UF College of Dentistry
UNIVERSITY of FLORIDA

Office of Education-Room D3-11

DMD ELECTIVE COURSE PROPOSAL

Date 10/10/2012

Check one:

✔	New Elective
	Elective Renewal
	Elective Modification

Course Title Spanish in Dentistry

Department Community Dentistry and Behavioral Science

Course Director Dr. Elizabeth Lense

Department Chair Approval: ✔ YES _____NO

Elective type (check all that apply):

✔	lecture		research		intramural
	laboratory		independent		extramural
	clinical		Grad seminar		international

____ Other, describe_____

Recommended Class Year: (check all that apply):

✔	1DN	✔	2DN	✔	3DN	✔	4DN

Number of students: Maximum_____ Minimum 5

Entry level prerequisite none

Student hours required

	Day	Evening	Weekend	Holiday/ Break Week	
Lecture/seminar		12			
Independent study					
Laboratory					
Clinical					**TOTAL HOURS**
HOURS		12			12

Elective semester offering: _____one time X_____recurring

Beginning date/semester 01/2013 Completion date/semester 12/2013

Elective Description: *(For additional space please request an ECO course be created for elective development)*

Course Goal

The goal of this interactive language course is three-fold: to help students understand various language barriers that may occur with Hispanic patients and their effect on the dental practice; to identify and appreciate cultural differences; to have an expanded knowledge and understanding of Spanish terminology commonly used in the dental office.

Outline

I. Introduction to Cultural Barriers
II. General Basic Phrases
III. Anatomy and Dental Terminology
IV. Dental Examination, Patient Assessment, and Treatment Planning
V. Dental Hygiene and Preventive Dentistry
VI. Restorative Dentistry
VII. Periodontics
VIII. Prosthodontics
IX. Oral Surgery, Oral Pathology, and Emergency Treatment
X. Endodontics / Radiology
XI. Orthodontics/ Pedodontics
XII. Post-treatment Assessment

Methodology/Activity planned:

This course will consist of lectures held once per month for one hour after school. Powerpoints will be presented by various faculty and students at UFCD, and each session will include an interactive portion where students will role play to practice the pronunciation and application of dental terminology. All lectures will be recorded and posted on Mediasite so that enrolled students may review the new vocabulary on their own.

Evaluation mechanism / Criteria:

This course will be evaluated as pass/fail based on participation. Students must attend at least 10 of 12 classes (2 absences will be granted) and during the final class will be expected to give a presentation to demonstrate their acquired language skills.

Childs,Gail Schneider

From: Guelmann,Marcio
Sent: Thursday, October 11, 2012 11:38 AM
To: Robinson,Boyd E; Childs,Gail Schneider; Abare,Censeri P
Cc: Perez,Edna; Primosch,Robert Eliot; Sposetti,Venita J; Batie,Crystal Nicole; Baccaglini,Lorena; Bhattacharyya,Indraneel; Johnson,Stephanie D
Subject: Pedo Rotations Spring Semester

Hi to all;
With the implementation of the new clinical model for the DMD Program, the Department of Pediatric Dentistry will engage in this project and will allow students rotating through our clinic to participate in the academic activities scheduled from 7:30 AM to 9:30 AM. Thus, we would like to request the implementation of the following changes starting January of 2013:

1. Students will rotate through our clinic 9 half-days (Mondays through Thursdays from 10:00 AM to 5:00 PM and Fridays from 10:00AM to 1:00 PM) instead of 8 half-days. This half-day increase (Fridays AM) will compensate for the time lost for patient care and will help the students meet all needed requirements for the rotation.

2. Students should report to the clinic at 9:45 AM in order to start patient care at 10:00 AM;

Please let me know asap of your approval of this change so we can adjust our patient schedule accordingly.

Sincerely,
Marcio.

Marcio Guelmann, DDS
Associate Professor
Chair & Residency Program Director
Department of Pediatric Dentistry
University of Florida College of Dentistry
1395 Center Drive, Gainesville, FL
Gainesville, FL 32610-0426
Tel: (352) 273-7635;Fax: (352) 273-6765
Mobile: (352) 278-3863

2012 Senior Exit Interviews: Summary Report

Faculty attendance: Drs. Teresa Dolan, Marcelle Nascimento, Boyd Robinson, Venita Sposetti and Patty Xirau-Probert.

