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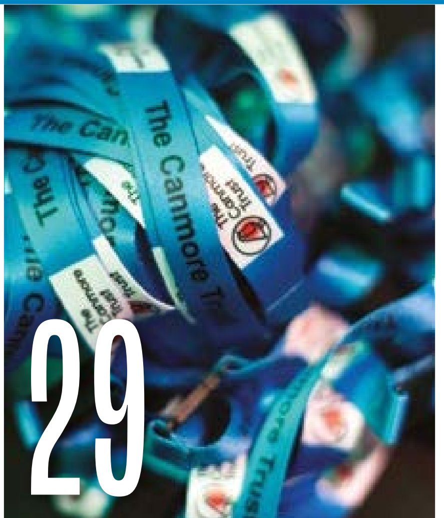

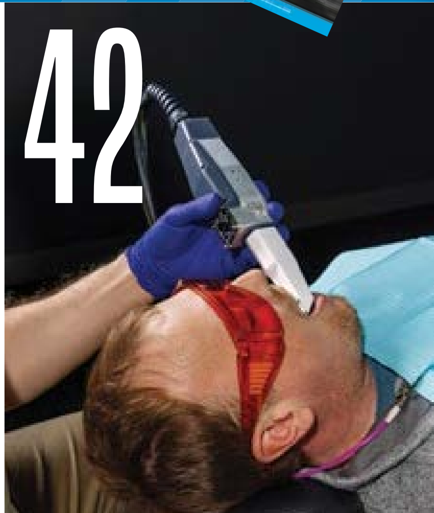

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MANAGING EDITOR
David Cameron
david@connectmedia.cc

EDITOR
Will Peakin
Tel: 0141 560 3019
editor@sdmag.co.uk

ADVERTISING
Ann Craib
Tel: 0141 560 3021
ann@connectmedia.cc

DESIGN
Ruth Turnbull

SUBSCRIPTIONS
Claire Nichol
Tel: 0141 560 3026
claire@connectcommunications.co.uk

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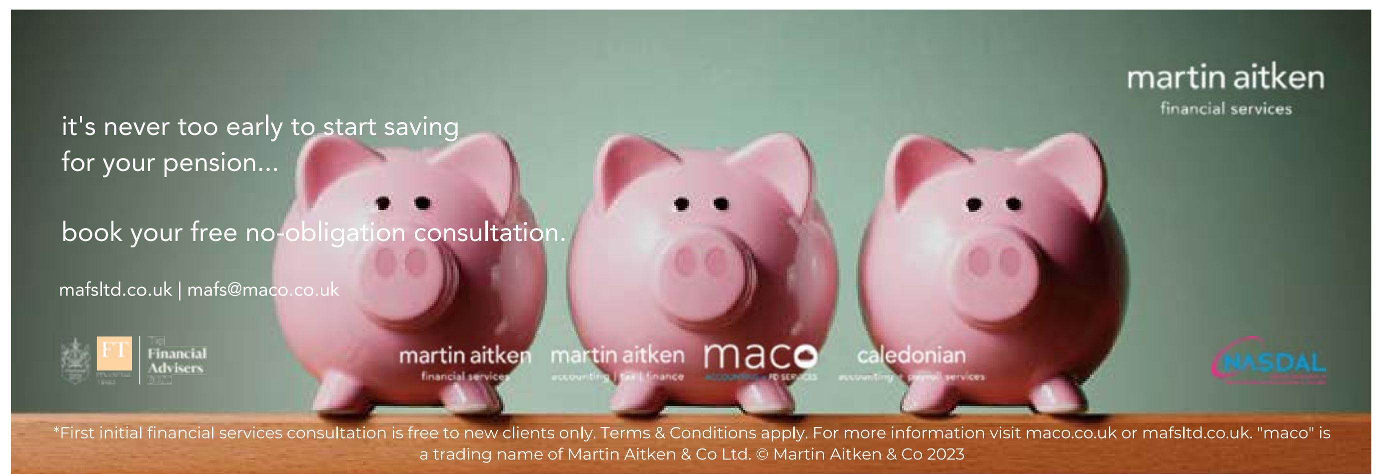

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A world view

Scotland has led the way with some of its oral health initiatives, but that should not stop us looking at what other nations are doing to improve outcomes

Oral disorders affect more than 40 per cent of the global population, with tooth decay being the most common non-communicable disease. Poor oral health impacts physical wellbeing, daily life, and socio-economic outcomes. The COVID-19 pandemic worsened access, especially for vulnerable groups. Oral health is closely linked to mental health, influencing and being influenced by neglect or pain. Oral cancer, a serious concern in Scotland, has rising rates tied to tobacco and alcohol, disproportionately affecting disadvantaged groups. Oral health also intertwines with mental health, as neglect or overcompensation in oral care often results from mental health challenges. Conditions like oral cancer – linked to tobacco, alcohol and poor lifestyle – pose serious risks, with higher prevalence among disadvantaged groups in Scotland.

The Scottish Government's 2023 dental reforms aim to improve equitable NHS dentistry access through a new payment system. This incentivises prevention-focused care and supports dentists with expanded treatment options. Building on the 2018 Oral Health Improvement Plan, the reforms modernise services and align treatments with best practices. Initiatives such as the Childsmile programme and targeted Oral Health Improvement Programmes address the needs of vulnerable groups, achieving notable improvements in child oral health and reducing inequalities.

However, according to the 2023 Scottish Health Survey[1], published in November, one third (34 per cent) of adults reported having difficulties when visiting the dentist, an increase from 2019 (20 per cent) and 2021 (23 per cent) and a return to a similar level as that recorded in 2009 (35 per cent). The most common difficulties reported when visiting the dentist were getting a suitable appointment (12 per cent), dental treatment being too expensive (10 per cent) and not getting dental treatment under the NHS (7 per cent). These difficulties have all increased since 2021 and the pattern is evident for male and female patients. The survey underscores the impact of dental health on overall wellbeing and the need for continued public health initiatives to improve access and awareness. Tooth decay and gum disease remain widespread, particularly among socioeconomically disadvantaged groups. Difficulty in getting appointments, high treatment costs, and lack of NHS dentistry availability contribute to inequalities. Poor mental health often leads to a neglect of oral hygiene, while chronic conditions exacerbate oral health issues. Scotland faces higher rates of oral cancer than other UK regions, largely driven by lifestyle factors. Disadvantaged populations, including children, care home residents, and those in prisons, experience worse oral health outcomes.

Historically, the Scottish Government and its various health agencies have been innovative in their approach, often world-leading when it comes to initiatives such as Childsmile. There are, indeed, also initiatives aimed at disadvantaged groups. Modernisation of NHS dentistry in Scotland is also under way. But a look around the world suggests that there may be more that could be done.

Not to compare Scotland with India or Australia in terms of landmass, but in those countries mobile dental clinics have helped reach people in underserved areas[2]. Finland's 'Health-in-All-Policies'[3] approach could be adapted here to include dental assessments as part of routine healthcare visits, identifying issues early and promoting prevention. And as we report in this issue, mobile phones can be used to improve oral health through text message prompts[4] and there is now technology to improve treatment outcomes by enabling orthodontists to monitor patients' oral health and treatments remotely[5].

A world view, drawing on what has demonstrably worked, is useful in this context and could both combat the issues raised by the Scottish Health Survey and increase the momentum of reform. Perhaps a project for someone within government? Scour the world for oral health initiatives where there is an evidence base demonstrating a positive impact and then propose how they might be adopted in Scotland.

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The risk of AI

It is a choice between experience combined with thinking unconstrained by algorithms – or confirmation bias based in educational dogma

We often think about the future in the New Year, but artificial intelligence (AI) and robots are growing traction in the media and even in the dental press. The first robotic prep has been carried out on a live patient. I watched the video, and it looked like a robotic prep. Therein lies the problem. Robots must be programmed and the ability to change that programming when the margin of the prep has caries, or even a filling on it, requires intervention. That intervention is from a programmer based on some data input, at this point likely a dentist. Latterly, it will come from the assessment of data through AI.

I feel the push of AI in the general media and all walks of life raises some interesting questions. My first is essentially whether or not the AI mentioned is really just a database searching program that 'learns' from reinforcement by assessing data sets based on parameters or algorithms created by people – or are they really artificially intelligent? I suspect a lot of it is the former, which will work well in simple and repeated tasks like accounting or bookkeeping processes or directly comparable data items like radiographs or scans.

I think radiographic analysis is one of the areas we can benefit from in dentistry. Whether this is really AI or simpler pattern recognition refined by large data sets is less important. If software providers can utilise all the data across multiple patients, practices, healthcare systems, countries and continents, then it should be beneficial. However, there needs to be feedback for these systems to benefit. For example, if a radiograph is assessed and a tiny area of caries or even a cancerous lesion is picked up, that is a great thing. However, the software can't know whether this is true unless the clinical reality is fed back by the operator and then assimilated into future decision making.

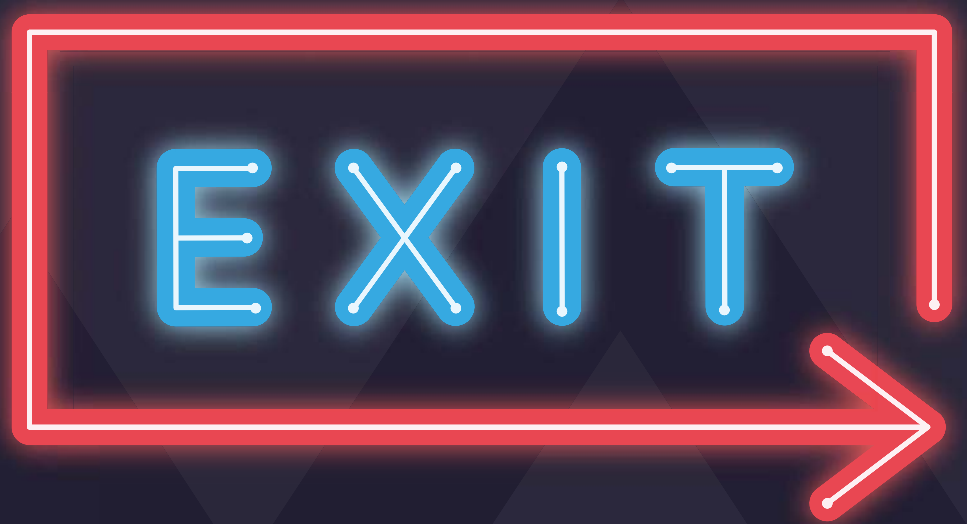
It could be argued that performing a restoration in the practice management system (PMS) could be linked i.e. the radiograph says caries and a filling is done on that tooth. My issue here is, if software suggests we cut, we need to fill it back up regardless of the presence of caries. What happens if we find nothing? Do we have a problem or feedback system like the yellow card scheme with pharmaceuticals? This would require active input by practitioners to improve the system. I don't think that can be relied upon, or built into PMS in a way that doesn't create another thing busy dentists need to report on. Unless we have really big cavities, we often don't record how the prep went, how much caries there was, did it correspond to the radiograph used, was it slow developing or fast acting, likely to worsen or get secondary caries? Standardising note taking would be required to allow the programs to work efficiently.

This is fundamentally the art or science argument about healthcare. If it was all exact and scientific, AI and computer programs would be easier to write, develop and improve. If people could leave their teeth at the surgery and come back later for them, it would be a lot easier to work on teeth in a reliable and uniform way. However, teeth are attached to people. People with wildly varied experiences, habits and methods of communicating problems. The ability of a human to interpret these inconsistencies and alter our operator performance and techniques accordingly is what separates us from robots. The generalist nature of dentistry also makes it tricky. Getting a robot to talk, diagnose, assess radiographs, convey the options, gain consent then perform endo, fillings, preps and perio simultaneously won't be simple. There's probably a programme or robot for each procedure.

I'm not taking a Luddite view, despite my rhetoric. There are definitely technological advances which can help dentistry and its processes. One of the hardest things to learn, I think, will be when to say no. A tooth is cracked, stained, broken, not perfect: what do we do? I've got patients with all of those things which have remained unrestored for years. I'm sure we've all restored a fracture by replacing a restoration only for another part to break. Sometimes the best thing is to do nothing at all. An AI generated treatment model might struggle with that concept. In years gone by there was always a suspicion of over-treatment by dentists based on the fact we don't get paid to do nothing. If an AI process was involved, I'd expect the number of treated teeth to increase massively as we treat every stain, crack or break. Long term data may show earlier intervention results in better outcomes.

As we introduce new practices and rely more on a digital workflow, there will be a steep learning curve in terms of how we use the systems and equipment to our and our patients' benefit. However, an increased reliance on tech may mean we become deskilled. Perhaps operators could be less qualified in the longer term? Perhaps it paves the way for robots?I worry that we become overly reliant on what the computer says and lose our physician's instinct. That nouse developed over decades of experience. That sense that, although everything seems OK and looks good on X-ray, that something isn't quite right. Intangible experience combined with free thinking intelligence unconstrained by algorithms or confirmation bias based in educational dogma?

We probably need AI to answer that.



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Restoring hope, one smile at a time

A CHARITY offering free dental care to women who have survived domestic abuse has been launched in Scotland.

The Diamond Smiles Foundation, spearheaded by Leanne Branton of Southside Dental Care in Edinburgh, aims to transform lives, starting with a smile.

The foundation was officially unveiled at an event in November where Leanne shared her vision with the audience: "This is about so much more than dentistry. It's about healing, restoring confidence, and giving hope to women who have endured unthinkable challenges.

"Our mission is simple yet profound: to help survivors of domestic abuse reclaim their oral health, their dignity, and their future."

Leanne shared a story that inspired the creation of the foundation: "One woman's journey deeply moved me.

"She had escaped an abusive relationship but was left with the physical and emotional scars of her trauma. Her teeth were damaged—a daily reminder of the abuse she endured—and her shattered smile held her back from job opportunities and social interaction.

"Her story isn't unique, and that's what struck me the hardest. Women like her need more than just dental care; they need the chance to rebuild their lives.

"That's where Diamond Smiles Foundation steps in. Through completely free dental treatments, including implants, we aim to restore not only their smiles but their self-confidence and independence."

At the launch event, Leanne spoke passionately about the foundation's mission: "Today is a milestone—the beginning of something truly transformative. The Diamond Smiles Foundation is here to provide a lifeline, offering vital dental care to help survivors of trauma rebuild their lives.

"This initiative is rooted in community, healing, and the belief that a smile can be a powerful tool for change. Together, we can uplift, inspire, and create a future filled with possibility for these women."

A pathway to help

The Diamond Smiles Foundation has established a referral pathway through trusted local charities, Women's Aid and Circle, ensuring survivors have access to the care they need. By partnering with these organisations, Diamond Smiles Foundation connects directly with women who will benefit most from the life-changing dental treatments provided. provide essential and specialist dental treatment to women who have survived domestic violence, thereby promoting their physical and mental health and wellbeing. The foundation is more than a charity; it's a movement to restore hope and dignity, said Leanne. She added: "This is just the beginning. Together, we can create lasting change and ensure every survivor has the opportunity to face the world with strength, confidence, and, most importantly, a smile." Follow the foundation on Instagram at instagram.com/Diamond.Smiles.Foundation to stay updated, or reach out via email at leanne@diamondsmiles.scot for more information.

GDC opens annual renewal period for dentists

THE General Dental Council (GDC) has opened the annual renewal period for dentists.

To streamline the process, it has outlined three steps for dentists to complete by the respective deadlines:

1. Pay the Annual Retention Fee (ARF) by 31 December.
2. Indemnity cover: Dentists need to confirm they have, or will have, indemnity cover in place by 31 December. For dentists covered under their employer's policy, they will need to make sure they have access to the details of the policy.
3. Complete a CPD statement by 28 January. Dentists must complete a minimum of 10 hours of CPD over the last two-year period by 31 December.

If dentists are in the final year of the CPD cycle, they should ensure they have completed the minimum hourly requirements for the full cycle. Dentists who have registered within the last 12 months will start their first cycle on 1 January 2025.

As part of the renewal process, the GDC also is encouraging all registrants to complete a short working patterns survey. The survey asks dentists how and where they work, and how long they work for each week. The feedback will continue to build the sector's understanding of dentists' working patterns and support future workforce planning.

www.egdc-uk.org

Infrared light more effective than X-rays in detecting cavities

New intraoral scanner presents patients with easy-to-understand 3D models

INFRARED light is three times more effective in detecting cavities than X-rays – and is inherently safer for patients and practitioners – a study has shown.

Perceptive, the US company which recently undertook the world's first robotic dental procedure, has completed an early feasibility study of the world's first in-vivo 3D intraoral Optical Coherence Tomography (OCT) system, in collaboration with PDS Health.

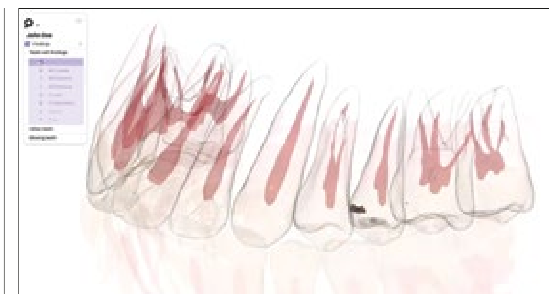
"Imagine a cone beam computed tomography image made using light instead of X-rays," said the company in a statement. "By utilising infrared light, it triples the sensitivity in detecting cavities compared with X-rays and enables the detection of cracks and demineralisation – all with intraoral scanner-like usability.

"This new imaging modality makes it easier for dentists to detect the reasons to recommend necessary treatments and gives patients the information and trust necessary to accept them."

Many dental conditions are asymptomatic and only detectable with low-sensitivity X-rays, sometimes leading to misdiagnoses or conflicting diagnoses and a lack of patient trust. Perceptive said its OCT technology enables dentists to detect dental issues with confidence and improve patient trust by presenting patients with clear, easy-to-understand 3D models.

"With more than 90 per cent sensitivity to dental pathology – three times the accuracy of traditional X-rays and without the risks associated with ionising radiation – this system provides an unprecedented level of diagnostic detail in an easy to understand way," said the company

"During the study, it became clear that Perceptive's imaging technology operates at a higher level than traditional intraoral scanners," said Karim Zaklama, DDS, a general dentist and multi-practice owner supported by PDS Health, and a lead investigator in the study.



"I've used various scanners for years, but this one stood out – it wasn't affected by moisture or condensation, and it allowed me to see into the deeper layers of the tooth with remarkable clarity.

"With this technology, I was able to diagnose issues in patients who presented with symptoms that couldn't be identified using conventional methods. Both my patients and I felt reassured knowing that we could finally pinpoint the problems and address them before they worsened."

Text messages can help improve teenagers' oral health

TEXT message reminders can help to improve tooth brushing habits in teenagers, particularly those from low-income families, a new study has shown.

Researchers from the University of Sheffield, in collaboration with the Universities of Cardiff, Leeds, York and Dundee, investigated the effectiveness of a new programme designed to encourage better brushing habits and reduce tooth decay in secondary school pupils.

Tooth decay affects a third of young people aged 12-15 years. This increases to nearly a half in youngsters living in areas of poverty. Young people with tooth decay often suffer from toothache, loss of sleep and problems eating; as well as it affecting their overall physical health and mental wellbeing. It can also lead to increased school absences.

The BRIGHT trial, funded by the National Institute for Health and Care Research (NIHR) and published in the journal *Health Technology Assessment*, included a classroom lesson and twice-daily text messages about toothbrushing. The researchers involved 4,680 students from 42 schools across England, Scotland and Wales.

While the overall impact on preventing cavities was not significant, the intervention showed a positive effect on self-reported brushing habits six months later. The report suggests the programme may be particularly beneficial for students from low-income families, as the analysis found some evidence of prevention of tooth decay within this group.

www.journalslibrary.nihr.ac.uk/hta/JQTA2103/#/abstract

Banana paste, princess crown, sleepy juice – what's in a name?

EFFECTIVE – and ineffective – terminology used by dental team members in Scotland when treating paediatric patients has been identified in a study (pubmed.ncbi.nlm.nih.gov/39433975).

Respondents were asked a series of questions on words they perceived to be effective and ineffective for describing eight dental procedures and three dental instruments and whether their word choice was affected by the gender and/or the age of the patient.

"There is clearly a wide variety of replacement terms in use in paediatric dentistry in Scotland," said the researchers at Glasgow Dental Hospital, Dundee Dental Hospital and Research School and the Edinburgh Dental Institute.

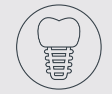
"While options are limited only by the imagination of dental team members, some favourite words are evident; the top word choice in each of the dental terms was selected by between 39% (fluoride varnish) and 96% (aspirator) of respondents."

The researchers added: "Individual creativity is still certainly evident today, however, with respondents using unique choices such as 'squirt gun' for local anaesthetic or 'roller coaster rumbles' for drill.

"While often humorous, this friendly terminology has the additional benefit of being tailored to the child. Person-centred care, of which good communication is integral, has been shown to improve patient outcomes."

What's in a name? See page 47.

