MONTEREY BAY

SmileLine

The Newsletter of The Monterey Bay Dental Society

Summer 2009

Inside This Issue

MONTEREY BAY
SMILELINE

Notes From Our President...

I'd like to provide you an update of some of the current happenings in our community, offering a few highlights evidencing the hard work and dedication of members who are involved in various committees and programs in the Monterey Bay Dental Society.

First, let me begin by offering a few details of how hard the volunteers on our peer review committee have been working. This is unfortunate, to a degree—but the Monterey/Santa Cruz/San Benito area is not unlike any other region in California or anywhere else in the United States, probably the world. We are experiencing a significant spike in workload for our volunteers (this is something seen in service organizations worldwide). Experts believe this is a direct result of the downturn in the economy and its effects on both sides of the fence: --in our case, dentist and patient. In regards to local peer review, this work load has fallen into the able hands of Dr. Richard Kent and 19 other volunteer dentists. In 2009 they have evaluated 16 cases spending numerous hours developing recommendations to the CDA Council on Peer Review. Thanks for your hard work and to all society members…remember Dave Stein's rule: document, document, document!

Once again Dr. Alison Jackson has headed up the elementary school dental education program. This program has replaced school dental screenings with a half-hour grade-appropriate lecture given by a volunteer dentist. I am very impressed with the Society's penetration into our area's schools. Twenty MBDS dentists provided lectures to 54 different classes in 25 schools in about 100 different classrooms. All told, over 1,000 children in K through 6th grades benefited from this effort! It was an amazing success this year and next year promises to be even better.

Our continuing education program is once again thriving. Putting a good series of lectures together is very difficult and time consuming. Dr. Marielena Murillo has stepped up to the task not only ably, but with style, and has coordinated a group of excellent speakers. So far we have had two lectures and two dinner meetings. The highlight of the year will be our lecture in August by Randall Berning. His lecture, "The Effective Doctor CEO – Turning Your Vision Into A Successful Business Plan", will deliver timely insight into how to plan and implement goals for a successful practice. In addition, there are two clinical lectures coming up: "Oral Pathology Update" by Drs. Roy Eversole and William Carpenter in July, and "The Perio-Restorative Interphase" by Dr. William Robbins in October.

There are numerous other success stories within our society—all of which benefit you, your practices, and dentistry's image in our community. I've touched on only a few here. Such programs would not happen without our dedicated volunteers. To those of you who are already involved, thank you! To those of you who are interested in becoming more involved, please let us know. Contact Carole or myself at any time!

Chad Cassady, D.D.S.

Stay the Course? Or.. Cut and Run?

The following editorial expresses your Society editor's opinions, predictions and suggestions relating to the slowdown most of us have experienced in our practices. He encourages your feedback and will be happy to publish any (appropriate) responses.

The current global recession is affecting everyone, everywhere. Even those who were smart (or lucky!) enough to have secured their savings into CD's or cash before the recession really got rolling are thinking twice before spending their money on pretty much anything. Folks who are retired, close to retirement, or whose jobs are "at risk" are being extremely careful regarding expenditures, including healthcare services. If you are one of the few dentists in private practice who don't believe you have experienced a change in your practice and income, I'm willing to bet that you aren't paying attention to what is going on at your front desk or your collections department (possibly the same individual). If you are like most of us, you're concerned, you're wondering how long things are going to be like this, if they are going to slowly get worse, or better, and what you can do to minimize the pain involved and more important, minimize changes in your life plans.

Personally, I have become acutely aware that I can't do much about people like Bernie Madoff, or the shortsightedness of banks who chose to lend trillions of dollars to people who had bad credit and couldn't afford to make their house payments, or CEO's of failing auto makers who flew their private jets to Washington to ask Mr. Obama if he could lend them a few hundred billion so that they could continue churning out gas-guzzling vehicles that the American public is no longer buying. The courts, the stock market, the U.S. Government and the collective actions of the U.S. consumer are rendering justice and determining which investment advisors, which banks and which car makers will survive.

Like it or not, the decisions and investments you make, along with the collective actions your patients make, will determine whether your practice will survive. More than ever, monitoring your practice to determine what is working, and what is not, being sensitive to where your money is going, assessing what you can do yourself that you have been paying someone else to do—this is a time to decide if you are best to "stay the course" or "cut and run". I think it is critical that you are realistic and open-minded in your observations. For example, there are numerous technologies that are purported to provide "state of the art" diagnostics or restorations. While alternative, less impressive or more labor-intensive means may already be in place, pressure from sales people, literature you may read, colleagues, or (most likely) your ego are pressing for the over-$100,000 expenditure.

