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**DEPARTMENT OF OPERATIVE DENTISTRY**  
**CLINICAL INSTRUCTION GUIDE**  
**(2006-2007)**

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NOTE: The Department of Operative Dentistry Clinical Instruction Guide is intended to be your guidelines for successful completion of your clinical operative dentistry courses. However, the Department of Operative Dentistry reserves the right to modify the contents of this guide when it is determined by the Operative Faculty that modifications are necessary to achieve the academic goals of the Department.

# OPERATIVE FACULTY

(2006 - 2007)

The following faculty will be assisting in the preclinical and/or clinical courses in the Department of Operative Dentistry during the 2006-2007 academic year. Grateful appreciation is extended to these individuals for their dedication and efforts in helping provide for the educational needs of students at the University of Oklahoma College of Dentistry. (Full-time faculty identified by asterisk.)

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We extend a special thank you to all our part-time faculty for their loyalty, dedication and support of the teaching mission of the Department of Operative Dentistry.

# DEDICATION

We dedicate this manual (and indeed all of our instructional methods and philosophies) to the memory of Dr. Earl William Collard, founding chair- man of the Department of Operative Dentistry. Dr. Collard established the department in 1972 and served as professor and chairman until his retirement in 1991. He was able to enjoy the fruits of his well-deserved rest until his untimely passing in 1997. The spirit of this remarkable leader continues to lead the department and its faculty, many of whom had the honor of working with and for him during his tenure.



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# FOREWORD

Preclinical Operative Dentistry I and II introduced you to the basic principles of operative dentistry techniques, focusing on various cavity preparation designs and indications and the correct manipulation/utilization of numerous restorative materials. You are now ready to apply those basic principles and techniques to clinical practice. Your admittance into clinic implies our trust that you possess the requisite baseline skills necessary to treat patients. Do not regard this confidence lightly. Clinical activity is not just a "natural" progression in your education. While your demonstration of technical ability has given you the right to continue your training in a clinical setting, manual expertise is only one facet of the well-rounded clinician. Equally important are the judgmental skills needed to determine and render proper treatment, the interpersonal relationship skills needed to build the confidence of your patients, and the professional management skills required to develop a successful approach to the business of dentistry. Clinical Operative Dentistry provides the initial opportunities to begin development of these skills. **Moreover, since your first experiences with local anesthesia and the removal of tooth structure will most likely be in operative dentistry, your orientation to clinic is very important to your overall approach to and success in all phases of clinical dentistry.**

Unlike preclinical courses where laboratory experiences are identical for all students, clinical dentistry involves inevitable variability primarily because of differing patient needs which precludes standardization of clinical experiences for all students. The point requirement system used in Operative Dentistry is designed to minimize these variations and ensure that all students satisfy at least an established minimum number of quantitative objectives. Monitoring this system, keeping track of individual progress, providing counseling when necessary, and ensuring that everyone has an equal opportunity to complete stated objectives are tasks not fully appreciated by students. Many rules and policies may seem unnecessary and even restrictive when viewed on a personal level. From an objective perspective, however, they are your protection against inequity, favoritism, and bias.

This Clinical Instruction Guide provides the information necessary to accomplish the clinical objectives of the Department of Operative Dentistry as you progress towards graduation. Read it completely and thoroughly; if you do not have a full understanding of its contents you may find your clinical experiences disorganized, confusing, and occasionally even unpleasant. If any information in this manual is

ambiguous or not sufficiently explained to your satisfaction, you are expected to seek clarification from the appropriate departmental faculty.

Your clinical training in operative dentistry will consist of the following courses (listed by number, title, and semester when offered):

<u>COURSE #/TITLE</u>	<u>SEMESTER</u>
OPDT 7391 Operative Clinic I	2ndYr (Spring)
OPDT 8191 Operative Clinic II	3rd Yr (Fall)
OPDT 8291 Operative Clinic III	3rd Yr (Spring)
OPDT 8391 Operative Clinic IV	3rd Yr (Summer)
OPDT 9191 Operative Clinic V	4th Yr (Fall)
OPDT 9291 Operative Clinic VI	4th Yr (Spring)

In addition, the department offers three electives during the senior year:

(Introduction to Teaching of Preclinical Operative Dentistry) involves student teaching in the preclinical laboratory. Offered in the spring; participation by invitation only.

(Preparation for Dental Licensing Examinations) is an orientation to the Western Regional Examining Board (WREB) licensure examination. Offered in the fall; all seniors eligible to participate.

(Advanced Operative Dentistry) provides additional clinical experience in complex tooth-colored restorative procedures. Offered in the spring; participation by invitation only.

Further information about these elective courses, including prerequisites and specific scheduling, will be made available during the senior year.



# CLINICAL OPERATIVE DENTISTRY

## GENERAL OVERVIEW

Operative Dentistry deals with the restoration of faulty, missing, and/or diseased parts of the clinical crowns of natural teeth. The primary objective of operative dentistry is to restore and maintain the natural dentition in an optimal state of health, function, and esthetics. To accomplish this objective, tooth structure is mechanically removed from teeth. Since excision of vital tissue is involved, cavity preparation is a **surgical** procedure. The restoration placed in the prepared cavity must satisfy this primary objective and must produce no untoward reactions in the tooth. Using correctly applied principles and techniques, the tooth must be in as good or better condition than it was prior to cavity preparation.

Operative dentistry has often been described as "bread and butter" dentistry since it generally comprises the largest percentage of the clinical work load of most general practitioners. However, it cannot be fully described without consideration of the correlated disciplines of oral diagnosis and periodontics. Teeth cannot be properly treated without thorough diagnosis of the problem and without due concern for the supporting structures. In addition, operative dentistry is often intimately related to treatment procedures in other areas such as endodontics and prosthodontics. Thus, the true scope of the discipline can only be defined in terms of its relationship to all other areas of dental treatment.

The departmental structure of the College of Dentistry and the requirement system that governs clinical training and evaluation can make it easy to compartmentalize patient treatment and as a result one can lose sight of the need for integrated and comprehensive patient care. This is detrimental because it minimizes the importance of interaction among the various disciplines which can lead to fragmented and often incomplete patient treatment. Although this manual pertains specifically to operative dentistry, there must always be due consideration for the other related disciplines. Without such consideration, operative dentistry becomes little more than an exercise in mechanics.

Your preclinical training provided you with the basic principles necessary to begin patient treatment. However, it could not prepare you for the diversity of experiences and problems you will see in a clinical setting. You are therefore strongly encouraged to continue consulting your preclinical texts and manuals (as well as the

many textbooks, journals, and periodicals available) as excellent sources for periodic review of principles and techniques. We will assume that you know what you are doing, that you retain and develop what you know, and that you demonstrate the maturity and judgment to seek answers for what you do not know. Your knowledge of operative dentistry will be subject to review, testing, and evaluation throughout your student clinical career. The discipline is much too dynamic and ever-changing to expect anything less.

### **GENERAL OBJECTIVES**

Upon completion of your clinical training in operative dentistry, you will be able to:

1. Apply basic principles of sound operative dentistry to maintain the natural dentition in an optimal state of health, function, and esthetics.
2. Relate operative dentistry to the other dental disciplines both in theory and in practice.
3. Teach your patients that operative dentistry is a vital and integral part of the science and application of preventive dentistry.
4. Use proper clinical judgment to determine the presence/extent of dental lesions, prepare the proper cavity with minimal injury to the teeth and surrounding tissues, and restore teeth under the best biomechanical conditions possible.
5. Apply principles of prevention during all phases of dental treatment.
6. Experience the principles of and develop skill in four-handed dentistry with emphasis on good body posture, correct hand/finger positioning, and proper utilization of dental auxiliary personnel.
7. Develop a high degree of professionalism in appearance, image, attitude, and demeanor.
8. Apply principles and procedures of asepsis, barrier technique, sterilization, and proper care/maintenance of dental instruments and equipment.
9. Learn the value, purposes, and principles of sound patient and time management.
10. Develop patterns of good personal health and hygiene, taking the requisite precautions in protecting yourself, auxiliary personnel, and patients.
11. Learn and apply the principles of good record keeping.

You will be expected to demonstrate increasing proficiency in the development and attainment of these objectives as you proceed through your clinical training. Thus, a senior student is expected to demonstrate a higher skill level in technical ability, clinical judgment, and time management than a sophomore student and would be penalized to a proportionately greater degree for noted deficiencies.

## DESCRIPTION OF CLINICAL SETTING

Clinical operative dentistry training is conducted in the Gold clinic. This 36-chair clinic is equipped with a central dispensary, X-ray room and darkroom, patient reception area, student laboratory, and three consultation rooms. Nitrous oxide, oxygen, and various medicaments are strategically located in the clinic should a medical emergency arise that requires adjunctive therapy. The Clinic Manual distributed by Clinic Operations describes where these items are located, what their purposes and effects are, and under what circumstances they should be used.

An appropriate number of operative faculty will be in attendance whenever students are assigned to gold clinic. This faculty will vary depending on the number and classes of students in clinic. Clinical faculty are responsible for supervising your work, providing educational/technical assistance as necessary, and assuming legal responsibility for your clinical training. Faculty are aware of your requirement and time constraints; they will try to strike a reasonable balance in providing you with necessary instruction without excessive time delays.

The procedures necessary to reserve operatory space in the clinic are discussed in detail in Section B of your Clinic Manual. Contact the Office of Patient Management (1-5422) if you need additional clarification.

## FACULTY COVERAGE AND ROTATION

For each clinic session, faculty are assigned to cover specific areas of the clinic. This reduces the need to provide coverage in widely spaced areas of the clinic and thus will help reduce the time you must wait to receive assistance or evaluation.

Faculty coverage will be rotated on a regular basis to give you the opportunity to work with all faculty. This will help make your clinic experiences as wide-ranging and fruitful as possible. The assignment of faculty to specific clinic areas is not prepublished; such assignment will be made just prior to the start of each clinic session.

On occasion (specific remediation, special clinical cases, etc.), you may need to work with a specific faculty member when in operative clinic. In such cases, you would be moved from your regularly assigned chair to one in the area being covered by the appropriate faculty member.

## CLASSES ASSIGNED TO OPERATIVE CLINIC

Each class (sophomore, junior, or senior) is assigned to operative clinic for a certain number of half-days each week throughout the school year. **Any class not normally**

**assigned to a given half-day of operative clinic will not be allowed access.** For example, no sophomore may utilize a clinic assigned only to juniors and seniors. There are no exceptions to this policy unless it involves a true emergency **and** is approved by the Department Chair or the Director of Operative Clinics.

### **OPERATIVE WORK DONE OUTSIDE OF GOLD CLINIC**

All work for which you wish to receive operative credit should be done in gold clinic to ensure proper faculty supervision and assistance. However, there may be instances when you place restorations in other clinics for which operative credit can be earned. To receive credit for such procedures, you must:

1. Secure permission from an instructor in the clinic where you are working to do the procedure in question.
2. Have that instructor evaluate your work in the Treatment Progress Notes section of your patient's chart.
3. Present this documentation to the departmental secretary who will transfer grades onto an operative grade form and assign appropriate point credit.

**Outside work is limited to restorations done in FPD, Endo, and OD clinics only.** You will also receive credit for any retentive pins placed as part of such restorations. Credit will **not** be given for any work done in other clinics. You will receive full point credit and a grade of “clinically acceptable” for all work done in other clinics.

### **CANCELLATION/NO-SHOW POLICIES**

You must reserve a clinic space per the computer patient appointment policy of the Office of Patient Management. Your name on this roster reserves a clinic space that no one else can use; therefore, you are expected to be present. If you or your patient must cancel the appointment, you are **required** to reopen your reserved clinic space so that other students may have access. Failure to do so prevents others from scheduling patients and demonstrates a lack of courtesy and responsibility.

To prevent your name from appearing on the attendance roster **you must cancel your appointment in Quick Recovery** before 7:00 a.m. If you are canceling your appointment after this time, cancel your clinic space as follows:

1. Enter a reason for the cancellation/no-show in the chart and sign it.
2. Fill out an Operative Daily Evaluation form (green sheet) with the appropriate box (student cancel, patient cancel, or patient no-show) marked.
3. Present both chart and green sheet to an attending operative instructor in gold clinic within 30 minutes of the scheduled appointment time.

