General Practice Residency

Detailed Description of Dentistry GPR Program at University of Virginia Health System

Related Information

Dear Applicant,

Greetings! The following is intended for anyone who has visited the University of Virginia General Practice Dental Residency program at our website and is seeking more information about the program. While the website provides a general overview of the program, I would like to think this attachment is a bit more specific. We continually re-evaluate and re-configure our program according to resident feedback, changes in the marketplace, technological developments, etc., but I consider this to be an up-to-date overview.

For the 2012-13 residency year, our second year residents are Oscar Vega ov2k@hscmail.mcc.virginia.edu (Virginia Commonwealth U. School of Dentistry) and Charles Beavers cmb5hc@hscmail.virginia.edu (U of North Carolina, Chapel Hill School of Dentistry). Graham Hearn (U of the Pacific, Arthur A. Dugoni School of Dentistry) and Ross Oates (U of Kentucky School of Dentistry) enter as first year residents. Latasha Sauls saulsln@gmail.com (Virginia Commonwealth U, School of Dentistry) and Matthew Aldred aldredmh@gmail.com (Virginia Commonwealth U. School of Dentistry) receive 2 yr certification of completion June 30, 2012. As of this writing, Matt is looking at private practice opportunities in Richmond, whereas Tasha is looking at private practice and other opportunities locally. James Peery III peery.james@gmail.com completed his second year of the residency 2011, and is working in 2 practices in Richmond while exploring the purchase of a practice. Shira Lazebnik shira.lazebnik@gmail.com also finished the GPR program 2011, and is completing the Orthodontic Residency at the Albert Einstein Medical Center in Philadelphia, PA. June 2010, Craig Deagle craig.deagle@gmail.com (Boston U School of Dentistry), Erick Sato sedation@gmail.com (U of the Pacific School of Dentistry) and Bobby Lunka blunka@hotmail.com (Virginia Commonwealth U. School of Dentistry) were graduates of our program. Both Craig and Erick went to Endodontic specialty residency programs, the former at Harvard and the latter at Oregon Health & Science U. Craig is finishing his program this year. Bobby Lunka entered private practice as an associate in Charlottesville, VA but will be starting an Oral Surgery internship June 2012. We could go farther back in time, if need be, but this will give you an idea of the diversity of career paths of our more recent residents. Feel free to contact any of these individuals to get their input on what they may perceive about our program's strengths or weaknesses. We will also provide on request additional names and addresses of program alumni for you to contact if you wish. After all, it might be interesting to get the point of view of a dentist 2, 5, 10, even 15 years post-residency as to how a GPR program influenced his or her career.

In terms of continuity of the program, we would prefer to have two second year residents and two first year residents each year, but our stance has been to recruit whoever we consider to be the most qualified residents each year, irrespective of whether they plan to be in the program for one or two years. While we still participate in PASS, we have decided to opt out of the MATCH system.. Nothing against the MATCH, but I have the impression over the last few years that applicants would rather get offers and establish their futures in late December, as opposed to waiting for a MATCH date in late January. I also believe that we are a competitive enough program historically to be able to recruit our top picks, and we do not like the idea of losing a pick to an early offer from another program while we

are forced to wait on the MATCH. In any event, as of this writing, it is the expectation that we will be recruiting two residents to begin the 2012 residency year as we are allotted 4 residents total.

Whether you are in a 1 or a 2 year tract, the first year of the residency has certain off-service rotations that are considered a requirement in addition to the "normal" clinic schedule rotations. ACLS, Physical Assessment (Physical Diagnosis), Anesthesiology, and Emergency Medicine are such rotations. An Otolaryngology off-service rotation takes place in the second year, as it is coordinated with second year resident involvement in the Head and Neck Tumor Board. The intention of the second year is that it can be potentially more flexible in terms of clinic experience and curriculum, depending on the resident's interest. Past examples of second year possibilities have included a Practice Management Course, offsite private practice rotations, Information Mastery course, Blue Ridge Oral Surgery rotation, and a VA Dental Clinic rotation. We have to be a bit “fluid” in terms of these options, because their status can change year to year. For instance, the Practice Management Course at VCU that we used to send our second year residents to was reconfigured this past year. I am told it is not as beneficial as it had been, so I am not sure we will continue it. The VA Dental Clinic rotation in Salem lost the coordinator we used to interface with, so we have had to scrap that option, at least until the clinic experience rebounds for our residents. For the residency year July 2012-13 we will be experimenting with an off-service rotation for our second year residents that sends them to Richmond on 2 Wednesdays a month to perform additional oral surgery and sedation under the supervision of our part time Oral Surgeon, Dr. Gary Smagalski.

