

THE BUDDING DENTISTS GUIDE TO.. DENTAL SCHOOL AND BEYOND

2021 EDITION



*A one-stop guide demystifying the process of
applying to dental school.*

WE ARE MEDICS





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Introduction

Welcome!

This Dental Applicants eBook, was originally produced in 2020 to ensure you reach your full potential. We aim to provide you with a comprehensive overview of the Dental admissions process, tips to guide you through each stage and essential insight into an array of key topics in Dentistry. We have also linked other free resources that we feel would aid your preparation throughout this document.

You do not need to be experts in all things Dentistry at this stage, that's what university is for! Simply having an awareness and appreciation of the process and core topics shows you've taken time to build your knowledge basis and are passionate about your journey into Dentistry.

All the contributors have thoroughly enjoyed working on this content for you and are immensely passionate about their course and imparting their own experiences so that they may assist and inform you through your own journeys. The eBook has been edited, and all content approved, by a team of current dental students, from a range of year groups.

This booklet has been updated with love from a collaboration between We Are Medics and a team of recently graduated & current dental students at Birmingham Dental School, tag us on Instagram - we would love to see you using it!

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Survey + disclaimer

Survey



A survey is available [here](#), this will allow you to leave a short review on the quality of the eBook.

Completing this survey is a way of supporting us, and we can use the results to secure more funding, which will allow us to create more exciting opportunities for you.

Please complete it **after** you have read through the eBook!

Disclaimer

This advice is based on personal experience, and we cannot guarantee successful Dental School applications based on it. However, as current dental students we believe that we have provided high quality information.

This is the 2021 updated version of our original Dental eBook, created in August 2020. Please ensure you separately verify any dates (e.g. for admissions tests & applications) and university requirements regularly - updates/alterations may occur due to COVID.



We do not support or endorse any company or individual which charges money for support during the dental application process. We strongly believe that this advice and information should be available for free.

Therefore, we do not support or endorse paid-for dental admissions courses. We believe this eBook provides excellent insight regarding the dental admissions process and key topic areas. We have linked to free resources throughout.

Any external content we recommend may contain adverts or suggest you need to purchase paid-for resources. We do not support such adverts or claims.



Choosing a Dental School

- Belfast
- Birmingham
- Bristol
- Cardiff
- Dundee
- Glasgow
- Leeds
- Liverpool
- King's College London
- Barts and the London School of Medicine and Dentistry (Queen Marys University of London)
- Manchester
- Newcastle
- Plymouth
- Sheffield



There are 14 unique undergraduate dental schools in the UK, each accredited by the **GDC (General Dental Council)**. The result of completing a course at any of them is the same, graduating as a Dentist ready to conquer the world (hopefully)!

But with so much choice, how do you find the one that suits **you** best?

First let us start with **your four options**, it's best to have an idea of your top choice/s and really understand what that university is looking for in their applications.

Choosing the right dental school can apply to or even firm can be tough and confusing. All the universities will pitch different point or have different niches that make them unique.

Understanding the differences between all the **different dental schools and programmes** will help in choosing which dental schools to apply to and then ultimately help when you must make that final decision!



Here are **some common buzz words** you may come across which are all different things to consider when making your choice.

A-Level Grades

- Often many students' first port of call when choosing a university.
- Typically, the **traditional offer is AAA**, however, these **can vary** for different reasons between universities.
- **Contextual offers** can be awarded to students who meet certain socio-economic eligibility criteria or have exceptional personal circumstances which can be as low as AAC.
- If you think you think you may fall into this category, the **admissions pages** of all the universities have more information where you can find out more about the selection process for this type of offer.
- Please note: Kings College London usually gives offers of A*AA and sometimes Plymouth can too.
- Make sure your predicted grades align with the typical offers of the universities you apply, give yourself the best chance of getting all those offers!
- Check out the **@wearemedics IG post about strategic applying** to see how you can gain more definitive Information on just how much universities value different aspects of applications



PBL vs EBL

- Please **don't ignore** these common little acronyms that you may find popping up everywhere in the application process.
- They are both **teaching styles** adopted by different dental schools.



PBL = problem based learning

Typically uses a case-based learning style in which there is a lot of time for personal research and group discussions as well as presentations to help learn content (e.g. Manchester and Cardiff use this style).

EBL = enquiry based learning



This learning style involves independent learning and coursework projects to consolidate information taught by the tutors (e.g. Birmingham uses this).

Universities are normally very open about their style of teaching but overall, a lot of courses teach over a **mixture of different methods**, alongside traditional lectures to help students grasp the different information, techniques and skills required for the dental degree.

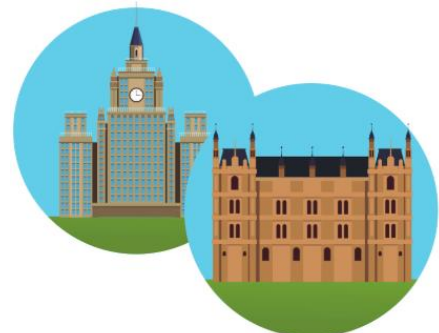
Clinical Start

- One thing a lot of applicants don't realise is that dental schools all start their clinical teachings at **different times** over the 5 years.
- Some universities such as Leeds or Birmingham hardly have any clinical contact in the first 1 or 2 years of the course and instead focus on biology, anatomy, and physiology, however, it means more of a focus on the actual 'dentistry' part of the course in the older years.
- Other universities like Kings College London, Manchester, and Bristol pride themselves on their early introduction to a clinical environment where from first year there is a lot of involvement with procedures and patients.
- There is **no right or wrong way** to teach dentistry and each university has its own methods.
- Think about when you would want to start having clinical experience in the course and make sure you know how your prospective universities spread their clinical learning.
- COVID-19 has altered this for many courses (e.g., at Birmingham students in younger years have more shadowing/assisting sessions with older years very early on in the course (1st/2nd year))



City versus Campus

- To some people, the distinctions between studying at a city-based university or on a campus university will make little difference.
- Typically, dental schools are **not local** to the university anyway, with some dental students having to travel or commute through the city daily.
- Universities such as Manchester, Leeds and Bristol have city centre campuses where the





buildings are dotted around the city, whereas Birmingham and Cardiff have contained campuses where all the main action takes place.

- Do your research and look at the online campus/university tours to see what sort of lifestyle you prefer.
- It is a personal decision, and some people tend to sway more towards city living than remote living just as an individual preference.
- There is no right or wrong!

Location

- Across the country, **price points** of living and accommodation do tend to change. London is typically more expensive than other universities like Liverpool or Newcastle.
- Even though this is reflected in any maintenance loan (for **accommodation** and living) taken out, it is normally not enough to reflect the increase in the cost of living. City centre accommodation is more expensive but living on the outskirts means a commute.
- Consider what will be best for you and look into what student accommodation is provided for first years and where students typically live for the following years after that.
- Most universities have a **student area** of the city or town where older students can rent shared houses or studio flats.
- Make sure everything fits in your price point and you can see yourself in the city! Another thing to consider at this point is how **far away** your respective university will be from where you live and how much it will cost to go home!
- **Travelling** from Scotland to London is significantly more expensive and takes a lot more time than Birmingham to London. Find out how much a typical train or coach journey would cost you and how convenient that journey is for you because you will likely be making numerous trips over the five years.
- For those who are considering potentially **commuting** to university, make sure you know how long it will take in the mornings and evenings and also be aware that a lot of universities will not have good or free parking nearby so do your research and don't get caught out!
- Once again COVID resulted in a **mixture of online & in person teaching during 2020/1 academic year**, so make sure that you are happy with the environment you live in & feel at home wherever you may find yourself.





Social and Nightlife

- This is a very simple one but is always something you should consider.
- If you do a sport or play an instrument and want to be involved in an orchestra or band, make sure that the university union has a **society** for it.
- Most **university-run teams** for all the traditional sports plus some more **niche** ones and also has plenty of music, theatre and creative societies, however, if you have your heart set on something, checking the union website's list of societies will help you to see if there is something of interest to you.
- A night out in Manchester is a lot cheaper than a night out in London!



Finally, remember that wherever you choose you will have to spend 5 years there. Make sure you pick somewhere where you can see yourself living and spending a lot of time in that city as it will become your second home.

Search through all the universities admissions pages to find out more and read about the course overview to make sure you are happy with the programme. Try to find out if there's a way for you to **connect with current students** to gain further insight where possible (e.g., online open days, your school alumni, internet forums, university Instagram accounts etc.)



Don't lose sleep over **dental school league tables**. These rankings change every year and use criteria that don't necessarily impact on your own undergraduate experiences. All the universities make sure their graduate dentists are **ready for the world** of clinical practice, so **the choice is up to you!**



Admissions Tests

All dental schools in the UK require applicants to take the **UCAT**, **whereas** the University of Leeds is the only university that **also** uses the **BMAT**.

UCAT (University Clinical Aptitude Test)

- **2 hour test** which assesses a range of abilities and qualities that dental schools consider important in the practice of dentistry and in health professionals. **Completed electronically.**
- **Areas assessed include:** decision making, verbal reasoning, abstract reasoning, quantitative reasoning and situational judgement.
- Receive a total score for the test immediately after completing it.
- The highest possible score for the UCAT is 3600. You will also receive an average score (your **total divided by 4**). For Situational Judgement, you will be assigned a band between Band 1 and Band 4 for situational judgement.
- **Usually**, an average score of 650 is considered good, and 680 considered high but the mean score varies each year and dental schools account for this.
- A score below 610 is usually considered low, but this **does not mean** that it's impossible to receive an interview offer, or that you shouldn't apply this year.
- It all depends on how the cohort performs during that year.

Key dates:

- **Registration for the UCAT:** 2nd June 2020 – 22nd September 2021
- Testing: 26th July – 29th September 2021



Useful **FREE** resources can be found [here](#) or [here](#).
Also note our **FREE 2021 UCAT eBook** available [here](#).



BMAT (BioMedical Admissions Test)

- **2-hour exam** required by the University of Leeds Dental School. Unlike the UCAT, which is completed electronically, the **BMAT is a pen and paper exam**, and so you won't receive results on the day of sitting.
- The BMAT consists of 3 sections:

Section 1– Aptitude and skills (60 mins)

- Tests general problem solving skills, data analysis
- All multiple choice

Section 2– Scientific knowledge and applications (30 mins)

- Applied GCSE biology, physics, chemistry and maths
- All multiple choice

Section 3– Written communication (30 mins)

- One page essay
- Choice of 3 essay titles (including both medical and non-medical topics)

Your raw score from sections 1 and 2 of the test are placed on a scale from 1 (low) to 9 (high). A score of 5.0 is considered average, 6.0 very good, and 7.0 exceptional. For section 3, you will be assigned a band, either A (highest), C or E (lowest) for your quality of written language, and a score from 1 (lowest) to 5 (highest) for quality of content.



Specification can be found [here](#).

Key dates:

Registration: 1st September 2021 – 1st October 2021 (for November sitting)

Testing: 3rd November 2021

Results released: 26th November 2021

Please note: usually there is also a September test date BUT this has been cancelled in light of COVID-19 [click here for more Information](#). The NOVEMBER 2021 BMAT will still be going ahead.



TOP TIP ALERT

It's important to take the UCAT/BMAT whenever YOU feel ready for it! (try not to cram)

UCAT = recommend revising for approx. 1 month (online)

BMAT = recommend 1.5 - 2 months (remember its a written exam)

Also check out this mini blog post - [changes to the BMAT In 2021](#).

No longer applicable for 2021 but...

What was the difference between the September and November sitting?

Was the same format regardless of when you take your BMAT. Results from either date will be considered equally by universities.

The **only difference** was that if you take the **BMAT in September**, you will be able to sit the exam and receive the results **before** submitting your UCAS application. This gives you the **opportunity** to **apply** to universities **strategically**, based on your result.

If you sit the exam **in November**, you will receive the results **after** you have submitted your **UCAS application**.

Useful resources can be found [here](#), [here](#) or [here](#).





Application Process Overview

This can vary so much for everyone, as cliché as it sounds – **no journey is the same**. Here's what it may look like...

- 1) Work experience – usually can sit in and observe from the age of 15/16.
- 2) Decide to apply to study dentistry.
- 3) End of year 12 – start UCAT prep. (see our UCAT Ebook for more!)
- 4) Open UCAS application and start looking at personal statements.
- 5) Visit open days or even better attend online sessions to find out more about the universities & follow their social media accounts to keep up to date with the latest.
- 6) Use UCAT score to finalise 4 dental schools to apply for
- 7) Start writing your personal statement (see our PS Ebook for more!)
- 8) Submit UCAS application with the teacher reference before the first UCAS deadline
- 9) Interviews – wait to hear back & do some basic preparation. (Oooh exciting, this Ebook may help!)
- 10) Wait for offers & continue focusing on your A-Levels.
- 11) Choose your firm and insurance.
- 12) Wait for A-level results. (Good Luck!)
- 13) Start Uni! Do it your way, get your degree & grow!