Student attendance: Nine sessions were scheduled between March 26 and May 8, with two sessions canceled due to low registration (three or less students). Of the 84 students in the Class of 2012, 68 students participated in the lunch sessions.

Purpose: Continuous improvement of the quality of the DMD educational experience at UFCD based on graduating student feedback.

Please note that both student and moderator comments are included in this document. Some observations were repeated during multiple sessions and may be paraphrased. Most observations are not generally indicated as direct quotes nor are they directly attributed to the source; the reader must use careful judgment in assessing these remarks for the purpose of improving the educational experiences of our DMD students, keeping in mind that they reflect the perceptions of our graduating dental students.

General Comments

- My overall experience was phenomenal.
- This was the hardest four years of my life, and I would definitely recommend this school to other dental students.
- The first two years of the curriculum felt disconnected from second two years. The students wished the curriculum was better integrated over the four years.
- Our transition to the clinics was difficult, and it was even harder with the implementation of AxiUm.
- The basic science education was excellent. Difficult… but excellent.
- Large lectures don't work. There should be more learning in small groups.
- Overall, we received a great education.

National Boards

- The school did a great job preparing us for the National Boards, both Part I and Part II.
- We had less review for Part II.

TEAM Program

- The TEAM program is great. However, we don't have anything to compare it to. But it is great that the specialists come right to the chair and specialists are always available.

- The TEAM leaders get involved in a lot of paperwork (e.g., missing charges) and spend less time with clinical teaching.
  This was a onetime effort where the Team leaders had to help clean up missing charges which had accumulated due to the newness of Axium. Some student probably heard a Team leader griping about dealing with missing charges. Team leaders do have to spend a lot of time doing record reviews with students but this is an integral part of our job.

TEAM Program: Patient assignment

- The "fair" distribution of patients and procedures were addressed in every session. However, the students understood the challenges regarding the "fair" distribution of patients and procedures and the difficulty in balancing patient assignment across students and TEAMs.
- "My biggest problem – discrepancy in prosthodontics units. Some students have 40 units, and I was breaking my neck to get 20. Isn't there a way to get the patients distributed more evenly?" This is done in some clinics, but not uniformly across clinics. Clinic 2A was better but I think that they have too many rules. It worked well, but the students don't always like all the rules in that clinic. But whatever they are doing – it works. The TEAM leaders do more chart reviews. On one hand we hear that Clinic 2-A is good at distributing patients and on the other hand there are too many rules? Which do they want?
  It is true that a few students seemed to have more available units than others simply from being lucky with their patient pool. However, if you talk to every Team leader, and also to most of the better students, they will point out the differences between the students who had no problems having enough units and those that had problems. Students who had no problems were always treatment planning, always looking to self recruit patients , always had a patient in the chair and were better at managing their patients. All Team leaders know which students are behind and make every effort possible to find patients for them and try to keep them moving forward. That's why we reviewed all seniors last month and we are scheduled to do the same for the Jrs in October. There is a problem with availability of fixed Pros procedures simply due to economics. When do we tell a good student that they have done enough Pros and take the cases that they have developed and give them to a student who has procrastinated from the beginning? That is a question we face constantly.

  I was busy all the time, but my 10 prosthodontic units fell through during the last two semesters. A lot of student productivity comes down to luck; the patients you get, whether or not they can afford treatment, etc. I got a lot of RPD and didn't get any fixed. OK because you get a lot of RVUs but I didn't get a lot of fixed clinical experiences. There is some validity in this statement. Part of the solution might be to go toward a case completion format. In the meantime we are looking at ways to be sure that the patient pool is equally distributed among all five care groups. The Team leaders should ensure equal distribution within the individual Teams.

- Drs. Spencer and Young are always on top of us, and made sure that students always had what they needed.
- All of the students in attendance at this session said they routinely self-recruited patients. We strongly encourage all students to be aggressive in self recruiting.
    - Some were friends of my other patients. But I ended up with too many patients. I had 45 patients.
    - Should you have a cap on the total number of patients per student– students can't handle too many patients. Yes! 25 should be the maximum number of patient in any student's pool. Anything in excess should be passed down to a Jr. if it is a productive patient or dismissed if not.

