is data stored?

Professional bodies such as the Medical and Dental Defence Union of Scotland (MDDUS) and



the General Dental Council (GDC) offer guidance, but it does not always reach those making day-to-day decisions in practice. In a healthcare environment, uncertainty does not lead to experimentation – it leads to inaction.

How to make AI note-taking work

The technology is available. The challenge is getting it into the workflow. These five steps can help close that gap.

1. Make a clear decision

If AI note-taking is something the practice wants to explore, that needs to be stated explicitly by practice leadership. Without that signal, teams will continue to treat it as an individual experiment rather than a shared process.

2. Define what good looks like

This does not require a fully developed policy, but it does

require clarity. What should an acceptable AI-generated note include? What needs to be checked? What level of editing is expected before it is finalised? A simple, shared standard removes uncertainty and builds confidence.

3. Start small

Rather than attempting to roll out AI across all documentation, focus on one specific use case – capturing consent discussions or summarising clinical findings, for example. Testing one scenario properly makes it easier to understand where the tool adds value and where it needs adjustment.

4. Treat AI output as a draft, not a final version

The role of AI here is not to replace clinical judgement but to reduce the time it takes to produce a usable first draft. Framing it this way helps manage expectations and reduces the risk of over-reliance.

5. Assign ownership

Someone in the practice needs to be responsible for testing, refining and guiding how AI note-taking is used. Without ownership, tools remain in the ‘interesting but optional’ category. With it, they have a chance to become part of how the practice operates.

Closing the gap

AI note-taking is not a future dental concept. It is available now, in many cases already integrated into the systems dental practices use every day.

The challenge is closing the gap between initial curiosity and consistent use – and that requires clarity, confidence and direction, not better technology.

A smiling male dentist with dark, curly hair and a beard, wearing a dark V-neck shirt, stands in a dental office. The background is softly blurred, showing dental equipment and a clean, professional environment. The lighting is warm and focused on the dentist.

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Restoring a worn dentition

Edward Bateman rebuilds posterior support and rejuvenates a worn smile with chairside milled restorations for a minimally invasive result

Edward Bateman
Principal dentist,
Tain Dental Care

Managing the worn dentition demands careful sequencing, a clear understanding of the patient's occlusion, and restorative materials that can be adjusted and refined as treatment progresses. Where posterior support has been lost and the anterior teeth are bearing an excessive load, a staged and reversible approach is invaluable.

The following case demonstrates how chairside

milled BRILLIANT Crios (COLTENE) restorations, combined with a digital workflow, delivered an aesthetic and functional outcome while keeping tooth preparation to a minimum.

Patient background
A 66-year-old man attended as a new patient, having been an irregular attender over the previous five years. He had previously been a regular attender for check-ups elsewhere.

His primary concerns were a loose lower front tooth and

dissatisfaction with his smile, which he felt had become very worn, with the teeth no longer particularly visible.

He had a history of multiple extractions over the years, which had left him with significant gaps and a compromised bite (Figures 1 to 5).

Clinical assessment
Clinical examination revealed missing teeth in the upper right, upper left and lower right quadrants, resulting in a marked lack of posterior support.

Consequently, the patient presented with an edge-to-edge bite on the front teeth only, which had led to excessive wear of the anterior dentition.

The lower incisors had over-erupted, with the LL1 grade 2 mobile, and the UR6 had also over-erupted into the available space. Despite these challenges, the patient was periodontally healthy and his oral hygiene was fair.

The absence of active periodontal disease provided a sound foundation on which to plan restorative treatment, with the priority being to address the destructive loading on the anterior teeth.

Treatment planning
The relationship between the overloaded front teeth, the edge-to-edge bite, and the resulting excessive wear was

discussed in detail with the patient. The key objective was to provide posterior teeth in order to improve the bite and to create the space required to restore the worn front teeth.

Implants were discussed as a means of replacing the missing posterior units, but these fell outside the patient's budget.

It was therefore agreed to provide removable chrome dentures for both the upper and lower arches, with the aim of improving and opening the bite. The aesthetic challenge of clasping the front teeth was discussed, and clear flexible clasps were selected to minimise their visibility.

The plan was that, once the patient was comfortable wearing the dentures, composite veneers would be placed on the UR3, UR2, UR1 and UL2, and the crown on the UL1 would be replaced with a composite crown, all fabricated in BRILLIANT Crios.

The lower incisal edges would be smoothed and sealed with composite, and whitening would be carried out at the outset to establish the desired shade.

Treatment execution
Treatment began with hygiene therapy, followed by impressions for bleaching trays. Whitening was carried out over three weeks, after which a further two weeks were left to allow the shade to stabilise and the bond strength to recover before



Figures 1-3: Patient presentation at initial assessment



Figures 4 and 5: Preoperative view showing excessive anterior wear and edge-to-edge contact

any adhesive restorations were placed.

A scan was then taken at the opened bite in order to fabricate the partial upper and lower dentures. This was achieved by scanning with a leaf gauge in place at the desired degree of opening, allowing the new vertical dimension to be captured accurately (Figures 6 to 9).

The dentures were fitted, and direct composite was added to the teeth to improve their length.

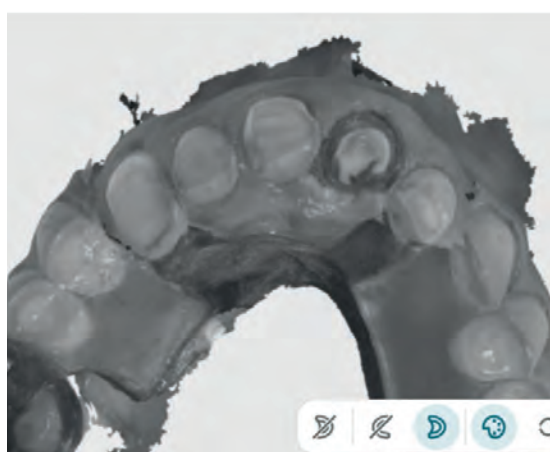
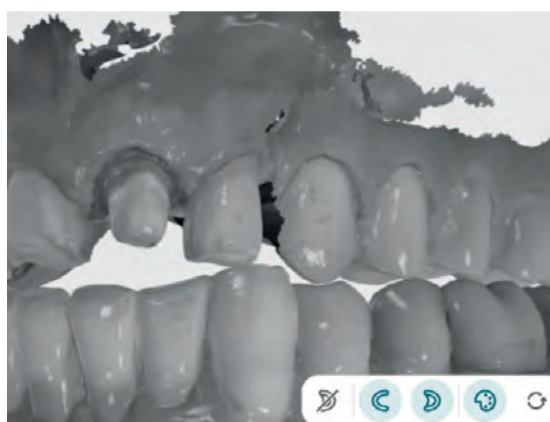
No tooth preparation was carried out at this stage, so that if the patient was unable to tolerate the increased occlusal vertical dimension, the additions could be removed and the situation reverted without harm.

At the three-week review, the patient reported that he was unwilling to wear the lower denture, finding it impossible to tolerate. It was agreed to continue with the upper denture only and to review progress.

After a further three weeks, the patient was wearing the upper denture well and felt comfortable, so it was agreed to proceed with the definitive restoration of the front teeth, preparing the teeth on one day and fitting the following day.

Two weeks later, the UR3, UR2, UR1 and UL2 were prepared for composite veneers, while the UL1 crown was removed and the tooth reprepared. The over-erupted lower teeth were adjusted and sealed with composite so that the incisal edges were even.

A scan was taken and the restorations were designed using Trios Design Studio, then milled from LT A3 BRILLIANT Crios blocks on a Roland DWX-42W mill in the practice on the same



Figures 6-9: Digital scan captured at the opened vertical dimension using a leaf gauge

day. The restorations were polished and sandblasted ready for fitting. The following day, the veneers and crown were cemented using COLTENE SoloCem.

Outcome

The patient was very happy with the final aesthetics, with both his smile and his bite improved in a minimally invasive manner (Figures 10 and 11).

Encouragingly, the mobility of the lower front tooth resolved once the adverse loading had been removed, confirming that the original problem had been occlusal in nature rather than periodontal.

Case reflections

BRILLIANT Crios was particularly well suited to this case. The resilience of the milled composite, combined with the ability to mill quickly in-house and achieve good aesthetics, made it an ideal choice.

Of particular importance in a wear case where the bite is being changed, the material is easily adjustable in the mouth, allowing the occlusion to be refined as treatment progressed.

The outcome would have been further improved had the patient been able to tolerate the lower partial denture, as this would have provided additional posterior support and a more balanced occlusion. Nonetheless, the result achieved was more than sufficient to meet the patient's needs, delivering a comfortable, aesthetic and conservative restoration of a worn and compromised dentition.



Figures 10 and 11: Final result showing improved aesthetics and a restored bite

Getting started in implant dentistry

For dentists getting started in implant dentistry, supervised clinical experience can teach what textbooks cannot – **Patric Aria Saraby** shares his insights

Patric Aria Saraby
Associate dentist at Bupa
Dental Care in Westbourne and
Verwood Dental Care

When I enrolled on my implant master's programme, I knew there would be a steep learning curve. However, nothing prepares you for placing multiple implants over consecutive days in a busy setting.

Earlier this year, I joined a dental mission in Fortaleza, Brazil, at ICEO, where I had the opportunity to place 20 implants under the supervision of experienced implant surgeons. Although I had spent countless hours studying CBCTs, drilling protocols and prosthetic principles, the clinical experience taught me lessons that textbooks simply cannot.

These are the five lessons that changed the way I think about implant dentistry.

1. Implant placement is far more about soft tissue than drilling bone

Before my first case, I was focused almost entirely on the osteotomy:

- Implant diameter
- Implant length
- Insertion torque
- Primary stability.

What surprised me was how much of the procedure depended on flap management.

A poorly reflected flap

immediately reduces visibility, increases tension and makes every subsequent step more difficult. Conversely, a well-designed full-thickness flap with careful tissue handling transforms the surgery.

I quickly realised that experienced implant surgeons often appear 'fast' not because they drill quickly, but because they manage soft tissue exceptionally well.

The implant is only one part of the surgery; the flap determines how smoothly everything else proceeds.

2. Bone has a personality

On paper, drilling protocols look identical. In reality, every patient feels completely different.

Some osteotomies almost guide the drill naturally. Others require constant tactile feedback. The difference between dense cortical bone and softer cancellous bone becomes obvious within seconds.

One of the biggest surprises was learning to trust tactile sensation rather than relying solely on depth markings or drilling sequences. Primary stability isn't simply measured by insertion torque, it's something you begin to feel. That tactile confidence only develops through repeated clinical exposure.

3. Guided surgery cannot replace surgical judgement

Planning software is remarkable. CBCT planning allows accurate implant positioning before the patient even enters the surgery. However, once the flap is reflected, reality doesn't always match the virtual plan. Bone contours vary. Extraction sockets appear different. Soft tissue thickness changes perception.

'Implant dentistry is not about placing fixtures into bone, it is about careful planning, precise execution, biological understanding and continual learning'

The surgical guide remains valuable, but it is exactly that – a guide.

Clinical judgement is still essential for deciding whether small adjustments are necessary while maintaining restorative principles.

The digital workflow enhances decision-making; it doesn't replace it.

4. Grafting is not the difficult part – knowing when to graft is

Before the mission, bone grafting seemed intimidating. Mixing particulate graft, placing collagen membranes and stabilising the material looked technically demanding. In practice, the mechanics are relatively straightforward.

The real challenge is recognising when grafting is required and understanding what outcome you're trying to achieve.

Sometimes the objective is contour preservation. Sometimes it's filling a dehiscence. While sometimes it's simply protecting exposed implant threads. The indication is far more important than the technique itself.

5. Implant dentistry is a team sport

One of the biggest lessons had nothing to do with implants. Watching

experienced surgeons work alongside assistants, dental nurses and mentors highlighted how much good implant dentistry depends on teamwork.

The assistant anticipates every instrument, the supervisor notices details you have missed, and the nursing team maintains efficiency throughout the procedure.

As the operator, you remain responsible for every decision, but successful implant surgery is rarely an individual achievement.

Learning from clinicians with decades of experience accelerated my own learning far more than practising in isolation ever could.

Final thoughts

Leaving Fortaleza, I realised I hadn't simply placed 20 implants. I had learned to respect the complexity of implant surgery.

The experience reinforced that implant dentistry is not about placing fixtures into bone, it is about careful planning, precise execution, biological understanding and continual learning.

Perhaps the biggest lesson was also the simplest. The more implants I placed, the more I appreciated how much there is still to learn. That, in my view, is exactly what makes implant dentistry such a rewarding career.

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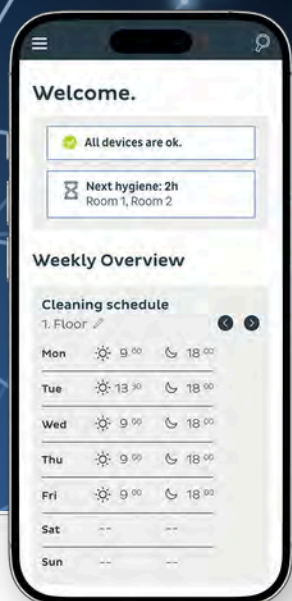


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Closing the gap

Nieves Ros presents a complex anterior case requiring the management of periodontal disease before commencing with orthodontic treatment and composite bonding

Nieves Ros
Principal dentist, Smmmile
Store Bristol

When this 56-year-old patient first came to see me at Smmmile Store Bristol, his concern was clear and immediate: a growing gap between his upper anterior teeth that had been developing over recent years and was increasingly affecting his confidence.