If you do not follow these steps, a green sheet marked "Student No-Show" may be filled out for you. In addition, you may receive a grade of zero on this green sheet. This is a very severe penalty which can seriously affect your overall clinical judgment grade for the grading period. If you cannot cancel in person for some reason, you may cancel by telephone (271-5735). Phone cancellations are also subject to the 30-minute time restriction.

Even if you cancel an appointment in the proper manner, get in the habit of stopping by the gold clinic to ensure that your name is not on the roster. If it is, bring the matter to the attention of the Director of Clinics. If the scheduling error is not yours, obtain signed verification and present it to the operative secretary within 48 hours of the scheduled appointment. The Student No-Show and zero grade will then be removed from your records.

The attendance roster will indicate your scheduled appointment time. You have 30 minutes from that time to reconcile your clinic space. If you know that you or your patient will be late, notify the instructor monitoring the attendance roster and a revised arrival time will be entered for you.

Cancellations are only valid if done through an operative faculty member or the department secretary. They are not valid if made with clinic dispensary personnel or the front desk reception clerk or by crossing your name off the attendance roster posted near the dispensary.

The distinction between cancellation and no-show is important. If you are given more than 24 hours notice, it is a cancellation; if there is no notification or it is less than 24 hours, it is a no-show. Cancellations give you some opportunity to schedule another patient in the reserved time slot -- no-shows do not. Should you wish to terminate a patient from the program, no-shows are much stronger evidence that the patient is no longer interested or motivated to receive dental care.

### **STUDENT CLINICAL RESPONSIBILITIES**

In addition to your responsibility for the complete treatment of your patients' dental needs, you will also be evaluated in areas that directly or indirectly pertain to your

role as a developing professional. All of your clinical activities should be viewed as a small-scale model of your future dental practice. Your success will be dependent not only on how well you provide your services but also on the image you project as a professional and the concern you demonstrate for your patients as human beings rather than as sources of income. With this in mind, the following responsibilities are as critical as your technical abilities:

### **Clinical Organization**

Every time you are in operative clinic, your organization and preparedness will be evaluated as part of your clinical judgment grade based on the following:

1. Organization of work area. All needed instruments and equipment available and arranged in orderly fashion. As instruments are used, they are returned to their original positions to facilitate retrieval when necessary.
2. Knowledge of the procedure being performed. When doing procedures with which you have had little prior experience, you are expected to secure as much faculty assistance as necessary without jeopardizing your patient's confidence in you as a practitioner.
3. Completeness of records and thorough documentation of work. Operative clinic documents and their uses will be detailed in the grading forms and records section of this manual.

### **Aseptic Technique**

The importance of asepsis to patient health and legal protection cannot be over-emphasized. Since you operate under the licenses of attending faculty, they will rightfully penalize you severely for violations of aseptic procedure. Proper protocol includes the following:

1. Adequate sterilization of all instruments/equipment. While Central Sterilization manages most of the instruments and equipment used, students will often use items they themselves provide without giving consideration to their cleanliness and asepsis. Common examples include

- keeping dental floss containers in scrub pockets or reusing dropped instruments, burs, and handpieces without proper resterilization.
2. Sanitization of the operatory (including all surfaces you will have occasion to touch during operative procedures) before seating the patient.
  3. Washing hands every time you return from leaving the operatory. If you have a beard or long hair, take the necessary steps to ensure that the operating field is not contaminated.
  4. Universal precautions (gloves, mask, gown and protective eyewear). Failure to utilize proper barrier control techniques is a severe violation of infection control.
  5. Students will be expected to adhere to the Infection Control Policy outlined in the University Of Oklahoma College Of Dentistry Health And Safety Manual

### **Professional Attitude and Image**

While you are expected to conduct yourself at all times in a professional and mature manner, this is especially critical in a clinical setting. The interpersonal relationship skills you develop in dealing with patients, faculty, staff, and classmates are a critical component of your overall professional growth.

1. Be sure your clothes, hair, and general appearance project a professional image. Always obtain a clean gown every time you work in clinic.
2. Project an interest in what you are doing and a willingness and motivation to learn. Accept constructive criticism but at the same time be inquiring and interested. Interact with faculty, staff, and patients in a relaxed, non-belligerent fashion.

### **Time Management**

Perhaps no aspect of your development will be as economically important as effective time management. Preparation and efficiency are the hallmarks of good time management.

1. Clinic sessions are conducted from 9:00am to 12:00 noon and 1:00pm to 4:00pm. Always evaluate your knowledge and skills in determining what you can and cannot do within these time constraints. Faculty will limit what you are allowed to begin until you have consistently proven your ability to manage time effectively and gauge your abilities honestly.
2. Occasionally, a procedure will become much more involved than originally planned and will take more time to complete than expected. Seek necessary assistance from faculty in such instances so that time overage is kept to a minimum. Willingness to admit that you need

assistance with unexpectedly difficult procedures demonstrates maturity and a concern for your patient and time management.

3. Students who do not complete their patient's treatment prior to the end of the clinic period may receive a poor grade on their green sheet and/or a reduction of points credited for the procedure that they worked on that day.

### **Record Keeping**

Proper and thorough documentation of all treatment represents vital training for your future management of books, charts, and records in your own practice. Record keeping is important for many reasons: (1) sequential documentation of rendered treatment; (2) current account of work completed and work outstanding; (3) record of work performed if the patient should seek treatment elsewhere; (4) documentation of medical considerations that dictate special handling of otherwise routine treatment; and (5) legal protection for the patient, the attending faculty, and yourself. You will need to become thoroughly familiar with the following documents:

1. Master Treatment Plan (MTP)
2. Operative Treatment Plan Work Sheet
3. Sequential Operative Treatment Plan
4. Treatment Progress Notes (TPN)
5. Operative Clinic Grade Form
6. Daily Operative Evaluation Form (green sheet)
7. Patient Encounter Form

These documents are discussed later in this manual and also in your main Clinic Manual. The forms and records used by the Departments of Oral Diagnosis and Periodontics are also important sources of necessary preview information as your patients are treated in operative clinic.

## OPERATIVE CLINIC PROCEDURE (Procedural Sequence)

The following outlines the steps you must take before you will be allowed to bring a patient into operative clinic for treatment:

1. Patient Screening and Assignment Patients are generally screened in the Department of Oral Diagnosis to determine acceptability as teaching cases. Following acceptance, they are assigned to students on the basis of student and patient needs and level of student development. Refer to your main Clinic Manual for detailed information on patient screening, acceptance, and assignment.
2. Oral Diagnosis Workup The Department of Oral Diagnosis will initially determine the patient's needs and which departments must be consulted to develop a master treatment plan. This initial workup may be modified considerably as each department involved in treatment is consulted.
3. Operative Dentistry Needs The following types of patients are generally not acceptable as good teaching cases: [1] rampant caries; [2] more than three difficult teeth to restore (pins required, core amalgams required, etc.); [3] more than three E&E's (excavate and evaluate); [4] multiple extensive cervical carious lesions.
4. Departmental Routing Following oral diagnosis workup, you then make arrangements to consult the various departments involved in the recommended treatment plan. During this routing process, you will arrange the treatment suggestions into a master treatment plan that will be returned to the Department of Oral Diagnosis for approval and printing.
5. Chart Development All departments involved in screening and treatment planning will have their own specific forms to indicate diagnoses and planned care. These documents are compiled in a patient chart that contains relevant information about health, planned treatment, special considerations, and so forth. Any time you bring a patient into operative clinic, you must have the patient's chart (with radiographs) available or no treatment of any kind can be rendered.

In addition to the process of getting a patient ready for treatment in the various clinics as described above, each department has also established its own requirements before treatment can be initiated. For Operative Dentistry, they include:

### Patient Records

Operative Treatment Plan (orange sheets) consists of three separate pages. The first page that must be completed involves a Caries Risk Assessment and a Preventive Treatment Plan. The next page that must be completed is the Operative Treatment Workup. The final page requires the completion of a Priority Care treatment plan and a Routine Care treatment plan. All of these sheets must be completed by the student and then checked and signed by an instructor.

Master Treatment Plan (MTP) must be printed and signed by the Department of Oral Diagnosis indicating acceptance of the plan. The MTP indicates treatment sequence and the departments involved in that treatment.

Medical and Dental Histories must be available that detail all adverse past or current medical conditions that may affect the mode or type of treatment rendered. You must be thoroughly familiar with this historical data and be able to answer any pertinent questions.

Treatment Progress Notes (TPN) comprise the dated entries of past treatment rendered at the College. It is assumed that all prior treatment will be listed in these notes in the order rendered. All entries must be complete and signed by the faculty attending when the work was performed.

Radiographs must be recent and of good diagnostic quality. The number and type of radiographs taken are generally determined at the time of patient workup; in most cases they will include a full-mouth survey (including bite-wings). Operative faculty may request additional films at any time before granting permission to begin treatment. Such requests may be to (1) update old radiographs, (2) verify existence of a lesion, or (3) improve quality of unacceptable films due to cone-cutting, proximal overlapping, unsatisfactory contrast, etc. Acceptable age of radiographs is generally up to 5 years for a full-mouth series and up to 1 year for bitewing films.

These are the minimum document requirements for an acceptable patient record. The records of those departments that normally precede operative dentistry in sequential treatment (oral diagnosis and periodontics) are also expected to be included in the chart.

### **Required Armamentarium**

Your tray request for operative clinic will provide you with the necessary instruments and equipment for the planned procedure. Armamentaria are specific for the procedures you are doing; you are expected to arrange them in your work area in a neat, orderly, and sequential fashion. You have the responsibility of

ensuring that the armamentarium is complete and that all instruments are sharp and clean.

Many items (such as composite systems, special instruments and burs, and limited supply equipment) are not provided by Central Sterilization but rather are obtained from the gold clinic dispensary. Most items will be dispensed at your request; some are dispensed only with a faculty signature (e.g. additional anesthesia). In any case, you are responsible for the return of all equipment to the appropriate locations.

## Operative Forms

To evaluate the quality of your work and to monitor the payment of fees for treatment rendered, a number of forms are used that must be filled out properly and be available before operative treatment is initiated.

1. Operative Grade Form This form identifies the tooth being treated, type of operative procedure, surfaces involved, and restorative material used. It is used to evaluate specific procedural steps and to provide feedback on quality of performance.
2. Daily Operative Evaluation Form Known as the "green sheet," this form is used to evaluate your judgmental processes and preparedness.
3. Patient Encounter Form While not specifically an operative document, it must be available for every patient before you begin any treatment. It is used to monitor charges for treatment rendered and to record patient payments.

## Patient Preparation

After your armamentarium is properly arranged and the required forms are available and correctly filled out, your patient must be seated, draped with a patient napkin, and ready to be checked by your instructor. The chart must be available for inspection and radiographs properly mounted on the viewbox. The instructor will then come to your operatory, verify your planned procedure, review your records, and give you Permission to Proceed (PTP).

To summarize the steps you must complete for every patient before you will be allowed to initiate any treatment (including administration of anesthesia):

1. Patient screening and assignment
2. Oral diagnostic workup
3. Departmental routing and master treatment plan
4. Development of patient chart
5. Specific operative requirements:
  - A. Patient records
    - a. Master treatment plan
    - b. Operative treatment plan
    - c. Medical and dental history
    - d. Treatment progress notes
    - e. Radiographs
  - B. Complete armamentarium
  - C. Operative forms
    - a. Operative grade form
    - b. Daily operative evaluation form

- c. Patient encounter form
- D. Preparation of patient - You should examine the tooth that you intend to treat to confirm your original diagnosis prior to having the instructor check it. You may examine the patient with the mirror and explorer without written permission to proceed. Do not initiate any other treatment until receiving written Permission to Proceed by an instructor.

# GRADING FORMS AND RECORDS

The preceding section dealt with items needing your attention before initiating operative treatment. This section discusses in greater detail the documents used to evaluate your clinical work and to provide the necessary legal protection for you, your patient, and the College.

