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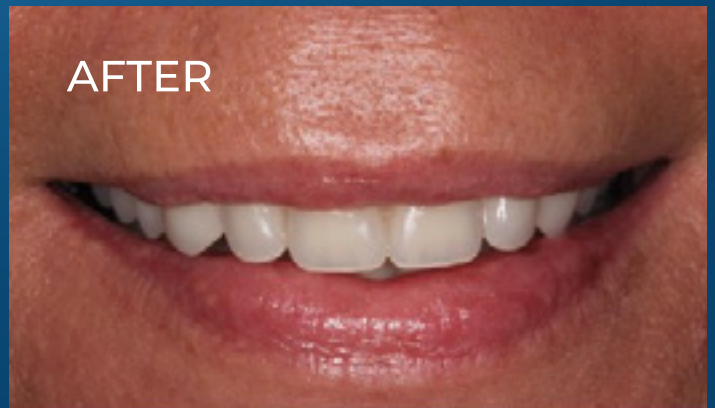
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MANAGING EDITOR  
David Cameron  
[david@connectmedia.cc](mailto:david@connectmedia.cc)

EDITOR  
Will Peakin  
Tel: 07718 477310  
[editor@sdmag.co.uk](mailto:editor@sdmag.co.uk)

ADVERTISING  
Ann Craib  
Tel: 0141 560 3021  
[ann@connectmedia.cc](mailto:ann@connectmedia.cc)

DESIGN  
Ruth Turnbull

SUBSCRIPTIONS  
Claire Nichol  
Tel: 0141 560 3026  
[claire@connectmedia.cc](mailto:claire@connectmedia.cc)

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# Let's put it to the vote

*The Holyrood elections next May could signal a change in the fortunes of NHS dentistry*

**T**he political landscape in Scotland has shifted significantly in recent years. For more than a decade, the Scottish National Party (SNP) has dominated Scottish politics, consistently winning elections and forming governments. However, recent polling and changes in leadership have introduced an element of uncertainty.

The SNP's long period of dominance has been built on its clear pro-independence stance and its record in government. While recent polls suggest a decline in support, they still place the SNP ahead of Scottish Labour in both constituency and regional list voting intentions. The SNP's ability to maintain a strong base of support, particularly among those who favour independence, remains its key strength. The party's challenge will be to re-energise its support base and convince voters that it can effectively manage public services and the economy.

According to Ipsos<sup>1</sup>, the SNP is still in pole position when it comes to Scottish Parliament voting intention, on 34% of the constituency vote. If replicated at the Holyrood elections next May, however, this would be a weaker performance than in 2021 when the party won 47.7% of the constituency vote.

Labour is in second place on 23% of voting share, ahead of Reform UK on 14%. The same three parties top the regional list voting intentions, with the SNP on a 26%, Labour on 22% and Reform UK on 16%.

Labour's strategy is to focus on domestic issues like the NHS and the cost of living, while largely sidestepping the constitutional question of independence. Its success will hinge on whether they can convince voters they offer a credible alternative to the SNP's long-standing rule.

As *Scottish Dental* was going to print, Anas Sarwar, its Scottish leader, was preparing to address dental professionals from across Scotland at Vermilion's biennial symposium (see page 12).

Unsurprisingly for a former dentist, he has strong views on the state of NHS

dentistry in Scotland. He believes that the service is in crisis and is on the brink of collapse, leading to a "two-tier system" where those who can afford to pay for private care do so, while those who do not have the means are left without.

He has cited various statistics to support his view, including:

- A decline in the number of active NHS dentists.
- A significant number of patients who are registered with an NHS dentist but have gone without an examination or treatment for several years.
- Stark health inequalities, with a much lower percentage of children in deprived areas being decay-free compared with those in wealthier areas.
- A dramatic increase in calls to NHS24 about oral and dental health problems.
- Four out of five dental practices across Scotland not accepting new NHS patients, and some health board areas having no practices taking on new patients at all.

Sarwar has blamed the Scottish Government's funding model, which he argues is "broken" and forces dentists to take on more private work to remain financially viable. He has also stated that a key issue is the lack of incentives for newly qualified dentists to work in the NHS.

Scottish Labour's proposed solutions include reforming the funding structure to incentivise dentists to take on NHS patients, developing incentives for newly qualified dentists to work in areas where they are most needed, expanding the Childsmile programme to better address health inequalities and ensuring that everyone can register as an NHS patient.

For its part, the SNP insists it is committed to securing equitable and sustainable access for patients to NHS dental services. In September, Jenni Minto, the Minister for Public Health, told the Scottish Parliament that its reform of payment for dental services in 2023, which introduced a prevention-based model, was delivering "high levels of service" and had been welcomed by the profession. For the year 2025-26 funding had been increased by 15%. Additional funding was also being provided from September to increase the number of domestic dental students by 7%.

It is to be hoped that the vote on 7 May next year is, indeed, helping to concentrate the minds of policymakers.

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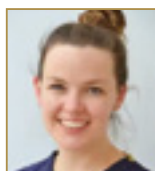


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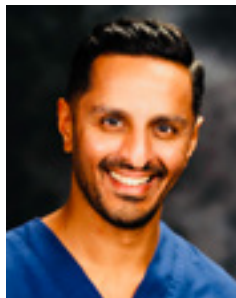
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GDC No. 75815 | BDS (Glas, 1999) | MFDS RCS  
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Abid is a graduate of the Glasgow Dental School.  
He has a master's degree at Glasgow University  
and a Diploma in Implant Dentistry from The Royal  
College of Surgeons in Edinburgh. He is a member  
of their Faculty of Dental Surgery, and he is the

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# Reflections on our profession

*We are in a better place than we were in 2018*

I thought I should reflect on the travails of the profession and how they have changed since I started writing this column in 2018. Obviously, there has been a global pandemic in that time which created a shift in the ability of the profession to deal with the day-to-day in a way never experienced. At the beginning of my writing this column, I did a trilogy of articles on the stresses faced by the profession. I focused on finance, expectations and regulation.

Finance is the one thing which has changed the most in our favour. The change in Determination 1 in November 2023 shifted the financial goalposts, especially with respect to laboratory fees. NHS dentistry is now more viable. Private care is much more prominent in the marketplace, especially following COVID-19.

Do I think things are perfect? Definitely not. The Scottish Government should look at the allowances, how they are paid, remove caps and ensure parity by making all fee increases inclusive of all the elements in the Statement of Dental Remuneration (SDR). I would also like them to commit to funding security in terms of a parliament-by-parliament continuity of the funding level. This would allow practitioners, and in particular practice owners, to plan and invest with some security over the five years and not worry that their investments become untenable at the whim of government ministers and civil servants.

I would suggest that we need to continue a viable Scottish Dental Access Initiative (SDAI) system to ensure continued expansion or improvement of services with suitable ties to NHS care. Long-term investment by individuals or corporates is risky, especially with interest rates higher than in the previous 15 years. The profession must have security to invest. The profession also needs investment to push the digital workflow, where efficiencies in time and cost will help support more basic care.

That leads onto the next pillar: expectations, which are ever increasing in both patients and professionals. The drive towards one-off plans, primarily to answer aesthetic desires, is a double-edged sword. Sure, there are big wins to be made in better margins and turnover improvements. However, changing these wins takes time, especially away from routine (NHS) care. It also leads to the 'asset' of registered patients being less well supported and may make them look elsewhere. If you do not have a patient base, it is even harder to get the leads to generate big plans. Your practice becomes less valuable at point of sale and that value is more tied to the practitioner than the entity. Dentists' own expectations of the type of work and the hours they do has

shifted significantly. Dental influencers push transactional dentistry, and its financial benefits and young professionals follow. They have less desire to work long hours; certainly not five days, weekends or evenings – while wishing to receive higher remuneration and maintain holidays and lifestyle expectations. Understandable, but it creates pressure on service provision. How can practices and health boards maintain good coverage across daytime and out-of-hours services when whole time equivalents (WTE) are greatly reduced? All that is offset by the expectations of patients being higher than ever before.

With respect to regulation, I do feel that the Practitioner Services Division (PSD) and the General Dental Council (GDC) are better than they were. I wonder how long that will last? If the shift in treatment trends continues, we are much more likely to receive more regulation and deal with more litigious patients. High value treatments combined with high expectations will create this. The indemnity providers have already shifted their emphasis by asking less about whether you place implants and more about clear aligners and composite bonding.

Being that they are primarily financial institutions rather than 'defence' organisations, that should tell you everything you need to know. So, the question is whether our profession is more or less stressed than in 2018? I think there is a significant proportion of the profession which has chosen to do less, in many cases for the same or more money by becoming more private focussed. Whether that equals less stress is another question. Does this desire simply create another problem for another day?

If we shift our workload and basic ethos away from routine general dentistry and NHS care, we will remove much of the stability our regular patients enjoy. This will create a paucity of access and care which, in turn, creates more basic work and a poorer foundation that advanced care is built on. It will also be highly likely that younger professionals will have to work longer to achieve the funds they need to retire. Maybe that fills the gap over time? However, I doubt it will be enough to stop things getting worse before, and if, they get better.

If I was a young practitioner now, I would think the profession is a better place to be than in 2018. It has more of an upside for professionals and the advances in AI and digital workflow should help to mitigate some of the reduction in WTE.

If I was a patient, I would see the landscape becoming more challenging in terms of decreased access and increased costs. That, in turn, creates poorer goodwill and more tension in the patient/dentist and patient/practice dynamic. I am for a quiet life. Work a bit more to keep patients happy and have a less stressful working life? Self-sacrifice is not trending...





# Plant-based alternative to antibiotics developed

*It could be used in periodontal disease treatment, writes Cristiane Paião\**

**A POWDER** based on morin, a natural compound extracted from guava leaves, apple and fig peels, certain teas and almonds, has shown antimicrobial, anti-inflammatory and antioxidant effects against bacteria that cause periodontal disease.

The substance, released in a controlled way through polymers, could help with non-surgical treatments as an alternative to antibiotics.

Researchers at São Paulo State University's School of Dentistry tested

morin on a multi-species biofilm formed by various species of bacteria that simulated the effects of the disease on patients' gums. The results were published<sup>1</sup> in the *Archives of Oral Biology*.

Morin was chosen because it is a natural, inexpensive and easily accessible compound.

"We have a fine powder obtained through spray drying – the same equipment used to make powdered milk – that can be used to make various types of oral hygiene products," said Brighenti.

"The idea is to provide a platform that acts as an adjunct and can be useful, for example, for people with reduced motor skills who are unable to brush their teeth properly, such as older adults and patients with special needs."

The researchers plan to continue testing morin first in animal models and then in clinical studies to investigate its other properties.

\*[www.linkedin.com/in/cristiane-paiao](https://www.linkedin.com/in/cristiane-paiao)

<sup>1</sup>[www.tinyurl.com/yc84ncvf](https://www.tinyurl.com/yc84ncvf)

# GDC publishes revised Scope of Practice guidance



**THE** General Dental Council (GDC) has published its revised Scope of Practice guidance following a review conducted with dental professionals, education providers, indemnifiers and other stakeholders.

The revised guidance has not changed the scope of practice for any of the seven dental professional titles, but the GDC said it provides "greater clarity

on existing title boundaries."

The regulator said the guidance will "better support dental professionals to use their professional judgement within these boundaries for the benefit of patients." It takes effect on 1 November.

Having a professional title does not automatically mean that a dental professional can or should do everything within

that title's scope. They must be trained, competent and covered by indemnity or insurance before carrying out any task that falls within their professional title's scope, said the regulator.

The revised Scope of Practice guidance<sup>1</sup> and the consultation outcome report<sup>2</sup> are published on the GDC website. To support its implementation, the GDC will deliver online sessions to explain changes to the guidance and address any questions. Registration is via Eventbrite<sup>3</sup>.

The Scope of Practice guidance was first introduced in 2009 to outline the skills and abilities every dental professional should have upon registration with the GDC, as well as those they might develop later in their careers.

Ross Scales, Head of Upstream Regulation at the GDC, said: "Our aim has been to provide the clarity and support that dental professionals have called for, allowing them to work to their full scope and use their professional judgement to put patients first."

<sup>1</sup>[www.gdc-uk.org/standards-guidance/standards-and-guidance/scope-of-practice](https://www.gdc-uk.org/standards-guidance/standards-and-guidance/scope-of-practice)

<sup>2</sup>[www.gdc-uk.org/docs/default-source/consultations-and-responses/scope-of-practice-consultation-outcome-report-2025.pdf](https://www.gdc-uk.org/docs/default-source/consultations-and-responses/scope-of-practice-consultation-outcome-report-2025.pdf)

<sup>3</sup><https://www.eventbrite.co.uk/e/understanding-the-updated-scope-of-practice-guidance-from-the-gdc-tickets-1704025087909>

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# Mediterranean diet could reduce gum disease

*Study finds that patients whose diets were rich in plant-based food showed lower levels of inflammatory markers*

**PEOPLE** following a Mediterranean-style diet are more likely to have better gum health, according to a study.

The study by King's College London Faculty of Dentistry, Oral & Craniofacial Sciences found that patients whose diets were rich in plant-based food which are typical of a Mediterranean diet, such as legumes, vegetables, fruits and olive oil, showed lower levels of various inflammatory markers.

It also indicated that people not following a Mediterranean diet tended to have more severe gum disease, especially if they consumed red meat frequently. In these patients, the researchers observed higher levels of circulating inflammatory markers, such as Interleukin-6 (IL-6) and C-reactive protein (CRP).

The research, published in the *Journal of Periodontology*<sup>1</sup>, evaluated 200 hospital patients enrolled in the King's College London Oral, Dental and Craniofacial Biobank by performing dental exams, taking blood samples and asking them about their diets through questionnaires.

The Mediterranean diet is known for its emphasis on fruits, vegetables, whole grains and healthy fats. It has been associated with a lower risk of developing



major diseases, including cardiovascular diseases, neurodegenerative disorders and certain cancers.

"Our findings suggest that a balanced, Mediterranean-type diet could potentially reduce gum disease and systemic inflammation," said Dr Giuseppe Mainas, first author of the study and a postdoctoral researcher.

He added: "We observed that there may be a connection between periodontal disease severity, diet and inflammation. These aspects should be holistically considered when assessing the treatment for periodontitis in patients. Our research offers an important starting point that can lead to more research to better understand

the relationship between foods intake and gum disease."

Professor Luigi Nibali, lead author and a Professor of Periodontology and Head of the Centre for Host-Microbiome Interactions, added: "There is emerging evidence about the role that a balanced diet might have in maintaining a periodontal healthy status. Our research shows the potential effect that a nutrient-dense, plant-rich diet could play in improving the nation's gum health. Nevertheless, more investigation is needed to develop personalised approaches to help people manage their gum health."

<sup>1</sup>[aap.onlinelibrary.wiley.com/doi/10.1002/jper.70016](https://aap.onlinelibrary.wiley.com/doi/10.1002/jper.70016)



## BDA West of Scotland President elected

**ALBERT YEUNG**, a Consultant in Dental Public Health with NHS Lanarkshire, has been elected President of the West of Scotland Branch of the British Dental Association (BDA).

In this role he will oversee the branch's continuing professional development (CPD) programme, foster collaboration between community, hospital and general dental services, and champion preventive, public-health-oriented dentistry throughout the region. Mr Yeung's leadership résumé includes a term as President of the British Association for the Study of Community Dentistry (2022–23) and current chair of the BDA Scottish Council. The experience positions him well to navigate the evolving Scottish

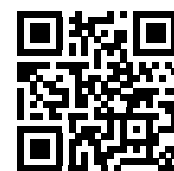
NHS dental contract and advocate effectively for both patients and professionals.

"I'm honoured to take the helm of the West of Scotland Branch," said Mr Yeung, "and I'm committed to overseeing a dynamic CPD programme, strengthening collaboration across community, hospital and general dental services, and championing preventive, public health focused dentistry for every patient in our region." The CPD programme for 2025–26 is available at [www.tinyurl.com/5e43ca57](https://www.tinyurl.com/5e43ca57). Information on booking the annual dinner on Saturday 21 March 2026 can be found at [www.tinyurl.com/yyxknb96](https://www.tinyurl.com/yyxknb96). The 2025–26 CPD programme will end on 25 March with a presidential lecture, *Have you got a sweet tooth?* ([www.tinyurl.com/56p3knez](https://www.tinyurl.com/56p3knez)).



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## Scotland faces worsening dental crisis

*Leading practitioner calls for fully funded NHS contract and workforce plan*

**SCOTLAND** is facing a worsening dental crisis with new analysis revealing the scale of workforce contraction and patient access barriers across the country, according to one of Scotland's leading dental practitioners.

The crisis is characterised by a severe decline in NHS primary care provision, manifesting as practice closures and limited patient access, particularly in rural and non-city areas, and an erosion of NHS secondary care capability, notably acute within the Lothian region.

Dr David Offord, practice principal and specialist oral surgeon at Edinburgh-based Vermilion, is calling for government intervention to turn around a beleaguered dental profession.

The warning came ahead of the fifth Vermilion Biennial Symposium at the beginning of October, when members of Scotland's dental community gathered at the Royal College of Physicians of Edinburgh to address what organisers describe as the most critical challenges facing the profession in decades.

"We're witnessing a measurable decline in the active NHS dental workforce, particularly in general dental services, exacerbated by reduced training pipeline inflow and

a significant exodus of dentists to private practice or retirement," said Dr Offord.

"The numbers tell a devastating story: 190 fewer active NHS dentists in just three years, 45,432 patients in Dumfries and Galloway alone losing access to NHS dental care and children waiting over a year for basic tooth extractions."

The crisis is particularly acute in areas outside of cities, including Fife, Moray, Dumfries and Galloway and Central Scotland, where entire communities have been left without access to NHS dental services. In Fife, where eight dental practices are currently mothballed, not a single NHS dentist is currently accepting new patients, while across Scotland, 82% of practices are closed to new adult NHS patients.

With a critical shortage of specialist dental consultants, particularly in oral medicine and restorative dentistry, NHS Lothian has recorded exceptionally long waiting periods for specialist dental treatment.

The longest recorded wait for an adult tooth extraction in Lothian reached two years, while the wait for children's tooth extractions can be more than a year. The statistics reflect a public health crisis with severe consequences for Scotland's most vulnerable populations. The gap in dental

participation rates between children from the most and least deprived areas has widened dramatically from 7% in 2010 to 20% in 2022, creating a two-tier system that abandons those who need care most.

"We're seeing patients resort to dangerous DIY dentistry, travelling hundreds of miles for treatment or going without care entirely," said Dr Offord. "This isn't just about oral health. Untreated dental problems can lead to serious systemic health issues, emergency hospital admissions and, in extreme cases, life-threatening infections." He added: "Scotland needs a comprehensive, fully-funded dental workforce plan that addresses recruitment, retention and training across all levels of care," said Dr Offord.