It can seem like a lot to achieve in such a short period of time all whilst still studying and revising for those all-important A-level exams which ultimately determines how much your hard work pays off. Even though the summer before year 13 seems daunting and the whole process seems incredibly long and convoluted, those who have gone through it and have reached the other side can tell you that it is definitely **all worth it in the end** and the more effort you put in, the more you get out of it.

Work experience can often (but not necessarily) come before that decision to study dentistry is even made. **For many** it's a toss-up between medicine and dentistry or even any other clinical-based degree like pharmacy, physiotherapy or nursing.

Gaining valuable **work experience** preferably across a different range of practitioner backgrounds makes a difference in consolidating the desire to embark on this amazing career.

My top tip is to write absolutely everything down that you see on work experience. Write down questions, answers, things you observed and things to research when



you get home. You will find this self-created resource of incredible usefulness when it comes to writing a **personal statement or prepping for interviews** as you can include detailed accounts something you saw briefly 2-3 years prior and really impress the readers of your application.

Please note: Given the current climate this will likely prove more difficult than usually...DO NOT PANIC... universities just want you to be WELL INFORMED, they want to see that you've gone out of your way to gain INSIGHT Into Dentistry.

INSIGHT is everything. It helps you become informed, prepared and hopefully excited about the future!

UCAT preparation

Should start **4-6 weeks** before taking the test and there are plenty of amazing resources out there. There is not too much to say here that can't also be found in our UCAT eBook already but just a reminder that a **'bad' grade** is **not the be-all and end-all** of the process. Make sure you understand what your result is and where it lies on the average and percentiles. Use this information to **strategically choose** which universities you are going to apply for as UCAT scores are weighted differently by each university.



Personal statements

Personal statements are the universities only insight into you and your personality before interviewing you? Use your personal statement to show your **commitment to your choice of the profession** and how your personality traits and the skills you've acquired have seen and learnt over the past few years will make you a successful clinical practitioner.

Universities don't just want to know what you've seen and done want to see how you have **reflected** on your work experience observations as well as how you can work as a team! Aim to have your first draft done by the beginning of year 13 and take it to your UCAS supervisor straight away!



Be **confident with your** four university **choices** and know that you could end up at any one of them. Feel free to have a preference in mind but make sure you can see yourself studying at the cities and universities you are applying for and make sure your predicted grades match with the typical offer that university gives out.

Since dentistry is your chosen course, **never** try to tailor your personal statement to another course simultaneously, because this **shows indecisiveness**.

Some people also tend to apply for a 5th course with a lower typical grade offer (but once again be happy with this back-up choice). Not everyone has submits **back-up 5th option**, it's up to personal preference really. It can be useful **if you're open to doing another course** should your dentistry application be unsuccessful. However, your fifth choice may not give you another if your personal statement is entirely dentistry related. **Contact the course provider** to find out if they typically accept these applications.

Offers for interviews...

Can arrive any time from November to February. Whether the interviews are face to face or over video, learning good interview technique is an invaluable skill that will also come to benefit you in the future as well.



Dental schools want to see logical and confident thinking as well as a demonstration of **sympathy and empathy** to prove you can communicate with patients in distress or disarray. Always come prepared with a reason why you want to study at that specific university.

Even if it is not your first choice dental school, go into each interview with the **mindset** that this is the only university you have ever dreamed of going to and act passionate about both the city and the course.

Around March time you will have had all offers come through. **Wisely** choose your firm and insurance and remember that if your insurance has the same grade requirements as your firm, not obtaining those grades at a-level may put



you in a difficult position. You can choose to discuss other options with your school and family all before you submitted, then the real hard work begins.

Hopefully on results day everything will run like clockwork, but try your best to **stay calm and collected**, see the day as opening new doors for you rather than closing them – regardless of what happens.

Getting your grades and seeing that UCAS track display your confirmed place for dentistry is a **dream come true**. If things go slightly wrong, you can always call up the admissions offices of the dental schools to discuss your application. This has sometimes proved successful in the past for students who have maybe dropped a grade.



My **overall advice** is to stay grounded, and not to get ahead of yourself. Focus solely on the part of the application that is ahead of you and embark on your journey with confidence and determination.



There will certainly be ups and downs but **pick yourself up** if you get rejected by a university, or you have a bad interview – remember that **it will all work out in the end!**

TOP TIP ALERT



Check out our IG post regarding FOIs and strategic applying...to gain clearer cut answers about exactly HOW Universities weigh different aspects of each application – as admissions pages can sometimes be vague.



Interviews

Dental school interviews fall into two categories: **panel**, or **MMI** (Multiple Mini Interviews), with many dental schools moving towards MMI.

Panel interviews tend to last around 30 minutes, in which you will be asked questions by several interviewers. The panel can also consist of people of different backgrounds within dentistry, for example, a clinician, a lecturer and a dental student. Questions in panel interviews tend to be **more traditional**, such as those about your motivation for studying dentistry.

MMI interviews consist of several stations, each with a theme. As well as stations about traditional topics, such as work experience for example, MMI interviews often include **more creative stations**, such as role play, manual dexterity, and communication stations. Each station tends to last between 5–8 minutes.

Think you're read, let's break down some potential topics for you...

TOP TIP ALERT

How about trying to answer these as you go along or better yet set up a mock interview with friends & family?

Motivation and the study of dentistry

- Why do you want to study dentistry? (Surprise surprise)
- Why not medicine/nursing etc.? (be respectful of other professions)
- If you were not offered a place for dentistry this year, what would you do?



Demonstrate commitment and dedication to dentistry by explaining how you would take a gap year and reapply. Discuss what you would do in the gap year to strengthen your application.

- Have you thought about what you would like to specialise in?



You don't need to restrict yourself here by choosing one specialty - you haven't gone through dental school or even tried them out yet. It's ok to mention that you found a specialty interesting during your work experience, but make sure you emphasise the fact that you're keeping your options open and are excited to learn more during the course. If you mention one, make sure you know what it entails and have genuinely explored it out of interest.

Knowledge of dentistry as a career

- What do you think is the biggest challenge in this career?
- Differences between NHS and private dentistry?
Consider: cost, cosmetic vs functional, length of appointment, materials available (e.g. Amalgam vs composite fillings)
- What role do dentists have aside from treating patients?



E.g., Educational role - Dentist's also provide advice on smoking cessation and healthy living

- What do you think could cause the patient-dentist relationship to deteriorate?
- Which of the 9 GDC standards do you think is most important and why?
Read up on the 9 standards. No need to memorise them as such just be familiar with them and how to implement these in practice
- What makes a good dentist?

Think about both technical ability and personal qualities

Work experience and volunteering

- What work experience did you carry out and what did you learn from it?
- From your work experience, can you tell me about a difficult situation you observed/had to deal with and what you learnt from this?
- After undertaking your work experience, what do you think makes a good dentist?





- What volunteer work have you done and what did you learn from it?
- How did your volunteer work prepare you for dentistry?

Depth and breadth of knowledge

- Do you read any publications that are relevant to your interest in dentistry? Tell us about an interesting article that you have read recently.
- Have you heard about any public health campaigns recently? Do you think this is a good way to spend public money?



For example: look up Dental check by One and its aim, any other Interesting public health Initiatives...

- What do you think the most important development in dentistry has been?

Consider: anaesthetic, fluoride toothpaste.

Personal insight

- How would you describe yourself in three words?

E.g. Resourceful, conscientious, driven, diligent, creative, caring

- What do you think you can bring to the field of dentistry?
- What qualities do you have that are suited to dentistry and why?
- What is your biggest achievement?
- How have your non-scientific hobbies prepared you for dentistry?
- Dentistry is a stressful career, how do you cope with stress?
- Are you more of a leader or follower?



Ethics

- What are the 4 principles of medical ethics and which in your opinion is the most important?

Read up on Autonomy, Beneficence, Nonmaleficence, Justice

- How could these four groups of people have problems accessing healthcare: Disabled, ethnic minority, homosexual, and homeless?
- When is it acceptable to lie?
- Would it be ethical for dentists to strike? If so, under what conditions?





- Is it ever acceptable to breach confidentiality?

Read up on consent and confidentiality

About the university

- Why do you want to go to this university specifically?

Teaching style (EBL vs traditional lecture-based), and why it suits you, mention specific facilities, student societies you're interested in

- Independent study makes up a large part of this course – tell us how have you managed this approach to learning in the past?

Overall advice

Keep your answers **natural** as possible, over rehearsal does not sound genuine and increase your nerves especially if you forget what you "should" say. **Be yourself**, try to think **carefully** about why they are asking you what they are and then put your spin on it – be **polite, professional, and sincere**.

Remember, the interviewers already know you're intelligent, now they want to see if you can communicate. Interviewers are human too and they've had to sit countless interviews to get where they are today, so they completely understand how it feels to be on the receiving end.



And most importantly **Good Luck!**

See Chapters 5–11 for more help!



Important Organisations

The two main organisations we will be discussing are the GDC and the BDA, however, in addition to these there are an array of other organisations within the dental field (e.g. for each of the dental specialities)

The GDC

The General Dental Council (GDC) is a **UK-wide regulatory body** for the dental team authorised through legislation to oversee the dental profession and maintain a register of qualified practitioners.

Governed by the Dentist's Act 1984, its purpose is to "protect patient safety and preserve the public's confidence in dentistry"

via:

- **Registering qualified dentists.**
- **Establishing key standards for the dental team**– professional rigorous codes of ethics created by the GDC establish what is expected of a dental professional.
- **Disciplinary structures**– used to investigate dental complaints and regulate professional conduct. The Fitness to Practice structure governs serious professional misconduct or persistent lack of professional performance.
- **An education committee**– sets learning outcomes to determine the educational requirements dental students must meet before entering the dental register. This ensures consistent high-quality dental education is delivered in UK dental schools.

The BDA

- Founded in 1880, The British Dental Association (BDA) is a **professional body and registered trade union** for dentists in the UK.
- They are **owned and run by** their members and the income, via paid membership, is reinvested for the benefit of the dental profession.
- The BDA represents the **voice of all dental fields** and **dental students** and ensures that dentists' views are represented in health policies developed by the government and other organisations. The BDA also offers **advisory publications** and information on the latest dental issues through the British Dental Journal and BDA News.



- The BDA **aims to support** dentists throughout their professional life through **advice and education**, on employment law and ethics, in order so that the best possible care can be given to patients.
- Their mission is to ["promote member's interests, advance the science, arts and ethics of dentistry and improve the nation's oral health"](#)



The Dental Team and Standards

Good patient care and delivery of treatment is founded on a good dental team. Every member of the team contributes to the patient's experience at the dentist and each member has a vital role to play in ensuring the best possible healthcare is provided to the patient. The team members must work together effectively, via successful communication.

The GDC's scope of practice defines and explains the abilities of each team member, who can only perform tasks/ treatments/ make decisions about patient care if they are appropriately trained.



The Team:

o **Dentist**

- Team leader, position of ultimate responsibility and coordinates all team members.
- Diagnose and treat oral health problems and provide advice on how the patients can take care of their teeth and gums via diet choices and good oral health.

o **Dental nurse**

- Works closely with the dentist, aiding them throughout the treatment preparing materials needed, ensuring instruments are available and cleans and sterilises used equipment. The dental nurse also plays a safeguarding role.

o **Dental hygienist**

- Help maintain patients' oral health by preventing and treating periodontal disease and providing information about how to effectively look after teeth and gum.
- Carry out treatment direct to patients or under the dentist's prescription.

o **Orthodontic therapist**

- Carry out certain parts of orthodontic treatment under prescription and close supervision of a dentist, usually an orthodontist.



o Dental technician

- Constructs dental prosthetics (bridges, crowns, veneers, dentures...). These devices are manufactured based on impressions taken of the patients' teeth as well as following the dentists' written and oral instructions- using materials such as plaster, wax, porcelain and metal.

o Clinical dental technician

- A balance between the dentist who would take the patient's impressions, and dental technician who would receive the impressions and then make the dentures. A clinical dental technician takes the impression and makes/fits the dentures.

o Receptionist

- The front line and face of the dental surgery - the first point of contact over the phone or on arrival to the clinic.
- Books in new patients, organises appointment times, greets visitors and undertakes other non - clinical tasks of administrative nature.



o Practice manager

- Responsible for the smooth running of the dental practice via organising rotas, staff meetings and ensures a safe environment is maintained for patients and staff.

o Domestic services

- Thorough hygiene and cleanliness are essential in a medical environment to prevent infection. Domestic services ensure that the surgery is clean, safe and tidy, reducing the risk of spread of infection.

o Maintenance/service engineer

- Install, modify, repair and service dental equipment to ensure it meets the regulatory standards and that it is used correctly, protecting staff and patients from mechanical or electrical hazards.

o Courier

- Deliver dental work to and from dental labs to the dental surgery for any urgent or non-urgent dental work dentists need. This ensures that patients receive the correct treatment at the right time.