Welcoming referrals in: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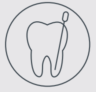
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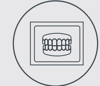
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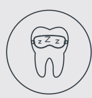
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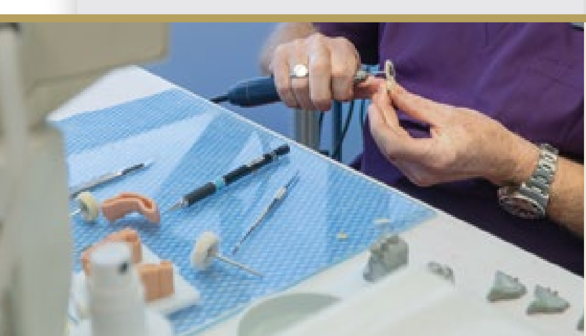

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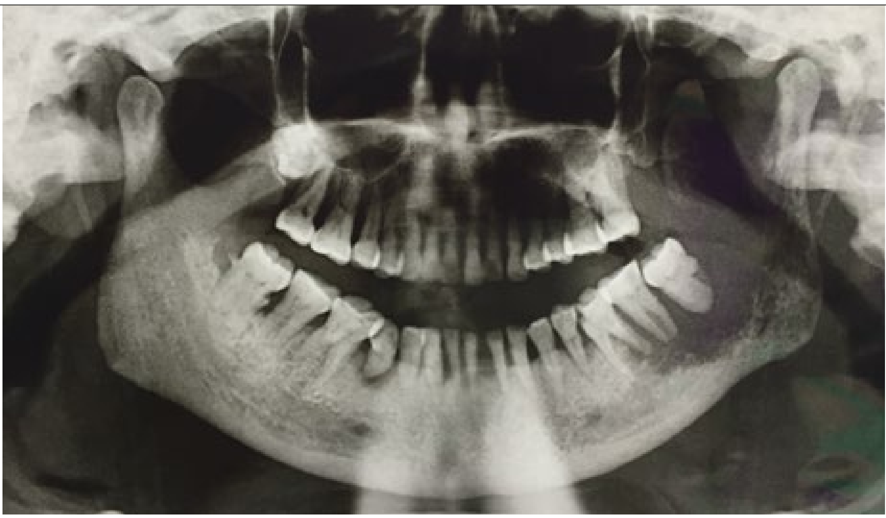
Mouth cancer cases in the UK hit a record high



More than 10,000 cases are being diagnosed annually, a 133 per cent rise over the last 20 years

THE number of mouth cancer cases in the UK has reached a record-breaking high; surpassing 10,000 for the first time, according to new data collected by the Oral Health Foundation.

The findings are part of the charity's State of Mouth Cancer UK Report 2024 (www.dentalhealth.org/thestateofmouthcancer) and were released to coincide with November's Mouth Cancer Action Month.

The report shows 10,825 new cases of mouth cancer are being diagnosed in the UK annually – representing a 133 per cent rise over the last 20 years.

Dr Nigel Carter OBE, Chief Executive of the Oral Health Foundation, warned of the growing threat mouth cancer poses to the population: "While many types of cancer are declining, mouth cancer continues to surge.

"Smoking and excessive alcohol consumption remain the most significant risk factors, but we are seeing a growing number of cases linked to the human papillomavirus (HPV) and other emerging causes. Mouth cancer can affect anyone, and the impact on a person's life can be devastating.

"We need to raise awareness of the symptoms, the risk factors and most importantly, the importance of early detection.

"Too many cases are diagnosed too late, often at the most advanced stage. This needs to change." The data reveals that most mouth cancers (66 per cent) in England are diagnosed in men, with those over-50 accounting for more than nine out of ten (90 per cent).

Around one in three (31 per cent) of the diagnoses occur on the tongue, while around one in five (22 per cent) are found in the tonsils. Other common areas affected include the lips, gums, inside of the cheeks, and the roof and floor of the mouth.

Mouth cancer symptoms include mouth ulcers that do not heal within two to three weeks, red or white patches in the mouth, and unusual lumps or swellings in the mouth, head or neck.

Interactive mouthpiece developed by researchers

RESEARCHERS have created a dental brace which combines sensors and components to capture in-mouth interactions and data.

The team from the MIT's Computer Science and Artificial Intelligence Laboratory (CSAIL) and Aarhus University believe that the device could potentially assist dentists and doctors in collecting health data.

They said it could also help motor-impaired people interact with a phone, computer or fitness tracker using their mouths.

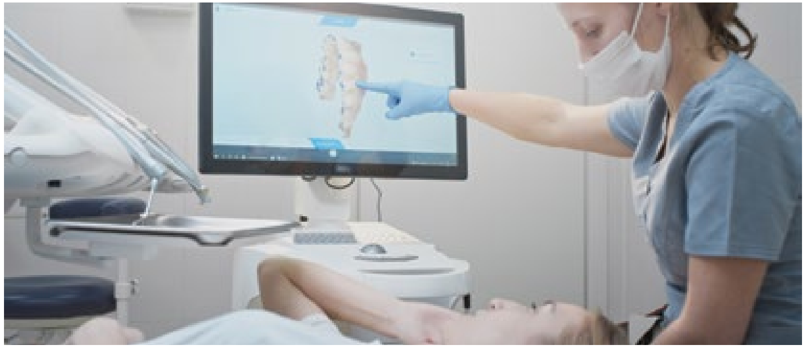
"The mouth is a really interesting place for an interactive wearable and can open up many opportunities, but has remained largely unexplored due to its complexity," said Michael Wessely, senior author of a paper about the device (https://tinyurl.com/2a7fau89).

"This compact, humid environment has elaborate geometries, making it hard to build a wearable interface to place inside. With MouthIO, though, we've developed a new kind of device that's comfortable, safe and almost invisible to others. Dentists and doctors are enthusiastic about MouthIO and its potential to provide new health insights, tracking things like teeth grinding and potentially bacteria in your saliva."

CDO discusses the future of dental technology education

THE Dental Technologists Association (DTA) has held a meeting with Tom Ferris, Scotland's Chief Dental Officer (CDO), to discuss the current state and future of dental technology education in Scotland.

The meeting was attended by key members of the DTA, including President Delroy Reeves, Council Members Rob Leggett and Jade Ritch, and Lead DCP Elaine Hutchison. Subjects discussed included funding, education and representation. During the meeting, several issues were addressed including funding for technician training, enhancing dental technology education, collaborative support for dental technologists as well as broader representation and future meetings. The DTA said it remains committed to advancing the field of dental technology and ensuring that dental technologists receive the support and training they need to succeed. A spokesperson added: "We look forward to continued collaboration with the CDO and other stakeholders to achieve these goals."



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Fitness to practise process streamlined

Regulator aims to reduce time investigating a concern

THE General Dental Council (GDC) has revised its fitness to practise process in an attempt to improve timeliness in investigating clinical practice concerns.

The move follows the pilot of a revised process for handling fitness to practise concerns raised about dental professionals with no previous allegations of fitness to practise impairments in the previous 12 months. Launched in September 2023, the main aim of the pilot was to reduce the time taken to investigate single patient concerns about clinical practice.

These were cases where the likelihood of closure at the assessment stage was high – the process change was designed to help ensure investigations were proportionate to the potential risks involved. The regulator limited the information requested at the initial stages of an investigation to relevant clinical records only during the pilot. It has demonstrated that the approach can significantly reduce the average time it takes to conclude an investigation.

Feedback from caseworkers highlighted quicker responses from registrants to requests for information.

Concluding cases took an average of 13 weeks during the pilot, more than half the 30-week key performance indicator for single clinical incident cases to reach the end of the assessment stage.

Theresa Thorp, Executive Director of Regulation at the GDC, said: “While investigations into fitness to practise concerns are an important part of the regulatory system that maintains public safety and confidence, reducing the negative impacts of investigations is a priority for us. The pilot has shown the potential to streamline investigations for certain types of concerns while upholding the GDC’s commitment to public protection.”

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College launches register of implant mentors

THE College of General Dentistry (CGDent) as launched a register that will enable trainees to identify and contact experienced and qualified implant dentistry mentors.

It has been developed in conjunction with the Association of Dental Implantology and the International Team for Implantology,

The new Register of Mentors in Implant Dentistry (cgdent.uk/register-of-mentors-in-implant-dentistry) will support high standards of training and practice in implant dentistry by providing recognition to those who have met specific standards in their clinical and mentoring practice.

Freely accessible and searchable by the profession at large, it will also enable those undertaking training in implant dentistry to identify and contact appropriately experienced and qualified mentors.

Mentoring is recognised as a critical element of a practitioner’s training in implant dentistry, and is among the requirements of the college’s Training Standards in Implant Dentistry document, which sets the minimum standards for training which those practising implant dentistry in the UK must have undertaken.

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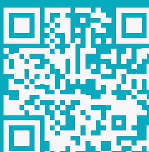

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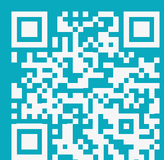

Contact the Membership Team

rcsed.ac.uk

Dental professionals' working patterns published

DATA about the working patterns of dental care professionals (DCPs) has been published by the General Dental Council (GDC).

Almost 44,000 DCPs responded to the working patterns questions, and the data published includes information on the proportion of DCPs who are providing NHS care and private care, whether they are working in clinical or non-clinical roles, and how many hours they are working.

Key highlights show that of the responding DCPs:

- The majority (86 per cent) were doing some clinical work (fully clinical 47 per cent, predominantly clinical 18 per cent, mix of clinical and non-clinical 22 per cent).
- Four fifths (80 per cent) were employed and 14 per cent were self-employed. However, this varied significantly by DCP title. Around two thirds of dental therapists (63 per cent) and dental hygienists (66 per cent) said they were self-employed. Only around a fifth (22 per cent) of clinical dental technicians said they were employed, with more than two fifths (43 per cent) saying that they were business owners/part owners and around a third (34 per cent) saying they were self-employed.
- The vast majority (94 per cent) reported working fewer than 40 hours per week, with 48 per cent working between 30 and 40 hours and 46 per cent working 30 hours or less.
- Just over a third (35 per cent) said they delivered a 'mix of NHS and private care', a quarter (25 per cent) said they were 'fully private, and one-in-seven (15 per cent) said they were 'fully NHS'.
- Nearly two thirds (64 per cent) stated their dental setting was 'general dental practice'. The next most frequently mentioned setting was 'specialist dental practice' (12 per cent).
- More than three quarters (77 per cent) reported having one place of work. However, this varied significantly by role, with 81 per cent of dental nurses working in one place, compared to around two-fifths of dental hygienists (38 per cent) and dental therapists (39 per cent).

Stefan Czerniawski, the GDC's Executive Director, Strategy, said: "For the first time, there is now a rich picture of where dental professionals work, the balance between private and NHS practice, and the balance between clinical and non-clinical roles and activities, across the four nations of the UK.

"We are confident that these insights will support strategic planning and decision-making by health services, governments and dental providers, ultimately helping patients receive the care they need."

PRACTICE SPOTLIGHT

MANAGING COMPLEX RESTORATIVE CASES

Abid Faqir, Scottish Centre for Excellence in Dentistry

ABID FAQIR is a graduate of the Glasgow Dental School and holds a membership of the Faculty of Dental Surgery, Edinburgh. He has obtained a master's degree from Glasgow University and a diploma in Implant Dentistry from the Royal College of Surgeons, Edinburgh.

Abid has a special interest in dental implants and the management of complex restorative cases, with a particular emphasis on immediacy. He has successfully placed more than 5,000 implants.

Utilising digital dentistry and guided surgery, he routinely manages complex restorative cases with a focus on smile design. He is a past president of the Association of Dental Implantology and an honorary life member. Outside of dentistry he has served as board member of the Glasgow Children's Hospital charity and the Riverside Museum Appeal.

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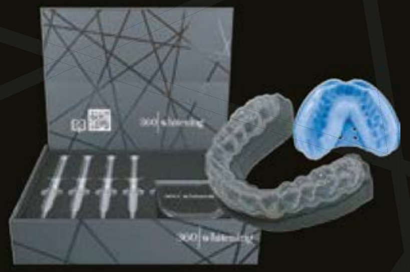

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GDC launches consultation on education

Regulator welcomes input from stakeholders across the dental education and training sectors

THE General Dental Council (GDC) has opened its consultation on proposed revisions to the Standards for Education, which will shape the future requirements for all UK programmes seeking GDC registration.

The regulator said it was committed to ensuring its quality assurance of dental education and training fulfils its primary purpose, to protect patients. The Standards for Education set out the requirements expected of all pre-registration programmes that lead to registration with the GDC.

These standards are the framework of its quality assurance processes. Providers are expected to meet the standards, which cover the areas of patient protection, quality evaluation and review and student assessment.

The GDC said it would welcome input from stakeholders across the dental education and training sectors in its consultation, which runs until 12:00 on 6 February 2025.

Responses should be submitted via the GDC's online consultation platform, where a PDF version of the consultation document is also available. It conducted two stakeholder workshops earlier this year, which helped to inform the development of the draft consultation.

> "THE REVISED STANDARDS FOR EDUCATION WILL REFLECT SIGNIFICANT CHANGES IN THE GDC'S STRATEGIC DIRECTION IN DENTISTRY, DEMOGRAPHICS, AND THE WIDER HEALTHCARE ECOSYSTEM"

The revised Standards for Education will reflect significant changes in the GDC's strategic direction in dentistry, demographics and the wider healthcare ecosystem.

The aim of the review is to simplify requirements, enhance clarity and introduce new areas relevant to today's dental education landscape. This update follows the publication of the new Safe Practitioner Framework in 2023, which set foundational expectations for pre-registration education across the UK. The GDC is currently working with education providers on its implementation.

"Providers must be aware of their duty to protect the public, ensuring that patient safety and care are paramount. They must have effective policy and procedures in place for the monitoring and review of their programmes, and student assessment must be reliable and valid," said Manjula Das, Head of Education and Quality Assurance at the GDC. "We want the revised Standards for Education to be clear and accessible for providers, while addressing the evolving needs of the professional groups we regulate."

www.gdc-uk.org/about-us/what-we-do/consultations-and-responses/#review

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New dental postgraduate dean

Lee Savarrio is taking over from Professor David Felix, who retires in April next year

LEE Savarrio, NHS Greater Glasgow and Clyde's Chief of Dentistry, has been appointed NHS Education for Scotland's (NES) dental director and postgraduate dean.

A spokesperson NES said that Savarrio "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.

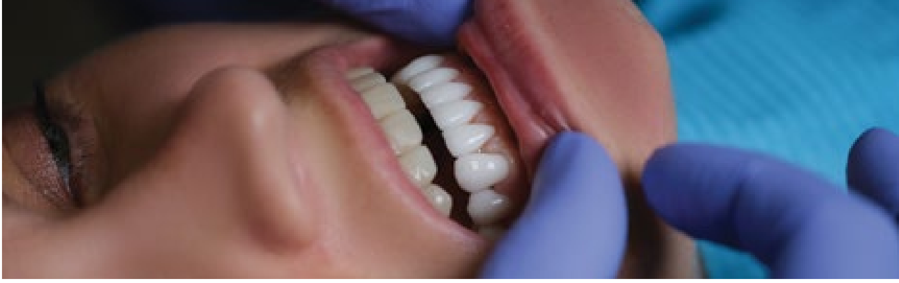
Following a handover period beginning on 1 January, Savarrio will take over from Professor David Felix who is retiring in April.

David Garbutt, NES's chair, said: "Lee's extensive background in dentistry and his leadership at NHS Greater Glasgow and Clyde will be instrumental as we continue to pursue our mission of enhancing the quality of care through a skilled and empowered health and social care workforce."

Savarrio said: "I will focus on advancing the mission to support quality care and outcomes in dentistry for the people of Scotland through a skilled, capable and resilient workforce.

"In the fast-changing landscape of healthcare provision and, in particular, teaching and training, I will strive to make sure the resources available to us are directed to initiatives that are most impactful and to areas of greatest need."

Advanced aesthetic dentistry award launched



CGDENT and Dentsply Sirona have launched the Tom Bereznicki Award for Advanced Aesthetic Dentistry.

The award is open to dentists who qualified in the UK, Ireland or overseas between 2019 to 2023 and have been practising in the UK for at least the past two years.

Thirty six successful candidates will each receive a fully funded place on a bespoke, hands-on two-day digital dentistry course at the Dentsply Sirona Academy in Weybridge. The course is repeated on three separate dates. Travel costs, hotel accommodation and subsistence are included in the prize.

The course has been designed by Dr Tom Bereznicki and is aimed at dentists with limited or no experience of working with a digital workflow. Participants will be guided step-by-step through the complete process of creating a digitally produced crown, from scanning to cementation.

To enter, candidates must submit pre-op photographs of an aesthetic case they are about to start treating and upload a final case report when treatment is complete. The case must involve more than one tooth, including at least one anterior tooth, and the use of composite to restore teeth. It must mainly follow an analogue workflow.

Full case eligibility guidance is outlined here: cgdent.uk/tom-bereznicki-award-for-advanced-aesthetic-dentistry

Work begins on new dental centre for army in Scotland

A CEREMONY has been held to mark the start of construction of a £22 million medical and dental centre at Leuchars Station, the military base in Fife.

The new building will replace the existing medical and dental centre, which was built in 1936. It will cater for the increasing number of personnel forecast to be based at the station in the coming years, as it becomes the British Army's hub in Scotland.

Around 3,700 personnel at the Army establishment and their dependants will benefit from the new building, which will house physical rehabilitation and mental health facilities as well as GP and dental services.

The building has been designed to be as sustainable as possible – including through thermal efficiency, solar panels, air source heat pumps and four electric vehicle charging stations.

Major TB Gray, station quartermaster, said: "It has been 10 years since the Army took ownership of Leuchars Station from the RAF and the troops returned from Germany to make Fife their permanent home.

"The new healthcare facility is one of many ongoing and planned multi–million-pound projects which will see Leuchars transform from an ageing RAF site into the largest army garrison in Scotland."

"THE NEW HEALTHCARE FACILITY IS ONE OF MANY ONGOING AND PLANNED MULTI–MILLION-POUND PROJECTS"

Introducing Dr Lyall Dominick

Dentist with an interest in endodontics

BDS MFDS RCPSG MSc
GDC No. 243639

Lyall graduated from University of Glasgow in 2013. He then carried out his vocational training training in the west end of Glasgow before moving full time into general practice, where he has worked for the last 10 years.

Lyall became a member of the Royal College of Physicians & Surgeons of Glasgow in 2018 and has recently graduated from the University of Birmingham with a master's degree in restorative dentistry. He also works part-time at Glasgow Dental Hospital providing complex endodontic treatment to patients referred from their general dental practitioners. Lyall is happy to accept referrals for non-surgical endodontic treatments. In addition, he is happy to register new adult patients for general and restorative dentistry.

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Calcification in infancy

Study provides new insights into inherited phosphate and pyrophosphate disorders

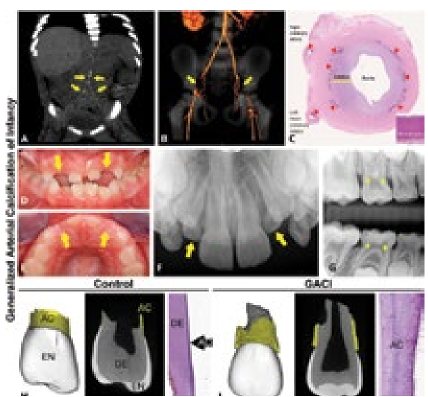
NEW antibody and enzyme replacement therapies may improve oral health in patients with disorders that reduce mineralisation

This is according to a study published in the November issue of *The Journal of the American Dental Association*.

The development of the four mineralised tissues that make up the dentoalveolar complex – enamel, dentin, cementum and alveolar bone – are affected by inherited disorders that disrupt phosphate and pyrophosphate homeostasis.

These conditions can lead to reduced mineralisation or inappropriate calcification of soft tissues.

The cover story, *Inherited Phosphate and Pyrophosphate Disorders: New Insights and Novel Therapies Changing the Oral Health Landscape*, is JADA's latest addition to its Oral Science Trends series.



The series is made up of invited reviews that explain where biomedical and clinical sciences are leading to impactful changes in dentists' ability to provide care and improve health.

In it, the authors discuss original data from experiments and comparative analyses and review articles.

They say research over the past two decades has expanded the understanding of mineral metabolism and led to novel treatments for mineralisation disorders.

"Newly implemented and emerging therapeutic strategies affect the dentoalveolar complex and interact with aspects of oral health care that must be considered for dental treatment, clinical trial design and coordination of multidisciplinary care teams," the authors said in the article.

jada.ada.org/article/S0002-8177(24)00370-2/abstract

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Glasgow Airport to get its own dental practice

PLANS to create a dental practice near Glasgow Airport, offering both NHS and private dentistry, have been submitted to Renfrewshire Council.

Helix Architecture Studio, of Falkirk, is seeking planning permission on behalf of an applicant for the transformation of a unit at Marchburn Drive, just south of the airport terminal building.

The application states: "The dental clinic will primarily serve employees working within the business estate, as well as staff from various companies based at Glasgow Airport. This part of the application recognises that the airport functions as a community in its own right and having a conveniently located dental clinic will be a welcome service for its workforce.

"This proposed clinic will address this gap by offering services to both residents and the local working population. It will also provide NHS treatment, helping to ease the waiting list for NHS dental services in the area. This will benefit the wider community, particularly by improving access to essential healthcare services."

Dental Cone Beam CT courses in 2025

THE Royal College of Physicians and Surgeons of Glasgow is hosting two Dental Cone Beam CT courses in February and March next year.

Dental Cone Beam CT 2A on 4-5 February will focus on teaching safe interpretation of cone beam computed tomography (CBCT) scans, and when to refer for radiological or surgical opinions.

The two-day course will enable participants to begin safely interpreting their own cone beam computed tomography scans, having been introduced to what normal 3D anatomy looks like. Delegates will then understand when to refer on for a level three expert radiological or surgical opinion should an anomaly or significant pathology arise.

Following on from this course, Dental Cone Beam CT 2B on 4 March offers an interactive, delegate-centred approach to learning and will enable attendees to maintain the safe operation and interpretation of CBCTs. It will enable delegates to consolidate learning and address any issues which may have arisen when putting their 2A experience into practice.

The course will include a focused session on bone disease and its presentation on dental imaging, radiological interpretation exercises and extensive peer learning, discussion and reflection on CBCT reporting skills.

community.rcpsg.ac.uk/event/view/dental-cone-beam-2a-4-feb-2025

community.rcpsg.ac.uk/event/view/dental-cone-beam-2B-04-mar-25

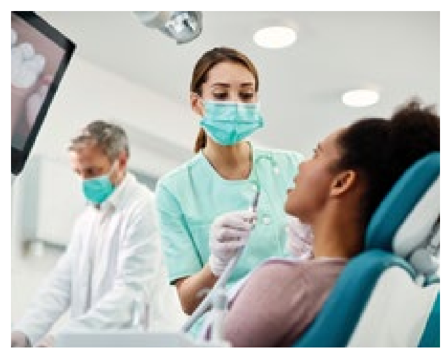
Dental nursing standards consultation launched

It follows publication of the GDC Safe Practitioner Standards last year

SKILLS for Health has launched a public consultation in support of a review of the Oral Health National Occupational Standards (NOS) for Dental Nursing.