Sooner or later, things will get better. There are signs various economists are quick to point to virtually every day that we are on the road to recovery. The reality though is that it will take some years for the U.S. economy to return to its pre-recession health. And a healthy economy will only follow real change in habits and policies. Lenders are now much more selective and cautious, particularly when it comes to first-time home buyers. Auto makers around the globe are rethinking and retooling multiple paradigms—towards efficiency, safety, and minimal environmental footprint. New vehicles are appearing designed for the short trip to Costco, Big Lots, or Trader Joe's, or the corner hardware or furniture store where good quality merchandise is affordable for families on tight budgets—and where customer service is still for real.

Consumer spending (yes, this is my prediction!!!) will be driven by value, durability, functionality—and by personal relationships and customer service. "High tech" may be your message, but it will only be perceived as valuable if you can prove that it gives your patient something that is going to be more comfortable, less invasive, last longer, look better and be more trouble-free than what the dentist next door (who happens to be available five days a week and is happy to see patients for emergencies at any hour) is doing.

I'm not suggesting you "cut" spending money on expensive materials or that you compromise the treatment you do in any way. Instead, I'm suggesting that providing the very best treatment your patient can afford, not cutting corners, taking time to do things well, being patient with folks who are uncertain if they are ready to move ahead with treatment you have recommended, answering questions and reassuring your patients, will ensure that your practice survives. Think twice about whether the big expenditure, the new toy, is truly needed, if it will pay for itself as the salesperson insists, if it will improve the quality (perhaps safety and durability) of care you provide. I am also suggesting that you (yes, you!) think about working a little harder if you haven't already, doing some of those prophies, filing some charts, even taking out the trash. Your practice is depending on you to stay the course.

Lloyd Nattkemper, DDS

Editor

Rock Wall 1, Wittenberg 0

Early May, Marin Headlands: San Benito/Monterey County oral surgeon Joerg Wittenberg has cycled across the Golden Gate from San Francisco, made his way around the face of the headlands and is headed north, threading the narrow shoulder Highway 1 allows between a sheer rock face on the right, and a 300 foot drop to the ocean on the left. There is wind, moderate traffic, gravel, lots of turns.

Something happens. A split second. Perhaps a moment looking out to the sea, perhaps an unseen rut, some sand, overbraking. Joerg is thrown from his bike. His helmet, though helping to cushion the impact to his head, is broken to pieces. He is found unconscious against the rock, multiple vertebral fractures, broken collar bone, pneumothorax.

Joerg is recovering. He is staying with family in Germany. He is currently wearing a "Halo", and according to Rick McBride, his partner, is under excellent care with is brother (who happens to be an orthopedic surgeon) and colleagues of his brother's. Joerg is bored, lonely, missing his practice, probably pretty uncomfortable, and could use some cheer.

Rick and I encourage you to send Joerg an e-mail or e-card. Send correspondence to:

mcbridewittenberg@sbcglobal.net

Lloyd Nattkemper, DDS
editor

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Monterey Bay Dental Society

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In This Issue

Staff Meetings –The Stuff of Nightmares (No Longer)

Sally McKenzie, CEO

There you are patiently waiting. Things were supposed to get underway at 8 a.m. It's 10 minutes past when you hear the back door slam. The crew saunters in. A chorus of labored sighs circles the room. Each person lands in his/her seat with a thud and assumes the position. Arms locked across chests. Heads cocked slightly to one side, piercing stares burn through you. They glance at each other with knowing smirks. Then as if perfectly choreographed and precisely on cue, they attack. A string of complaints and gripes and grievances fire off at you like machine guns. They don't like the new computer systems. Who decided the insurance was going to change. When are they going to get their raises? Has anyone smelled the refrigerator lately? The alarm jolts you awake, heart pounding. You realize it was just a bad dream, and not another staff meeting.

Okay, maybe your staff meetings, thankfully, aren't as scary as the example above, but far too many dentists and dental teams view them as costly and stressful exercises in futility that ultimately result in lost production and lower revenues. The common lament from doctors is, "I quit having staff meetings because everyone was looking at me to have all the answers." Or, oftentimes, doctors say little gets accomplished because they just turn into gripe sessions. Conversely, team members will assert, "We give input but nothing ever changes." Staff meetings –desperately needed by all dental teams, deeply despised by many.