TEAM Program: Care Group Operations

- When asked about the potential impact of extending clinic hours into the evening, students were generally positive and commented that this would allow some patients to attend and not miss as much work, and also would allow the 1 and 2DNs to possibly assist in the clinics.
- The Big/Little system works well, but is not uniformly implemented in all the Care Groups. We would like to have more big-little interaction. Rotations, scheduling, requirements etc. make it difficult to work as well as we would like.
- "I was a clinic 1A transplant – I knew all the rules. But my new clinic didn't really follow the rules."Some students who were transplanted from Clinic1-A to a new clinic were unhappy with the change but the majority adapted very well.
- Clinic 2A got everything done and didn't have to poach patients. Some of this is due to scheduling. Some coordinators do a better job with scheduling. If students don't take the initiative that their schedule was full. Coordinators are not equal. Jerri Wainer who is in charge of the coordinators does a good job within her power and HR regulations to manage them as well as rules permit.
- Clinic 2A follows all the rules (unlike many other care groups). ????
- Clinic 2B is a "free-for-all." I'm not sure what is meant by" free for all" 2-B has not been the clinic needing the most attention during the past year.
- When we had paper charts, the charts were audited. Now no one audits the charts or reads the notes. No one looks at the medications, for example. Faculty should read the notes prior to care. Some faculty don't read anything. We need to go back and do chart audits. It is too easy to get away with things. Team leaders are doing audits on student's patient pools on a regular basis and we are learning to take advantage of the information in Axium to do a better job. It is true that we don't read every note in every chart. This is a responsibility of all attending faculty on an ongoing basis. That's why we have calibration sessions for all faculty like the one last month directed toward this very issue.
- One of my treatment coordinators was on top of everything. My new one helps but I have to ask her to do things. My AxiUm messages get lost. She isn't as good. As I just commented, all coordinators have different capabilities and are not equally effective.

- Students should be able to provide feedback about the treatment coordinator. Their role is key to a student's productivity. Correct!
- The students would like to provide input for the performance reviews for the dental assistants. They spend a lot of time on Facebook instead of helping the students. This issue is being addressed by clinic administration.
- The students shouldn't be doing all of the cleanings. We use Santa Fe hygiene students, but they are booked out months in advance. No! They are not booked out months in advance but they are not present to handle all the student patient recalls. Students are responsible for keeping up with their patient's ongoing periodontal maintenance. The presence of the Sante Fe students in the clinic does not change that responsibility. We need earlier clinical experiences. Agreed!
- The first weeks you are in the clinics, you don't have a clue. Perhaps you could have a mentoring program and pair up students so that they are better oriented. We do have just such a program in DEN 6015. If they took the shadowing experience seriously they would be prepared!
- Some SPC couldn't handle the extra load of students when we closed Clinic 1A. That is correct.
- Coordinators have a lot of responsibilities. They do a lot of things that are not in their job description. They are constantly working on things other than scheduling. Some of the business office issues take a lot of time. They should direct us where to go to get something done, and not have to do it themselves. The job description of coordinators includes many things other than simply scheduling. I would need to know what job is being referred to in this statement.
- There should be a way to quickly know the level of experience of a particular senior student. Can we keep the same faculty for a semester, and then rotate? Others felt that it was nice to get a mix of faculty. Every attempt is being made by both Pros and Operative to keep the same coverage within a care group for at least a semester. It is impossible to always be 100% consistent.
- Students would like clinical experiences earlier in the curriculum. As do we all.
- They like the little/big system, and felt that students should progressively take on clinical responsibilities. I agree.
- There is no real problem with chair availability.
- Ghost appointing is still happening. And is being aggressively corrected.
- Faculty spends too much time in the center lab. A good majority (especially the older faculty and the residents) spend all their time in the center lab. We stand in line for 30 or 40 minutes for a start check or a prep check. I would like to know when someone waited 30 to 40 minutes. Give a name and date. Only a small minority of faculty are guilty of staying in the center lab. The division heads are aware of the issue and are addressing it.
- My TED funds were a disaster because the faculty changed the treatment plan four times! I don't think this is a constant problem.
- Some dental assistants are lazy. They can't be found, they come in late, and they are always on Facebook. Clinic 2B is especially bad. This is a case of one

individual and the issue was addressed. 2-B probably now has the two best assistants in the college.