The standards describe the knowledge, skills and understanding an individual needs to be competent in their role, and the consultation has opened following the publication of the General Dental Council's (GDC) Safe Practitioner Standards in November 2023. Since then, a UK-wide steering group and subject matter experts have been working in tandem to align the content of the NOS to the new Safe Practitioner framework. The consultation represents the final stage of the review, providing stakeholders with the opportunity to input into the final version of the NOS before they are published early next year. Caroline Taylor, Associate Postgraduate Dental Dean at NHS Education for Scotland, is chair of the steering group responsible for undertaking the Oral Health NOS review. Explaining the importance of the review to the future of the profession, she said:

"The National Occupational Standards Strategy 2022 aims to refine and modernise the NOS and ensure its continued relevance and effectiveness in creating a skilled workforce, for now and the future. The NOS underpin all apprenticeships and vocational qualifications in Scotland. The GDC has published the new Safe Practitioner framework which details behaviours and outcomes for dental professional education, and the clinical knowledge and skills specific to the scope of practice of each professional group. Therefore, to ensure that the Oral Health (Dental Nursing) NOS are fit for purpose for the future dental workforce



and are reflective GDC Safe Practitioner framework by August 2025, all of the Dental Nursing standards have been reviewed and updated for consultation." The review of the Oral Health NOS for Dental Nursing is one of a series of upcoming consultations. The next one – a consultation in support of a NOS review for Dental Technicians – is scheduled for early 2025. The public consultation opened on 25 November and will remain open for four weeks. Individuals and organisations to contribute to the review via an online survey: ***survey.alchemer.com/s3/8088045/Oral-Health-Dental-Nursing-National-Occupational-Standard-Consultation***

Introducing

Audrey Kershaw

Oral Surgeon

BDS (Glas) 1987,
FDS RCS (Edin) 1991
GDC No. 62146

Audrey qualified from Glasgow University with BDS in 1987 and since then has predominantly been employed in oral surgery posts. She is on the GDC specialist list and has over 35 years' experience in oral surgery.

She is available for referral of patients with oral surgery needs, including but not limited to:

- Wisdom tooth removal
- Soft tissue biopsy
- Surgical extractions
- Medically complex patients
- Anxious and phobic patients

Audrey takes particular care in helping patients who are anxious about dental treatment, who struggle to go numb at the dentist or who find dental treatment difficult due to complex medical histories and hidden disabilities. She very much understands that although what she does is routine to her team, to her patients it can be an unknown and daunting experience.

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If you would like to refer a patient to Audrey, visit: westhilldentalpractice.co.uk/referrals

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EFP calls attention to interactions between diabetes and gum disease

Studies show that people with diabetes are at a threefold higher risk of developing severe gum disease

THE European Federation of Periodontology (EFP) has drawn attention to the often underestimated interactions between diabetes and gum disease.

Studies show that people with diabetes are at a threefold higher risk of developing severe gum disease. The connection between these conditions is particularly evident in patients with poorly controlled blood sugar levels. The higher the level of hyperglycaemia, the more severe the gum disease tends to be. As diabetes continues to impact millions of lives globally, understanding its effects on oral health (as well as the effects of gum disease on diabetes) is essential for improving overall health. This year's theme, *Diabetes and well-being*, emphasises the need for accessible care and support for all individuals living with diabetes – and that includes prioritising gum health.

"Recent research has shown that diabetes is not only a major risk factor for periodontitis but that the relationship between the two conditions is bidirectional, meaning they both influence and exacerbate one another," said Anton Sculean, chair of EuroPerio11, the congress in periodontology hosted by the EFP. "Moreover, moderate/severe periodontitis is associated with an increased risk of all-cause and cardiovascular disease-related mortality in adults with diabetes." People with diabetes are significantly more susceptible to developing severe gum disease, with studies showing that they are at a threefold higher risk. Additionally, diabetes disrupts the body's inflammatory response, resulting in an exaggerated immune reaction in the gums that leads to further tissue damage.

Conversely, periodontitis can complicate diabetes management. The inflammation caused by gum disease isn't confined to the gums; it can spread throughout the body, increasing, in turn impairing insulin sensitivity.

Analysing dental implant positional changes

BA novel methodology for analysing dental implant positioning in vivo, advancing beyond traditional methods that rely on post-placement cone beam computed tomography (CBCT) scans, has been outlined in a paper published by the *British Dental Journal* (www.nature.com/articles/s41415-024-7905-7).

The core of the methodology is comparing stereolithography (STL) files, representing pre-planned and actual post-placement implant positions. These STL files, exported from guided surgery planning and computer-aided design software, focus on clinically significant key points, such as the apical and coronal midpoints. Additionally, the method uses pose detection, differing fundamentally from CBCT scan approximations.

Relying on pose detection instead of scanner resolution, this method aligns with international standards and overcomes CBCT and intraoral scanner limitations. It allows for a more precise and accurate assessment of implant positions, independent of scanner technology constraints. Further refinements include potential detailed reporting of apical deviations, enhancing implant placement accuracy.

This research has significant implications for dental implantology, says the author, enhancing implant placement precision and overall procedure success.

Oral care for children: highlighting excellence

THE 2025 NASDAL Dental Check by One Practice of the Year award has been launched.

Now in its seventh year, the award seeks to recognise a dental practice that has been successfully implementing and supporting the British Society of Paediatric Dentistry (BSPD) Dental Check by One (DCby1) into its practice.

The aim of the award is to increase the number of children aged up to two years who access dental care.

The NASDAL DCby1 Practice of the Year award seeks to highlight excellence in the provision of oral care for children with a prevention focus, and showcase the opportunity to achieve real business improvement.

Particular credit is given to applications from dental practices with evidence supporting their contribution to the overall health of their community.

The judging panel takes into consideration creative approaches that may show qualitative and/or quantitative results.

The award will be presented by Jason Wong, England's CDO, at the BDIA Dental Showcase in on Friday 14 March 2025.

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Royal College Advanced Certificate in Clinical Education	
Practical Advice for New Consultants	6 CPD
Clinical Learning Environment	4 CPD

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DATES FOR YOUR DIARY

2024

6 DECEMBER
CGDent Scotland Study Day
Glasgow Science Centre
cgdentscot.org.uk/glasgow-study-day/speakers

2025

30 JANUARY
College of General Dentistry 2025 Fellows' Winter Reception
Cutlers' Hall, London
cgdent.uk/2024/09/09/fellows-winter-reception-30-january-2025

14 MARCH
BDIA Dental Showcase 2025
London ExCel
bdia.org.uk/events/bdia-dental-showcase-2024

1-3 MAY
ADI Team Congress
The Brighton Centre, Brighton
www.adi.org.uk/association_dental_implantology_congress

20-21 JUNE
The Scottish Dental Show
Braehead Arena, Glasgow
sdshow.co.uk

Note: Where possible this list includes rescheduled events, but some dates may still be subject to change.

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A spokesperson said: "Not only is this great for skill consolidation and progression – especially for newly qualified clinicians – but it also affords new and exciting life experiences to benefit practitioners for years to come."

To express interest in this programme, email joinus@clydemunrodental.com or complete this form: tinyurl.com/5n9an4du

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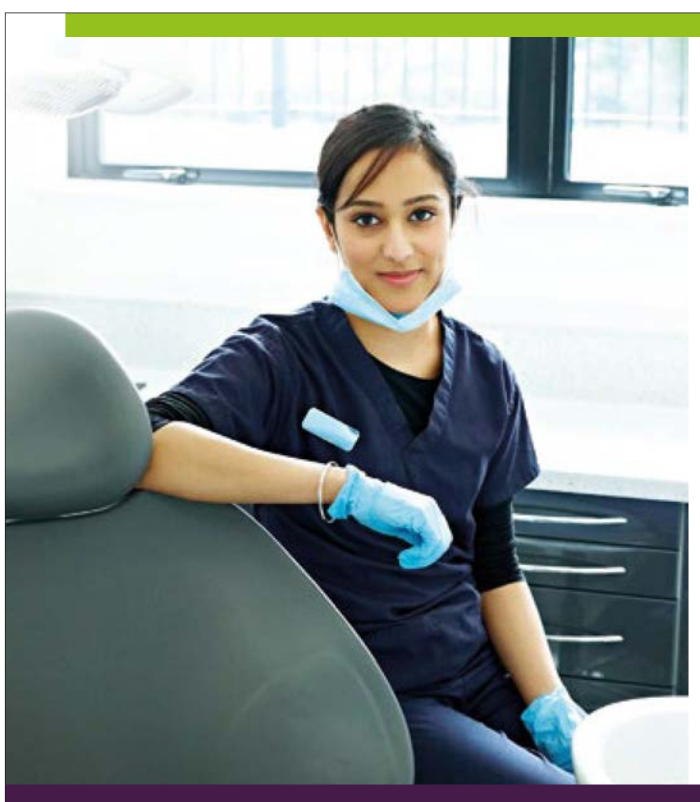

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CANMORE TRUST WELLBEING CONFERENCE 2024

Finding common paths towards hope and suicide prevention

The Canmore Trust hosted its two-day Wellbeing Conference in November at the Radisson Blu Hotel in Glasgow.

It brought together more than 200 doctors, nurses, veterinary surgeons and dentists, as members of the healthcare professions with the highest rates of suicide, to offer mutual support, to encourage wellbeing, and to find common paths towards hope and suicide prevention. The Canmore Trust[1] was founded by John Gibson and his wife Isobel following the loss of their son Cameron, a young veterinary surgeon, in 2019.

The conference featured a number of renowned speakers, including Professor Rory O'Connor, President of the International Association for Suicide Prevention[2]; Alice Hendy MBE, founder of the award-winning charity R;pple[3]; Fiona Drouet MBE, founder of EmilyTest[4]; Richard McCann[5], internationally-acclaimed motivational speaker and author of Just a Boy; and Haylis Smith, Suicide Prevention Scotland's National[6] National Delivery Lead.

On the Friday evening there was a fundraising dinner, with the theme 'Celebrating Life', which was hosted by BBC weather presenter, and Canmore Trust ambassador, Judith Ralston.

Professor O'Connor spoke about his 30 years working to understand and prevent suicide, including co-leading NQ Mental Health Research's Gone Too Soon project[7], which brought together a 40-strong multidisciplinary global team of academic, policy, clinical, and lived and living experience experts with the specific aim of understanding the driving forces behind these deaths and what needs to be done to tackle this public health crisis.

The work resulted in the paper *Gone Too Soon: priorities for action to prevent premature mortality associated with mental illness and mental distress*[8]. This identified 12 key risk factors and mechanisms and 18 actionable solutions across three organising principles: the integration of mental and physical health care, the prioritisation of prevention while strengthening treatment, and the optimisation of intervention synergies across socialecological levels and the intervention cycle.

Professor O'Connor said that these solutions included: accessible, integrated, high-quality primary care, early life, workplace, and community-based interventions co-designed by the people they should serve, decriminalisation of suicide [in countries where that remains an issue] and restriction of access to lethal means, stigma reduction, reduction of income, gender and racial inequality and increased investment.

He also spoke about the development of the IMV Model[9], a recognition that suicide is characterised by a complex interplay of biology, psychology, environment and culture "and that we need to move beyond

psychiatric categories if we are to further understand the causes of suicidal malaise".

Professor O'Connor also highlighted that 75 per cent of suicides are by men and that more work needs be done to understand the causes.

"For me," he said, "suicide prevention is about two things. First thing is, can we stop people becoming suicidal in the first place? If we can't do that, can we stop them acting on their thoughts of suicide? There's so much evidence that if we can work collaboratively with individuals who are vulnerable, that we can hopefully save lives in terms of restricting access to the means of suicide."

Professor O'Connor said Scotland was leading the way with some of its initiatives, such as the Distress Brief Intervention (DBI) programme[10]. The DBI's 'ask once get help fast' approach has two complementary levels.

The first is provided by frontline staff, such as NHS 24, emergency departments and the police and ambulance services who can offer a "seamless referral, with confidence and clarity", to DBI Level 2. This second level is provided by trained third sector staff who contact the person within 24-hours and provide "compassionate, problem-solving support, wellness and distress management planning, supported connections and signposting for a period of around 14 days".

Professor O'Connor concluded: "We need to make sure that compassion is embedded everywhere but, also, we need to be self-compassionate. As John Gibson said, in introducing the conference, it's tough working in this area. We all have our own experiences. We need to look after ourselves and be kind to ourselves. We need to embrace the complexity. We need to rethink models of care.

"Lastly, there is connection. Anything we can do that promotes human connection, potentially saves lives. Anything we can do, which interrupts those suicide thoughts – we know suicidal thoughts cause a wave of intensity – anything we can do, a WhatsApp message, a phone call, a smile, can save people's lives."

> **"WE NEED TO MAKE SURE THAT COMPASSION IS EMBEDDED EVERYWHERE BUT, ALSO, WE NEED TO BE SELF-COMPASSIONATE"**

If you need help, you can talk to someone at any of the organisations listed at thecanmoretrust.co.uk/get-help-now

References

[1] thecanmoretrust.co.uk

[2] www.iasp.info

[3] www.ripplesuicideprevention.com

[4] www.emilytest.org

[5] richardmccann.co.uk

[6] www.gov.scot/policies/mental-health/suicide

[7] www.mqmentalhealth.org/a-roadmap-to-prevent-people-being-gone-too-soon

[8] www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(23)00058-5/abstract

[9] suicideresearch.info/the-imv

[10] www.dbi.scot

The regulator's view

Theresa Thorp, Executive Director of Regulation at the GDC, spoke at the conference. She said: "We are aware of the acute pressures within the NHS and access, in particular, to NHS dental services. We recognise that this has an impact on the wellbeing of patients and dental professionals. Overall, the dental sector and those who work in it are experiencing a lot of pressure."

GDC commissioned research had shown that while most registrants who had been involved in fitness to practise investigations or hearings perceived the outcome to have been fair, they added that the process itself had negatively impacted their health, wellbeing, behaviour and practice. In the week of the conference, the GDC reported on dental professionals who died while fitness to practise concerns were investigated or remediated.

The report made clear that some individuals took their own life while fitness to practise concerns were being investigated or remediated. "Any death by suicide is a tragedy," she said. "The impact on the health and wellbeing of dental professionals during what we know can be a difficult and stressful process is of deep concern to us. In addition to acknowledging that the GDC must do better, the GDC's report serves as a call for everyone in the dental sector to reflect on the environment, systems and processes involved in being a dental professional.

"Looking ahead, the GDC's direction of travel is moving towards supporting positive professional practice and away from an enforcement culture. We want to help practitioners to avoid becoming subject to regulatory proceedings in the first place. One way we do that is by setting and assuring the standards for undergraduate education, to ensure that people joining the register are safe. Another is that we provide guidance on the professional standards required throughout a dental professional's career.

"There is more we would like to do to share learning from fitness to practise, and to work with stakeholders to help dental professionals to understand what is expected of them. Ultimately within fitness to practise, we want to get faster, without compromising quality outcomes, and make sure the process is fair to witnesses and registrants. And this is to serve our overarching objective, which is to protect the public."

Theresa Thorp's full speech can be read here: www.sdmag.co.uk/canmore-conference-regulators-speech

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ACCESS ALL AREAS?

With public dental services under increasing pressure the focus is on providing care to core patient groups

I was humbled and honoured when I was asked to be presidentof the BDA's Community Dental Services (CDS) Group by my colleagues on the management committee, *writes Graham Smith.*

The last Scottish president of the group was the late Jackie Morrison, whom we sadly lost earlier this year. Many will recall attending his presidential conference in 2009, which was held at the Radisson Blu Hotel in Glasgow. Jackie was fondly remembered with a round of riotous applause after a moving tribute from David Paul.

The presidency changes every year (the exception being during the pandemic) and the incoming president hosts the annual conference and scientific meeting in their home area; my area being Scotland-wide. I became president-designate in 2020. The pandemic ensured that I didn't take office until 10 October this year, so I've had quite a long time to plan the conference!

I wanted to make it a memorable one for delegates and showcase Scotland. Sarah Rockliff, senior local services manager at the BDA, and the wider BDA team were a huge support to me and ensured that the event was planned and executed so professionally.

The conference itself began with a networking event on 9 October. The regional and national divisions met for an informal discussion. This was followed by a social event with food and a quiz at Brewhemia, Edinburgh. The presidential dinner and drinks reception were held at the Royal College of Physicians of Edinburgh on 10 October. Guests were piped into the historic venue in Edinburgh's New Town, and enjoyed an excellent ceilidh after the dinner.

The main conference was held at Murrayfield Stadium on 10 and 11 October when we welcomed more than 200 delegates to the city. I first visited the stadium nearly 50 years ago, when I stood as a schoolboy on the old open terraces to see Scotland defeat the mighty Wales team of that era. Nowadays, the stadium has changed beyond recognition and we were accommodated very comfortably in the president's suite. It did amuse me to think we were sharing a venue not only with the legends of Scottish and world rugby but also with the likes of Bruce Springsteen, Oasis and Taylor Swift.

The theme of the conference was 'Access all Areas?'. I chose this to reflect access in the widest sense. Access to dental care is a real issue for the whole population at present, but as Public Dental Services (PDS) come under increased pressure due to lack of General Dental Service (GDS) access, I wanted to highlight our core patient groups and how we provide dental care to them.

I thought we had a really good mix of presentations, which were all relevant to PDS dentists. We had excellent speakers on both days, discussing topics such as delivering dental care to bariatric patients, sedation and general anaesthetic for special care patients, paediatric dentistry, medication-related osteonecrosis of the jaw, dentistry for homeless patients and prisoners, and delivering realistic dental care for older patients. We had an excellent overview on access for vulnerable patient groups and about accessing self-care, and how we need to care for ourselves to enable the best standard of care for our patients.

A new feature this year was a panel discussion on careers in the CDS and PDS, and the challenges our services face going forward. As well as the main programme we had our annual poster competitions. The standard is always excellent, and this year was no exception. There were 11 exhibitor stands present on the day which were well visited by delegates. We are especially thankful to our main sponsor, Wrights.

One of the huge benefits of having PDS/CDS topics over two full days is being able to meet and chat to colleagues. Some I had known for a long time. Professor Marie-Therese Hosey and Dr Carol Boyle were in my year at the University of Glasgow (1985), so we actually met 44 years ago.

Others I was meeting having only chatted via Teams or Zoom, and of course it was a real pleasure to meet new colleagues from all over the UK for the first time. I found it interesting to get an idea of what is happening in different parts of the UK, meeting up with like-minded people and realising we are facing similar problems.

There was a widespread consensus amongst delegates that the PDS is facing challenges. Recruitment issues were a recurring theme as I spoke to colleagues, particularly to Band A (dental officer) posts, but also to senior and specialist grades. In fact, more than one senior colleague remarked that their service no longer advertises Band A posts, as they know they have little chance to attracting candidates.

It was always the case that the PDS found it harder to recruit to remote, rural and Island posts, but now even posts in urban centres remain unfilled. The PDS faces an additional pressure in that it has an aging workforce. Many PDS dentists are approaching retirement and this, coupled with an increasing struggle to recruit, leaves the service facing a potential crisis in the next few years.

The PDS is valued by its patients. I certainly think that if it did not exist then you would have to invent it. The service has shown its adaptability, no more so than during the pandemic. I'm sure it will continue to evolve and adapt going forward. I only hope that government values it too, and has the vision to develop its potential and allow it to do what it does best; caring for some of the most vulnerable, marginalised and fragile patients in our society.

During my 12 months as president, I plan to promote the work of the CDS group and highlight its value to CDS/PDS dentists, providing an opportunity for CPD which is tailored to a CDS/PDS clinicians and a chance to network and socialise with dentists from across the UK who provide dental care to a similar mix of patient groups.

Details of the presentations can be found here www.bda.org/media/03qlnzfe/cds-group-conference-2024-programme.pdf

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.

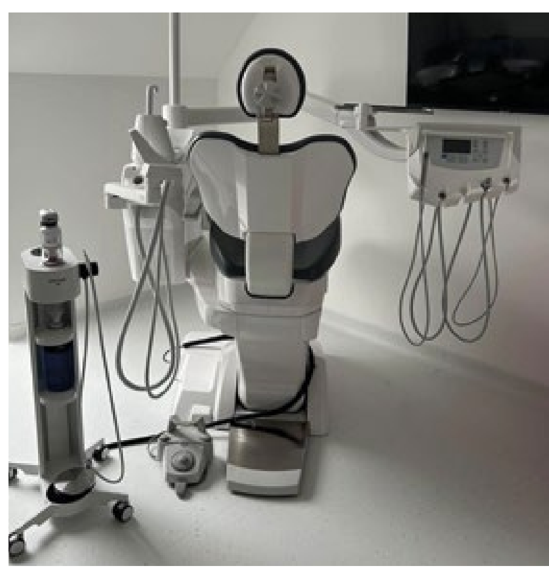
"IWT was involved in the early stages of planning to install all of our dental chairs, the LDU and X-ray equipment as well as the IT/AV offering," said Kay. "They collaborated with both our architect and builder throughout the project to ensure that nothing was a surprise along the way.

"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 audio visual equipment that we have in every area of the clinic."

HOW DID THE PROCESS WORK?

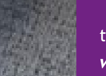
"They attended planning and site meetings – assisting me in the preparation of the new space, back when it was a blank canvas – working out the correct equipment for the practices needs.

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, 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 all at IWT and is testimony to their dedicated team of expert technicians and the exceptional service they provide.

www.iwtech.co.uk

PART 2

THE PRINCIPLES IN PRACTICE SERIES: SHARED DECISION MAKING

Shared decision making – what it is and how to practise it to deliver outcomes that matter to patients

aking the most appropriate decision is becoming increasingly complex for both patients and professionals. It is known that healthcare providers can have differing perceptions of their patients' need for information[1] and their preferences for involvement in decisions about their own health[2].

Shared decision making (SDM) allows the dental team and patients to navigate these decisions together in a collaborative way. SDM moves communication away from a "Dentist knows best" philosophy towards a more personalised approach to care.

What is shared decision making?