## MASTER TREATMENT PLAN (MTP)

The Master Treatment Plan (Page 22) is a computer-generated record of all treatment to be rendered and should always be kept behind the appropriately marked tab in the patient's chart. It lists the sequence of proposed treatment, the departments that will supervise specific treatment, the individual teeth to be treated, and brief descriptions of proposed treatment.

The final sequence of the Master Treatment Plan is determined after you route your patient through the individual departments involved in treatment. Once routing is completed, the final plan is submitted to the Department of Oral Diagnosis for approval. The MTP is not considered complete or approved unless an appropriate Oral Diagnosis faculty member has signed it.

Each department will provide its own guidelines for the makeup of its section of the Master Treatment Plan. For Operative Dentistry, the MTP must accurately and completely reflect the Operative Treatment Plan Sequence and individual restorations must be entered on separate lines, even if you plan to complete more than one restoration during a given appointment. The operative section of the MTP should be appropriately placed in the overall treatment scheme (generally following oral diagnosis, periodontics, and special emergency treatment and preceding the specialty disciplines).

Without a typed and approved MTP, you may not begin any operative treatment. If extenuating circumstances (such as emergency treatment) demand that treatment be rendered before the typed MTP is available, written and signed approval from the Director of Clinics is required. **Any other treatment rendered without an approved master treatment plan may result in no credit given for the procedure(s).**

When you request Permission to Proceed, your instructor will verify that the lesion is listed on the MTP. If the lesion does not appear on the typed plan but is verified by your instructor, he/she will add it to the Master Treatment Plan and give Permission to Proceed as described. Once a procedure is completed, the instructor will enter and initial the completion date.

If the MTP becomes messy and disorganized due to excessive written entries, operative faculty may request that it be re-typed.

**OPERATIVE CARIES RISK ASSESSMENT and**  
**PREVENTIVE CARE TREATMENT PLAN**

(See Treatment Planning Policies, Page 50)

The Caries Risk Assessment (CRA) is located on the last orange page in the Operative department's section of the patient records. (See page 23) It is an instrument to aid you in identifying for each individual patient the risk of the development of future carious lesions. A clinical and radiographic examination of the patient, along with an interview of the patient, provides information for the caries risk assessment. The CRA consists of five main sections including diet, caries activity, fluoride exposure, salivary flow, and plaque retention. Following the interview and clinical exam, the clinician should be able to assign the appropriate score based on the numbers assigned to each criteria. The total points will indicate that the patient falls into one of three categories: Low caries risk (CRA of 4 or less); Moderate caries risk (CRA of 5-9); or High caries risk (CRA of 10 or more, or at least 3 cavitated carious lesions). This assessment is based on a subjective evaluation of criteria that are believed to be good indicators of the patient's future risk of the development of carious lesions.

This information will be helpful in determining the aggressiveness of the treatment planned for the patient. Often Moderate and High caries risk patients will need more aggressive modes of both restorative and preventive treatment in an effort to prevent future disease. Remember, a patient's Caries Risk Assessment changes over time. If we have been effective in our preventive and restorative treatment, the patient's caries risk should decrease after a year or so.

The section located below the Caries Risk Assessment on the same page is the Operative Preventive Treatment Plan. The Operative Preventive Treatment Plan consists of three columns labeled Indications, Treatment Options, and Codes. The column labeled Indications provides a guideline of clinical situations that would suggest the need for additional preventive care. The guidelines are based on such things as the Caries Risk Assessment, patient's home care, and morphological defects in the pits and fissures. The student will assess the need for additional preventive care, and circle one or more of the corresponding treatment options that are listed in the second column of the form. These treatment options include but are not limited to antimicrobial rinses, oral health care instructions, over the counter fluoride rinses, prescription fluoride gels, in-office application of fluoride varnish, and application of preventive sealants. The third column lists the associated ADA dental codes for the various preventive treatments. After selecting the appropriate

preventive care treatment options to be utilized for the patient, the student will have an instructor review the plan at the same time that the rest of the operative treatment plan is presented. The instructor must sign at the bottom of the page in the appropriate box on the form.

### **OPERATIVE TREATMENT PLAN WORKUP**

(See Treatment Planning Policies, Page 50)

The Operative Treatment Plan Workup (Page 24) is a worksheet used to help finalize your operative treatment plan. This is the second orange sheet kept behind the Operative tab in the patient's chart. The workup sheet is divided into 32 lines for each of the individual teeth and 6 columns labeled Tooth, Surfaces, Material, Priority, Preventive, and Comments. The Tooth column identifies the number and the descriptive name of the tooth. The numbering system used is the Universal (military) system of 1-32.

During the completion of the Operative Treatment Workup sheet you must complete the information required for each tooth needing treatment in the operative clinic. Beside the appropriate tooth number, enter the surface of the tooth to be treated and the material to be utilized. The column marked "priority care" is to be filled in as needed by the instructor reviewing your treatment plan. The reason to develop a treatment plan is to establish an organized approach for providing care in an appropriate sequence. Operative dentistry procedures constitute only one part of the overall treatment for the patient's comprehensive care plan. Generally, a standard sequence involves the initial treatment of the periodontal tissues prior to restorative dental work. On some occasions, the patient may have teeth that are severely damaged by caries or trauma, or are causing pain for the patient. In these cases, some restorative care must be provided earlier in the sequence of treatment to alleviate pain and prevent irreversible damage to the teeth. These teeth are placed in a "priority care" category, and treatment will be initiated on them as soon as possible. The instructor will help you identify teeth that fall into this category and indicate them by initialing the box in the column labeled "Priority Care". These teeth must be treated prior to beginning a more routine treatment planning sequence. The treatment for these teeth frequently involves more complex restorative procedures. DS II students who are just beginning their clinical experience will not be allowed to treat these teeth. The patient will be referred to a DS III or DS IV student for the limited care of these more complex procedures.

When you schedule your patient for treatment planning, fill in the workup sheet with all lesions, defective restorations, and pertinent observations. Your proposed operative treatment plan must be integrated with the other dental disciplines. You and the instructor will then review your findings and make any corrections as necessary. The comments column should be used extensively to make notes about proposed sequencing, identify teeth to be observed but not treated, and remind you

of questions you wish to ask your instructor. When routing has been completed, you and the instructor must sign and date this workup sheet.

### **Priority Care/Caries Control Treatment Plan**

The first orange sheet behind the Operative tab in the patient's record folder is the Final Sequenced Operative Treatment Plan (See page 25). This sheet is divided into a "Priority Care" treatment plan and a "Routine" treatment plan. The Priority Care Treatment Plan section is designed to identify teeth in need of immediate care due to severe damage caused by caries or trauma, and/or the patient experiencing pain. These must be treated as soon as possible to alleviate pain and prevent irreversible damage to the teeth involved.

The Priority Care Treatment Plan has the following nine columns:

Sequence: Identifies the order the treatment is to be completed in.

Tooth: Identifies tooth to be treated

Surfaces: Identifies surfaces involved

Procedure: Identifies treatment to be provided

Department Referral: Identifies department other than Operative that should provide care for the tooth

Refer to DSIII or DSIV: Identifies procedures that are too difficult for the student of record to provide. It also has a place for the name of the upper classman who eventually provides the treatment.

Date of Treatment: Identifies the date treatment is provided.

Faculty signature: Requires signature to indicate treatment has been provided.

### **Routine Operative Treatment Plan**

The lower portion of the first sheet is the Routine Operative Treatment Plan Sequence (Page 25).

**All treatment listed in the Priority Care section of the treatment plan must be completed before any treatment on the Routine Care Treatment plan may be started.**

Pertinent information from the workup sheet is transferred to the routine care treatment plan in the proposed routine treatment sequence. This 32-line sheet is divided into six columns labeled [1] Tooth Number, [2] Surface, [3] Material, [4] Procedure Number, [5] Date of Treatment, and [6] Instructor Signature. When routing is completed, you must transfer information onto this sheet as follows:

1. Tooth Number: Enter the Universal number of the tooth. Use one line for each restoration so that work performed can be easily monitored.
2. Surface: Enter the surface(s) involved for each tooth.

3. Material: Enter the restorative material to be used in treatment. (Seal= Sealant; PRR= Preventive Resin Restoration; RES= Resin Composite; AM= Amalgam; GI= Glass Ionomer)
4. Procedure Number: Enter the appropriate code number for the procedure. Consult the Clinic Fee Schedule (posted at each clinic station) for correct procedure code numbers.

When all information is entered, your instructor will sign and date this sheet. At this point, operative routing is completed. As with the workup sheet, the sequence sheet is not considered valid without an operative instructor signature.

As you begin each listed procedure, the attending instructor will enter the start date and sign his/her name in Columns 6 and 7. Even though this sheet is arranged in planned sequence, deviations ("skipping") will occasionally occur. Procedures may also be added or deleted at the discretion of the faculty. The instructor making the change must sign all such changes in the original sequence. Sample entries for both the workup and sequence sheets are found on Pages 24 and 25.

### TREATMENT PROGRESS NOTES

The most important part of the patient chart is the Treatment Progress Notes (TPN) section, which is a written record of every procedure you do. Anything involving the patient or your relationship with him/her should be entered here, dated, and countersigned by the appropriate faculty. In addition to treatment procedures, such entries might include conferences with faculty about treatment, cancellations or broken appointments, interpersonal relations that indicate potential problems, significant medical information such as premedication, and so forth. Treatment Progress Notes should always be the top pages of the chart.

Permission to Proceed for every procedure must be entered in the TPN and signed by faculty. Requests for additional anesthesia, specialized equipment and materials, nitrous oxide, etc. must also be entered and signed. Following treatment, a complete entry describing everything done must be written down and signed by both you and the attending instructor. Incomplete records will result in a lowering of your clinical judgment grade. The information entered should include at least: 1)Date; 2)Procedure Number; 3)Clinic Fee Form Number; 4)Tooth Number and Surfaces; 5)Health History Review; 6)Anesthesia Description; 7)Treatment Description; 8) Other pertinent Information. Consult with your instructor if in doubt about what additional information should be included.

The sample entry on Page 26 would be interpreted as follows: Permission to Proceed was given to replace an MOD amalgam restoration in Tooth #12. The defective restoration and all caries were removed, with a near exposure in the distobuccal area. The One-Step Plus Adhesive System was used. Anesthesia was obtained with one carpule of xylocaine with vasoconstrictor. Note that the Operative Grade Form number is entered to facilitate any needed cross-referencing. The entry must be signed by both student and attending instructor.

### CLINIC ENCOUNTER SLIP

The Clinic Encounter Slip (Page 27) is used to monitor charges and patient payments. Always verify that the patient's name and chart number, your name, and your student number are properly entered. This form must be available to receive Permission to Proceed. At the end of the clinic session, the attending instructor will verify the tooth number, surfaces, procedure number, description, fee, and other pertinent information, along with his/her signature. This form is mandatory for each patient treated in the gold clinic.

### OPERATIVE GRADE FORM

The Operative Grade Form (Page 17) is used to evaluate the quality of your work. It is identical to the form used in preclinic. To briefly review:

**Procedure No. & Fee** In the upper left corner are boxes to enter the procedure number and corresponding fee. You are responsible for these entries. The blank box to the right of Procedure No. is initialed by the instructor after verifying that the correct procedure number has been entered

**Permission to Proceed** The three boxes immediately below the Fee box (Permission to Proceed, Instructor No., and Starting Date) are filled out by the instructor when Permission to Proceed is granted.

**Grade Form ID No.** Below the Starting Date box is the Grade Form number (printed in bold type). Enter this number on the green daily evaluation sheet, and the treatment progress notes to allow for any necessary cross-referencing.

**Patient & Student Identification** The upper right-hand space is reserved for patient and student identification. Enter the patient's name and chart number, your name, and your student number.

**Procedure Information** Below the Grade Form ID number are boxes used to fully identify the operative procedure:

**Tooth No** -- Enter the appropriate Universal number of the tooth being treated.

**Material** -- Check the restorative material you are using: amalgam (AM); composite (Comp); glass ionomer restorative (GI); ION crowns, IRM temporaries, etc. (Other)

Pins -- Write in the number of pins used.

Core -- If the restoration is an interim procedure for a cast crown, the faculty will check initial this box.