As a businessman who regularly led client meetings, his smile mattered – not just aesthetically, but professionally. He described becoming progressively self-conscious about it, noticing that it had started to alter the way he carried himself.

Examination and diagnosis

A clinical examination was carried out and revealed that the diastema and tooth migration were not simply a cosmetic issue. The patient had been diagnosed with active periodontal disease by a previous dentist, and this was the root cause of the tooth shifting we were observing.

X-rays confirmed generalised bone loss and, critically, significant bone loss on the mesial aspect of the UL1 (Figure 1) – a finding that would profoundly influence every treatment decision that followed.

Additionally, the UL3 had been previously root canal treated and restored with a crown, adding a further

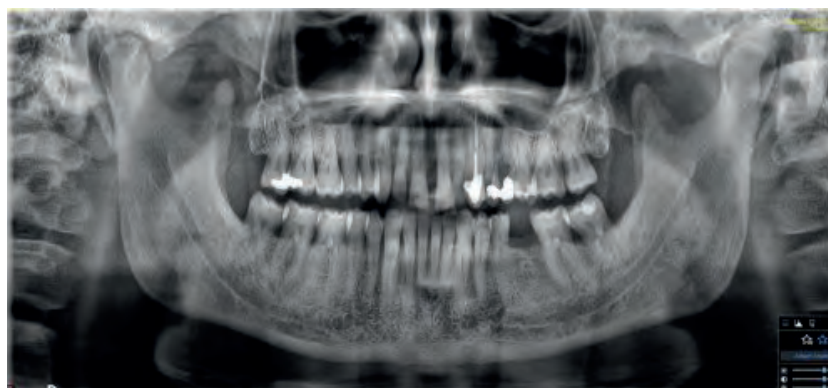


Figure 1: Panoramic radiograph (OPG) at presentation. Generalised bone loss is evident, with particular involvement of the mesial aspect of UL1 – a key constraint in treatment planning



Figure 2: Pre-treatment frontal intraoral view. The central diastema and anterior tooth migration driven by periodontal bone loss are clearly visible



Figure 3: Pre-treatment close-up smile view, demonstrating the aesthetic impact of the anterior spacing and colour mismatch with the existing UL3 crown

restorative variable to an already complex picture (Figures 2 to 5).

Periodontal probing confirmed deep pockets with active bleeding on probing across multiple sites. Understanding this patient as a person was equally important. He had a clear ‘driver’ personality type: direct, outcome-focused, and eager to understand timelines, risks, and realistic expectations. Ambiguity was unwelcome.

This shaped how I communicated throughout the case – with transparency and precision at every stage.

Treatment options

Before any restorative or orthodontic treatment could be considered, the active periodontal disease had to be brought under full control. This was non-negotiable.

We embarked on a structured course of periodontal therapy – including oral hygiene instruction and a full course of supra- and subgingival debridement – with close monitoring until probing depths had reduced and bleeding on probing was eliminated. Only once the periodontium was stable did we discuss the restorative and aesthetic pathway forward.

The options for addressing the spacing were substantially limited by one critical constraint: the UL1 could not be moved.



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The bone loss on its mesial aspect meant that any orthodontic force applied to that tooth risked further periodontal attachment loss. A conventional approach attempting full gap closure was therefore not viable.

The solution we agreed upon was a carefully sequenced combination: Invisalign to redistribute and reduce the spaces strategically, followed by direct composite bonding across the upper anterior five teeth to achieve a harmonious, symmetrical result – all with ULI held stationary throughout.

Treatment

With the periodontium stable and the patient fully consented, we commenced Invisalign treatment.

The ClinCheck digital planning was instrumental here: by mapping tooth movements in advance, I was able to impose hard constraints around the ULI and design the redistribution of spaces so that the final bonding would be both clinically feasible and aesthetically predictable (Figures 6 and 7).

The ClinCheck images illustrate a key planning decision: the spaces were not fully closed orthodontically. The larger central diastema (3.0mm) was reduced substantially but redistributed, with smaller residual spaces (0.3–0.5mm) planned strategically between teeth to allow symmetrical composite additions without placing any movement demands on the ULI. Managing a patient with known bone loss throughout orthodontic treatment requires vigilance, and we maintained a close periodontal recall schedule



Figure 4: Pre-treatment right lateral intraoral view, showing the occlusion and existing posterior restorations

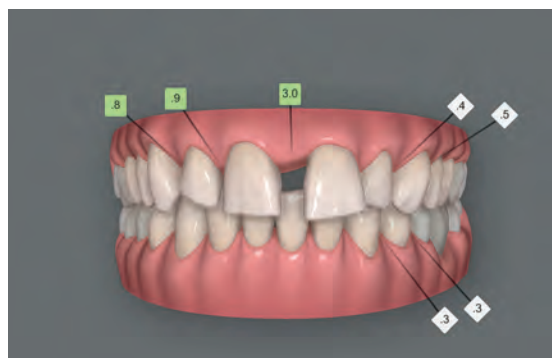


Figure 6: Invisalign ClinCheck – initial tooth position showing the original spacing distribution, including the central diastema and lateral gaps, prior to orthodontic treatment

interspersed throughout the aligner series. The patient was highly compliant, motivated by a clear picture of the outcome ahead.

Once the orthodontic phase was complete, direct composite bonding was carried out across the UL1, UL2, UR1, UR2 and UR3. A layering technique was used to replicate natural enamel translucency and surface texture.

The central challenge was matching the existing crown on UL3 – which the patient wished to retain – requiring careful shade selection and incremental layering to harmonise with the ceramic restoration's optical properties without replicating it exactly (Figures 8 to 11).

Aftercare

Given the underlying periodontal history and the presence of direct composite restorations, a robust maintenance programme was essential.

The patient was placed on periodontal recall schedule, combining professional cleaning with monitoring of probing depths, bone levels, and any signs of relapse. He was also counselled on composite bonding maintenance – the risk of staining, the need to avoid biting hard foods, and the expectation that periodic polishing or minor refinements would form part of his long-term care.

He took to this positively. Maintenance appointments became something he engaged with proactively – a meaningful shift from a patient who initially arrived carrying the weight of a longstanding, unmanaged condition.



Figure 5: Pre-treatment left lateral intraoral view, highlighting the position of the UL3 crown and the spaces mesial to it

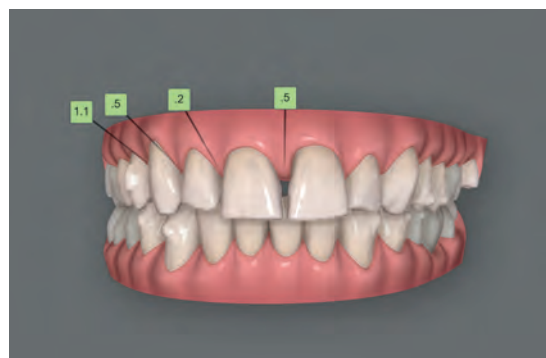


Figure 7: Invisalign ClinCheck – planned end position, showing the intentional redistribution of residual spaces adjacent to UL1 and laterally, to be resolved with composite bonding

‘This case was a reminder that treating a patient well means treating the whole picture’

Case reflection

This case tested every dimension of clinical decision-making – not just technically, but in terms of communication, expectation management, and adaptability under genuine uncertainty.

Looking back, I am proud of how the sequencing held together: treating the periodontium first, planning orthodontics around the hard constraint of the ULI, and using composite bonding to resolve what orthodontics alone could not.

The ClinCheck planning proved particularly valuable, as it allowed me to show the patient – visually and precisely – exactly where spaces would end up before any aligners were fitted.

If I were to approach anything differently, I would perhaps invest even more time in pre-treatment visualisation tools: a detailed digital smile design or mock-up to show the expected composite result alongside the planned orthodontic outcome.

Given his personality type, concrete previews were especially reassuring during the longer orthodontic phase, and earlier access to those visuals might have reduced some of the



Figure 8: Post-treatment frontal intraoral view. The anterior spaces have been resolved through the combination of orthodontic redistribution and direct composite bonding



Figure 9: Post-treatment right lateral intraoral view, demonstrating improved tooth proportions and harmonious occlusion



Figure 10: Post-treatment left lateral intraoral view



Figure 11: Post-treatment close-up smile. The result demonstrates improved symmetry, natural tooth proportions, and a seamless integration with the retained UL3 crown



Figure 12: Pre-treatment full-face smiling portrait – the impact of the anterior spacing on the patient's confidence is evident even in his smile



Figure 13: Post-treatment full-face portrait. The transformation in the patient's confidence is immediately apparent

uncertainty he experienced mid-treatment related to the future bonding.

The UL3 crown matching was the other area of inherent unpredictability. Matching composite to an existing ceramic restoration is always challenging, and while the result was successful, future cases like this might benefit from closer characterisation of the original restoration before beginning bonding.

Conclusion

This case illustrates what becomes possible when periodontal health, orthodontics and restorative dentistry are planned as a coherent whole rather than in sequential isolation.

By accepting the limitations imposed by the UL1's bone loss early in the process – rather than trying to work around them reactively – it was possible to design a treatment pathway that was both clinically sound and aesthetically rewarding.

More than anything, this case was a reminder that treating a patient well means treating the whole picture. This was not simply a man with a gap in his teeth; he was someone whose professional identity and personal confidence were deeply connected to his smile (Figures 12 and 13).

Seeing him now – relaxed at recall appointments, confident in how he looks, and an enthusiastic advocate for the practice – is the most meaningful measure of success.

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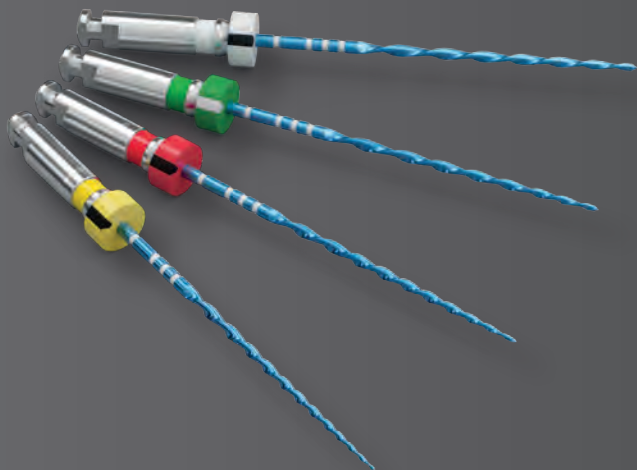
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Championing children's oral health

Andrew Osafo reports back from Dental Wellness Trust's visit to Mora Primary School where a team of volunteers provided oral health assessments as well as screening and fluoride varnish application

Andrew Osafo

Dentist and ambassador for the Dental Wellness Trust

Dental Wellness Trust recently visited Mora Primary School in north west London for another one of its many school-based dental outreach visits.

'It was a fantastic day,' said the school's deputy head, Kate Bass. 'We have been working with the Dental Wellness Trust for seven years now. Initially with a dentist coming into school to talk to our youngest children – and it has since grown into an entire school initiative with the whole school brushing their teeth in school, as well as these outreach sessions too.'

'Dental Wellness Trust provides the toothbrushes, toothpaste, holders and plates. The serving plate with 30 blobs of toothpaste on it... the children come and get their toothbrush, scrape the plates, brush their teeth... it takes literally five minutes.'

Almost 300 children also had oral health assessments during this special outreach morning, with screening and fluoride varnish application. Kate said: 'The result of this oral health collaboration with Dental Wellness Trust is that we don't seem to have children with rotten teeth, needing extractions, having time out of school and being in pain. The children love it too, they were coming in today saying: "The dentists are here! I'm so excited to see the dentist!"'

Dr Linda Greenwall MBE, founder of the Dental Wellness Trust, was on site with a team of volunteers. She said: 'We are noticing that a lot of the children's teeth are improving because of the commitment that Mora Primary School has towards supervised toothbrushing. Good oral health leads to good general health, and that is a key message.'

'Going from being anxious and nervous, to smiling with confidence, with a happy, healthy smile, healthy teeth and no bleeding anymore make outreach days like this even more special.'

How you can get involved

The Dental Wellness Trust relies on sponsorship, donations and volunteers to help extend its work. Volunteer opportunities include half-day school-based outreach and screenings and fluoride applications, refugee outreach clinics, as well as a South African outreach programme.

For further information, email info@dentalwellnesstrust.org or visit dentalwellnesstrust.org.

To donate or fundraise, visit justgiving.com/charity/dentalwellnesstrust.

Upcoming events

Looking for a fun challenge for a worthy cause? Join the Tough Mudder event on Sunday 20 September in London to raise funds and awareness for the Dental Wellness Trust. For more details, email lucy.dennis@privatedentalmentor.co.uk.

On Thursday 10 September 2026, one of Dental Wellness Trust's largest fundraisers of the year takes place – dinner at the House of Commons. Secure your seat by emailing funding@dentalwellnesstrust.org.