SDM is a process by which patients and healthcare professionals work together to choose investigations and treatments based on a combination of clinical evidence, clinical judgement and the patient's informed preferences. It is a vital component of person-centred care. SDM itself is not new, and many will believe they practise it already; however, it is important to highlight that SDM goes beyond the provision of opinion (paternalistic) and information (informative) to the patient[3]. True shared decision making is a two-way exchange of these between clinicians and patients (Figure 1).

While most practitioners aim to arrive at the best clinical decision, they can miss the opportunity for bidirectional sharing of knowledge and information. The only way to achieve true shared decision making is through meaningful conversations with patients. This involves a two-way exchange of clinical knowledge and expertise and patients contributing knowledge of their own preferences, values, risk tolerance and their concerns.

How to practice shared decision making

There is a range of tools that patients and healthcare professionals can use in partnership, to facilitate meaningful conversations. They focus on discussing risks and benefits in ways patients can understand.

One such example is the BRAN tool. BRAN – an acronym for: Benefits, Risks, Alternatives or do Nothing – is a tool comprising questions to support patients make informed choices about their care

Figure 1: the spectrum of shared decision making. Adapted from Dignity in Action[4]

SHARED DECISION MAKING

SWEET SPOT FOR SDM

PATERNALISTIC

CLINICIAN: *This tooth is heavily decayed and can't be restored. I recommend we take it out, and we can restore the space with a bridge... let me tell you about the risks and benefits...*

CLINICIAN: What matters to you most with this tooth? Is it being pain free, having it restored to how it was, or something else?

PATIENT: The most important thing for me is to be pain free, and if I can still chew, then, I'd like the option with the least effort/appointments. I would really struggle to make the appointments.

CLINICIAN: There are numerous options, including...

...Given that you've said being pain free is most important and you can still eat the food you enjoy, I think we could monitor this for the time being. What do you know about replacing teeth, if the time came?

INFORMATIVE

CLINICIAN: *The tooth is heavily decayed and can't be restored. There are numerous approaches to this. Here are all the options, and their risks and benefits. Let me know which you think you'd prefer...*

and treatment options. The BRAN tool is promoted as part of the NHS24 'It's OK to Ask' national campaign[5], the aim of which is to raise awareness of the 'BRAN' questions amongst patients and the public, encouraging them to ask questions and become involved in their own care.

The questions are:

- What are the **Benefits**?
- What are the **Risks**?
- What are the **Alternatives**?
- What if we do **Nothing**?

Patient interviews and focus groups conducted by Dr Heather Cassie and funded by The Healthcare Improvement Studies (THIS) Institute[6], with patients from across the UK, explored the use of SDM in the context of reducing unnecessary tests and treatments in primary care dentistry.

Findings identified a need for information to help them understand the decision-making processes around their treatment options and a desire to be more involved in conversations about their care.

> *"I think for me the most important thing is communicating that [risk assessment process] to the patient and how that decision's been come to and arrived at and communicated in a clear and accessible way."* - Patient 1
>
> *"If your dentist is offering you these treatments, ask them why, ask them why that treatment works, what are the benefits of that treatment? What would happen if you don't get it? Get the facts straight first before you agreed to get it."* - Patient 14

When asked about using the BRAN tool to structure conversations, one focus group participant commented:

> *"It is stimulating and reassuring to see dentistry doing this. It's just brilliant. It's very, very responsible. The message you're giving out to people like me is that you are compassionate about your patients."*

D — Define the decisions and expectations

Explain: share personalised information, check and clarify understanding

Consider options: Benefits, Risks, Alternatives, No action

Invite views: values, beliefs, matters, life context

Decide together: weigh priorities

Evaluate the decision: review, check understanding, follow-up actions

Figure 2: the DECIDE tool for structuring conversations with patients. Adapted from Realistic Medicine Shared Decision Making (DECIDE)[9]

Another tool to support structuring conversations is the DECIDE model[7,8,9], shown in Figure 2. BRAN and the DECIDE are included in the NHS Education for Scotland 'Having Realistic Conversations' training resource[10]. DECIDE is also recommended across Scotland for structuring conversations with patients to involve them in decisions about their care.

Conclusion

Having meaningful, open conversations about a patient's care allows you to really hear your patient, leading to decisions that are right for them, and outcomes that matter to them. Shifting the paradigm to this default takes time and concerted effort from clinicians and patients alike. However, granting patients the ability to involve themselves more actively in their care allows a sharing not only in decision making, but in responsibility for their own oral health.

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5 It's OK to Ask | NHS inform.

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8 Guo, Kristina L. PhD, MPH. DECIDE: A Decision-Making Model for More Effective Decision Making by Health Care Managers. The Health Care Manager 39(3):p 133-141, 7/9 2020. Available at: DOI:10.1097/HCM.0000000000000299.

9 Shared Decision Making (DECIDE) | Turas | Learn.

10 Having Realistic Conversations | Turas | Learn

FACULTY UNVEILS NEW DIPLOMAS RECOGNISING ENHANCED SKILLS

Exams will assess and recognise dental practitioners who have gained enhanced expertise

WORDS
WILL PEAKIN

The Royal College of Surgeons of Edinburgh's Faculty of Dental Surgery (FDS) has launched a new and innovative suite of examinations designed to formally assess and recognise dental practitioners who have gained enhanced skills and expertise in a defined area of dental practice.

While the pathway, assessment and recognition of dentists who have undertaken specialty training is long established, many dentists develop an interest in one or more branches of dentistry which they pursue through academic endeavour, attending meetings and conferences, or undertaking short training courses and university programmes.

This professional commitment generally goes unrecognised, and the aim of the Diploma examinations is to provide evidence and benchmarking of this self-development.

The level and curriculum of these new Diploma examinations is based on the skills required for providers of Level 2 Complexity of Care as defined by NHS England, or that of a dentist with a special interest.

The first Dental Diploma Examinations to go live in 2025 will be Dental Sedation, Paediatric Dentistry, and the Restorative single specialty examinations, namely Endodontics, Periodontics and Prosthodontics. Oral Surgery and Oral Medicine Diploma Examinations will follow.

Each examination will comprise single best answer and clinical case questions which will be fully digital. The RCSEd quality assurance standards mean that question writing, blueprinting, standard setting, examiner calibration and psychometrics will continue to be part of the process. These provide reassurance that the holder of one of the Dental Diplomas has reached a pivotal point in their career where their commitment has been recognised by one of the world's most respected awarding bodies.

These Diplomas are not intended to replace full specialty training pathways and successful practitioners will not be able to call themselves specialists but can claim to have been tested in these specific areas to a high standard.

Professor Grant McIntyre

The qualification may be simply for self-reflection or may act as a first step in career progression into a chosen specialty.

Successful candidates may also wish to use these qualifications as part of their portfolio of evidence towards Level 2 service commissioning, or as part of the portfolio for mediated entry applications to specialist listing as their career develops.

Successful completion of a Diploma examination allows successful candidates to use the post-nominals Dip RCSEd and bestows the benefits of being a Dental Associate of the College.

Professor Grant McIntyre, Dean of the Dental Faculty at the RCSEd, said: "With our long history of quality assured assessments for the whole dental profession, these new diplomas provide an opportunity for dentists, both from the UK and countries across the world, to test their learning and understanding in one or more areas of dental practice, and evidence their achievements to themselves and their patients."

More information and to sign-up to take part, visit: tinyurl.com/56zez27x

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The programme has become the 'go to' for dental guidance

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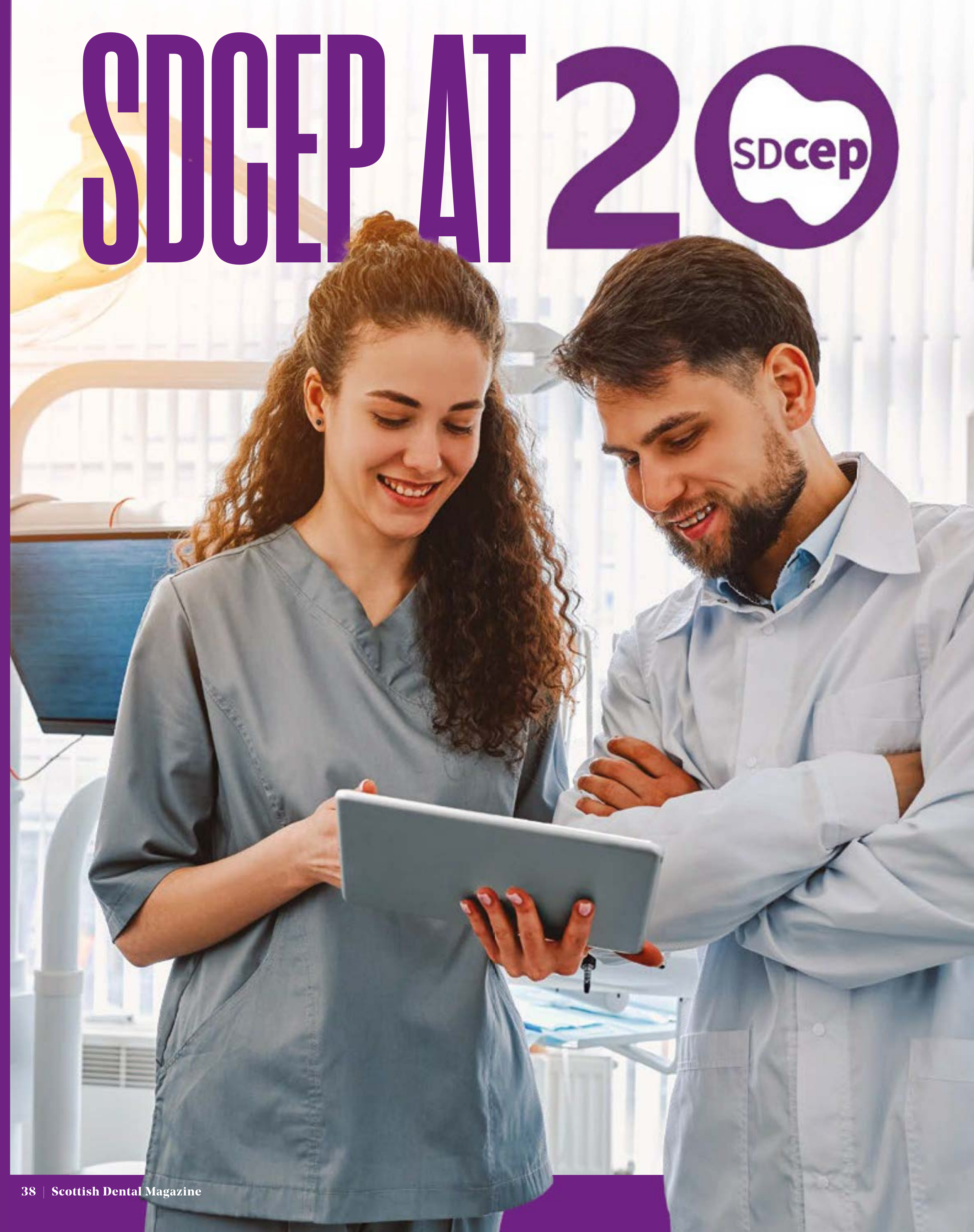

he Scottish Dental Clinical Effectiveness Programme (SDCEP), operating within NHS Education for Scotland, is a well-regarded source of user-friendly, evidence-based guidance for dental teams and, in some cases, other healthcare professionals. 2024 marks SDCEP's 20th anniversary and much has been achieved in the last two decades.

"In the early 2000s, Scotland's National Dental Advisory Committee identified a need for guidance on priority topics for the dental profession," said Professor Jan Clarkson, SDCEP's Director. "However, at that time there was no obvious means of achieving this. Scotland's Dental Action Plan funding subsequently provided the opportunity to create something new. In July 2004, encouraged by the then Chief Dental Officer Ray Watkins and backed by the NHS Education for Scotland's Postgraduate Dental Dean Jim Rennie, a guidance development programme was established."

With Derek Richards as Specialist Advisor, Professor Jeremy Bagg chairing a steering group and Dr Doug Stirling leading guidance development, the SDCEP name was soon adopted, and a distinctive brand emerged with the first guidance publication in 2006, *Conscious Sedation in Dentistry*.

Dental sedation was one of several guidance topics assigned to SDCEP from the outset. Others included instrument decontamination, drug prescribing, dental caries in children, oral health assessment and emergency dental care. SDCEP has also responded to requests from the profession for guidance on emerging concerns, such as drugs associated with osteonecrosis of the jaw, periodontal care, and novel anticoagulants and, since 2010, has provided advice on practice management and quality assurance via the online Practice Support Manual.

"EVOLVING A RIGOROUS METHODOLOGY HAS BEEN CRUCIAL TO SDCEP'S SUCCESS IN PROVIDING RESOURCES THAT ARE BOTH EVIDENCE-INFORMED AND USER-FRIENDLY"

"Evolving a rigorous methodology has been crucial to SDCEP's success in providing resources that are both evidence-informed and user-friendly," said Doug Stirling. "To ensure end-user input, for each guidance topic a Guidance Development Group is convened made up of representatives of the profession and other stakeholders, including patients and chaired by a clinical lead. In 2016, SDCEP became the only dental organisation to gain National Institute for Health and Care Excellence (NICE) accreditation for its guidance development process, which signifies quality and reliability."

SDCEP also has a long-standing and valuable collaboration with Cochrane Oral Health and other links with the Royal Colleges and several specialist societies help achieve efficiencies and consistent messaging.

Fundamental to achieving NICE accreditation has been the contribution of SDCEP's partner programme Translation Research in a Dental Setting (TRiaDS), led by Dr Linda Young. "It's through the work of TRiaDS that stakeholder views, current practice and potential barriers to implementation of guidance recommendations are identified and we evaluate guidance implementation." said Dr Young.

"TRiaDS also informs, designs and tests theoretically guided interventions to promote guidance implementation. In this way, TRiaDS adds to SDCEP's understanding of professional behaviour change in healthcare – eliciting which interventions work and in what circumstances."

In addition to developing guidance, SDCEP has responded to requests from the profession in other ways, such as providing 'implementation advice' about reducing dental amalgam use and antibiotic prophylaxis for infective endocarditis, which is cited in the related NICE guideline and highlights the quality and relevance of SDCEP's work. Similarly, throughout the COVID-19 pandemic, SDCEP provided several resources to support practices and policy decisions, including a practice recovery toolkit and rapid reviews on aerosol generating procedures and ventilation. Use of SDCEP products is not restricted to Scotland, having become recognised as a valuable resource throughout the UK and beyond. The guidance is used extensively in undergraduate and postgraduate education and has been adopted in numerous other countries.

Going forward, SDCEP has moved from providing its guidance in conventional printed or pdf format to website delivery. This helps ensure users have access to the most recent information and makes focused updating more practical. With heightened concerns about the climate crisis, SDCEP has started highlighting how following recommendations in its guidance can help practices provide care more effectively and efficiently, thereby contributing to reducing the environmental impact of oral healthcare.

NHS Education for Scotland's Dental Director, Professor David Felix said, "Over the past 20 years, working closely with the profession, SDCEP has evolved to become the 'go to' for dental guidance. Many thanks must go to SDCEP's unique and skilled team and to the many dental colleagues and other contributors who, have willingly given their time and shared their expertise to help craft SDCEP resources that are evidence-based, user-friendly and greatly valued."

www.sdcep.org.uk
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REIMAGINING DENTAL EDUCATION

A virtual reality journey from Kuopio, Finland

A study[1] conducted at the Institute of Dentistry University of Eastern Finland in Kuopio has shed new light on the effectiveness of virtual reality (VR) haptic reinforced preclinical training in dental education.

The key findings were:

• Improved learning outcomes: the research revealed that combining VR haptics with conventional tooth preparation exercises can enhance students' learning outcomes.

• Increased confidence: more than two-thirds of the students reported improved self-confidence after practicing in the VR haptic environment.

• Practical benefits: students appreciated the practicality of the exercises and the immediate feedback provided by the VR equipment.

• Clinical measurements: The group that started with VR haptic training showed more consistent and closer-to-ideal tooth preparations in their final exams, with less damage to neighbouring teeth.

The study highlights the potential of VR haptic technology to revolutionise dental education. It offers students the opportunity to practice unlimited times in a low-stress environment, complementing traditional hands-on training. While the research demonstrates promising results, it also notes that further studies are needed to fully integrate VR haptics as a primary learning method in preclinical dental education. This pioneering research not only contributes to the field of dental education but also showcases the potential for student involvement in cutting-edge research, paving the way for future innovations in dental training methodologies. This study highlights the potential of VR-haptic technology to enhance learning outcomes in preclinical education, making training more effective and accessible.

Background

In 2022, our supervisors Dr Outi Huhtela and Dr Szabolcs Felszeghy, members of the UEF VR and Haptic Thinkers (uefconnect.uef.fi/en/vr-haptic-thinkers), curious about the buzz surrounding VR and haptic technologies, initiated a study to explore the effectiveness of virtual reality haptic training. They divided 40 preclinical students into two groups on a prosthodontic course. One group began with VR-haptic training, while the other continued with traditional plastic tooth exercises. Midway through the study, the groups switched their training methods.

The results:

• Confidence boost: more than two-thirds of the students reported feeling more confident in their skills after practising in the virtual environment.

• Enhanced precision: students who started with VR-haptic training demonstrated greater accuracy in tooth preparations and caused less damage to adjacent teeth during their final exam.

The student authors

• Flexible practice: the VR system allowed students to practice at their convenience without depleting physical resources, eliminating the struggle over limited lab time.

• Instant feedback: the VR-haptic system provided immediate feedback, akin to having an instructor with x-ray vision guiding students through their exercises.

• Low-stress environment: mistakes made in the VR setting did not result in wasted materials or embarrassment; students could simply click to retry and improve their performance.

Reference

[1] VR-haptic and phantom head dental training: Does the order matter? A comparative study from a preclinical fixed prosthodontics course pubmed.ncbi.nlm.nih.gov/37823540/

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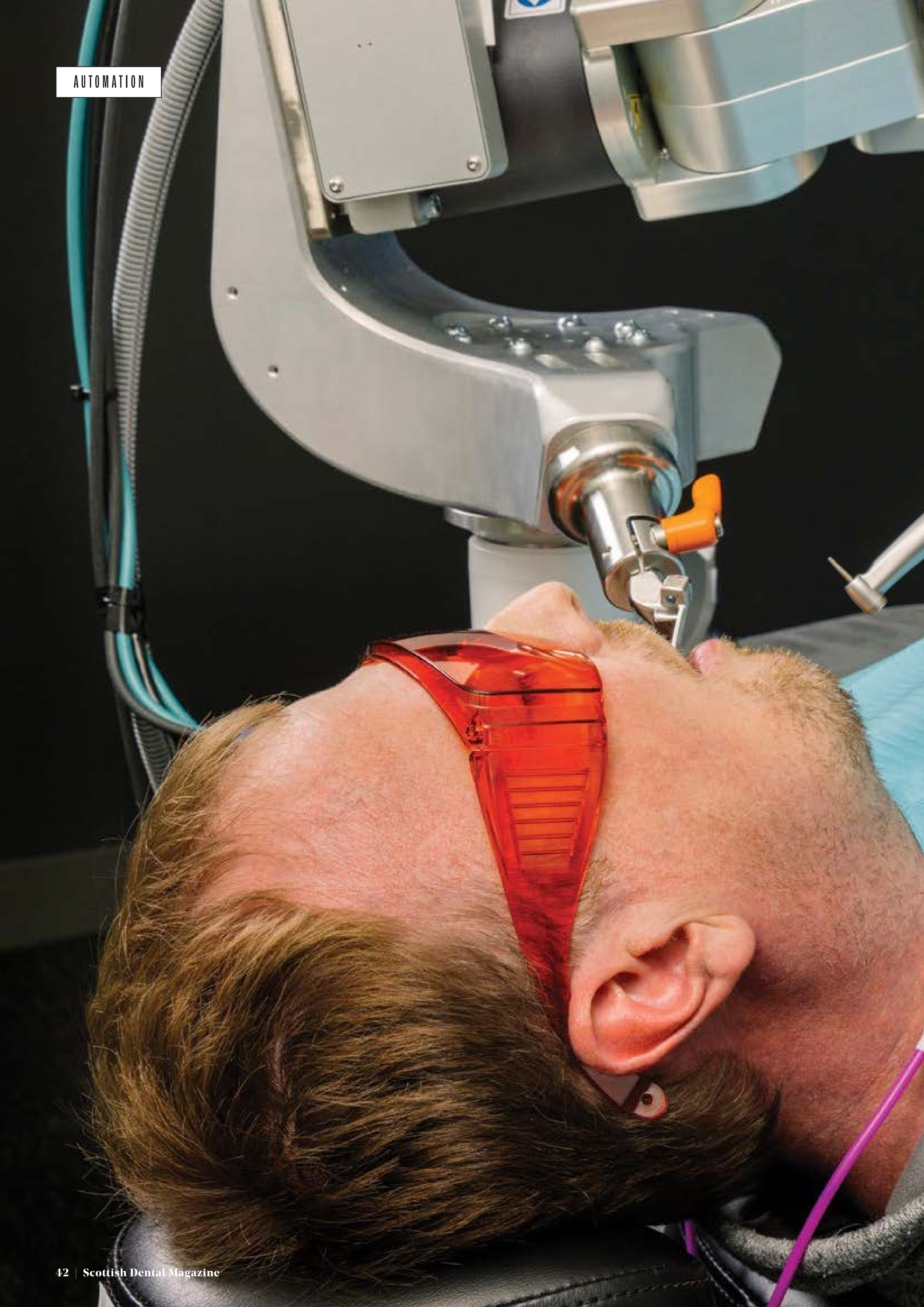

OPEN WIDE

WORDS
CHRIS CIRIELLO

How AI, robotics and 3D imaging will transform patient care

The healthcare landscape is changing at an astonishing rate with the advent of artificial intelligence (AI). Notwithstanding all the advances, dentistry has been slow to adopt AI, despite numerous technological innovations in the last decade – from digital X-rays and intraoral scanners to the adoption of 3D printing. While these tools have undoubtedly improved dental care, the industry is now on the cusp of a far more transformative leap: the integration of AI, robotic systems and 3D imaging technologies.