Vermilion's symposium (see the next edition of *Scottish Dental* for a full report) challenged political leaders to deliver concrete solutions to the crisis with a call for:

- A new, fully funded NHS contract making primary care dentistry an attractive career option, thus improving patient care.
- A comprehensive national dental workforce plan with long-term funding commitments.
- The establishment of a new Edinburgh Dental Hospital and School to provide integrated training of dentists, specialists and dental care professionals.

## University withdraws funding from Edinburgh Dental Institute

**RECRUITMENT** by the University of Edinburgh to its undergraduate and postgraduate dental education programmes has been "paused", a spokesperson confirmed.

The revelation comes after an enquiry by *Scottish Dental* magazine which the university treated as a Freedom of Information request. "In 2024, we made a strategic decision to pause recruitment to our undergraduate and postgraduate dental education programmes.

"The undergraduate degree programme was paused after confirmation that external funding for the course had been withdrawn. Postgraduate student numbers were low and unable to be increased due to limited access to external dental facilities required to teach students.

"All students who were matriculated at that time will continue in their studies until they have completed their undergraduate or postgraduate degrees. The shortfall in funding is currently being met within the University, with all students due to graduate by 2028."

NHS Lothian said its services at the Edinburgh Dental Institute were continuing and it had recently recruited of both oral medicine and restorative dentistry consultants. A spokesperson said: "The conversation around the potential establishment of a new dental school would sit with the Scottish Government, NHS Education for Scotland and the University of Edinburgh."

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# Facing the future with confidence

*Optimism and opportunity were foremost at this year's NASDAL Scotland Forum*

**SCOTLAND** is better placed than any other UK nation's dental sector to face the future with confidence, according to Roy Hogg, chair of NASDAL Scotland.

Speaking after the organisation's annual forum in Glasgow at the beginning of September, he said: "What emerged was a picture of cautious optimism. While recruitment challenges, compliance pressures, and rural access remain real issues, the mood in the room was clear: Scotland seems to be better placed than any other UK nation to face the future with confidence."

For the first time in a number of years, many new graduates are now leaving dental school with the ambition to own practices, the forum heard. This renewed appetite for ownership, across both NHS and private sectors, marks a significant cultural shift. "There's a real buzz around independent ownership again," said one delegate. "Associates are thinking beyond the treadmill and looking at building businesses."

A consistent theme was the need to better prepare young dentists for ownership. While clinical training is strong, many leave dental school with little or no understanding of running a business. "The Deans [of dentistry] don't see it as their responsibility," one attendee noted. "But if we don't bridge

that gap, we're setting young dentists up to struggle." NASDAL was encouraged by delegates to explore training opportunities, creating a roadmap that could support graduates who aspire to ownership.

Delegates noted that Scottish dentists seem "quieter" than their counterparts elsewhere in the UK, with fewer complaints, fewer protests and less 'noise' overall. "Silence can be golden," said one contributor. "It might just mean that Scottish dentists are more content than their colleagues elsewhere."

Many felt that Scotland currently offers the best system in the UK for patients and practitioners.

The forum closed with predictions for the coming years, including:

- A "lively" Scottish election in 2026, with manifesto pledges around free dentistry.
- Retention of the independent contractor model; changing it would be a "disaster".
- A strong practice sales market, with more churn, mixed practices and growth of dentist-led groups.
- Corporates returning selectively, while entrepreneurial independents seize more control.
- A continued focus on work-life balance, with earlier retirements and part-time working seen as permanent shifts.

## Dental market gains ground

**THE** Scottish dental market is experiencing significant growth, with strong demand from buyers and growing transaction volumes despite external challenges, according to specialist business property adviser Christie & Co.

Activity levels are at their highest in recent years, with independent buyers and small-group operators driving momentum. "Following a strong finish to 2024, the start of 2025 is seeing a surge in practice viewings and a significant increase in both new practices brought to the market and the number of practices that are under offer compared with this time last year," said Kevin Strain, senior business agent.

"We expect the positive trajectory seen so far in 2025 to persist. Independent buyers will likely remain the driving force behind market activity. Corporate buyers, on the other hand, are expected to be more selective in their acquisition approaches, assessing purchases with greater scrutiny than ever before."

He added that sellers should be aware of impending changes to Business Asset Disposal Relief, which will see the tax rate increase from 14% to 18% in April 2026.

"These changes may prompt some sellers to accelerate their plans to capitalise on the current tax benefits. Additionally, rising National Living Wage rates and higher National Insurance contributions could affect practice profitability."



**WE EXPECT THE POSITIVE TRAJECTORY SEEN SO FAR IN 2025 TO PERSIST. INDEPENDENT BUYERS WILL LIKELY REMAIN THE DRIVING FORCE BEHIND MARKET ACTIVITY**



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\*Source: YouGov Survey 2023



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# New fellowship routes launched

*Be recognised through experience and expertise, not just qualifications*

**THE** College of General Dentistry (CGDent) has launched a portfolio-based route to joining its Fellowship community.

The new route, which will be available in relation to specific fields of practice, means that both Associate Fellowship and the Clinical & Technical domain of College Fellowship can now be achieved through recognition of a wealth of clinical experience and expertise, not just advanced qualifications.

Under the new scheme, those with at least five years' post-qualification experience in the discipline for which they are applying, and who meet the specification for prior training, can submit a portfolio of six suitably complex cases. They should be undertaken within the past five years, for assessment. The expected standard for cases is that

which would be achieved with a relevant 120 credit, Level 7 Diploma or at Level 2 clinical complexity.

As well as qualifying the applicant for Associate Fellowship and the Clinical & Technical domain of Fellowship, a successful portfolio can also be published as a recognised qualification in the College's Member Register. Both Associate Fellowship and Fellowship of the College are open to dental professionals in all team roles.

Associate Fellowship acts as a stepping stone to Fellowship, recognising enhanced knowledge and skills as well as a commitment to lifelong learning and the highest levels of patient care.

Fellowship is the most distinguished membership of the College and is recognised

with the postnominal designation 'FCGDent'. It is a mark of excellence, significant commitment to the science, art and practice of dentistry, and distinction across clinical and professional domains.

All dental professionals with 10 or more years' post-qualification practice may apply for Fellowship by route of experience.

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## GDC appoints new council members

**THE** General Dental Council (GDC) has appointed two new lay council members, Bill Gunnyeon and Mike Driver.

Bill brings healthcare regulation and governance experience. An experienced non-executive director, his previous roles have included President of the Faculty of Occupational Medicine, Lay Governor at Glasgow Caledonian University, Chair of the Board of Trustees of the Institution of Occupational Safety and Health, and most recently, Chair of the General Osteopathic Council.

Mike brings experience in government finance and senior leadership. His Civil Service career started at the Department of Health and Social Security, before progressing through operational delivery, regional management, and policy roles.

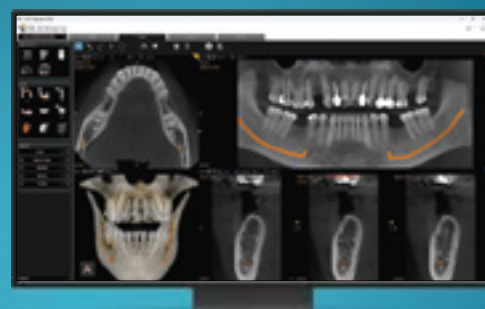
As Head of the Government Finance Function (GFF) at HM Treasury, Mike focused on strengthening its role across government. From August 2020, he spent six months as the Interim Permanent Secretary at the Ministry of Justice, before his appointment as the Senior Responsible Officer for the Borders and Managed Quarantine Programme at the Department of Health and Social Care.







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# Water disrupts protection of tooth enamel

*Initially more so than apple juice, according to a study*

**WATER** causes greater initial disruption to saliva's protection of tooth enamel than apple juice, researchers have found.

Saliva plays an important role in preventing friction and bacteria in our mouths by creating a slippery film on teeth.

It also helps repair early damage to tooth enamel. It is known that this protective layer is affected by different drinks, but until now it was not clear exactly in what way and for how long.

Using 32 healthy participants, scientists analysed how rinsing with apple juice for one minute impacts saliva, before doing the same test using water. They found the mouth's natural defences bounce back remarkably quickly when exposed for a short period of time.

While apple juice temporarily disrupted saliva, the effects began to wear off within just 10 minutes. Even more surprisingly, the team discovered that water caused greater initial disruption to saliva's protective properties – but the recovery time was much faster.

The team used cutting-edge laboratory techniques – normally used in engineering – to measure exactly how slippery and protective saliva is before and after drinking apple juice and water.

The study revealed which specific proteins in saliva are affected when you drink apple juice. Understanding these proteins could lead to new toothpastes and mouthwashes designed to boost the mouth's natural defences.

“The key finding is that one brief drink of apple juice isn't harmful – the lubrication comes back to normal and the proteins in saliva do their protective work,” said Dr Mahdi Mutahar, senior lecturer at the University of Portsmouth's School of Dental, Health and Care Professions, and the study's lead author.

“The biggest shock though was discovering that rinsing mouths with tap water caused more friction and disruption than apple juice. The Portsmouth water we used contains minerals that seem to interfere with saliva's lubricating proteins, more than the fruit juice did.”

Portsmouth tap water contains high concentrations of ions including sodium, potassium and magnesium, which interfere with saliva's main lubricating protein, mucin.

“We were genuinely surprised by these results,” he added. “It's long been believed that apple juice, like other acidic drinks, immediately harms our oral health, including the teeth.”

“However, our research shows that saliva plays a vital role in protecting and quickly repairing the mouth to prevent lasting damage.”

“But it's important to point out that long-exposure to apple juice – by repeatedly drinking it or not washing your mouth out with water after taking a sip – can have a long-term negative effect on our oral hygiene.”

Future research may investigate adding protective proteins to everyday drinks; a move that might not only neutralise harmful acids but also strengthen the mouth's natural defences by supporting saliva's ability to repair and protect teeth.

## College addresses sexual misconduct in healthcare

**A COURSE** designed to help tackle disturbing levels of sexual misconduct in healthcare has been launched by the Royal College of Physicians and Surgeons of Glasgow.

The tailored active bystander training has been developed by two Scottish Clinical Leadership Fellows – dentist Katharine Dunn and surgeon Anna Bleakley – and is believed to be the first of its kind. It follows the publication of the *Breaking the Silence* report<sup>1</sup> into sexual misconduct by the Working Party on Sexual Misconduct in Surgery in September 2023.

Katharine Dunn, Scottish Clinical Leadership Fellow at the College and a Specialty Registrar in Restorative Dentistry

at the Edinburgh Dental Institute, said:

“Inappropriate behaviours are often witnessed by others but are left unchecked owing to the ‘bystander effect’. Sometimes this is a feeling that someone else will step in, or perhaps a lack of confidence – or just not having the right words – to address an inappropriate behaviour in that moment.”

“The course gives participants the practical skills to become active bystanders, helping to support culture change and prevent small behaviours escalating to potentially bigger ones.”

Development of the course has been supported by Professor Christine Goodall, Vice President (Dental) and Dean of the College's Faculty of Dental Surgery. The

course forms part of the College's 10-point action plan on sexual misconduct launched in March 2024 and led by Professor Goodall, which includes education and training, strengthening the code of conduct and supporting cultural change.

Health professionals who wish to attend the active bystander training course are invited to book their place on the Royal College website<sup>2</sup>.

<sup>1</sup><https://www.rcoa.ac.uk/about-us/strategy-vision/equality-diversity-inclusion/breaking-silence-sexual-misconduct-surgery>

<sup>2</sup><https://rcpsg.ac.uk/education/active-bystander-training-for-tackling-sexual-misconduct-in-healthcare>

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# Introducing Dr Lyall Dominick



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Lyall graduated from the University of Glasgow in 2013 and spent many years in general dental practice in the West of Scotland, building a strong base in general dentistry skills.

He became a member of the Royal College of Physicians and Surgeons of Glasgow in 2018 and gained a Master of Science degree with Distinction in Restorative Dentistry from the University of Birmingham in 2024.

Since 2022, he has worked part time as a Specialty Dentist in restorative dentistry at the Glasgow Dental Hospital providing complex endodontic treatment for patients referred by their general dental practitioners.

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# Consistent and stable

*DentalElite's annual benchmarking report details practice trends*

**CORE** dental practice cost categories have shown consistency over recent years, suggesting a stable operating environment, according to DentalElite.

In the dental consultancy's latest benchmarking report, it says that laboratory costs, in particular, have demonstrated minimal year-to-year fluctuation, maintaining their reputation as a predictable and manageable expense. Similarly, material costs have remained largely stable.

The average payout ratio for fee-per-item dentistry has remained stable at approximately 47% of revenue. This consistency reflects steady treatment pricing and reliable cost control across the board. The data suggests that recruiting private dentists on a 45% payout is both realistic and competitive, especially where the annualised chair gross exceeds £300,000.

The average payout ratio for dental plan work has ticked slightly upwards in the 2025 data. However, given the variety in plan

models and how they are implemented, this increase should not be over-interpreted, says the report. On average, plan payouts sit just below 45% of revenue, which aligns with expectations when factoring in differences in pay structures and recharge policies.

Gross profit margins have remained relatively stable over the past three years, with an average of 47.51%. This steadiness suggests effective cost management and revenue generation across the sector. However, while many practices pay more than the National Living Wage, the recent statutory increases have created upward pressure on staff salaries across the board.

Meanwhile, in terms of the consolidation landscape, practices generating more than £900,000 in revenue with EBITDA margins above 20% remain the primary focus for consolidators and corporate groups. This profile continues to set the benchmark for high-interest acquisition opportunities.

But for owners, the key takeaway is that while building turnover and profitability will broaden your buyer base, opportunities to sell exist across the spectrum of practice sizes and performance levels.

The report recommends that rather than focusing solely on reducing costs, the greater opportunity lies in increasing revenue through better use of available resources and manipulating some existing operational factors.

"Optimising spare chair capacity, diversifying services, and enhancing patient flow can significantly boost profitability – and in turn – EBITDA margins," it says. "These are the metrics that elevate a practice into the high-value segment of the market and attract a wider range of potential buyers."

**The report can be downloaded here:**  
[dentalelite.co.uk/benchmarking-report](https://dentalelite.co.uk/benchmarking-report)

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NEWS

# Evident celebrates 50 years

*A fresh brand and exclusive  
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**EVIDENT** is marking its 50th anniversary with a new brand identity and a series of exclusive promotions designed to thank the profession for five decades of trust and support.

Since 1975, Evident has partnered with dental professionals nationwide, delivering premium products, tailored service and industry-leading expertise. From pioneering Apex Locators to supplying its first loupe in 1993, the company has consistently been at the forefront of clinical innovation. Since 2009, its partnership with ExamVision has set the benchmark for optical clarity, ergonomic precision and customised fit.

Today, Evident counts many of the UK's most respected clinicians among its clients including Dr Nick Fahey, Dr Linda Greenwall, Dr Tidu Mankoo, and Dr Rhodri Thomas.

"This is the company to go to for loupes," said Dr Greenwall. "They've supported me for many years, helping me find the perfect set-up for my needs." Dr Thomas added: "Evident's expertise and service are second to none. They've been an invaluable partner throughout my career."

The 50th anniversary offers, available for a limited time only, include **15% off ExamVision HD and Kepler loupes, plus free prescription lenses (worth up to £1,400) and free Blue Light Protection (worth £425), 15% off ExamVision PowerGo/Total light, and 'buy one, get one free' on BulkEZ PLUS refill syringes for new customers.** Dental professionals can also access Evident's free *Dental Professional's Guide to Choosing the Right Loupe* and book personalised demonstrations with its expert team.

Stephen Selwyn, founder of Evident, said: "Reaching 50 years is a proud milestone. Our refreshed brand reflects both where we've come from and where we're going. These offers are our way of saying thank you to the profession, while reaffirming our commitment to delivering the very best in product and support."

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### NEWS

## GDP pay and orthodontic fees to increase by 4%

*But the deal has been criticised  
by the British Dental Association*

**THE** Scottish Government has accepted the recommendation of the 53rd Report of the Review Body on Doctors' and Dentists' Remuneration (DDRB) of a 4% increase on the pay element for NHS general dental practitioners (GDPs) and orthodontic fees.

As in previous years, the increase on pay will apply to gross item of service fees and capitation payments. The pay award will be implemented from 1 November and backdated to 1 April.

The pay award will be included in the 'October paid November' schedule for claims with an acceptance date on or after 1 November. Backdated payments will be included in the 'November paid December' schedule for claims with an acceptance date from 1 April to 31 October.

But the details have been criticised by the British Dental Association (BDA). It said in a statement: "As in previous years, we called for the Scottish Government to apply the pay uplift to the full package of remuneration in the Statement of Dental Remuneration (SDR), but they did not implement this.

"Also, the Scottish Government did not act upon the DDRB recommendation to negotiate the expenses/cost of care element of the uplift directly with the Scottish Dental Practice Committee.

"Of particular concern for the current financial year is the impact of measures in the UK Autumn Budget to increase the National Minimum Wage and employer National Insurance contributions. We asked for full mitigation of the increase in employer's National Insurance contributions."

### DATES FOR YOUR DIARY

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registration](https://profile.eventsair.com/oral-health-summit-2025/registration)

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Glasgow Science Centre  
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#### 2026

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# FAST FORWARD

## 30 YEARS

*After attending the 30th anniversary celebrations of Independent Care Plans, Robert Donald looks at what has changed in that time*



**T**he 30th anniversary celebrations of the launch of Independent Care Plans (ICP) were held at Cameron House on Loch Lomond on 6 September. The event was attended by 80 colleagues and partners from all over Scotland, including those who have been closely associated with ICP over the years. These included members of Highland Dental Plan (HDP) Lothian Independent Dental Practitioners (LIDP), Fife Dental Care (FDC), Moray Firth, Grampian, Tayside and other individual dental practices throughout Scotland.

It does not seem that long ago since Highland dentists set up their own, locally controlled private capitation scheme against a background of crippling NHS funding cuts and mounting bureaucracy. Some of my more senior colleagues will remember 8 July 1992 when the government

imposed the now infamous 7% NHS fee cut. This was the catalyst for Highland dentists to take a concerted action in setting up HDP. It came about following the introduction of the UK Government's 'new' dental contract in 1990. More patients had registered, and more work had been done – about £200 million more than government had budgeted for.

In order to balance the books, fees were slashed by 7% and, following a hastily arranged ballot of British Dental Association (BDA) members, 58% voted not to accept new NHS patients of any age and 80% voted not to accept new NHS charge-paying adult patients. On the back of this advice, the Highland Local Dental committee organised an emergency meeting of General Dental Practitioners and the foundations were laid for the setting up HDP. From humble beginnings, it grew and prospered and in 1995 Independent Care Plans was launched following the recommendations of the HDP

expansion committee, enabling other like-minded dentists throughout the country to set up their own dental plans. These plans are now administered from a spacious suite of offices at River House in Inverness by 11 friendly, efficient and dedicated staff.