- Can't the computers in the clinics be "locked down" so that the assistants can't access Facebook? Shouldn't faculty and students be blocked out as well? The assistants from Santa Fe are great.
- America and Marisara are great.
- Marisara is the best assistant – you should put her in charge of the assistants.
- Jasmine is a great assistant.

TEAM Program: TEAM meetings

- The TEAM meetings have become worse; they were better last year. Giving the presentations three times took up so much time, and we never had time for other educational team meetings. Some students recommended going back to having only one treatment planning presentation, and adding other learning experiences. This (case presentations) is being changed to open up our Team meetings to function as they were originally intended. We also hope to make the Team meetings and morning huddle part of a graded course.
- Others described Friday TEAM meetings as "a big waste of time." "They are boring." They have become boring because we have only been doing the same thing as part of DEN 7016 for the last year and this is being changed this semester. They should be used as a time to fill in gaps in student learning. Case reviews can be helpful, but should be scheduled in smaller groups.
- The students wished that the Friday TEAM meetings involved more brainstorming, case discussion, and treatment planning discussion. Agreed.

APGD Clinic

- While virtually all comments about APGD were positive from those students who had the experience, there were also students who described the program "unfair" because it was not available to all students. However, many students who made negative remarks did not apply to the program. In fact so few applied for the spring semester of 2012 that we had to let several students stay for a second semester. This year we have more applicants and we'll have a totally new group for the second half of the year. Some of the fairness issues raised had to do with the student-to-faculty ratios (and not having to wait for faculty checks) and differences in policies regarding lab work.
- "The best experience in the school."
- Every team meeting in APGD was awesome. I wish I could have done that. We do literature reviews. They are really useful clinically and have been well received. Could these sessions be incorporated into the main clinics? That is a goal.
- The faculty reinforce critical thinking skills.
- The students enjoyed having a different level of supervision as a senior student. They loved working with Dr. Rey and Dr. Watson. They knew each student and

trusted the student based on their skill level. The students were able to provide multidisciplinary care and true comprehensive care in an efficient manner.
- There was no waiting for faculty "checks."
- The students felt that they were really practicing dentistry. Production is higher because there are less obstacles and road blocks.
- When assigned to this clinic I couldn't wait to get up and go to school.
- Dr. Watson can't sign off on operative competencies. You have to announce it in 2A, and it's a real hassle to get operative competencies when you are in the APGD. It's a hoop.
- We like seeing four patients per day.
- There was confusion about the selection process, and some division among the class about the program.
- Beth is always in and out of the clinic, and takes a lot of "smoke breaks." Beth carries the load of two coordinators and she does it well managing APGD students multiple appointments and the recall system for the college.
- We need better assistants to do four handed dentistry. It is really hard to work without an assistant.

Clinical Competency Assessments
- Semester clinical requirements: there should be some leniency in terms of competency deadlines. If you follow the proper order and sequence your treatment plans, you don't get your work done at the right time to meet semester deadlines.
- TEAM Leaders know the students better than any other faculty, and they should be able to assess competencies. This is one of the reasons why Team leaders don't grade competencies. We know the students too well and we have a built in bias. The disciplines are also calibrated for their specific procedures. Unless we are teaching in the pre-clinics we may not be as consistent in our grading. Then there is the question of having time on the clinic floor to grade competencies along with all other things we cover.
- TEAM leaders should be able to sign off on competencies (mentioned several times).
- Do students ever fail competencies? The college should do an analysis of first time pass rates on all clinical competencies. If everyone passes – what's the point? Interesting point.
- Operative faculty are not calibrated.
- Juniors and seniors should not have the same competencies at the same time – makes it too difficult to find that particular clinical lesion (mostly referring to Class II amalgams).

Periodontology
- The curriculum in the first two years was very repetitive.

- Dr. Harrison is great; he listens to the students. He is one of the best things that happened to the department.
- The students liked the new rotation in graduate periodontology because they previously did not get enough experience in these procedures.
- Other students did not agree and felt that the rotations took away from their learning time and students should not be forced to work as dental assistants for the residents. They asked for more flexibility in the rotations in terms of scheduling as well as the number of experiences based on the student's level of interest.
- Some students commented they used to be able to do crown lengthening procedures in the Care Groups, but now they are to be done in the graduate clinic.
- The perio resident's treatment plans are designed for "maximum resident benefit." They often recommend too much treatment, change treatment plans and cause frustration and patient confusion. This is also true in endo.
- Grad Perio was described as "an abyss" because care is not well coordinated. Once you send a patient to Grad Perio for care they never make their way back to the Care Groups.