This new wave of innovation promises not just to improve diagnostics and treatment but to revolutionise the very way dental care is delivered. AI-driven robotic platforms, combined with cutting-edge imaging technologies, could enable fully automated dental procedures, increase diagnostic accuracy, and reduce the need for invasive treatments. This new era will provide patients with safer, faster, and more personalised care while making dental practices more efficient and accessible.

But what exactly will this technological transformation look like? How will it impact the way dentists diagnose and treat patients? And perhaps most importantly, what will it mean for the millions of people who currently avoid or delay dental care due to anxiety, cost, or lack of trust in the system?

Challenges in modern dental practice

Before delving into the future, it's worth examining the challenges that persist in today's dental care. Despite many technological advancements, dentistry still faces several limitations that can impact both patient outcomes and experiences.

One of the primary challenges is diagnostic accuracy. Traditional X-rays, while widely used, often fall short in detecting the full range of dental issues. For instance, X-rays only provide about 30 per cent diagnostic accuracy, meaning that many problems such as early-stage cavities, cracks, or issues beneath the gum line can go unnoticed. This can lead to delays in treatment and the potential for more severe issues down the road.

Another issue is patient trust and understanding. Many patients, particularly those without visible symptoms or pain, are often sceptical of diagnoses based on X-ray images that are difficult to interpret. This scepticism is reflected in treatment acceptance rates. Around 70 per cent of patients decline recommended dental treatments, often because they do not fully understand the diagnosis or the necessity of the procedure. This reluctance to proceed with treatment can exacerbate oral health problems, leading to more invasive and costly interventions down the line.

Beyond the diagnostic and patient communication challenges, there's also the issue of time and efficiency. Many dental procedures require multiple visits, long chair times, and significant waiting periods for lab work, such as dental crowns or bridges. This not only inconveniences patients but also puts a strain on dental practices, limiting the number of patients a practice can effectively serve.

Taken together, these challenges highlight the need for a more efficient, accurate, and patient-friendly approach to dental care. Fortunately, recent advances in AI, robotics, and 3D imaging technologies offer the potential to address these issues head-on.

A new era of precision and efficiency

One of the most exciting developments in dentistry is the integration of AI and robotics into the treatment process. While these technologies are already making waves in fields like surgery and radiology, their application in dentistry is only just beginning. However, the potential impact is profound.

AI has the power to revolutionise how dentists interpret diagnostic images, manage treatment plans

and even predict patient outcomes. By analysing vast amounts of data from previous cases, AI algorithms can help dentists identify patterns and anomalies that might otherwise go unnoticed. For example, AI can be trained to detect early signs of oral diseases, such as periodontal disease or oral cancer, at a level of precision far beyond human capabilities. This can lead to earlier interventions and better outcomes for patients.

In addition to diagnostics, AI can assist in treatment planning by providing predictive models for how a patient's condition will progress. This allows dentists to offer more personalised care, tailored to the specific needs and risk factors of each patient. For instance, AI can predict how a patient's teeth will shift over time, enabling orthodontists to create more accurate and efficient treatment plans for braces or clear aligners.

Robotics, meanwhile, are set to transform the way dental procedures are performed. Robotic systems can assist dentists in performing high-precision tasks, such as drilling, cutting, and placing implants, with an accuracy that surpasses the human hand. By eliminating the variability and fatigue that can affect human practitioners, robotic systems offer a level of consistency and reliability that can significantly improve patient outcomes.

Robotic systems can assist dentists in performing high-precision tasks

The potential for fully automated dental procedures is already becoming a reality. In the future, robotic systems could take over routine tasks, such as filling cavities or performing cleanings, allowing dentists to focus on more complex cases or patient communication. This would not only increase the efficiency of dental practices but also reduce the risk of human error, improving the overall quality of care.

The rise of 3D imaging technologies

While AI and robotics promise to enhance the precision and efficiency of dental procedures, 3D imaging technologies are poised to revolutionise diagnostics and patient communication.

Traditional X-rays provide a two-dimensional image of a highly complex, three-dimensional structure. This can make it difficult for dentists to accurately assess the full extent of a problem, particularly in hard-to-reach areas beneath the gums. Moreover, the flat, black-and-white images produced by X-rays are often confusing or unconvincing to patients, leading to scepticism and lower treatment acceptance rates.

> "THE POTENTIAL FOR FULLY AUTOMATED DENTAL PROCEDURES IS ALREADY BECOMING A REALITY"

3D imaging, by contrast, offers a far more detailed and accurate view of the patient's oral structures. Technologies such as optical coherence tomography (OCT) provide high-resolution, cross-sectional images that allow dentists to see inside the tooth and below the gum line with unprecedented clarity. This level of detail enables the early detection of issues like cavities, cracks, and infections that might otherwise go unnoticed until they cause more severe problems.

More importantly, 3D imaging can help build trust between dentists and patients. When patients can see a clear, three-dimensional image of their dental problem, they are far more likely to understand the need for treatment and agree to the recommended procedures. This not only improves patient outcomes but also helps dental practices build stronger relationships with their patients.

The combination of AI-driven 3D imaging and robotics could be particularly transformative in the diagnosis and treatment of complex dental issues. For example, AI could analyse 3D images to identify potential problems, while a robotic system could perform precise, minimally invasive procedures to address the issue. This integrated approach would enable earlier, more accurate interventions, reducing the need for invasive treatments and improving patient satisfaction.

The Perceptive Technologies team

Real-world applications of AI and robotics in dentistry

While many of these technologies are still in the early stages of development, there are already promising examples of AI, robotics and 3D imaging being applied in dental practices around the world.

One recent example is the world's first fully automated dental procedure performed by a robotic system, which was conducted by our team at Perceptive Technologies. In this groundbreaking trial, a robotic arm, guided by AI-driven 3D imaging, successfully performed restorative dental work on a human patient.

The system completed the procedure for a dental crown in just 15 minutes, compared with the two lengthy office visits typically required for similar procedures. This trial not only demonstrated the potential for robotics to improve the efficiency and accuracy of dental procedures but also highlighted the feasibility of fully automated dental care in the near future.

In another case, AI-powered imaging software has been used to analyse dental X-rays and detect signs of decay and gum disease that even experienced dentists might miss. This software has been shown to significantly improve diagnostic accuracy, particularly in the early stages of disease when treatment is most effective. As AI algorithms continue to improve, they will become an invaluable tool for dentists, helping to ensure that no potential problem goes unnoticed.

As these technologies continue to develop, the future of dentistry will continue to evolve. AI, robotics, and 3D imaging have the potential to address many of the challenges that have long plagued the field, from missed diagnoses and delayed treatments to patient scepticism and inefficient procedures.

For patients, the benefits are clear. These technologies will enable earlier detection of dental issues, more personalised treatment plans, and less invasive procedures, leading to better overall oral health. Moreover, the increased accuracy and transparency provided by 3D imaging will help build trust between dentists and patients, encouraging more people to seek care and adhere to treatment recommendations.

For dentists, the integration of AI and robotics will streamline workflows, reduce the risk of human error, and allow practitioners to focus on what matters most: providing high-quality, personalised care to their patients. These technologies will also enable dental practices to see more patients in less time, improving both efficiency and profitability.

Of course, the widespread adoption of these technologies will require significant investment and training. Dental schools and continuing education programmes will need to adapt their curricula to ensure that practitioners are well-versed in the use of AI, robotics and 3D imaging. Regulatory bodies will also need to establish guidelines and standards for the safe and effective use of these technologies in clinical practice.

Despite these challenges, the potential benefits of AI, robotics and 3D imaging in dentistry are too great to ignore. As these technologies continue to evolve, they will undoubtedly transform the way dental care is delivered, improving both patient outcomes and the overall dental experience.

In the not-so-distant future, a visit to the dentist may look very different from today. Instead of treatments involving more than one appointment, and that cumulatively take hours to complete, patients could receive a precise diagnosis and minimally invasive treatment – all within a matter of minutes. And with AI, robotics and 3D imaging leading the way, dentistry will become more efficient, more accurate and more patient-centred than ever before. The future is bright for dental care – and for the millions of people who will benefit from these technological advancements.

Dr Chris Ciriello is the Founder and Chief Executive of Perceptive Technologies.
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AI-powered imaging software has been used to analyse dental X-rays and detect signs of decay and gum disease that dentists might miss

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Originally from Italy, Giulia graduated in dentistry from the University of Genova in 2008. In 2013 she completed her postgraduation specialisation in orthodontics, followed by her masters at University of Cagliari.

She's worked as an orthodontist in a paediatric hospital in Genova, teaching undergraduates and has been involved in clinical research to identify new therapeutic approaches for patients affected by rare genetic syndromes. Giulia has published several articles in international journals, collaborating with Seton Hill University, USA. She moved to the UK in 2015 and worked in Edinburgh and London practices. She's now settled in Edinburgh with her family.

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WHAT'S IN A NAME?

"WHAT'S IN A NAME? THAT WHICH WE CALL A ROSE BY ANY OTHER NAME WOULD SMELL AS SWEET"

– WILLIAM SHAKESPEARE.

Perceived effective and ineffective dental terminology when treating paediatric patients: a cross-sectional survey

WORDS
MAIREAD HENNIGAN, ALICE HAMILTON AND ANTONIELLA BUSUTTIL-NAUDI

In paediatric dentistry, Shakespeare's line is not necessarily the case. The careful choice of wording and the use of descriptive language or euphemisms to explain procedures may be the difference between the acceptance or refusal of treatment by a child. Explaining procedures in a way that a child can understand results in a reduction in their fear.

In its latest handbook, the *American Academy of Pediatric Dentistry* states that "successful treatment of paediatric dental patients depends on effective communication". Successful communication should be uncomplicated, specific, minimise jargon, use repetition and be appropriate for the patient's understanding, as well as using a patient-centred approach. Using child-friendly language, or 'Childrenese', to substitute words for more acceptable phrases is an effective way to communicate with children.

Recent articles have highlighted the importance of awareness around jargon use in a dental setting for the adult patient; however, there is a lack of studies exploring this for paediatric dental patients. The authors are aware of only one large study, which was published more than 40 years ago, highlighting effective terminology used for paediatric patients. Since publication of this study in the 1980s, techniques, materials, pop culture and social boundaries have changed.

We conducted a Scotland-wide survey which investigated the word preferences used by paediatric dental team members when treating children. The aim was to provide members of the dental team who have limited experience of paediatric dentistry, those who have recently graduated, or those who wish to improve their communication with children, with a selection of perceived effective and ineffective words when describing common treatments to paediatric patients. A voluntary, anonymous survey was disseminated to NHS dental team members who routinely treat paediatric patients in the community public dental service (PDS) and hospital dental services (HDS) throughout Scotland. There were 209 responses to the survey, which was sent to 1,054 participants: a response rate of 19.8 per cent. The respondents – of whom 41 per cent were dental nurses, 35 per cent were dentists who worked in community, 10 per cent were dental hygienists or therapists, and 4 per cent were paediatric specialists or consultants – worked in 11 different health boards across Scotland.

There is clearly a wide variety of replacement terms in use in paediatric dentistry in Scotland. While options are limited only by the imagination of dental team members, some favourite words are evident; the top word choice in each of the dental terms was selected

Fluoride varnish	Special toothpaste varnish (n=81)	Special paint (n=80)	Banana paste (n=77)
Fissure sealant	Protective coating (n=163)	Plastic coating (n=89)	Fissure sealant (n=80)
Composite restorations	White/tooth coloured filling (n=198)	Bandage/plaster (n=64)	Composite filling/restoration (n=29)
Preform metal crown	Silver/metal cap (n=117)	Silver/metal hat (n=108)	Princess crown (n=108)
Extraction	Wiggle/wobble (n=173)	Take tooth out (n=121)	Tooth fairy reference (n=108)
Local anaesthetic	Put to sleep (n=136)	Sleepy juice (n=118)	Numbing medicine (n=82)
Inhalation sedation	Happy gas (n=119)	Laughing gas (n-103)	Special air through the nose (n=75)
General anaesthetic	Go for a sleep (n=121)	Put to sleep (n=98)	General anaesthetic (n=51)
Rubber dam	Rubber cover/sheet (n=87)	Stretchy cover/sheet (n=84)	Coat/jacket/raincoat (n=67)
Drill	Electric toothbrush (n=145)	Buzzing/buzzer (n=118)	Tooth polisher (n=88)
Aspirator	Hoover/vacuum (n=201)	Straw (n=90)	Sucker (n=64)

Table 1: The three most commonly reported words/phrases to describe the given dental terms in order of most used

Dental term	Respondent percentage	Ineffective words
Local anaesthetic	45.5%	Injection, jag/jab, needle, sharp scratch
Fluoride varnish	34.4%	Banana, paint
Extraction	32.1%	Extraction, pull
Dental drill	27.8%	Drill, bee
General anaesthetic	15.8%	Put to sleep, general anaesthetic, knocked out, gas
Inhalation sedation	14.4%	Sedation, gas
Composite restoration	12.4%	Composite, filling
Fissure sealant	12.0%	Fissure sealant, plastic, paint/nail varnish
Aspirator	11.0%	Aspirator, hoover, suction/sucker
Preformed metal crown	9.6%	(preformed) metal/stainless-steel crown, silver, pirate
Rubber dam	5.3%	rubber dam, clamp

Table 2: The most commonly reported ineffective words to describe this dental terminology

by between 39 per cent (fluoride varnish) and 96 per cent (aspirator) of respondents. The word choices are unaffected by the gender, years of experience and job role of the dental team members and are generally not affected by the health board region.

When compared with the large-scale US survey of more than 40 years ago, the four overlapping studied terms – drill, rubber dam, extraction and local anaesthetic – share at least some of the same top three word replacements, despite the differences in time and location. Individual creativity is still certainly evident today, however, with respondents using unique choices such as 'squirt gun' for local anaesthetic or 'roller coaster rumbles' for drill.

While often humorous, this friendly terminology has the additional benefit of being tailored to the child. Person-centred care, of which good communication is integral, has been shown to improve patient outcomes.

The General Dental Council standards state that dentists must communicate effectively with patients and that dentists must give information in a way the patient understands. There is also the added consideration of the triadic communication with the patient, the parent/guardian and the dental professional, which can have added complexity when choosing language that each person understands.

Dental team members reported that 'local anaesthetic' had the highest reported ineffective words associated (45.5 per cent), with word choices such as 'injection', 'jag', 'jab', 'needle' and 'sharp scratch' commonly reported as negatively received by children. Substitution for the dental terms, 'extraction' and 'dental drill' also had relatively high numbers of perceived ineffective words (32.1 per cent and 27.8 per cent, respectively), with 'extraction' and 'pull' being received negatively to describe the extraction of a tooth, and words like 'drill' and 'bee' mentioned as poorly received when describing a dental drill.

It is suggested by the authors that a child might be anticipating pain or discomfort by these descriptions. In addition, more than one-third of respondents reported negatively received words when describing fluoride varnish to children. In this case, 'banana' and 'paint' caused a negative response. There were divided opinions on the use of 'banana' to describe fluoride varnish. It features in the top three most common and effective ways to describe fluoride varnish, but many respondents said that it could be received negatively due to the anticipated taste. It was suggested that many children may not like the taste of bananas – several respondents use the word 'fruity' instead as it is less specific.

'Childsmile varnish' was also noted as positively received by one respondent, likely due to the fact that many children in Scotland are familiar with the Childsmile fluoride varnish application programme, where the Childsmile team attend nurseries and schools to apply fluoride varnish twice a year. Some respondents suggested that children may also anticipate a bad taste if the words 'paint' and 'nail varnish' are used for 'fluoride varnish' or 'fissure sealants'.

The use of the euphemism 'sleep' when describing a 'general anaesthetic' (GA) had mixed opinions from dental team members. This was by far the most common way for respondents to describe a GA (97 per cent). In particular, 43 per cent reported commonly using the term 'put to sleep'. However, of the 16 per cent of respondents who reported negatively received terms for GA, two-thirds would specifically avoid the phrase 'put to sleep'.

Proposed reasons for this were that a child may develop a fear of sleeping, or that they may associate this with a pet being euthanised or a family bereavement. It was suggested to avoid the term 'putting to sleep' and to instead use 'going for a short sleep/ snooze' to describe the hospital appointment. Other words which had negative connotations included being 'knocked out' and receiving 'gas', potentially due to a perceived threat to the child.

We can conclude that in a sample of Scottish dental team members who treat paediatric dental patients:

- There were a wide range and variety of words and phrases used to describe dental terms, treatments and dental instruments.
- The child's age commonly influenced the choice of language. The chosen terminology was not generally influenced by the child's gender, except in the case of pre-formed metal crowns.
- The three preferred replacement terms for each of the 11 dental terms have been identified through this study. These could be used as a guide to direct staff and unify terminology across the Scottish health boards.
- 'Local anaesthesia', 'fluoride varnish' and 'extraction' had the highest reported proportion of negatively received terminology.

For each treatment and dental instrument included in the questionnaire, there is a wide scope for creativity and there is certainly not one 'correct' way to describe each dental term. This is reflected in the many different alternative words and phrases suggested by the participants. It is hoped that this study provides insight into words that are thought to be effective and ineffective by dental team members who have experience working with children.

This is an edited version of the authors' paper (tinyurl.com/mncr5vnw) published by the British Dental Journal.

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Dr Ioannis Sagxaridis
Dental Surgeon

Practice Limited to Endodontics
DipDS Thessaloniki, Greece, PostDip (Endodontology)
GDC 190470

Dr Calum Imray
Dental Surgeon

Practice Limited to Endodontics
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ORTHODONTICS

REMOTE MONITORING

Island, rural – even urban – practices and their patients are set to benefit from a new AI-powered technology

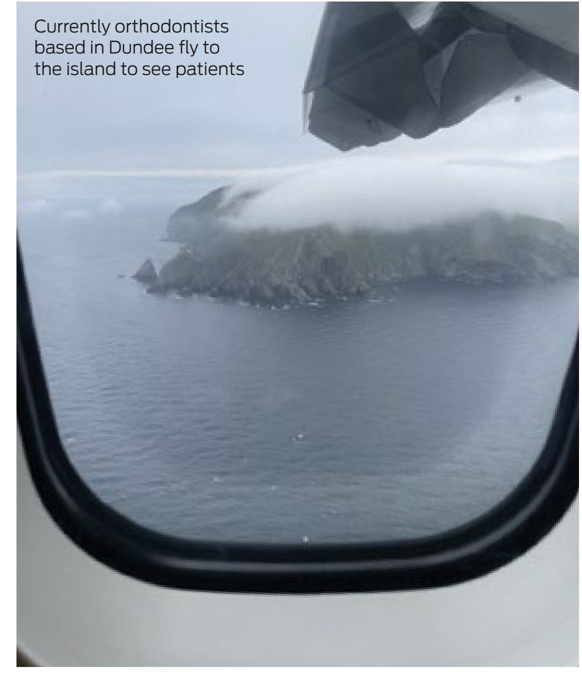
Imagine being able to monitor your patients' orthodontic treatment remotely. Island communities in Scotland are now benefitting from a technology that uses artificial intelligence (AI) to enable remote monitoring of orthodontic treatments, *writes William Peakin*.

Its creators say that technology improves the quality of care, the patient experience and practice efficiency. Practices in urban areas are now also exploring whether the technology could help them increase efficiency, boost capacity, manage staff shortages and tackle waiting lists.

Earlier this year, members of DentalMonitoring – the company behind the technology – travelled to the Shetland Islands to train the team at Brae Dental Health Centre in its use and onboard their first 100 patients. Previously, the NHS has provided orthodontics on Shetland through this NHS dental practice, despite having no orthodontists living on the island. The clinic opens on certain weekends and orthodontists based in Dundee fly to the island to see patients.

NHS Shetland and DentalMonitoring first started discussing the possibility of working together in the autumn of last year and it was clear there were opportunities to use the technology to help tackle some of the challenges faced in providing orthodontics on the island. It was not only a case of the orthodontists needing to get to Shetland, but also patients living on the isles of Unst and Yell having to travel by ferry to attend their orthodontic appointments.

Overall, the aim was to offer patients a more convenient option, to create a more robust orthodontic service for the islands – by helping to reduce the strain placed on the orthodontists who regularly give up their weekends to work on Shetland – and improve treatment through weekly monitoring of patients.



Currently orthodontists based in Dundee fly to the island to see patients

DentalMonitoring was created by Philippe Salah, who graduated from the École Polytechnique in Paris with a PhD in Biophysics. He fell in love with orthodontics after partnering with an orthodontist to build Harmony, a company that made custom lingual treatments with a fully digital workflow. By 2014, Philippe had recognised that AI was the next frontier in medical care, and so he brought together a team of engineers and orthodontists to develop DentalMonitoring.

The development of its AI-powered platform began with a focus on teaching the AI to analyse intraoral images and identify different patient issues across all orthodontic treatment types; pre-treatment, braces, aligners, retention and so on. After several years of research and refinement, the company launched a system that allows patients to upload photos of their teeth using the DentalMonitoring app along with a ScanBox that attaches to the patient's smartphone.

The AI analyses the images to track tooth movement, oral hygiene, aligner fit, and prescribed protocols set by each orthodontist, providing real-time feedback to both patients and practitioners. Since its launch, DentalMonitoring has been adopted by orthodontic professionals in more than 50 countries worldwide. In 2023, DentalMonitoring UK started working with the NHS where they now monitor more than 9,000 NHS brace patients across a range of hospitals and private practices.

The system allows practitioners to oversee treatments remotely, improving workflow and enhancing patient engagement. The company says feedback from clinicians has been very positive, with many noting how the platform has provided big improvements in patient hygiene, reducing treatment lengths, reduced unnecessary appointments and management of emergencies.

Of the 100 patients that started on Shetland, most were already in-treatment patients, while some were due to be bonded-up and begin their treatment shortly. A further 100-plus patients will now be added to DentalMonitoring by the team on Shetland and begin monitoring their teeth in the coming months, converting all orthodontic patients on the island on to DentalMonitoring.

In doing so, this will allow the progress of the patients to be tracked on a weekly basis. So that, for example, if part of the brace is damaged or if hygiene deteriorates, the practice can intervene and fix the problem. The images will also allow for the orthodontists on the mainland to see how their patients are doing without being on the island. It means that therapist/nursing team on the island can easily discuss a patient with the orthodontist remotely, knowing they are both seeing the same up-to-date, high quality intraoral images.