The strengths of the company are that it is run by dentists for dentists with minimal third-party interference, Scottish-based, including Dental Emergency Assistance support (DEAS), and locally controlled, allowing close monitoring of quality and DEAS claims.

But fast forward 30 years and here we are still facing the same issues of 'real terms' NHS funding cuts and mounting bureaucracy. I recently came across a media briefing that the BDA produced in 1999 on NHS dentistry. It stated: "Dentists don't leave the NHS for ideological reasons. They leave because they are finding it more and more difficult to provide an acceptable quality of care and spend the appropriate amount of time with each patient under the present fee structure and still maintain a viable practice."

What has really changed in the intervening years? The Scottish Government's approach to funding NHS dentistry continues to be unrealistic, unsustainable and creates a fundamentally flawed baseline for future funding arrangements. Access to NHS care is as much a postcode lottery as it ever was. Add in the workforce shortages sweeping across the country and the outlook looks bleak. In response, more of my colleagues understand the benefits of having a dental plan which allows their patients to budget for their care and at the same time reduce financial pressures for the practice.

While the profession in Scotland continues to face difficult times ahead, I am convinced that putting patients first is the only way forward. All dentists should be allowed to provide care in an environment where they are able to put patients' interests first without having to worry about whether the system that is funding the care provides adequate resources for the treatment or the care that is needed. It is no surprise that the demand by dentists for dental plans advances apace. Here's to the next 30 years!

**Robert Donald is a director of Independent Care Plans UK. Formerly a GDP and practice owner based in Nairn, he retired from clinical practice this year.**

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# MDDUS SUCCESSFULLY DEFENDS DENTIST IN COURT

*Case demonstrates the importance of contemporaneous records and expert opinion*

**L**eading UK indemnity provider MDDUS has successfully defended a Scottish dental member at proof (trial), at the All-Scotland Sheriff Personal Injury Court. The case has been reported on social media and below is a summary of the case from the perspective of MDDUS.

## The facts

Patient X initially attended for an examination. Bitewing radiographs and a periapical radiograph were taken.

Caries were noted in a number of teeth but particularly in LL8, which was fully erupted.

Clinical findings were explained to Patient X and treatment options provided. It was explained that

WORDS  
HELEN KANEY

pain in the lower left quadrant was most likely due to LL8, which would require either observation or extraction, as it was considered by Dr C to be unrestorable. Patient X requested that LL8 be extracted and an appointment was arranged.

Dr C took the view that the periapical radiograph taken was sufficient to assess the root morphology of LL8 and its proximity to the inferior dental nerve and that an OPG was not required.

Patient X was informed of the risks of the extraction, which included a risk that the extraction might fail and that Patient X might need to be referred to an oral surgeon.

The extraction was attempted, and the treatment took place over the course of an hour, but unfortunately the crown of LL8 fractured due to the extensive decay. Dr C was unable to section the roots, and it was not possible for the extraction to be completed. A sedative dressing was placed and the patient was referred to an oral surgery practice.

Picture above is representative of caries and is not specific to the case detailed here

Haemostasis was achieved and written and verbal post-operative instructions provided. The patient was asked to contact the practice if any issues developed. This all took place on a Wednesday in mid-October 2022.

Patient X contacted the referral practice the next day, Thursday, and was given an appointment for the following Monday. Patient X had normal post-extraction symptoms on the two days following the attempted extraction (Thursday and Friday) and had Patient X contacted Dr C's practice he would not have reported any symptoms justifying a follow-up appointment.

However, Patient X's symptoms worsened over the weekend, but he did not contact Dr C's practice because it was closed, and he had an appointment at the oral surgery referral practice on Monday. When Patient X was assessed then, he had a firm swelling on the LHS of the mandible and severe trismus.

He was immediately referred to





hospital where he was admitted and diagnosed with a left sublingual abscess and an OPG was taken. Patient X was taken to theatre for incision and drainage and surgical extraction of LL8. He had a 2cm incision of the lower left neck area to drain pus from the sublingual space.

### The experts' views

Patient X had solicitors acting for him who instructed an expert witness. MDDUS also instructed a defence expert. Both experts were experienced general dental practitioners.

In these circumstances, Patient X's solicitors would instruct an expert opinion on the standard of care provided, specifically to ascertain, based on the *Hunter v Hanley* test<sup>1</sup>, whether the expert believes that there was a breach of duty. Once breach is established the expert must opine whether that breach caused the injury complained of.

The *Hunter v Hanley* test is the legal test in Scotland which establishes whether there has been any breach of duty in the standard of clinical care provided. A patient, when trying to establish breach of duty, must establish by way of expert evidence:

- That there was a usual and normal practice;
- That the defender did not adopt that practice;
- That the course the doctor (or dentist) adopted was one that no ordinary professional man of ordinary skill would have taken if he had been acting with ordinary care.

Patient X's expert was of the opinion that a restoration should have been offered and that Patient X should have been warned of the risks of nerve damage, albeit these initial aspects were not pursued at proof. Patient X's expert also took the view that an OPG should have been taken and that OPGs are the appropriate view when considering any potentially complex extraction. Had an OPG been taken then Patient X would likely have been referred for the extraction. This would have avoided the complications that arose. It was suggested that Dr C should have had a follow-up review of the extraction site, implying an in-person appointment.

Patient X's evidence was that his severe symptoms did not start until over the weekend, when Dr C's practice was closed and patient X had not tried to make contact with the practice out of hours.

In evidence, Patient X's expert stated that it was usual and normal practice for a dentist to pro-actively contact patients and check up on them after any invasive procedure. Under cross examination, he agreed that there were no guidelines recommending routine follow-up and that it was not mandatory. He denied that he was advocating a gold standard rather than the provision of reasonable care.

The defender's expert had sat through all the evidence with permission from the Sheriff. His experience was that radiographs could be a poor predictor of whether an extraction will be easy or difficult. The periapical radiograph taken was appropriate for assessment and the taking of an OPG would not have changed the management plan. There is generally no evidence to support radiographic examination prior to routine extractions.



**FOLLOWING A FAILED EXTRACTION, IT WAS STANDARD PRACTICE TO REFER THE PATIENT TO SPECIALIST CARE, WHO WOULD THEN ASSUME THE DUTY OF CARE ONCE THEY SAW THE PATIENT."**

### Sheriff's decision

All witnesses were found to be credible and generally reliable. Although in evidence Dr C said that he could not specifically recall giving post-operative advice, it was his usual and normal practice to do so, and his contemporaneous notes recorded that appropriate safety netting advice was given. Patient X's written pleadings (drafted by his legal team) regarding the duties breached were opaque.

Some of Patient X's expert witness oral evidence did not accord with the written pleadings, which is not permitted in the Scottish courts. Patient X's case was that an inadequate radiographic assessment materially contributed to the failed extraction, but the sheriff did not agree. Patient X's expert did not identify any usual and normal practice. The selection criteria referred to confirm that there is no mandated standard practice in relation to required radiography for the removal of an LL8.

Not all practices have an OPG machine and the periapical radiograph available was sufficient. He regularly extracted molar teeth without any radiograph at all. Even if there was an established practice of obtaining an OPG prior to the extraction of a third molar, it could not be said that no reasonable dentist exercising ordinary care would have failed to do this (the *Hunter v Hanley* test). In any event, the OPG subsequently taken in hospital did not disclose any concerns, so this point would have failed on causation.

In terms of post operative care, the defender's expert said that, following a failed extraction, it was standard practice to refer the patient to specialist care, who would then assume the duty of care once they saw the patient. In the intervening period the original dentist still had a duty of care.

There was no guidance mandating follow-up care after referral. While some patients were called after procedures, this was not standard practice.

### Summary

Patient X failed to prove his pleaded case. Even if there had been a usual and normal practice, based on the defender's expert opinion, it could not be said that the action taken was one that no ordinary dentist acting with ordinary skill and care would have taken. Patient X failed to prove any breach of duty, based on *Hunter v Hanley*.

### Conclusion

Please do remember that such clinical negligence claims turn very much on their own facts and circumstances.

This case demonstrates the importance of contemporaneous records and highlights the need for careful expert opinion, based on the appropriate legal tests.

MDDUS members can be assured that we robustly assess clinical negligence claims and will defend cases at civil trial on behalf of our members where appropriate. We will not be browbeaten by patients' solicitors into settling defensible claims.

### About the author

Helen Kaney BDS LLB Dip LP MBA  
FCGdent is Deputy Head of Dental Division, MDDUS.

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<sup>1</sup> *Hunter v Hanley* 1955 SC 200 2cgdent.uk/selection-criteria-for-dental-radiography

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# UNLOCKING THE TRUE POWER OF DENTAL EDUCATION



WORDS  
SZABOLCS FELSZEGHY

*Can virtual reality and haptics reinvent how we teach and learn our profession?*

**T**he landscape of dental education in the 21st century is undergoing a profound and unprecedented transformation, propelled by advances in artificial intelligence (AI), digital technologies, virtual reality (VR) and haptic devices. These developments are not simply incremental; rather, they represent disruptive innovations that are fundamentally reshaping how educators prepare future dental professionals to deliver improved oral health care.

It is imperative that VR-haptic devices and related digital tools be viewed not merely as supplementary aids for preclinical, clinical or postgraduate training, but as essential instruments – the ‘hidden key’ – capable of unlocking new paradigms in teaching, learning and skills development across all levels of dental education. This shift holds the promise of elevating standards and outcomes in professional training and patient care alike.

## The multi-tasking Dr X of modern dental education

Digital, VR and haptic technologies must be recognised not as optional adjuncts but as central pillars in

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**DIGITAL, VIRTUAL REALITY (VR), AND HAPTIC TECHNOLOGIES MUST BE RECOGNISED NOT AS OPTIONAL ADJUNCTS BUT AS CENTRAL PILLARS IN CONTEMPORARY HEALTHCARE EDUCATION”**

contemporary healthcare education. These innovations serve multifaceted roles within dental training: they act as powerful amplifiers of knowledge acquisition, facilitate the development and refinement of manual skills, promote optimal ergonomic practices and even contribute to the wellbeing of learners through psychotherapeutic applications.

The incorporation of these technologies within both foundational and advanced dental curricula represents a formidable advancement in preparing professionals to meet the continually evolving requirements of oral healthcare delivery. It is noteworthy and concerning that, despite more than a decade of evidence





substantiating their effectiveness, adoption of these resources at a global scale remains limited, falling short of fully realising the transformative potential they offer to dental education.

### Generation Z and the manual dexterity dilemma

The COVID-19 pandemic served as a powerful accelerator, propelling dental education rapidly into a digital era. While this shift enabled continuity in learning through online platforms, it also exposed a critical challenge: contemporary dental students – digital natives immersed in smartphone and computer use – are increasingly deficient in the manual dexterity traditionally cultivated through hands-on, analogue experiences. This emerging gap manifests starkly at the outset of preclinical training, where students often demonstrate insufficient foundational skills.

The consequences extend beyond the technical, contributing to heightened anxiety and stress as students grapple with acquiring these essential competencies. Furthermore, educators face daunting obstacles bridging the divide between digital familiarity and practical manual proficiency. Ultimately, this skills deficit poses a tangible risk to future patient care quality, emphasising the urgent need for targeted interventions within dental curricula. Addressing this challenge is paramount to ensuring that graduates are not only technologically literate but also possess the refined manual abilities indispensable for safe and effective clinical practice.

Despite the overwhelming benefits offered by digital, VR and haptic technologies in dental education, several persistent barriers continue to impede their widespread adoption. A primary obstacle is the high initial cost associated with acquiring these advanced systems – a challenge that is especially acute in developing regions where financial resources are limited. This fiscal barrier often restricts access, resulting in inequities in educational opportunities across institutions.

Resistance to change also plays a significant role in slowing adoption. Many educators and institutions remain comfortable with traditional teaching methods, and this entrenched mindset can be difficult to overcome. The shift to technology-enhanced learning requires educators not only to learn new tools but also to reimagine curricula and workflows, a complex endeavor that demands time, effort and institutional support.

Additionally, integrating these technologies into existing educational frameworks can be logistically challenging. Successful implementation necessitates curriculum redesign, alignment with learning objectives and faculty training, all of which require careful planning and resource allocation. Without structured support, these integration hurdles can discourage educators from embracing innovation.

Finally, although evidence supporting the efficacy of digital and haptic technologies is growing, there remains a need for further rigorous validation to establish these tools as essential components of dental education universally. Ongoing research is critical to demonstrate long-term benefits in skill acquisition and clinical outcomes, which, in turn, will help build confidence among stakeholders.

Addressing these barriers through cost-effective solutions, comprehensive faculty development programmes, institutional commitment and continued research will be vital for realising the full potential of these transformative technologies in dental education.



## VR HAPTIC DEVICES REPRESENT THE CRITICAL MISSING LINK NECESSARY FOR CULTIVATING STRONGER, MORE AGILE AND MORE ADAPTABLE DENTAL PROFESSIONALS

### VR-haptics: one of the powerful solutions

The future of dental education is unequivocally digital, and VR haptic devices stand at the forefront of this transformation – extending their impact well beyond preclinical and clinical stages into postgraduate education and continuous professional development. These technologies are rapidly becoming indispensable across all levels of dental training, underpinning the full spectrum of dental competence. From novice learners acquiring foundational manual dexterity to experienced practitioners refining advanced technical skills, ergonomic practices and stress management techniques, VR haptic systems offer tailored, immersive and effective learning experiences.

In conclusion, the evidence is unequivocal and compelling: VR haptic devices represent the critical missing link necessary for cultivating stronger, more agile and more adaptable dental professionals. These technologies empower learners across the entire spectrum of education; not only enhancing student training but also revolutionising postgraduate education and fostering continuous lifelong development.

We are witnessing an era of radical, irreversible change in dental education, where failure to adapt is no longer acceptable for educators, institutions or future practitioners. To secure the future of oral healthcare, stakeholders must come together to overcome reluctance and embrace VR haptic technologies not as optional enhancements but as essential foundations of dental education at every level. The future belongs decisively to those who recognise this imperative and act with vision and urgency.

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# TRANSFORMING

Operation  Smile

*Dragons' Den stalwart helps put new smiles on the faces of children*

**S**cottish businessman and former stalwart of the TV show *Dragons' Den*, Duncan Bannatyne has a longstanding and significant relationship with Operation Smile.

The global non-profit organisation provides free cleft lip and palate surgery to children and young adults who would otherwise have to live with their life-altering conditions.

If left untreated, a cleft condition is likely to leave children facing daily challenges, from long-term health issues, such as dental and orthodontic problems, to speech impediments, nutritional challenges and emotional problems.

However, since 1999, Operation Smile has provided more than 13,420 patients in Morocco with cleft surgery and hosted 152 additional surgical programmes in the country. Bannatyne has previously visited the Philippines, Mexico, Vietnam and Ghana with Operation Smile, witnessing first-hand the transformative impact of their work.

Bannatyne, founder of the Bannatyne Group, which operates health clubs, spas and hotels across the UK, has supported the organisation financially for a number of years. Earlier this year, he and his wife Nigora and two of his children,

Tom and Emily, along with Nigora's daughter Gabby, joined Operation Smile's most recent surgical programme to Morocco to see the charity's work for themselves.

One in 800 children born in Morocco has a cleft condition. This particular programme, part of Operation Smile's Women in Medicine female-led initiative, saw a team of doctors and nurses carry out life-transforming operations to correct cleft lips and palates for 111 children.

In addition to surgery, each patient receives other services, including nutritional support, speech therapy, oral healthcare and psychosocial support, for them and their families.

Because education programmes sit at the heart of Operation Smile's strategy, this mission also enabled skill sharing and mentorship for female Moroccan medical professionals, to help build capacity in the areas of greatest need.

Bannatyne, who personally funded the medical team's travel and week-long stay in Morocco, plus all the equipment they needed, said: "There were five days of operations. The first two days were spent seeing all the children and getting them on to the treatment register and operations began on the third day. It looks like organised chaos, but it's fantastic to see so many

WORDS  
WILL PEAKIN

# LIVES

## Women in Medicine provides education pathways

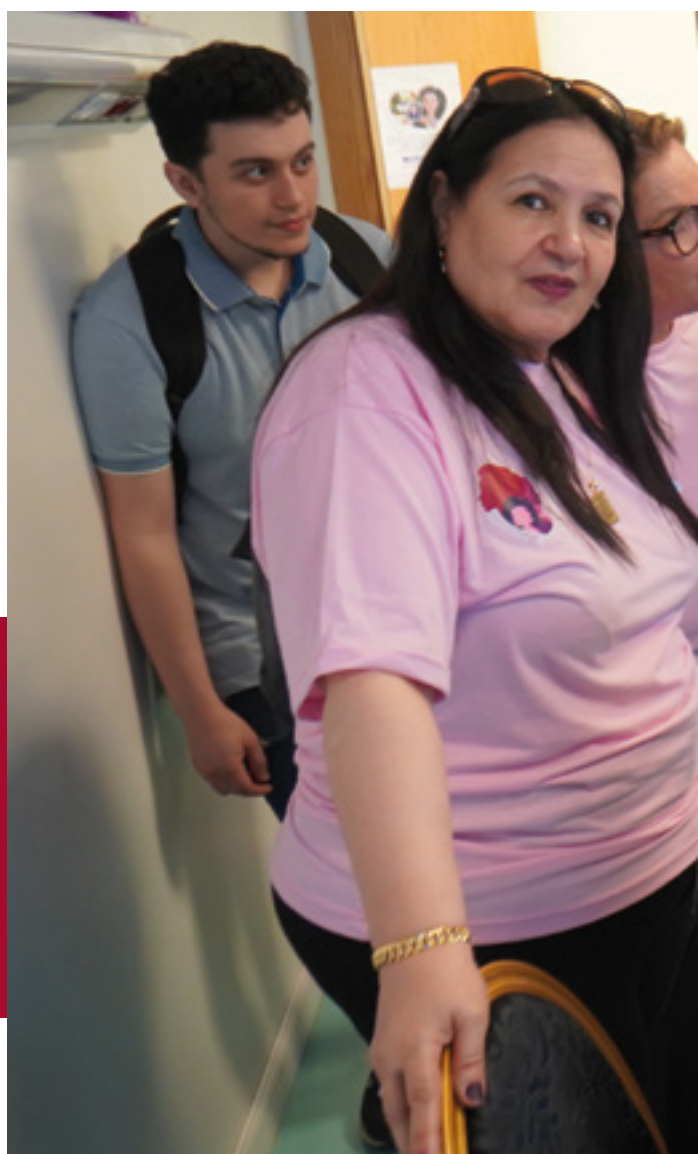
Operation Smile's Women in Medicine initiative provides education pathways for women to become global leaders in medicine, health care and surgery.

Its aim is to advance the number, standing and leadership of women in international healthcare. Indeed, increasing the number of women in healthcare professions is pivotal to meet the shortfall of trained specialists overall.