As to how this second year may come into play in terms of career path, I already mentioned that Drs. Lazebnik, Deagle and Sato are in Orthodontics and Endodontic residencies. When it comes to specialty interest, we do not discriminate in our selection process if an applicant wishes to pursue a specialty. However, some incoming residents do not develop an interest in a specialty or are not sure about that interest until they have been in the program for awhile. One of the advantages of a 2 year tract, as we see it, is to have the opportunity to identify any such interest and pursue it. In a one year tract, if somebody decides by December or later that he/she wishes to specialize, it is essentially too late to apply to a specialty program for the following July. In addition, even if a person recognizes such an interest at the outset of a residency, an application to a specialty program would have to start after as little as 1-2 months of the GPR program, which hardly leaves much time to develop a specialty-specific "portfolio" and recommendations based on genuine familiarity with the applicant.

Our goal, however, is still to produce General Practitioners, and we hope that the didactic and clinical experiences that our residents take from the program will make them more skillful in ALL the specialty areas than a comparable GP who has not had the benefit of a residency.

One last thought on the 2 year vs. 1 year tract: Personally, when I was finishing dental school, I had a lot of questions about where I would practice, what sort of practice I would have, and whether I might have a specialty interest. I applied to 1 and 2 year programs, but the application, interview, and, ultimately, the matching process stretched out over a third of my senior year. In the end, I decided that I wanted a 2 year program just so I could practice and learn for a year without having to worry about where I would wind up. My interest in the academic and hospital aspect of Dentistry did not really become apparent to me until my second year, and the rest is history. If you are pretty much set on where you want to go and what you want to do, I would suggest pursuing a 1 year tract. If you are not sure, then you might want to consider a 2 year tract. Either way, a dental career is a marathon, not a sprint, so the time element is not as critical as you might think.

FACILITIES

We currently have 2 clinics in which we operate—1222 Jefferson Park Ave. ("JPA"), which is a block from the main hospital, and the dental clinic at the Kluge Children's Rehabilitation Center ("KCRC"), which is about 2 miles away from our JPA clinic. The JPA clinic is a 12 operatory clinic in which we treat both private and specialty care patients (more on this later). Four of the operatories are primarily designed for hygiene, whereas the others are procedure oriented. We actually have a 13th operatory which is large enough to accommodate a mobile stretcher, but it is mainly used as a recovery room, when it is not being used for consult care. If it makes any difference to you, we currently use Adec carts, Star handpieces, and Adec chairs. The operatories are dual entry, and they can be switched to accommodate both right and left handed dentists. They are plumbed for nitrous units, nitrous oxide being one of our several sedation adjuncts. We are currently looking to enlarge the no. of operatories at this facility, with the possibility to involve an additional faculty member. In the process, we may well equip these operatories with electric handpieces, just to offer some diversity in terms of equipment design.

The JPA building is a 5 story building designed for outpatient clinics and other services. Medical Records is in the basement, Employee Health and Human Resources are on the first floor, Dentistry and Payroll are on the second floor, University Medical Associates (essentially outpatient Internal Medicine) is on the third floor, Sleep Disorders Center is on the fourth floor, and the Life Support Learning Center is on the fifth floor.

Our KCRC clinic is a 3 operatory clinic that has Star handpieces, Pelton Crane chairs, and Adec carts. Two of these operatories are primarily designed for hygiene, whereas the third operatory is for more complex procedures. Nitrous oxide is available here too, but we also used other sedative adjuncts as necessary. KCRC is a multidisciplinary treatment facility for children and adolescents, though that definition seems to extend into patients in their twenties sometimes. Most of the care at this facility is administered through a variety of outpatient clinics, such as Pediatrics, Physical Therapy, Speech and Hearing, and Occupational Therapy. The inpatients present in the facility are usually non-critical chronic care rehabilitation patients or patients new to the U.VA medical system who are admitted for a 2-4 week stay for a multidisciplinary evaluation and treatment plan. Dentistry might be one of the services evaluating and treating such patients. The Health System recently broke ground for a new Children's Medical Center, which will eventually replace KCRC. The location is pretty much adjacent to our 1222 JPA building. The idea of this new facility is to further consolidate the various Pediatric services, including Dentistry, in one location.