An urgent need for better oral health

The UK has an ongoing oral health crisis – with one in four children currently living with mainly preventable tooth decay leading to pain and infections. It is estimated that around 60,000 school days annually are lost in the UK as a result.

It is often children from the most deprived communities who are suffering the worst effects of tooth decay with many children never having visited a dentist before.

The Dental Wellness Trust delivers oral health education, prevention and clinical care to schoolchildren around the world. Its programmes in the UK for children in school, nursery and community settings reach more than 100,000 children both directly and indirectly.

Internationally, thousands more children in underserved townships and communities are supported, including in South Africa where the Dental Wellness Trust's sister charity, the Dental Wellness Foundation, operates.

As the Dental Wellness Trust's newly appointed ambassador, I am excited to support its crucial work and events, such as this Mora Primary School outreach, that focus on the importance of oral health education to create a lifetime of healthy smiles for children.

I invite you to join us in stopping preventable tooth decay in the UK and worldwide by volunteering, donating or fundraising.

The Dental Wellness Trust would like to thank Mora Primary School, all the volunteers who assisted on the day as well as the sponsors who made the event possible: Admetec, DMG, Henry Schein, Matchstick Monkey, SDI, Sonisk, SurgiTel, Ultradent and Ultralight Optics.





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Flying high

Flying Smiles founder **Fiona Perry** shares how she's gained a unique perspective on oral healthcare by taking it directly to patients

Fiona Perry
Dental hygienist and founder
of Flying Smiles

No two days look quite the same for Flying Smiles founder Fiona Perry.

From the cargo bike that first became synonymous with Flying Smiles to the recently launched Molar Express, the way Fiona travels may have moved on, but the focus remains the same: bringing oral healthcare directly to people who need it.

As the service has grown, Fiona has also become

increasingly aware of communities where people are not necessarily financially deprived, but are service deprived, with limited access to oral healthcare close to home.

Along the way, she has met patients who have challenged assumptions, broadened perspectives and reminded her that every appointment comes with a story.

'The patients who have taught me the most are often the ones I never expected to meet,' she says.

Seeing differently, thinking differently

'One of the greatest privileges of mobile dentistry is the opportunity to see patients in the context of their everyday lives,' says Fiona.

Rather than meeting somebody for a short appointment in a clinical setting, Fiona sees where people live, who supports them and some of the day-to-day challenges that influence their health.

'When you visit somebody at home, you understand

much more about their daily life and the challenges they are managing,' she explains.

Something as simple as attending an appointment can involve arranging transport, relying on family members or managing health conditions that make leaving home difficult. Many of these challenges are largely invisible within a traditional clinical environment but become much easier to understand when seen firsthand.

That broader perspective has shaped the way Fiona

approaches patient care and reinforced the importance of meeting people where they are, both literally and figuratively.

Among the people who have had the greatest impact are families with neurodiverse children. For some children, the journey to a dental appointment can be stressful long before they reach the practice. Changes in routine, unfamiliar surroundings and anxiety can all create challenges for both children and parents. 'These are families who



Mobile Dental Conference 2027

The UK's first conference dedicated to mobile dentistry is set to take place on 30 April 2027 in Edinburgh. Expect practical learning, fresh ideas and inspiring conversations about the future of community-based oral healthcare. Book your place and learn more at bit.ly/4xmGdhp.

care deeply about oral health,' says Fiona. 'They want support and they want to engage. Sometimes they simply need services that work with their circumstances rather than against them.'

She has also met nervous patients who have gradually drifted away from dental care over time. Often, this happens without any conscious decision. Life gets busy, appointments are missed and eventually returning begins to feel overwhelming.

What Fiona has found consistently is that many of these patients are not disengaged from their oral health. Quite the opposite; they value prevention, want advice and are keen to look after themselves but may need a different route back into care.

Longer lives, changing needs

Another group that has made Fiona think differently about oral healthcare is older adults.

One of dentistry's great success stories is that more people are retaining their natural teeth into later life. The challenge is that many are also managing crowns, bridges, implants and heavily restored dentitions that require ongoing maintenance.

At the same time, mobility issues, changing health conditions and the realities of ageing can make attending regular appointments more difficult than it once was.

'As a profession, we've become very good at helping people keep their teeth,' says Fiona. 'The next challenge may be helping people continue caring for them as their circumstances change.'

Flying Smiles has never been about replacing dental practices. Instead, Fiona sees mobile dentistry as another option for people whose circumstances make accessing care more difficult, helping oral healthcare fit more comfortably into their lives. For all the practical benefits of mobile dentistry, it is often the human moments that leave the greatest impression. One of Fiona's proudest moments involved helping a patient receiving palliative care feel comfortable enough to smile and speak again after their mouth had been cleaned and moisturised.

'Oral healthcare is about so much more than teeth,' she says. 'It's about confidence, comfort, dignity and quality of life.'

Experiences like these are what continue to motivate her. Every day spent out and about with Flying Smiles offers a different perspective, but the underlying lesson remains the same: some of the most meaningful improvements in oral health happen when care is built around the realities of people's lives.

If you are thinking about broadening your scope, developing new skills or exploring different opportunities, support is available through the BSDHT. Find out more at bsdht.org.uk.





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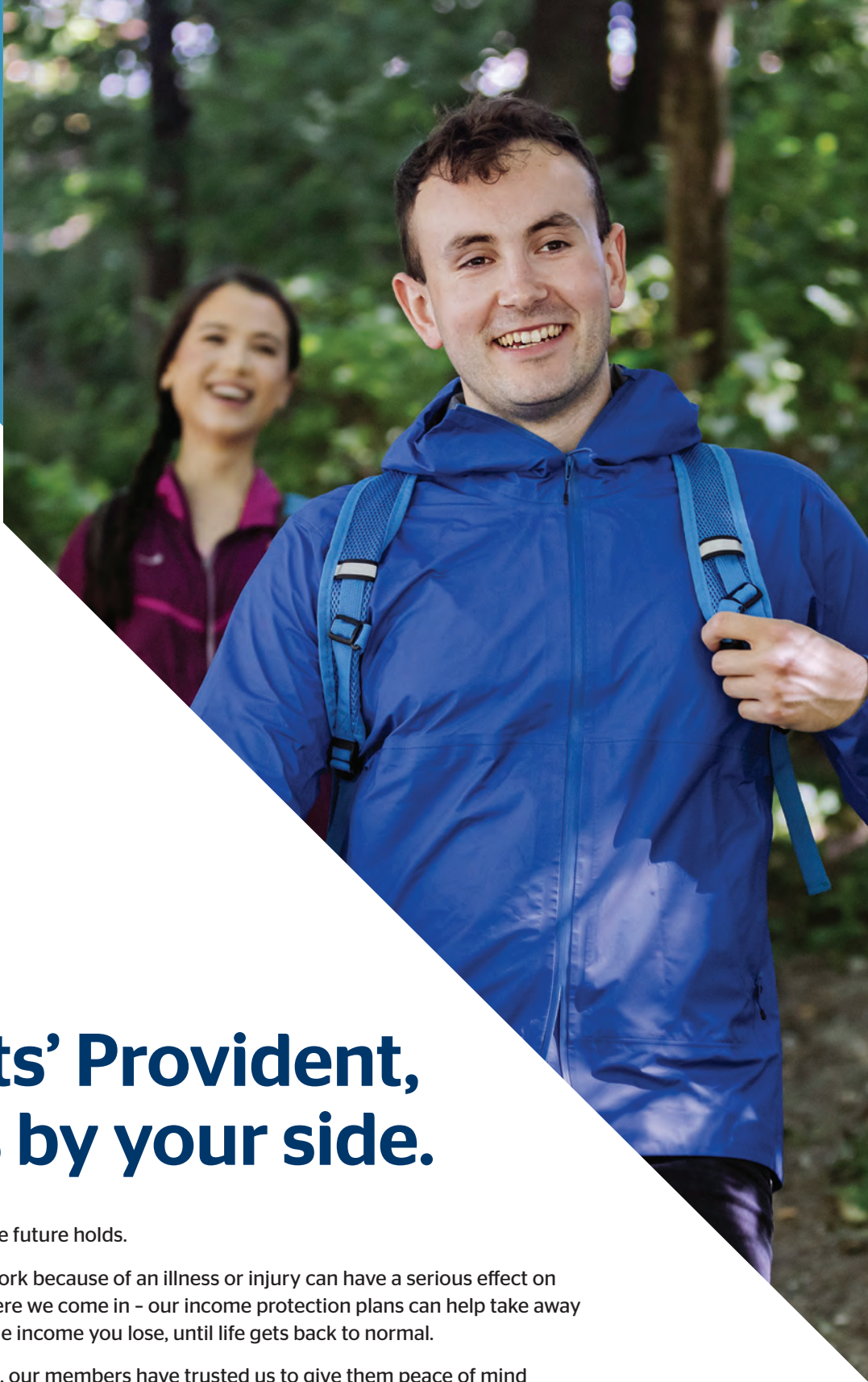
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The loneliest role in the dental practice?

Practice managers are often the people holding everything together behind the scenes. But who supports them, asks **Pat Langley**

Pat Langley
Clinical director,
Dentistry Compliance

'It's actually quite a lonely job.' That comment came up during a recent breakfast discussion between practice managers hosted by the Association of Dental Administrators and Managers (ADAM) and Dentistry Practice Services, and judging by the reaction around the room, it clearly resonated.

For all the conversations happening within dentistry around recruitment, compliance, patient care and business performance, there are still very few honest conversations about the emotional pressure that can come with being a practice manager. Because while the role can be incredibly rewarding, it can also feel relentless.

Keeping it all moving

Practice managers often sit at the centre of everything. Supporting clinicians. Supporting dental nurses. Supporting reception teams. Managing rotas, staffing issues, complaints, compliance, sickness, last-minute emergencies and operational pressures, all while trying to keep the day moving.

One attendee described the role as 'becoming everyone's sponge'. Another talked about answering calls late into the evening and waking



up already thinking about staffing issues before the day had even started. Much of that work goes unseen.

Patients may never realise the amount of organisation happening behind the scenes to keep a practice functioning smoothly. Teams may not always recognise the emotional load that practice managers carry either, particularly in larger practices where pressures can quickly build.

Honest conversations

What stood out most during the discussion, however, was the relief people felt simply being able to talk openly with others who understood.

There was no empty corporate language or polished leadership talk in the room, and no pretending everything was under control. Just honest conversations about the realities of the role.

The challenges being discussed felt familiar across almost every practice represented. Difficult staffing conversations;

burnout; delegation; feeling responsible for everyone. Trying to support teams while still protecting your own wellbeing.

And perhaps most importantly, the sense that many practice managers are navigating these pressures quietly. That is one of the reasons why peer support matters so much within dentistry.

Having the opportunity to step back from the day-to-day running of a practice and hear 'we're dealing with that too' can be incredibly powerful. Sometimes people are not necessarily looking for a perfect solution. They simply want reassurance that they are not failing.

Stronger support

For Dentistry Practice Services and ADAM, these conversations reinforced just how important it is to create more spaces where practice managers feel heard, supported and connected.

Support is not always about adding more processes or more pressure. Sometimes it is about helping practices create more structure, clearer communication and stronger operational support around the people carrying so much responsibility every day.

Because while practice managers spend much of their time supporting everybody else, they need support too.

Practice manager conversations

The Association of Dental Administrators and Managers (ADAM) and Dentistry Practice Services brought practice managers together at this year's British Dental Conference & Dentistry Show in Birmingham for a special breakfast meeting.

This series of articles presents some of the topics that were raised during the morning's discussions.

Want clearer support around compliance, HR and day-to-day practice operations? Dentistry Practice Services can help your practice strengthen its processes and reduce pressure on the people managing them. Visit dentistry.co.uk/practice-services and adam-aspire.co.uk for more information.

Facing the future

Carol Somerville Roberts on staying ahead of the curve and why one clinician's threat is another's opportunity

Dr Carol Somerville Roberts
President of the BACD

As cosmetic dentists, the dynamic landscape of new technologies and techniques presents both anxiety and opportunity. It can be difficult to know what is suitable for our own workflows but also what will most benefit our patients and our practice.

It is therefore vital that we keep an eye on the horizon and identify the coming changes.

Consider the way restorative treatments were delivered just 10 years ago, when analogue techniques dominated the daily workflow. In the time since, more and more dental practices and

laboratories have become, if not fully digital, then at least hybrid in their approach to treatment planning.

This raises the question: what will our workflow look like in another 10 years?

A digital future

There are many exciting developments occurring right now. For instance, robotic surgery is emerging as a practical possibility, such as for preparing teeth for veneers. The technology already exists and is growing in awareness. The investment cost is undoubtedly high, but in 10 years it may be more affordable for practices to integrate.

Between the growth in AI solutions and software and

the sophisticated equipment being made to support them, it is highly likely that many dental practices will be fully digital.

It is easy to be wary of change, especially those that directly affect our day-to-day

'It is important to remain open to what the future brings'

lives. But it is important to remain open to what the future brings; one clinician's threat is another's opportunity.

A digital workflow streamlines the experience for the patient, enabling more to be accomplished within a single appointment. From this perspective digital and AI solutions are certainly something to be embraced, providing they are used correctly and optimise treatment outcomes.