Initiatives include women-led surgical outreach programmes, educational

opportunities for women in healthcare training and leadership, thought leadership on advancement of women in global medicine and gender and health equity innovation research.

Operation Smile carries out hundreds of surgical programmes to help people with cleft lip and cleft palate. Just £150 provides one child with cleft lip or cleft palate with a life-changing operation. For more information, visit [www.operationsmile.org.uk/fundraise](http://www.operationsmile.org.uk/fundraise)





“

## IT LOOKS LIKE ORGANISED CHAOS, BUT IT'S FANTASTIC TO SEE SO MANY PEOPLE'S LIVES BEING CHANGED

people's lives being changed.” He also witnessed first-hand the effect surgery has by accompanying some children into the operating theatre and later seeing the emotional reaction of the young patients when they looked in the mirror, along with that of their families. “They’re just shocked at how much we’ve changed their lives,” he said.

Babbantyne’s health club staff are also keen to contribute, regularly holding fundraising events. “They just want to get involved all the time,” he said. “This year they’ve held a *Britain’s Got Talent*-style event, fun runs and various fitness fundraisers and they’ve raised more than £45,000, which is absolutely fantastic.”

Mairead O’Callaghan, Executive Director of Operation Smile, said:

Duncan Bannatyne and family with members of the Operation Smile team at a clinic in Casablanca

“It was an absolute privilege to spend time with Duncan, Nigora and their children during this programme and we are incredibly grateful for their continued support.

“The Bannatynes have been part of the Operation Smile family since 2013, when they funded and attended our surgical programme in Mexico.

“We have also been touched by the energy and enthusiasm of staff from The Bannatyne Group, whose fundraising efforts helped make this programme possible. We very much look forward to working together in the future with our shared goal of transforming the lives and futures of more children with cleft conditions.”

### Operation 100 for enhanced healthcare infrastructure

Earlier this year, Operation Smile announced the launch of Operation 100, an initiative aiming to equip cleft operative teams with advanced skills, essential equipment and enhanced healthcare infrastructure.

These teams will be able to independently deliver life-changing surgeries at district hospitals, making essential cleft surgery accessible within two hours of home for nearly 500 million people.

With more than five billion people – more than two-thirds of the world’s population – lacking access to safe, affordable surgery, the global surgical crisis demands urgent action.

To meet the 143 million surgeries needed in low- and middle-income countries annually, the world requires 2.2 million more surgeons. Operation 100 aims to help close this gap by training and equipping local surgical

teams to bring safe, high-quality care closer to home.

Leveraging Operation Smile’s 40-plus years of expertise in expanding surgical access, this strategy will train 100 surgical teams across 100 hospitals, providing them with specialised skills, essential equipment and strengthened healthcare infrastructure.

“For too long, patients have been forced to travel for days, exhausting their resources just to reach surgical care – only to be turned away,” said Kathy Magee, Co-founder, President and CEO of Operation Smile.

“Operation 100 is about building hope. By strengthening district hospitals, we’re not just expanding access to essential health care and surgery – we’re building resilient healthcare systems, equipping local health care professionals and ensuring sustainable access for generations to come.”





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# ARE WE CHOOSING WISELY?

WORDS  
DR HEATHER CASSIE, DR LAURA BEATON AND DR MEGAN CRICHTON

*Realistic Dentistry is not about doing less; it is about doing what matters most*

# D

entistry often operates in shades of grey, with clinical decisions rarely black-and-white and multiple treatment options that may all be appropriate. This uncertainty can challenge both patients and dental teams, from weighing potential risks and benefits to navigating patient preferences and expectations.

Realistic Dentistry, grounded in the principles of Realistic Medicine<sup>1</sup>, provides a framework to navigate these complexities. By placing patients at the centre of care and focusing on outcomes that matter most, it supports evidence-based, personalised decision-making that is clinically sound, sustainable, equitable and professionally fulfilling.

Effective treatment planning requires careful consideration of the Benefits, Risks and Alternatives and the consequences of Doing Nothing (BRAN), a framework that helps ensure decisions are transparent, patient-centred and aligned with best practice<sup>2</sup>.

At the Scottish Dental Show earlier this year, we delivered a workshop introducing Realistic Dentistry, with

a particular focus on shared decision-making in primary care. Designed for all members of the dental team, the session was very well attended.

We used a world café-style approach, applying the BRAN framework to explore three common scenarios: paediatric caries, recall intervals and antibiotic prescribing – all supported by relevant Scottish Dental Clinical Effectiveness Programme (SDCEP) guidance to reinforce evidence-based practice<sup>3</sup>.

Discussions were focused on three scenarios and are summarised here:

## Scenario 1: Paediatric caries

Nina, aged seven, from a Scottish Index of Multiple Deprivation (SIMD) 1 area, has dental anxiety and multiple carious lesions; early caries in eight deciduous teeth and extensive decay in one requiring extraction. Medically fit, she is pre-cooperative for extractions in the dental chair. She has three siblings, and the nearest public dental service (PDS) clinic is a 50-minute bus journey. Her first permanent molars have recently erupted. Nina has been placed on the general anaesthetic (GA) waiting list with an estimated one-year wait.

Children presenting with advanced dental caries face immediate pain, infection, and collateral effects on wellbeing, schooling and family dynamics. Prompt intervention offers tangible **benefits** such as pain relief, infection control, avoidance of antibiotics and emergency visits and improved quality of life. GA allows

comprehensive treatment in a single session but entails inherent **risks**, potential delays and the possibility of otherwise restorable teeth deteriorating further.

SDCEP's Prevention and Management of Dental Caries in Children guidance advises a risk-based recall strategy: children at higher caries risk should receive enhanced prevention (such as fluoride varnish) every three months, while others may be seen every six months, with flexibility for longer intervals when justified and documented<sup>4</sup>.

**Alternatives**, including Hall crowns, silver diamine fluoride, pulpomies, sedation-assisted extractions, plus preventive measures, can stabilise disease while building trust. **Doing nothing** risks recurrent pain, complex infections, potential hospitalisation and developmental tooth damage potentially causing greater disruption to the child and their family.

## Scenario 2: Realistic recall

Jennifer, 48, attends as a new patient. Medically, Jennifer is fit and well, doesn't smoke, drinks alcohol well within recommended limits, and has a good diet. On examination, you note exemplary oral hygiene, with Code 0s during the BPE. You communicate this to Jennifer, who asks if she is getting a scale and polish today – her previous dentist did one every six months. Jennifer does not like them at all but knows they have been part of her care.







Tailoring dental recall intervals to individual risk offers clear **Benefits:** low-risk patients can safely have longer recalls, improving convenience, reducing costs, prioritising dental professional time and boosting satisfaction while avoiding unnecessary scaling or polishing that can damage enamel. **Risks** include misclassifying patient risk, delayed detection of caries, periodontal disease or oral cancer, but also the potential for overtreatment or unnecessary invasive procedures, setting precedents for future care.

**Alternative** strategies, such as electric toothbrush use, targeted oral hygiene instruction, selective hygienist referral, praising good oral hygiene or offering an initial six-month review, may maintain standards and motivate patients. **Doing nothing** in the form of universal six-month appointments or simply giving the patient what they want, may avoid immediate conflict but risks inefficient NHS resource use and unnecessary treatment.

### Scenario 3: Antibiotic prescribing

Umar, 32, attends for an emergency appointment. Umar is fit and well with generally good dental health but has a recently placed large restoration in his lower left first molar. You diagnose irreversible pulpitis. Umar is insistent on receiving antibiotics – he wants out of pain. However, there are no indications.

When faced with acute dental pain, some patients expect antibiotics as a quick remedy. The **benefits** of this are transient relief, patient satisfaction and building trust to allow the clinician time to listen, explain treatment options and help the patient absorb information about the need for extraction. Prescribing antibiotics without addressing the cause, however, carries significant **risks**, such as antimicrobial resistance, adverse drug effects, postponement of definitive treatment and setting patient expectation precedents. SDCEP's Drug Prescribing for Dentistry guidance<sup>5</sup> emphasises accessing up-to-date prescribing information via the SDCEP Dental Prescribing website, aligning with BNF/BNFC standards.

**Alternatives** include extraction, pulpotomy, root canal treatment or the use of analgesics or sedation for anxious patients. Clinicians can also provide counselling about the limited role of antibiotics, advice on pain



relief and create time for the patient to consider their options by numbing them up to enable informed decision-making without pain. **Doing nothing** in relation to a toothache was considered unethical. Without intervention infection can progress rapidly to abscess, systemic spread, and potential hospital admission.

### Conclusion

The BRAN framework underscores the importance of informed, evidence-based decision-making in dentistry. This workshop demonstrated how BRAN can be applied in practice to support shared decision-making conversations between patients and their dental teams across a variety of clinical scenarios.

Whether managing childhood caries, planning recall intervals, or responding to requests for antibiotics, clinicians must carefully weigh the Benefits, Risks, Alternatives or whether they can Do Nothing, while communicating openly and empathetically with patients.

It is important to note that these insights were generated during a one-hour session without direct patient involvement. Further options and perspectives may emerge during real-world patient/clinician conversations.

Realistic Dentistry is not about doing less; it is about doing what matters most. By aligning care with patients' needs and national guidance, clinicians can deliver treatment that is evidence-based, patient-centred, equitable and sustainable.

A workshop at the Scottish Dental Show demonstrated how BRAN can be applied in practice

Do you have a scenario that you would like to share about successful shared decision making? If so, please let us know by contacting Heather Cassie at [h.c.cassie@dundee.ac.uk](mailto:h.c.cassie@dundee.ac.uk)

### Acknowledgements

Many thanks to those who attended the workshop and contributed to the discussions and thank you to members of the Realistic Dentistry group who helped to develop the case study scenarios.

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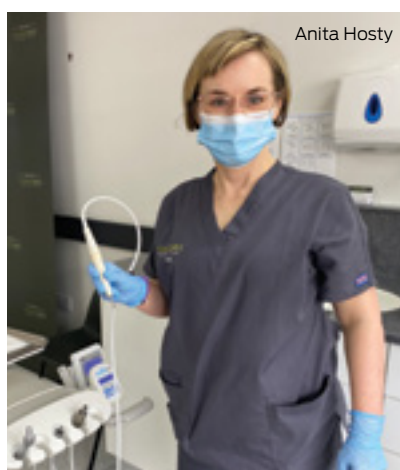
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# WHY DOES IT HURT

WORDS  
ANITA HOSTY

## BEING A DENTAL PROFESSIONAL?

*Musculoskeletal pain in dentistry is expected and accepted – but you can effect change*



Anita Hosty



**B**eing a dental professional is demanding, both physically and mentally. The repetitive motions and sedentary nature of treating patients often lead to musculoskeletal pain and discomfort. Even with precautions and ergonomic equipment, many dentists and dental professionals still face

a high risk of developing work-related injuries. This constant physical strain can affect their long-term wellbeing and make the profession challenging to sustain.

Many dental professionals consider early retirement to escape the physical and emotional toll of the job. However, this choice brings significant challenges, including financial implications and the loss of valuable expertise within the dental community.

In one study<sup>1</sup>, musculoskeletal disorders were the most common cause of ill-health retirement among dental professionals, accounting for 55% of cases. In another<sup>2</sup>, musculoskeletal issues contributed to more than 10% of the 185.6 million working days lost due to sickness or injury.

Early on as a dental nurse, I developed lower back pain from working without an assistant chair. I requested one from my employer, but even with the chair, the pain persisted. Years passed, and I began to accept the persistent pain as part of my daily life, even considering a career change.

I eventually took up the gym, focusing on Pilates, Bodybalance, and Tai Chi. Over time, these exercises reduced my aches and pains, leading to a noticeable improvement in my physical wellbeing. Life sometimes interfered, causing me to pause my exercise routine. However, I always returned to it because of the clear benefits. The good thing is that you can always resume your routine once circumstances allow.



### Is prevention the key?

For dental professionals, musculoskeletal pain is common. However, addressing it proactively through self-care, regular breaks and seeking professional help is essential. By prioritising their wellbeing and adopting healthy habits, they can mitigate the negative effects of their demanding profession and continue to provide quality care.

Prevention is not just easier and cheaper, it is a fundamental investment in your long-term health. Taking care of your body now means you can avoid a lifetime of reactive, expensive and often painful treatments later.

### How your body reacts while you work

When you are focused on your work as a dental professional, your mind prioritises the patient, often ignoring what is happening to your body. This intense concentration can lead to several physical issues:

- **Poor posture:** Your shoulders may creep up, your upper body can hunch forward, and your head often juts down and forward. These positions are a natural response to trying to access the small, dark environment of a patient's mouth. Unfortunately, they often lead to significant strain.
- **Muscular strain:** This compromised posture puts your body out of its natural alignment, leaving your core muscles unsupported. Daily twists and awkward movements while working can lead to muscular tension, stiffness and pain.
- **Stress and fatigue:** Incorrect time management can cause stress, which makes your muscles tense up, contributing to stiffness and pain. The combination of mental and physical strain can leave you feeling exhausted by the end of the day, which can ultimately lead to burnout.

These physical challenges and the pain that follows can create a vicious cycle, distracting you from your work and making your job even more stressful.

Dental professionals often experience pain due to a combination of physical and lifestyle/occupational factors. This is primarily caused by static and awkward postures maintained for long periods.

### Physical factors

Working on a patient forces you to hold one position for an extended time, which keeps your muscles inactive. This can lead to a weak core, back and shoulder muscles. A weak core also impacts your pelvic floor, a group of muscles that supports your internal organs and is essential for stability. This contributes to poor balance and poor posture, as your body is not adequately supported in its neutral alignment.

### Lifestyle/occupational factors

Beyond the physical positions you're in, the nature of the job itself contributes to pain. Repetitive strain, especially in the hands and wrists, is common from performing small, precise movements. Additionally, dentistry is a stressful profession, and stress can cause your muscles to tense up, leading to further stiffness and pain. The demanding nature of the job with long working hours often leads to an inactive and sedentary lifestyle with poor work-life balance, which can exacerbate physical pain and lead to both physical and mental burnout.

Rethink your approach to ergonomics. Instead of solely relying on tools like saddle seats and loupes, consider your body the most crucial tool. By mastering proper posture and movement, you can make your body work with you, not against you, to prevent pain and injury.

Developing a good, neutral posture is a vital habit for dental professionals. To achieve this, simply ask yourself one question throughout the day: "How is my posture?" This quick self-check, especially before seeing your patient, is a powerful reminder. You already know what correct posture feels like; this question helps you make a natural, immediate adjustment.

Mastering a neutral posture is essential for dental professionals. By following these simple steps, you can train your body to work with you, not against you, throughout the day:

- **Sit or stand tall:** Elongate your spine as if a string is gently pulling your head toward the ceiling.
- **Maintain natural curves:** Let your spine keep its natural S-shape.
- **Align your head:** Keep your chin parallel to the floor, eyes gazing straight ahead.
- **Relax your shoulders:** Roll your shoulders down and back, gently squeezing your shoulder blades together.
- **Breathe easily:** This position should feel natural, not forced, allowing for full, deep breaths.

Remind yourself to check your posture as often as you can, especially when you are speaking with a patient. About 20% of your work involves talking to patients about their oral health, which is a great opportunity to practise these steps and reinforce good habits.







Being aware of bad habits is the next step toward correcting them. One of the most common issues is raising the shoulders and holding tension without realising it. Additionally, be mindful of awkward, bad twists performed by dental professionals to access a patient's mouth. These small, repeated actions cause significant strain over time.

### Posture tips for sitting

Here are some tips for maintaining a good neutral posture while sitting at work:

- › Align your body: Keep your head, shoulders and hips on the same vertical plane.
- › Adjust your hips: Ensure your hips are positioned higher than your knees.
- › Plant your feet: Keep your feet flat on the floor for stability.



## MAINTAINING A NEUTRAL POSTURE DOES NOT MEAN STAYING STILL; MOVEMENT IS THE KEY

Maintaining a neutral posture does not mean staying still; movement is the key. The general government exercise recommendations for adults<sup>3</sup> are:

- **Aerobic activity:** At least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity activity per week. This should be spread out over four to five days or every day.
- **Strengthening:** Activities that work all major muscle groups should be done at least two days a week.
- **Reduce sedentary time:** Break up long periods of sitting or lying down with some form of activity.

**For a free assessment of musculoskeletal issues for your team member or yourself, contact Anita at:**

**E:** [contact@loosehands.com](mailto:contact@loosehands.com)

**W:** [www.loosehands.com](http://www.loosehands.com)

**F:** LOOSE HANDS for Dental Professionals

**I:** [@loose\\_hands\\_for\\_dental\\_pro](https://www.instagram.com/loose_hands_for_dental_pro)

### About the author

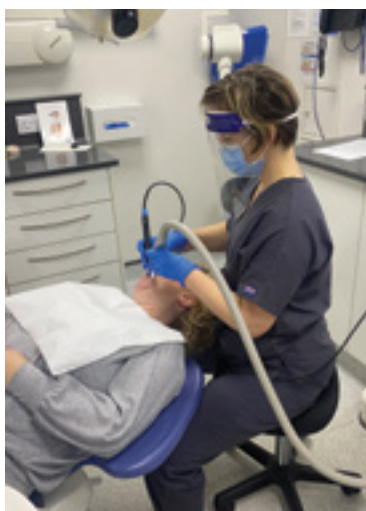
Anita Hosty, RDH / fitness instructor, is the creator of LOOSE HANDS, an ergonomic and fitness programme for dental professionals.

### References

<sup>1</sup> [www.nature.com/articles/sj.bdj.2010.813](https://www.nature.com/articles/sj.bdj.2010.813)

<sup>2</sup> [tinyurl.com/54ecybrj](https://tinyurl.com/54ecybrj)

<sup>3</sup> [www.nhs.uk/live-well/exercise/physical-activity-guidelines-for-adults-aged-19-to-64/](https://www.nhs.uk/live-well/exercise/physical-activity-guidelines-for-adults-aged-19-to-64/)



### Spinal mobility exercises

Maintaining a neutral posture is vital, but so is the movement. Your body needs a break from static positions, and these simple exercises can help improve spinal mobility and relieve tension.

#### The Hug

This exercise helps stretch your upper back and shoulders.

- › Inhale while sitting or standing and raise your arms out to the sides.
- › Exhale as you wrap your arms around yourself, giving yourself a hug.
- › Focus on extending your upper spine and feeling a gentle stretch.
- › Repeat the movement.

#### The Modified Hug

This variation adds a gentle spinal flexion to increase mobility.

- › Inhale while sitting or standing and raise your arms out to the sides.
- › Wrap your arms around yourself.
- › Exhale as you move your upper trunk down to your knees, rounding your upper back then back up again with your upper trunk.
- › Repeat the movement, alternating which arm is on top each time.

#### Side bend for spinal mobility

This exercise helps to improve the flexibility of your spine and the muscles along your sides.