> "IT WILL CREATE A MORE ROBUST ORTHO SERVICE ON SHETLAND WITH IT BEING LESS AT RISK FROM POOR WEATHER OR ORTHODONTIST AVAILABILITY TO TRAVEL TO THE ISLAND"

Rick Anderson, an account executive at Dental Monitoring, said: "In time, with patients scanning each week it may allow the Dundee-based orthodontists to prescribe remotely to the orthodontic therapists based on the island. This could help reduce the number of visits they would need to make to Shetland and mean their time on Shetland could be spent starting new patients and reducing the waiting list.

"Hopefully, through using DentalMonitoring, it will create a more robust ortho service on Shetland with it being less at risk from poor weather or orthodontist availability to travel to the island. There is also an environmental impact to consider, in that by monitoring patients remotely we may see fewer car and ferry journeys being needed from the patients, as well as fewer flights being taken by the orthodontists.

"Until now, in Scotland, DentalMonitoring had primarily been associated with private orthodontic care, with many assuming that the latest AI powered tech is too costly to use in NHS work. But with the Shetland project up and running, other NHS areas in Scotland are engaged in conversations to see if they could do something similar.

"While many regions have challenges relating to access for their patients, urban areas are also exploring whether the technology could help them to increase efficiency, boost capacity, manage staff shortages and tackle waiting lists."

www.dentalmonitoring.com

Rick Anderson, of DentalMonitoring, with the Brae Dental Health Centre team.

MAKING THE TRANSITION

What's stopping you making the moving from associate to principal?

WORDS
ALUN K REES

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

IN the dim and distant past, I was forced by naivety and events to learn many business lessons the hard way. It was a time of high interest rates (10%+), and a new NHS contract, when my dreams hit the buffers of reality. I discovered that bankers really were someone who lends you an umbrella in the sunshine but demands its return when it starts to rain.

My survival came with new, non-dental, accountants who spoke in words of one syllable and didn't make a fuss. I vowed to learn more about 'business' and embarked on the MBA course at the Open University; although I did the bookwork I didn't graduate, as the assessments overlapped with my father's final illness.

It did mean that I learned a lot of principles and case studies plus the language, which seemed designed to bewilder the innocent. These experiences, plus later work with a great coach, led to my learning to keep things simple, and eventually devising 'The Seven Pillars of a Successful Dental Practice'. I have used these with clients for a decade and a half and it's why I say I'm "the antidote to business coaches".

This piece was an attempt to discuss the merits or otherwise of 'sunk-costs', it then evolved through thoughts on the wisdom of business ownership. It ended up as pseudo-philosophical piece on the wisdom or otherwise of independent practice and how should a dentist navigate their way through the shoals of professional life to a rewarding (in all meanings) existence.

A sunk-cost in business decision-making is defined as "a cost that has already been incurred and cannot be recovered". It has been said that some education and time spent in a 'dead-end' jobs should be defined as sunk-costs. That is not always the case. I believe that my decade-long mix of resident hospital jobs and associate posts in practices, good and less so, helped me to decide what I did want and, importantly, did not want from my own practice. I saw them as an investment of that most valuable and scarce of resources – my time.

When you made the decision to have a career in dentistry how did you think it would work? What were your dreams, hopes and expectations? Unless you had dentistry in the family, the chances are you knew as little as I did, a set of snapshot images from my own experiences and memories, of a successful and secure professional who took me from six-year-old phobic to a confident teenager.

'Prospective-costs' are future costs that may be avoided if action is taken. Seeing them both for what they truly represent to you and getting the balance right in a business and a career is vitally important. At some point you may well realise that not committing to being a practice owner was a mistake and you are repeating sunk-costs

Looking at things in purely monetary terms can be persuasive but time is very important and no measures of happiness and satisfaction ever seem to appear in the calculations made by economists. Now, 'Bygones principle' applies; this states that past so-called mistakes are irrelevant, gone like water under the bridge, and should not influence future rational decisions. This presumes we learn from our errors but sadly humans, and dentists are definitely no exception, have a tendency to repeat mistakes, sometimes until pain demands a change.

Most of us do not want to drift from job to job, taking time to build relationships with patients and team members before becoming disenchanted or until the culture proves intolerable, it does not lead to a happy life. Yet the roundabout of associates and other staff is a reality. The phrase 'from pillar to post' originated from the practice of punishment in medieval Europe where a person would be tied to a pillar or post to be whipped or beaten before being moved to another pillar or post for more punishment. I have encountered dental team members whose stories remind me of this.

In spite of the responsibilities of ownership dentistry is a profession, which bestows great privilege as well as duty. I always felt far more restrained and at risk of complaints while I was an associate. Taking control by owning your own practice, away from imposed confines and controls from a principal, practice manager or corporate bean counter can be refreshing. The freedom to attract and serve the patients that you choose and treatment plan for them at a pace that works for both of you cannot be undervalued.

If you have wanted to make the move to ownership what's really stopping you? To paraphrase Henry Thoreau: "the mass of associates lead lives of quiet desperation and go to the grave with the song still in them." I'm not knocking working as an associate, I accept that practice ownership isn't for everyone, but the professional and personal rewards are great.

I often speak of the snakes and ladders of a dental career, as an associate I always felt the dice were loaded but never in my favour. As a principal the ladders were steep but rewarding and I knew the walls could be climbed one step at a time.

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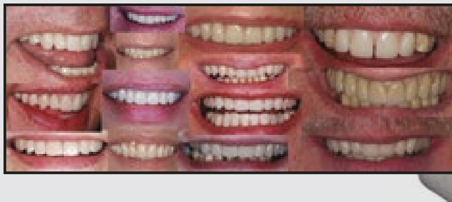

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Aesthetic crown lengthening and minimally invasive laminate veneers to resolve Altered passive eruption

Cimara Fortes Ferreira, Edival Barreto Magalhães, Barbara Zini

Introduction

The aesthetic appearance of an individual's smile plays a significant role in their social and psychological wellbeing[1]. A "gummy smile," characterised by an excessive display of gingival tissues (>3 mm) during smiling, is considered unattractive[2,3]. A pleasant smile is when the gingival margin of the maxillary teeth is approximately 1mm from the upper lip. To maintain a pleasant smile, it is recommended that this distance does not exceed 2-3mm.

Several factors, including altered passive eruption (APE)[4], vertical maxillary excess[5] and hypermobile upper lip[6], can contribute to this condition. APE, a localised tooth-related factor classified as developmental or acquired condition[7] is subdivided into two types. Type I involves the gingival margin being incisal or occlusal to the cementoenamel junction (CEJ), with the mucogingival junction (MGJ) positioned apical to the crest of the bone. Type II is characterised by a normal gingival dimension, with the free gingival margin incisal or occlusal to the CEJ and the MGJ positioned at the CEJ. Both types have subdivisions, with subdivision A indicating that the alveolar crest is 1.5 to 2 mm apical to the CEJ and subdivision B indicating that the alveolar crest is coincident with the CEJ[8].

Treatment options for APE type I include gingivectomy, apically positioned flap, and osseous resective surgery. A comprehensive treatment plan involving prosthodontics, orthodontics and periodontics is necessary for addressing APE type II. However, caution must be exercised during osseous resective surgeries to prevent excessive bone resection and subsequent gingival recession, which can lead to aesthetic complications[9].

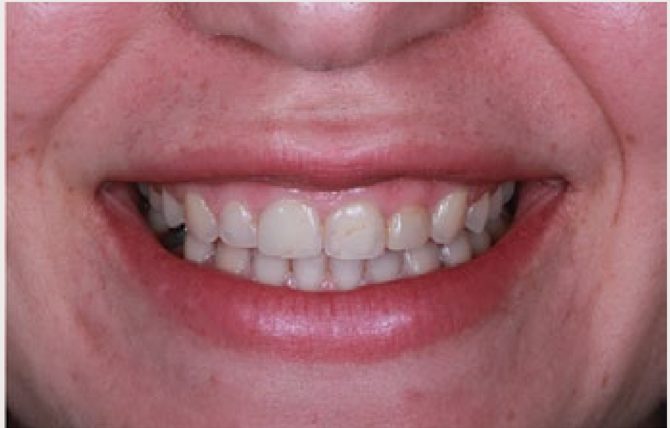
Case description and results

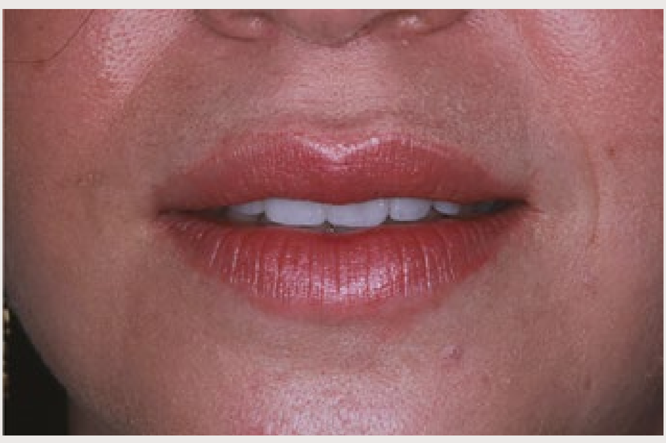
The case was a Coslet type I subdivision B that required surgical crown lengthening using selective osseous correction[10]. The patient, a 46-year-old female, presented to a private clinic with a chief complaint of unpleasant aesthetics. Her medical history was non-contributory. A clinical evaluation was conducted at the first appointment following the clinical protocol described in the literature[11]. Her dental history revealed significant dental restorative work that had been done in the last 16 years.

Her periodontal probing depths were within 1-3 mm. She was diagnosed with periodontal health and with a developmental and acquired condition[7], APE[12], and Coslet type I subdivision B[8]. She presented facial and lip symmetry and normal lip mobility. The maxillary anterior teeth showed normal width but reduced length, and she showed a slight right deviation of her maxillary anterior midline.

An intraoral evaluation revealed that the position of the mucogingival junction was approximately 5mm from the gingival sulcus, characterising excessive gingival display[4] (Figure 1).

Figure 1 (a) Frontal view. Note the excessive gingival display and reduced height for the anterior maxillary teeth during patient's high smile. (b) Perspective view. Note the reduced size of the patient's #9 and 10





> “THE USE OF A DIGITAL WORKFLOW IN DENTISTRY HAS BEEN DETAILED AS A STEP-BY-STEP PROCESS TO ENHANCE THE GINGIVAL ARCHITECTURE IN THE AESTHETIC ZONE”

The use of a digital workflow in dentistry has been detailed as a step-by-step process to enhance the gingival architecture in the aesthetic zone[13]. The patient's dental casts were created, and a mock-up was developed using the Digital Smile Design protocol[14] to achieve an aesthetically pleasant dental arrangement that harmonizes with the patient's facial features[15] (Figure 2). The patient expressed satisfaction with the proposed aesthetic solution and approved the treatment plan.

The initial assessment using the pink aesthetic score (PES)[16] indicated scores ranging from eight to nine for the six anterior maxillary teeth, primarily due to tooth contour. The white aesthetic score (WES)[16] for the same teeth varied from three to five, mainly attributed to the lack or absence of tooth form, volume, colour surface texture and translucency.

The treatment plan included crown lengthening and 0.4-0.6 mm wide ultrathin ceramic laminates, as well as lithium disilicate laminate veneers (LDLV) from teeth #5-13. The successful use of layered pressed-ceramic LDLV technique has been described in the literature[17]. The patient approved the treatment plan, and in the following week, the crown lengthening was conducted.

The surgical appointment involved using the mock-up as an aesthetic stent for the crown lengthening procedure (Figure 2). After administering anaesthesia, the aesthetic stent was inserted, and the future position of the CEJ was marked. An internal bevel incision was made based on the markings for each tooth, preserving the interdental papilla. Subsequently, an intrasulcular internal bevel incision (Swan Morton, UK) was made with a 15C blade (Figure 3a), and a collar was obtained. After collar removal, subgingival enamel was exposed. The golden proportions were rechecked using a periodontal probe (Figure 3b).

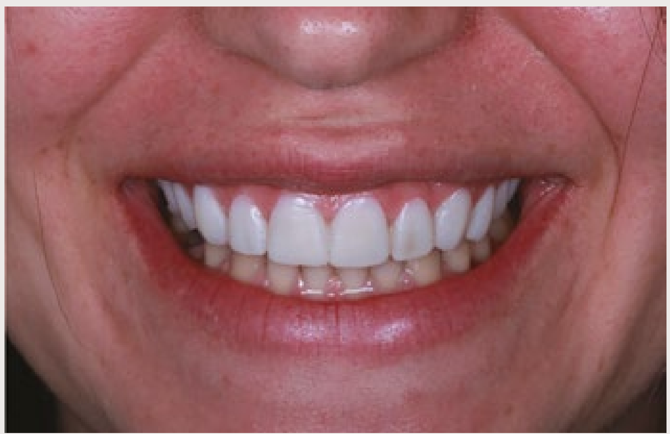
Next, a full-thickness buccal flap was elevated to the level of the mucogingival junction. After flap reflection, the bone showed to be at the CEJ (Figure 4a). The distance from the bone crest to the CEJ was measured transsurgically, using the aesthetically driven surgical stent (mock-up), for the osteotomy. The osteotomies were performed to achieve 2mm between the CEJ of the crown line angles and the aesthetic gingival stent margins. A 1mm bone reduction was carried out from the line angles to the mesial and distal proximal sites of the proposed restorative margins. No bone reduction was performed interproximally for the mesial sites of the central incisors. A periodontal probe was used to assist the bone reduction procedure. Manual (#2 Fedi, #36/37 Rhodes chisels) and rotatory instruments were used for osteotomy and osteoplasty.

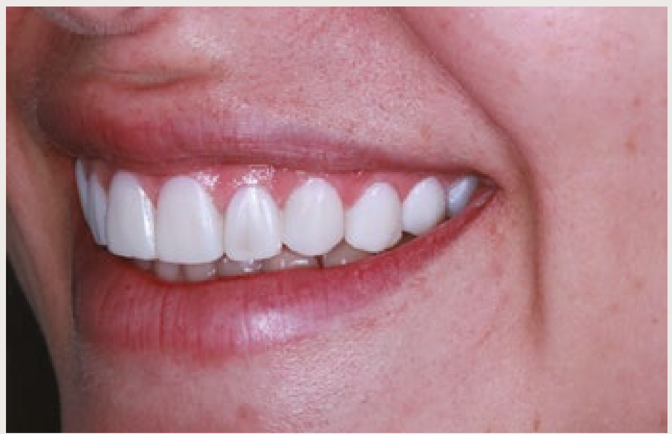
Following bone reduction (Figure 4b), the surgical sites were thoroughly irrigated with saline solution, and the buccal flap was repositioned. Next, digital compression was conducted for one minute, and a 3/8 circle 13 mm needle with a 6-0 polypropylene thread (Atramat, Japan) was used to stabilize the flap with simple interrupted sutures.

The patient received postoperative instructions and was placed on a pain control regimen (750 mg of paracetamol four times a day for the following three days). Oral hygiene instructions, including the use of 0.12% chlorhexidine gluconate oral rinse (PerioGard, Colgate, Johnson & Johnson) twice daily for two weeks, were provided, and the patient was advised to refrain from mechanical plaque control in the operated sextants for two weeks.

Additionally, the patient was instructed to refrain from toothbrushing for two weeks, apply ice packs for the first 24 hours post-surgically, consume only soft foods during the first week, and avoid any other mechanical trauma to the surgical sites. Flossing was permitted for the mesial aspect of the central maxillary incisors after 10 days postoperatively and 21 days

Figure 2 (a) Frontal and (b) perspective views of the patient's smile using the mock-up. Note an aesthetically pleasing smile



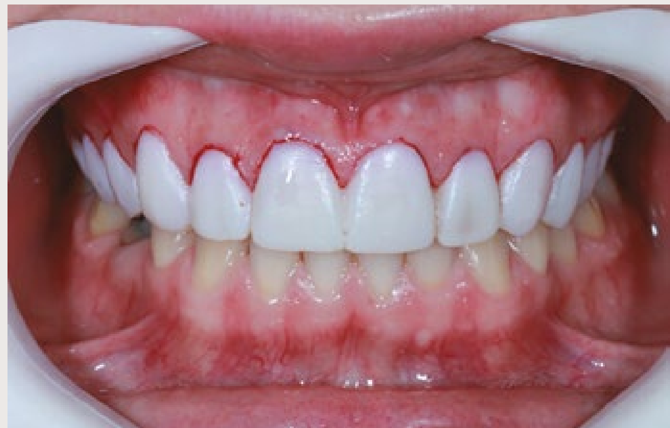


postoperatively, to allow sufficient healing of the interproximal sites that received a bone reduction procedure.

After seven days, the patient was instructed to use a two-year-old soft bristle paediatric toothbrush, brushing only in the direction from the gingival tissues towards the tooth. The patient was discharged, and the sutures were removed at the 10-day appointment.

At the 15-day postoperative appointment, the patient received prophylaxis prior to suture removal (Figure 5a). The provisional restorations were placed after 60 days of healing and the definitive restorations were cemented six months postoperatively using a photopolymerizing resin-luting cement (Variolink Esthetic, Ivoclar Vivadent) (Figure 5b).

Figure 3 (a) Mock-up used as aesthetic stent for the crown lengthening procedure planned for teeth #4-14. (b) A periodontal probe was used to assist during the bone reduction



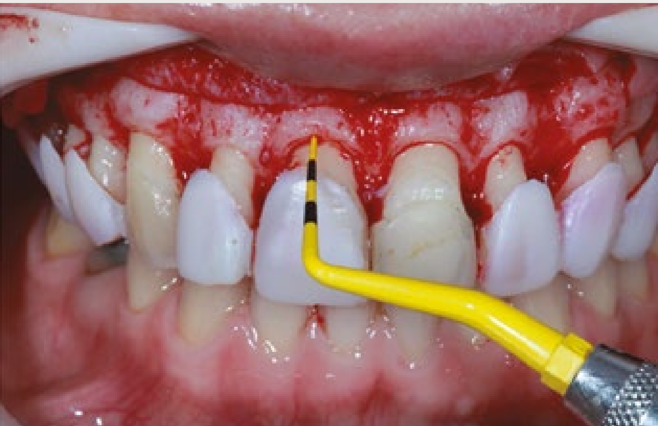
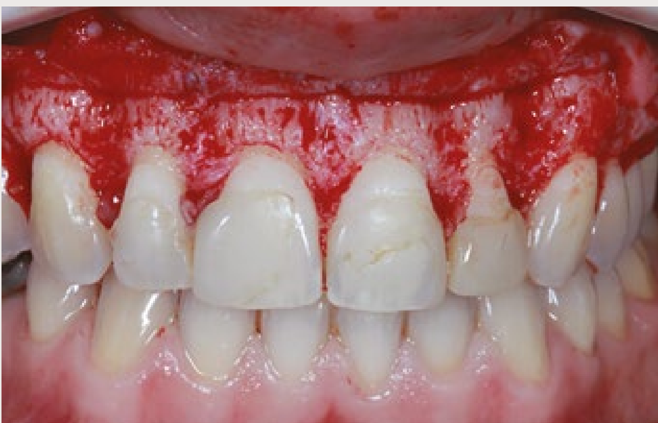


Figure 4 (a) Frontal view after a full-thickness flap was elevated. Note the presence of the bone at the level of the cementoenamel junction from teeth #6-11. (b) Frontal view of the bone after bone reduction was conducted. Note the presence of extensive overhang of the mesial aspect of the restorations for tooth #8



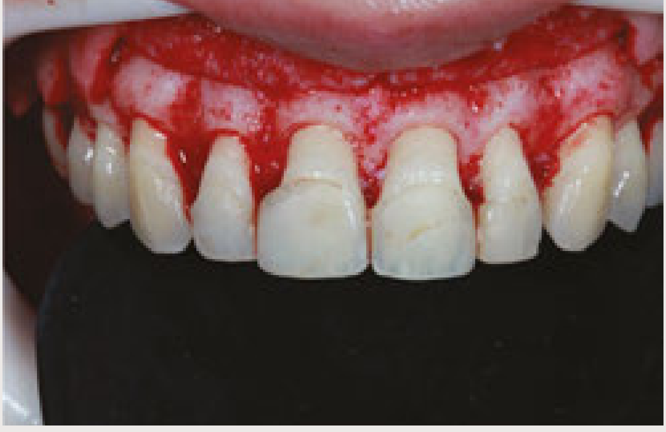
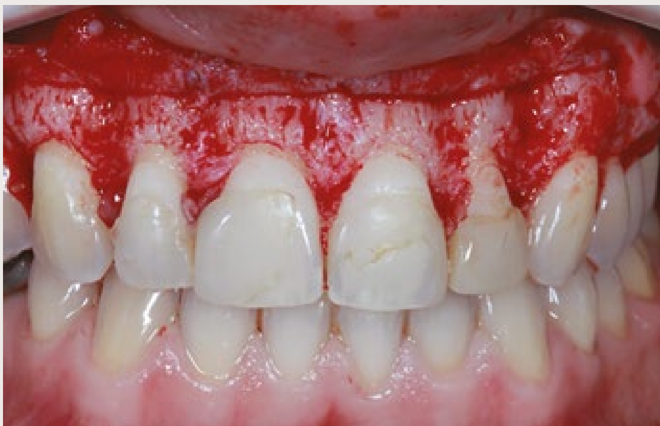


Figure 5 (a) Fifteen days postoperatively after the sutures were removed and the provisional restorations were placed. The patient returned for suture removal. Note the presence of slight marginal erythema, which may be expected at this follow-up period. (b) Frontal view six months postoperatively with the final laminate veneers