Some other facilities, not necessarily "dental" clinics per se, would be the Main Hospital wards, Emergency Room, and Operating Room. Dentistry provides consult care and treatment in the wards and ER. We also provide dental treatment under general anesthesia in the OR for those patients who cannot tolerate such treatment in a conscious state.

FACULTY

The faculty consists of 4 full time general practitioners and 3 part time specialists. The generalists are: Thomas Leinbach, VCU School of Dentistry; UVA GPR; Chairman, tel@virginia.edu Andrew Martof, UNC School of Dentistry, GPR, and Fellowship; Medical Director, abm@virginia.edu Brian Hoard, VCU School of Dentistry; UVA GPR; Dental Director-Children's Medical Center; Director-GPR bch3n@virginia.edu Ted Galbraith, Case Western School of Dentistry; UVA GPR, Externship/Internship Director trg8h@virginia.edu

All of us have certain strengths, areas of expertise, and particular areas of interest, but we consider ourselves to be generalists who do (and teach) some of everything. Our part time (1-2 clinical days a month) specialists:

Endodontist—Robert Grover, VCU School of Dentistry, UNC Endodontics residency
Orthodontist—Bill Horbaly, VCU School of Dentistry, OSU Pedodontics residency, U. Pitt Orthodontics residency
Periodontist—David Abbott, UNC School of Dentistry, U. Minn. Periodontics residency (Also faculty, Dept. of Periodontics, VCU School of Dentistry)
Oral Surgeon—Dr. Gary Smagalski, SUNY School of Dentistry, U. of California Los Angeles Oral Surgery residency. (Also faculty, Dept. of Oral Surgery, VCU School of Dentistry)

In addition to the above, we have a variety of local private practitioners, both generalists and specialists, who lecture to our residents on their areas of expertise and interest from time to time. Some of these dentists act as off-site rotations for our residents to learn different aspects of dentistry, including practice management tips. While technically not on the staff, we consider them to be "faculty".

PATIENT TYPE

Our residents and faculty treat both private patients and indigent patients. The ratio is probably along the lines of 70/30. The private patients come to us as though they would to any other private practitioner, though a large percentage of these tend to be employees of the U.VA Health System. Their workplace proximity to the JPJ facility, in particular, makes it easier for them to access our clinic. In addition, our clinic is a participant in the dental insurance plan that they have as employees of U.VA.

The majority of the indigent patients we see are “special care” patients—patients who have special medical problems in which dental care is important relative to their overall medical rehabilitation plan. Our clinic is not a public health facility per se. We leave treatment of medically "normal" but dentally diseased indigent patients to local facilities, such as the Health Department, the Free Dental Clinic, and the Charlottesville Area Dental Access Clinic. Some of our residents, by the way, volunteer their time at such facilities and state public health initiatives (Ex: Mission of Mercy Dental Project), but this is not a requirement of the program. It is impossible to list all the situations which classify a patient as “special care”, but some examples would be:

Head and neck cancer patients: Many such patients receive chemotherapy and radiation therapy in addition to surgical excision. The radiation therapy, in particular, renders them susceptible to xerostomia (elevated decay rate) and osteoradionecrosis. The chemotherapy may render them susceptible to immunosuppression such that a dental abscess could be life threatening. Our department

evaluates such patient's pre-radiation/chemotherapy and addresses any potential dental problems in advance of such treatment. We also see them for follow up care. In terms of cancer patients in general, we can potentially be consulted on any such patients who will be given immunosuppressing medications. Some of these patients, such as Paget's disease or multiple myeloma, are now receiving bisphosphonate medications as part of their therapy. The potential impact of this medication on the dental status is probably obvious to you.

Inherited coagulopathy patients: Patients with hemophilia, von Willebrand's disease, or other inherited coagulopathies require a special approach to the delivery of dental care. The department works with Hematology/Oncology to make the medical adjustments that will allow dental treatment.

Organ transplant patients: The U.VA Health System is involved with virtually every type of organ transplant one can imagine, including heart, liver, kidney, and lung transplants. These patients are generally receiving immunosuppressant medications to prevent organ rejection, and Dentistry may be consulted pre-or post-treatment to eliminate the potential complications of dental infection in the face of such immunosuppression.