DO NOT FILL THE BOXES FOR SURFACES!! At the time your cavity preparation is checked, your instructor will mark the surfaces involved and assign appropriate point credit.

**Evaluation** The middle section of the form is used to evaluate your work. As each phase of work is completed, the instructor will initial the appropriate box to record a grade ranging from F (failure) to TEQ (total exceptional qualities) for each of four categories: Moisture Control (rubber dam, cotton roll isolation etc.); Cavity Preparation (including caries removal, pulp protection, etc.); Restoration Insertion; and Completed Restoration. These evaluations are equally weighted and are averaged to arrive at a total grade for the procedure. Additional boxes in this section are for faculty use and are self-explanatory. The lower right-hand space marked "Comments and/or Instructions" is for additional faculty notations and comments.

The backside of the Operative Grade Form (Page 18) lists current procedure numbers, descriptions of what evaluations mean, and numbered critique areas that may be referred to by the faculty when evaluating your work.

### **Use Of The Operative Grade Form**

This form is provided in triplicate. When you receive Permission to Proceed, the instructor will sign the appropriate spaces on the top (white) copy. All evaluations and comments are also marked on this copy, which will be retrieved and filed as a procedure started. You retain the pink and hard copies until the procedure has been fully completed. At that time, the attending instructor will retrieve the bottom (hard) copy, which will be filed as a procedure completed. The pink (middle) copy is your record of the completed procedure. The white and hard copies are retrieved together for a procedure started and completed in the same appointment.

Retain all pink copies of work completed to protect against inadvertent loss of your records by the Department. If you can produce your copy to verify that a procedure has been completed, you will be given appropriate credit. If you cannot produce the pink copy, you will receive no credit. You should never leave grade forms in your patient charts; these charts can pass through many hands, increasing the possibility of loss of these forms. If you lose an Operative Grade Form for work in progress, consult with the Director of Operative Clinics for appropriate reconciliation.

PROCEDURE NO.  
**02160**

PROCEDURE NO. CHANGE

FEE

FEE CHANGE

**J. Smith 150-08**

PERMISSION TO PROCEED

**Mary Jones  
1234**

INSTRUCTOR NO.

STARTING DATE  
**9-1-06**

THE UNIVERSITY OF OKLAHOMA  
AT OKLAHOMA CITY HEALTH SCIENCES CENTER  
COLLEGE OF DENTISTRY

NO. **10000**

OPERATIVE DENTISTRY

08

Tooth No.

Materials  AM  Comp  GI  Other

Surfaces  M  O  D  F  L  I

Pins

Core

- Approval Without Rubber Dam
- Caries Removal
- Pulp Protection
- Matrix

FAILURE	MARGINAL	CLINICALLY ACCEPTABLE	MANY EXCEPTIONAL QUALITIES	TOTAL EXCEPTIONAL QUALITIES

- MOISTURE CONTROL
- CAVITY PREPARATION
- RESTORATION INSERTION
- COMPLETED RESTORATION

Temporize

Date Completed    (M, Day, Yr.)

Replace

Refer to:

COMMENTS AND/OR INSTRUCTORS

\_\_\_\_\_

## OPERATIVE DENTISTRY

### PROCEDURE CODE NUMBERS

AMALGAM	Pts	RESIN	Pts	OTHER	Pts
<b>1-surface 02140</b>		<b>01351</b>		<b>02799</b>	
Cl I, pit	1	Sealant	1	Temp Ion Crown	2
Cl I, occlusal	2	<b>1-surf 02330 (Ant)</b>		<b>02931</b>	
Cl V	3	Cl I or VI pit	1	Temp SS Crown	2
Cl VI	1	Cl V	3	<b>02940</b>	
<b>2 surface 02150</b>		Incisal repair	2	Temp Restoration	1
Cl I 2 surface	3	<b>2-surf 02331 (Ant)</b>		<b>03121</b>	
Cl II 2 surface	4	Cl III 2 surface	3	Pulpotomy	2
Cl III 2 surface	3	<b>3-surf 02332 (Ant)</b>		<b>09910</b>	
<b>3-surface 02160</b>		Cl III 3 surface	5	Desensitize Fl	1
Cl I 3 surface	3	<b>4-surf 02335 (Ant)</b>		<b>09911</b>	
Cl II 3 surface	7	4 + surfaces	7	Desensitize Resin	1
Cl III 3 surface	5	Cl IV	5	<b>09972</b>	
<b>4-surface 02161</b>		<b>1-surf 02391(Post)</b>		Microabrasion	2
Cl II 4 + surface	8	Cl I pit	1	<b>09972</b>	
<b>Core 02950</b>		Cl I occlusal/PRR	2	Bleaching/arch	6
1 surface Core	1	Cl V	3		
2 surface Core	2	<b>2-surf 02392(Post)</b>		<b>No Code</b>	
3 surface Core	3	Cl I 2 surface	3	Oper. Tx Review	2
4 surface Core	4	Cl II 2 surface	4		
5 surface Core	5	<b>3-surf 02393(Post)</b>			
<b>Pin 02951</b>		Cl I 3 surface	4		
Per retention pin	1	Cl II 3 surface	7		
		<b>4-surf 02394(Post)</b>		<b>09230</b>	
		Cl II 4 surface	8	N2O analgesia	0
		<b>Core 02950</b>		<b>00110</b>	
		See amalgam		Misc consult	0
		<b>Veneer 02960</b>			
		Direct Resin Veneer	3		

### WHAT YOUR EVALUATION MEANS

<b>MARGINAL</b>	Below average within dental profession Questionable service to patient Procedure may or may not succeed
<b>CLINICALLY ACCEPTABLE</b>	Average within dental profession Patient receives dollar value service Adequate longevity expected Good restoration; desirable qualities and virtues
<b>MANY EXCEPTIONAL QUALITIES</b>	Above average within the dental profession Optimum longevity expected Very good restoration
<b>TOTAL EXCEPTIONAL QUALITIES</b>	Not book quality in procedure Perfection achieved

## DAILY OPERATIVE EVALUATION FORM

Commonly known at the green sheet, this form (Page 20) is used to assess your clinical judgment during a given operative procedure. It is identical to the form used in preclinic. To briefly review:

**Student & Patient Information** On the top part of this form, enter your name and class, your chair assignment, date, patient name, procedure(s) being performed, corresponding Operative Grade Form ID number(s), and whether you are doing daily work or a clinical examination.

**Evaluation** The remainder of the form is filled out by the attending instructor as your performance in the listed skill areas is assessed. Each skill area can be evaluated as negative (-), neutral (OK), or positive (+). Your overall evaluation at the bottom of the form is not necessarily an addition of the various skill area scores. It is, rather, an overall assessment of your total performance using the individual scores only as a guide. The severity of one negative evaluation may be serious enough to warrant a poor overall evaluation even though all other skill areas were assessed positively. When your clinic activity is completed the instructor will sign this form in the bottom right corner. Consult with your instructor if you need clarification of your final evaluation.

### Use Of The Green Sheet

This form is provided in duplicate. When you complete treatment, your instructor will fill in and sign the form, and retrieve the green (top) copy. The yellow (bottom) copy is your record. As with Operative Grade Forms, do not keep these forms in patient charts. If you wish to consult with faculty regarding your progress in clinical judgment, you should be able to produce your copies.

NOTE: An Operative Grade Form and a patient encounter form are filled out for every procedure done in gold clinic. A green sheet is filled out for every patient seen in gold clinic.



**OPERATIVE DAILY EVALUATION**

CHAIR NO. 34 DATE 9-1-0 4  
 STUDENT J. SMITH II III IV 0216 0  
 PATIENT(S) Mary Jones NAME Procedure  
 CLINIC SLIP NO.(S) 1000 0 DAILY WORK   
 EXAMINATION

CRITERIA	EVALUATION			
	-	OK	+	
1. PROFESSIONALISM (Appearance & Attitude)			☞	
2. PATIENT MANAGEMENT (Empathy, Education)		☞		
3. CLINICAL JUDGMENT (Application of Knowledge)			☞	
4. ORGANIZATION OF WORK AREA ( Efficiency, Neatness, & Instruments)		☞		
5. OPERATIVE SKILLS			☞	
6. TIME MANAGEMENT			☞	
7. TREATMENT PLANNING				
8. RECORDS		☞		
9. OTHER				
10. ATTENDANCE	STUDENT NO SHOW	STUDENT CANCELLED	PATIENT NO SHOW	PATIENT CANCELLED

OVERALL EVALUATION	F	D	C	B	<b>A</b>
	- 74	75 - 77	78 - 82	83 - 85	86 -

COMMENTS

86

INSTRUCTOR SIGNATURE: \_\_\_\_\_

## **PERMISSION TO PROCEED**

The following is a summary of the steps necessary before you can begin operative treatment in gold clinic:

### **Chair Assignment**

1. Reserve clinic space: sign up for gold clinic.

### **Work Area Organization**

1. Have all instruments/equipment organized in a neat and orderly fashion.
2. Sanitize your work area according to published guidelines.
3. Have radiographs available and mounted on the viewbox.

### **Self And Patient Preparation**

1. Be clean and neat in your dress and appearance.
2. Wear proper clinic attire.
3. Have protective eyewear, mask, gown, and gloves on.
4. Seat and drape your patient.

### **Patient Records**

1. Have an approved Master Treatment Plan available.
2. Verify that all required operative pre-treatment procedures (periodontics, emergency treatment, etc.) have been completed.
3. Have a sequential Operative Treatment Plan sheet filled out and signed.
4. Ensure that the work you plan to do is listed on the Operative and Master Treatment Plans or can be verified by your instructor.
5. Confirm for yourself that the treatment that you intend to begin that day is indicated by examining the tooth with a mirror and explorer. (You may examine the patient without obtaining permission to proceed from your clinical instructor, do not proceed with any other treatment prior to receiving written permission to proceed from your instructor.)
6. Have a Clinic Encounter Slip available for faculty signature.
7. Have any other patient documents requested available.
8. Request Permission to Proceed in your Treatment Progress Notes.

### **Grading Forms**

1. Have the Operative Grade Form properly filled out and ready for faculty signature. Do not mark surfaces on this form!
2. Have the Daily Operative Evaluation Form (green sheet) properly filled out and available.

### **Miscellaneous**

1. Have study models available, if requested by attending faculty.
2. Be able to provide any additional items requested or answer any questions posed by attending faculty regarding your proposed treatment.

Grade forms, green sheets, and certain patient chart records are available in the wall dispensary located in the student laboratory in gold clinic.

It will take you a few clinic sessions to become familiar with the routine for securing Permission to Proceed. Most of the foregoing steps will become second nature over time. In addition, they will prepare you for future practice by developing a well-organized approach to the introductory management of your patients.