In his book, Death By Meeting, author and management guru Patrick Lencioni sums up the problem with meetings this way. First, they are boring, dull, and tedious. Second, they are not effective. "The most justifiable reason to loathe meetings is that they don't contribute to the success of our organizations." You might think from such comments that Lencioni advocates a total dismissal of this tired business ritual. In fact, the opposite is true.

Most critical business decisions are made in meetings, the same is true for the business of dentistry. It is in staff meetings that the team identifies and solves problems, examines areas of responsibility/systems, establishes policies, presents information, motivates and educates one another, exchanges ideas - at least that is what's supposed to happen.

So how do you create business meetings that achieve all of the above and more? First, shift your attitude. Look at meetings not from the standpoint of revenue lost but rather the potential for significant revenue gain. Next, treat meetings as you would any other system. Establish expectations and standards.

When and Where

In addition to daily huddle meetings, which are short discussions focused on patients and treatment scheduled for the next two days, dental teams need one two-hour meeting each month for in-depth discussion focused on addressing key practice issues. If possible, the meetings should be held off-site in a conference room with a conference table, and eliminate outside interruptions. Seek consensus from the staff as to the best time to hold staff meetings, and remember that meetings scheduled outside normal work hours should be paid.

The Agenda

Every staff meeting must have an agenda that includes standard items the practice is continuously monitoring. These are all areas affecting the profitability/ success of the practice. For example: numbers of new patients, recall patients, collections, treatment acceptance, production, accounts receivables, unscheduled time units for doctor and hygiene, uncollected insurance revenues over 60 days, overhead, etc.

One person – not the doctor – is responsible for compiling and distributing the agenda to everyone in advance of the meeting. However, this person is not in charge of developing the entire agenda. That task is the responsibility of the full team.

Post the agenda in the breakroom or other area where staff will see it regularly and can add items as they come up during the month. Issues that present themselves regularly in the daily huddle but require more involved discussion and analysis should be put on the monthly meeting agenda.

List the most critical issues highest on the agenda to ensure there is adequate time to talk about them. Determine how much time you will spend discussing each matter, avoid getting bogged down on unrelated topics, and insist that team members come prepared to discuss the items listed.

The Meeting

Assign a facilitator/ leader, other than the doctor, to guide the group in the discussion. Talk about only what is on the agenda. First, cover the key systems. Each month the individual team members report on the status of their specific areas. For example, the scheduling coordinator would report on key indicators within the scheduling system: 1. The number of new patients scheduled for the month. 2. The number of new patients actually seen. 3. The number of emergency patients scheduled for the month. 4. The number of emergency patients treated for the month. 5. The number of emergency patients converted to comprehensive exams. 6. The number and dollar amount of unscheduled time units for the month. 7. The number of patients with unscheduled treatment.

Staff Meetings –The Stuff of Nightmares (No Longer)

Now that everyone knows the numbers, the group can discuss if the practice is on track with its scheduling goals. Use the collective problem solving skills of the team to develop strategies to identify solutions to problems that may be occurring in the scheduling system.

Opinions, Views, and Disagreements

Seek input from everyone, and don't be afraid of conflicting opinions. In fact, encourage discussion. If agreement is reached too quickly on major issues, chances are good that members of the team are not sharing their views openly and honestly. They are waiting to whisper their true feelings at the meeting after the meeting. While consensus is good to strive for, it's not always possible. Ultimately, the team needs to agree that while individuals may have disagreements during the discussion, everyone supports the final decision, which is made by the doctor.

The Plan of Action

Delegate responsibility and establish deadlines for completing tasks identified during the staff meetings. For example, if hygiene cancellations are high and the group has developed a plan to reduce the cancellations the person responsible, probably the hygiene coordinator, needs to know she/he is accountable for implementing the changes and should be prepared to report on the effects of those changes at the next monthly meeting.

Once the systems are reported on, the remaining time can be used to cover other items on the agenda, including staff training and education. For example, if members of the team attended a continuing education program, they should be expected to share with the team highlights from the program and specific techniques or strategies that they believe could be implemented in the practice.

If the office is offering a new service or product, the staff meeting is an excellent venue to instruct the team on the new item, answer any questions and ensure that every employee is prepared to answer questions from patients. In addition, journal articles on numerous practice issues can be shared and discussed during the meetings.