Prosthodontics

- We need a course in "prosthodontics trouble shooting" – especially for RPDs.
- We never learned to adjust RPD clasps. This was taken out of the RPD course. Can we get discarded RPDs to practice on? The class was taught at an odd time. I don't think we learned anything. I am graduating without a lot of knowledge of how to design an RPD. Maybe students should have a guide to the 10 most common RPD designs. It is also late in the curriculum. I delivered a senior's partial before I knew anything about partials.
- Medical College of Georgia has an RPD design app. Can we use it?
- The lab refresher course was excellent.
- The students could use additional instruction in how to write a better lab script.
- RPD frameworks take too long, and are often of poor quality.
- The denture course is well done.
- Prosthodontic unit requirements are fair and probably too low.
- Prosthodontics has picked up for the juniors. The juniors are trying to get their units and they compete with the seniors.
- Some prosthodontic faculty spend all their time in the center laboratory– especially Dr. Mauderli. You have to drag him into the operatory. He checks things off but doesn't teach you anything. (This was mentioned several times.)
- Dr. Mauderli "gives up competencies like candy."
- Some students mentioned that Dr. Kerdani is not very helpful to the students.
- "Requiring 20 prosthodontics units was unfair."
- Because we were held accountable for the 20 prosthodontic units I will graduate with more experience and I'm feeling more confident in prosthodontics procedures. The unit requirements force you to work harder.
- Faculty calibration – certain faculty in prosthodontics only do some things certain way. They get very touchy about their favorite way to do things.
- Some prosthodontics faculty are well calibrated, and others never leave the center lab or will refuse to cover certain procedures because they are not comfortable with those procedures.
- Dr. Dasilva is very helpful, and genuinely cares about the students and the work.
- I never had an opportunity to do a fixed bridge.
- Dr. Jimenez is one of the best teachers here. He is very interested in the students and will go into the lab, if needed, to help the students.
- Dr. Jimenez can be very difficult. He should be willing to share his knowledge with all students. He can be very negative in front of patients and students. Some patients comment that he has a negative attitude.
- Barry is amazing, and very helpful to the students. Sal is also helpful.
- Every session included negative comments about the QA system, and it was described as not being efficient or student friendly.

Student/Faculty/Staff Relations

- Each session included some discussion about lack of faculty calibration, differences of opinion among faculty and how that negatively impacts patient care.
- Some schools refer to the student dentists as "doctors," and this helps builds the students confidence levels. They suggested that we survey other schools to see how many refer to their clinical students as "Doctor..."
- Students often commented that "faculty treat us like children." They wished faculty trusted them more, especially when they are in their senior year.
- Drs. Howard and Harrison are the two best clinical faculty – they "still like us."
- Departments should be flexible, especially when patients don't show up and you can't get your work done. Everyone is following the script, and doesn't think, use common sense, or are empowered to use a flexible interpretation. I wouldn't treat people that way.
- Some faculty have strong biases and are not consistent in the way they interact with students.
- There are some faculty who do not treat you with respect, and there should be an anonymous way to complain about a faculty.
- Every department has a gate keeper who can be very mean.
- Students reported that they didn't feel as though they have a student advocate, and they need someone who can treat confidential information confidentially.
- The students suggested having a complaint box or an 800 number to file complaints.
- My overall experience would have been better if we knew that someone cared.
- Someone who is good is Jerri Wainer.
- Some people listen but don't feel empowered to do anything about it.