○ Patient – the centre of the dental care

- The dental team is centred around the patient, always acting in the patient's best interest to deliver the best possible dental treatment tailored to the patient.

Registered with the GDC (pay an annual fee).

Not registered with the GDC.

Interview Questions to consider

1. Who is the most important member of the Dental Team?
2. How important is team working and communication in dentistry?
3. What are the qualities of a team player and a team leader?
4. When were you good/bad in a team?
5. How important is teamwork/leadership in dentistry?
6. What can go wrong in a team? What would you do if a team member wasn't pulling their weight?
7. Who are the GDC? Who are the BDA?



Standards for The Dental Team

The 9 Standards

[Based on GDC's Standard Guidelines](#)

1. Put patients' interests first.
2. Communicate effectively with patients
3. Obtain valid consent
4. Maintain and protect patients' information
5. Have a clear and effective complaints procedure
6. Work with colleagues in a way that is in patients' best interests
7. Maintain, develop and work within your professional knowledge and skills
8. Raise concerns if patients are at risk
9. Make sure your personal behaviour maintains patients' confidence in you and the dental profession

Why Do They Matter?

- Dentists have a **responsibility** to treat patients with the upmost professionalism, **honesty and transparency** as they are placed on a pedestal by society due to the wreath of knowledge they hold. As the population trusts dentists with confidential information, in return **society expects** a certain quality of dental treatment.
- To ensure that dentistry is being performed to a **consistently high standard**.



- Ensure dentists are acting for the right reasons – the **patient's best interests**.
- Dentist are **acting morally** and **ethically** at all times.
- **Protect** the dentist and the patients.
- Patients expect to be treated as individuals and dentists have a **duty** to behave professionally.
- These standards set out what is expected of the dental profession.

TOP TIP ALERT



Whilst you do not need to memorise the standards at this point, having an overall awareness of them and being able to apply them in various scenarios demonstrates your understanding of their significance with the profession.

Looks really good to interviewers and shows you've done some research into the profession.

Now let's see have a look at how these principles can be breached...

TOP TIP ALERT



How about jotting down notes for the each of the scenarios yourself before you check out our thoughts on them. Which GDC principles are involved? etc...

Example 1: An elderly patient attends your dental practice you speak slowly and excessively loud without justification, despite them demonstrating no hearing Impairments or difficulties in understanding you. Furthermore whenever they ask questions you do not explain clearly, only using technical language that they are not familiar with and carry on with the treatment planned (you have not presented alternative options at any point) and when the dental nurse corrects or attempts to stop you, you reply aggressively.





What went wrong?

- **Standard 1** = By addressing the older patient in a patronising manner, you have not treated them with the dignity, respect and fairness they deserve. It is important you are aware of how your tone of voice and body language might be perceived and adjust it to each patient accordingly.
- **Standard 2** = Although you made attempts to answer the patients questions (which is an important part of the consent process), you used technical language when describing aspects of their treatment to them, furthermore, you did not confirm with them if they understood the information.
- Effectively communicating with patients is essential you must listen to them carefully, avoid jargon and use an interpreter when English is not their first language (not necessarily family - needs to be someone the patient has permitted to translate for them, note confidentiality issues). Encourage patients to ask questions and check understanding by asking them questions and summarising key points.
- **Standard 3** = You seem to be rushing to deliver a certain treatment and have not given the patient time to consider all options before gaining consent. Therefore, you have not obtained valid consent (written or verbal, part of this process would be explaining all the relevant options and ensuring that patients understand the decisions they are being asked to make. **(see Chapter 7)**)
- **Standard 6** = By speaking aggressively to your nurse you have not respected them in your interactions and have failed to work in a way that is in patients' best interests.

Example 2: You carry out a procedure on a patient that you have only ever seen in a video and somehow it works so you want to share it with your friends and colleagues on Instagram. When you post the picture, you include the patients name, date of birth and address (with asking them), you also tagged them and put humiliating comments about their appearance before and after.

What went wrong?

- **Standard 4** = You've shared confidential information with the world essentially, it was your responsibility to maintain and protect patients' information. Part of this means you should never post any information about patients on social





networking or blogging sites (unless you have obtained consent to do so, even then no personal details should be disclosed)

- **Standard 7** = You should only ever work within your knowledge, skills, professional competence and abilities- only carry out a task or a type of treatment if you are appropriately trained, competent, confident and indemnified (covered by your insurance).
- When you leave dental school this does not give you a free pass to attempt anything and everything, you must ensure you have the appropriate training, knowledge and skills to perform a task safely. If needs be you must carry out further training or develop your competency until you can practice safely.
- **Standard 9** = You are in a public position of responsibility and it is part of your professional duty to ensure your personal behaviour maintains patients' confidence in you and the dental profession- ensure that your conduct, at work and in your personal life, justifies patients and public's trust in the dental profession.
- Never post anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media.

Example 3: A patient complains to dental nurse about the dentist speaking rudely to them when they asked the dentist to wash their hands after touching the inside of the bin to pick up a pen they had dropped. The nurse does not feed this back to the dentist or the team until the patients next visit 6 months. This was not the first time the patient complained about the dentists' cross-infection habits.



What went wrong?

- **Standard 5** = Patient's complaint was dismissed, delayed and not listened to carefully by the dental nurse or dentist. It is important to have a clear and effective complaints procedure and respect a patient's right to complain whilst completely involving them in the complaints process. Patients who complain must have a prompt and constructive response (responsibility of all members of the dental team).
- **Standard 8** = A colleague's consistent inability to follow the infection control procedure or failure to replace important equipment which is broken in the surgery as promised. You must raise concerns if patients are at risk due to the



surgical environment, the health, behaviour or professional performance of a colleague, or if someone is asking you to do something that conflicts with your duties to put patients' interests first and protect them.

Implications of Breaching

- Ultimate loss of dental- patient rapport.
- Loss of patient's and public's **trust, respect and confidence** in the dental profession.
- Reluctance for the patients to go to the dentist and seek help when necessary; hence a **subsequent degradation in oral and general health**.
- The dentist may find it difficult to continue practising perhaps because of the lack of positive and transparent communication.
- A serious breach could result in the dentist being given a '**fitness to practise**' warning or even be removed from the GDC register.
- An incohesive dental team reduces the effectiveness of the team to act in the patient's best interests and the quality of the dental care given.
- More patients could be put at risk of harm as the dentist could be severely lacking practice in certain areas- the complaint could act as constructive feedback, used in order to allow the dentist improve themselves and an effective complaints procedure will improve the efficiency of the surgery and ultimately the quality of dental treatment delivered.
- Acting beyond your scope of practice puts patients and the dentist at medical risk.
- **Whistleblowing** ultimately protects the dentist and the patients, ensuring that the utmost professional behaviour is conducted constantly.

[More case studies for further practice are available here.](#)





Consent

The concept of consent is an essential part of practicing dentistry, not just from a medicolegal aspect but also in an ethical sense because all interactions with patients should be done based on mutual agreement, understanding. Consent can be either **implied or expressed: written or verbal**.

It's often outlined by various dental defence/insurance organisations as well as the BDA and GDC. In fact [GDC principle 3](#) as part of standards for the dental team is to "**obtain valid consent**". Consent is such a huge topic both in the wider healthcare setting and within dentistry and tends to get overcomplicated by many, but it's nothing to get overwhelmed about and is quite straightforward. Remember to put the **patient's best interests first** and never carry out treatment outside your competency (do not overpromise).



The trick is to take a step back; have a **rational and logical approach** to any situation, there's plenty of guidance available for you to refer on the governing body websites.

Who is involved in consent?

- The patient
- The dentist
- The dental team members
- Sometimes: other family members, chaperones (e.g. if they have a **power of attorney** to make medical/financial decisions on behalf of the patient.)...

Principles of Informed Consent

- Informed consent means that you must provide the patient with **all information** regarding the basis of treatments planned, the pros/cons, risks, alternatives as well as the consequences if no treatment is carried out.
- Consent should be **voluntary** and the individual giving it must have **capacity** to understand the information presented to them, be given time to understand it and be able to ask any questions they may have at any stage of the treatment process.
- The **4 pillars of informed consent** are: autonomy, beneficence, non-maleficence and justice.



1. Autonomy = an individual's right to self-determination and freedom from external control/influence.

2. Beneficence = moral obligation to act in the benefit of others

3. Non - maleficence = to not harm others.

4. Justice = to equally weigh benefits, risks, resources, and costs.



They are explained quite simply [here](#) (outside of the context of the dental field).

What factors can influence a patient's capacity to consent?

- **Age** of the patient.
- If the patient has any **medical conditions** that may influence their **decision making abilities** (e.g. dementia, mental health conditions, substance abuse issues...).
- Background factors to consider:
 - What is the **purpose of** their **visit** to the dental practice (e.g. is it a routine examination, have they had sleepless nights because of dental pain, are they attending an emergency appointment)
 - What **type of treatment** are they consenting to and what's their baseline level of knowledge about it (e.g., word of mouth rumours can sometimes influence their decision making?)
 - Are they attending the appointment **with anyone**? If yes, who is it? (Notice how they interact with the patient, is the patient comfortable around them.)
 - What **time of day** is it? Is this any emergency appointment?
 - Etc...



Importance of consent

- **Medicolegally** necessary
- **Ethically** required
- The patient is usually happier if the dentist has a **clear and rigorous** consent practice whereby, they are always kept informed, respected and ensure that their **best interests** are the heart of your approach to treatment.
- Both the team members and dentist themselves are able to establish a **healthy rapport with the patient** based on exchange of information and a collaboration for specific outcomes.



- Aside from any written consent, dentist should always **make notes** in the patients record about **any discussions** they have with them regarding consent **or any refusal** to consent, even if it's based on verbal discussions. If it doesn't get recorded it's as though it never happened.



Issues if there is insufficient/no consent

- Patient can **complain**.
- Patient **loses trust** in the dentist and can become agitated or unhappy.
- The **team members** would also be unhappy and may have consequences of their own to face.
- **Legally** can get into trouble - you are not permitted to even touch a patient without consent.
- **Breaching** the basics of consent means you can face criminal charges and even be struck of the GDC register (banned from practicing dentistry) or you could only be allowed to do certain treatments and need to be supervised when carrying these out (like a probation period).
- The different **regulatory bodies** - GDC, NHS and CQC would each have various consequences in place.



Gillick Competence

- An example of a case being used to set out guidelines for healthcare practice.
- The Gillicks test competence test is used by professionals to assess whether or not a **child under the age of 16** has sufficient capacity to consent to a specific medical intervention/treatment.
- Children can be deemed competent if they demonstrate that they have **sufficient understanding** and awareness of the proposed intervention, can weigh up and **rationally assess** the risks and benefits of each of the options.
- If children are not deemed competent then someone with **parental responsibility** is able to step in (**or** sometimes the **courts** do) so that a treatment can be decided and commenced.



- In cases **where a child refuses medical treatment**, but it could lead to their death or permanent harm, any decision they make can be overruled.
- Additionally, any concerns about a child should be raised with **children protection services**, or any other required agencies, even if they do not want this. It's the dentist/team's duty to **appropriately raise** any **concerns** immediately.
- Click [here](#) or [here](#) for some great resources.

Summary of interesting laws and regulations

- **Main principles:**
 - GDC's principle 3 – from standards from for the dental team
 - Care Quality Commission (CQC) regulation 11
- **Legally:**
 - **Mental Capacity Act** (2005)
 - **Mental Health Act** (1983)
 - **Children's Act** (1989)
 - **Human Rights Act** (1993)
 - **Montgomery** (2015)
 - **Gillick Competency** (1985)
 - **Bolam Test** (1957)
 - Etc...



Remember consent is never a one off step, its dynamic/on-going and should therefore be regularly checked at each stage of treatment, informing patients of all progress. The individual consenting should have freedom to choose and capacity to make a choice based on adequate information being proved to them.