Run correctly, staff meetings are the most effective means to identify and solve problems, establish policies, share information, motivate each other, define areas of responsibility, and exchange ideas. Use them to your practice's full advantage and turn this recurring nightmare into a sweet dream.

Sally McKenzie, Certified Management Consultant, is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides highly successful and proven management services to dentistry and has since 1980. McKenzie Management offers a full line of educational and management products, which are available on its website, www.mckenziemgmt.com. In addition, the company offers a vast array of Practice Enrichment Programs and team training. Ms. McKenzie is the editor of the e-Management newsletter and The Dentist's Network newsletter sent complimentary to practices nationwide. To subscribe visit www.mckenziemgmt.com and www.thedentistsnetwork.net. She is also the Publisher of the New Dentist™ magazine, www.thenewdentist.net. Ms. McKenzie welcomes specific practice questions and can be reached toll free at 877-777-6151 or at sallymck@mckenziemgmt.com.

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Got Skills?

Santa Cruz County ROP Dental Assisting Program

These are challenging times for vocational education, especially for those programs serving adults and high school students. We are constantly hearing about the budget and its effect on education. The Dental Assisting Program has been affected by the budget, and a decision has been made in reducing the number of classes offered. However, we are truly fortunate! The Santa Cruz County ROP directors have elected to keep the Dental Assisting Program due to the success of the program, its students, and the support of our dental community!

So, you ask, "What is new at the Santa Cruz County ROP?" The Dental Assisting Program has revised its current curriculum to include more didactic and preclinical lab instruction for our students while maintaining a standard of providing educationally-qualified dental personnel for our dental community.

Our goal is to include more didactic instruction provided by our local dentists, and incorporating more volunteers within our dental industry (RDA's, RDAEF's) to provide additional "hands-on" support to our students. Due to the recent budget cuts, our instructional aide staff has been severely reduced.

For the past several years we have incorporated preliminary preparatory training for our students for the "coronal polish certification" courses, OSHA training, CPR certification, and Dental Radiology certification. Two of our staff members have recently become CPR Instructors, so that we may provide more direct support for our students during the certification process.

Students will be attending classes Monday – Thursday from 3:30 pm – 7:30 pm with more individualized preclinical lab instruction. We will be incorporating "smaller labs" to meet the individual needs of our students. Due to the support of our dental community in Santa Cruz County, we now have a clinical lab with four operatories!

Our students are required to participate in an internship and job shadow of a minimum of (200) clinical hours. We wish to thank the

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Got Skills? continued

dentists and dental staff who have supported this instructional portion of our program for our students! Their "one-on-one" chairside assisting experiences have provided our students with the type of clinical instruction needed and expected by the dental community in preparing them for our workforce!

The dental radiology portion of our program is held at Cabrillo College, Dental Hygiene Department. We have incorporated additional instructional hours on several Saturdays for our students in the areas of extra-oral radiographs such as panoramic films, instruction in occlusal films, and "digital x-ray" workshops. The "digital x-ray" workshops are held at the office of Dr. Julius Kong in Watsonville. We even incorporated an activity to include "trouble shooting the endodontic films!"

As of January 2009, a new program was introduced for our high school students in Santa Cruz County as a prerequisite to the Dental Assisting Program open to juniors and seniors, the "Dental Occupations Program." The Dental Occupations Program is a one-semester program exploring all of the occupational resources within the dental industry, as well preliminary didactic instruction to prepare students to be successful in the Dental Assisting Program. This program will be offered twice a year to juniors and seniors who are interested in the dental field, and is taught by Minerva Zepeda, RDA.

We are currently working on curriculum for "coronal polish" certification as well as a new course in "infection control" which will be required as stated recently by the Committee on Dental Auxiliaries, Section 1750: "The employer of a dental assistant shall be responsible for ensuring that a dental assistant who has been in continuous employment for 120 days or more has already successfully completed, or successfully completes, a board-approved course in infection control within a year of the date of employment." This new law will be in effect by January 1, 2010.

On a personal note, it has been a long-time desire for me and fellow staff members to be able to provide our dental community with "local" resources for those individuals seeking continuing education in preparing for the RDA written and practical examinations by offering tutoring services. If you have any staff members who are currently preparing for these exams, please have them contact me, as we want to identify the number of individuals who would be interested in this type of service.