It isn't all about cutting-edge technology though. More research into materials and cohesion can help identify exciting alternatives to traditional restorative solutions.

Then there are the patients themselves: what aesthetic trends will rise and fall in the years to come? We are already seeing a preference for minimally invasive natural aesthetics and a growing distance from the stereotypical Hollywood smile. As clinicians, we must adapt to the requirements of patients and be able to deliver the treatments that they are seeking.

Future frontiers

If the last six years have taught us anything, it's that the future is far from certain. We can speculate, anticipate and prepare for a variety of changes, but the reality is likely to be different with so many external factors shaping dentistry as a whole.

Navigating the frontiers of the future is best done as a collective – a collective built on mutual support, first-class education and the networking opportunities that enable us to push further. It is also crucial to collaborate at an international level and hear from dental professionals from across the world.

Such opportunities await attendees of the BACD 22nd Annual Conference. Taking place on Friday 13 and Saturday 14 November at the Royal College of Physicians, the theme of this year's event is 'Future Frontiers – Innovating Cosmetic Dentistry'.

As president of the BACD, I am greatly looking forward to the conference for its new two-day programme and also because it will tease what 2027 and beyond will look like for both the BACD and cosmetic dentistry as a whole.

There is a lot of buzz around our headline speakers. The blend of education and networking underlines the importance of community, working towards the common goal of improving cosmetic dental treatments for our patients and facing the future frontiers together.

Find out more about the BACD 22nd Annual Conference at bacd.com/annual-conference.



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Gender stereotypes and dental nursing

Abubakar Mir draws on his experience as a male dental nurse to consider why dental nursing remains female dominated and the impact that stereotyping continues to have on the profession

Abubakar Mir
Dental nurse

Dental nursing has been long assumed to be a female dominated profession, with only around 1.85% of dental nurses in the UK being male (General Dental Council, 2025). While this perception is slowly changing, gender stereotypes surrounding the role still exist.

As a young male dental nurse working in practice, I have seen the way these assumptions and misconceptions can influence how dental nurses are viewed by patients, colleagues and even ourselves. I have experienced numerous assumptions around gender and age and the way it can affect how dental nurses are portrayed.

I hope that by sharing my experience as a male dental nurse, I can start to break stereotypes and encourage a more inclusive conversation within the profession.

Starting young in a stereotyped role

I grew up in a struggling but demanding household where both of my parents were unemployed and unable to speak English. Their desire was for me to enter a role focused around meeting other people's needs and making an impact in society. The reason I initially entered this field

was to please my parents. Not until I was a qualified dental nurse did I realise I wanted to be the reason why people can put their trust into healthcare workers.

I began my career in dental nursing at 16, an age often associated with immaturity or lack of professionalism. Choosing this path so early was a very nerve-wracking decision as it prompted questions not only about my gender but also whether I was 'too young' to understand the responsibilities involved in working within healthcare. I was extremely scared and worried that I would struggle around others.

However, starting at a younger age proved to be one of the most valuable decisions I have made. It allowed me to develop my

clinical skills, professionalism and confidence from an early stage. Over time, this has improved my character and reinforced my commitment to dentistry as a long-term career.

Why are gender stereotypes still present?

With men making up just 1.85% of the dental nursing workforce, it is perhaps no question that assumptions still exist around who 'fits' the role. Historically, caring and supportive roles within healthcare such as dental nursing have been associated with women. Meanwhile, men in dentistry are more often expected to pursue roles such as dentists, specialists or practice owners.

While none of these roles are gender specific, these assumptions have a big impact on perceptions today. As a male dental nurse, I have encountered patients who assume I am the dentist or question why I chose dental nursing rather than pursuing another role. These comments reinforce the idea that dental nursing is either a temporary position or not a suitable long term career choice for men.

Professional growth and career progression

Dental nursing is not a limitation; it is a foundation of the dental field. My journey from starting as a trainee dental nurse at 16 to now a qualified dental nurse pursuing further progression into dental therapy at 19 reflects the opportunities available within the profession. Especially for those who are motivated and committed.

The experience I have gained as a dental nurse has made a huge impact in developing my understanding of patient care, clinical environment and teamwork. These skills are transferable to the progression of a clinician, which creates a broader, more restorative and preventive clinical scope. This is achievable and realistically possible for anyone to pursue after qualifying as a dental nurse.

Why representation matters

Representation within healthcare professions is essential. When a patient sees a diverse dental team, in terms of gender, age and background, it challenges assumption and helps normalise gender misconception within the clinical setting. Even within a dental team, it allows for different perspectives – strengthening the teamwork overall creating a team balance promoting morale, mutual respect and professional development within the team. For young men considering dental nursing, the low percentage of

males in the workforce may be discouraging. But by increasing awareness and sharing real experiences, we can help challenge perceptions and create an encouragement for a wider range of individuals to consider the profession. Diversity strengthens dentistry, benefiting both healthcare individuals and the patients they serve. It will also increase the number of dental nurses overall.

Looking ahead

The dental profession continues to increase and perspectives towards gender roles and career pathways are changing. While stereotypes still exist, they are increasingly being challenged through education, conversation and representation. As a male dental nurse who began this journey at 16 and continues to progress professionally, I am proud of the role I play within the dental team. By sharing my experience and using social media, to show updates on my journey in this field, I hope to promote a more inclusive understanding of dental nursing, one that values skill, professionalism and ambition over fear. Dentistry focuses on teamwork, empathy and competence – qualities that are not defined by age or gender.

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'Everything points to the workforce'

Nigel Jones speaks to Neil Carmichael about the importance of solving the workforce issue and the risks of people falling through the cracks

Nigel Jones
Director, Practice Plan

Neil Carmichael
Executive chair, ADG

Nigel Jones (NJ): The challenge I worry about, Neil, is what happens to the working poor? We seem to have a continued drift towards private dentistry. Some of the language used by people like Steven Kinnock, where he talked about having a budget and cutting our cloth according to that, and highlighting urgent care and children, which I think is entirely appropriate, seems to edge us down the path towards a core service.

I worry about the people who might end up in the middle, where they don't necessarily qualify for state subsidised care and can't afford private dentistry.

However, that links back into the workforce issue because if you have more dentists, there's more competition for patients and you meet that need.

Neil Carmichael (NC): Everything points to the workforce. You need a workforce that's feeling confident, good about itself, well-trained, properly accountable and so on. But you need more of everything I've just said because we

simply need more dentists, hygienists and therapists. If we were able to achieve that, we'd solve many of our problems and challenges.

It's also important to remember that a lot of people are moving towards private dentistry because there are more things people can have done to their teeth these days. I'm talking about cosmetics here. We need to be alert to the needs of those who simply want NHS dentistry to give them the appropriate care so that teeth continue to be looked after. But we also need to recognise that some people want more than that, and that's where the cosmetic side comes in.

So yes, we need a good delivery of NHS care, while the private sector recognises the importance of the NHS and vice versa. We see that in our groups because they're essentially the best example of the mixed economy of dentistry: private, NHS and

community all providing dentistry across the UK. I see that working every day. What we now need to do is make sure that, in NHS dentistry especially, we reach out to the people who need it most, with more dentists and probably more focus on their needs.

NJ: I totally agree with that. You made a reference there to the wider dental team helping create capacity. An important part of the next 10, 20 years for dentistry in the UK is making more effective use of those other professionals within the dental team.

You were touching on demand for cosmetic dentistry, as well as NHS dentistry. Another area of growing demand will be people in the stage of life I'm starting to enter now, where, broadly speaking, we've had quite a good result. More people are keeping their own teeth.

But if you keep your own teeth into later life, that needs maintenance and care. So, there's a growing demand for general dentistry, NHS dentistry and cosmetic dentistry. That's where the supply and demand is out of kilter at the moment, which creates an interesting market dynamic.

'Supply and demand is out of kilter at the moment'



NC: You're right, and we touched upon that when we launched our report on the future of dentistry. We have two problems here. One is demographic change: we have more elderly people in the population than ever before, and that's made more difficult as we have a falling birth rate. So, the workforce is diminishing, but the number of people needing work done is increasing.

Most people now have their own teeth and don't have dentures. So, we need to think about how we look after an ageing population with their own teeth.

That is a huge demand, and it means dentistry, like healthcare, has to respond to it. Dentistry is relatively easy to understand because it's so easy to measure, and that's why we know we need more dentists, therapists, hygienists and dental nurses.

NJ: Absolutely. Dental nurses are a big part of that and there were some interesting stats at the last ADG conference from the General Dental Council about the relative decrease in the proportion of dental nurses across the profession.

It's interesting to consider what's pertinent for groups. But what the ADG is lobbying on is relevant to single-site practices as well, because they're facing the same recruitment challenges: dentists for NHS or private lists, and nurses too.

That's a really important point that might get lost: that not everyone appreciates the work the ADG is doing on behalf of the wider profession, not just groups. I would signpost people towards the strategy the ADG has launched on its website. It makes for a very interesting read, and I'd recommend people take a look.

To learn more, call Practice Plan on 01691 684165 or visit www.practiceplan.co.uk/be-practice-plan.

Bridging the oral health perception-behaviour gap

Anna Peterson and Claire Berry see for themselves how collaboration between dental professionals and industry has the potential to transform the nation's wellbeing

A new survey¹ commissioned by Oral-B reveals a striking disconnect in oral health habits: 82% of Brits believe they are brushing their teeth correctly, yet only 12% follow the full recommended routine.

For dental professionals, this poses a challenge in translating understanding into repeatable, effective at-home habits. How best to motivate patients to change their behaviour and turn evidence-based advice into something sustainable?

The findings suggest that the basics are still being overlooked:

- 16% brush only once a day
- Around 60% brush for less than two minutes
- 74% fail to floss daily
- 50% use a manual toothbrush
- 28% either don't use the recommended toothpaste or are unsure whether they do.

The Oral-B Brushing Habits Survey highlights key opportunities to boost patient engagement by meeting patients where they are.

Oral health ranks below healthy eating and exercise as a wellbeing priority, with only 37% of patients prioritising it, compared with 52% for healthy eating and 47% for exercise. This suggests that dental teams would be wise to position oral health within a wider wellbeing conversation, rather than as a separate health concern.

About 35% avoid smiling because they are self-conscious about their teeth, while 48% feel more confident when their oral health is good. Focusing on confidence and aesthetic concerns therefore offers another entry point for effective engagement.

Taking prevention beyond the practice

But effectively bridging the gap between knowledge and action also means reaching people who do not regularly attend dental appointments.

The Oral-B Brushing Habits Survey forms part of its wider Brush for Better campaign. Its Brush for Better bus is currently on a nationwide tour (July to October 2026), bringing oral health education, expert advice, and practical guidance directly to communities.

As part of Oral-B's partnership with DentaId The Dental Charity, the purpose-built dental bus will, at the end of its journey, be donated to the charity to join its fleet of mobile dental units delivering dental care to underserved communities.



Thank you!

Oral-B would like to thank all the dental professionals who have given up valuable clinical time to join the Brush for Better bus tour and take expert oral health advice directly to communities across the UK.

Their knowledge, enthusiasm and commitment have been central to the campaign, helping people move beyond simply knowing what they should do to understanding how to build better, more sustainable oral hygiene habits.

By meeting people where they are, demonstrating effective brushing techniques and answering questions face to face, they are helping make evidence-based oral health advice accessible to people who may not regularly visit a dental practice.

Anna Peterson is a dental therapist practising at Whelby Dental in Chipping Ongar, Essex, and Claire Berry is an award-winning dental hygienist working in private practice in northern England. They joined the Oral-B team at the start of the Brush for Better bus tour.

For Anna, the tour offers invaluable opportunities to intervene early with those who might have overlooked the importance of oral hygiene.

She explains: 'By waiting for people to attend a dental practice for oral health education, we miss not only a huge number of people but also those who need it most. In a market full of options, people are not always sure which oral health tools are best. By taking oral health education into community settings, we overcome that barrier. It is no longer just about keeping teeth in the mouth; to have a healthy body, we need to start with a healthy mouth.'

Claire says: 'In dental practice, we primarily see motivated and engaged patients who recognise

the importance of visiting us, often because of their health literacy. Community outreach is essential in engaging people who do not attend for various reasons, as many issues are largely preventable. By helping them understand the need for improved plaque and biofilm control and by equipping them with the right techniques and tools, we can prevent disease.'

Show, don't just tell

Anna says: 'Having the Oral-B iO Test Drive, which offers the chance to actually use the brush, is invaluable. We can talk to people and try to educate them, but most already know what they should be doing; they just don't do it. As soon as you say, "Try this toothbrush and tell me how your teeth feel", they immediately have so many questions, such as

"Should my teeth always feel this clean? What else should I be doing to improve my oral health?"'

Claire adds: 'This moves us from simply providing information to helping them develop sustainable routines using evidence-based practices and tools. We can create lasting change with patients wherever they may be. Our job is to engage patients and educate them. This requires understanding the psychology of behaviour change. It takes time and often numerous appointments.'

'In the first instance, however, people need the fundamentals,' Anna adds. 'What brush should they use, what toothpaste, how many times a day and for how long? Emphasising these basics will greatly improve oral health.'