Other helpful reads:

- [A great source from the DDU](#)
- [How should you keep clinical records](#)
- [Myth busting around consent](#)



Dental Specialities and sectors

If you're applying to dental school, you probably have one image of what a dentist is in your mind; the one that you see at your dental practice twice a year who dabbles in a little bit of everything and maybe your orthodontist if you've ever had braces!

When you do get into dental school, you quickly realise that the dental field is deceptively large with lots of clinical and non-clinical routes that you can travel down and experience.

This guide gives a snapshot of the different types of dentistry that you can practise.

Conservative Dentistry:



This field in dentistry is the one you will be most familiar with. Conservative dentists practice minimally invasive dentistry, which means that they will encourage you to get into good habits with oral health and intervene when dental disease is present, placing fillings and crowns to restore teeth as best they can, while keeping as much of the tooth as possible.

Endodontics:



If you've ever had a root canal, you have had endodontic treatment! Endodontics is a field that specialises in the treatment of roots, and the scope of practice goes far beyond the conventional root canal. One treatment an endodontist specialist may carry out is an apicectomy; the removal of a root tip.

Periodontics:



Do you spit blood when you brush your teeth? Periodontology focuses on the tissues surrounding the teeth that hold them tightly in bone. A periodontist will help you improve your oral hygiene and understand the importance of brushing your teeth to stop the gums from receding and the teeth falling out.

Treatment of gum disease (periodontitis) is the bread and butter of periodontology, but there are many surgeries that a qualified periodontist can carry out, such as the removal of gingival overgrowths.

Prosthodontics:



Dentures, dentures, dentures!

Prosthetic dentists focus on replacing missing teeth, either with a denture or fixed appliances such as bridges and implants.



Orthodontics:

An orthodontist's job is more than just straightening teeth. They ensure that your top and bottom teeth are aligned to bite together properly, which ensures a healthy jaw joint, as well as moving teeth that need it before other treatment.



Paediatric dentistry:

Paediatric dentistry focuses on the treatment and safeguarding of children. One extremely important role of a paediatric dentist is to help children form good lifelong habits as well as treating developmental conditions that affect the teeth, such as enamel hypoplasia.



Special Care Dentistry:

This specialty is involved in the treatment of patients that require extra measures, such as those with learning disabilities, dementia and severe dental anxiety. A special care dentist will also carry out home visits and may also practice dentistry in care homes or prisons.



Oral surgery:

An Oral Surgeon specialises in the extraction of teeth as well as taking tissue samples and biopsies. They practice surgical techniques that a normal dentist cannot do to remove difficult teeth or roots



Oral Medicine:

Oral Medicine is a relatively new field that focuses on medical conditions that affect the mouth as a whole, not just the teeth. If you have a lesion in the soft tissues of your mouth you may be seen by someone in Oral Medicine for an assessment and diagnosis.



Maxillofacial surgery:

Maxillofacial surgeons have to be dually qualified in both medicine and dentistry. This specialty goes beyond the mouth and focuses on the head and neck as a whole. Max fax surgeons will remove head and neck cancers and treat facial trauma.



Dental Public Health:

Dental Public health focuses on the oral health of the population; developing policies that can be implemented to tackle oral health problems at a systemic level. Dental Public Health officers will also carry out surveys such as the "Child Dental Health Survey" to get a snapshot of the oral health overall locally, regionally and nationally. Water fluoridation is one of the most successful public health initiatives ever implemented.



Current Affairs in Dentistry

Brexit

What is Brexit?

- A commonly used term used to refer to the **British exit**, the UK leaving the European Union (EU).
- In **June 2016** there was a **referendum** held for the UK public to decide whether they wanted to leave or remain in the EU, the result being 52% siding with 'leave' and 48% siding with 'remain' (a very close and topical call).
- After the 2016 vote the UK formally left the EU on the 31st of January 2020 and is now currently in an **11 month transition** period, during with **agreements** will be made between the EU and UK regarding various aspects of their relationship.

[Here is](#) a nice BBC article with more information, but let's not delve too much into the politics of this!



What's the relevance to Dentistry and overall impact on the profession?

- **Major concerns** exist regarding the current and future workforce, implications on innovations within the healthcare field, collaborations between professionals throughout the EU, the ease of medicines/medical devices being imported from Europe as well as implications on financial aspects of practicing dentistry.
- Some **key groups** to look out for are, dental students, EU dentists who currently work in the UK and those who want to leave the UK, potentially as well as employers/colleagues.



- There are strong concerns regarding the **shortage of healthcare workers** in the UK post Brexit with many EU dentists deciding that it may be better for them to leave the UK in the foreseeable future (depending on how the qualifications that they need may change).
- 17% of the UK's workforce consists of EU Dentists, approximately 22% of these individuals deliver NHS Dentistry and 30% work in socially deprived areas.
- It's interesting to look at the different **phases of dental migration** that there have been (e.g. 2007–2014 Romania and Bulgaria provided the main sources of dentists who came to the UK to work...). See [here](#) for more details.
- [Here](#) is an interesting paper to look at from the BDJ, (written **before the vote** to leave) showed many **hypothetical ideas** about what a vote to leave would mean for UK Dentistry.
- Good things about this paper:
 - It highlighted that for many years more people from outside the UK (mainly from the EU) have been new entries to register with the GDC than those who actually qualified at UK based Dental Schools, this highlights just how much the **workforce** will be impacted.
 - Discussed several scenarios that could unfold within the workforce specifically e.g. by potentially having all dentists from outside the UK completing a GDC approved examine before being able to practice here, could help in achieving **more consistent standards**.
 - Clearly highlights what could have been the case had we voted to stay (what the case was for the dental profession when the UK was still a part of the EU).
- Click [this](#) for a collection of mini blogs on this topic. (Mainly they all highlight the immense **uncertainty around this topic within the profession** as we wait to see how guidance's may be modified during this transition period. One of the most pressing concerns for now is how dental recruitment will be impacted, already many EU dentists feel that it will be difficult for them to remain in the UK (if they are already here) or for them to come to the UK when there is such a mist of confusion.)



The BDA/GDCs stance

Although both the BDA and GDC have a **neutral stance** around Brexit, many within the profession have emphasised the **need for more engagement** from them (e.g. for the BDA to work with other groups/individuals in order to gain clearer insight regarding the contingencies being put into place to address the impacts of the vote on the profession. Click [here](#) for an example of this).



As we are currently in the transition period post-Brexit, more consistent advice and information will hopefully emerge for the Dental Profession. **Combined with the current global pandemic** it will be interesting to see just how we will adapt to such a new and unique set of circumstances. I'm positive that the new-found passion of **pockets of professionals** within the field to **support** one another will help us to tackle all challenges that may come our way.

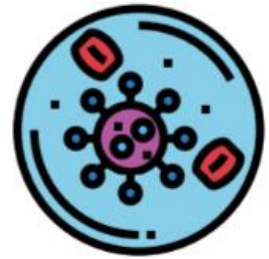




COVID-19 and Dentistry

What is COVID-19?

- Coronavirus disease 19, is an infectious disease caused by the SARS-CoV-2 virus
- **Common symptoms:** fever, cough, fatigue, shortness of breath, loss of smell and taste
- Most cases demonstrate mild symptoms however some can progress more severely leading to **respiratory issues** and even death.
- **Spreads via** people during close contact, commonly through small droplets produced by coughing, sneezing, and talking. (Droplets = Aerosols)
- Currently there are **no vaccines** or specific treatments for COVID-19. Instead there is an **emphasis on management** of the symptoms and supportive care.
- In March, the UK Government imposed a **lockdown**, this consisted of bans on all "non-essential" travel, contact with people outside your home as well as **widespread closure** of almost all schools, businesses, and facilities, including dental practices.



Impact on Dentistry

- Dental professionals are a **high-risk group** in terms of **exposure to, and transmission of** COVID-19. Due to the close face-to-face contact with patients and also because many of the procedures they do are 'aerosol generating'.
- Therefore, the **NHS England Chief Dental Officer** had announced the suspension of all routine and non-urgent dental care in March.
- **Dental practices** responded by carrying out consultations over telephone and form triage and advice services instead.
- The main aims being to defer dental treatments for as long as possible. The only treatments offered followed the AAA approach = **Advice, Analgesics (pain relief medication) and/or antibiotics.**
- The **profession's main concern** throughout the crisis has always been patient safety.





- **Delays in** seeking dental treatment can lead to spread of infection, which can then leave patients with treatment options that are not ideal and, in many cases, irreversible.
- **Other concerns** delayed diagnoses of dental diseases or cancer due to the suspension of routine check-ups, in addition to the placement of sub-optimal temporary care given to patients who are currently mid treatment.
- From the 8th of June, general and community **dental services opened to resume** face-to-face care (both routine and urgent) for most patient groups. Including aerosol generating procedures (AGPs) and non-AGP procedures, with a continuous emphasis on practice in line with infection control measures.



Impact on Infection Control

Transmission in dental settings can occur via 4 major routes:

1. **Direct exposure to respiratory secretions containing droplets of blood or saliva.**
2. **Indirect contact with contaminated surfaces/instruments.**
3. **Inhalation of suspending airborne viruses.**
4. **Contact with infection-containing aerosols, propelled by coughing and talking without a mask.**

Transmission of the virus via droplets and aerosols because, despite all the precautions taken, it is almost **impossible to completely remove aerosol production** during dental procedures

Dental handpieces use high-speed gas to rotate with running water, which leads to the generation of a considerable amount of aerosol mixed with patients' saliva and/or blood, these aerosols can then be **transmitted throughout** to dental practice (between staff and patients as well as amongst other patients at the clinic).

How do we tackle these issues?

- Use mouth rinses **before dental procedures** = to decrease the number of bacteria/viruses present in the mouth (further research required on just how effective this can be)
- Use of **rubber dam for dental procedures** = rubber dam (a square sheet) use to isolate a tooth/or multiple teeth from the rest of the mouth. Use of



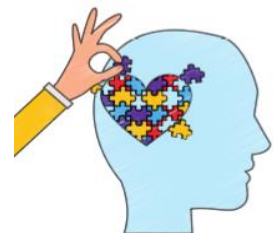
them dam reduces the generation of aerosols contaminated with saliva and blood (although you still need high volume suction to maximum prevention).

- **Focus on hand hygiene** = to avoid contact with eye, mouth, and nose areas.
- **Use of protective equipment** (e.g., masks, protective goggles, gowns, helmets, gloves, caps and facial shields) is strongly recommended, especially as airborne transmission is considered as one of the main routes of infection.
 - (**NOTE:** Although this has become standard for most healthcare personnel now, it is still quite new and therefore daunting at times for dental professionals, who strive to do what's safe and best for their patients and staff, in addition to their families and themselves.)

Impact on Mental Health

COVID-19 has placed **significant pressures on dental professionals**, who have had to:

- Wear stricter personal protective equipment (PPE) when at work.
- Isolate from their families.
- Dealt with the risk of infection (exacerbated when there is inadequate availability of PPE)
- Pressures associated with being overworked
(Notably these additional measures have often led to frustration and exhaustion)



- The fear of the unknown can trigger anxiety in otherwise healthy people, as well as those with previous mental health problems.
- This increased anxiety is **often related to** the risks associated with contracting COVID-19.
- **Financial impacts** cannot be neglected, as many dental practices have been forced to close for extended periods of time and ensure that they have **appropriate shielding measures** in place. And even when now that they are open, public concerns mean that many patients are cancelling appointments.
- The **self-employment** aspect of primary care dentists means that they are especially **vulnerable** in comparison to their NHS employed medical colleagues.



- Overall, there are concerns regarding future employment within the sector as well as uncertainty regarding individual practice development plans.

Dental Education:

- The **suspension of face-face-teaching**, transmission to online teaching and completed pause placed on online teaching has also been a source of stress for many.
- Students have been required to stay at home and learn online during this pandemic.
- Anxiety and uncertainty surrounding dental **students gaining sufficient experiences** in dental procedures, meeting treatment requirements and alterations have been made to the curriculum to accommodate missed teaching.

Potential Links to Oral Hygiene

(Click [here](#) for the paper this is based on, or [here](#) for a shorter summary of its findings.)