Acquired bleeding disorder patients: Patients with acquired coagulopathies, such as liver disease patients (viral or alcoholic hepatitis) require medical consultation and modification to allow oral surgery procedures to take place without hemorrhagic consequences.

Cardiac disease patients: Aside from the fact that some of these patients might receive transplants, there are a variety of non-transplant patients who require special considerations (other than SBE risk) for the delivery of dental care: impaired myocardial function, mechanical heart valves or atrial fibrillation patients on anticoagulants, etc.

Renal dialysis patients: Again, some of these patients ultimately receive transplants, but many are maintained on hemodialysis. Such patients might be at risk for SBE as a result of the shunts for hemodialysis, and dental health is therefore of critical importance.

HIV patients: While the Universal Precautions used in Dentistry has made treatment of HIV patients almost routine for the most part, many of these patients have additional medical problems associated with their HIV, such as liver viral hepatitis, etc. These additional considerations may make them too complex for treatment elsewhere.

Handicapped patients: There are a variety of mental or physical handicapping conditions that require a special approach to the delivery of dental care.

The aforementioned list is hardly complete, but it will give you an idea of the concept of special care patients. In terms of the delivery of care, a resident's private patients would be comprehensive care patients--you would be providing all the care for these patients, except for routine hygiene services. We do not have a "block" delivery system of care per se. Your private patients tend to remain as your private patients alone, but special care patients might be shared among the staff. While the private patients are considered full fee patients, a resident can discount procedures of interest (implants, crown and bridgework, cosmetic procedures, etc.) as a "residents' case" (I prefer this term to "teaching case") to help provide a treatment plan to a patient who otherwise might not be able to afford the care, even with insurance. The University's dental insurance coverage for employees is such that there is reasonable provisions for these patients to access most treatment plans that you would like to provide for them.

On the subject of dental hygiene services, we are sometimes asked if the residents have to provide all such care for their patients as they likely do while in dental school. You are not expected to provide routine scaling, prophylaxis, etc. services for your patients. We have full time dental hygienists to provide this care, though on occasion we do some hygiene ourselves. While your future career is likely to involve devotion of your clinic time to more productive procedures, maintenance of routine dental hygiene skills while in a residency is still a good idea—man private practitioners I know still do some of their own scaling and root planning.

In case you are wondering, you can also expect to have a dental assistant assigned to you when you are working in the clinics. This is not usually the case in dental school, but we certainly do not expect you to be your own assistant while in our program. In addition, almost all of the laboratory work is sent out to a variety of private laboratories that we use. You will perform some minor laboratory procedures in our program, but we do not expect you to spend your time in the residency doing all the laboratory work you did in dental school.

RESIDENT EXPERIENCE:

These are the major areas and experiences I would expect a resident finishing our program to take with him/her. We would expect a second year resident to develop more in this respect by virtue of a longer time period spent in the program (Some implant treatment plans, for instance, take awhile to implement from surgery to restoration). If you plan to practice in a rural environment with limited options for specialty referral, all of this will be valuable to you. On the other hand, even if you plan to practice in a more urban area, the competition between you and the GPs and specialists in the area will make it necessary for you to be able to treat as many different situations as possible to remain competitive. Patients, as a rule, would rather be able to get as many different kinds of treatment done in one place, as opposed to having to go to different locations to accomplish the treatment. The more services you can offer and patient types you can treat in your practice, the more attractive your practice will be.

1. Medically compromised patient dental care: For most dentists, there is limited exposure to this patient type in dental school. The problem is that the medical health of your average dental school patient probably does not reflect the majority of society. In this era of evolving medical techniques that prolong life, the reality is that a greater proportion of your patient population will be medically compromised. If you expect to be able to treat them, you will have to know how to modify dental care according to their medical condition. We will teach you not only the particular concerns of a variety of medical problems but also how to communicate and jointly treatment plan patients with your medical colleagues.

2. **Hospital dentistry:** This ties in with 1), but we will teach you actual hospital protocol, including operating room dentistry, in-house consultation services, and emergency medicine.