I am proud to say we have a phenomenal instructional team and volunteers (Dr. Sam Christensen, Dr. Steven Graf, Dr. John Stevens, and Dr. Ballan Tuck) whom I would like to thank wholeheartedly for their continued support of our Dental Assisting Program!

We are always in need of volunteers and internship opportunities for our dental assisting students. If you would be interested in assisting our program in any way, please feel free to contact me! Thank you for the opportunity to serve you and our dental community!

Respectfully,

Debbie M. Reynon, CDA RDA AA AS

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Ethics Column

By Al Grosnick DDS
MBDS /Ethics Commitee Chair

What is Ethics?

What does the word ethics mean to people? Some would say it has to do with what our feelings tell us is right or wrong. Some might feel it has to do with religious beliefs. Others would think that being ethical is doing what the law requires, or conforming to standards of behavior our society accepts.

The different view of ethics that people have shows us that the meaning of "ethics" is hard to pin down.

Some tend to equate ethics with their feelings. But feelings frequently deviate from what is ethical, so being ethical does not appear to be a matter of following one's feelings.

Many people identify ethics with religion. Most religions advocate high ethical standards and can provide motivations for ethical behavior. But if ethics were confined to religion, then ethics would only apply to religious people. Ethics, however, applies to the behavior of atheists and saints alike. So ethics cannot be confined to religion nor is it the same as religion.

Being ethical is not the same as following the law. Although laws often incorporate ethical standards, they can deviate from what is ethical.
Also, being ethical is not the same as doing whatever society accepts. In any society, most people accept standards that are ethical. But standards of behavior in society can deviate from what is ethical and the lack of social consensus on many issues makes it impossible to equate ethics with whatever society accepts.

So what is ethics? Ethics is two things. Ethics refers to well based standards of right and wrong that prescribe what we ought to do, usually in terms of rights, obligations, benefits to society, fairness, or specific virtues. Ethics, for example, refers to those standards that impose the reasonable obligations to refrain from things like stealing, assault, or slander. Ethical standards also include those that enjoin virtues like honesty, compassion, and loyalty.

Secondly, ethics refers to the study and development of one's own ethical standards. As mentioned, feelings, laws, and social norms can deviate from what is ethical. So it's necessary to constantly examine one's standards to ensure that they are reasonable and well founded. Ethics also means, then, the continuous effort of studying our own moral beliefs and our moral conduct and striving to ensure that we, and the institutions we help to shape, live up to standards that are reasonable and solidly based.

Adapted from Issues in Ethics IIE, V1, N1

The Dentist's Number

By Doug Carlsen, DDS

The Number, a widely used term used to identify the actual amount of money one needs to retire comfortably, is referred to constantly. Let's take a closer look.

Over the last three years I've conducted a survey of retired dentists to find consumption habits and income needs. The pre-retirement family incomes range from $120,000 to $800,000. Incredibly, I've found that there is a clustering of retirement income at $140,000 per year. Of interest, the doctor that earned $800,000 in his practice is living on an income of $155,000. The retirement incomes found are no where near the oft-touted 80% of pre-retirement income used by many financial planners. Is there a flaw in that reasoning?

According to Laurence Kotlikoff, Professor of Economics, Boston University, "The replacement rate method of retirement income calculation is a horrible offender… It generates overtargeting mistakes on the order of 50%. As a result, it leads to saving and insurance recommendations that easily can be five times too high."1 Additional comment is available in the Journal of Financial Planning.

Cross referencing Bureau of Labor Statistics information for higher income retirees and interviews from dentist retirees, I have devised a retirement income projection form to estimate retirement income scenarios for couples. Retirement incomes range from 18% to 70% of pre-retirement income.

Let's take the average 53 year old boomer dentist, who wishes to retire at 66 and currently has an income of $200,000, savings of $225,0002, and a spouse earning $40,000. Now, let's calculate a representative "number" using standard retirement tables.3 All figures are in 2009 dollars.

Assuming the house is paid off and the kids no longer live at home, his retirement income will be the average of $140,000. Almost all dentists will max out with $28,000 in social security benefits per year, with spouses receiving at least $14,000 due to the spousal benefit provision. [If you think Social Security won't be around in retirement, either you're living on Mars or need a new financial planner. Call me.]

After subtracting an additional $16,000 per year for sale of practice ($400,000 after fees at withdrawal of 4% per year), our dentist needs to generate $82,000 per year in retirement from savings. An annuity multiplier to age 95 shows $1,623,280 in total savings needed. This is his number!