- COVID-19 **can affect some patients more severely than others**, dependent on their risks factors (e.g. age, gender, and certain health conditions) which can result in additional complications and even mortality.
- However, there are a select few of patients who do not suffer severe complications but have **no identifiable risk factors** (e.g. 10-15% of people under the age of 60, with no risk factors can exhibit moderate to severe reactions to COVID-19
- Patients who suffer from **more severe forms of COVID-19**, they are at increased risk of developing complications such as pneumonia, acute respiratory distress syndrome (ARDS), septic shock and can even die.
- Although the **origin of COVID-19 is viral** in nature, bacterial Infections may lead to **additional complications** such as pneumonia and ARDS. (In the 2009 H1N1 influenza pandemic, bacterial infections were identified as the main cause of death as opposed to the virus itself. (**Bacterial infections** are often understudied as diagnosis is often complicated.)

In severe cases of COVID-19, bacterial superinfection could be common?...

- Some patients suffering from **severe infections** can demonstrate a significantly **higher neutrophil count** and lower lymphocyte count than in mild patients.



- A high neutrophil count is **abnormal for a viral infection** but can be seen in bacterial infections.
- 50% of patients with patients with **severe COVID-19** have had **a bacterial infection present also**.

Respiratory infections and oral health:

- The lungs are unique due to their specific environment that allows **specific bacteria equilibriums**.
- Equilibriums **can shift** during illness allowing overgrowth and injury to the lungs.
- **Contamination** of the airways by inhalation of microorganisms in aerosols or by breathing in secretions from the oral cavity, that are associated with oral diseases (e.g. like the p.gingivalis bacterium which cause periodontitis)
- **Inflammation** and **infection** then occurs in response to bacteria infiltrating the lungs when you breathe in saliva.
- Therefore, it's proposed that **inadequate oral hygiene can increase the risk** of inter-bacterial exchanges between the lungs and mouth = increases the risk of respiratory infections.
- **Periodontal disease patients:**
 - 25% **increased risk of cardiovascular disease**
 - Triple the **risk of diabetes mellitus**
 - 20% **increased risk of high blood pressure**

all these conditions = more likely to have severer forms of COVID-19
- **Good oral hygiene** is therefore essential to maintain, if not improved to: **reduce the bacterial load** present in the mouth, reduce the risk of a bacterial infection in the lungs and to reduce the risk of further complications.
- The bacteria present in patients with severe COVID-19 are linked to the oral cavity.



Other resources I used:

1. [Comparison of South Korean and British Dental responses.](#)
2. [NHS document: COVID-19 guidance and standard operating procedure.](#)
3. [Being a front-line dentist during the pandemic.](#)
4. [Rubber Dams.](#)
5. [Mental Health consequences \(in Dentistry\).](#)



Navigating the world of COVID-19 & Dentistry

Where to begin?

Firstly, you do not need to be an expert on this constantly evolving topic, but being able to appreciate its significance within the world of healthcare is essential.

Especially as you will one day be joining a profession that has been forever changed by COVID-19.

There are several ways to navigate the world of COVID-19 & Dentistry...

1. The General impacts...on key groups (e.g. the profession, businesses, students, emergency dental care, backlogs of patient treatments...)

2. Return to Dental Practices & Changing the face of Dentistry (e.g. triaging care, aerosol and non-aerosol procedures, PPE, redeployment across the NHS & experiences...)

3. AAA triaging system and antibiotic resistance (e.g. guidance given to the dental profession at the start of the pandemic/early 2020, solutions & alternatives...)

4. Public Health considerations (e.g. DIY Dentistry during the pandemic – safety issues & attitudes...)

How to stay informed but not overwhelmed?

There is naturally a wealth of information online and with constant updates & evolving nature of the pandemic even now it can seem like there too much to look through & too little time

Just stick to 2-4 sites that you can skim through briefly, taking concise notes on anything you find interesting that week/month.



Sites such as "Dentistry.co.uk", "Dentistry Today" & **especially the BDA's very own COVID specific page** ([here](#)) can be helpful to get you started.

Have a look at this two part article published in December 2020 looking at "The Clinical, Legal & Economic consequences" of COVID-19 on the Dental Profession. [Click here \(part 1\)](#) & [here \(for part 2\)](#).

The key points & subheadings are great ways to break-up information into manageable chunks.



Key Topics

The Basic Science of Tooth Decay

The Structure of a Tooth:

- The **enamel** is the outer layer of the crown of the tooth. It is the hardest tissue in our body! This is because its highly mineralised to protect our teeth.
- **Enamel** and **dentine** act as a barrier to protect the pulp. Tooth decay can affect both enamel and dentine.
- The **pulp** is the innermost part of the tooth and contains all the nerves and blood vessels which supply the tooth.

Click [here](#) for more information on tooth anatomy (including a diagram).

What is tooth decay?

Also referred to as "dental caries". It is the demineralisation of the tooth tissue structure which weakens the tooth and can lead to further breakdown.



What causes this demineralisation?

- Bacteria in our mouths ferment the sugar from our diet. The fermentation process produces acid which then lowers the pH.
- When the pH surrounding a tooth is below the critical pH (5.5), demineralisation occurs.
- The diagram known as the "[Stephan's curve](#)" is used to explain this phenomenon. It shows how changes in pH can determine whether a tooth gets mineralised or demineralised.

What does tooth decay look like?

- The appearance varies based on what stage the tooth decay is at.
- Early tooth decay appears as small white lesions in the enamel. in contrast well established decay (lesions) can appear dark brown/black.
- These may also be cavitated – which is when the tooth has broken down due to the decay, leaving a "hole" in the tooth.

Some great diagrams and clinical photos can be found [here](#).



Why do we treat tooth decay?

If tooth decay is not treated, it can lead to:

- Sensitivity
- Pain
- Infection



How do we treat tooth decay?

Usually, the decayed part of the tooth is removed, and a filling is placed. If the infection has reached the nerve (pulp), a root canal treatment or extraction may be considered.

What increases the likelihood of someone developing tooth decay?

- **A high sugar diet** – the more sugar we eat the more there is for the bacteria to ferment!
- **Not using fluoride** – fluoride in water supplies, in toothpaste and mouthwashes can help to remineralise the teeth and helps to prevent further tooth decay.
- **Reduced saliva production/dry mouth** – saliva provides a buffering action against the acid produced by bacteria.
- **Tooth anatomy** – sometimes teeth are harder to clean because of 'pits and fissures' which trap sugar and bacteria. Toothbrush bristles may be too big to reach into them, therefore these areas are more prone to developing tooth decay.
- **Tooth positioning** – some teeth are harder to clean because of where they are (e.g. if there is crowding).



Ways to prevent tooth decay:

- ✓ **Good oral hygiene measures** – this includes the use of a fluoride toothpaste, interdental brushes, mouthwashes, and a good brushing technique (we instruct our patients to use the modified BASS technique).
- ✓ **Fluoridated water** – in some areas of the country the water is fluoridated! Birmingham is one of those areas.
- ✓ **Fluoride varnish and fissure sealants** – your dentist may provide these to protect your teeth.



Periodontal disease

Before we discuss periodontal disease (also known as gum disease), it is important to understand how the presence of dental plaque can first cause inflammation of the gums, known as gingivitis which can then progress to periodontitis when the inflammation starts to involve additional tissues that support tooth tissue.

Once you have periodontitis/periodontal disease it never 'disappears', although it can enter phases where it's stable, in remission or unstable.

Dental plaque

- Plaque forms on our teeth throughout the day, more accumulates between our teeth and at the point where the tooth meets the gum- the gingival margin.
- It is soft in texture and made up of microorganisms and food debris that exist together in an entity called a **biofilm**, allowing it to stick to the tooth.
- This biofilm of plaque can be broken up and removed by regular and effective toothbrushing and cleaning between teeth using **interdental brushes** such as those manufactured by Tepe.
- If the plaque is left to grow it can cause 'gum disease'. It can also harden to become **calculus**, which is very difficult to remove.
- **Gum disease** is a broad term and there are many specific diseases under this umbrella.



Want to see what plaque can do to your teeth? Click [here!](#)

Gingivitis

- Gingivitis refers to **inflammation** of the gingival tissues- the gums
- It caused by bacteria from the biofilm irritating the host cells and has varying degrees of a characteristic appearance
- The gums may appear **puffy and redder** than usual
- Some gingivitis patients experience bleeding when brushing, flossing, or spontaneous bleeding of the gums.
- It is managed by **removing the biofilm** through more thorough toothbrushing and **effective cleaning** between the teeth



- If the plaque has **hardened into calculus**, it will be very difficult to remove and a visit to the dentist or dental hygienist to have a professional clean is required, followed with optimal oral hygiene instructions to avoid future build up
- The key aspect of gingivitis is that it is **readily reversible**, with no permanent side effects on the gums and teeth if managed appropriately.
- It is very important that gum health is **stable before** starting any other **complex dental treatment**, as it forms the foundations for stable teeth.



Periodontitis

- Periodontitis is a **follow-on** from this initial inflammation, but it involves more than just the gums.
- Each tooth sits within the gum, and which itself rests on more connective tissue and bone. The tooth is **anchored** in from all aspects of the root surface (under the gum) by fibres called the periodontal ligament
- In periodontal disease, the **periodontal ligament, connective tissue and bone** can be destroyed to varying extents
- This means the tooth has **less anchorage** than before. As a result, the gum may shrink downwards away from the tooth, revealing more of the root surface—**recession**
- Teeth may begin to **drift** and become **wobbly** and eventually can fall out. The signs of gingivitis such as puffiness and redness, may also be observed.
- This bone loss and other effects occur in a specific population. In these individuals the immune system has a **hyper-inflammatory response**. This means that although the immune system is trying to protect the body from the plaque bacteria, the processes by which it does this cause **accidental damage** to the surrounding connective tissue and bone.
- **Risk factors** include poor oral hygiene, smoking tobacco, poor diet, certain medications, diabetes and age.
- These risk factors can be **managed and reduced**. However, once **bone** has been lost, it **cannot grow back** and any change in these risk factors such as poor oral hygiene, can cause further bone loss quite rapidly.

The transition from health to gingivitis to periodontitis



Fluoridation

Fluoride is a natural mineral. It is found in many foods as well as drinking water. It helps strengthen the tooth structure by re-mineralising the enamel. Greater mineralisation means the tooth is more resistant to developing dental decay. The amount of fluoride in a substance is usually given as parts per million (ppm). The higher the ppm, the more fluoride.

Where can fluoride be found?

- **Drinking water**
 - Fluoridated water – 1ppm
 - Non-fluoridated water – 0.05 to 0.2ppm
- **Specific foods**
 - Tea – 0.1 to 0.5ppm
 - Fish – 2.3 to 5.4ppm
- **Oral hygiene products**
 - Toothpaste
 - Children's toothpaste – 1000ppm
 - Adult's toothpaste – 1350 to 1500ppm
 - Mouthwash – 450ppm
 - Fluoride varnish (provided by dentists) – 22600 ppm



Benefits of Fluoride

- ✓ **Strengthens** the tooth structure and makes it more resistant to tooth decay.
- ✓ Addition of fluoride to water has been proven to **reduce tooth decay** by 40-60%.
- ✓ **Children** who have fluoride when their teeth are developing have shallower grooves on the surface of their teeth, making them **easier to clean**.
- ✓ Proven to **reduce** the amount of **acid bacteria** on the tooth surface produce.
- ✓ Research has shown children living in poorer areas where the water supplies are not fluoridated can have 5x more decay than children living in more affluent or fluoridated area.



Disadvantages of Fluoride

- × **Fluorosis** – fine white pearly streaks or flecks on the teeth.
 - It occurs due to overexposure to fluoride when the teeth are developing





- People may not be happy with the appearance
- ✱ Some people argue that fluoridated water can be harmful however there is **no scientific evidence** to support these claims.

Click [here](#) or [here](#) for more.



Amalgam

What is Dental Amalgam?

- Amalgam fillings are also called 'metal fillings' or 'silver fillings'.
- Amalgam is one of the **oldest dental materials** still in use.
- Consists of an **alloy** of **at least one metal** from silver, tin, copper and/or zinc, **alongside elemental mercury**. The copper increases its corrosion resistance and increases strength.
- When amalgam fillings are placed, they are not at full strength, a chemical process occurs **overtime** to allow them to reach their full strength.
- Amalgam fillings are **held in place** slightly **differently** to white fillings made from composite. They rely wholly on mechanical retention – this means drilling a cavity in a tooth which is a specific shape to physically hold the filling in place, against various forces. Whereas composite relies on chemical bonds with enamel to hold it in place.