- › Sit or stand straight on the floor with good posture.
- › Inhale as you slowly raise your arms up to above your head. Keep shoulders down.
- › Exhale as you bend your torso to one side, moving your arms

in the same direction. Feel a gentle stretch along the opposite side of your body.

- › Inhale as you return to the centre.
- › Exhale as you repeat the movement to the other side.

This exercise can be done a few times on each side to help release tension from a long day of work.

The Teaser is a challenging Pilates exercise that builds core strength, balance, and control. It requires a strong core and good balance. Here are simplified versions for different skill levels.

#### Beginner/intermediate Teaser

- › Sit on the floor with your knees bent and feet flat on the ground.
- › Lean back with your upper body, engaging your core. Your hands should be on the floor behind your back for support.
- › Lift one knee up at a time, then place it back down.
- › Repeat with the other leg. To increase the challenge, you can try raising your arms off the floor while lifting your knees.

#### Advanced Teaser

- › Sit on the floor, **engage your core muscles** and keep engaging.
- › Lean back with your upper body, using your hands on the floor for stability.
- › Lift one knee/leg up, then the other, and hold them up together in a V shape.
- › For the full Teaser, raise your arms above your head and hold this position for up to 20 seconds.
- › Repeat the exercise as desired.



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Specialist Prosthodontist  
BDS (Glas), MFDS RCPS (Glas)  
MClinDent (Edin)  
MRD RCS (Edin)  
- **GDC NO 81960**



### CHARLIE MARAN

Specialist Periodontist  
BDS MSc (Restorative  
Dentistry)  
- **GDC NO 63897**



### ADRIAN PACE-BALZAN

Specialist Endodontist  
BChD MFDS RCPS (Glasg)  
MPhil MClinDent (Prosthodontics)  
FDS(Rest Dent)  
RCS (Glasg)  
- **GDC NO: 83943**



### KATHY HARLEY

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BDS MSc FDSRCS (ED)  
FDSRCS (England)  
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Clinical Director and Implant Surgeon  
BDS (Glasg.) 2005 GDC No 85401



### **Dr Duncan Weir**

Implant Surgeon  
BDS (Glasg.) 2009 MFDS CLINIMPDENT - GDC No 176892

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[www.edinburghdental.co.uk](http://www.edinburghdental.co.uk)

0131 667 4433

[info@edinburghdental.co.uk](mailto:info@edinburghdental.co.uk)





# WHO'S WHO

Welcome to the 2025-2026 Who's Who compiled by Scottish Dental magazine. The list in this edition is representative, rather than comprehensive, so please refer to [www.sdmag.co.uk/whos-who-2025-2026](http://www.sdmag.co.uk/whos-who-2025-2026) for additional entries.

## Professor Aileen Bell

Aileen Bell is head of Glasgow Dental School. She graduated from Glasgow University as the Most Distinguished Graduate for 1998 with a BDS with Honours and was awarded the Dean Webster Prize and the Lord Provost's Prize for the most marks obtained in Dental School examinations. In 1998, she embarked on a two-year General Professional Training Programme, with one year in General Dental Practice as a Vocational Dental Practitioner and one year as a GPT House Officer in Glasgow Dental Hospital and School.

She obtained an MFDS from The Royal College of Physicians and Surgeons of Glasgow and was awarded the T.C. White Medal for outstanding performance in part C of the exam. From 2000-2002, she worked as a Senior House Officer in Glasgow Dental Hospital and School after which she took up the post of Specialist Registrar in Surgical Dentistry in Glasgow (2002-2004).

She then moved to an academic specialty training post as Clinical Lecturer/Honorary specialist registrar in Academic Oral and Maxillofacial Surgery with the University of Glasgow and took up a Clinical Senior Lecturer/Honorary Consultant role in Oral Surgery in Glasgow in 2009. She was Deputy Director (2009-2013) and Director (2013-2021) of the Undergraduate Dental programme before being awarded a Chair as Professor of Oral Surgery & Dental Education in 2021 and taking up the post as Head of Dental School the same year.

## Professor David Conway

David Conway graduated from Glasgow University BDS in 1996. Following brief periods in general dental practice, hospital dentistry in Bristol and Edinburgh, and SHO posts in oral and maxillofacial surgery at St John's in Livingston, he

attained FDS RCS (England) in 1999. He returned to Glasgow in 2000 for a clinical lectureship in dental public health combined with a specialist registrar training post based in NHS Lanarkshire and NHS Argyll & Clyde Health Boards. David completed the MPH at Glasgow in 2002 and specialist training in dental public health in 2005 (FDS DPH RCS, and FFPH). He was awarded a PhD in 2008 for research on the epidemiology of oral cancer from a socioeconomic perspective.

Since 2005 he has held the position of Honorary Consultant in Dental Public Health, which has been with Public Health Scotland since its inception in April 2020 where he is currently the dental lead. David was appointed Professor of Dental Public Health in 2015 in the School of Medicine, Dentistry and Nursing, where he is the current Director of Dental Research, and he also Co-Leads the Oral & Dental Specialty Group in NHS Research Scotland. The past year (2024-2025) he has been clinical head and neck cancer lead for NHS Scotland supporting the production of the Head and Neck Cancer Care Management Pathway. His research interests focus on health inequalities, head and neck cancer epidemiology, and child oral health including the ongoing evaluation of Childsmile – the national child oral health improvement programme for Scotland.

## Paul Cushley

Paul Cushley is NHS National Services Scotland's (NSS) Dental Director. This role was created within NSS to ensure that dentistry and oral health is both considered and has a voice in the design, creation and delivery of health and social care services across the NHS in Scotland. Paul brings a range of clinical experience in dentistry to his NSS role, having had a long and varied career in the hospital service, general dental practice (as an

associate, partner and principal), the prison service and latterly in the public dental service.

## Dr Lisa Currie

Lisa Currie is the Clinical Director of The Orthodontic Clinic, a multi-award winning specialist practice in Aberdeen. Lisa gained her BDS with honours at Dundee Dental School in 1996. After completion of her postgraduate training in Edinburgh, she became a Specialist Orthodontist in 2003 and during her training, carried out a research degree in sleep apnoea and was awarded her MSc in Orthodontics from the University of Edinburgh.

Lisa undertook her consultant training in Birmingham Dental Hospital and Stoke-on-Trent, becoming a Consultant Orthodontist in 2006. Lisa became Consultant Orthodontist at Borders General Hospital/ Edinburgh Dental Institute in 2006. She then moved to specialist practice in Aberdeen in 2010 and was appointed as Honorary Senior Lecturer at Aberdeen Dental Hospital and School in 2015.

In 2019, Lisa was elected as a Fellow of the Faculty of Dental Surgery in Orthodontics, FDS(Orth), from the Royal College of Physicians and Surgeons of Glasgow, a real acknowledgement of her dedication to the specialty.

## Dr Kevin Davey

Kevin Davey is interim dean of the University of Dundee's School of Dentistry. He has more than 20 years teaching experience at undergraduate and post-graduate levels, particularly in relation to clinical periodontology and dental education.

Since 2014, he has been the undergraduate academic lead for periodontology. In recent years, he has



## SELINA ALEXANDER AND RICHARD O'BRIEN • PRACTICE PLAN

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SUPPORT MANAGERS  
AT PRACTICE PLAN

**SELINA** Alexander is a Regional Support Manager at Practice Plan who recently celebrated 30 years' of working in the dental industry. After starting her first job as a Trainee Dental Nurse aged 16, Selina gained experience in many different roles in practice over the next 25 years before taking on responsibility for a group of 10 practices as Regional Manager. She also spent two years working in Mergers and Acquisitions for Scotland at Portland Dental Care before joining Practice Plan. Away from work, as well as being a regular at her local gym, Selina is a keen supporter of the Scotland rugby union team and attends as many matches at Murrayfield as she is able. Making up the other half of the Scottish team is Richard O'Brien. Richard has 19 years' experience of sales and territory management within the dental industry and has a knack for building strong relationships and customer focused

solutions. His diverse career has seen him managing territories focusing on dental solutions, conducting training sessions, and ensuring safety compliance in CDS and NHS clinics. He also has considerable experience as a hands-on trainer and presenter. Outside of work, Richard is dedicated to personal growth and team success. He co-founded and led a successful brewery, and when he is not working, he might be found on the golf course or avidly indulging in one of his many loves of craft beer, coffee or red wine!

Practice Plan is the UK's leading provider of practice-branded patient membership plans and this year celebrates 30 years of welcoming practices into the family, helping them to grow profitable businesses.

**Selina Alexander**  
E: [Selina.alexander@practiceplan.co.uk](mailto:Selina.alexander@practiceplan.co.uk)  
M: 07966 842309

**Richard O'Brien**  
E: [Richard.O'Brien@practiceplan.co.uk](mailto:Richard.O'Brien@practiceplan.co.uk)  
M: 07892 705319

## ANDREW MCGREGOR • PARK ORTHODONTICS

SHARING EXPERIENCE  
AND KNOWLEDGE

**ANDREW** is a Specialist Orthodontist and owner of the Park Orthodontics in Glasgow. Having practised orthodontics since 2007, he has a real passion for the specialty which has led him to embrace new technologies and share his experiences and knowledge.

Andrew is now a Diamond Apex Invisalign practitioner, putting him and his team in the top 1% of European Invisalign providers. His clinic is also one of the few practices treating children and teens with the first and teen products. Away from his clinic, Andrew is one of the principal lecturers for the Post Graduate Diploma in Orthodontics course run by Identiti UK. Apart from being a lot of fun, years of teaching and mentoring enthusiastic dentists has developed his skills and understanding of ortho-restorative

cases. His treatment philosophy has shifted from 'treating the teeth', to 'treating the face' over the years. If that wasn't enough, Andrew co-directs the annual Scottish Orthodontic Conference which is held on the last Friday in January. This day-long event is held at the Royal College of Surgeons and Physicians in Glasgow and attracts orthodontists, dentists and their teams from all over the country (weather permitting!).

Still motivated to keep learning, Andrew really enjoys working with referring colleagues, either collaborating or simply offering treatment planning and general advice when needed with their own orthodontic patients. Feel free to get in touch with Andrew directly if you'd like to discuss any of his projects listed above: [andrew@parkorthodontics.co.uk](mailto:andrew@parkorthodontics.co.uk)

**Andrew McGregor BDS, MSc, BSc MFDS RCS, MOrth RCS**  
GDC: 80505  
Park Orthodontics, 14 Royal Terrace,  
Glasgow G3 7NY.  
T: 0141 332 5107  
E: [andrew@parkorthodontics.co.uk](mailto:andrew@parkorthodontics.co.uk)  
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### Hannah Steven – Implant Surgeon

BDS Glasgow, MFDS RCPS (Glasg)  
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### Dr. Rebecca Smith – Ortho, Implant & Restorative Dentist

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been principally involved in academic leadership activities, both within the school and the wider university, in the roles of Associate Dean for Learning & Teaching (ADL&T – 2021 onwards) and Associate Dean for Quality & Academic Standards (ADQAS – 2015 to 2021). He has also been the panel lead for enhancement reviews of various dental health-related programmes in Lithuania (2015 and 2020).

### Robert Donald

Robert Donald is currently a Director of Independent Care Plans UK. Formerly a GDP and practice owner based in Nairn, he retired from clinical practice this year. Robert qualified from Edinburgh Dental School with honours in 1983, before spending 18 months in a training position at the Edinburgh Dental Hospital. He entered general practice in 1985, gaining the diploma in General Dental Practice in 1992. He is a past Chairman of Independent Care Plans UK and Director of Highland Dental Plan.

Robert was previously a Chairman of the Scottish Dental Practice Committee, vice-Chairman of the Scottish Dental Vocational Training Committee and vice-chairman of the Scottish Association of Local Dental Committees. He served as a non-executive Director of MDDUS from 2010 until 2021

and was also a past Chairman of the UK Council of the BDA. Robert was presented with the British Dental Association Fellowship Medal in September 2022 to honour his distinguished service to the BDA and the dental profession. In July 2023, he was admitted as a Fellow of the College of General Dentistry. He recently stood down from the British Dental Association's Scottish Council in March 2025 after serving seven years as Chairman.

### Professor John Gibson

John Gibson has enjoyed a career in academic dentistry and has held various roles at various times, including Head of the Institute of Dentistry in the University of Aberdeen, Professor of Medicine in Relation to Dentistry in the University of Glasgow, Associate Postgraduate Dental Dean with NHS Education for Scotland, Chair of Dental Protection, Chair of the General Dental Council's Fitness to Practise Panel and President of the British & Irish Society for Oral Medicine. He is currently Emeritus Professor of Oral Medicine in the University of Aberdeen, Chief Executive Officer of The Canmore Trust (SC051511) and a member of the Scottish Government's Lived & Living Experience Suicide Steering Group, and the Suicide Bereavement Support Steering Group.

John recently received an Honorary Life Fellowship from the British & Irish Society for Oral Medicine and has been awarded the President's Award of the College of General Dentistry for 2024. On 20 October 2019, John's youngest child, Cameron, died by suicide at 24-years-old and John's world changed forever. John now works to prevent suicide, and offer support to individuals, families and communities affected by suicide, through the actions of The Canmore Trust ([www.thecanmoretrust.co.uk](http://www.thecanmoretrust.co.uk)) – a charity set up by the Gibson family.

### Professor Khaled Khalaf

Khaled Khalaf was appointed Professor and Honorary Consultant in Orthodontics and the Director of the Institute of Dentistry, University of Aberdeen, in 2022.

He has been working in clinical academia, in the field of Orthodontics, working in Higher Education Institutes and NHS Hospitals, over 25 years and has worked in several countries, but predominantly in the UK. He completed his PhD in 2002 from the University of Sheffield and a post-CCST clinical academic training programme in 2011 from Newcastle University & The James Cook University Hospital, Middlesbrough & Newcastle Dental Hospital followed by the completion of the ISFE in



## DR TARIQ ALI • CENTRE FOR IMPLANT DENTISTRY

# THE GO-TO-GUY FOR IMPLANT REFERRALS



DR TARIQ ALI qualified from the University of Glasgow in 1998. After developing a special interest in dental implantology, he has gained more than 20 years experience in the field. In 2019, he established the Centre for Implant Dentistry, a dedicated implant referral practice, located in the centre of Glasgow. Dr Ali works solely within implant dentistry and is a recognised leader in his field, providing cutting-edge solutions for patients faced with edentulism – from single implants to complex full-arch cases. He is passionate about implant dentistry and the use of the latest technology available: including intra-oral scanners, 3D printing, and most recently, the X-Guide, a 3D navigational system which delivers real-time guidance on drill position during surgery. He is also passionate about implant education and

as such, founded and runs a Diploma in Implant Dentistry (Level 7), the first of its kind in Scotland ([www.dentalimplantdiploma.com](http://www.dentalimplantdiploma.com)).

The centre has been accredited as an All-on-4 Centre of Excellence, achieving the gold standard in dental implants. The centre accepts referrals from single unit cases to complex full arch treatment. Referring dentists can also refer for bone/soft tissue grafting, sinus lifts, sedation, and CBCT scans. Referring dentists may also choose to restore the implants for their patients, earning in the region of £1,000 per crown, since he runs a Refer and Restore Course regularly. Dentists also gain 21 hours of verified CPD if they attend this course (email [info@centreforimplantdentistry.com](mailto:info@centreforimplantdentistry.com) for more information).

**Dr Tariq Ali BDS (Glas) MJDF RCS (Eng) MFDS RCPS (Glas)**  
**DiplImpDent RCS (Eng)**  
 GDC No: 74600  
 E: [info@centreforimplantdentistry.com](mailto:info@centreforimplantdentistry.com)  
 T: 0141 248 1444  
 W: [www.centreforimplantdentistry.com](http://www.centreforimplantdentistry.com)  
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Orthodontics and the attainment of a Fellowship in Orthodontics (FDS-Orth) of the Royal College of Surgeons of England. He gained a Fellowship of the Higher Education Academy (FHEA) in 2009 and a Fellowship of the Faculty of Dental Trainers (FFDT) RCS Edinburgh in 2017. He has been heavily involved at different levels of administration in higher education including, for example, Programme Director, Head of Department, internal and external accreditation lead and currently as the Director of the Institute of Dentistry, University of Aberdeen. His main research interests include hypodontia; evidence-based orthodontics (RCTs, systematic reviews and meta-analyses) and medical/dental education research.

### Gordon Matheson

Gordon Matheson CBE has been Head of Scottish Affairs at the General Dental Council (GDC) since January 2020. In this role, he leads on stakeholder engagement in Scotland and ensures that GDC policy developments are fully informed by the distinct Scottish context.

Previously, he was Leader of Glasgow City Council from 2010-15, during which time the city hosted the acclaimed 2014 Commonwealth Games. In 2016, he was appointed Visiting Professor at Strathclyde University's Institute for Future Cities and Honorary Professor at Glasgow Caledonian University.

He has also led the public affairs and policy functions in Scotland for two UK charities, RNIB and Cancer Research UK.

### Gordon Morson

Gordon Morson has worked in general practice since qualifying from the University of Glasgow in 1998. He works in Alloa and has been a partner in a large, mainly NHS, practice there since 2004. He is currently Chair of Forth Valley Local Dental Committee and a member of the Area Dental Committee and Performance Review Group.

He has been involved in dental politics for more than 25 years. Gordon also has a significant interest in dental education, having organised Forth Valley's educational programme for dentists and DCPs for more than 15 years.

He is a VT trainer and contributes to the training programme, speaking about communication and dental politics. In 2022/23, he was a member of the Advisory Group on the changes to Determination 1 of the SDR. He is a member of the upcoming CPI working group.

### David Offord

Dr David Offord is a specialist in oral

surgery and practice principal at Vermilion – The Smile Experts. Vermilion is a private referral-only dental practice with clinics in Edinburgh and Kelso.

David leads a team of 50 clinicians, nurses, managers and administrative staff across both sites.

His clinical practice is now entirely implant surgery, working in close collaboration with colleagues within the multi-disciplinary team. Born and bred in Greenock, David was in the last year group to graduate from the University of Edinburgh Dental School in 1994.

His varied career has included spells in general practice in Edinburgh, Australia and Singapore and oral and maxillofacial roles in Wales, London, Falkirk and Fife. For five years he combined oral surgery staff grade jobs with working in specialist practice, before he opened Vermilion in 2011.

A Fellow of the College of General Dentistry, David holds a Diploma in Conscious Sedation from the University of Newcastle and the Membership of the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow and is currently working towards a PhD at the University of Ghent.

For four years, he was the Scotland representative on the board of the Association of Dental Implantology, and in 2025 he was elected as the regional representative for East Scotland on the College Council.

### Andrew Paterson

Andrew Paterson graduated from the University of Edinburgh in 1987 and practised in a specialist referral-based restorative practice in Glasgow for 22 years.