**CARIES RISK ASSESSMENT (CRA)**

**DATE : 6/20/06**

Risk Factor	Assessment Criteria		
DIET	Eats or drinks sugar sweetened beverages five or more times/day.	1 pt	1
	Chews regular (non-sugar-free) gum.	1 pt	
	Drinks any sugar-sweetened beverages between meals.	2 pts	
	Eats mints, candies, pastries, chips, crackers, etc., between meals.	2 pts	
	Does not drink or eat dairy products (milk, cheese) every day.	1pt	
CARIES ACTIVITY	Cariou s lesions are present. (cavitated)	3 pt	1
	Number of cavitated carious lesions.	1 pt each	3
	Number of non-cavitated enamel only carious lesion.	1 pt each	1
	Five or more restored carious lesions.(amalgams, composites, crowns)	2 pts	2
FLUORIDE EXPOSURE	No fluoride from water, supplemental drops or tables.	1 pt	1
	No fluoride from daily use of fluoridated toothpaste, rinse or gel.	1pt	
SALIVARY FLOW	Mouth feels dry when eating a meal.	(3 of 4) 2pt	
	Difficulty swallowing food.		
	Has to sip liquids to aid in swallowing.		
	Amount of saliva in mouth seems "too little" most of the time.		
PLAQUE RETENTION	High Unacceptable amounts of plaque observed	1 pt	1
	Low Acceptable plaque control observed	0 pt	
Total score for all factors evaluated			<b>10</b>

**Caries Risk Assessment**   
  **High-CRA >10**  
 or > 3 cavitated lesions  
 3 mo re-evaluation   
  **Moderate**  
**CRA 5-9**  
 6 mo re-evaluation   
  **Low**  
**CRA 4 or less**  
 1 yr re-evaluation

**OPERATIVE PREVENTIVE TREATMENT PLAN OPTIONS**

Indications	Treatment Options	Code
Moderate or High caries risk or Deficient fluoride exposure or Unacceptable plaque level or Demineralization	1. Antimicrobial 0.12% Chlorhexidine Rinse (Peridex) 1/2 oz rinse & spit out before bedtime for 14 days Rx Date : _____	<b>09630</b>
	2. Plaque control: Oral hygiene instruction	<b>01330</b>
	3. OTC Fluoride (ACT/Fluorid Oral B 0.05% NaF) along with twice daily use of fluoride toothpaste	<b>09630</b>
	4. Rx Fluoride Gel (Prevident - 1.1% NaF) in addition to twice daily use of fluoride toothpaste Rx Date: _____	<b>09630</b>
	5. Remineralization - for smooth surface demineralization -5% NaF varnish for 2 applications -1 week apart Application Dates: #1 _____ #2 _____	<b>01204</b>
<b>Tooth numbers to be remineralized (with surfaces):</b>		
Tooth#		
Surface		
Moderate or High caries risk with Deep retentive fissures	<b>Preventive Sealants</b>	<b>01351</b>
	Tooth#	
	Tooth#	
Student Signature: Hap E. Studert	Faculty Signature: <b>Terry Fruits</b>	Date: 6/20/06

Initial Gingival Tissue Evaluation			
<b>Color</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Reddened	
<b>Plaque Retention</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Unacceptable	
<b>Bleeding</b>	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Slight	<input type="checkbox"/> Substantial

Caries Risk	
High	<input checked="" type="checkbox"/>
Moderate	<input type="checkbox"/>
Low	<input type="checkbox"/>

### **OPERATIVE TREATMENT PLAN WORK-UP**

(List only teeth to be treated)

TOOTH	SURFACES	MATERIAL RES/ AM/ GI	PRIORITY CARE	PREVENTIVE FL/SEAL	COMMENTS
1	UR3Molar				
2	UR2Molar				
3	UR1Molar				
4	UR2PreMolar	MOD	RES		
5	UR1PreMolar	MODF	AM	X	Pin
6	URCuspid				
7	URLateral				
8	URCentral				
9	ULCentral				
10	ULLateral				
11	UICuspid				
12	UL1PreMolar	MO	RES		
13	UL2PreMolar				
14	UL1Molar				
15	UL2Molar	DO	AM	X	E & E
16	UL3Molar				
17	LL3Molar				
18	LL2Molar	O	AM		PRR
19	LL1Molar	MO	AM		
20	LL2PreMolar	O	RES		
21	LL1PreMolar				
22	LLCuspid				
23	LLLateral				
24	LLCentral				
25	LRCentral				
26	LRLateral				
27	LRCuspid				
28	LR1PreMolar				
29	LR2PreMolar	MOL	AM	X	ENDO?
30	LR1Molar	O	RES		PRR
31	LR2Molar				
32	LR3Molar				

Student Signature: Hap E. Student

Faculty Signature : Terry Fruits

Date: 6/20/06

**PRIORITY CARE/CARIES CONTROL TREATMENT PLAN**

(Must be completed prior to Preventive Treatment and Routine Operative Treatment)

Sequence	Tooth #	Surface	Procedure	Dept. Referral	Refer to DS III or IV		Date of Treatment	FACULTY SIGNATURE
					Yes	Student Name		
1	5	MODF	Pin Am		X	John Doe DS IV	7/14/06	Terry Fruits
2	15	DO	E&E		X	Jane Doe DS IV	7/22/06	Terry Fruits
3	29	MOL	Endo	Endo	X	Joe Blow DS IV	8/3/06	Terry Fruits
4								
5								
6								
7								
8								
9								

Initial Operative Treatment	Date	Fac. Signature
Priority Care/Caries Control Treatment Completed	8/3/06	Terry Fruits
Preventive Operative Treatment Initiated	6/20/06	Terry Fruits

**ROUTINE OPERATIVE TREATMENT PLAN**

Sequence	Tooth #	SURFACE	MATERIAL SEAL/ PRR/ RES/AM / GI	PROCEDURE NUMBER	DATE OF TREATMENT	FACULTY SIGNATURE
1	18	O	AM	2140		
2	19	MO	AM	2150		
3	20	O	RES	2391		
4	4	MOD	RES	2393		
5	12	MO	RES	2392		
6	30	O	RES/ PRR	2391		
7						
8						
9						
10						
11						
12						
13						
14						
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23						
24						
25						
26						
27						
28						
29						
30						
31						
32						

**QC – Completed Operative Treatment Review**

Student Signature: Hap E. Student

Faculty Signature: Terry Fruits

Date : 6/20/06



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# DETERMINATION OF COMPETENCE

Assessment of professional growth and competence involves consideration of many interrelated factors. It is impossible to standardize student clinical experiences and unrealistic to expect all students to demonstrate the same level of expertise, professionalism, and maturity at any given stage of evaluation. A fair assessment of competence must consider the quantity of work performed, the quality of that work, and the judgmental skills exercised in producing that work. Stated another way, evaluation must consider both the product (end result) and the process (means used to achieve the end result).

Operative Dentistry uses an evaluation system that assesses your clinical competence at the end of each of the six grading periods. This system considers the three major areas of quantity, quality, and clinical judgment.

## QUALITATIVE OBJECTIVES

Quality refers to the characteristics of the work performed. Your work will be compared to standards as established in and by the dental community. A good average dental restoration would be classified as "Clinically Acceptable" (CA). Restorations above the average would be described as "Many Exceptional Qualities" (MEQ) or "Total Exceptional Qualities" (TEQ); those that fall below accepted standards would be classified as "Marginal" (M) or "Failure" (F). Quality will be assessed for each unit of work performed in clinic. The grading form used, the specific areas of evaluation for each procedure, and the effect of quality assessment on your total clinical grade are described later in this section.

## CLINICAL JUDGMENT OBJECTIVES

Your thought processes and actions in effecting the best possible treatment for your patients will determine your clinical judgment. Whereas quality refers to product evaluation, clinical judgment is process evaluation. This is an important part of your clinical evaluation and will count 10% of your grade in each grading period. For each patient you treat, an Operative Daily Evaluation Form (green sheet) will be used to evaluate your process performance in the following areas:

**Professionalism** Your appearance, manner, attitude, and ability to instill confidence, cooperation, and trust in your patients.

**Patient Management** The care, empathy, and concern you demonstrate for your patients' physical and emotional needs; your level of rapport with your patients; your ability to educate them in the maintenance of oral health and hygiene.

**Knowledge of Subject** Your preparedness for and knowledge of the procedures you are performing.

**Organization of Work Area** Your efficiency and organization in arranging all necessary equipment, instruments, and supplies; the completeness of your armamentaria; your utilization of auxiliary personnel to best advantage.

**Operative Skill** Your increasing proficiency in technical ability as you progress through your clinical experiences; your level of motivation and desire to improve your skills.

**Time Management** Your ability to demonstrate punctuality, properly gauge your activities in relation to available clinic time, and manage allotted time to full advantage.

**Treatment Planning** Your diagnostic skills in developing a complete, properly sequenced, and well-planned treatment scheme in managing patient needs.

**Records** The compilation of all necessary treatment documents as a full and complete medico-legal record of your activities during patient treatment.

**Other** Rapport with clinical faculty and staff; utilization of alternative treatment approaches as required; ability to accept and implement constructive criticism; etc.

### **QUANTITATIVE OBJECTIVES**

Quantity refers to the total number of clinical operative procedures you complete. Quantitative objectives are necessary to ensure that all students perform at least an established baseline amount of work that will assist in the evaluation of achieving "competence". In addition, quantitative requirements set a standard by which all students can be evaluated fairly and equitably. We have developed a quantitative requirement scheme based on points. To be **considered** for graduation, you must accumulate a minimum number of points that reflects the amount and type of work performed. You must, in addition, earn these points in specific categories that represent the major areas of operative dentistry you will be exposed to in practice.

You will be **considered** quantitatively eligible for graduation when you have accumulated a minimum of 410 points distributed as follows:

**Class II Restorations: A minimum of 110 points.**

- At least 20 points of the 110 Class II points must be Class II Amalgams
- At least 20 points of the 110 Class II points must be Class II Resins

Example: 70 points of Class II amalgams and 40 points of Class II composite resins would meet the minimum requirement of 110 points of Class II restorations

**Composite Resin Restorations: A minimum of 60 points.**

These must be Class I, III, IV, V and VI composite resin restorations. Class II composite resins will not be counted in this category because they will be used to satisfy the Class II restoration requirement.

The remaining 240 Operative Points can be earned by completing whatever restorative treatment your patients require.

Core restorations must satisfy all requirements of a final restoration (contour, contact, anatomy, marginal integrity and occlusion) to be counted as a Class II restoration.

All amalgam restorations will be considered “completed” at the initial appointment as long as they have been smoothly carved, and adequately margined and finished. A second polishing appointment will not be necessary. The Western Regional Examining Board has a similar requirement for finishing of the amalgam restoration on the board examination. If the clinical instructor feels that the amalgam restoration has not been adequately carved, margined or finished, a second appointment will be required to do so.

In addition to the above points, you must also complete a minimum 4 pin retained restorations to be **considered** for graduation.

A list of those operative procedures you will have occasion to perform and their associated point values is reproduced on the following page. This chart is posted at every operative clinic cubicle for your convenience. Procedures not listed (e.g. composite veneers) are usually done under the close supervision of a particular instructor who will determine the appropriate point credit.

In addition to the 410 points needed to be **considered** for graduation, minimum point totals have been established for each of the six grading periods. This is to space your operative activities such that your progress is consistently paced. Note from the following table, to be eligible to receive a passing grade, you must accumulate the specified minimum number of points by the end of each grading period. If you do not accumulate the minimum number of points by the end of each grading

period, you will receive a failing grade for that grading period. Point totals in the following table are cumulative.

MINIMUM POINTS REQUIRED PER GRADING PERIOD					
I	II	III	IV	V	VI
15	50	120	170	250	410

**NOTE: THE ACCUMULATION OF 410 POINTS IN THE ABOVE MENTIONED CATEGORIES PLUS THE COMPLETION OF 4 PIN-RETAINED RESTORATIONS ARE THE MINIMUM CLINICAL EXPERIENCES NEEDED TO BE CONSIDERED FOR GRADUATION BY THE DEPARTMENT OF OPERATIVE DENTISTRY. SIMPLY COMPLETING THE ABOVE MENTIONED 410 POINTS AND COMPLETION OF 4 PIN RETAINED RESTORAIONS DOES NOT GUARANTEE CLEARANCE FOR GRADUATION BY THE OPERATIVE DEPARTMENT.**

The quality of your work (daily work, clinical examinations, clinical judgment) will be computed into a certain grade. You must also complete the minimum quantity of work to receive that grade. For example, if you have a combined quality grade of 86% at the end of Grading Period II (Fall, 3<sup>rd</sup> Year) you would warrant a grade of "B" for Grading Period II. However, you must also have accumulated at least 50 points. If you do not accumulate at least the minimum established points for a specified grading period (in this example 50 points) you will receive a failing grade for that grading period. See chart page 28.

Example: Quality Work (daily work, clinical examinations, clinical judgment) = 86%

Points = 50 or more  
Grade for Grading Period II = B

Example: Quality Work (daily work, clinical examinations, clinical judgment) = 86%

Points = 49 points or less  
Grade for Grading Period II = F

Evaluation in the three areas of quantity, quality, and clinical judgment is generally sufficient to provide a fairly accurate picture of your clinical progress. Since

evaluations are related to the "standard" of the dental community, you can be fairly confident that success as measured in operative clinic will be a good reflection of success as a future dentist.