3. **Emergency dentistry:** This ties in with 1) and 2). The list of potential dental emergency situations you might encounter is too extensive to list here, but the "major" categories of education and experience are dentoalveolar trauma and dental infections. Again, this is The Medical Center is classified as a major trauma center, and this plus the presence of numerous athletics programs at the U. of Virginia leads to some rather interesting dentoalveolar trauma situations.

4. **Sports dentistry:** Our department is a resource for the U. of Virginia Sports Medicine program. In addition to managing the major categories in 3) with respect to student athletes, Dentistry provides preventive care in the form of dental mouthguard construction.

5. **Dental implants**: Our residents both surgically place and restore implants. Our primary implant system has been Zimmer, although we also use a fair amount of Biomet 3i. A resident finishing our program should be able to place single tooth implants, implant supported bridges, and implants related to overdentures. In addition, you can expect experience in the area of immediate implants (extraction of hopeless tooth and placement of implant at the same visit) and immediate provisionalization. You will also learn how to use membranes and bone substitutes to support implant surgery.

6. **Fixed and removable prosthodontics**: As you would expect, you will provide crown and bridge restorative dentistry and partial and removable prosthodontics. Your interest will probably be skewed more towards the former, because this remains the restorative preference of both dentists and patients. However, but you should not overlook removable prosthodontics, particularly complete dentures. For a private practitioner starting out, removable prosthodontics is a great practice builder until you can accumulate more of the fixed prosthodontic patient referrals. And do not overlook the fact that complete dentures indirectly lead into the area of implant dentistry, as many patients will desire implants to improve their denture experience (Ex: Overdentures with locator attachments).

7. **Cosmetic dentistry:** This ties in a bit to 6), particularly the fixed prosthodontic aspect. There are a no. of different porcelain systems you can be exposed to in terms of crowns, bridges, veneers, and inlays/onlays. But cosmetic dentistry also includes techniques such as vital bleaching and periodontal surgery techniques.

8. **Oral surgery:** Simple exodontia is something that you will already have some experience with by virtue of dental school, but we expect you to learn surgical exodontia techniques, such as surgical extraction of erupted teeth, surgical extractions with primary closure, and extraction of impacted third molars. This is not to say that we expect you to be able to extract all impacted teeth on completion of our program, but you should be able to recognize potential complications associated with different situations and establish your own comfort zone. Implant surgery ties into oral surgery (as well as periodontal surgery, below), and some dentoalveolar trauma situations also tie in with oral surgery. Non-exodontia surgeries, such as biopsies, frenectomies, and exostoses removal will be covered too.

9. **Periodontics:** Implant surgery, osseous and soft tissue grafting, frenectomies, and crown lengthening procedures are all taught in our program. However, we do not overlook the considerations of treatment planning and more conventional treatment planning in periodontics either.

10. **Endodontics:** Our program teaches rotary endodontics, using the Tulsa based system, but this is incorporated into conventional hand instrumentation too. Even the most experienced endodontic specialists will tell you that rotary instrumentation is not the answer to all endodontic situations. This area ties into the area of dentoalveolar trauma, as such trauma often leads into endodontic therapy. It also ties into fixed prosthodontics (more specifically, core buildup techniques and crowns), as this is the usual progression for endodontically treated teeth. On the other hand, some teeth with endodontic problems might have such a poor prognosis, both from endodontic and restorative standpoints, so you need to be able to recognize these situations and consider implant options instead. In any event, endodontic expertise is a valuable practice builder, as most dental insurance policies provide coverage

for this service and competing dentists seem to lack the expertise that will allow them to treat these patients in their own practice.

11. Orthodontics: While our residents do not usually deliver comprehensive orthodontic care, some have elected to do such cases because of interest in an orthodontic specialty. At the very least, our residents should be able to develop the skill of recognizing developing malocclusions and knowing when and under what circumstances to seek orthodontic referral. In addition, space maintenance and habit correction techniques are also taught. Orthodontic education also includes some facial esthetics education, which is applicable to cosmetic restorative dentistry.

12. Pedodontics: Our residents learn to provide dental care to a variety of pedodontic patient types, using modalities of sedation or general anesthesia on patients who cannot be treated otherwise. Pediatric patient care is also an overlooked practice builder, because dentists who treat children almost automatically incorporate their parents into the practice. And dentists who are successful with pediatric patients are likely to keep them into their adolescent and adult years, periods in which their dental needs may increase and benefit the practice.