He has previously been an NHS Consultant at Glasgow Dental Hospital, Crosshouse Hospital, near Kilmarnock, and Leeds Dental Institute and a Clinical Senior Lecturer/Honorary Consultant at Dundee Dental School/NHS Tayside.

Andrew is a volunteer with the UK dental development charity Bridge2Aid, which is involved in oral health training in rural Sub-Saharan Africa. Andrew is part of a 'flying faculty' that supports the Dental School at the Kamuzu University of Health Sciences in Malawi.

He currently works as a Clinical Senior Lecturer and Honorary Consultant in Restorative Dentistry at the University of Glasgow where he is Education Lead for Restorative Dentistry. Andrew is the Examination Board Chair for the restorative specialty membership examinations of RCS(Eng) and RCPS.

### Lee Savarrio

Lee Savarrio, BDS, FDS, RCPSG, FDS (Rest Dent) RCPSG, MSc (Med Sci) was appointed the new Dental Director and

Postgraduate Dean of NHS Education for Scotland (NES) on 1 January and following a handover period, he took over from the previous post holder, Professor David Felix, who retired in April.

Lee joined NES from NHS Greater Glasgow and Clyde where he was employed as Chief of Dentistry and brings a wealth of experience in advancing NES's vision to support better rights-based quality care and outcomes through a skilled, capable and resilient health and social care workforce.

He has held positions in the Royal College of Physicians and Surgeons of Glasgow, both on the education committee as lead for the Clinical Anatomical Simulation Centre, as well as Director of Membership Services. He has also served on the Specialty Training Committee and Specialist Advisory Committee for restorative dentistry and is the current Chair of the Strategic Board for Glasgow Caledonian University's dental therapy programme.

### Charlotte Waite

Charlotte Waite has been the British Dental Association (BDA) Scotland Director since November 2022. Graduating from the University of Dundee in 2001, she completed general professional training in the East of Scotland, located in Australia and then worked for the Community Dental Service.

She was an elected representative on a number of BDA committees and Chair and Vice Chair of the BDA England Community Dental Services Committee, where she advocated for the profession and spoke up for vulnerable patient groups.

In 2019, she secured a Westminster inquiry on NHS penalty charges. A change in policy followed, with the Department of Health abandoning its 'fines first' policy. She also represented the BDA as part of a project to promote the use of Makaton in the dental setting, to help break down barriers to communication for patients with learning disabilities.

As BDA Scotland Director, a key role for Charlotte is to support BDA representatives in negotiations with the Scottish Government, to ensure the BDA influences policy across a range of stakeholders and to oversee outreach to the Scottish Parliament, officials, the press and wider stakeholders.

She supported the BDA Scottish Dental Practice Committee in its negotiations with the Scottish Government in relation to Payment Reform, which was implemented in November 2023. Last year, she gave evidence on behalf of BDA Scotland to the Scottish Covid-19 Inquiry on the impact of the pandemic on dentistry in Scotland.

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FDS RCS (Eng) 1997; MB BS (Lond)  
2000; DiplImpDent RSCed; SFHEA;  
MSc; FCGDent PhD DIC GDent PhD  
DIC, Founder and Chief Executive  
GDC No. 69265  
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I: vssacademy1



**Alan Goldie**  
Managing Director  
E: [agoldie@vssacademy.co.uk](mailto:agoldie@vssacademy.co.uk)  
M: 07801 583539



**Amy Lewis**  
Postgraduate Student  
Support and Administrative  
Manager  
GDC No. 119343  
E: [amy@vssacademy.co.uk](mailto:amy@vssacademy.co.uk)  
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# Nathan's journey: managing a challenging Class III malocclusion with two-phase orthodontics

Dr Nirmal Shah, Specialist and Consultant Orthodontist, The Row Dental

**N**athan was self-conscious about his 'underbite' and crowded teeth. He had difficulty biting into sandwiches and often hid his smile. His parents noted his prominent lower jaw since childhood.

By age 13, Nathan had a reverse overjet and a concave facial profile. Despite being anxious, he wanted a solution that would avoid future jaw surgery. Growing class III patients pose a particular challenge for orthodontists, as it can be difficult making safe extraction decisions when mandibular growth remains uncertain.

This case report narrates how a two-phase orthodontic approach – combining advanced orthopaedic protocols and fixed appliances – transformed Nathan's occlusion and profile, backed by current evidence-based techniques.

## Clinical examination and diagnosis

**Extraoral assessment:** Nathan presented with a skeletal class III malocclusion on a background of maxillary deficiency and mild mandibular prognathism. He showed a mild mentalis strain on lip closure, reflecting relative lip incompetence. His nasolabial angle was increased at  $113^\circ$ , suggesting a recessive upper lip, and the mentolabial angle was also increased at  $165^\circ$ , consistent with his prognathic chin. There was no obvious facial asymmetry on the frontal view. However, the concave profile clearly affected his self-esteem and social confidence.

**Intraoral assessment:** Nathan presented in the late mixed dentition. He had a class III incisor relationship with a reverse overjet of 2mm and an anterior and bilateral posterior crossbite involving the upper incisors and molars. The molar relationship

was class III. Both arches exhibited severe crowding (approximately 8–9 mm space deficiency per arch).

Notably, the upper canines were impacted, palpable high in the buccal sulcus with insufficient space to erupt. The lower right second premolar was unerupted due to crowding as a result of early loss of the deciduous molar. Oral hygiene was acceptable with no active periodontal issues, although the lower right second permanent molar had a small occlusal cavity which was restored prior to treatment.

**Radiographic findings:** Radiographic findings confirmed skeletal class III with the maxilla retropositioned relative to the cranial base, while the mandible was prognathic: SNA was reduced ( $80^\circ$ ), SNB increased ( $85^\circ$ ), giving ANB  $-5^\circ$ . The upper incisors were proclined, and lower incisors retroclined; typical compensation in skeletal class III cases. Soft tissue analysis showed the upper lip to be 4mm behind Ricketts' E-plane and the lower lip to be 2mm ahead, confirming a deficient upper lip projection and mild lower lip protrusion.



Figure 1: Extraoral photograph in the profile view, showing a concave appearance

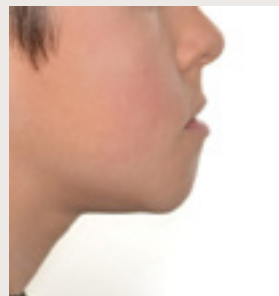


Figure 2: Extraoral photograph in the frontal smiling view, showing a reverse smile arc

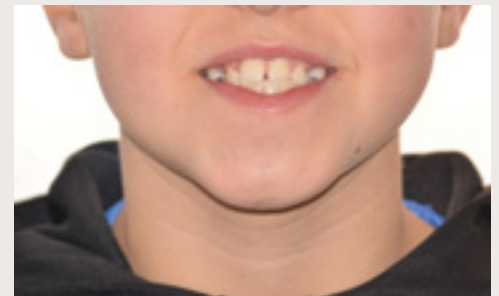


Figure 3: Intraoral pre-operative photographs





Figure 4: Pre-operative lateral cephalogram



Nathan's malocclusion fell into the category of a moderate class III that traditionally might require orthognathic surgery in adulthood. However, given Nathan's age and desire to avoid surgery, an early orthopaedic and orthodontic intervention (growth modification and dental camouflage) was planned.

### Treatment objectives

Key treatment objectives were established as follows:

- Orthopaedic correction: Stimulate forward growth of the maxilla. Achieve a positive overjet by protracting the maxilla, improving the facial profile and incisor relationship.
- Transverse expansion: Widen the maxillary arch to correct the unilateral posterior crossbite and provide space for erupting teeth, including the impacted canines.
- Anterior crossbite correction: Prevention of gingival recession. Failure to correct an anterior crossbite early can precipitate adverse growth and development of the mandible.
- Alignment and space creation: Relieve upper and lower arch crowding. Facilitate the eruption of UR3, UL3 and LR5 by creating sufficient space.
- Class I occlusion: Achieve class I buccal segment relationships bilaterally. Ensure coincident midlines and a functional overbite/overjet.
- Facial aesthetics: Improve soft tissue profile – reducing the concavity by enhancing midface projection. Clockwise rotation of the maxillo-

mandibular complex to make the chin appear less prominent.

- Stability: Plan for retention and long-term stability, given the risk of relapse in class III due to continued mandibular growth. Importantly, minimise dental compensation that could relapse and aim for as much skeletal change as possible while growth potential remains.

### Treatment plan

#### Phase 1 - Alt-RAMEC expansion and facemask protraction

Appliance design: A bonded rapid maxillary expansion appliance (RME) was fabricated for Nathan. It had acrylic coverage on the posterior teeth to increase the vertical dimension slightly (promoting a downward-backward mandibular rotation) and a midline hyrax screw. Using a bonded (instead of banded) expander provided bite-opening which helped disclude the teeth during crossbite correction.

Alt-RAMEC protocol: A modification to the original alternative rapid maxillary expansion and constriction protocol described by Liou (2005)<sup>1</sup> was used once the initial amount of expansion was achieved to correct the transverse discrepancy. Nathan's parents alternated between expansion (one turn daily for seven days) and constriction

(one turn daily for seven days), to loosen the circummaxillary sutures and enhance protraction effectiveness.

Protraction facemask: A protraction facemask was introduced alongside the modified Alt-RAMEC protocol. Nathan was instructed to wear the facemask as much as possible, primarily after school and overnight. Elastics delivered a force of 400g per side at a downward-forward angle.

Nathan diligently wore the facemask for six months. The expansion appliance was kept in place during this entire protraction period to serve as an anchorage for elastics and to retain transverse changes.

By the end of phase 1, notable changes were observed: the anterior crossbite had been resolved into a positive overjet of about 2mm. His profile already appeared less concave; the upper lip support improved as the maxilla came forward, and the mandible rotated slightly downwards and backwards, making the chin appear less pointy.

Cephalometrically, the SNA angle increased by roughly 2°, while SNB was slightly reduced due to the backwards rotation – leading to an ANB change from -5° to -1° (still a skeletal class III tendency, but significantly improved). Importantly, soft tissue effects were

Figure 5: Bonded rapid maxillary expansion appliance with buccal hooks



Figure 6: Protraction headgear

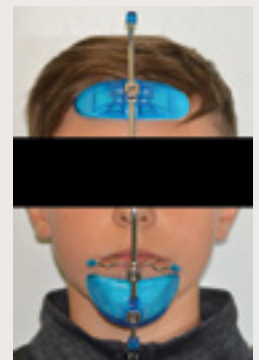
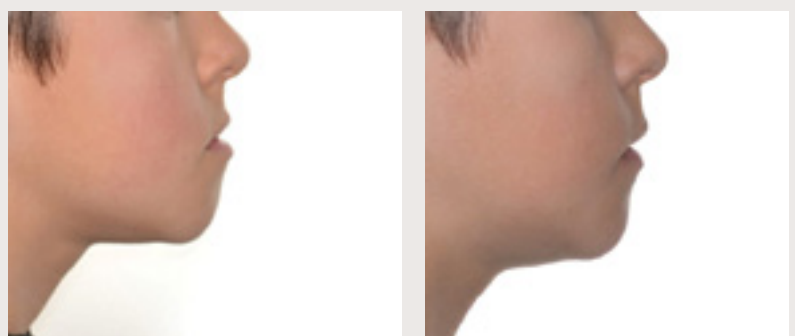


Figure 7: Soft tissue changes following phase 1 protraction headgear





positive but modest – the upper lip moved forward, and the nasolabial angle decreased slightly as a result of protraction.

By age 13 and six months, Nathan had a much improved occlusal relationship; a corrected anterior bite and transverse dimension, though his dental arches were still irregular due to crowding. At this point, the RME appliance and facemask were discontinued. An upper removable appliance was provided to retain the expansion. We allowed a short observation period to ensure the new occlusal relationship was retained before transitioning to fixed braces.

Most of the evidence regarding protraction headgear supports treating patients aged eight to 10 years, ideally during the first cervical vertebral maturation stage, as the circummaxillary sutures are more responsive prior to fusion (Baccetti et al. 1998)<sup>2</sup>. More significant skeletal and occlusal changes are typically observed in these younger patients; however, improvements in

Figure 8: Intraoral photographs after phase 1 treatment.



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ANB angle are often not maintained at six-year follow-up (Mandall et al. 2006)<sup>3</sup>.

#### Phase 2 - fixed appliances and dental camouflage

Phase 2 began once orthopaedic correction had been achieved and the patient was ready for fixed appliances. The objectives in this phase were to relieve the crowding and dental compensation, align impacted teeth, and establish a stable functional occlusion, all while maintaining the orthopaedic gains.

**Extraction sequence:** The treatment plan involved a premolar extractions to address crowding: The LR4 was extracted at the beginning of treatment to facilitate the eruption of the impacted LR5. Then LL4, UR5 and UL5 were extracted. This extraction pattern, often termed a “class III extraction pattern”, provides space to retract the lower anterior teeth and to align the upper canines without overly proclining the upper incisors.

Overly proclined upper incisors do not contribute to good dental and facial aesthetics. The extraction decisions were timed after Phase 1 when Nathan was slightly older (around 14) and had passed his peak pubertal growth spurt – this timing gave us more confidence that we were making ‘safe’ extraction decisions.

**Temporary anchorage device (TAD) use:** A 1.5mm × 8mm titanium temporary anchorage device (VectorTASTM, Ormco) was placed to allow for asymmetric space closure whilst maintaining the lower centre line.



## THE SOFT TISSUE CHANGES WERE SUBTLE YET SIGNIFICANT TO HIS APPEARANCE: FOR EXAMPLE, THE UPPER LIP MOVED FORWARD BY A FEW MILLIMETERS RELATIVE TO THE NOSE, AND HIS CHIN PROMINENCE WAS LESS STARK

**Retention:** Strict instructions were given for indefinite nightly wear of his retainers. The vacuum-formed retainers were reinforced with a wire extending across the palate to maintain the transverse correction.

#### Outcomes and results

**Facial aesthetics:** Nathan’s facial profile improved from concave to straight, with enhanced midface projection and reduced chin prominence due to maxillary advancement and mandibular rotation. His lips sat together at rest without strain, and the upper lip support was visibly improved. The soft tissue changes were subtle yet significant to his appearance: for example, the upper lip moved forward by a few millimeters relative to the nose, and his chin prominence was less stark.

**Intraoral and dental occlusion:** The final occlusion was a solid class I

molar and canine relationship on both sides. The anterior crossbite was fully corrected and a class I incisor was achieved. Both upper and lower dental midlines were centered with the facial midline.

The upper arch was well-aligned and appropriately broadened; no posterior crossbite remained. The lower arch crowding was resolved. The previously impacted UR3 and UL3 were in a proper position with healthy gingival contours. The lateral excursions were free of interference and canine guidance was established.

#### Discussion

This case illustrates successful treatment of a moderate class III malocclusion in adolescence using a combination of Alt-RAMEC protocol, facemask therapy and comprehensive

Figure 9: Intraoral photographs showing fixed appliances and TAD to maintain the lower centre line during asymmetric space closure





Figure 10: Pre and postoperative extraoral photographs showing an improvement in facial profile, chin point and nasolabial angle



Figure 11: Pre and postoperative extraoral photographs showing an improvement in the smile arc

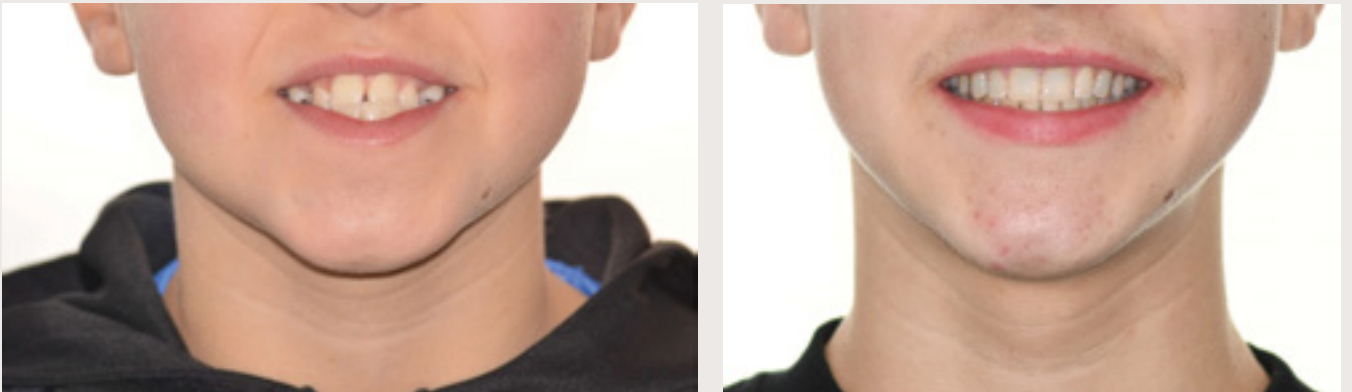


Figure 12: Postoperative intraoral photographs







fixed appliance treatment with extractions and TADs. The treatment approach was tailored to maximise skeletal changes early on and then use fixed appliances to detail the occlusion.

Growth considerations and stability: Class III malocclusion often poses a long-term stability challenge because of unpredictable mandibular growth. Literature indicates that while short-term outcomes of facemask therapy are positive, the long-term stability tends to diminish. A recent systematic review (Raghupathy et al. 2023)<sup>4</sup> found that many patients treated with facemasks tend to revert toward class III in the long run due to late mandibular growth, despite the maxillary changes being largely stable.

The review emphasises that the key determinant of success is how the mandible grows during adolescence. In Nathan's case, we mitigated this risk by timing phase 1 just before his pubertal peak and monitoring growth. Additionally, by proceeding with orthodontic camouflage (extractions and incisor retraction) once his growth was slowing, we effectively compensated for any slight residual class III tendency. The stability at 18 months post-treatment has been excellent, likely aided by the fact that he had nearly completed growth at the point of debond.

The extraction versus non-extraction debate: Extraction decisions were made after phase 1, once Nathan had passed peak pubertal growth, providing greater confidence about the long-term stability of the results. A critical decision in this case was to extract teeth for camouflage. Alternatives could have included trying a non-extraction approach with more dentoalveolar compensation (e.g. proclining upper incisors further, and distalising lower molars with TADs).

Excessive class III mechanics will cause unwanted side effects such as counter-clockwise rotation of the occlusal plane, resulting in a more prominent chin, as well as flattening or reversing a smile arc. We opted for extractions to directly address the crowding and impacted teeth, as well as to allow proper incisor positioning, because overly proclined upper incisors are not aesthetically pleasing.

Soft tissue results: From a soft tissue perspective, treating class III early has psychosocial benefits. Nathan's confidence dramatically improved as his facial appearance normalised.

Comparison to other approaches: If untreated, Nathan's class III may

have worsened or required surgery in adulthood. Our approach illustrates that in a motivated young patient, we can significantly reduce the severity of class III. One might question if starting at 13 was 'too late' for protraction; indeed, many protocols suggest earlier (age 8–10) is optimal.