### **Grading Period I Spring 2<sup>nd</sup> Year**

Second semester students will be required to have six patients with typed and approved master treatment plans completed before they can treat patients in Gold Clinic. During this grading period, sophomore students may earn **up to 16 points** in operative dentistry by assisting junior or senior dental students in the gold clinic during their assigned clinic periods.



# EVALUATION OF PERFORMANCE

As mentioned earlier, clinical competence will be measured in terms of quantity, quality, and judgment. Your combined performance in these areas will determine the grade you receive in each grading period according to the following percentages:

Daily Clinical Work	30%
Clinical Examinations	60%
Clinical Judgment	10%

Evaluation will be provided in terms of performance description, rather than a number or letter grade. Your quality evaluation will fall into any one of five categories: Total Exceptional Qualities (TEQ); Many Exceptional Qualities (MEQ); Clinically Acceptable (CA); Marginal (M); or Failing (F). This scale encourages you to assess your work in terms of clinical acceptability, expected success/longevity of the procedure, relationship to accepted standards in the dental community, and service to the patient. You should already be familiar with these descriptors since they were used in your preclinical laboratory courses.

## DAILY CLINICAL WORK

For grading periods II - VI, the grades earned for all clinical procedures (except clinical examinations) will be weighted and averaged to arrive at a mean grade for daily clinical performance. This grade will count 30% of your total clinical grade for each grading period.

Weighting of procedures is based on associated point value. The grade received for a 4-point procedure will count four times the grade received for a 1-point procedure. To illustrate: Assume you earn a grade of 90% for a Class II MO amalgam (4 pts) and 70% for a Class I pit amalgam (1 pt). Your overall grade is calculated as follows:

$$(90 \times 4) + (70 \times 1) / 5 = 430 / 5 = \underline{86\%}$$

Without weighting, your mean score would be 80%  $(90 + 70/2)$ . The weighted grade of 86% reflects better performance on the more difficult procedure.

All work done in operative clinic is cumulative and will count towards the 410 total points required for graduation consideration. However, your daily work grade for each grading period will be determined on the work completed during that period only.

**CAUTION!!** Some students may get far enough ahead in their point total accumulations that they relax their efforts in a later grading period and do only the required clinical examinations. This is very unwise since the computer will record a grade of zero for daily work (since none was performed) and incorporate that zero as 30% of the total grade. Regardless of how far ahead you get, always do at least one daily work procedure in each period to avoid this type of grade penalty.

### CLINICAL PROFICIENCY EXAMINATIONS

Evaluations earned for examinations will be weighted and averaged to arrive at a mean grade for clinical examinations. This grade will count 60% of your total clinical grade for each grading period **except** Grading Period I (spring, 2nd yr); no clinical examinations are required during that period. The schedule for clinical examinations is as follows:

1. **Grading Period II (fall, 3rd yr)** Two Class I Occlusal **or** two Class II amalgams or composites (or one of each). These examinations may be taken together on the same half-day of clinic.
2. **Grading Periods III-V (spring & summer, 3rd yr and fall, 4th yr)** One Class II amalgam or composite **and** one Class III, IV, or V composite.
3. **Grading Period VI (spring, 4th yr)** Participation in Mock Boards and/or complete operative clinical competency exams. Details to be announced

With the exception of Mock Boards (which will be scheduled for you), you may schedule clinical proficiency examinations at your convenience provided you have completed eligibility requirements (see next section). Examinations must be completed during the grading period in which they are scheduled. Failure to do so will result in an automatic grade of F. Moreover, you may not do clinical proficiency examinations earlier than the period in which they are scheduled.

### Clinical Examination Protocol

You may schedule clinical examinations at any time during a grading period, except for Grading Period II. During Grading Period II (Fall 3<sup>rd</sup> Year) you must have completed a required level of daily work activity (15 points) before scheduling a clinical examination. These eligible points ensure that you at least have completed some clinical activity before scheduling a higher weighted examination.

To receive examination credit, all examinations must be completed during the appointment in which they are begun.

## Tooth Selection for Clinical Proficiency Examinations

Since the intent of clinical proficiency examinations is to allow you to demonstrate clinical proficiency and to provide the training and experience to successfully pass the regional board licensing examination, tooth selection criteria are designed to mirror current board requirements as follows:

### **Class I Amalgam**

1. Must involve the full occlusal surface of any posterior tooth.
2. May be a primary carious lesion or may replace an existing defective restoration.
3. Tooth must be in occlusion with the opposing arch.

### **Class II Amalgam or Class II Composite**

1. Must involve a minimum of two surfaces (MO or DO) of any posterior tooth except the mesial of mandibular first premolars.
2. May be a primary carious lesion radiographically or clinically into dentin on at least one proximal surface or may replace an existing defective Class II restoration.
3. Tooth must be in occlusion with the opposing arch; proximal contact with the adjacent tooth must be restored.

### **Class III or IV Composite**

1. Must involve the proximal surface of any tooth.
2. May be a proximal primary lesion radiographically or clinically into dentin or may replace a defective permanent restoration.
3. Surface to be restored must have proximal contact with an adjacent tooth. However, the preparation need not involve the contact area.
4. Incisal edge fractures are not acceptable candidates for clinical examinations. All Class IV preparations must involve the proximal contact area.

### **Class V Composite**

1. Must involve the cervical one-third of the facial surface of any anterior or premolar tooth.
2. May be a primary carious lesion or may replace an existing defective restoration.
3. Pit restorations are not acceptable. It will be at the discretion of the clinic instructor to determine if the lesion or defect offers a clinical experience that will qualify it as an effective examination situation.

Final approval of tooth selection for any clinical examination is at the discretion of the instructor monitoring the examination. Should you have a potential test case which has questionable acceptability, seek advice from operative faculty prior to scheduling the examination.

## CLINICAL JUDGMENT

An Operative Daily Evaluation Form (green sheet) is filled out for every patient treated in operative clinic. For each of the six grading periods, the grades earned on all accumulated green sheets will be averaged as a mean grade for clinical judgment. This grade will count 10% of your total clinical grade.

All green sheets for treatment planning will be averaged separately from all other green sheets. This one average grade will then be averaged in with all other green sheet evaluations to calculate your mean grade for clinical judgment.

A green sheet must be collected and recorded each time your name appears on the master attendance roster, regardless of whether you work in clinic or cancel your chair reservation.

For Grading Period I (spring 2<sup>nd</sup> year), the green sheet will also be utilized to record points that are credited for assisting upper classmen.

## QUANTITY (POINT SYSTEM)

Remember that points are only credited for completed clinical activity (validated when the hard copy of the grade form is turned in). If you begin a procedure in one grading period but complete it during a later period, the associated points will be credited in the later period.

Because the point system is based on the number of surfaces involved, there is some potential for abuse by students. Removal of tooth structure without cause is flagrantly unprofessional, unethical, and equivalent to malpractice. The following policies have been established to monitor use of the point system:

1. You will fill in all appropriate information on the grade form **except** the surfaces involved. At the time of final preparation check, your instructor will mark the surfaces involved, check to see that you have entered the correct procedure number, and assign the appropriate points. **CAUTION!!** If your preparation includes any surface not approved by the instructor, you will receive no points for the procedure, the number of points that would have been assigned will be subtracted from your overall point total, and you will receive a grade of zero on your green sheet.
2. Faculty have the option of adding or subtracting up to two points on any procedure entailing a deviation from the "norm" that makes it easier or

more difficult. Examples include cusp capping (points added) or restoring a tooth with no opposing occlusion or adjacent tooth (points subtracted).

3. Amalgam or composite restorations done in FPD, Endo, or OD clinic will receive operative point credit provided departmental guidelines are followed.
4. Certain clinical procedures traditionally preserve tooth structure (oblique ridges of maxillary molars and transverse ridges of mandibular first premolars). Retaining these structures may not warrant additional credit just because two "separate" restorations are involved. For example, separate occlusal and distolingual groove preparations in a maxillary molar may be one procedure worth 3 points (not two procedures worth 5 points). If in doubt about procedures such as these, consult with your instructor.
5. Nominal point credit will be given for certain temporization and pulp treatment procedures provided they are planned as such. You will receive no points if you must temporize a tooth simply because you ran out of time. However, if you plan an E&E (excavate & evaluate) or if you must temporize a carious pulp exposure, you will receive the designated points for a temporary restoration.
6. When you and an instructor are working together on a "non-standard" procedure, point credit will be at the discretion of the faculty.
6. Specific point credit policies have been established for work outstanding on patients who must be terminated or inactivated. Refer to the section on Other Operative Policies later in this manual.

### **PIN PLACEMENT REQUIREMENTS**

In addition to the 410 points minimum needed to be considered for graduation, you must also complete a minimum of 4 pin retained restorations. Policies governing pin placement are as follows:

1. The need for pins will be determined by the attending instructor who will enter the number of pins in the "Pins" box on your grading form and initial next to the box.
2. Pins placed in FPD or Endo clinic will receive pin retained amalgam restoration credit provided documentation in the chart is signed by an FPD or Endo instructor. You must request pin credit within 48 hours of placement. Failure to do so will result in no credit.

## WHAT YOUR CLINIC GRADE MEANS

The following subjective grade descriptions are guidelines for those students interested in a more detailed meaning of a particular assigned grade:

**Grade of A** Denotes clinical excellence. The patient has received superior restorative treatment above the standard of clinical acceptability. The student has exceeded departmental objectives qualitatively and has demonstrated superior abilities in patient treatment. The student has met the minimum quantity of work for the specified grading period.

**Grade of B** Above-average qualities in many categories. Treatment demonstrates optimal expectations of longevity. The student has performed qualitatively above clinically acceptable standards on a consistent basis, and demonstrates continuing professional growth and a high level of knowledge, motivation, and ability. The student has met the minimum quantity of work for the specified grading period.

**Grade of C** Clinical acceptability. Treatment rendered restores the patient to an acceptable state of health, function, and esthetics and demonstrates a reasonable expectation of longevity. The student has met the minimum quantity of work for the specified grading period.

**Grade of D** Clinically unacceptability. Treatment rendered demonstrates questionable longevity. The student does not demonstrate an adequate level of professional growth. Treatment must be restored to clinically acceptable standards.

**Grade of F** Clinical failure. Treatment rendered must be replaced or repeated. The student has not demonstrated the minimum clinically acceptable standards on which future success depends. He/she has not completed required clinical examinations and/or has failed to observe departmental policies on which a passing grade depends. The student has not met the minimum quantity of work for the specified grading period.

## DETERMINATION OF COURSE GRADE

Your grades for all clinical activity (daily work, examinations, clinical judgment) in each grading period will be weighted and converted to a percentage. To be eligible for a given grade, you must accumulate the minimum number of points (refer to the table on Page 28) and a combined percentage according to the following:

A	89% and above
B	86% - 88%
C	78% - 85%
D	73% - 77%
F	72% and below

Final scores will be as computed and will **not** be rounded to the nearest whole number.

### RECONCILIATION OF RECORDS

As you progress through clinical operative dentistry, the number of patients you treat, the number of procedures you perform, and the amount of paperwork necessary to document your progress will all increase. Accordingly, you should have a strong interest in the correct management of your records, especially those dealing with evaluation and grades. We have developed a system of periodic record checking designed to keep you regularly informed of your progress and to provide us with information necessary for grade assignment and consultation.

Before you can be cleared for graduation, all work outstanding must be fully reconciled. For every white (start) copy of a grade form on file, there must be a corresponding hard (finish) copy indicating completion. At the approximate midpoint of each grading period, you will be given a progress report that specifies your accumulated points (total and by category), number of procedures outstanding, etc.

Work outstanding (uncompleted) must not exceed ten total procedures at any given time. You also may not start any new operative procedure on any patient that has five or more procedures outstanding. If either of these situations occur, you will not be allowed in operative clinic except to address these limits. **CAUTION!!** If you start any procedures not related to reconciliation of excess work outstanding, they will receive no credit. These policies are intended to help you stay current with your workload and approach graduation with a minimum of "catch-up" work to do.

Do not discard any grade form if the white (top) copy is on file with the department. If you start a procedure in operative clinic and it is referred to another department, do not assume that the operative grade sheet is automatically voided. Bring the

grade form to the department secretary (along with appropriate documentation) for reconciliation. You must account for all procedures for which start sheets are on file.