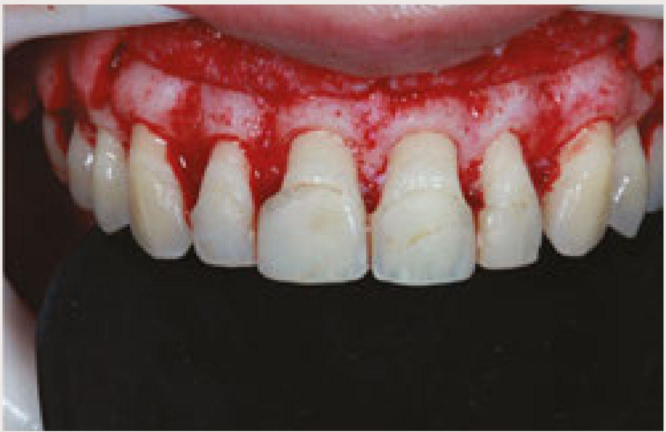
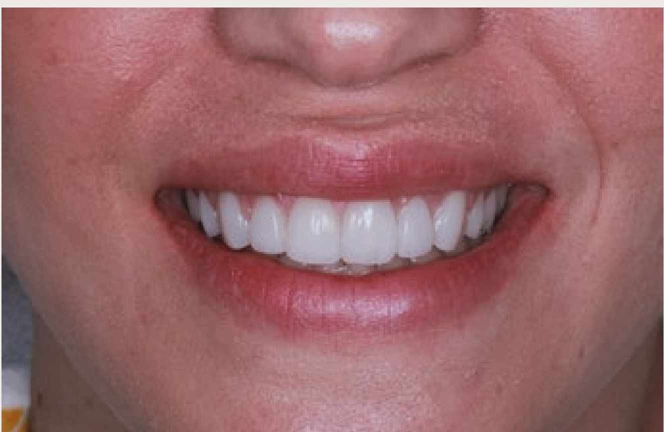


Figure 6 (a) Frontal view of the patient's smile six months postoperatively. Note the aesthetic smile. (b) Perspective view of the patient's smile six months postoperatively



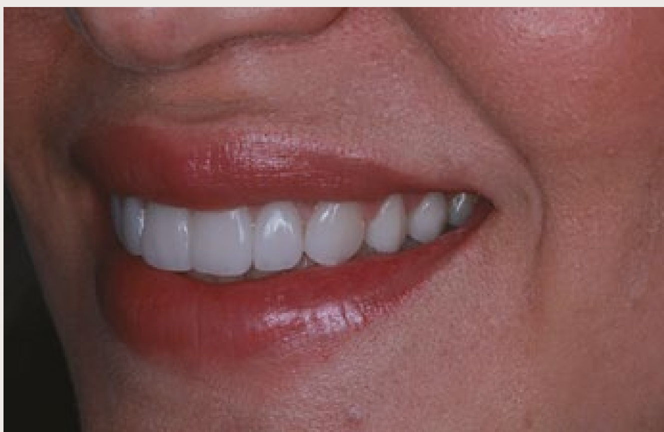
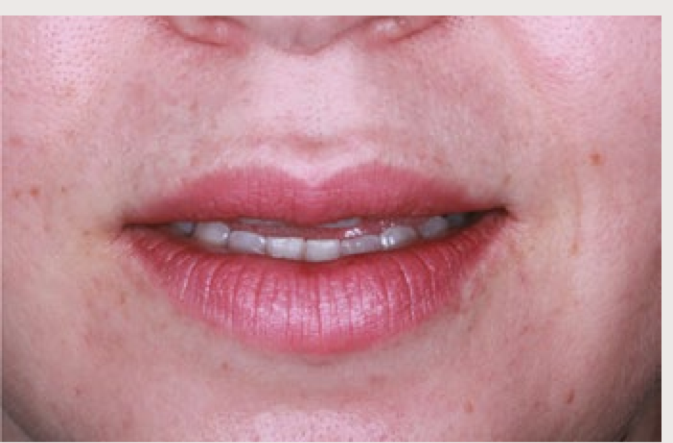
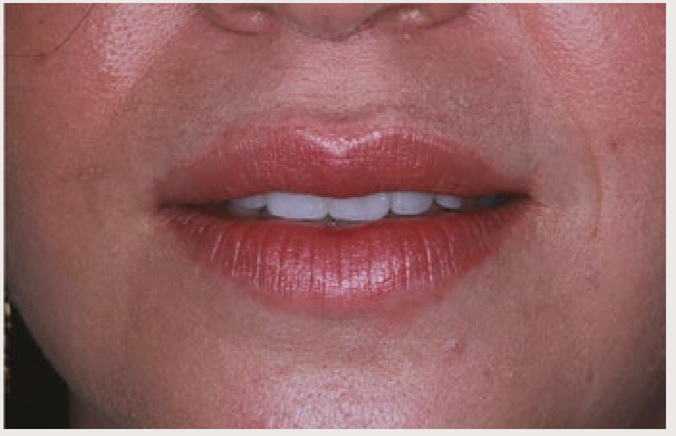


Figure 7a Preoperative frontal view of the lack of lip in repose. (b) Postoperative frontal view of the lip in repose showing the presence incisal edges of the anterior maxillary teeth





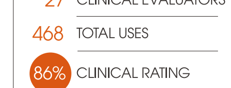
During the six-month follow-up, the patient exhibited an aesthetic smile (Figures 6a and 6b), attributed to achieving aesthetic equilibrium through adhering to the golden proportion measurements for the anterior maxillary teeth. The patient's final PES[16] was 10 for the six anterior maxillary teeth due to recovery of the gingival contours. For the same teeth, the patient's final WES[16] was 10 due to complete tooth form, volume, colour, surface texture and translucency.

> "THE PROPOSED TREATMENT OF CROWN LENGTHENING AND LDLV SUCCESSFULLY ADDRESSES THE PATIENT'S AESTHETIC CONCERN"

Discussion

The altered passive eruption is commonly addressed with an aesthetic crown lengthening procedure, which involves gingivectomy or apically positioned flap with or without ostectomy[10]. Aesthetic crown lengthening procedures have been documented in a controlled clinical trial[18]. In this case, the patient exhibited gingival display of 3mm or more when smiling, a finding known to impact aesthetics negatively[19]. The proposed treatment of crown lengthening and LDLV successfully addresses the patient's aesthetic concern. The concept of patient satisfaction has been evaluated in dentistry and medicine revealing its multidimensional characteristic and the need for a better definition[20]. This treatment combined aesthetic crown lengthening, using the Digital Smile Design (DSD) concept, and a digital wax-up to fabricate pressed LDLV layered with feldspathic porcelain[17].

In addition, Belser et al's proposed modification to the PES and the WES[16] was used to evaluate the esthetics before and after treatment. This method of evaluation quantifies aesthetics, allowing for comparison of treatment results between studies. The proposed treatment of an APE type I subdivision B, with aesthetic crown lengthening and the use of ultrathin LDLV, resulted in an increase in the PES from 8 to 10 and a significant increase in WES from



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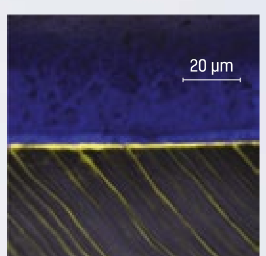

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A confocal micrograph of a gap-free Stela-dentine interface. Note the penetration depth of Stela Primer (yellow) within the dentine tubules.

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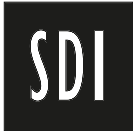

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3.5 to 10. These scores quantify the deficient patient; however, the "gummy smile," which would be represented by the pink aesthetics, showed to be of lower importance when using the scale when compared to the WES, which was significantly low at the patient's initial visit. The authors suggest a limitation of the PES score for "gummy smile" cases. Adding the length of the gingival tissues to this evaluation would facilitate giving them a more accurate aesthetic score.

Mootha et al[21] compared the use of different tools for aesthetic treatment planning the anterior maxillary teeth and their relation to the various geometric proportions in an Indian population sample. In this study, the use of the Digital Smile Design software protocol and Chu's proportion gauge[22] range leads to pleasing smiles in the studied population. The present case report used the Digital Smile Design protocol for the aesthetic treatment planning of the anterior maxillary teeth.

The literature supports the use of digital workflow to improve treatment planning for gingival/tooth architecture in the aesthetic zone. The use of a diagnostic mock-up or overlay as a crown lengthening surgical guide to improve the "gummy smile" has shown to be a viable option as a surgical guide for crown lengthening[13]. This case report used a digitally made aesthetic stent to guide the surgeon during the surgical procedure, and the patient accepted outcomes presented during the treatment planning phase.

The cement system used in this case utilises a novel dibenzoyl germanium derivative photoinitiator which exhibited statistically superior colour stability and a higher degree of conversion when compared to Calibra, Variolink-N, and NX3 resin cements in an *in vitro* setting[23].

A limitation of this case report is the lack of use of digital technology to precisely measure the amount of increased lip support reached with the executed treatment.

Conclusion

An APE type I subdivision B case was treated with aesthetic crown lengthening and minimally invasive LDLV to resolve the patient's aesthetic concern. The proposed treatment reduced the gingival display significantly and increased the crown height to length proportions reaching an aesthetic smile and patient satisfaction.

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Effective management of a fractured tooth in a child

Stephan Lampl, Deepa Gurunathan

Traumatic dental injuries in children, a major dental health problem across the globe, pose unique functional and psychosocial challenges [1, 2]. Treating this condition often requires the application of evidence-based diagnostic and treatment practices that are optimally contextualised and individualised to the specific requirements of a child.

Predisposing factors of dental trauma could be related to the person's anatomic features such as increased overjet or inadequate lip coverage of the upper anterior teeth. Accidental falls are common causes of these traumatic dental injuries in children and their heterogenous clinical presentations can be categorized into nine fracture and six luxation variants.

A conspicuous complexity in the management of traumatic dental injuries is that traumas to the primary and the permanent teeth are separate entities and hence treated separately. Furthermore, the management of tooth injuries in children with mixed dentition can be challenging. The Dental Trauma Guide and Trauma Pathfinder provide useful recommendations for the diagnosis and treatment of these heterogeneous presentations.

Furthermore, recommendations from the American Academy of Pediatric Dentistry (AAPD) suggest the objective of treatment of primary and immature permanent teeth with large fractures is to maintain the pulp vitality for continued apexogenesis [6]. Along with this, preservation of the remaining tooth structure is an important restorative consideration in children with traumatic injury to and erupting teeth.

On the premise of available evidence that paediatric full crowns as compared to conventional restorations can conserve tooth structure and maintain pulp vitality, we treated an eight-year-old child with a fractured permanent lateral incisor using a paediatric full crown fabricated using a novel hybrid glass material. The outcomes seen in this child along with a review of literature on the crown materials for achieving optimal restoration of function and aesthetic outcomes, while preserving pulp vitality and remaining tooth structure are presented herein.

The Dental Trauma Guide and Trauma Pathfinder provides easy-to-follow recommendations and flow charts for arriving at a correct diagnosis of traumatic dental fractures and luxations of permanent teeth. The diagnostic workup described in this case report was generally in line with these recommendations. However, the Dental Trauma Guide and Trauma Pathfinder recommends radiographs with periapical, occlusal, and eccentric exposures for detecting fracture lines in the root for crown fractures without pulp exposure.

The appropriateness for the choice of full-coverage paediatric crowns as a treatment option was derived from a premise that maintaining pulp vitality and preservation of remaining tooth structure are important restorative considerations in children with traumatic injury to the tooth. This premise is supported by a systematic review by Innes et al., which indicates that crowns placed on primary teeth with decay or those that have had a pulp treatment are associated with a lesser likelihood of failure or pain in the long term as compared to conventional filling.

Furthermore, the acceptance of crowns is high with both patients and dentists and the latter find crown-related procedures comparatively simpler even when restoring severely damaged primary molars. Another study by Kaptan et al. notes that full-coverage paediatric crowns require less additional treatment and have a higher survival rate compared to conventional fillings.

FULL-COVERAGE PAEDIATRIC CROWNS REQUIRE LESS ADDITIONAL TREATMENT AND HAVE A HIGHER SURVIVAL RATE COMPARED TO CONVENTIONAL FILLINGS"

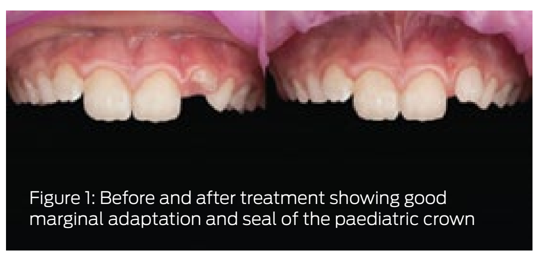

Figure 1: Before and after treatment showing good marginal adaptation and seal of the paediatric crown

Several materials including stainless steel, zirconia, resin composites, and hybrid glass material can be used for fabricating full-coverage paediatric crowns. While stainless steel crowns are associated with high clinical success rates and have been recommended by the British Society of Paediatric Dentists, many dental practitioners consider stainless steel crowns unsuitable for most children as their placement entails a cumbersome restorative technique in a busy routine practice.

Furthermore, nickel–containing stainless-steel crowns may also carry risks of allergic reactions and hypersensitivity. Over the years, the aesthetic advantages of zirconia have garnered an increased attention over stainless steel. However, paediatric crowns fabricated with zirconia require the removal of a higher amount of tooth structure and subgingival preparation margins of 1–2 mm to restore primary teeth.

Overall, this case report underscores the usefulness of a conservative approach for restoring an erupting permanent tooth in the mixed dentition using a paediatric full crown fabricated using a novel hybrid glass material. Improvements in function and aesthetics were achieved along with preserving tooth vitality, minimal stress, and clinically noticeable child and parental satisfaction. These initial findings merit further investigation in future clinical studies.

Full report, pictures and references: doi.org/10.1155/2024/6888443

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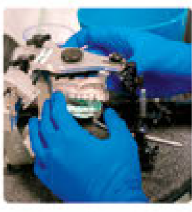
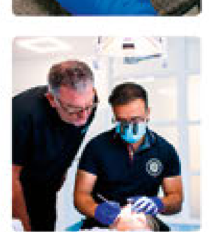

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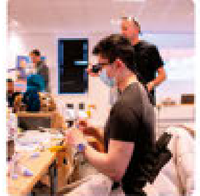

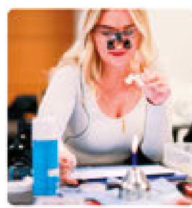

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LAURA WHYTE • COLTENE

COLTENE'S NEW REP FOR SCOTLAND

COLTENE is delighted to welcome Laura Whyte to the team, as the new Territory Manager for Scotland.

She brings a wealth of experience to COLTENE, having started her career in dental nursing at the age of sixteen. She progressed into practice management and was responsible for running a number of sites for many years. After leaving the practice side, Laura gained years of valuable sales experience with Coca-Cola and then found her way back into dental in her last role, in dental lab product sales with John Winter.

Laura is a people person and is very much looking forward to meeting all the clinicians and team members throughout Scotland, introducing them to COLTENE, supporting them and helping them to deliver outstanding treatments to their patients.

Laura grew up in Dundee and lives with her family in Arbroath.

Laura Whyte,
Territory Manager Scotland
E: laura.whyte@coltene.com
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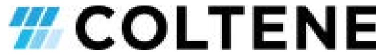

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BRIAN M RHONEY • ACTEON UK

TERRITORY MANAGER, SCOTLAND & NORTH

BRIAN has over 24 years of dental sales experience having started with dental laboratory supplier, John Winter and Co. Ltd in late 1999, starting as Technical Sales Representative and later progressing to Sales Manager before moving into surgery sales, having had spells with Dentsply Sirona, and Straumann, Brian is probably best recognised for his time as Surgical Manager for Henry Schein, where he spent 8 years covering Scotland, Northern Ireland and North England. Having sold general consumables and equipment for laboratories and practices, CAD/CAM systems, Biomaterials and Implants, Brian has extensive knowledge across dentistry, particularly in the surgical field and in early 2022 was delighted to bring that knowledge to his current role as Territory Manager, Scotland & Northern England, with Acteon UK Ltd.

Brian says: "I've known Acteon for many years, from when they were more better recognised as Satelec, specifically from my time promoting their surgical products at Henry Schein but wasn't fully aware until joining them of just how wide a range of different products they manufacture, From top quality hand instruments right through to cutting edge CBCT's. I am delighted to be part of the Acteon family and am proud to be promoting our high quality products to both distributors and end users."

Brian M Rhoney, Territory Manager, Scotland & North England
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TOP TIPS FOR SELLING YOUR DENTAL PRACTICE

Martyn Bradshaw, of top dental practice brokerage PFM Dental, gives his top tips when getting ready to sell your dental practice

1 VALUATION

Regardless of whether someone is selling on the open market or simply selling to their associate, I always suggest that they instruct a valuation from a reputable valuer. This is the time to ensure that you get the pricing right and take advice from someone who deals with dental practice sales on a daily basis. Valuers like us will happily undertake a valuation for clients as a stand-alone service.

2 IDENTIFY BUYER TYPES

When getting a practice ready to market, understanding who your practice will be suitable for, and therefore the likely buyers, will ensure that you and/or your agent are targeting the correct buyer type. The practice should be analysed both under an associate-led and principal-led model – determining the suitability of corporate vs principal buyer. A good agent or valuer will be able to discuss and advise accordingly.

3 SUITABLE AGENT

Using a specialist dental practice sales agent should cover the related agency cost multiple times over. Most agents will have thousands of dentists looking for dental practices and can therefore reach a wide audience of potential buyers. As well as helping to achieve the best price, having a choice of multiple buyers also allows you to choose the right fit for your practice. The agent should also deal with the sale from marketing all the way through to completion, making sure that the sale stays on track and resolving any issues.

4 SOLICITOR

Similar to having a specialist agent if you are selling on the open market, there are a number of good, specialist dental solicitors. Within the sale agreement a vendor will provide indemnities and warranties, and it is the responsibility of your solicitor to minimise the risk of these. A non-specialist solicitor is not likely to know what is expected or overkill.

5 GET ORGANISED

The legal work involved in a dental practice sale is certainly getting more onerous, and we see that the majority of the time spent is actually on the 'due diligence' – the information that a buyer's solicitor is asking about the practice. The more prepared you are the better. If you are coming up to selling your practice, starting to keep documents to hand will make the process significantly easier.

6 THINK TAX

While getting the best price for the practice is the key driver for most people, the way in which the deal is drawn up can affect your tax liability. The most important thing for you is the net proceeds from the sale. There is no point in getting an extra £20,000 if you don't take good tax planning advice and spend an extra £30,000 in tax. Your accountants should be informed of the sale at your earliest opportunity. An agency such as PFM Dental will liaise with your accountant to assist where possible.

7 TIMESCALES

Ensure that you are thinking about the sale of the practice early enough. If you are looking to sell to a dentist who is going to take over from you then you need to leave enough time to find a buyer and go through the legal work. If you have a large practice and are looking to sell to a corporate, not only will you have the time to get to completion but will likely have a tie-in afterwards.

> "A WELL-CONSIDERED PLAN FOR SELLING YOUR PRACTICE SHOULD NEVER BE UNDERESTIMATED"

Again, if you are unsure, a good valuer or agent will be talking through the timing to ensure that you don't start the process too late for your circumstances. Many dentists wishing to sell will instruct a valuation around one to two years before they wish to sell.

CONCLUSION

A well-considered plan for selling your practice should never be underestimated. Start early, have a valuation of the practice and work with a valuer/agent to determine your likely timescales. When you are ready, make sure you have a suitable team around you (specialist agent, solicitor and accountant) to ensure that the sale goes through as smoothly and efficiently as possible.

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. His days are spent valuing and dealing with the sales of dental practices. PFM Dental is one of the leading dental sales agencies in Scotland.

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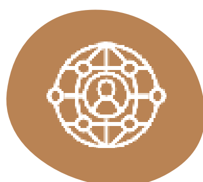

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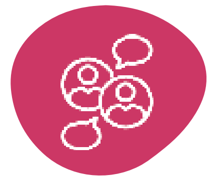

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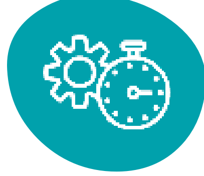

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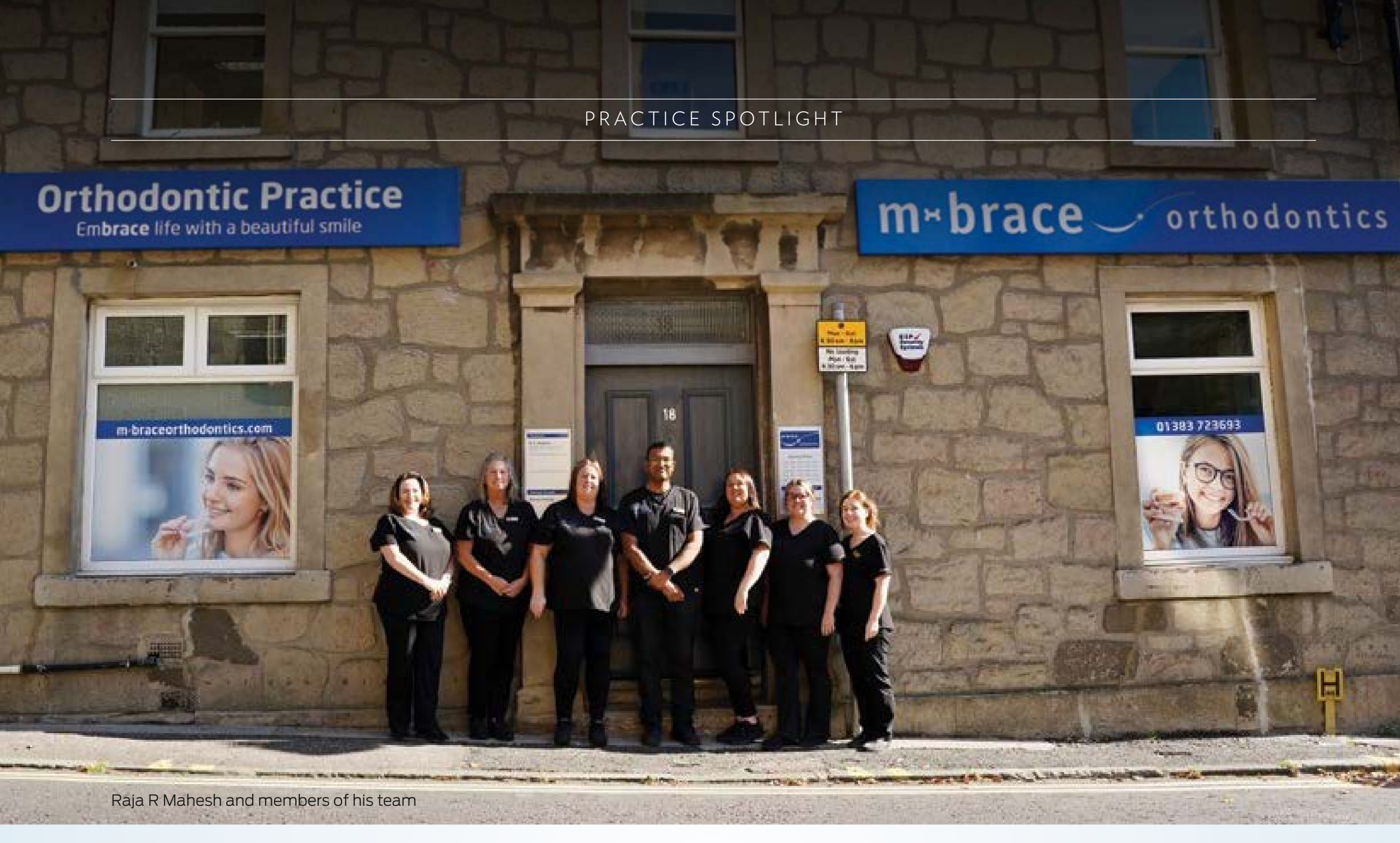

Raja R Mahesh and members of his team

M-BRACE ORTHODONTICS CELEBRATES 15 YEARS OF GROWTH AND INNOVATION

From a single chair to four practices employing nearly 40 staff and serving more than 32,000 patients

M-Brace Orthodontics marked its 15th anniversary in October, a milestone reflecting the practice's steady growth and commitment to innovation.