While earlier is better, studies have shown even late mixed dentition facemask treatment can produce positive changes, just a bit less pronounced. Our successful outcome at 13 years of age supports the view that timely intervention can still be effective in early adolescence, provided careful monitoring is in place. While soft tissue changes become more subtle as patients get older, they are often sufficient to tip the balance – correcting a crossbite and modestly improving the soft tissue profile – thereby addressing patient concerns without the need for orthognathic surgery.

Although TADs can effectively protract the maxilla (e.g. bone-anchored devices), recent studies (Mandall, 2024)<sup>5</sup> suggest the long-term skeletal benefits diminish, questioning the justification of general anaesthesia for miniplate placement.

Long-term outlook: Nathan will be reviewed through the rest of his growth. Given the family had no history of class III, we are cautiously optimistic. In the worst case scenario of significant adverse growth, orthognathic surgery could be revisited in adulthood.

### Conclusion and clinical insights

Nathan's case underscores the value of combining rapid maxillary expansion, facemask therapy and extraction-based orthodontics to significantly improve class III malocclusions without surgery.

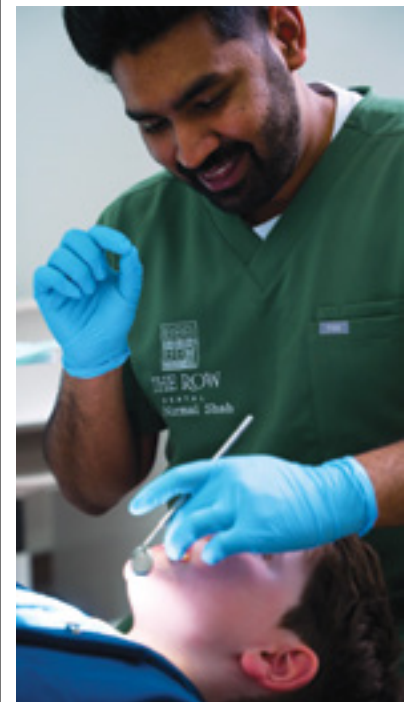
His outcome at 18 months showed a well-maintained occlusion and no regression of his overjet – a promising sign. His parents report a boost in his self-confidence; he's now a gregarious 16-year-old who smiles freely in photos. With the foundations laid by this treatment, Nathan is likely to enjoy a lifetime of improved oral function and facial aesthetics.

Cases like this reinforce the value of interceptive orthopaedic treatment – turning a challenging class III into a success story.

In conclusion, modest improvements can still be achieved when treating slightly older class III patients. While the forward and downward movement of the maxilla may be limited, other benefits can include clockwise rotation of the mandible and occlusal plane, improved display of the maxillary dentition (as class III patients often

present with vertical maxillary deficiency), modest anteroposterior changes, a smoother transition to fixed appliance therapy, and more confident extraction decision-making.

**Dr Nirmal Shah is a specialist orthodontist based at The Row Dental. He is also a consultant orthodontist with a specialist interest in the treatment of orthognathic and cleft lip and palate patients, as well as in the use of temporary anchorage devices and aligner-based therapy.**



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# PLANNING FOR YOUR RETIREMENT OR SELLING YOUR PRACTICE?

It is essential to plan ahead to minimise your tax liabilities

**W**hether you are preparing to retire or looking to sell your dental practice, it is essential to plan ahead to minimise your tax liabilities.

With the right strategy, you can reduce exposure to Capital Gains Tax (CGT) and Inheritance Tax (IHT) while ensuring a smooth financial transition.

## CAPITAL GAINS TAX

CGT may apply when you sell a valuable asset such as your dental practice or premises. The tax rates will depend on your income level but making effective use of your annual exempt amount, which allows you to realise £3,000 of tax-free gains each year, can reduce your overall tax bill.

You may also be able to offset current gains against previous losses you've made on other investments or assets, which can further reduce your GCT liability.

Advance planning is key as it can unlock reliefs and exemptions that might not be available if you leave tax planning until the last minute.

## SUCCESSION PLANNING

Taking a proactive approach to IHT planning can significantly reduce the tax burden on your estate and benefit your beneficiaries, particularly in light of incoming reforms.

Making full use of available reliefs is essential, such as the nil rate band and residence nil rate band. With careful planning, you may be able to remove the value of your dental practice from your estate for IHT purposes. Business assets may qualify for relief, reducing your IHT liability. Meanwhile, trusts can be used to pass on wealth in a controlled, tax-effective way.

Having a valid Will ensures your assets are distributed tax-efficiently and according



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to your wishes, avoiding intestacy rules, which may trigger unnecessary tax costs.

## CONSIDER YOUR EXIT PLAN

Every dental practice is different, and so is every exit plan. Whether you are selling, retiring or transferring ownership, we can help you create a tax-efficient strategy tailored to your goals.

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# FANCY WORKING IN BARRADISE?

My experience as a dentist on Barra - a six-month journey in paradise, by Kate MacLaren

**A**fter completing a Dental Core Training post in a busy Oral and Maxillofacial Surgery unit, I was looking for change in pace; somewhere I could challenge myself and enjoy a high quality of life. Little did I know that my six-month stint on the island of Barra would provide me with an experience that felt like an endless holiday while doing work that felt meaningful and rewarding. Nestled in the Outer Hebrides, with a population of just over 1,000, Barra has proven to be a hidden gem that more dentists should consider. From the moment I arrived on Barra, I was embraced by the island's close-knit community. With a small population, everyone knows each other, and the support and kindness I received from the locals made me feel at home almost instantly. The stunning beaches on were my sanctuary after a busy day in the surgery. Whether it was a peaceful walk along the shore or a cold water dip, the beauty of Barra was a constant source of relaxation and joy. Barra's outdoor lifestyle is perfect for anyone who loves adventure and staying active. Whether that is surfing, kayaking or wild swimming, each weekend felt like a mini holiday, filled with new outdoor experiences. One of the highlights of my time on Barra was a boat trip to the island of Mingulay,

12 nautical miles south. Exploring the island from the water offered a new perspective on its beauty and experience the incredible wildlife. I was lucky enough to spot seals and dolphins – and you can sometimes even see whales if you are lucky.

Barra boasts impressive community facilities, including a well-equipped sports centre which has a gym, a swimming pool and sauna. The sports centre quickly became a regular part of my routine and the swimming pool was a great place to unwind and socialise. These facilities ensured that even on rainy days, there was always something to do. One of the unexpected delights of living on Barra was the vibrant craft scene. The island hosts regular craft classes during the winter months, which offer an opportunity to learn traditional skills such as sewing, art and pottery. These classes are a great representation of the Scottish coorie tradition. The classes provided a cozy, communal space where residents could gather, share stories and create beautiful handmade items. In just a few weeks I had learned to use a sewing machine and made my very own Christmas cushion!

Winter on Barra does not come without its fair share of wild weather! The island's rugged beauty is often amplified by the dramatic Atlantic storms that send waves

crashing onto the shores. Watching these natural spectacles from the safety and warmth of my home was one of the many unique pleasures of island life.

Travelling to and from Barra is an adventure in itself. The island is accessible by ferry from Oban, which provides a scenic and relaxing journey across the Hebridean waters. For those looking for a quicker route, there is a flight from Glasgow which lands directly on Barra's beach; a memorable experience that adds to the charm of living on this remarkable island.

On Barra, I felt a profound sense of purpose in my work. The connections I formed with my patients and the gratitude they expressed made my role incredibly rewarding. Working in such a supportive and appreciative community enhanced job satisfaction and professional growth. The job itself is a salaried role to provide general dentistry to the community of Barra, based in a well-equipped single surgery within the public dental service, meaning you can focus on providing quality dentistry within the NHS but without the pressure of targets.

For any dentist seeking a fulfilling career and a life filled with adventure and tranquillity, Barra is the ultimate destination.

*Building on Success, Investing in the future*  
– page 71



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# TURNKEY SURGERY DESIGN

Vermilion's stunning second floor expansion is a showcase for IWT's expertise and exceptional service

IWT Dental Services was the obvious choice, says Kay MacMillan, General Manager at Vermilion – The Smile Experts. "I have worked with Ian [Wilson] and Bruce [Deane] on two other clinic build projects for Vermilion and we have developed a good working relationship," she said.

Their latest collaboration has been on Vermilion's £800,000 second floor expansion at 24 St John's Road in Edinburgh.

"We were looking to expand our current offering by doubling our clinic capacity, offering our referring practitioners more specialist services and to reduce patient wait times," she said. "It was also an opportunity for us to bring our hygiene and admin team back under the one roof and condense the working week."

The expansion covers 3,500 square feet and comprises a swish reception and staff area, five beautifully executed surgeries, a high-end LDU and space for continuing professional development courses with capacity for live video links to the surgeries.

"IWT was involved in the early stages of planning to install all of our dental chairs, the LDU and X-ray equipment as well as the IT/AV offering," said Kay. "They collaborated with both our architect and builder throughout the project to ensure that nothing was a surprise along the way."

"Bruce also worked with a bespoke supplier to install their high-calibre dental cabinets in all of our surgeries and LDU. Ian was responsible for the IT and the AV equipment that we have in every area of the clinic."

## HOW DID THE PROCESS WORK?

"They attended planning and site meetings – assisting me in the preparation of the new space, back when it was a blank canvas – working out the correct equipment for the practice's needs."



Surgery >



They also provided detailed schematic drawings to ensure that the equipment was installed accurately in the surgeries and LDU.

"The install was seamless, with minimal disruption in the clinic during this time. All of the technicians were professional and supportive throughout; the guys are a credit to both Bruce and Ian. There were challenges during the project – it's not surprising with a large team of people working on the build – but I feel we all worked together to achieve an amazing result overall."

< Reception area

## WHAT QUALITIES DO IWT BRING TO A PROJECT?

Kay said: "They're personable and they have a hands-on approach, wanting to understand your business needs while offering their knowledge. Ian and Bruce are always there to help."

## ABOUT IWT

IWT provides industry-leading solutions for dental practices of any size and at any stage in their development.

Their partnership philosophy offers full optimisation of your practice, equipment and workflow, enabling you to focus maximum attention on your patients.

From single-surgery installations to end-to-end managed services, including building works, plumbing, electrics, flooring, dental chairs and bespoke cabinets, IWT are experts in working with you and your team to identify your specific requirements and deliver your vision.

IWT has long-established relationships with leaders and vanguards of dental equipment supply, and their experience in delivering excellence throughout the industry allows them to offer you cutting-edge innovation and complete practicality, regardless of budget. They strive to provide your business with the right equipment, supported by their expert advice and exceptional customer service.

Their service covers IT and networking, dental chair supply, imaging supply and project management.

Their high client retention rate is a source of great pride to everyone at IWT and is testimony to their dedicated team of expert technicians and the exceptional service they provide.

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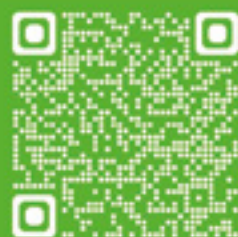
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# TAKING THE NEXT STEP IN SUSTAINABILITY – THE MC REPAIRS FREEPOST BOX

Contributing to a more sustainable future, one repair at a time

Just under a year ago, we achieved ISO 14001 for our environmental management systems – a massive milestone in our journey to becoming the UK's leading sustainable and independent repair centre. Since then, we have continued to place sustainability at the heart of our business. We know how important it is for dental professionals to work with suppliers who share the same commitment to reducing environmental impact. That is why we are delighted to unveil the latest step in our green journey – the launch of our new, reusable **MC Repairs FREEPost Box**. This innovation will gradually replace our current plastic FREEPost Packs, helping us cut down on unnecessary waste while still providing the same fast, first-class service you rely on.

## WHY THE MC REPAIRS FREEPOST BOX MATTERS

For years, our FREEPost Packs have been a convenient way for practices to send us equipment in need of repair. While these packs already contained 30% recycled content, the enclosed bubble bag was part of the recyclable content and, although they were durable, they contained a high amount of plastics and were not reusable.

Our new FREEPost Box changes that. Designed with durability and reusability in mind, it is fully recyclable at the end of its life. Better still, we will return your repaired equipment in the very same box, ready for you to use again. If the box becomes worn, we will take care of recycling it responsibly and provide a fresh replacement!

## SIGNIFICANT SUSTAINABILITY IMPROVEMENTS MADE

- **Recyclable and reusable:** A smarter, greener alternative to our previous single-use packaging.
- **Two convenient sizes:** Practices can now choose the right fit for their repair needs, avoiding excess packaging.
- **Durable by design:** Built to withstand multiple uses, making the box highly efficient.
- **Updated design:** A refreshed and more professional design that reflects our new branding and our commitment to sustainability.

## CONCLUSION

The introduction of the MC Repairs FREEPost Box is just one part of our wider sustainability journey. From waste reduction to energy efficiency, we are continuously



Carl Wise  
Managing Director  
T: 01253 404 774  
E: carl@mc repairs.co.uk

reviewing our operations to make sure we deliver solutions that are good for both our customers and the planet.

We are proud that our environmental efforts are already helping dental practices across the UK align with their own green initiatives. With the FREEPost Box, we hope to make it even easier for our customers to contribute to a more sustainable future, one repair at a time.

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# BUILDING ON SUCCESS, INVESTING IN THE FUTURE

## Expanding oral health services in the Western Isles

**T**he Western Isles, also known as the Outer Hebrides, form a chain of islands off the northwest coast of mainland Scotland. Characterised by their rugged beauty, close-knit communities and remote geography, these islands present unique challenges and opportunities for healthcare delivery.

NHS Western Isles is committed to overcoming these barriers and delivering community-focused dental care across Scotland's remote island communities. Central to this success is the nationally recognised Childsmile programme, which has significantly improved oral health outcomes for children through preventive interventions such as supervised toothbrushing and fluoride varnish applications.

The impact of Childsmile is clearly reflected in the National Dental Inspection Programme (NDIP). Specifically for Western Isles, in 2003, only around 36% of Primary 1 children were free from obvious dental decay. By 2024, this figure had risen to 73%. These results demonstrate the power of prevention in improving health outcomes and reducing inequalities.

Building on this success, NHS Western Isles is expanding its oral health services to ensure similar progress across all national Oral Health Improvement Plan initiatives

are given more dedicated attention and resource. This year marks a significant milestone with the expansion of the Oral Health Improvement Team, introducing new roles – including an Oral Health Improvement Manager, Priority Groups Co-ordinator and a dedicated Childsmile Co-ordinator. These appointments will strengthen the service's ability to plan and deliver holistic targeted support.

This expansion aligns with the Scottish Government's Population Health Framework, which advocates for a shift from treatment to prevention with a concerted effort to reduce health inequalities. The framework emphasises the importance of tackling the root causes of poor health and creating conditions that support wellbeing across all communities.

In the Western Isles, where access to dental services can be challenging due to geography and workforce shortages, a renewed focus on prevention is essential. The region has a markedly ageing population, and dedicated resources are needed to support older adults and other priority groups. To inform future service delivery, NHS Western Isles is conducting an Oral Health Needs Assessment, which will guide targeted interventions and community outreach, particularly for individuals who face barriers to accessing clinics.

To further address access challenges, NHS Western Isles is launching a recruitment campaign to build and sustain a resilient dental workforce. This initiative aims to ensure that patients – from the Butt of Lewis to Barra – can access high-quality care when and where they need it. The recruitment drive is not just about filling vacancies; it's about creating a sustainable, equitable service and making careers in remote and rural dentistry attractive and rewarding.

Joanne Bark, Director of Dentistry, shared her perspective: "There's a huge degree of satisfaction knowing what a difference you can make within a small community, which can be hard to replicate in a busy mainland board. For dentists looking for the next step in their career and life milestones, this is a truly attractive place to work – surrounded by incredible landscapes and a strong sense of community. Having lived and worked here for nearly three years, I see the passion our team has for their local community. With a relatively small population, every addition to our team has a meaningful impact."

NHS Western Isles will be recruiting in the coming months. Those interested in exploring island life or applying for permanent or temporary roles are encouraged to visit the NHS Western Isles Vacancies page at [www.wihb.scot.nhs.uk/vacancies/](http://www.wihb.scot.nhs.uk/vacancies/) or contact Joanne Bark directly at [joanne.bark2@nhs.scot](mailto:joanne.bark2@nhs.scot)



# WHY A SQUAT PRACTICE AND A DENTAL MEMBERSHIP PLAN GO HAND IN HAND

Thinking of taking the plunge and setting up a squat practice? Practice Plan Regional Support Manager, Connie Dunlop, explains why introducing a membership plan is a smart move

**O**ver recent years, squat practices have gained in popularity. Large numbers of patients struggling to gain access to dental treatment has helped alleviate some of the perceived risk among dentists about the prospect of starting from scratch.

Although one of the many benefits of setting up a squat is not having to pay for the goodwill value of a practice, the set-up costs are still considerable and need to be recouped. Consequently, every decision you make must be strategic to attract and retain patients and ensure financial sustainability. This is why introducing a membership plan can be an important move that offers a host of benefits for both your patients and your business.

## BENEFITS OF A PLAN

If you are an Associate striking out and opening your first practice, then you may well have come across membership plans before. However, you may not have appreciated all the benefits a plan can offer a practice.

In simple terms plans allow patients to spread the cost of their oral health care over a period of months. At Practice Plan we can tailor plans to suit your practice's needs but typically they include oral health examinations, hygiene appointments, X-rays, and sometimes emergency visits. Some practices also choose to offer discount on treatments. They are aimed at encouraging preventive care and developing long-term relationships between patients and the practice.

## BUILDS PATIENT LOYALTY FROM THE WORD GO

A membership plan helps you create a loyal patient base by offering value and consistency. In a squat practice, patient retention is just as important as acquisition. Patients who commit to a monthly plan are more likely to return for regular appointments, follow through with treatment plans, and recommend your practice to others. This loyalty is always valuable to a business but especially so in the early stages

of your practice when word-of-mouth and reputation are important for building patient numbers.

## PREDICTABLE MONTHLY INCOME

One of the biggest challenges for a business, but for a new practice in particular, is managing cash flow. As the business has no history, it can be difficult to forecast income with any semblance of accuracy. Having a membership plan provides predictable, recurring revenue that can help take some of the guesswork out of forecasting. Regular monthly payments from members gives you a clearer picture of your baseline income, making it easier to plan staffing, marketing and investment in equipment or technology.

## ENCOURAGES PREVENTIVE CARE

Practices report that their plan members are more likely to attend their regular hygiene and oral health examinations than pay-as-you-go patients. As these appointments have already been covered by their monthly membership fee, unlike pay-as-you-go patients there's no saving to be made by postponing visits to the surgery, so they're more likely to turn up. Which is probably why anecdotally our practices report that their plan patients generally have better oral health than their other patients. Also, as patients are attending the practice more frequently, any emerging problems can be nipped in the bud so more invasive treatments can often be avoided. By having a membership plan you can position your practice as one that prioritises prevention. This can help build trust and demonstrate a commitment to long-term patient wellbeing which can be an important point of difference when you are just finding your feet in a competitive market.