For Anna and Claire, the key lesson is that the challenge isn't just about broadening patients' knowledge of oral health, but about turning that knowledge into sustainable at-home oral hygiene habits.

Providing access to often-overlooked community members is empowering and can be transformative, but industry support is vital.

Anna adds: 'Studies have shown that people on lower incomes are at higher risk of tooth decay and gum disease. By bringing oral health education to community settings, we overcome barriers and reach those who need it most.'

With nearly half of respondents in the Oral-B Brushing Habits Survey saying they would change their at-home care after learning more about the wider impact of a healthy mouth, the Brush for Better bus is helping to bridge that gap by turning awareness into meaningful changes in oral health habits.

Reference

1. The Oral-B Brushing Habits Survey was conducted by OnePoll, commissioned by Oral-B, and conducted online among 2,000 UK adults between 16 and 20 June 2026. Nationally representative by age, gender and region



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The power of drip feeding your investments

Iain Stevenson explores pound cost averaging, and explains how the strategy can be used effectively for investing

Iain Stevenson
Head of dental, Wesleyan
Financial Services

As a dentist, you know that small, consistent actions can make a significant difference over time. Whether it's encouraging patients to maintain good oral hygiene or committing to ongoing professional development, prevention and consistency are often key to long-term success.

The same principle can apply to investing.

Rather than investing

a large sum all at once, some investors choose to drip-feed their money into the market through regular contributions – a strategy known as pound cost averaging. This involves investing a set amount at regular intervals, helping to spread your exposure across different market conditions.

For example, if you had £12,000 to invest, you could invest it as a lump sum or contribute £1,000 each month over a year. If markets fall during that

period, your regular contributions buy more units at lower prices. If markets rise, you benefit from having money invested earlier (although, this may mean that you are also buying units at a higher price).

While pound cost averaging doesn't guarantee higher returns and may perform differently to investing a lump sum, it can help reduce the worry of committing everything on a single day.

Little and often

This approach can be particularly relevant for dentists who often make significant pension or ISA contributions around the end of the tax year. While using your allowances is important, relying solely on a last-minute investment can mean your money is exposed to market conditions at that exact point in time.

Regular investing can provide structure, encourage good

habits and help you stay focused on your long-term goals – whether that's retirement planning, building financial security or creating a legacy.

Investing always carries risk and the value of investments can fall as well as rise and you may get back less than you invest.

However, just as prevention is at the heart of dentistry, a steady and considered approach can help you build financial resilience over time.



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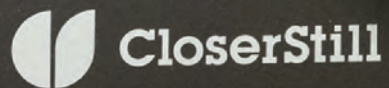
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That shift in mindset not only improves patient care but also creates significant opportunities for practice growth and profitability because you’re uncovering needs that might otherwise go unnoticed ”

Amit Patel



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Navigating the business of you

In the first of a three-part series, [Minesh Patel](#) explores the financial foundations and blind spots for self-employed dental professionals

Minesh Patel

Associate dental practitioner

Dental school invests thousands of hours in developing clinical competence, and the profession is rigorously trained in the delivery of patient care. Far less time, however, is devoted to understanding what happens after income is received.

The transition from foundation or vocational training into life as a dental associate or practising independently as a self-employed dental care professional (DCP), represents far more than a clinical milestone.

Once you enter self-employment, you are no longer simply delivering treatment; you are operating a 'business of one'. That business has revenue, costs, compliance obligations, risk exposure and strategic decision-making needs.

Whether working predominantly under an NHS contract or building a private list, self-employment introduces a complex set of responsibilities that extend well beyond teeth. Bookkeeping, taxation, cash-flow forecasting and personal financial protection all become part of the professional landscape.

The most financially resilient clinicians are rarely those who earn the most. More often, they are the ones

who build sound financial systems early in their careers. Financial structure is not about an obsession with money; it underpins ethical care and long-term professional sustainability.

Mastering the 'tax pot' mentality

One of the earliest shocks for the newly self-employed professional comes not from dentistry, but from HM Revenue and Customs (HMRC). Unlike salaried employment, many associates and DCPs receive net income after direct costs, such as laboratory fees, license fees, and superannuation contributions etc.

There is no PAYE system quietly deducting tax behind the scenes. The money landing in your account is not all yours.

A simple but highly effective discipline is to set aside approximately 30-35% of monthly income into a separate, easy access, high-interest savings account; a dedicated 'tax reserve' account.

While the precise percentage will vary depending on earnings, pension contributions and student loan obligations, the principle remains; tax liabilities should be ring-fenced as income is received, not retrospectively funded.

This 'tax account' should not be for discretionary

spending. Any unexpected expenses should be catered for by having a separate 'emergency fund' account.

The 'double tax' shock: payments on account

For many dentists and DCPs new to self-employment, the first real financial wake-up call arrives in January of the second year. Under HMRC's Self Assessment system, dental professionals must make 'payments on account'.

This involves paying the previous year's tax bill plus 50% of the following year's estimated liability. Without advance planning, this can produce considerable cash-flow stress.

Statutory tax payment deadlines fall on 31 January and 31 July each year. For clinicians who have not been proactively reserving funds, the January payment can feel particularly punitive; arriving shortly after the festive period, during quieter clinical months, and just after dentists' annual GDC fees have been paid.

Making Tax Digital: a new compliance framework

The UK tax landscape has entered a new phase. From 6 April 2026, HMRC's Making Tax Digital (MTD) framework came into effect, marking one of the most significant compliance changes in a generation.

Under MTD, self-employed professionals will be

Income protection insurance: key policy considerations

- Policy term or duration – this is the policy length. Longer terms typically carry higher premiums
- Deferred period – this is the waiting period before benefit payments commence. Longer deferral periods reduce premiums. Caution: ensure you maintain a sufficient emergency fund to cover expense needs during this interval, especially if this exceeds three months
- Index (inflation) linking – this protects the purchasing power of benefits over time, though premiums will increase accordingly
- Level cover. Monthly benefit amount remains fixed throughout the policy term. Premiums are usually cheaper, but does not protect against inflationary erosion
- Guaranteed and reviewable premiums. Guaranteed premiums remain fixed for the policy duration. Reviewable premiums may increase periodically, sometimes significantly. Guaranteed premiums are often initially higher, but they reduce the risk of future affordability concerns.

required to maintain digital records and submit quarterly updates where their total gross income exceeds:

- £50,000 from April 2026
- £30,000 from April 2027
- £20,000 from April 2028.

For many dental professionals, these thresholds will already be met. Income and expenses will now need to be tracked using MTD-compatible software, or managed digitally through an accountant.

The reporting deadlines are:

- 7 August (for period 6 April to 5 July)
- 7 November (for period 6 July to 5 October)
- 7 February (for period 6 October to 5 January)
- 7 May (for period 6 January to 5 April)
- 31 January (annual tax return and declaration for the full tax year 6 to 5 April).

Instead of submitting a single annual Self Assessment return, clinicians will now have five reporting obligations each year.

This change is more than an administrative adjustment. It reflects a broader trend; increased transparency and

scrutiny by HMRC. Informal record-keeping and retrospective organisation practices that have historically been common among the self-employed are becoming increasingly risky strategies.

There is a potential upside however; maintaining contemporaneous digital records throughout the year can significantly reduce last-minute administrative pressure, provide real-time insight into cash flow and profitability, allow projected tax liabilities to be monitored, and facilitate more efficient collaboration with accountants which supports better financial decision-making.

The cost of getting it wrong

Self Assessment errors are surprisingly common among the self-employed, and the dental workforce is no exception. Analysis by the Institute for Fiscal Studies, based on HMRC audit data, suggests that error rates among self-employed taxpayers' approach 60%, with under-reporting of income representing the most frequent issue.

While many discrepancies are relatively modest, the consequences can still be significant. Around 4% of cases involved tax liabilities exceeding £10,000, often accompanied by substantial interest charges and penalties. As digital reporting expands under the MTD, HMRC's ability to identify inconsistencies will only increase.

Importantly, engaging an accountant does not remove personal responsibility. You remain legally liable for the accuracy of your tax return. Timely submission of complete financial records is not merely courteous; it



is prudent governance. It allows for accurate calculation, forward planning, and avoidance of costly penalties.

Compliance, therefore, should not be viewed purely as an administrative exercise; it is a fundamental component of financial management.

Protecting your most valuable asset: you

Dentistry is both physically and cognitively demanding. Musculoskeletal disorders, hand injuries, visual strain, burnout, and stress-related illness are well-recognised occupational risks. Yet income protection is often viewed as 'optional'.

For self-employed dentists and DCPs, illness or injury carries an additional financial consequence. Unlike salaried NHS roles, there is no employer-funded sick pay; when clinical work stops, income stops. For this reason, income protection insurance warrants serious consideration, particularly for clinicians with dependants or large fixed overheads.

Policies offering an 'own occupation' definition are especially important. These pay out if you are unable to perform clinical dentistry specifically, rather than any alternative occupation.

Without 'own occupation' wording, an insurer could argue that although a back injury prevents you from undertaking clinical procedures, administrative or advisory duties remain possible, and a claim may be declined. Therefore, 'any occupation' cover is typically inferior and carries material risk.

Most providers typically insure anywhere between 50% and 75% of gross earnings. Although this appears restrictive, benefits are usually paid tax-free, meaning the replacement income often approximates previous net earnings.

In addition to the key policy considerations listed in the box, it is helpful to distinguish between:

- Critical illness cover, which provides a lump sum payout on diagnosis of specified conditions
- Income protection, which provides an ongoing monthly benefit.

For many clinicians, a monthly replacement income may

represent the more functionally appropriate form of cover; however having both policies will help financially mitigate a broader range of ill-health related scenarios.

A further note; these protections are in place while you are living. Adequate life insurance should also form part of robust estate planning, alongside having a power of attorney and a will.

Life insurance: protecting more than income

For dentists and DCPs, life insurance is equally important. This can provide a lump sum that can repay mortgages, settle personal liabilities, and provide disposable cash to loved ones. This prevents economic hardship for family members and reduces the risk of forced asset sales.

Unlike many employees, self-employed clinicians do not receive employer death-in-service benefits.

For practice owners or partners, life insurance plays a vital role in business as it can:

- Repay commercial mortgages, practice loans or equipment finance
- Facilitate business continuity for the entire dental team and the patients
- Fund cross-option agreements for incorporated practices and can ensure ownership transfers smoothly without financial strain on surviving partners.

Life cover can offer significant advantages for associates, DCPs and practice principals. Arranging cover early, before health complications arise is highly desirable; underwriting is simpler and premiums are lower.

Financial foundations for professional freedom

A dental career can span decades. The early years of self-employment are rarely about maximising income alone. They are about building systems; structured tax reserves, emergency funds, protection policies and accurate financial tracking all provide the foundations for better decision making.

Dentistry prides itself on record-keeping, auditing and governance in clinical practice. Monetary management deserves the same diligent approach.



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Dental tourist information service

Simon Kidd looks at how you can avoid getting burned when your patients choose to combine their holidays with elective dental treatment

Simon Kidd

Head of the Dental Defence Union

The phenomenon of dental tourism has exploded in recent years, accelerated by social media and highly competitive offers to tempt cash-strapped patients. Unfortunately, some discover that the deal is too good to be true and the media has published some lurid cautionary tales.

It's sad that patients feel they need to travel abroad for affordable treatment and it's a huge shame that this issue has become another opportunity for some to criticise UK dental professionals for 'inflated prices', ignoring the significantly higher overheads in this country.

At the same time, dental tourism has real dentolegal and financial implications for UK dental professionals, whether they're being asked for pre-travel advice or called upon to pick up the pieces should something go wrong.

'Turning these patients away is not an option'

Advice before travel...

In their advice to patients who are considering going abroad for dental treatment, the General Dental Council (GDC), NHS and Oral Health Foundation recommend they consult their own dentist.

The GDC says: 'It's always a good idea to speak to your own dentist before considering travelling abroad for your treatment, as they may be able to offer advice based on your dental history. They will also need to be aware of your plans in case of any later complications.'

From a dentist's perspective, these consultations can be challenging because the patient has the right to make their own decisions and mistakes. All you can do is follow GDC standards by listening, discussing treatment options and helping them make an informed choice, which includes explaining the potential risks.

It's important to avoid criticising dental standards in other countries, although you can still make them aware that there might be a different approach to things like consent and aftercare.

Whether patients intend to travel independently or use a dental holiday package, they need to do their own research into providers and clinics.

It's not up to you to comment on their plans but you can signpost them to independent advice for patients from the GDC, NHS and the Oral Health Foundation, which cover risks, what to expect and suggested questions.

...And after

In the event of complications, a patient would ideally return to the dentist who originally carried out the procedure who has records and relevant radiographs. But, of course, it isn't practical for an emergency patient to jump on the next plane – they're more likely to present at their usual practice.

Turning these patients away is not an option. The GDC expects dental professionals to act in a patient's best interests, particularly if there are urgent treatment needs. Even if we think a patient's decision to undergo treatment overseas was unwise, declining to see them simply because they've had treatment elsewhere could give rise to complaints, including possible allegations of discrimination.