Operative

- Operative competencies don't make sense. For example, if you have never excavated decay and now you have to do a competency – you can't ask for help. The timing of competencies and requirements can be a real challenge and causes problems with continuity of care.
- Between third and fourth year, the CEREC requirements changed and it's hard to find the proper procedure to get things done in the sequence as required. There are too many deadlines and rules that don't make sense.
- We wish we had more CEREC and esthetic dentistry.
- The AestheTec Clinic is difficult to schedule, and there are not enough available appointments.
- They shouldn't make it hard to do a competency. You need to declare it during the morning huddle. A student had an emergency patient and didn't have the

opportunity to announce the Class IV during huddle. The student was not allowed to use the patient for a competency.
- Operative stopped posting which faculty were scheduled in the clinic. This reduces continuity of care.
- Students made positive comments about the AestheTec Clinic. They liked the fact that there is close supervision by faculty and they had the opportunity to work with faculty who were enthusiastic about esthetic dentistry.
- Some faculty just don't want you to provide treatment and they slow you down every step of the way. Dr. Susan Nimmo and Dr. Geraldeli are the outliers.
- Dr. Geraldeli is not on board with the operative philosophy. He doesn't like Class II amalgams. He does too many indirect pulp caps. And he is always asking betting questions – which is inappropriate in the clinic. "I'll bet you $100 bucks that there is no decay under that restoration." This is embarrassing in front of the patient.
- Now there is an operative 3000 RVU requirement for the junior year. This is a really bad idea.
- Some things in operative are not weighted appropriately for RVUs, such as caries control.
- Dr. Howard is amazing.
- Dr. Wynkoop is efficient, kind, a great help, great with time management, and calm.

Implant Dentistry
- Students often commented that they wished they had additional opportunities to plan and provide implant dentistry.
- Great room for improvement. Both departments would like to place more implants. All the pieces are there but you can't get adequate implant consult appointments. You have to do it with Dr. Nimmo and he has only 3 half days a week, or 6 a week. He may see 2 or 3 per session. You have to be there with your patients, etc. Then you refer to perio and they require a second consultation.
- I needed an implant consultation but couldn't get an appointment until June. I gave the patient to a third year student.
- Drs. Aukhil and Nieva have different clinical philosophies and then you need a second consult in perio. Dr. Nimmo doesn't have adequate time to do the consultation. Same is true in the Implant Center.
- The follow-up problems: when you need to restore, some DMD clinical faculty say "I don't do implants." We should have a list of faculty who can work with you on restoring implants.
- The same is true for laser treatment. Not all perio faculty will cover you for laser treatments.
- Some students commented that they just refer the patient to grad perio because there are too many hoops to jump through in the student program.

OMFS/Hospital Rotation/OMFDS

- Comments were uniformly positive about the SOS clinic.
- DMD students get a lot of experience in oral surgery and students had only great things to say about the SOS clinic. One student commended, "no tooth extraction scares me!" They appreciated the level of supervision and the quality of instruction in this clinic.
- Dr. Dennis and Foerster are great.
- A student commented, "I wish I was better at writing scripts."
- The comments about the hospital rotation were mixed, and several students commented that the students' reactions to the hospital rotation reflected their clinical interests. Some commented about the importance of exposure to all types of dental practice including hospital dentistry. Some asked if the rotation could be scheduled earlier in the curriculum. Another commented that it was "cool" to be in the OR. Others suggested a menu approach to scheduling such specialized rotations, allowing students to select some rotations based on their interest.
- Students wished they had more opportunities to do biopsies. Some wanted to have the opportunity to shadow Drs. Bhattacharyya and Cohen to get more experience in clinical pathology.
- The feedback about the oral oncology rotation was mixed. Some thought it was very valuable, and others didn't like the experience. Others described the tumor board as "interesting" while others described it as a "waste of time."

Orthodontics

- Because orthodontics doesn't use AxiUm, and students can't access records in Dolphin, and this "gets in a way of patient care."
- Students felt that they didn't learn much from the orthodontic rotations, except for Dr. Neubert who is the only resident who tries to teach the students. The care is provided by residents and they are not teachers. We have a half day per semester – too much. Should be an elective.
- The residents need an orientation to what is expected in terms of teaching the dental students. They should review the cases with the students, and the session should have some structure.
- The conferences are good. I like Dr. Hodge. I like the treatment planning presentations.