Controversy Surrounding Amalgam

The use of amalgam in dentistry is rapidly reducing worldwide. This is down to a number of factors:



1. All amalgams **contain mercury**, albeit in very low quantities.
 - Mercury is a toxic element, linked to causing negative effects on the brain upon exposure at certain levels ("mercury poisoning"). So it makes people very reluctant to have something like this present in their mouth.
 - Levels of elemental mercury in amalgam are very low, with several studies revealing those patients are not likely to suffer negative consequences due to having an amalgam filling placed.
2. Many people have raised concerns with disposal of mercury, which can have **harmful effects on the environment** where it ends up.
 - The Minamata Convention, convened by the United Nations Environment Programme in 2013, declared at use of amalgam will now gradually be completely phased out due to its harmful environmental effects upon disposal.
 - All dental clinics must now dispose of their waste amalgam in special containers, and through specialist waste disposal companies.

3. Aesthetics



- In modern dentistry, a general trend is that patients are becoming more conscious of their aesthetics and are thus becoming less keen to have fillings which are silver and not the same colour as their teeth.

4. Movement towards '**minimally invasive/destructive dentistry**'

- Advancements in dental materials have led to the development of more efficient adhesive materials – those which strongly bond fillings to teeth, therefore the need for fillings that rely strongly on mechanical retention (e.g. amalgam) requiring more natural tooth destruction – via drilling are more avoidable.

When is Amalgam Still Used? (Indications for Amalgam)

- **Large fillings on back teeth** – the molars experience large forces during chewing, which can cause fillings to break or fall out; amalgam fillings offer good resistance to fracture under such heavy chewing forces.
- **A core material under a crown** – sometimes a tooth is so broken down, that more material needs to be added in order to drill a shape which can then hold a crown on top of it; amalgam can be used to build the tooth up for this purpose (sometimes called **a Nayyar core**).
- In a cavity which **previously contained an amalgam filling** – if a cavity has been prepared in the correct shape to hold amalgam (or a cavity does **not favourable** for placement of a more aesthetic composite filling), amalgam may still be the best choice.
- Patients who are not overly concerned about **aesthetics**/would like the cheapest option – if the filling is going to be far back in the mouth, it may not be visible when somebody speaks and eats; amalgam fillings are also cheaper than tooth-coloured alternatives and either of these factors may still lead somebody to opt to have an amalgam filling placed.

Restrictions imposed mainly through the Minamata Convention (cases where amalgam cannot ever be used):

- **In primary (deciduous) teeth** – in children, alternative materials such as composite, or glass ionomer can and must be used instead of amalgam.
- **In pregnant or breastfeeding ladies** – although there is no specific evidence linking amalgam to causing harmful effects on the unborn child, avoiding amalgam means there is no risk and may give peace of mind.

Physical Properties of Dental Amalgam

- **Strength** – amalgam fillings can be quite brittle immediately after placement and thus break easily.
- **Corrosion** – over the years after it is placed, surface corrosion and breakdown may occur within an amalgam filling due to chemical interactions with its surroundings. If this occurs you need to replace the filling.



- **Rigidity** –just remember it is still always better to try to preserve natural tooth structure rather than readily drill and fill.

Amalgam vs Composite Fillings

Composite ('white' or 'tooth-coloured') fillings are now largely replacing amalgam fillings in dental practice. With modern materials, it is generally believed the strength of white fillings has now finally reached that of amalgam.

Here is a list of advantages/disadvantages to consider between these two common types of filling:

- Amalgam fillings are **less aesthetic than tooth-coloured composite, generally cheaper than any other material and require more aggressive preparation of the tooth to place the filling compared to composite.**
- Placement of amalgam is far **less technique-sensitive** than composite – composites need multiple stages to ensure they adhere to teeth, but amalgam is simply packed into a cavity.
- Ideally when placing a composite filling, **no moisture (water, saliva, blood)** can be present, this is less critical with amalgam.
- Amalgam fillings do not significantly **change shape during setting** (they are 'dimensionally stable'), whereas composites do shrink as they set – this increases the risk of the filling pulling away from the cavity wall and allowing harmful bacteria back in to cause more decay.

Questions to consider

- 1.How does disposed amalgam (mercury) negatively impact the environment?
- 2.Do you believe amalgam should be totally phased out? Why do you hold the opinion you do?
- 3.Would you be willing to have an amalgam filling in your own mouth?
- 4.What is minimally invasive dentistry? What are its benefits?
- 5.How would a cavity drilled for amalgam need to look compared to one drilled for a composite filling? (more advanced dental school level)
- 6.What is resistance form and what is retention form? (You will not need to know this in depth for an interview, but awareness of something like this may well impress examiners!)



A useful resource I used:

[Pickard's Guide to Minimally Invasive Operative Dentistry](#)

This book is recommended to use at dental school level, so don't get bogged with knowing its ins and outs at this stage!



NHS Dentistry vs Private Practice

Key Differences Between NHS and Private Dentistry

1. Cosmetic vs Functional Dentistry

- Patients can have **cosmetic treatments** performed privately (e.g. tooth whitening in the absence of an underlying medical disease causing the tooth discolouration = purely cosmetic).
- Whereas any treatment provided on the **NHS must** be a procedure which provides **functional benefit**; something purely cosmetic cannot be performed on the NHS.
- **Functional treatment** can sometimes additionally help improve **aesthetics** (e.g. fabrication of a denture to improve chewing whilst also filling an unsightly space where a tooth is missing).
- **Aesthetic treatment** = performed to improve a patient's dental appearance, **whereas cosmetic treatment** = concerns 'fine tune' appearance or treatments purely to facilitate 'added beauty'.

2. Budgeting/pricing of treatments

- **NHS treatment** tends to be provided on a limited budget in order to make greatest use of taxpayers' money.
- Each practice has a **fixed and set budget** each year. As a result of these factors, the quality of materials used and aesthetics of prostheses produced in NHS treatment may not be as high as that available privately.
- **Private practices** may have the luxury of using more advanced techniques, better materials and **private laboratories** to produce dental prostheses. Crowns/bridges/dentures made privately may be made by specialist technicians, which, alongside using more advanced materials, often means they resemble natural teeth and gums more accurately than what would be available through the NHS.
- That said, **private treatment** is thus **priced accordingly** so is likely to exceed that of NHS treatment prices, sometimes significantly.
- All **NHS treatment is grouped** into one of three treatment bands; each band has a fixed price:

NHS Dental Treatment Banding

Band 1 (£22.70)

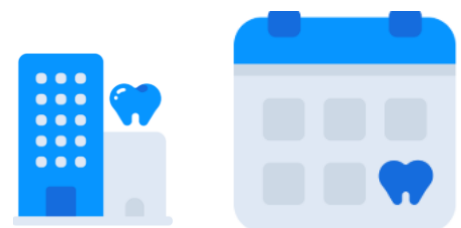
Includes things like examinations, diagnosis, advice (e.g. on caring for teeth, diet, treatment options), x-rays, scale, and polish.

Band 2 (£62.10)

Treatment includes fillings, root canal therapy and extractions (if needed on top of band 1 treatment).

Band 3 (£269.30)

Encompasses more complex treatments which require the use of a laboratory, e.g. crowns, bridges and dentures





To gauge the difference between NHS and private practice pricing, a crown in private practice can cost well in excess of £500, but the quality of the materials used, the duration of the crown and its appearance can all be fully optimised.

3. Appointment times

- **Private practices** often **offer longer appointments** and are more **flexible** in the appointment times available – they may have late evening or weekend appointments.
- **NHS appointments** may prove to be harder to get hold of, with **longer waiting times**, and the need to take time off school/work to go to the appointment.
- There may also be more difficulty with **accessing a specialist** in NHS dentistry compared to privately, and there may be a longer waiting list.

Quick Quiz

Which two of these cases do you think would not be able to have treatment on the NHS? (*The answer is at the end of this section!)

1. A 69-year-old male has a painful top-right molar which has now formed an abscess.
2. A 33-year-old female would like tooth whitening as her yellow teeth are lowering her mood.
3. A 5-year-old child has chipped their front upper tooth.
4. A 27-year-old male would like an implant to replace a missing lower premolar which was lost due to severe decay.
5. A 53-year-old lady needs upper and lower dentures as she only has 5 teeth left.
6. A 12-year-old girl needs braces to fix upper incisors which stick out badly.

The UDA System

Currently at the time of writing (July 2020), dentists working under the NHS are **paid according** to the number of **Units of Dental Activity (UDAs)** they carry out per year. Each type of treatment carries a fixed number of UDAs with it, which the dentist is credited with once the treatment is complete. **UDAs are allocated as follows:**

- Band 1 treatments = 1 UDA each
- Band 2 treatments = 3 UDAs each
- Band 3 treatments = 12 UDAs each

There is a lot of **controversy** around the UDA system, with many feeling it is unfair and does not always reward the amount of work done. UDAs are allocated based on the completion of a course of treatment in one patient, not on the number of individual teeth treated.

For example, this means a dentist would receive 3 UDAs upon completing root canal treatment on a patient who needed one tooth treating, but would still receive 3 UDAs upon completion of treatment in a patient who needed root canal treatment on 4 separate teeth.



In Scotland, dentists are still paid through a “fee per item” system, where each specific procedure carried out is reimbursed with a set fee – some people argue this is fairer.

There are still **benefits** of the UDA system. For example, the money paid per UDA can be adjusted in areas where there is a greater need for more dentists, in the hope of attracting more clinicians to work in this region.

NHS Contracts

The role of the UDA system was designed to **allow the performance of individual practices to be measured**. NHS contracts are awarded to practices, allowing them to carry out dentistry in the area they are located in.

If UDA targets are consistently not met by the practice, they could have their contract terminated or downgraded for the next year, or see their budget reduced.

TOP TIP ALERT



Details of NHS contracts are **unlikely to be necessary** to do well at an interview to get into dental school, but there are a couple of key things worth being aware of:



- **Individual dentists** work as self-employed individuals, but under contract to a specific practice. They are **‘performers’** of dentistry, and each dentist must be on the **NHS performers list**.
- **Each practice** has a member of staff (often a performing dentist, but not always) who is the **‘contract holder’**. This person is **responsible for** ensuring the practice meets the terms of the contract it has been awarded by the NHS, and that all performers in the practice are **productively contributing** to meeting the criteria set out in the contract.

Questions to consider

1. Should any cosmetic treatment be offered on the NHS? What about a patient whose mental health and self-esteem is affected by poor dental appearance?
2. Is the UDA system a fair way to reward dentists? Is it actually possible to make a better system?
3. Is treatment banding a fair way to charge patients? Should any treatments be in a different band to where they are now?
4. Should NHS practices be doing more to make appointments more accessible?
5. Should NHS practices invest in more advanced materials or equipment using taxpayers' money?
6. If you needed treatment, would you go to an NHS or private practice? What **factors** are influencing your own decision in this situation?



Useful Sources I used:

[What are differences between NHS and private dentistry?](#)
[Units of Dental Activity](#)

**Answer to Quick Quiz:**

Numbers 2 and 4 would not be available on the NHS. The tooth whitening, although lowering the patient's mood, would offer no functional benefit so is purely cosmetic.

The implant is replacing a tooth that was lost due to decay, not through an accident or medical condition beyond the patient's control, so again could not be provided on the NHS – a denture or bridge could be done at an NHS practice to replace the missing tooth, however.



Dentistry in the wider context

Oral Health and General Health

The mouth is often referred to as a 'window' to your general health. General health and oral health are interlinked and an understanding of this is important to achieve holistic patient care. This section will give you a **brief overview of factors** that impacts upon oral and general health. It is not necessary to know the details of the topics discussed below as you will be **taught the details in dental school**.

Alcohol

- Alcohol intake has been **associated with** many impacts on oral health including an **increased risk of** oral cancer, periodontal disease, tooth wear, dental caries and trauma.
- **General health** is also impacted by alcohol intake. Examples include drug interactions (prescribed and non, illegal/legal), liver disease and heart disease.
- The **social and psychological health** of a patient is also affected by alcohol intake which affects the dental management of a patient. Anxiety, compliance to dental treatment and dental attendance are factors that relate to excessive alcohol consumption.
- Dentists must **advise and support** their **patients** about reducing their alcohol intake to lower their risks of developing oral and general health complications.
- It is very important for dentists to ask about and accurately record alcohol intake when taking the history during a patient consultation.



Click [here](#) to see the source I used. Or [this link](#) for free similar material (a lot more detail than needed for interviews).

Bleeding Disorders

- There are many bleeding disorders affecting patients, examples including inherited conditions such as **haemophilia and Von Willebrand disease**.
- General dental practitioners **may be** the **first to suspect** and **identify** certain bleeding conditions due to patient complaints such as bleeding when brushing.
- As a general dental practitioner, you must be able to **manage** and **appropriately refer** patients with bleeding disorders.
- General dental practitioners must **communicate** with hospital dentists, medical practitioners and haematologists to plan the care of patients with bleeding





disorders. A team approach to care is critical to ensure safe and responsible management of those at risk.