The only appropriate course in this situation is to carry out an appropriate assessment along with any special tests and investigations so you can diagnose the problem and discuss the relevant treatment options, risks, benefits and costs.

Record-keeping is particularly important so it's clear what treatment was carried out by another dentist. Remember,

by helping these patients, you do not take on liability for any treatment provided overseas, instead you are only responsible for advice and treatment you have provided to the patient within the UK.

Staying within scope

Inevitably, the care you can provide is limited to what's within your personal scope of practice although you can still manage their pain and anxiety. As the GDC guidance makes clear: 'If a task, treatment plan, type of treatment or decision is outside your scope or you do not feel that you are trained and/or competent, or you are unsure whether you are indemnified or insured to do it, you must refer the patient to an appropriately trained colleague (either where you work or in an alternative setting)'. Explaining the rationale for a referral and the process is important and will help reduce the risk of complaints about your decision not to personally provide care.

Depending on the treatment and the complications, stabilising the patient may be only the first step in their road to recovery. Once the immediate emergency has passed, you need to decide whether you can provide any further necessary remedial care. Again, this will depend on your training

and competency, familiarity with the materials and techniques used by the overseas provider, and the complexity of care needed.

And, of course, this will come at a cost, even for NHS patients, which can be difficult for them to hear. However, you can at least point them to guidance from the NHS Business Services Authority and from the Chief Dental Officer for England who has said: 'Self-funded care that the NHS would not routinely fund would not usually be offered or replaced once stabilisation has been achieved...'

'Should the patient request/require further reparative or reconstructive elective care, the provision of care and choice of care setting would be subject to NHS acceptance criteria with reference to the complexity of need.'

An economic decision

Most UK dentists would prefer that patients didn't travel for treatment but that ship has sailed. However, it's important to remember that dental tourism is about economics and not a reflection on standards in this country.

Most patients still trust their own dentist and recognise that when it comes to their long-term oral health, there's no place like home.

You could take a fortnight off. You just couldn't turn your phone off.

That's the gap. Not what your team knows — but what actually keeps running when you're not there.

Last summer, a practice owner I work with was abroad when a patient sent him a photograph of a fire engine parked outside his practice. No message with it. He rang the practice himself to find out what had happened.

This summer, the same two owners went away again. Things went wrong while they were gone, because things always do. Nobody rang them.

“They don't come to us now unless it's really big.”

That took a year, and none of it was about knowing more than they already knew.

The Implementation Gap Scorecard

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Two minutes

Magdalena Harding
Specialist financial adviser,
Wesleyan Financial Services

Each stage of a dental career offers different opportunities and financial considerations.

From establishing a strong foundation to planning for life after practice ownership, making informed decisions at the right time can help you achieve both your personal and professional goals.

Building strong foundations

For newly qualified dentists, the focus is often on developing clinical skills and building experience. However, it's also an important time to put financial foundations in place.

Understanding income, managing debt, protecting earnings and starting to save early can all make a meaningful difference over the long term.

For many dentists, buying a first home is a major milestone. Specialist mortgage advice can be valuable, as lenders may take a different view of professional income. This might be the case if you're self-employed, undertaking postgraduate training or working across multiple practices.

Making your money work harder

As your dental career progresses, it's likely that your income will increase and your financial priorities will evolve. This is the ideal time to review your pension arrangements, build an investment strategy and make the most of available tax allowances.

Dentists are typically long-term planners, and

the same approach can be applied to personal finances. A well-structured investment strategy, aligned with individual goals and appetite for risk, can help create financial resilience and support future ambitions.

Bear in mind the value of investments and any income can go down as well as up and you may get back less than you invest.

Turning ambition into reality

Buying a dental practice is one of the biggest financial decisions a dentist can make. It requires careful planning, from assessing affordability and securing funding, to understanding cash flow, profitability and the ongoing responsibilities of ownership.

A successful practice acquisition isn't just about securing finance. It's about making sure the business supports your wider lifestyle and financial objectives. Working with advisers who understand the dental profession can help you navigate the complexities involved.

Preparing for a successful transition

Selling a practice represents the culmination of years of hard work, but it requires preparation. Ideally, exit planning should begin well before a sale is considered. This can include improving practice value, reviewing pension and investment arrangements, and considering how personal finances will look after stepping away from ownership.

A successful transition is about more than the sale itself. It's about creating confidence for the next



Dental career financial milestones

Magdalena Harding discusses the key decisions dentists face at every career stage

chapter, whether that means retirement, reduced clinical commitments or pursuing new interests.

Protecting your legacy

As retirement approaches and wealth accumulates, preserving your income becomes just as important as generating it.

Whether your wealth is tied up in a dental practice, property, investments or pensions, thinking ahead can help make sure it's passed on in the most tax-efficient way possible.

Inheritance tax (IHT) and estate planning are often overlooked until later in life, but starting the conversation early can provide greater flexibility and more options. (One thing to note: the Financial Conduct Authority (FCA) does not regulate inheritance tax planning and trusts.)

Reviewing wills, considering gifting strategies and understanding how different assets will be treated on death can all

form part of a well-rounded financial plan.

When you've spent decades building a successful business and personal wealth, effective estate planning means more than reducing tax. It's about protecting your legacy and making sure that the value created over a lifetime benefits the people who matter most.

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The shopper myth

Stop calling patients shoppers like it's a bad thing, argues **David Nelkin**

David Nelkin
CEO and founder of
Xcelerator Dental

In my 15 years in dentistry, the most common complaint I have heard from practices about their leads is some version of 'they're just shoppers', or 'they're only asking about price'. It is usually said with a sigh, and it is almost always said as though the marketing has gone wrong somewhere.

'A shopper is someone who is spending money'

This is exactly where you need to change your mindset. Nothing has gone wrong at all, and the word being used as a criticism is, in fact, a description of the best sort of enquiry a practice can get.

A shopper is someone who is spending money. If you have one on the phone, the only thing left to do is lose them, and that is exactly what most practices are doing within the first minute.

A shift in mindset will reap huge rewards, reduce your marketing budget, and grow your practice.

A shopper is a buyer

When somebody walks into a car showroom and asks what the car costs, nobody on the sales floor thinks 'another shopper, what a waste of an afternoon'. They think a buyer has just walked in.

Somewhere along the way, the dental industry decided that price-conscious enquiries are worth less than the patient who calls up and asks nothing whatsoever about cost. However, I'd contest that, for high-value treatment, that patient does not exist. Anyone spending thousands of pounds on their teeth is going to shop, because shopping is what spending money looks like.

Comparing practices is not a red flag

We know that patients enquiring about dental treatment average around three enquiries to three different practices.

If someone is about to spend thousands of pounds, or is just looking for a new dentist, they are going to look around, compare what they find, and ask what it costs. That is a healthy, engaged buyer.

Treating it as an insult, or as proof that the marketing has delivered the wrong sort of person, is the quickest way to hand that patient to the practice down the road.

In fact, almost nobody actually buys on price.

Once a patient has spoken to your team, felt how they were treated, read your reviews and understood what you do differently, price is very rarely the thing that decides it.

But none of that can happen if the call is over in 30 seconds. However, that's what happens in a lot of practices – because the patient asked how much Invisalign costs and somebody told them a number. The enquiry was not the problem there. The handling was.

So, when someone asks the price, rather than giving them it, ask them a question instead:

- What are you hoping to change?
- Have you had any treatment before?
- When would you like to get started?
- Have you already been quoted somewhere else?

Every one of those moves the conversation off the number and onto the person, and every one of them hands your team something that can be used.

By the time a price does come out, it arrives with context attached, and with a reason to choose you over the practice two miles away that quoted three hundred pounds less.

Shopping around

None of this is sophisticated; it is basic sales, and it is being ignored across an entire industry that has quietly decided asking about cost is a character flaw in the patient.

The question worth asking about your leads is not whether they are shopping. It is what your team does in the first 60 seconds once they are.

Shoppers are patients. Shoppers are revenue. Shoppers are the reason the marketing exists in the first place. If a practice is losing them at hello, that is a fixable problem, and it is considerably cheaper to fix than the ad budget getting the blame for it.

If you want to talk through how enquiries are actually being handled in your practice, I'm always happy to chat.



Discover how you can grow your practice with cross-channel marketing by visiting www.xceleratordental.com.

Guiding, supporting and defending dentists

Anne Budenberg explains how the DDU can support you throughout your career

Anne Budenberg
Dentolegal adviser,
Dental Defence Union (DDU)

Regardless of what stage of your career you are at, it's important to surround yourself with a strong support network that you can depend on for good advice, reassurance and help.

By renewing with the DDU every year, you can be sure that this includes unrivalled dentolegal expertise from an organisation of fellow professionals.

Here are just a few of the reasons that thousands of dentists choose to renew with the DDU each year.

24-hour dentolegal advice and guidance

Our dentolegal team is available between 8am and 6pm Monday to Friday and provides an on-call service for dentolegal emergencies or urgent queries 24 hours a day, 365 days a year so you can be sure a dentolegal adviser is available when you need help or guidance.

Calling the advice line does not affect your current or future subscriptions.

The DDU dentolegal team is staffed by specially trained dentists with real-life experience of the pressures and challenges faced in practice so they can offer practical and non-judgmental advice, whatever the situation.

As a not-for-profit mutual defence organisation, owned by our members, our sole



purpose is to support dental professionals, and our only obligation is to our members.

Successfully defending members' reputations

Many dental professionals have concerns about facing a claim for compensation or a letter from the GDC. Indeed, during a 30-year professional career it is possible that a dentist might face a clinical negligence claim.

If you face a claim, you can be assured that the DDU understand how stressful this is and the importance to our members of mounting a solid defence of their position. If we can defend the claim, we will. We think it is vital to do this for the profession. What's more, we have an enviable record of success in defending members' reputations at the GDC.

Access to clinical CPD

DDU members have access to free clinical education from Red Whale, one of the UK's leading healthcare education providers. The 12-month programme offers over 10 hours of GDC verifiable CPD, covering the common clinical challenges you face in day-to-day practice. You'll continue to have access to our dentolegal educational content to help you confidently manage your risk in practice.

Self-employed contract advice

Our dentolegal experts can offer general advice on the wording of self-employed agreements, review contracts against best practice guidelines, and provide DDU model contracts, developed with specialist dental lawyers.

Before signing a contract, you may wish to take advantage of this service. Call our advice line if you have any questions about your contract.

For DDU members who need specific legal advice in a contract dispute, we have negotiated competitive rates.

DDU membership app

The DDU's app is available exclusively for members. Customise the app to get tailored content, search frequently asked questions and read the DDU's case studies, guides and articles whenever you want.

The app is available to download from Google Play and the Apple App Store.

The DDU is staffed by dentolegal experts who are all experienced dental professionals. To learn more and to join the DDU, visit www.theddu.com/join.

Miranda SteeplesDCP adviser,
Dental Defence Union

Starting a new role is an exciting time, bringing fresh opportunities, but before you get started, it is essential to carefully review your contract.

A written agreement ensures that the rights, obligations, and financial arrangements are clear for both parties, and acts as a record to protect against misunderstandings.

When reviewing the contract, the first thing to ensure is that the 'date of agreement' and 'date of commencement' are correct, not least because they may affect other clauses within the agreement.

Next, check what documents you need to provide. The practice will require several different documents from you such as references, qualification certificate, GDC registration, current indemnity or insurance. A contract may be terminated with immediate effect if these documents are not shared within a certain timeframe, so do check if there is a deadline for this.

Other things to mind of when reviewing your contract include:

- **Facilities.** In some agreements we review at the DDU, other staff members are mentioned within the 'facilities' section, for example, if there will be chairside support from a dental nurse. Check if there's the option to refer and utilise the skills of a dental hygienist or dental therapist, and the fees for this
- **Hours.** Are the anticipated working days and hours as expected? Will there

be any additional charges if you want to work outside of these hours?

Ensure you have clarity on this before you sign the agreement

- **Time away.** Take care with the use of terms like 'annual leave' or 'holiday' as this may suggest that the arrangement is akin to employment
- **Locum arrangements.** Some agreements stipulate the need to substitute yourself with a locum any time you want to take time away from the practice, while others require it only after a certain number of days of planned absence. Engaging the services of a locum can be costly, so check your contract carefully and enquire about any potential fees
- **Payments/schedules/targets.** Information about remuneration may be found at various points throughout the agreement. Many templates have a section of 'schedules' at the end of the document. Check that all the figures align with what you've discussed with the practice.

Additional considerations

It is also worth checking the contract for mention of termination. Agreements vary, but the length of notice period we commonly see at the DDU is three months' written notice for either party to terminate the agreement.

There may be a list of reasons for the practice to immediately terminate the agreement with you, and sometimes the points in these clauses link to other parts of the contract.

Read them carefully and be sure you understand what



Signing contracts with confidence

Miranda Steeples discusses what you need to know when signing a new contract

you are agreeing to, and that you are happy to abide by the conditions set out for you.

Retention fees is another area that should be reviewed. While having a large proportion of money deducted from your final monthly pay can seem unsettling, it is common that a retention figure is withheld by the practice upon termination of the contract.

A retention fee could benefit you if this allows remedial treatment to be carried out without delay, therefore, reducing the potential for complaints. Agreements and arrangements vary but expect to see around 40% of one month's average monthly contribution, or 5% of six months' gross pay being retained. These totals may be deducted in one lump sum or in three equal

tranches from the final three months of the term of the agreement.