Pediatric Dentistry

- Students consistently commented that they do not feel competent in more complex restorative procedures on children based on their rotations at the college, and learn most of their clinical pediatric dentistry at the extramural sites.
- Comments included: "The faculty don't let you do anything. We work as assistants. You are assigned for a week; you can do new and recall exams,

cleanings and sealants. But usually students are not allowed to do pulpotomies or SSCs. 95% of what you do is what a dentist would delegate to an auxiliary."
- As a counter point, a student commented that if you want to do more complex procedures, the pedo faculty will let you. But they don't push things on you. Some students don't want to do anything in pediatric dentistry.
- Dr. Perez refuses to cover some procedures.

Endodontics
- I love endo and I love the way they keep track of us and assign us patients. This has made our lives a lot easier.
- The faculty really owned the problem of not having adequate clinical experiences and we're grateful to have the four experiences. The department really stepped up and solved a problem.
- The students made both positive and negative comments about the endodontic residents. Some complained that when the residents do consultations in the care groups, the endodontic residents "steal all of our patients. And they are mean." But other students commented that it depends which resident shows up in the clinic.
- I didn't know you can do caries control in endo, and they will help excavate decay; this is not widely known among students. TEAM leaders should know all the rules and encourage students to do this.
- Interdepartmental communications is not always the best. Patient transfers between clinics don't always work efficiently. Some don't do their notes in a timely way. It's hard to figure out what was going on with a patient that was referred to another clinic.
- I will graduate with only four root canals and I would have liked to do more.

Extramural rotations
- Overall, I had a positive experience. These rotations were a highlight of the program. I learned a lot at Jacksonville, Winter Garden, Orange Blossom Trail and Tallahassee; these were great.
- The rotations are great but we are out of the clinic a lot which can be challenging in terms of providing comprehensive care.
- The students were assigned a lot of restorative procedures at the Orange Blossom clinic.
- Eastside received mixed reviews; there is a lot of down time, patient cancelations, and a lot of sitting around. Students reported that they were assigned a lot of cleanings and extractions, but little restorative treatment.
- "St. Pete was terrible. I never had an assistant."
- Naples – it is great to stay at the beach but they didn't push you to be productive. UF pedo was a waste of time. They don't let you do anything. Countryside lets you do treatment. In Naples you are seeing Dr. Hester's patients, and patients are not scheduled for the students. But he would check your work.

- Rotations disrupt patient care in the Care Groups, and you can only get RVUs. Why can't we do competencies while on rotation?
- Jennifer Brock never returns emails and is not very pleasant to the students.
- Drs. Wray and Morse are great!

Mock Boards

- Mock boards were a very valuable experience.
- Mock boards were a little crazy, but it I'm glad we did it.
- The faculty did not use the CIB for the prosthodontics section.
- The first day of the Mock Board was very disorganized. Even the patients complained that things were slow.
- UFCD should make the Mock Board one of the competencies.
- Drs. Harrison and Kellowitz did a great job and went above and beyond to help the students. Dr. Harrison wrote individual emails about what the students did wrong and how to correct these issues for the boards.
- Prosth gave no feedback to the students.
- The new CIB caused some challenges.
- Dr. Echeto is very positive and very organized.

Biggest "Time Wasters" from the students' perspective

- Setting denture teeth. APGD doesn't' have to set teeth, and it is not productive. Dr. Robinson is looking into this. It's a big waste of time. Senior students should not have to do lab work.
- Three appointment COEs… does it have to take nine hours to do a COE?
- Study models for all patients is a waste of time.
- When operative faculty spend 20 minutes talking about decay. This is very frustrating.
- When faculty change treatment plans.
- Lack of faculty calibration.
- Can patients complete their medical history ahead of their dental visit by completing the form on-line?
- It is really hard to re-sequence treatment plans in AxiUm.
- Sometimes QA is 10 students deep waiting for faculty.
- We could see more patients if someone helped us turn over our chairs, and if the dental assistants were more helpful.
- Lunch is too long.

There is a lot of red tape, and you often didn't know where to go.

- "Anything involving Erik and Sal." The rules aren't clear. Students are told that students cannot ask them questions. The assistants have to bring the cases to them during a specific time. Not user friendly. He made a flow chart but it didn't get shared with the students. The students wished there were a flow chart about how cases should be managed, how to access the forms, etc.

- I have a good relationship with Erik and Sal, but there have been instances where things got delayed because of lack of communication (e.g. if a case was TED funded). This can delay treatment.
- TED funds – get rejected. Need an easier way to identify patients on TED funds or on a payment plan. There are always discrepancies about whether a patient is current on their payment plan or if there is a balance of TED funds. This happened to me six times.