Our dentist has $225,000, which will grow to $483,750 by retirement. Therefore, he needs to save $1,139,530 in the next 13 years. Another calculation reveals that $59,111 annual savings will be needed until age 66.

On a family income of $240,000 with a mortgage and high tax rate, it is nearly impossible to save $59,000 per year. Having our doctor retire two years later, savings needs drop to $40,500 per year---much more manageable.

Note: couples need to generate a retirement income estimate before calculating retirement savings needs. The 80% rule is not appropriate for most professionals, according to Dr. Kotlikoff and others.

Manual calculations, which I use in workshops and for income evaluation, and sophisticated Monte Carlo software, which I use for private consultations, are available. Monte Carlo programs monitor the couple's actual portfolio to project scenarios using actual market returns over the last 100 years. Multiple spending and savings scenarios can be utilized, even part-time work in retirement.

There were numerous assumptions involved in the above dentist's calculations involving portfolio returns, life expectancy, and average consumption habits. Please contact me for further details.

The information provided in this article should not be construed as investment advice. Please meet with a qualified investment adviser to finalize the amount you need to save for retirement and to develop a proper plan to achieve your "number." But please make sure he or she doesn't just pull an income figure out of the air!

(Endnotes)

1 Laurence Kotlikoff, "Why Target Practice Equals Financial Malpractice," Investment News, June 11, 2007

2 Michael Gerber and Amy Morgan, "The E-Myth for Dentists: Why Most Dental Practices Don't Work and What to Do About It," Dental Economics, May, 2007.

3 Worksheets from Employee Benefit Research Institute, American Savings Educational Council, and American Association of Individual Investors.

About Doug Carlsen

Douglas Carlsen, DDS, retired at age 53 from a 25-year private dental practice in Albuquerque and clinical lecturing at the UCLA School of Dentistry. He writes for Dental Economics and Dentaltown, lectures nationally on retirement strategies, and consults on personal finance, practice scheduling, and cash flow. His most popular individual consultations are "Find Your Retirement Number" and "Schedule Analyzer." Visit his web site at www.golichcarlsen.com; contact at 760-798-0886 or drcarlsen@gmail.com.

Ask, Advise, Refer

By Laurie Lang

As the Project Director of the Santa Cruz County Tobacco Education Program, I'm often asked how to encourage smokers to quit. I asked my sister, a former smoker, what made her quit smoking after many years of trying. She said it was something her dentist had told her. He said, ". . . whatever it takes, find a way to quit. It's the single best thing you can do for yourself." His expressed concern was all it took for her to stop that day, 20 years ago.

Today, we have many more tools for our healthcare providers that have been shown to be effective over the long term. Surveys have shown that 70 % of self-reported smokers would like to quit. There can be lots of obstacles in their way and cessation specialists try to remove as many of those obstacles as they can. To that end, the California Smokers' Helpline (1-800-NO-BUTTS) was established in 1992. This is a free, statewide tobacco cessation program which is operated by U.C. San Diego. Since its implementation, the helpline has served over 450,000 Californians. The service is confidential and operates Monday through Friday, 9am to 9pm and Saturday from 9am to 1pm. There is also an after-hours voice mail service. The Helpline has services for those who would like to quit chewing tobacco as well. The counselors are professionals trained in smoking cessation and the services are offered in English, Spanish, Vietnamese, Cantonese, Mandarin, Korean and for the deaf. There are also counselors for teens, pregnant/nursing women and non-tobacco using clients who are calling about someone they know who is a smoker.

Almost 90% of smokers surveyed preferred a quit line to a group clinic setting for its ease of access and convenience. It also works! A randomized, controlled study published in 1996 found that those smokers calling the quit line who had multiple counseling sessions over the phone had a much higher abstinence rate after one year than those smokers who had a single counseling session or who just received self-help materials. Those receiving self-help materials had approximately a 15% abstinence rate at 12 months compared to 20% for the single counseling and 27% for the multiple counseling group.

So what happens in each call? The initial session takes 30-40 minutes and is designed to build self-confidence, motivate quit attempts and devise an individualized plan. There can be up to 5 follow-up sessions of about 10 minutes each, which convey support and help prevent relapses. The phone will be answered by a live person about 95% of the time.

Why do people call the helpline? The overwhelming majority of callers (41.5%) tell us they were referred by their health care provider! You are the single,most important referral source for your patients who smoke. Here's how you can make a difference:

1.Ask your patients if they would like to quit smoking.