There may also be mention of protection of goodwill, which may also be referred to as 'restrictive covenants' in the contract. This describes a radius from the practice premises, within which you may not practice, within a certain timeframe after leaving the practice. The most common restrictive radius we see is set at three miles from the practice, and this is commonly seen for a period of 12 months.

Finally, there is often a clause that discusses how patient care will be managed on termination of the agreement.

This clause is usually read in conjunction with a schedule that details the types of treatments that, if not completed by the time you finish the position, the practice owner will not

continue and complete on your departure.

You would need to return to complete any treatments that have been listed as exceptions.

You should note these details carefully to be sure that, whatever your future plans may be, you are able to commit to these completions.

Good communication

If there is anything you are unhappy with or don't understand in your contract, then have a conversation with the practice and try and reach an agreement.

What is offered is a starting point for negotiation, but once signed, you should expect to be bound by it.

The DDU provides free contract review and advice for its members. For more information, visit www.theddu.com.

Dentistry Show London 2026: make time for what's next

With Dentistry Show London returning to Excel London on 9–10 October 2026, now is the time to secure your free place at one of the capital's key dates for the dental profession

Finding time away from a busy practice isn't always easy. But with dentistry evolving at pace, taking time to look beyond the day-to-day has arguably never been more important.

From new technologies and changing patient expectations to workforce pressures, NHS reform and the growing influence of AI, the profession is navigating significant change. Dentistry Show London (DSL) offers two days to explore what that change could mean for you, your team and your practice.

Bringing together more than 4,000 dental professionals, 100+ speakers and over 180 exhibitors at Excel London, DSL is designed to provide inspiration, practical education and access to the latest thinking from across the profession – all under one roof.

Education that reflects dentistry today

At the heart of the show is a comprehensive education programme covering the issues dental professionals are facing right now.

Among this year's renowned speakers, Chief Dental Officer for England Jason Wong MBE will explore what has changed

six months on from NHS contract reform and what comes next for oral health. Dr Victoria Sampson, founder of THS Labs, will examine the growing understanding of the oral-systemic link and its role in overall health.

Professor Martin Thornhill, Emeritus Professor of Oral Medicine at the University of Sheffield, and specialist periodontist and RW Perio founder Dr Reena Wadia are also among the experts joining this year's line-up.

Across the wider programme, delegates can explore everything from clinical excellence and aesthetic and digital dentistry to business management, professional development and the issues affecting the wider dental team.

Whether you're a dentist, dental nurse, hygienist, therapist, technician, practice manager or practice owner, the breadth of the programme means you can shape your visit around the areas most relevant to you.

Moreover, the emphasis isn't simply on listening. Interactive discussions, demonstrations and practical learning opportunities will provide plenty of ideas that can be applied beyond the show.

The aim? To ensure you take something valuable back to your practice – whether that's a clinical insight, a different approach to patient care, an idea for improving efficiency or simply a fresh perspective.

See what's changing and what's coming next

Beyond the education programme, the exhibition floor offers an opportunity to get hands-on with the products, technologies and services shaping modern dentistry.

More than 180 exhibitors are set to attend, with leading names including Straumann Group, Colgate, Haleon – Sensodyne, Listerine, Dently, DEXIS and Nobel Biocare, alongside a wide range of emerging and specialist businesses.

For practices considering investment, looking to improve workflows or simply wanting to understand what is new in the market, it is an opportunity to achieve in a day what could otherwise take weeks of research and individual conversations.

You might arrive knowing exactly what you want to find or leave having discovered a solution you didn't know you needed.



Step outside the practice

The value of DSL also lies in bringing the profession together.

With thousands of dental professionals expected to attend, the show creates space for conversations that can be difficult to find time for during a normal working week.

It's a chance to reconnect with colleagues, meet new people, speak directly with experts and suppliers and hear how other dental teams are approaching the same opportunities and challenges.

For practices attending as a team, there is even more scope to make the day work harder by exploring different sessions and exhibitors before coming back together to share what you've discovered.

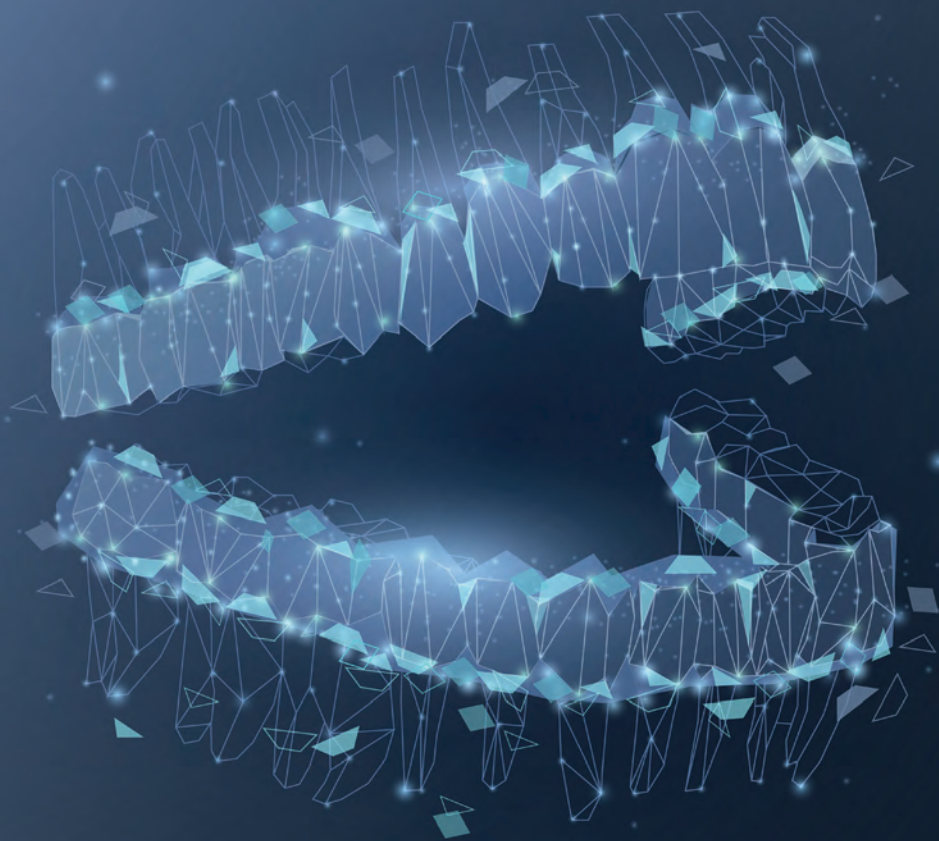
Secure your place now!

With education, innovation, networking and the wider dental community all coming together in London for two days, DSL offers an opportunity to invest time in your own development and the future of your practice.

Registration is free for dental professionals so there is every reason to be part of it.

So, if the 9–10 October isn't already blocked out in your diary, what are you waiting for?

Dentistry Show London takes place at Excel London on Friday 9 and Saturday 10 October 2026. Register for your free place today at london.dentistryshow.co.uk.



Gain more, grow faster, get ahead.

Dentistry Show London stands at the centre of a profession in transformation. As AI reshapes diagnostics, private dentistry grows, workforce dynamics evolve, and NHS reform shapes care, DSL unites the sector to navigate what's next. With 100+ leading speakers, 100+ hours of Enhanced CPD education, and 180+ exhibitors, it delivers practical insights, new connections, and real opportunities, helping practices and teams thrive in a rapidly changing UK dental landscape.

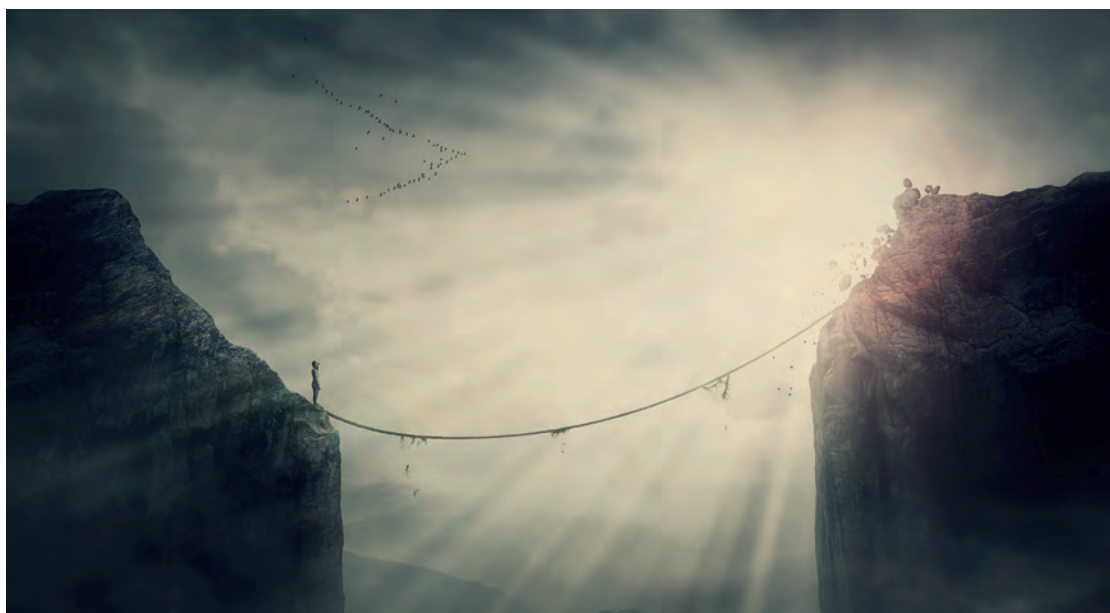


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The gap between knowing and doing

Everyone comes back in September with good intentions. **Mark Topley** explains why most don't survive contact with the diary

Mark Topley
Dental leadership and team
performance coach

Somewhere in the middle of a fortnight off, you had one of those clear-headed moments where you saw exactly what needed to change. Maybe you wrote it down. Maybe it's still in the notes app on your phone, under a shopping list.

Then the work diary reopens, two people are off sick, the compressor plays up, and by the end of week two the list has gone the way of every list before it.

Most owners read that as a discipline problem, but it isn't. You didn't forget, and you didn't lack commitment. What you ran into is the

gap between knowing and doing, and it's the single biggest thing holding practices back – bigger than recruitment, bigger than the contract, bigger than most of what we spend our time worrying about.

Booting up

The uncomfortable bit is that almost every practice I work with already knows what to do. They've been on the courses, read the books, sat through the study clubs and nodded along. The knowledge is in the building. What's missing is the installation.

Think about the last training your team invested in. Six weeks on, how much

'Steady progress will get you further by Christmas than a brilliant fortnight in September followed by silence'

of it had actually changed the way the practice runs? For most, the honest answer sits somewhere between 'almost none' and 'some of it, for a while'.

That's not a reflection on the training, and it's certainly not one on your team. It's what happens to good ideas when nobody deploys them.

Knowing is cheap.

Deploying is the work

An idea is deployed when four things are true:

1. Someone owns it by name, not by department
2. There's a written standard for what good looks like, so it isn't living in your head
3. It runs on a rhythm – a slot in the huddle, a monthly review, something that means it gets touched without you remembering to touch it
4. There's a date in the diary to check whether it's working.

Four things. Not a transformation programme, not a new manual, not a team away day. Notice what they have in common: they're all structural. None of them rely on anyone trying harder in October

than they did in September, which is just as well, because willpower is the least reliable material you can build a practice out of.

In last month's article, I wrote about why delegation disappoints, and this is the same argument just from a different angle. Hand over a task without the authority and it bounces back to you. Learn something without deploying it and it never leaves your head in the first place. Both are failures of structure wearing the costume of a people problem.

Pick one thing – just one

The instinct in September is to fix everything at once, and that instinct is exactly why nothing sticks. Six changes launched in a week is six things half done by half term.

So, pick one. The thing you keep coming back to, the one that would take the most friction out of the week if it were properly running. Give it an owner, write down what good looks like, put it on a rhythm, set a review date for mid-October. Then leave the rest of the list alone until that one is bedded in.

Consistency beats intensity, and steady progress will get you further by Christmas than a brilliant fortnight in September followed by silence.

If you want a straight read on how wide the gap is in your practice, I've built a short scorecard that measures exactly that – 10 questions, about three minutes, and a proper answer on where the drop-off is happening. You'll find it at scorecard.marktopley.co.uk. Then pick your one thing, and hold the line on it.

To get in touch with Mark, visit marktopley.co.uk.

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CQC registration has changed: what new dental providers need to know

In part two of this two-article series, Pat Langley looks in more detail at the financial implications that entrepreneurial dentists wanting to start up a new 'squat' practice need to consider in light of the recent CQC changes to the registration process

Pat Langley
Clinical director,
Dentistry Compliance

As outlined in part one of this series, opening a new dental practice is a big undertaking, and it has never been more important to ensure you have clear, comprehensive, and accurate professional support in all areas from advisers and suppliers who understand the dental industry.

A failure to do so may not only slow your registration process; it may also incur considerable additional costs if you need to correct any errors.