## MAKES PRIVATE DENTISTRY MORE ACCESSIBLE

In some areas of the country access to NHS dental care is, at best limited, or in some cases non-existent meaning private dentistry



Connie Dunlop  
Regional Support  
Manager,  
Practice Plan

is the only option. Offering a membership plan can ease the financial burden of patients in these types of areas.

By spreading the cost of care over monthly payments, patients can budget for their oral healthcare and are more likely to perceive private dentistry as affordable and manageable. This is particularly helpful to a fledgling practice as patients often cite cost as a barrier to accessing private dental services. A well-structured plan can help overcome that objection.

## SIMPLIFIES PRICING

Trust is essential when building rapport with patients and rapport is the basis of a long-term relationship with patients. One way to help cement this is to have transparent pricing. Being subjected to additional 'hidden costs' is a surefire way to damage a new dentist/patient relationship.

Having a membership plan simplifies your fee structure and makes it easier to communicate the value of your services. Patients appreciate knowing exactly what they're paying for and what they can expect to receive in return. Having clarity around pricing can help reduce anxiety around costs and improve treatment uptake rates, especially for patients who are new to private dentistry.

## INCREASES PRACTICE VALUE

As any accountant will tell you, you need to have an exit strategy as soon as you start your business as this will inform many of the decisions you make about the way you structure and run your business. Having a strong base of membership patients enhances the value of your practice. So, if your plan is to sell or bring in partners further down the line, the revenue from a membership plan is a key indicator of the financial health and state of patient loyalty of the practice. Not only that, but membership plans can also be used as a marketing tool to attract new patients.

Read the full article here -  
[www.sdmag.co.uk/hand-in-hand](http://www.sdmag.co.uk/hand-in-hand)



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# MANAGING CHANGE

Martyn Bradshaw from PFM Dental discusses key factors in selling your practice

**S**elling a dental practice can be a complicated scenario, as with any business it is never at standstill and things are always changing. So how do you manage this and make sure that you get the best price and terms for your practice?

## PRACTICE VALUATION

A practice valuation should never be underestimated and is the starting block for your sale. While people may consider statistics of an average practice this is not the way to go with a valuation. You do not want to be estimating the value as you could be leaving significant value behind. While the accounts of the practice will give a good historic basis, they should not be the sole factor in looking at your practice value.

Most accounts will be six to 12 months out of date and if you have seen growth in the practice turnover this should be shown in the valuation. As a valuer we would always ask for the last 12 months' income to the end of the last month; in essence re-writing your profit and loss and creating a new EBITDA with all the updated income.

Any updated costs will also need to be included, such as staff costs now – not what were previously in the accounts. Any personal costs and tax reducers should also be removed. The practice may also need to be 'normalised', in that if the Principal is not working full time with Associates also working at the practice, then a valuation will want to take into account of a full time Principal (shifting around Associate costs).

## BANK VALUATION

Typically, a bank will require a valuation of the practice; one that they instruct. This bank

valuer will then undertake an up-to-date valuation of the practice, and it is important that the details provided are clear for them – as to updated income, costs that have been removed and why. Typically, a bank valuer will contact an agent and request a reasonable amount of information, but in fact we would supply them with more information than they may request – things that affect the valuation in a positive light.

Purchasers' funding is reliant on the bank valuations, so if these come in less than the offer placed, the buyer may not have the surplus cash to cover the difference. The bank valuation is a very important part of the process and care needs to be taken to ensure that this matches what is being paid. Otherwise, there can be a significant loss in the sale price being achieved.

## BUSINESS CHANGES

Ultimately, the sale of the practice is not achieved over night. The typical legal process can take four to six months and things will change in the practice during this time. For example, what do you do if you need to undertake staff appraisals/ wage rises during the legal process?

The buyer will have had their calculations based on the previous staff costs.


What if an associate is looking to leave – do you replace them? This is quite normal, due to the length of sales. However, you should tread carefully with any changes and ideally keep to a minimum. With staff changes, and especially increases

in hourly rates, we do suggest involving the buyer to some degree. This may be as simple as running the suggested increases by the buyer before agreeing with the staff, giving them the feeling of being involved. However, you should always remember that the deal is not agreed until signed on the dotted line, so you must do what is right for the practice until this time.

This then follows on to what happens if an associate leaves during the process? It may be that the buyer wishes to come and work in the practice post sale so can fill the position. However, what happens if the sale drags out or falls through? You may have experienced a significant drop in income which will affect the valuation going forward, or how the bank assess. Care should always be taken.

## CONCLUSION

During the sale of your dental practice there will invariably be events that occur that need to be considered or change the practice in some way. The minimising of this is key, and where things need to be changed, seeking guidance to ensure that the sale and the value are not impacted are important. As you would imagine a good agent, who has vast experience of matters like these, can advise and assist throughout.



*Martyn Bradshaw is a Director of PFM Dental and undertakes hundreds of valuations each year. With more than two decades of experience, Martyn understands the intricacies of dental practice sales to corporates, private buyers, partners and associates alike. [pfmdental.co.uk](http://pfmdental.co.uk)*



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Vision Care provides free eye tests and glasses to homeless and vulnerable people, restoring their sight and, in turn, their dignity and independence. Dentaids works tirelessly to deliver dental care to impoverished communities in the UK and overseas, relieving pain and improving overall health. The abseil is more than just fundraising; it is an opportunity for the community to come together and support a worthy cause. It is a huge challenge – a test of nerve and teamwork. Every donation, no matter how big or small, will directly contribute to Vision Care and Dentaids's vital services and motivate us as the team prepare to step off that ledge.



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# NHS VS PRIVATE

## Striking the right balance

**F**or many dentists, the past year has brought big questions about how to keep their practices financially healthy. Rising staff costs, higher lab fees and everyday overheads are putting pressure on margins, and for practices heavily reliant on NHS work, it can feel like the numbers are just not stacking up. Exploring private options doesn't mean abandoning the NHS; it is about finding a balance that keeps the practice sustainable. From dental plans and hygiene memberships to cosmetic treatments, even a modest shift in income mix can make a real difference. In some cases, it helps cover rising costs without affecting patient care. For rural or smaller practices, it can be the difference between struggling and having breathing room to invest in staff or equipment. Understanding your numbers is key. What does each NHS course of

treatment actually cost you, once you factor in staff, materials and overheads? How does that compare with private treatments? Simple scenario planning can highlight where small changes in patient mix could have the biggest impact. Every practice is different. Some may benefit from focusing on preventive work, others on adding select private treatments that fit the local patient base. The important thing is knowing your margins, testing different approaches and being ready to adapt as the Scottish NHS continues to evolve. Finding the right balance now isn't just about surviving – it is about building a practice that thrives in the years ahead. Small changes, informed by a clear view of costs and revenue, can give dentists more control and confidence to focus on what matters most: delivering great care for their patients.



Anna Coff, Senior  
Technical Manager  
EQ Accountants  
E: [anna.coff@eqaccountants.co.uk](mailto:anna.coff@eqaccountants.co.uk)



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# AI IN DENTISTRY AND DATA PROTECTION

## Balancing innovation with privacy rights

**A**rtificial Intelligence (AI) has the potential to revolutionise dental care, offering transformative benefits in diagnostics, treatment planning, operational efficiency and patient engagement. However, as AI systems increasingly rely on sensitive health data, the need for robust governance in relation to the handling and protection of patient personal data has never been more important.

In this article, we consider the legal, privacy and ethical standards required to protect patient personal data to ensure that dental practices embracing AI technologies operate within the requirements of UK Data Protection Laws and Regulations when integrating AI technology into patient care.

### AI OPPORTUNITIES IN DENTISTRY

We are seeing a number of emerging AI technologies being developed, tested and adopted to support dental practices. These technologies include diagnostic tools to:

- Provide predictive analytics to identify patients most at risk of conditions such as oral cancers
- Assist with the development of treatment plans
- Identify the earliest signs of decay
- Create records of patient discussions and to extract insights
- Automate and streamline administrative tasks.

The possibilities appear endless, and many dental practices are looking at ways these innovations can improve patient outcomes and reduce costs. Embracing these opportunities does not come without some risk. In a healthcare setting, these tools are more likely to process large volumes of personal and special category (sensitive) data about patients, and this raises questions and concerns about data protection, privacy, consent, compliance and accountability.

### AI AND DATA PROTECTION CHALLENGES

All dental practices must process personal data about patients in accordance with the requirements of the UK Data Protection Act, UK GDPR and now also the Data Use and Access Act 2025, which received Royal Assent on 19 June and is expected to be implemented by June next year. The key requirements to consider include:

- Establishing a lawful basis for processing personal data. Where AI is utilised, this may

be based on patient consent, scientific research or where processing is carried out for reasons of public interest in public health.

- Being transparent. It is essential that patients are told how their personal data will be used, and this applies to processing using AI systems. Processing using AI and the effects of such processing may not be immediately obvious to a patient, so it is essential to tell patients what the reasons for using AI and consequential effects may be (whether positive or negative). The Data Use and Access Act 2025 has revised the approach that organisations can take to using AI to make automated decisions about patients, and compliance with those requirements must also be prioritised.
- Data minimisation and security must always be considered. Practices should only process the minimum data necessary to achieve the desired outcome and always carry out due diligence to make sure that any third party AI technology procured is secure and conduct data protection impact assessments to ensure privacy controls are baked into new data processing activities from the start.

### AI AND ETHICAL CHALLENGES

Ethical considerations can be complex.

For example:

- Bias: AI systems can produce bias results and can hallucinate. If data quality is poor or inaccurate, the results may be skewed and inaccurate which could have a detrimental effect on the patient or negatively impact patient care. This has the potential to increase the risk of complaints, claims and other legal issues arising.
- Consent: Patient consent can be challenging due to the perceived power imbalance between clinician and patient and challenges in relation to transparency and clarity and communicating the right to opt-out where applicable. Seeking advice and training on this point can assist dental practices in successfully navigating these challenges.
- Accountability: identifying AI tools to assist your practice may take time and demonstrating accountability with data protection law is crucial to the decision making process. Reaching a sound decision which meets legal, privacy and ethical standards while also meeting your commercial and operational needs may involve consultation and collaboration between a number of stakeholders and professional advisors.



**Morgan O'Neill**  
Director, Data  
Protection Services,  
Thorntons Law LLP  
T: 0330 2367008  
E: moneill@  
thorntons-law.co.uk

### BEST PRACTICES FOR AI AND DATA PROTECTION

To ensure that your practice demonstrates accountability and compliance with relevant data protection laws and ethical standards we recommend that consideration is given to:

- Defining a clear use case and purpose for processing personal data via an AI tool.
- Complete a data protection impact assessment to document your approach, privacy and ethical considerations and build privacy controls into the process from the start.
- Where possible minimise the amount of personal data processed to only what is strictly necessary to pursue your intended outcome/result.
- Consider transparency and how you will communicate clearly your AI strategy to patients.
- Audit your use of AI tools to identify any bias or hallucinations or potential security risks.
- Always manage consent in accordance with the requirements of data protection law.

AI has the potential to greatly improve patient care and create efficiencies and cost savings, but it must be deployed responsibly and used in accordance with legal requirements. Thorntons Data Protection Team can assist your practice with the safe introduction of innovative AI tools.



# REVIEWING THE SCOTTISH DENTAL MARKET

In this article, Joel Mannix shares an overview of this year's Dental Market Review 2025 report findings

**W**e recently launched our Dental Market Review 2025 report, which provides an in-depth overview of the UK dental market over the past 18 months. Here are some of the report's key takeaways.

## OWNERSHIP AND COMPOSITION

There are currently 1,019 dental practices in Scotland:

- 61% are owned by independent or dual-site operators (1 to 2 sites)
- 20% are owned by mid-sized and small groups (3 to 29 sites)
- 19% are owned by corporates and large groups (30 sites and over).

We are seeing a shift in market sentiment from caution to renewed enthusiasm, supported by a broader and better-capitalised buyer pool. As corporates re-enter the marketplace alongside resilient independents, competition for quality practices is expected to intensify in late

2025, driving heightened activity and reinforcing the appeal of cultural and clinical fit in transactions.

## DEMAND AND SUPPLY

Between the first half of 2023 and the first half of 2025, corporate buyers increasingly targeted private practices, reflecting a strategic shift toward higher-margin, consumer-driven models amid ongoing NHS funding challenges. Small and medium-sized groups also leaned toward private and mixed-model acquisitions. Meanwhile, independent and first-time buyers broadened their focus, supported by improved access to funding and growing confidence in the sector's overall stability.

## SENTIMENT IN THE SECTOR

In June, we reached out to more than 38,000 dental professionals to get their views on the sector. Our key findings include:



Joel Mannix,  
Director - Dental,  
Christie & Co

- More feel positive or neutral about the sector than feel negative
- The greatest area of growth is likely to come through general dentistry (28% to 30%), with specialist services just marginally behind (24% to 26%)
- 86% feel that digital dentistry is at the forefront of future growth
- 49% of respondents are likely to invest in new technology and equipment in the coming years.
- 29% of respondents say that recruiting

additional staff is their next most likely investment.

*For a free copy of the Dental Market Review 2025, or to find out more about the Scottish market, contact: joel.mannix@christie.com or call 07764 241691*



## Your Trusted Experts In Dental Practice Sales

Christie & Co are excited to announce the launch of our latest Dental Market Review, our most insightful edition yet, at a time when confidence is building across Scotland's dental sector.

The report explores the renewed activity from corporate groups and independent operators, highlighting how a more vibrant and opportunity-rich environment is reshaping the market here in Scotland!

### SO FAR, IN 2025 OUR DENTAL TEAM IN SCOTLAND HAS SEEN:



**33** new practices being launched to the market



A **47% increase** in viewings compared to last year



**£41.1M** in offers received

Whether you're planning to buy, exit, or simply stay informed, these insights will no doubt be invaluable. Speak to the experts today:



**JOEL MANNIX**  
Director - Dental  
T: +44 (0) 7764 241 691  
E: joel.mannix@christie.com



**KEVIN STRAIN**  
Senior Business Agent - Dental  
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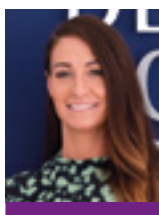
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# THE COST OF STANDING STILL

Why now is the time to review your numbers

In today's dental landscape, the one thing you cannot afford to do is nothing. Rising wage costs, lab fees, and supply price hikes are all applying pressure to practice margins. While this may feel like 'business as usual', the true cost of standing still can be much greater than you realise.

For every £1 reduction in annual profit, a practice can see up to £8 wiped off its capital value at the point of sale. This multiplier effect means that even modest drops in profitability today can translate into very significant reductions in future exit value. It's a sobering reminder that inaction



**Victoria Forbes**  
Director, Dental Accountants Scotland  
E: victoria@  
dentalaccountantsscotland.co.uk

is not a neutral decision, it is often the most expensive one.

So, what can be done? The first step is visibility. Do you have a clear picture of your practice's current performance? Are you comparing your results to sector benchmarks? Small refinements in diary zoning, chair utilisation or private treatment pricing can generate meaningful improvements in both cashflow and long-term value.

We see first-hand that practices which regularly review their numbers, adapt quickly and implement small changes are the ones that continue to thrive. By contrast, those

who delay action often face the double impact of squeezed day-to-day income and a diminished sale price when the time comes to exit.

At Dental Accountants Scotland, our focus is to help you stay ahead, not just keep up. Reviewing your numbers is not about creating extra work, it is about protecting what you've built and ensuring your practice's future value.

If you would like a no-obligation conversation about how your practice compares and what opportunities may exist to strengthen results, we would love to hear from you.

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## > DENTAL ELITE

### THE PERFECT SALE AND PURCHASE WITH DENTAL ELITE



The Goodwill Guide for 2025 revealed a continued trend from 2024 with significant tier four activity and tier one buyers buying larger practices.

Phil Kolodynski, Director of Practice Sales, and Tommy Glasscoe, Financial Consultant, from Dental Elite discussed this and more at the British Dental Conference and Dentistry Show. Illustrated with a number of case studies, they delved into how to make the perfect sale, highlighting the importance of effective planning, preparation, and execution through factors such as an early initial valuation, boosting EBITDA and FMT, and maximising viewing opportunities. They also discussed the importance of analysing trends when planning a purchase, and ensuring finances are in order ahead of time to help the process go smoothly. They also discussed the benefits of ongoing support during both practice sale and purchase with the team at Dental Elite uniquely able to assist.

For more information contact Dental Elite. Visit [www.dentalelite.co.uk](http://www.dentalelite.co.uk), email [info@dentalelite.co.uk](mailto:info@dentalelite.co.uk) or call 01788 545 900

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*\*Work in progress, available for sale starting Q3 2025*

For more information on Carestream Dental visit [www.carestreamdental.co.uk](http://www.carestreamdental.co.uk) For the latest news and updates, follow us on Facebook and Instagram @carestreamdental.uk

## > COLTENE

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“Handling is smooth and predictable, allowing for faster placement with fewer adjustments. It offers excellent malleability and maintains shape well before curing. Shade matching is natural, seamless and polishes beautifully.

“The 4mm curing depth, achievable in 20 seconds, significantly streamlines my workflow and the depth of cure is reliable, with no signs of under-curing or post-operative sensitivity. This feature is a real time-saver in busy clinical settings, especially in posterior restorations and children.

“The customer service from COLTENE is brilliant.”



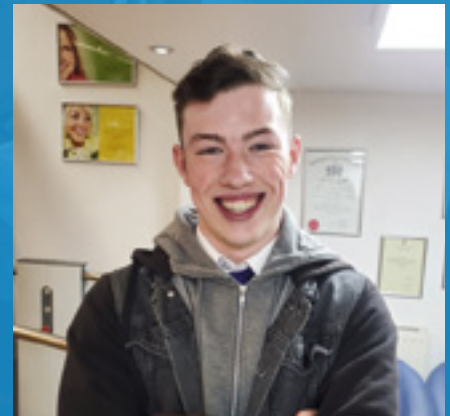
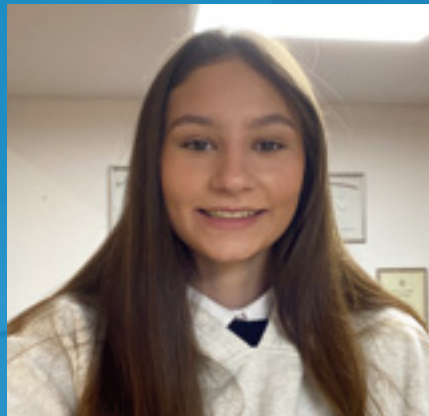
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**Alastair Fraser**, Principal Dentist, Greygables Dental



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