Suggestions

- Have lunches/interviews with students at the end of the second year in addition to the senior class lunches.
- Students would like to know more about the expenses associated with the senior year (e.g. board costs) earlier so that they can plan better. Can Tom Kolb send something out to the students in the summer or early fall about the costs of boards, availability of loan funds, etc., to cover these costs?
- Students should be tested on the state board laws and rules before entering the clinic, and then have a refresher prior to the board exam.
- Could we have a mobile unit in each care group, in case you need some additional supplies? There are a lot of wasted supplies because students don't want to go to the supply room if they need something.
- Students would like a "hot line" or a mechanism to settle disputes with faculty or staff.

Other comments

- The simulated patient experience is not authentic, and thus, a waste of time.
- The IFH course was not useful, and felt dangerous at times.
- The students would like to have pharmacy students rotating in the clinics.

The Job Market

- It is difficult to find an associate-ship in a private practice. Many dentists are selling practices rather than taking on associates.
- There are opportunities in corporate practices.
- A lot of graduates are "going corporate" because they want a guaranteed base salary.

Other comments about staff

- I love Censeri!
- Beth is the best coordinator.
- Tara Taylor is amazing.

Other Compliments

- The intraoral cameras in the clinics are great.
- I got a very good education. I know I complained a lot but we feel we are fully prepared.
- When I compare my education to the education at other schools, I know we get a great education.
- The students complimented the renovated lobby.

UFCD Curriculum Management Stream 2 Review Assignment

Due Date:

Curriculum Committee Member	Course
Dr. Culp Dr. Rey Dr. Bhattacharyya S/D M. Yanes	**DEN5210 Developmental Biology and Psychosocial Issues over the Lifespan** **DEN5221 Oral Health Management and Psychosocial Issues over the Lifespan** **DEN7241 Emergency and Disaster Preparedness** **DEN7319 Dental Care for the Geriatric Patient**
Dr. Spencer Dr. Guelmann Dr. Clark Dr. Harrison S/D H. Freymiller	**DEN6350 General Pathology** **DEN6251 Science and Clinical Management of Dental Pain** **DEN6351 Oral Pathology** **DEN6260 Oral Medicine and Pharmacotherapeutics** **DEN6262 Principles of Pharmacology** **DEN6440 Introduction to Oral Surgery (Part I)** **DEN7441 Introduction to Oral Surgery (Part II)** **DEN7442 Overview of Advanced Oral and Maxillofacial Surgery**
Dr. Robinson Dr. Sposetti Dr. El-Kerdani S/D. T. Sisson	**DEN7417 Orofacial Pain** **DEN7433 Evidence-based Endodontics** **DEN8352 Advanced Differential Diagnosis** **DEN8263 Advanced Oral Medicine and Clinical Pharmacology** **DEN8423 Periodontics in General Practice** **DEN8303 Advanced Radiologic Interpretation** **DEN8462 Advanced Topics in Prosthodontics**

Ellie Bushhousen to evaluate course material in all courses.

PLEASE NOTE: To access the AHC SharePoint site (anything at https://intranet.ahc.ufl.edu/) you must use a computer that is on the AHC network, or you must connect to the AHC VPN. The AHC VPN is separate from UF's campus-wide VPN. The AHC VPN is accessed at https://vpn.health.ufl.edu/.

Instructions

First, use the course link above to review the course syllabus, documents and schedule

Second, access the most recent course evaluation within this folder posted as a pdf to assist in your syllabus review,

Third, assess the evaluation form on the UFCD intranet (use your gator link username and password) at this link
https://apps.dental.ufl.edu/intranet/ZF/Education/syllabusEvaluation
Complete the evaluation form with any comments and submit.

Additional References:

UF Faculty Handbook/ Course Syllabi
http://handbook.aa.ufl.edu/policies.aspx

The syllabus for a course is a written record of the instructor's plan for the organization and management of the course, and his or her expectations of the students. The **UF Policy on Course Syllabi** outlines the information that must appear in all course syllabi, independent of course level or discipline. Instructional faculty are expected to post their course syllabi to a student accessible website and submit copies of course syllabi to the departmental office to document compliance with this policy.