Financial considerations and planning

The change is not just 'more paperwork'. For squat practice owners, it can affect the whole financial model. The owner may be carrying rent, loan repayments, fit-out costs, staff recruitment costs, equipment finance and professional fees before they can legally start treating patients and generating income.

This commercial reality should not be overlooked. Most squat practices operate on tight budgets, particularly in the final stages before

opening, when cash is flowing out, but income has not yet begun. If a new provider cannot submit a complete CQC application until the premises, equipment, certificates and supporting documents are effectively ready, this can create a difficult funding gap.

Rent, loan repayments, equipment finance, contractor invoices, staff recruitment costs and professional fees may all be falling due while the practice is still waiting for registration and is unable to treat patients. For new owners, this makes financial planning every bit as important as compliance planning.

Contingency should be built into the business plan, lenders should understand the registration timeline, and opening projections should allow for the possibility that a rejected or incomplete application could delay the first day of trading.

In the new registration environment, cashflow planning is not separate from CQC readiness; it is part of it.



Can a dental squat be treated as urgent?

Some new providers may wonder whether their application can be fast-tracked, particularly where a completed practice is ready to open but cannot yet trade. The CQC's urgent registration route is, however, narrow. Applications are usually assessed in the order they are received, and urgent consideration is reserved for cases where registration is critical to increasing capacity in the health and social care system or reducing pressure on the NHS or social care.

This means that an NHS squat may have a route to urgent consideration if local commissioners support the case, but a purely private squat is unlikely to qualify simply because the owner is under financial pressure or ready to open.

For a private squat to be considered urgent, the CQC would require formal evidence from an appropriate commissioner or senior public body representative, and financial hardship alone would not be enough.

This reinforces the need for owners to plan conservatively. Urgent registration should not be relied upon as part of the opening strategy.

For most start-ups, the safer assumption is that the application will proceed through the ordinary registration process, and the business plan should allow for that.

Tight cash flow may make the application feel urgent to the owner, but that does not necessarily make it urgent in CQC terms.

The CQC's changes have made the registration process more exacting for new dental providers. But for those who prepare early, personalise their documents and treat compliance as part of the business plan rather than a bolt-on, the route to opening a new practice remains very achievable.

Dentistry Practice Services

Dentistry Practice Services provides CQC registration support and full compliance support to dentists wanting to open a new squat practice. For more details, contact ryan.hall@fmc.co.uk or scan the QR code.



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When is CBCT truly needed?

The question of when to use CBCT is complex. **Nimisha Nariapara** explains where CBCT adds value and moves from useful to necessary

Nimisha Nariapara
Trade marketing manager,
Carestream Dental

Cone beam computed tomography (CBCT) is one of the most discussed technologies in the profession, and with good reason. The ability to view anatomy in three dimensions, to assess bone volume and quality before placing dental implants, or to evaluate a complex case from every angle, is a

real advantage in practice. The diagnostic information these images can provide is, in many cases, irreplaceable. But the question of when CBCT is truly required – rather than simply useful or interesting – is one that the industry is still working through. And the answer, demonstrated in the IRMER principles that govern dental radiography in the UK, may have more nuance than it seems.

The justification principle in three dimensions

Every instance of radiographic exposure in UK dental practice must be justified: the expected clinical benefit must outweigh the radiation delivered. For CBCT, the dose delivered is substantially higher than for conventional 2D radiography. It varies but is typically several times that of a full-mouth periapical series, and much higher than a single intraoral radiograph (Li, 2013). That dose differential does not make CBCT unjustifiable, but it does introduce an extra layer of complexity to the choice. Current guidance from the College of General Dentistry is that CBCT should not be used as a first-line investigation where conventional 2D radiography would provide sufficient information.

The imaging modality should be selected based on need, not convenience, curiosity, or the availability of the equipment. Taking a CBCT to assess a straightforward periapical area that a well-positioned periapical radiograph would adequately evaluate is likely not justifiable exposure, for example.

Where a CBCT can add value

Where CBCT moves from useful to necessary is generally scenarios where three-dimensional

information will affect the diagnosis or treatment planning in a way that two-dimensional imaging cannot.

Dental implant planning is the most commonly cited. Assessment of bone volume, bone quality, and anatomical relationships in three dimensions changes what can be planned and what can be placed with confidence.

Complex endodontic cases with calcified canals, suspected vertical root fractures, or resorption, will benefit from the three-dimensional view in ways that periapical radiographs cannot replicate (Scarfe et al, 2009). Orthodontic cases involving impacted teeth are also well-established in terms of indicating CBCT necessity (Kapila and Nervina, 2015).

Field of view and dose optimisation

For practices with CBCT capability, the field of view selection decision is a further expression of the optimisation principle. A large field of view delivers a higher dose than a small one, and captures more, but the case itself should determine which field is appropriate. A targeted small field of view for a single-tooth endodontic assessment delivers a fraction of the dose of a large field selected out of habit or convenience.

This is a practical clinical

skill that CBCT training should address directly: learning to select the minimum field of view that answers the clinical question, rather than defaulting to larger volumes on the assumption that more data is always better.

Integrating CBCT into a practice workflow

When it comes to potentially incorporating CBCT into the practice, it's just as important to take workflow and referral into consideration. Which cases will be imaged in-house? Which will be referred? Who will report the images, and what training is in place to ensure findings both expected and unexpected are properly acted upon? A CBCT taken for an implant assessment may incidentally reveal something outside of the immediate or expected anatomical vicinity. There is still an obligation to act on this finding.

The question of when to use CBCT is complex, current, and a good one to be asking. It's important, while answering it on a case-by-case basis, to ensure that the available technology is working in harmony with the rest of the practice.

For the references that accompany this article, email siobhan.hiscott@fmc.co.uk.

For more information about Carestream Dental, visit carestreamdental.co.uk.



CBCT in practice

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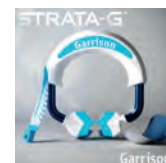
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For many practice principals, the question isn't simply whether to sell their practice, but how to secure its future while continuing to play an active role in its success.

Dr George Billis, a practice principal who recently joined DeNovo Dental Partners, describes his experience: 'I initially assumed it would be similar to a traditional corporate or group acquisition model,' he explains. 'I was pleasantly surprised that it felt more partnership-based and long-term.'

Having explored a range of options for the future of his practice, it was DeNovo's emphasis on ongoing involvement that proved decisive for Dr Billis. 'The idea that I could remain involved and aligned with the future of the practice, rather than simply selling and stepping away, was the moment I wanted to explore further.'

He cites the shared commitment to practice culture as one of the most compelling elements. 'The focus on working together after completion and maintaining the identity and values of the practice was what reassured me most that this was a genuine partnership.'

'DeNovo felt more like joining an aligned group of partners.'

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1 OCTOBER 2026

Aly Virani

Lessons in dentistry

Why did you decide to pursue a career in dentistry?

Growing up, I had a profoundly unsympathetic dentist who absolutely terrified me. When he finally retired, his replacement was a revelation: confident, competent and, crucially, kind. It was my first glimpse of the impact a good clinician can have on a patient. Beyond the relief of no longer dreading my check-ups, I liked the look of his day-to-day life. It was a career built on working with your hands and talking to actual people, rather than staring at a computer screen in an office. I was sold.

Tell us an interesting fact about yourself...

During my foundation training year, I made a firm, confident declaration that there were exactly two things I would never do in my career: periodontics and implants. Fast forward to today, and my clinical practice is restricted entirely to implant dentistry.

It taught me that your career path is rarely shaped by the subject matter itself; it is shaped by the people you meet. If you are surrounded by individuals who are wildly passionate about what they do, that passion is contagious. You cannot predict which doors will open, so it is best not to boldly announce you are nailing them shut.

What is most recommended gadget?

Forget the high-tech gadgets for a moment: buy a cheap dictaphone. With the patient's consent, voice record every consultation or important discussion. A copy goes into the notes, and you can send one to the patient.

It serves two brilliant purposes. Firstly, knowing you are being recorded keeps you incredibly sharp, honest and comprehensive in your communication. Secondly, if a misunderstanding ever arises, there is no debate. Both parties can simply refer to the exact expectations that were set. It is an unbelievably simple, low-cost habit that will save you endless headaches.

What has been your most memorable experience within the profession?

In 2017, I attended an implant course in Vitoria, Spain, and sat at lunch with two fourth-year dental students from

'You cannot predict which doors will open, so it is best not to boldly announce you are nailing them shut'



Aly practises implant dentistry at Hereford Dental & Implant Clinic

Austria. Listening to them was genuinely humbling. They were so knowledgeable that it highlighted just how far behind our UK dental schools had fallen.

While we were largely being trained for the NHS in hospitals where modernisation moved at a glacial pace, these students were being taught cutting-edge dentistry by global leaders. It completely shattered my perspective on education. It inspired me to travel the world to learn – not just from the speakers at the front of the room, but from the international delegates sitting next to me.

What do you believe the future of dentistry holds?

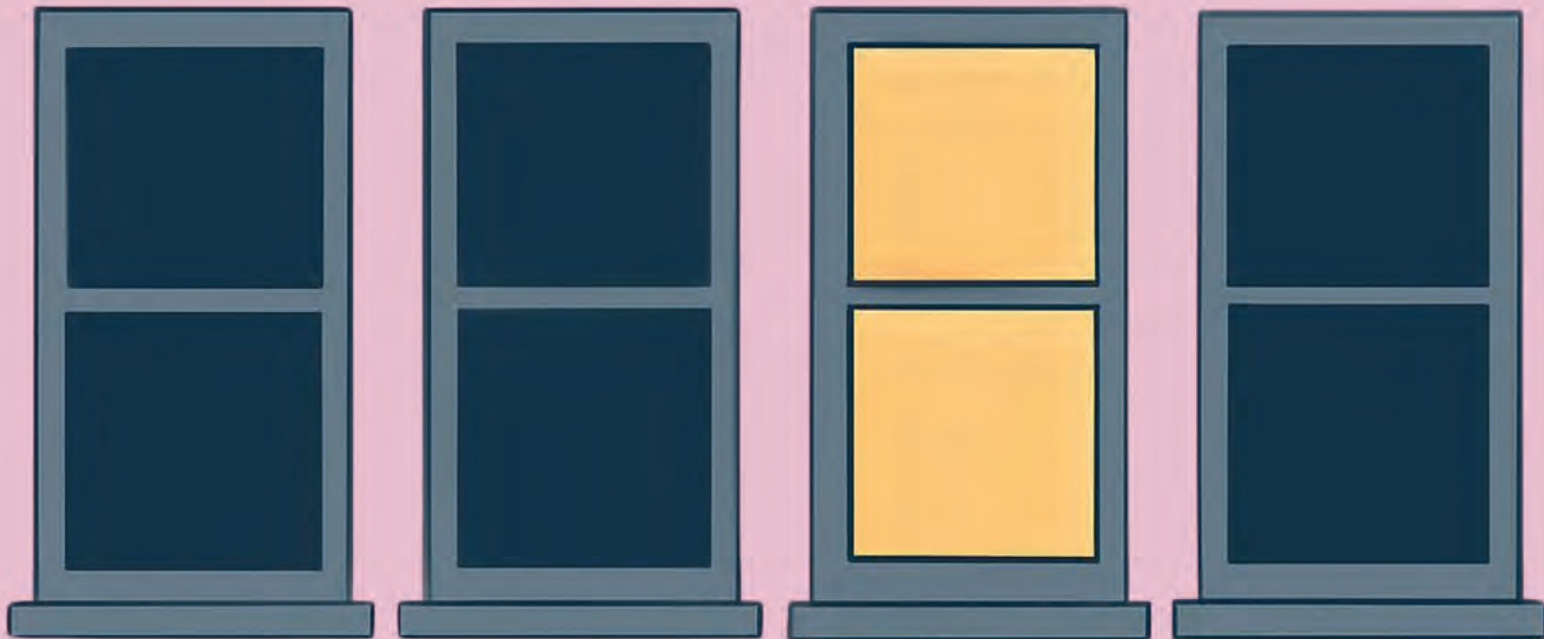
We now have data acquisition at our fingertips through AI, digital scanning and software. Because of this, I see the 'jack-of-all-trades' general dental practitioner fading away in favour of multidisciplinary teams.

Soon, our dental nursing and technical colleagues will handle the bulk of diagnostic data gathering. Clinicians will then do what we were actually trained to do: use our clinical judgement to interpret that data, make decisions, and communicate them to the patient. It will mean greater efficiency, better outcomes, upskilling for the whole team, and a profession with far less stress and trepidation.



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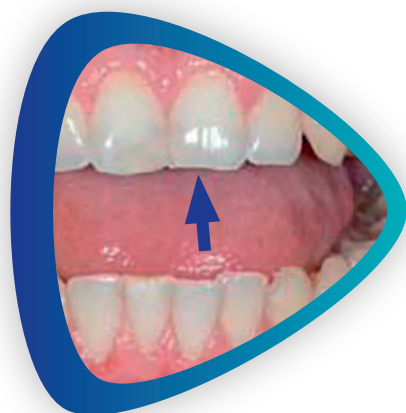
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1. Recession, dentine hypersensitivity, tooth wear periodontal health and associated risk factors: an observational, cross sectional multi-centre epidemiological study in 7 European countries, December 2023

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