### **STUDENT CONSULTATIONS**

If your progress report indicates that consultation is needed, you must make an appointment to see the appropriate course director within five school days of receipt of the report. During consultation, all discussions, recommendations, and suggested follow-up will be documented.

The majority of consultations will result from deficiencies noted on your progress report. You may, however, request consultation with any operative faculty any time you feel such interaction would be helpful.

# ANESTHESIA AND SEDATION

As a group, dental patients are perhaps most united by their anxiety and fear of discomfort. There is no better practice builder than to enjoy a reputation of being "painless" and demonstrating care and concern for the patient comfort. The proper use of local anesthesia and adjunctive sedation techniques is as important to your overall success as your technical skills and diagnostic judgment.

Although your didactic and introductory clinical instruction in local anesthesia and nitrous oxide inhalation sedation is under the direction of the Department of Oral Surgery, we have established definite policies for the use of these agents.

## LOCAL AND TOPICAL ANESTHESIA

A primary clinical goal should be to maximize patient comfort with a minimum of chemical agents. To this end, always be sensitive to patient needs and moods. One of the best "pain reducers" you can employ is a kind word or gentle touch -- some evidence that you are truly concerned about the patient's anxiety level. Do not assume that nervousness or anxiety is a sign that more anesthesia is needed; the problem may be more psychological than systemic. In some cases, additional anesthesia may be warranted; in others, it can actually be a disservice that demonstrates a lack of knowledge and clinical judgment.

After Permission to Proceed has been granted, you may apply topical anesthetic and administer one carpule (1.8cc) of local anesthetic. If after a reasonable period of time your patient does not exhibit expected signs of anesthesia, request a second carpule in your Treatment Progress Notes and have your instructor initial it. Clinic dispensary personnel will then issue a second carpule. Be prepared to discuss why you feel profound anesthesia was not obtained with the first injection and what you plan to do differently. Your instructor has the option of administering the second injection for you if he/she feels such assistance is warranted.

If a third carpule is needed, it will be administered by the instructor or by you with the instructor observing your technique. Inadequate anesthesia after the third carpule will generally result in dismissal of your patient. This is to protect the patient from unnecessary trauma (physical and psychological). Moreover, additional anesthesia beyond the third carpule will generally be ineffective due to gross

saturation of surrounding tissues and interstitial spaces with the anesthetic agent already administered.

### Needle Selection

Our policy on needle selection for local anesthesia is based on the Handbook of Local Anesthesia, Stanley F. Malamed, C.V. Mosby Company, 4nd Edition, page 90. Selection of a needle depends on several factors, foremost of which is aspiration potential and depth of soft tissue penetration.

1. 25-gauge long is recommended for the following nerve blocks: inferior alveolar, Gow-Gates mandibular, infraorbital, buccal, and maxillary.
2. 25-gauge short is used for mental and incisive nerve blocks.
3. 27-gauge short is used for maxillary infiltration (supraperiosteal), posterior superior alveolar and palatal nerve blocks and infiltration.
4. 30-gauge short is not routinely used but may be recommended by your instructor for local infiltration to produce hemostasis.

### NITROUS OXIDE SEDATION

Occasionally, a patient may exhibit apprehension and anxiety sufficient to warrant premedication or adjunctive inhalation sedation in addition to local anesthesia. If your patient requires premedication, he/she should obtain it from a family physician. If this proves difficult and the attending instructor feels that premedication is warranted, the instructor will prescribe the appropriate medication but only after a thorough review of the patient's medical history.

If nitrous oxide sedation is indicated, you must have satisfied the following in order to use it in clinic:

1. Successfully complete your nitrous oxide sedation course.
2. Work with an instructor also trained in the use of nitrous oxide.
3. Write a request for nitrous oxide in the chart and have it initialled by the faculty. Dispensary personnel will procure the proper setup for you.

Permission to use nitrous oxide is generally limited to late juniors and seniors. However, this is ultimately at the discretion of the instructor who must be willing to provide even closer supervision if you have had no training.

We have established policies for the administration of nitrous oxide in operative clinic that are based on the known effects of this agent and the normal precautions that should be taken with its use:

1. Nitrous oxide is a drug introduced into the circulatory system by increasing its concentration in the pulmonary alveoli. It is commonly used to aid the induction of general anesthesia. If administered in high enough concentrations and with an open delivery system, Stage II of general anesthesia can result; in fact, Stage III has been reported. This excitatory Stage II is definitely not desired. It occurs most commonly when the dentist tries to obtain analgesia with nitrous oxide by increasing its concentration to higher levels. You are allowed to use nitrous oxide only as an aid for conscious patient sedation, not solely for achieving analgesia (even though some analgesia is reported during the sedation process).
2. Seldom is sedation not achieved at concentrations of 35% nitrous oxide or less. Excessively high concentrations will not be tolerated. If you have difficulty obtaining sedation, secure the assistance of your instructor. Do not arbitrarily keep increasing the concentration.
3. The term conscious sedation implies continuous monitoring of the patient, preferably verbally; he/she must understand orders or questions and be able to respond coherently. Nitrous oxide concentration is excessive (and must be immediately remedied) if prolonged time elapses before the patient responds or he/she becomes "giddy" or reacts incoherently.
4. The patient must be titrated to achieve sedation. Begin with administration of pure oxygen and slowly increase the concentration of nitrous oxide until desired sedation is achieved. Never begin with administration of the therapeutic concentration of nitrous oxide. Always enter the concentration of nitrous oxide used in the patient's chart.
5. Never leave a sedated patient unattended. If you must leave even for a short time, summon a fellow student or your instructor to monitor your patient until you return.

Abuse of these policies will bar your use of inhalation sedation for future operative procedures. Reinstatement of this privilege can only be effected after personal consultation and appropriate remediation.

One measure of your clinical judgment is the decision to use inhalation sedation when indicated. An equally important measure is the decision not to use it indiscriminately. All too often, nitrous oxide is used at the first sign of patient anxiety when good "chairside manner," a kind word, and patience would be sufficient. Keep in mind that nitrous oxide is a drug. Any time you can reduce or

eliminate the need for external agents, there is a proportionate decrease in the chances of adverse reactions and unfortunate accidents.

# PREVENTIVE DENTISTRY

## PROGRAM

There is no separate Department of Preventive Dentistry in the College of Dentistry; all clinical departments share in the teaching of this important facet of dental education. Prevention has effectively replaced restorative concepts as the major focus of dentistry. The following objectives incorporating preventive principles in operative practice have been developed:

1. Apply those preventive practices and procedures which have the potential for preventing oral disease, including:
  - a. Dental health education
  - b. Fluoridation consultation and application
  - c. Nutrition and dietary control
  - d. Thorough oral examination and plaque control
  - e. Detailed home care instruction
  - f. Conservative operative procedures
2. Motivate your patients in the prevention of oral disease. A patient who continually demonstrates neglect or lack of concern for his/her oral condition may reflect your failure to apply the principles and practices of prevention. There are, of course, patients who resist all efforts at motivation. You must notify the appropriate faculty of such patients so they can be terminated from the program.
3. Utilize secondary preventive measures which include operative procedures that may initiate unfavorable oral conditions, if performed incorrectly. Examples include:
  - a. Cavity preparation outlines not extended for prevention; gingival cavosurface margins that unnecessarily infringe upon gingival or periodontal structures.
  - b. Use of restorative materials that do not adequately satisfy the parameters of function, esthetics, and conservatism and are not conducive to optimum longevity.
  - c. Failure to re-establish proper anatomical form, contour, contact, and occlusal harmony which may lead to oral dysfunction and/or lack of protection of adjacent hard and soft tissues.
  - d. Restorations not totally finished/polished which compromises maximum longevity and minimum plaque retention features.

4. Always consider the protection of remaining oral structures before replacing missing structures or restoring defective structures.

### EVALUATION OF PREVENTION TECHNIQUES

If your patient is to receive the full benefit of dental care, prevention must go hand in hand with restorative treatment. While the major components of prevention (oral prophylaxis, home care instruction, plaque control, etc.) are introduced and reinforced by the Department of Periodontics, their implementation is of equal concern to those departments responsible for subsequent treatment. Before you will be allowed to begin any operative procedures, your patient must demonstrate the ability and motivation to maintain a reasonable state of oral cleanliness. The following policies consider the incorporation of preventive principles in operative dentistry:

1. How you manage your patient's oral health will be reflected in your clinical judgment grade. Asking to perform treatment on a patient with a high plaque index or grossly stained teeth demonstrates little concern for prevention. If your patient exhibits oral conditions indicating that plaque control has not been effectively mastered, you may begin operative treatment only after the following have been completed:
  - a. Thorough oral prophylaxis
  - b. Reinforcement of home care instructions
  - c. Reasonable plaque control index

Attending faculty will evaluate the above measures and determine their acceptability before allowing any operative treatment. In cases of severe oral neglect, faculty may refuse to allow treatment without additional preventive measures and clearance by the Department of Periodontics. This would of course be deferred if your patient presented with an emergency condition demanding immediate attention.

2. If a lack of effective home care and plaque control is noted three times in the same patient without evidence of improvement, the Director of Clinics will be notified that the patient is an unsuitable teaching case and should be dismissed from the teaching program. While you may be reluctant to lose such patients because they can satisfy your needs in other departments, remember that each time you must institute full preventive measures in operative clinic you deny yourself valuable time that could be spent on restorative procedures.

In summary, prevention is an important and essential aspect of all phases of dental care. By the time you are ready to institute restorative care, you should know what a "clean" mouth looks like and what steps it takes to get there. If you bring your patients into operative clinic with good oral hygiene, the assumption can be made that you are consistently practicing the principles of prevention.

# OTHER OPERATIVE POLICIES AND GENERAL INFORMATION

This section deals with other operative policies, procedures and general information not addressed in previous sections.

## ISOLATION PROCEDURES

The use of rubber dam in operative clinic is mandatory. Adequate vision, access, and manipulation of moisture-sensitive restorative materials demands complete isolation. Accepted isolation principles are detailed in your preclinical syllabi. Briefly, they include the following:

1. Posterior isolation: from midline to at least one tooth distal to the tooth being treated (if possible).
2. Anterior isolation: from first premolar to first premolar.
3. Single tooth isolation is not acceptable.
4. Rubber dam clamp: ligated and stable on the anchor tooth with no damage or strangulation of gingival tissue.
5. Face napkin and Young's (U-shaped) frame must always be used.
6. Rubber dam completely inverted around the necks of the teeth with no interseptal bunching or gingival tissue extrusion.
7. You must exercise judgment in determining when the overall condition of the rubber dam demands its replacement.

The use of rubber dam may not always be practical or expedient. If you feel that it cannot be used, notify your instructor who will verify this and allow you to proceed without rubber dam. In such instances, cotton rolls and a saliva ejector or svedopter must be used throughout the procedure.

NOTE: There are varying weights and colors of rubber dam available in gold clinic. The type used is generally at your discretion and that of your instructor. However, for all procedures involving esthetic restorative materials, the rubber dam of choice is the conventional dark grey.

## CARIES REMOVAL

Whenever possible, all caries is removed from the tooth. Should a pulp exposure result, you and your instructor will determine if direct pulp capping is feasible or if

root canal therapy is indicated. In certain instances, indirect pulp capping may be approved by your instructor.

### **HIGH-SPEED CUTTING PROCEDURES**

Air-water spray coolant must be used during all high-speed cutting procedures. If your finishing and polishing procedures include the use of high-speed rotary instrumentation, air-water coolant is not necessary. However, air coolant is mandatory.

### **REMOVAL OF DEFECTIVE RESTORATIONS**

When replacing existing restorations, all of the old restoration and any underlying base must be fully removed. If you are replacing a defective restoration that you yourself recently placed, the instructor may allow partial removal of the restoration to avoid unnecessary trauma. This is solely the decision of the instructor; never institute repair procedures without permission.