- Patients are often anxious about the risk of bleeding during and after dental treatment, therefore **reassurance and clear instructions** are important to support these patients. It's often not just about how you treat the patient during treatment but also about how you support them during recovery and plan for potential pitfalls.

TOP TIP ALERT



Can you notice some themes appearing...an emphasis on teamwork and whole patient care is absolutely essential. You're not just treating teeth you're treating a PERSON! (think about this concept in interviews, it puts may things into perspective.

Click [here](#) to see the source I used. Or [this link](#) for free similar material (more detail than you need to know for interviews).

Pregnancy

- Dentists should be aware that the body changes during pregnancy due to **hormonal activity**, and how the changes affect the **management** of the patient.
- **Hormones impact the cardiovascular system** and the blood system; there is an increased blood volume and increased risk of blood clotting.
- During late pregnancy, women may experience low blood pressure when **lying down on the dental chair** as the weight of the abdomen compresses the inferior vena cava, therefore reducing cardiac output. Dentists must consider patient positioning to ensure patient comfort and **prevent** any **deterioration** in health.
- Dentists must also be **aware of drugs** that may be toxic to the foetus, keeping radiation doses as low as practicable from dental x-rays and **timing routine dental procedures** during the safest period, the **second trimester**.
- Always **risk assess** these patients carefully and ensure they fully understand the pros and cons of carrying out any treatment (a normal part of consent).
- **Amalgam cannot be used** to fill teeth in pregnant women, except when strictly deemed necessary.
- Existing **gingivitis (gum disease)** may be **exacerbated** during pregnancy, and some patients may develop localised swelling on the gums known as a pregnancy epulis.



Click [here](#) to see the free resource I used





Systemic Conditions and Dentistry

Coeliac Disease



What is coeliac disease?

- A life-long immune-mediated intolerance to gluten (a protein found in wheat) in genetically susceptible patients.
- When a person affected by coeliac disease eats gluten their immune system attacks the lining of their small intestine, including the villi.
- This results in a lack of absorption of essential nutrients including iron, calcium, folate and fat-soluble vitamins.
- Around 1% of the population are diagnosed with coeliac disease, and 90% of people remain undiagnosed.

What are the general symptoms of coeliac disease?

- Abdominal pain
- Weight loss
- Diarrhoea
- Bloating and excessive wind
- Tiredness due to malabsorption of nutrients
- Itchy rash
- Nerve damage



What are the oral signs and symptoms of coeliac disease?

Oral signs and symptoms may be the only presenting features of coeliac disease where general manifestations are not obvious. These include:

- Tooth enamel defects
- Delayed tooth eruption
- Recurrent oral ulceration
- Angular cheilitis (inflammation of corners of mouth)
- Oral lichen planus (autoimmune condition causing lacy white patches, redness and swelling of the lining of the oral cavity)
- Atrophic glossitis (red smooth tongue due to loss of tongue papillae)



How does this relate to dental practice?

- In patients with undiagnosed coeliac disease, general dental practitioners may recognise any oral signs and symptoms as they have regular contact with



generally well children who may not have any other general symptoms – dentists must be aware of the general and oral signs and symptoms of general diseases!

- Dentists must liaise with general medical practitioners to organise blood tests for the diagnosis of coeliac disease in patients, highlighting the importance of communication and teamwork in delivering patient care.

Click [here](#) to see the source I used. Or click [this link](#) to see a free resource I used (has lots of great pictures too).



Diabetes and periodontal disease

Diabetes refers to having high and uncontrolled blood sugar for a prolonged period. There are **two broad classifications**:

Type 1: Autoimmune destruction of beta cells means the pancreas is unable to produce enough insulin. Insulin acts to transport glucose from the blood into cells and thus an absence of this causes **increased blood sugar**. Generally, these patients have been diagnosed at a young age and are **insulin-dependent**, meaning they require **artificial insulin injections** periodically for blood glucose control.

Type 2: In these patients, the pancreas does initially produce insulin. However, the cells **become resistant to the insulin** and so again, **blood sugar is increased**. **The major risk factor is** excessive weight and obesity, with initial management strategies being a healthy diet and regular exercise. Some patients also require medication and insulin injections

Uncontrolled diabetes has **many systemic impacts** ranging from problems with the cardiovascular disease, retinopathy and glaucoma, nephropathy, and damage to nerves.

There is also increasing research and evidence between patients who have **diabetes and periodontal disease**, with those with diabetes being at 2.8–3.4x **higher risk of developing it**.

A **bi-directional relationship has been described** meaning that in patients with periodontal disease, poor glycaemic control can worsen its effect e.g. more bone loss. Similarly, if the periodontal state of the patient is controlled and stable, there has been evidence of improved blood sugar control.

Key points

- As dental practitioners it is very important to have the medical knowledge to **appreciate conditions** such as diabetes, even if you are not directly managing them
- There are **many associated conditions** with uncontrolled diabetes and so management of these should be considered
- There are many considerations for these patients, for example morning appointments are preferable for most patients as there is reduced risk of a **hypoglycaemic episode** (extremely low blood sugar), where the patient might faint



- Some dentists are also undertaking '**point of care testing**' by which they test their patients' blood sugar, **to optimise patient encounters** with healthcare professionals and diagnose diabetes at earlier and more manageable stages

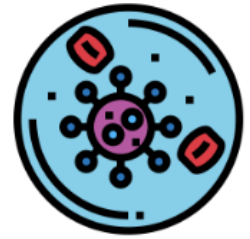




HIV and Dentistry

What is HIV/AIDS?

HIV (Human Immunodeficiency Virus) is a virus that damages the cells of the immune system, and so **diminishes ability to fight everyday infections** and disease.



AIDS (Acquired Immune Deficiency Syndrome) is the name used to describe the potentially life-threatening infections and illnesses that occur when your immune system has been severely damaged by the HIV virus.

There is currently no cure for HIV, but there are very effective drug treatments that enable most people with the virus to live long and healthy lives. With an early diagnosis and effective treatments most people with HIV will not develop any AIDS-related illnesses and will live a near-normal lifespan.

Epidemiology of HIV/AIDS in the UK

In 2018, there were an **estimated 103,800 people** living with HIV in the UK, of which around 7,500 are unaware of their HIV status, so undiagnosed. Anyone can get HIV, but men who have sex with men and black Africans are disproportionately affected. Of those diagnosed, 97% are receiving treatment and of those, 97% then have undetectable levels of HIV in their blood.

The UK epidemic is expected to decline but the main barriers to this are **discrimination, stigma, and lack of knowledge**.

Oral signs of HIV/AIDS

70% of AIDS patients have oral manifestations which occur due to an infection that cannot be fought off by the immune system. Some of these oral manifestations are detailed below:

Candidosis: An infection of species of fungi called Candida. It is the most frequent oral feature of HIV and can appear as a **white or red patch** in the mouth. There are different types of Candidosis with the most common being the pseudomembranous type (also called oral thrush).

Dentists can prescribe antifungal medication to treat this condition, however some types can potentially turn cancerous so a **biopsy** (a sample of tissue taken for microscopic examination) is necessary to rule out signs of cancer.



Hairy Leukoplakia: A thick white coating on the sides of the tongue with a 'hair-like' appearance that's **asymptomatic** and **commonly seen in males** with HIV. It is caused by Epstein-Barr virus infection.

Kaposi's Sarcoma: The **commonest oral cancer in HIV+ patients**. It is caused by a virus called Human Herpesvirus 8 (HHV-8) which causes an uncontrolled reproduction of cells that line the blood vessels. It can appear as red or purple patches in the mouth and can progress quickly if not treated.

Dental management and transmission

It is unethical and unprofessional to refuse to treat a HIV-infected patient despite the possibility of acquiring an infection or transmitting it to other patients. In dental setting, there are **standard infection control precautions** which are effective against all infectious diseases including HIV.

HIV can be transmitted from the patient to the operator through a '**needle stick injury**', where there's an accidental entry of infected blood into the donor.

However, this is very rare because:

- **Operators are trained** to take particular care to avoid accidental self-injury with a contaminated instrument.
- Often such little blood will be transferred, so it is likely to not have transmitted the virus.
- In the UK, **most patients are on anti-HIV drugs** so are of low infectivity (a greater risk is posed by patients unaware of their HIV-positive status).
- Dental practices are required to have procedures in place that allow **anti-HIV drugs** to be **given within 24 hours**, which is more than 90% effective in preventing transmission.

As healthcare professionals, it is important that dentists understand how HIV/AIDS affects people, especially its **oral manifestations**, as they can be the **first people to notice** changes in the mouth and can help with early diagnosis. This is why HIV/AIDS is covered in much more detail in dental school.

Sources used:

- NHS: HIV and AIDS found [here](#).
- HIV Statistics found [here](#).
- Clawson's Essentials of Oral Pathology and Oral Medicine [eBook](#). (Not a free link, recommended for use in dental school!)



Multidisciplinary nature of Dentistry

Isolated, only focused on one piece of the puzzle and cut off from the rest of the healthcare profession. Common misconceptions that tend to float around and tend to be linked to the Dental field.

However, Dentistry is so much more than it initially seems there are multiple opportunities to work within multidisciplinary teams and continuously develop your skills/knowledge basis whilst simultaneously exploring interests of your own.

Aside from working with the Dental Team there are multiple opportunities to collaborate within dentistry, for example by working with individuals from different specialities and additional opportunities to collaborate with an array of other healthcare professionals on multiple levels. (Which explains why there is a desire to see the traits of a successful team worker within each aspiring dentist/dental student.)

Sometimes single cases require different specialists within the dental field to collaborate to provide a holistic and patient centred approach to care.

For example:

A Case to consider

A General Dentist refers a patient into a Dental Hospital to receive further treatment. The patient has recently been diagnosed with a form of oral cancer, has a bleeding disorder (for which he takes warfarin) and is also a ex-smoker. In terms of their dental treatment they have gross (severe) decay throughout their mouth (affecting multiple teeth), some teeth can be saved but many will need extracting and a denture will likely be required. The patient has never worn a denture before...

Which specialist's do you think could come together to discuss the best way to manage this patients case? (refer to chapter 8 and 10)



This is a bit tricky so take your time and try not to get overwhelmed, **break it down** into problems and potential solutions. It's **well above** what you'd likely be asked at interviews but a typical case you may asked to be discuss when at dental school.



- **Key things to note in their medical history: oral cancer** (patient will be receiving treatment for this so factor it in to any other procedures/treatment planned), **bleeding disorder** (they are at risk from excessive bleeding with extracting teeth, extra precautions likely to be needed), **ex-smoker** (risk factor for gum disease) etc.
- **Key things to notice in terms of their oral health:** severe decay (think why this has happened – diet, oral hygiene habits, generalised neglect...), extractions (a denture will be needed for functional and aesthetic purposes) etc.
- **Which specialities could be involved in this case?**
 1. Oral Surgeon = for extractions
 2. Oral medicine = oral cancer management
 3. Periodontist = management of any gum disease
 4. Prosthodontist = denture provision
 5. Restorative dentist = restoring teeth that can be saved



You can begin see just how many different skill sets would be required in the management of this one patient!



General Dentists are trained in the core principles and can manage 'most' cases; however, they can refer those that may need a more complex approach to management (if appropriate).

Multidisciplinary collaborations can also occur between various **professionals** (e.g. a paediatric or special care dentist contacting a paediatric doctor regarding the management of a child with learning impairments who also has a suspected genetic syndrome with oral manifestations).

Additionally, **dental problems** could sometimes **escalate** beyond the breadth of the scope of practice of general dentistry very rapidly. For



example, a dental abscess progressing to a facial swelling and breathing obstruction – e.g., Ludwig's Angina (a very rare case when dental conditions can become life threatening – urgent referral to A&E is required).



Reflecting on Scientific Journals

One of the biggest challenges when starting any university degree within the healthcare field is to gather valid and relevant information from scientific articles. Some of you may have already faced this task with the extended project qualification.



It is down to you to assess whether the information you find is:

- **Valid** – does the information carry any credit? Did the study or investigation follow good scientific methodology? Was the study or investigation designed to eliminate bias?
- **Relevant** – can the information be applied to you specifically? One example may be a treatment study that was conducted in a hospital setting, which although successful may not be possible to carry out in general practice!

What is bias?