13. Sedation dentistry: Sedation dentistry allows you to deliver care to a portion of the population who might not otherwise seek dental care. Our department has always taught inhalation, oral and intravenous sedation techniques for pediatric, adult, and medically compromised patients. However, with the proliferation of dentists employing DOCS techniques and the resultant establishment of licensure requirements to practice sedation, this training has become more important to remain competitive while complying with the training requirements mandated by the dental board of whatever state you plan to practice. The Virginia Board of Dentistry is actually in the process of establishing permit requirements for the practice of sedation by generalists, so we expect to gear our clinical and didactic training in this area to satisfy any particular additions in requirements that might go along with the permit process.

14. Teaching: Some of our residents are interested in the pursuit of part or full time faculty positions in Dentistry. We have no research requirement, but opportunities periodically present themselves for clinical studies originated by other departments. There is ample patient material for publication, if that is a desirable facet in terms of portfolio development for an eventual faculty position. The second year resident mentors their first year counterparts, and all residents have the opportunity to teach dental school externs rotating through our program, undergraduate interns, and medical residents in the Health System. We actually plan to have the second year residents organize some formal lectures to allied patient care facilities in the hospital, such as Student Health. Even if you do not plan to “teach” formally as a faculty member somewhere, you will no doubt do some informal teaching in terms of your own office staff (esp. new employees), local dental study clubs, local hygienist associations, etc., so this represents a good opportunity to begin to develop the skills to do so.

WEEKLY SCHEDULE

Your weekly schedule will depend on the particular rotation you are on. The clinic day is usually 8:00 AM to 4:30 PM. With 4 residents, we have the 12 months calendar divided into 3 month rotations for each resident. If you elect to interview at our program, we can provide you with more specifics as to the daily schedule and goals for each rotation, but the rotations are currently divided into Dent. Resident, Private, Surgery, and Children’s Specialty (KCRC) rotations. These particular titles are somewhat for convenience to define what might be a priority, based on clinic time, for a particular

rotation, but it would be incorrect to assume that you only treat one patient type or provide one type of care on any rotation. Your patient type or type of care can change from day to day or from morning to afternoon within the rotation, no matter which rotation you are on. The various faculty function as your supervisors during these periods, and the faculty assignments vary from day to day and morning to afternoon too. Regardless of the rotation, you will always maintain a certain amount of private patient time so that you can keep a continuity of care with your private patients of record. In addition, all rotations have sessions on a weekly basis in which all faculty and staff are together--Monday morning (8:00 AM-9:00 AM) rounds, Thursday afternoon (4:30 PM-5:30 PM) rounds, and Friday afternoon residents'' conference (1:30 PM-3:00 PM).

DIDACTIC COMPONENT

Aside from the informal/spontaneous instruction that arises in the course of clinic activities under supervision of the faculty, the residents receive didactic information in the course of the aforementioned rounds and conference. The purpose of Monday and Thursday rounds is to discuss in-house patients of record, outpatient consults, emergency room patients, operating room patients, upcoming activities, resident concerns, etc. Potentially any dental case of common interest with teaching potential can be presented in rounds. Residents with treatment planning questions that cannot be answered in the course of the clinic sessions can present such cases at rounds for everyone's input. Any such presentation might include a combination of radiographs, models, and photographs that are shared among the staff for the purpose of discussion.

The Friday afternoon residents' conference is arranged as more of an actual lecture session. The lecturer might be one of our faculty or an outside private practitioner who is a GP or specialist, any of whom could lecture on a dental topic or a dental-medical area. We also have physicians allied with the U.VA Health System periodically lecture on topics in medicine that are relevant to the practice of dentistry. Some of the dental product manufacturers also provide sales/technical representatives or dentists to lecture on areas of dentistry. For example, both the Zimmer and 3i implant manufacturers are currently providing a lecture series to our program. Even some dental laboratories that we utilize provide lectures on dental techniques from a clinical and laboratory perspective.

Dr. Smagalski also typically gives a lecture at the end of each Tuesday he is present at the Dept. of Dentistry. His lecture topics include aspects of physical assessment, sedation, and oral and maxillofacial surgery.

In addition to the above, first year residents take a Physical Assessment course. This is a combination of didactic and laboratory sessions designed to provide a resident with the basics of physical assessment so that he/she can more appropriately plan dental treatment for medically compromised patients. This course currently takes place on selected Monday afternoons within the first half of the year.