Since its establishment in 2009, M-Brace has expanded from a single chair in a rented space to four fully operational practices across Central Scotland, employing nearly 40 staff and serving more than 32,000 patients.

Founder and Principal Orthodontist Raja R Mahesh, who has been on the General Dental Council's Specialist List in Orthodontics since 2004, has guided the practice with a vision for blending traditional orthodontic values with the latest technological advancements.

M-Brace Orthodontics offers a wide range of treatment options, including NHS and private services, and focuses on Invisalign, clear fixed braces, and lingual braces.

In keeping with the demand for patient-centred care, M-Brace Orthodontics has integrated the latest digital orthodontic technologies, including iTero Lumina scanners, to ensure precision in diagnostics and treatment planning.

Mr Mahesh has also achieved 'Diamond Provider' status for his success in Invisalign treatments, a recognition awarded to practitioners who demonstrate a high number of successful cases.

"Orthodontics is an evolving field," says Mr Mahesh, "and our mission at M-Brace is to ensure that we are always at the forefront of this evolution. Whether through new technologies or a patient-centred approach to care, we constantly strive for every patient."

After 15 years, Mr Mahesh remains passionate about advancing orthodontic care and has built a strong team of clinicians, nurses, and administrative staff who share this vision. Several team members have been with the practice from the very start, refining the solid foundations and supportive culture Mr Mahesh has nurtured over the years.

M-Brace Orthodontics' ethos, 'Embrace Life with a Beautiful Smile,' continues to guide both its patient care and community involvement, which includes sponsorship of local sports teams, donations to food banks, and support for patient-led charitable initiatives.

M-Brace Orthodontics, founded by Raja R Mahesh, operates four practices in Glenrothes, Bathgate, Airdrie and Dunfermline.

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M-Brace Orthodontics integrates advanced technology, including iTero Lumina scanners.

Mr Mahesh holds 'Diamond Provider' status for Invisalign treatments.

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BY YOUR SIDE

From buying a practice, through growth, to selling or retiring – get the best advice

Are you ready to own a dental practice? Make sure you are clear on why you want to take this step and whether you are financially ready. Consider the purchase price, first year running costs and potential refits/upgrades. Determine your budget and negotiating position.

What type of practice are you looking to buy? Think about the unit size, location, your role (in or out of the practice?) and the return required. Warranties and indemnities are typical features of sale and purchase agreements. Read the small print very carefully and ask your solicitor to run their rule over it. What about finance? Speak to your bank, and a couple of others, and ask us to help you to prepare the practice business plan and financial projections.

GROWING THE PRACTICE PROFITS

Align your strategy with the opportunity for growth. Think about a growing, ageing population, as well as increasingly health conscious consumers visiting more regularly and keen to explore cosmetic related treatments. Develop referrals and online word of mouth via social media. Produce video content for use in the practice and your website to entice new and repeat customers.

There will be challenges: regulatory changes, both existing and in the pipeline, the NHS budget in the local area and competitive threats from larger operators. Issues to consider as part of your growth planning include aligning pricing with patients' ability to pay and providing a variety of payment options. Think about accessibility, opening hours and convenient parking. And then there is staff training and product knowledge, and your online presence and strategy – ensure your website is optimised and mobile friendly.

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To maximise the price you receive, you should aim to present the practice in its best possible light, e.g., the condition of premises, the equipment, fixtures and fittings, the value of NHS income, footfall and customer numbers and loyalty, and your online presence and marketing strategy. Sometimes it can take a few months to get the dental practice ready for sale, in other situations it can take years.

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Support for Dental Therapists

Joanne Beveridge, MClinEd, DipDT, DipDH
Dental Therapist

Joanne joins Clyde Munro as our new Clinical Advisor for Dental Therapy Support, bringing her experience and passion for the profession to the role.

She began her career in 1997 as a dental nurse, working in practice and salaried/hospital services. She graduated from the University of Dundee in 2004 with a diploma in Dental Hygiene and went on to complete her diploma in Dental Therapy at Edinburgh Dental Institute.

Joanne has a keen interest in clinical education and adult periodontology. In Edinburgh, she helped shape the programme to focus on a modern curriculum and introduced a theoretical and practical dental skills programme for students at the Royal (Dick) School of Veterinary Studies.

She continues to treat patients in private practice and is an educational associate with the General Dental Council.

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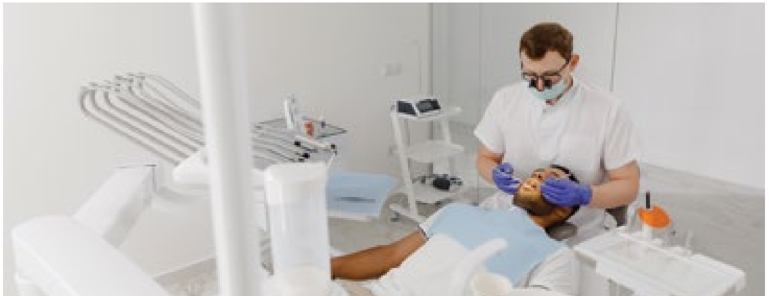
MAXIMISING PRACTICE EFFICIENCY

A year on from the new NHS SDR, Victoria Forbes reflects on what it means for practices

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



It's hard to believe, but it's now been a year since the launch of the revised NHS SDR, which brought significant changes to the way we approach patient examinations. The shift from the traditional six-monthly dental examination to a more flexible 6–24 month timeframe, depending on clinical need, has had a substantial impact on practice operations.

As the first cycle of this new system concludes, practices now have a clearer picture of their chair capacity and patient flow. With most practices adjusting to a 12-month examination schedule, there is a valuable opportunity to reflect on how best to utilise this time for both clinical and commercial benefit. The ability to register new patients should be assessed on an ongoing basis.

One key area to focus on is diary zoning. By strategically planning the diary, practices can optimise their chair utilisation, ensuring that each available slot is used for the most appropriate treatment. This proactive approach allows for a balance between meeting clinical needs and driving commercial growth.

In the current environment, where costs continue to rise, particularly with wages and taxes, maximising chair time is more important than ever. By targeting areas where your team can increase capacity, whether through restorative work, additional patient care, or streamlining operations, your practice can maintain financial stability while still providing excellent patient outcomes.

At Dental Accountants Scotland, we strongly advise reviewing your diary management and ensuring that you are taking full advantage of the opportunities presented by this new model. With rising costs showing no signs of abating, a well-planned approach to chair utilisation will be key to maintaining profitability and efficiency in the months ahead.

If you'd like help to maximise your practice's potential, we're here to assist. Get in touch with us if you would like a chat.

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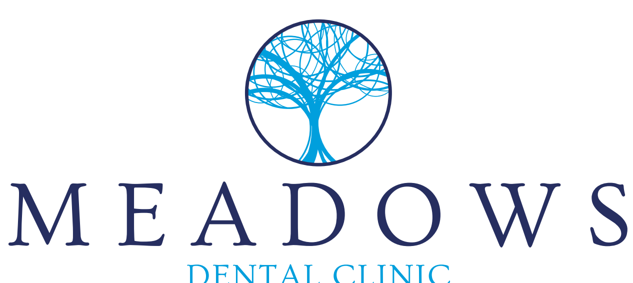

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MClinDent (Edin)
MRD RCS (Edin)
- GDC NO 81960

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)
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CHALLENGING TIMES

In the wake of the Budget, practices can be supported in providing cost effective service, writes Anna Coff

Anna Coff, Senior Technical Manager
EQ Accountants
E: anna.coff@eqaccountants.co.uk

In recent years, businesses have come through Covid, minimum wage hikes and a cost-of-living crisis. Just when you thought there was light at the end of the tunnel, the new Chancellor has targeted business owners with an employers' NIC increase with effect form 6 April 2025, designed to raise circa £24bn annually.

The change has different strands, the first being the rate of NIC being raised to 15% from the current 13.8%. There follows a reduction in the Secondary Threshold to £5,000, this being the level of pay above which Employers' NIC is paid. To slightly offset this, particularly for those smaller employers, the Employment Allowance is to be raised to £10,500.

However, businesses fully and part funded by the Government should assess whether they meet the eligibility criteria for this allowance. In the past many mixed dental businesses did not qualify for this allowance due to the level of their NHS income. It is vital that dental practice owners are aware of this.

Among those badly affected will be larger healthcare businesses such as large dental practices, nurseries and care homes. Employees aged between 18 and 21 will receive large minimum wage increases, together with rises for those over 21. These charges, combined with the NIC hikes, will hugely increase the cost of service delivery. We are concerned that we may see employers unwilling to recruit.

Challenging times for our healthcare, agriculture and leisure clients to name but a few. We'll be happy to discuss these changes with you and seek alternative ways to provide cost effective, excellent service.

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TAKING CARE OF PERSONAL DATA

A practical guide to data protection for dental practices

In the UK, all dental practices are subject to the requirements set out within the Data Protection Act 2018 and UK General Data Protection Regulation. The requirements are plentiful and apply to the use of patient and employee data. In this guide, Morgan O'Neill, Director of Data Protection Services at Thorntons, shares five top tips for dental practices seeking to maintain and improve compliance with data protection law.

1 APPOINT A DATA PROTECTION OFFICER (DPO)

Practices will process medical data, which the GDPR refers to as special category data. This type of personal data is sensitive and requires additional protections under data protection law. For practices, the processing of this information triggers the requirement to appoint a DPO, responsible for overseeing and monitoring the use of personal data within the practice and advising the practice of its obligations under data protection law. Practices may appoint a suitable member of staff with sufficient knowledge to the role of DPO, appoint an external DPO or arrange to share a DPO with other practices.

2 PUT IN PLACE DATA PROTECTION POLICIES AND NOTICES

Policies and procedures should be put in place to govern data protection in the practice. They should contain plain language, tailored to the practice and accessible to all staff. Practices are required to be transparent about how they use patient and employee data and the best way to achieve this is to provide a privacy notice to patients in paper form, by hand or via a website and also to have a separate employee privacy notice within a recruitment pack or staff handbook. These documents should be maintained and reviewed annually to keep them up to date.

3 TRAINING AND AWARENESS

Data protection is a collective responsibility for all working in a dental practice that handles personal data. It's important that data protection training is carried out, at least annually, to ensure that all staff have sufficient knowledge of data protection. Lack of training and awareness is often cited as one of the biggest causes of data breaches and data breaches can have financial and reputational consequences. There are several online training modules available, or a practice could invite an external consultant to provide their team with a tailored and relevant training session.

4 SECURITY

All practices should ensure that security is prioritised by only using trusted secure systems to store patient and employee records, which are protected by unique passwords. Restrict access to systems and data to only those who need it to perform their role. Practices should monitor the use of applications such as MS Teams Chat and WhatsApp to communicate about patient matters and restrict the sharing of sensitive patient and employee data via mobile apps wherever possible. Consider the security of paper documents and physical records and limit access to areas where physical copies of data are stored and held.

Morgan O'Neill
Director, Data Protection Services, Thorntons Law LLP
E: moneill@thorntons-law.co.uk

5 KNOW HOW TO SUPPORT AND RESPOND TO PATIENT RIGHTS REQUESTS (DATA SUBJECT RIGHTS REQUESTS)

Since GDPR came into force in 2018, the number of data subject rights requests received by organisations has increased significantly. There are eight data subject rights requests including subject access requests, erasure/deletion requests and data rectification requests. It's important that all practices are equipped to recognise, process and respond to a request within one month of receipt. Patients (and employees) can make a request verbally, by email, in writing and via social media and generally, no fee will be charged. Failure to respond to a request on time and appropriately can lead to a complaint being escalated to the Information Commissioners Office (ICO) and the ICO takes an interest in organisations who do not meet their obligations to respond to data protection requests.

If you are unsure how to navigate data protection for your practice, Thorntons Data Protection Team is here to provide practical solutions. We can provide an outsourced data protection officer service, shared data protection officer service and advice on specific matters.

FIND OUT MORE

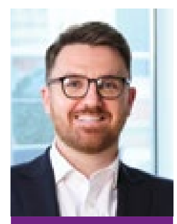
For more information, please scan the QR code to the left, or call our specialist Data Protection Team on 03330 430350

SNAPSHOT: THE SCOTTISH DENTAL MARKET IN 2024

Stability and optimism has returned, resulting in strong buyer demand and completion volumes, writes Joel Mannix

The dental practices sales market in Scotland has been buoyant this year, with the Christie & Co team completing 114 per cent more transactions north of the border compared with 2023. This rise can be attributed to a change in market dynamics; where confidence took a hit, and ultimately resulted in a market correction in 2023. However, more stability and optimism has since returned resulting in strong buyer demand and completion volumes.

First-time and independent buyers continue to dominate the Scottish market landscape, with 92 per cent of our deals in 2024 completing to the independent market. This trend highlights the growing appeal of the Scottish dental sector to new entrants and the substantial opportunities it offers.



Joel Mannix
Head of Dental,
Christie & Co
E: joel.mannix@christie.com
M: 07764 241691

A good example of such activity is the sale of Slateford Dental Care, a six-surgery mixed-income practice located in the heart of Edinburgh. Following a full, and very competitive sales process involving corporate and independent parties, the practice was purchased in late 2024 by an associate at the practice. This made for a smooth legal process as well as premium post-sales conditions, both of which were very appealing to the seller.

OUTLOOK FOR THE MARKET IN 2025

The changes announced in the Autumn Budget on 30 October could accelerate consolidation in the UK dental market, especially for practices that are struggling with rising wages and operational costs.

The limitations on NHS-oriented practices may prompt mixed or NHS-heavy practices to reconsider their operational focus or M&A options, while larger buyers with the resources to manage these costs may find acquisition opportunities more favourable.

We expect deal volumes in Scotland to remain buoyant, with independent buyers fuelling the pursuit on new acquisitions. We also anticipate a resurgence in appetite from corporate consolidators, who have otherwise been stagnant in the last 12 months.

If you're considering buying or selling a dental business in Scotland and would like to discuss your options, contact Joel Mannix.

DENTAL PRACTICES ON THE MARKET IN SCOTLAND

THE CHRISTIE & CO TEAM REPORTS:

a **114% increase in transactions** compared to 2023.

59% more practices brought to market

32% increase in viewings

35% rise in the number of offers received

23% growth in the aggregate value of all offers received

38% increase in the number of deals agreed

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THE APEX OF DENTAL DEVICES

Nicolas Coomber on the benefits of a reliable electronic apex locator

Nicolas Coomber is COLTENE national account and marketing manager

Removing inflamed pulp and sealing a tooth preserves its natural strength, making root canal treatment possible. This is nearly always preferrable to extracting the tooth. The apex of the tooth contains all the blood vessels and nerve fibres needed to keep the tooth alive. However, tooth decay, leaky fillings and dental trauma can damage the apex, opening it up for harmful bacteria to infect the root canal.

An open apex can prevent root canal treatment success as there is no natural barrier to contain the added filling. Because of this, closing the open tooth root is a crucial clinical challenge, one which is best aided by using a reliable electronic apex locator (EAL) to find the position of the apical foramen and work out the length of the root canal space.

THE WORKING LENGTH

Whilst radiographs are used by practitioners for diagnosis and determining the working length of the tooth root, an EAL can be more effective for the latter, with a 99.7% accuracy versus the 98.1% of a digital radiograph and 96.1% for a conventional radiograph. The working length of a tooth must be reliably determined for the success of the operation as it keeps the preparation inside the restricted radicular area; apical extrusion is then avoided and good obturation is secured. Inaccuracy in locating the apex and defining the working length can lead to damage of the apices and periapical tissues, limiting the success of post-operative healing.

Moreover, accidental over-instrumentation can result in a root canal with no apical constriction. In these instances of treatment failure, the patient will be dissatisfied, with discomfort, pain and inconvenience, surmounting to a negative experience.iv The importance of determining working length therefore demands a device as effective as an EAL to ensure treatment success and create a satisfying experience for the patient.

PATIENT COMPLIANCE

Childhood trauma is a common cause for an incompletely formed tooth root, with the highest frequency for dental trauma among children of 12-14 years. This is often attributed to the increase in participating in aggressive sports and other physical activities, whilst infants and preschool children are most likely to experience dental trauma caused by a fall at home. Paediatric dentists treating these injuries are likely to perform apexification and using an EAL can make the treatment easier – one of the major advantages of an EAL is its non-invasiveness, making it a preferrable option when delivering complex root canal therapy that requires patient compliance, especially among children.

Unlike the experience of a radiograph, in which having to bite down on the intraoral film causes discomfort and can trigger the gag reflex, an EAL is more agreeable. It connects the patient's lip with the endodontic file in the root canal, turning the body into a minimally invasive electric circuit. A painful or uncomfortable treatment can both inhibit its success and lead to a negative experience for the young patient, with the potential to increase dental anxiety or fear; an EAL can provide greater clinical confidence whilst also being a satisfactory experience for the patient. Emetophobic adult patients may also prefer an EAL for treatment, whilst the reduction in radiation exposure compared to a radiograph makes it a more appealing alternative.

Moreover, an EAL streamlines the workflow, taking less time and providing results quickly, without the practitioner having to step out of the room. Combined with its non-invasiveness, the efficiency of an EAL makes it optimal for treatment success and patient satisfaction.

BEST IN THE BUSINESS

For a first-class apex locator, consider the CanalPro Jeni from Coltene, an innovative endomotor that features a digital assistance system designed for root canal preparation. The angled handpiece of the integrated apex locator allows for constant, precise measurement of the working length; afterwards the machine changes to the next file size until the required preparation size has been achieved. Capable of so much more, the CanalPro Jeni assistance system uses complex algorithms to control the variable file movements in millisecond intervals by receiving feedback of the current intensity, torque and file stress, preventing over-instrumentation. This makes the system a safe, simple and effective solution.

A comfortable experience and a successful treatment can improve how patients engage with the dental practice. By harnessing the best technologies, practitioners can deliver excellent endodontic work for adults and children alike, preserving the natural teeth.

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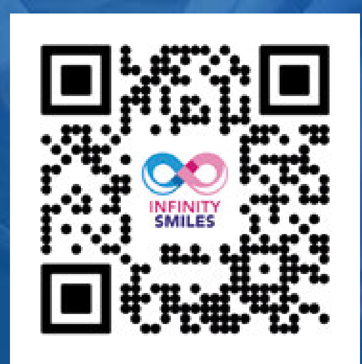

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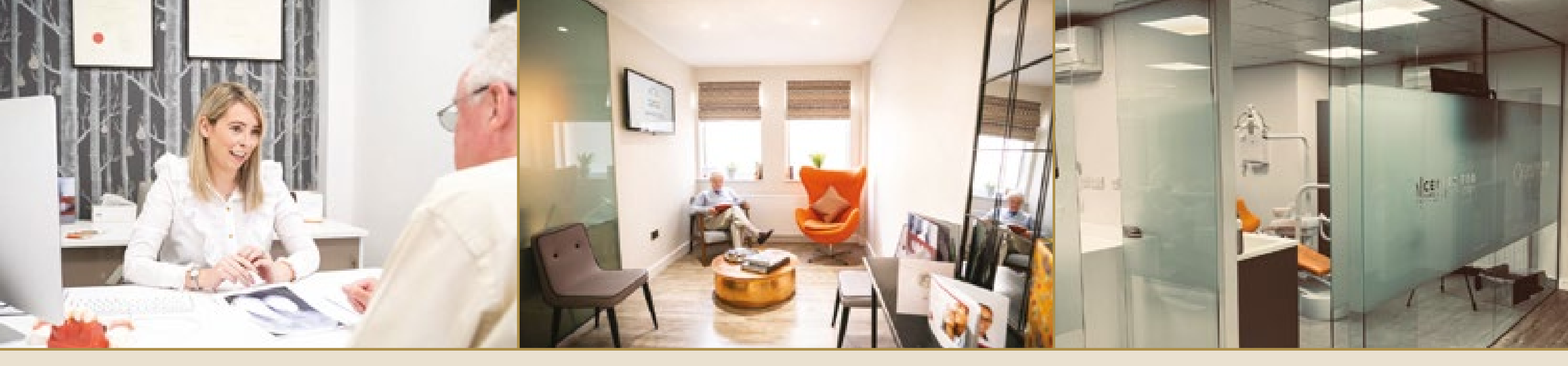

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Alastair Fraser, Principal Dentist, Greygables Dental

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