### **POSTERIOR COMPOSITE RESTORATIONS**

There will be times a posterior composite may be indicated either for cosmetic or for other reasons. Department policy currently requires that:

#### Treatment Planning

1. The patient must present situations that would indicate the use of composite restorative material. Such as:
  - In need of a restorative in a very esthetic area of the arch.
  - No existing metallic restorations.
  - Sensitivity to amalgam (verified by allergy testing through their physician)
2. The lesion must be incipient and the anticipated outline or extensions of the preparation must be very conservative.
  - The buccal-lingual width of the prep can be no greater than 1/3 the width of the occlusal table (measured from buccal cusp to lingual cusp tip.)

- The gingival floor of a proximal box can not extend to or beyond the CEJ. (There must be enough sound enamel along the gingival cavosurface margin to establish a good adhesive bond between enamel and resin.)
  - The anticipated extensions of the restoration should not include any contacts of functional slides directly contacting the resin composite. (With the exception of the Class II marginal ridge)
3. The lesions treatment planned for posterior resin composite restorations will be restricted to conservative Class I preparations and conservative Class II preparations.
  4. Patients should not exhibit any abnormal occlusal function such as bruxism or clenching.
  5. At the time of treatment planning, the patient should be informed of the possibility that during the actual procedure the preparation may extend beyond these established guidelines for the use of resin composite in posterior restorations. If this should occur, the use of amalgam restorative material may be necessary as a substitute (unless an allergic situation exists in which case the patient will be referred to Fixed Prosthodontics for evaluation of a cast gold restoration.)

#### Preparation Guidelines

1. The outline must be conservative as stated in the above comments on treatment planning (B-L width no greater than 1/3 the occlusal table)
2. Proximal walls of the Class II proximal box will be extended to just minimally break contact with the adjacent tooth.
3. The gingival wall must not extend beyond a point that allows an adequate amount of enamel for effective etching and bonding at the cavosurface margin.
4. The internal form of the preparation will differ from the amalgam preparation as follows:
  - Rounded internal line angles
  - No retentive groove required in the proximal box.
  - Buccal-lingual width can be more conservative than in an amalgam prep. Bevel facial and lingual proximal wall cavosurface margins.

5. For Class II lesions an interproximal wedge should be placed before beginning the preparation of the tooth to help establish an adequate proximal contact. (Review the section on pre-wedging in the second preclinical operative manual.)

### Insertion

1. The main restorative material used for restoration of posterior composite restorations will be a hybrid restorative material. (Exceptions may be based on an individual instructor's judgment)
2. Review the process of placing the resin composite in increments. (Second preclinical course manual)
3. Utilize a 0.001 inch dead soft matrix band or a sectional matrix band for Class II resin composite restorations. These are different from the regular stainless steel matrix bands provided for amalgam insertions. (Review this in the second preclinical course manual)
4. Place Fortify (Bisco) composite surface sealer following occlusal adjustment, final finishing and polishing, and evaluation by your instructor. **Applying the surface sealer prior to instructor evaluation will result in a grade reduction.**
5. Great care should be taken to completely eliminate any occlusal contact on the resin composite material.

## **ADJACENT ("BACK TO BACK") CAVITY PREPARATIONS**

If you must restore adjacent teeth with contacting proximal restorations, it is advisable to restore them at two separate appointments to maintain maximum control of interproximal contact and contour. As you develop proficiency, you may be allowed to treat adjacent lesions by preparing both teeth, restoring one to proper form and contour, waiting a suitable time for initial set of the restoration, and then restoring the second tooth. Do not institute such procedures without faculty consent.

## **DAMAGE TO ADJACENT TEETH**

If you damage an adjacent tooth during cavity preparation, your instructor will determine if recontouring can correct the defect or if a restoration must be placed (or replaced). If you must place a restoration due to damage you caused, you will do so

for no credit and at no charge to the patient. Whether the affected surface can be recontoured or requires a restoration, you will receive a failing grade for the cavity preparation and/or the restoration.

### **MANAGEMENT OF PULP EXPOSURES**

Pulp exposures can be mechanical or carious. Mechanical exposures are caused by the operator because of overpreparation. Carious exposures are caused during caries excavation and are generally unavoidable since department philosophy is complete caries removal. Mechanical exposures will receive a failing grade for both cavity preparation and clinical judgment. Carious exposures will generally be graded without bias. Treatment of pulp exposures is by direct pulp capping or root canal therapy and will be determined by your instructor. Choice of treatment will involve consideration of such factors as size of exposure, age of patient, degree of salivary contamination, etc.

### **DIAGNOSTIC CASTS**

Although not generally required as part of operative treatment, diagnostic casts can be of great assistance in treatment decisions. If you have such models, they should be available during patient treatment in operative clinic.

### **WORKING WITH DIFFERENT INSTRUCTORS**

You are encouraged to work with the same instructor for any one given procedure. If you must use two instructors, fully explain to the second instructor everything you were advised to do by the first. The second instructor will generally allow you to continue as you were initially directed.

### **CALLING INSTRUCTORS FOR WORK COMPLETION CHECKS**

When you complete work on your patient, the following must be done before you call your instructor for final evaluation:

1. Have a clean mirror, explorer, floss and articulating paper available.

2. Keep your patient draped and in a reclined position (unless there will be excessive delay before the instructor gets to you).
3. Have all pertinent records completely filled out and available.
4. Have instruments readily available should the instructor need them.

If the above is not done before requesting a final check, the instructor may refuse to evaluate your work. It is discourteous to your classmates and to your patient to needlessly tie up an instructor who must wait until you are ready to be checked.

### **SHARP INSTRUMENTS**

You are expected to sharpen or replace any instrument that cannot perform its function. Failure to do so will adversely affect your grade in clinical judgment.

### **NUMBER OF PROCEDURES STARTED**

You may begin only one clinical procedure at a time. When cavity preparation has been completed and if enough time remains to complete a second procedure, your instructor may give permission to begin the second procedure. Also fill out only one Operative Grade Form at a time to reduce waste and expense. These policies ensure that you manage your clinic time properly, do not begin procedures that cannot reasonably be completed, and develop courtesy and consideration for the restricted time of both your patient and the faculty.

### **LOST PATIENT CHARTS**

Patient charts are handled by many people and occasionally a chart will not be available when needed to record patient treatment in gold clinic. If your chart is temporarily lost or misplaced, the faculty will still allow you to work in clinic provided you:

1. Take at least one periapical radiograph of the tooth to be treated.
2. Have the instructor verify the lesion or defective restoration.
3. Complete a short medical/dental history.
4. Fill out appropriate Treatment Progress Notes describing the procedures done and noting that the chart has been lost or misplaced.

Your instructor will make an entry in these notes that no further operative work may be done until the chart has been located or a new chart developed.

## **PATIENT TRANSFER**

Occasionally, patients are transferred from one student to another because of graduation, poor personal interaction between student and patient, or patient needs that are too difficult for a given student. In all such cases, the student to whom the patient is transferred must reroute the patient through operative clinic and develop a new Operative Treatment Plan Sequence. This may or may not entail a new Master Treatment Plan. The student who transfers a patient to another student is responsible for all operative work in progress at the time of transfer. Students may not complete work for credit that has been started by another student.

## **FACULTY OFFICE HOURS**

Office hours for operative faculty can be obtained from the department secretary. Please demonstrate courtesy and consideration by keeping unannounced visits to a minimum and by not seeking appointments before or after school hours or during the lunch hour, unless prior arrangements have been made.

## **LIMITED TREATMENT** **(Students Treating other Students)** **(Students Assisting Students)** **(Dental Hygiene Recall Patients)**

We expect each student to develop treatment plans and complete the treatment for the patients in their own patient family. Treating patients outside of the family of patients that the student has worked up is not encouraged and will be allowed only in a few exceptions.

We will follow the guidelines defined by the office of the clinic director in regard to limited treatment of patients.

Patients seen for dental hygiene recall may require restorative treatment. These patients will be assigned to a dental student by the clinic director's office for dental treatment. Once assigned, the dental student will bring the patient to the Gold Clinic for an operative evaluation prior to beginning treatment.

## **OPERATIVE TREATMENT PLANNING**

When you develop an operative treatment plan, it should be done with full consideration of both the patient's needs and your capabilities. Consider the following when determining proper treatment plan sequencing:

1. Obvious emergencies (pain, swelling, etc.) are always listed first, regardless of the difficulty level of such needs. These will be listed in the "Priority Care" section of the treatment plan and must be completed by you or an upperclassman prior to starting routine operative procedures. Some of these may be referred to other clinics such as Endodontics or Oral Surgery.
2. All extensive lesions or defective restorations that have the potential of developing into emergency situations are listed next. These also will be listed in the "Priority Care" section of the treatment plan.
3. Remaining necessary treatment should be sequenced with a consideration of your abilities and the needs of your patient. Your initial clinical experiences as a sophomore should be limited to Class I pit or occlusal restorations until you have developed the expertise and confidence necessary to do more complex treatment.

As a sophomore, there will be some procedures listed in your treatment plan that you will not be able to provide treatment for initially due to your inexperience. These teeth will be noted as "priority care" situations and will be listed in the priority care section of the treatment plan. The instructor will note which of the teeth need immediate care and will indicate on the treatment plan that they need to be referred to an upper classman (DS III or IV) for immediate attention. Although you will not get to treat these types of teeth now, be patient because you will get to treat them when you become more experienced. The next year the new class of DS II's will be referring them to you.

You should also initially try to sequence maxillary restorations ahead of mandibular restorations. While gravity and direct vision favor the mandibular arch, block anesthesia is required; maxillary teeth can often be infiltrated individually. It is more considerate of your patient to sequence treatment such that the comparatively more uncomfortable mandibular block injections are limited as much as possible. When you can accomplish multiple restorations per clinic session, the maxillary/mandibular distinction becomes less important.

### **TREATMENT PLANNING POLICIES**

(See Treatment Plan Workup, Page 12)

Prior to actual routing, thoroughly review the tentative operative treatment plan as developed in Oral Diagnosis and modify it as necessary; do not accept the tentative plan as gospel. Gross deviations between what you list and what the patient actually needs reflects inadequate interest and/or preparation. Take the time to

review and modify the treatment plan before you call an instructor for verification. He/she will then review with you the findings as listed on your Preventive Treatment Plan and Treatment Plan Workup sheet, and modify them as necessary before they are transferred to the Priority Care and Routine Operative Treatment Plan Sequence forms. As you transfer the workup information to these forms, enter one restoration per line.

A Master Treatment Plan will not be generated without routing through operative clinic. No operative treatment plan will be accepted by the Department of Oral Diagnosis that has not been developed and signed on the appropriate orange forms.

To ensure that no potential lesions are masked by either calculus or stain, the teeth must be clean prior to final treatment plan development. If the patient's hygiene is such that full diagnosis cannot be accomplished, it may be necessary to reappoint your patient for an additional visit.

A new Operative Treatment Plan Sequence is required on all transfer patients. At the discretion of the faculty, a new Master Treatment Plan may also be required.

The treatment planning process can be very time-consuming. Therefore, no routing will be started after 11:30am for morning clinic sessions and after 3:30pm for afternoon sessions. Since the first half-hour of clinic periods is normally a very active time when students need faculty for start checks and consultations. In addition, no treatment planning will be done before 9:30am or before 1:30pm.

During clinics that are only half-full or less, please use an unoccupied chair close to the main area of clinical activity so that faculty can concentrate their activities in a smaller area. If you wish to route your patient through operative clinic and are not on the schedule, notify an attending instructor who will direct you to an unoccupied chair (if available) or ask you to wait until one becomes free.

## MOCK BOARDS

During the Spring semester of the senior year (usually in April), a Mock Board clinical examination may be scheduled to prepare you for the actual licensing examination. Mock Boards may be scheduled by the Office of Patient Management and will simulate as closely as possible the procedures and time constraints of the licensing board.

**Be sure to have lesions saved in your patient family to use on the mock board.**

The Operative part of Mock Boards counts as your required clinical competency examination for that semester. Therefore, you are required to participate in Mock Boards as a pre-requisite for graduation consideration. If you cannot participate for a valid reason, you must complete the necessary operative procedure(s) under examination conditions before the end of the semester or receive a grade of "F" for the grading period.

More detailed information regarding Mock Boards will be distributed as its scheduled time approaches.