OFF SERVICE COMPONENT

The off-service rotations were mentioned at the beginning of this document—ACLS, Emergency Medicine, Anesthesiology, and Otolaryngology. The timing of these rotations vary, but, whenever they would occur, the resident would just take time out of whatever clinic rotation he/she is on to participate in the off-service rotation. We can provide you with the goals for each of these rotations at interview. The second year of the residency offers the opportunity for elective off-service rotations.

EMERGENCY CALL

The Department provides hospital dental emergency and inpatient consult call coverage 24 hours a day. Any such concerns during daily work hours are managed through our clinics. Weeknight and weekend emergencies or consults are managed by the on-call resident via a long distance paging system (you are not required to stay in the hospital when on call). The call system employs both resident and faculty backup advice/supervision. It is a rarity for an in-house consult to require after-hours care, as most of these are better managed in our clinics where we have a better environment to treat the patient. As for dental emergencies, the Emergency Room is not intended to function as an after-hours walk-in dental emergency clinic. Our residents are involved only in true dental emergencies, such as dentoalveolar trauma or dental infections requiring incision and drainage. Routine or lesser dental emergencies are initially managed by Emergency Room personnel in the form of antibiotics or analgesics, with follow up care provided by dentists in the private sector or clinics that provide indigent dental care. With the usual arrangement of 2 first and 2 second year residents, first year residents split weeknight call (Monday through Thursday), whereas all 4 (first and second year) residents split weekend call (Friday evening through Sunday) equally.

BENEFITS

There are benefits common to all housestaff, and these can be viewed at the Graduate Medical Education web site:

http://www.medicine.virginia.edu/education/graduate-md/GME/for-applicants This site includes the annual stipend for first and second year residents (dental residents have the same first and second year stipends as their medical counterparts). Bear in mind that chief resident has a one step increase over the second year stipend. Residents receive 20 days of combined annual leave, although state and federal holidays recognized by the Health System would be given in addition to this leave time. Scrub uniforms and clinic jackets are supplied and laundered by the hospital. The first year residents receive $400 towards CE courses and second year residents receive $800. It has been our experience that most CE courses and meetings apply the discounted ("student") rate towards our residents.

CHARLOTTESVILLE http://www.cvillechamber.org/

If you are not familiar with the Charlottesville (City)/Albemarle (County) area, there is a capsule summary of the region available at the housestaff web site. In summary, Charlottesville (founded 1762) is a city with a population of approximately 40,500. The adjacent/surrounding Albemarle County has a population of approximately 90,700. I would describe Charlottesville as a "college town", with the U. of Virginia being founded by Thomas Jefferson in 1819. U.VA has approximately 13,400 undergraduate, 4,700 graduate, and 1,700 first year professional (Law and Medicine) students. The School of Medicine was founded in 1825. The U. of Virginia Health System consists collectively of the School of Medicine, Medical Center, School of Nursing, and the Claude Moore Health Sciences Library. Charlottesville is pretty much centrally located in the state of Virginia. By car, Washington, DC is about 2.5 hours northeast; Richmond is about 1.25 hours east; and Virginia Beach is about 3 hours southeast. In contrast to other cities farther north or south, one can say that locals experience all 4 seasons in Charlottesville, with true spring, summer, fall and winter weather. While we experience some hot summer and cold winter weather, the mountains and central location tend to shield the area from the heat and cold extremes of northern and southern states, respectively. Area historical attractions include the Rotunda (The focal point of Jefferson's original Academic Village), Monticello

(Home of Jefferson), Ash Lawn (Home of James Monroe), and Michie Tavern. Current growth areas appear to be the original Downtown area and north (in the direction of DC) and east (in the direction of Richmond) of the city. If you decide to visit our area and interview with our program, I can also provide my personal analysis of the restaurant and nightlife scene in the areas of The Corner and the Downtown Mall upon request. There is a LOT of construction going on in Charlottesville right now, both in association with the Health System and the Undergraduate and Graduate programs, as well as city and county construction—my impression is that everybody is taking advantage of the low interest rates and other building costs in this particular economy to do all these projects now. Anyway, if you are driving around in this area and see a lot of construction going on, do not be surprised (I would not classify this as "typical" activity for the area).

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