It is defined as “**a systematic distortion of a statistical result due to a factor not allowed for in its derivation**” – certain factors will bias results in a certain direction and there are many types of bias:

- **Recall bias** – when participants in a study are asked to recall events and are limited by their own memories and perception of events. E.g. a participant exaggerating symptoms.
- **Selection bias** – research samples can under or over represent certain people or groups and the best way to overcome this is randomisation.
- **Observation bias** – when study participants know that they are being observed alter their behaviour.
- **Confirmation bias** – when researchers either purposefully or subconsciously look for patterns in their data that align their own ideas or opinions.
- **Publishing bias** – studies with negative or statistically insignificant results are less likely to be published as they are perceived as less interesting. All results obtained with good scientific method should be published – to learn from if nothing else.

Click [here](#) to see where these definitions came from.



Where can I look for information?

One way of being more confident of the information of the study is knowing where to look!

Information published in *peer reviewed scientific journals* are often more trustworthy, as the studies have been reviewed by other people in that field to assess the methodology and validity of information.



Some **examples of peer reviewed scientific journals** are:

- Nature (www.nature.com)
- BDJ Open (www.nature.com/bdjopen/) – this is an open access peer-reviewed dental journal
- BMJ (www.bmj.com)

TOP TIP ALERT



With a endless lists of scientific journals/sites now being widely available it can be hard to figure out just where to begin. So the trick is to start with what interests you in your chosen field and go from there...jot down anything that sparks your interests as you read & also any questions you have.

Getting your head around reading scientific articles is hard!

But the best way to do so is to find a subject that you are interested in, read through all of the information, including the methodology and ask yourself some of the questions posed above: is this information biased? Is the information from a trustworthy source? How have the authors come up with the results? Are they supported by evidence? Can I spot any gaps in the methodology?

Asking yourself these questions will help you decide whether or not to trust the information in the discussion or summary section.

“Any fool can know. The point is to understand.” – Albert Einstein



Revising for your A-levels

If you are applying for Dentistry, then you probably have a clear and effective way of revising and working towards your all-important A-levels.

Here is a list of A-level entry requirements for undergraduate BDS Dentistry (5 Years) as checked on each University website on August 2021:

University	Grades
University of Birmingham	AAA with Biology + Chemistry
University of Bristol	AAA with Biology + Chemistry
Cardiff University	AAA with Biology + Chemistry
University of Dundee	AAA with Chemistry + another science
University of Glasgow	AAA with Biology + Chemistry
Kings College London	A*AA with Biology + Chemistry
University of Liverpool	AAA with Biology + Chemistry
University of Manchester	AAA with Biology + Chemistry
Newcastle University	AAA with Biology + Chemistry
University of Plymouth	A*AA-AAA with Biology + another science
Queen Mary University London	A*AA with Biology + Chemistry
Queen's University Belfast	AAA with Biology + Chemistry
University of Sheffield	AAA with Biology + Chemistry

*This is not a comprehensive or official list. For full details, information and entry requirements please visit www.ucas.com

Dental School is very academically demanding, and you must have a certain degree of **diligence and motivation** to get the work done, alongside ways of managing stress and anxiety. As we all know, "hard work and no play makes Jack a dull boy!"



I came from a comprehensive school, where guidance for entry into dental school was not concrete and **self-motivation and organisation was key** to getting the grades, I needed to achieve a place!



Here are a few tips that helped me when preparing for my A-levels:

1. Know your weaknesses

- Take the time to sit down and work out which topics you are less confident or struggle with.
- Plan to spend more of your time to focus on these topics

2. Neglect nothing

- Even if you do feel confident in certain subject areas, spend less time on them, but do not neglect them completely as a high mark question might be the deciding factor for a final grade

3. Have a plan

- Plan out when you are going to revise topics. Use this as a guide, it is not concrete. If you miss something, reschedule it. Revision plans are fluid, as long as you get the work done!

4. Work SMART:

Sit down with a calendar, or diary and plan out what you are going to revise at which times.

Each revision session or topic should be SMART:

- **Specific:** state what it is you want to do; I organised my sessions into single topics
- **Measurable:** develop a way to monitor your progress; this might be a checklist or something similar. I used an excel spreadsheet and used a traffic light system to visually see my confidence levels
- **Achievable:** set achievable goals; rather than saying "I'll learn half of biology today" think "Ok I'll do Topic A this morning"
- **Relevant:** stick to the A-level specification, this is your biggest ally. My top tip for learning content is first learn the basics of each topic and then do the extended learning if you have spare time
- **Time-bound:** state when you will get it done. Teenagers and Young adults have short attention spans (around 10 minutes with relapses in-between) so don't think you can spend a solid day revising! Split your plan into chunks with breaks in-between (by using [this technique](#)) can help.

5. Work however you find best



People learn by different means, such as mind maps, posters, flash cards or regurgitating as much as possible and then filling in the gaps! My Preferred revision method was to write out question sheets that I would get a friend/family member to ask me

6. Wind Down:

A-levels are one of the most stressful times in your life and can feel all-encompassing. It is so important that you make time to relax and de-stress. Chronic stress and high cortisol levels are associated with a reduction in memory and negative impact on learning, impaired immune system leading to more frequent illness and other bodily complications. Click [here](#) for more on this.



Make sure you have an activity to manage stress, such as exercise, music or arts and crafts and spend time with friends and family

Active Body = Active Mind:

Be sure to exercise as much as possible as there are many benefits both physically and mentally, to yourself and your learning.



7. My biggest tip I could give is SPEAK UP!

Do not be afraid to speak to people about your worries and anxiety. Bottling up anxiety is the worst thing you can do. If it's something academic, speak to a teacher or classmate, if there are more serious things causing you anxiety speak to your parents, family, friends, or even speak with your GP for advice or referral to other services

Summary:

1. **Work SMART.**
2. Have a **plan.**
3. Enjoy your life before university and **make time to relax!**
4. **Exercise.**
5. Make sure you **speak to people** and **manage your** anxiety.



Core Topics & Resources List

Disclaimer: Please note these lists were compiled randomly based on topics that aspiring dentists may benefit from having some awareness of, this list is not exhaustive & is not intended to be a specification for how to get into Dental School.

It covers several but not all topics from the world of Dentistry & by no means do you need to know each one in exceptional detail (that's what a degree in Dentistry & then continued learning is for!).

Just pick a handful you're interested in and start exploring them.

Core Topics

- **Important organisations & their roles: the GDC & BDA**
 - differences between them
 - Scope of practice for members of the Dental Team
 - The 9 standards for the Dental Team
- **The NHS**
 - Contracts & Reforms
 - NHS .vs. Private Dentistry .vs. mixed practice
 - Community Dentistry
 - Who is entitled to FREE treatment .vs. the 3 charge bands
 - Funding
- **Medical Ethics**
 - Autonomy
 - Beneficence
 - Non- maleficence
 - Justice
 - Confidentiality - when to break consequences



it &



- **Dental Public Health**
 - Children & dental decay
 - Sugar tax
 - Inequalities in access to dental care for different populations
 - Dental Attendances & waiting lists – due to COVID
 - Lifelong gum disease & management
- **Minimally invasive Dentistry & Preventative Dentistry**
- **Dental decay (caries)**
- **Periodontal (gum) disease, the spectrum between gingivitis & periodontitis**
- **Water Fluoridation**
 - Dental Fluorosis
 - Ethics
 - The British Society on Water Fluoridation
- **Dental Amalgam**
 - why & how is it being phased out
 - The Minamata Convention (2013)
 - alternatives to amalgam – composite & glass ionomer cement
- **Dental Health & General Health**
- **Oral Hygiene & Dietary Advice**
- **Hot Topics**
 - Covid-19 (see relevant section above)
 - Oral Cancer – HPV, smoking & alcohol
 - Gum disease & heart disease
 - Gum disease & diabetes
 - Cosmetic Dentistry & Social Media
 - Dental Tourism



- Quick Fix Dentistry (e.g. especially with brace treatments)
- Tooth Whitening & Veneers
- New Technologies – intraoral scanning, 3D printing, Implants, Invisalign

Resources

- [Standards for the Dental Team](#)
- [Scope of Practice](#)
- Delivering Better Oral Health – an evidenced based Toolkit for Prevention (2014) by Public Health England – [summary tables](#) & [full version](#).
- Water Fluoridation by Public Health England Monitoring Report [summary](#)
- Improving Oral Health – [Community Water Fluoridation Toolkit](#) (DO NOT READ the entire document, Section 2/3 – skimming through these is more than enough) <https://www.sdcep.org.uk/>
- Steele Review of NHS Dental Services in England, [here](#).
- [Scottish Dental Clinical Effectiveness Programme webpage](#)
(TRY TO STICK TO/START WITH THE PATIENT INFORMATION LEAFLETS when looking at the different guidance's, all other information is what qualified professionals would be expected to know, so don't worry)
- [Sugar tax, BDJ \(2016\)](#)
- [The Minamata Convention webpage\(2013\)](#)
- Phasing Down Amalgam, BDJ (2013), [part 1](#) and [part 2](#).





Student Quotes



Something you wish you knew about dental school before applying!

"I wish I knew that dental school was **so much fun!** Having an understanding that the course is also about having fun as well as working is something that could have been beneficial when it came to interviews. Dental schools are not only looking for academics, but they are also looking for **people that will contribute to their community** and get involved with all the **activities** that go on within the university and the **dental societies!**"

"Something to be aware of is probably that dentistry is so **much more than just drilling and filling teeth** – working in a mirror is something that takes months and years of practice, being able to communicate with patients of all ages and backgrounds is key, and then there is all the paperwork to do as well! It's **definitely still a great career!**"

"I wish I knew just **how varied the dental field is**, it's not just about brushing and fillings. There are so many unique specialities which open an array of different pathways for you to pursue. Even the day-to-day scope of practice for a general dentist is incredibly broad. I can't wait to find my niche and continue to develop my interests further, there are **endless opportunities to do so.**"

One piece of advice you would give your sixth-form self.

"Try and **not to compare yourself** to others, most dental student applicants are used to being the brightest and top of the class. You will most certainly stress yourself out by constantly comparing and competing. Focus on being the most authentic form of yourself, **do your thing and do it well.**"

"I would tell my sixth form self to compartmentalise their time– ensure your revision time doesn't coincide with your **socialising time and your 'me time'**. Similarly, don't make your living space your working space."





"Don't let the process of applying to dental school consume your entire sixth-form life. Try to enjoy your time at school and only **have specific days/times when you work on university related things.**"

Highs and challenges of dental school so far!

"**Challenge** has been the volume and intensity of exams- particularly at Birmingham. I try to maintain a **work-life balance** during this time but there definitely a lot of content to cover and learn. **The highs always involve patients being happy** with the treatment you've given them as well as being told you've explained a concept well to them and given them more confidence in the dental setting."

"Biggest highs have to be when you do something on a real patient for the first time and the staff tell you **you've done a good job!** The Lows are probably ironically **the nerves** that come before doing something for the first time, or if something does not go to plan when on clinic - but **support** is always **available** to get through this."



If you could rewind back to your UCAS days would you still have applied to study Dentistry?

"**Yes, 100%!** I'm in first year and I'm absolutely loving it so far. Most of this year we learnt raw biological science as well as observing treatment sessions in the dental hospital and I have thoroughly enjoyed the challenges and the excitement of this year."

"I would **consider my options more broadly** to have a more informed decision, rather than fixating in dentistry, as I have developed interest in other topics such as Law and Economics. But I still think **I would opt for dentistry!**"

"**Of course, I would have still applied!** Sure, it is a challenging course, but working with the public and meeting so many new people is a **wonderful experience**, and there is honestly no better feeling than seeing someone really happy that you have been able to help them and improve their life in some way by fixing their dental problems!"



*"I always wanted to do a healthcare related course; it was debate of dentistry vs medicine for me at the time of applying. I now realise how much I enjoy dentistry itself - through building a **rapport with my patients** by seeing them on a regularly basis and the heavy emphasis on using **practical skills to help solve problems**. It's the idea of going on the treatment planning **journey** that continues to peak my excitement for this field, I only hope this continues to grow!"*



Final Words

Thank you for picking our guide to kick-off your journey to dental school in the right way, the entire team and I hope you found it informative and easy to use.

This eBook was designed to help you get started on the beginning of your pathway to "Dental School and Beyond", we hoped to bring together aspects of the application process and provide tips, tricks and an overview of key topics along the way.

We all wish we had something like this to demystify the dental application process & introduce us to core topics within the field, so be sure to share this with all aspiring dentists out there.

Good Luck with the rest of your journey's and please let us know how you get on with this eBook. (See survey on page 3)

Best wishes,

Karishma
Editor