2.Advise them that it's the right thing to do for their health.

3.Refer them to 1-800-NO-BUTTS

Free materials are available from our office to use as referral aids. Please call Andrea Silva at 831-454-4304 for more information or email andrea.silva@health.co.santa-cruz.ca.us - Thank You!

Tobacco Retail Licensing:

By Laurie Lang

What Is It and Why Is It Good For Santa Cruz County?

While many of us have differing opinions about various tobacco policies, we all seem to agree on one: tobacco sales should be limited to those 18 years of age and older. Unfortunately, some retailers are not as careful as most tobacco retailers in checking for IDs when completing a tobacco sale. In March of 2008, our Tobacco Education Program completed a Youth Tobacco Purchase Survey (YTPS) where high school students were trained to test whether or not they could successfully purchase tobacco products in retail stores throughout the county. We found that they were successful 17% of the time. This is fairly high for our small county but there is something that can reduce this number. It's called Tobacco Retail Licensing (TRL) and it means that any business owner who sells tobacco products would be charged a yearly business fee, which would fund enforcement of the current laws which prohibit tobacco sales to minors.

Here's why Santa Cruz County needs a TRL policy:

- TRL works – a 2001 study published in the medical journal Preventive Medicine found that "enforcement programs capable of producing a 5% reduction in adolescent smoking at a cost of no more than $250 per year per tobacco retailer, could save 10 times as many lives as equally funded programs for early detection of breast cancer and colorectal cancers."1 Also, those counties who have enacted strong TRL policies have had great success in reducing tobacco sales to minors. For example, in San Luis Obispo County, they were able to reduce their tobacco sales to minors from 17% before a TRL policy was passed to 0% after the policy was passed.

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- We can't rely on federal and state programs – while there are laws on the books (Penal code 308(a) and the STAKE act) that make it illegal to sell tobacco to minors, there is little money to pay for enforcement and the state's enforcement program is underfunded. Our local police and sheriff's department cannot conduct an enforcement program without funding. Only about 3% of our state's 80,000 tobacco retailers are checked for tobacco sales to minors.
- Fees for enforcement programs do not punish retailers – there are many licensing programs in our state which regulate businesses. For example, thosev who sell alcohol for consumption off premises pay a yearly fee of $446. A furniture and bedding retailer pays an annual fee of $240 and a retail water facility license costs about $325 (adjusted annually). Licensing makes sense when we have a vested interest in compliance with the law or when non-compliance threatens health and safety.
- We can't afford NOT to fund enforcement – TRL protects the most vulnerable in our community from addiction to tobacco. Tobacco addiction costs our society millions of dollars in healthcare costs, not to mention the untold suffering from lung cancer, emphysema and other tobacco-caused illnesses. Tobacco remains the only addictive product that can be sold with only a one-time fee for business owners. Controlling youth access to tobacco translates directly into savings in health care as well as health insurance, as it costs more to insure smokers and, in general, smokers have more visits to their healthcare providers than non-smokers.

What Can You Do?

We are asking all business owners to support a TRL policy for our county. Here's what you can do:

1. Contact your Supervisor and express your support for a new TRL policy.
2. Write a letter to the Editor about why you support this policy.
3. Contact your City Council members and ask them to draft a TRL policy.
4. Make your own business smoke-free and encourage your employees who are smokers to quit. For free help, anyone can call the California Smokers Helpline at 1-800-NO-BUTTS. This is a free, confidential program that offers one-on-one counseling over the phone.
5. Join our Tobacco Education Coalition, which promotes and advocates for a tobacco-free lifestyle and environment. Call Andrea Silva at 831-454- 4304 for more information.

About Laurie Lang

Laurie Lang is a Senior Health Educator for the Chronic Disease and Injury Prevention Program in the Santa Cruz County Public Health Department. As such, Laurie is the Project Director for the Tobacco Education Program and administers the Dental Program funded by the California Department of Public Health. Laurie has a Masters' degree in Health Science and is an adjunct faculty member at Cabrillo Community College in the Health Sciences Department. She served as the Public Information Officer and Training Lead for the Emergency Preparedness Program in Santa Cruz for 4 years prior to her current position and was the Director of the Wellness Program at Santa Clara University from 1992 to 2002.

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GOT X-RAY STUFF?

If you are converting to digital radiography and have analog equipment or supplies no longer being used, Cabrillo College Dental Hygiene is looking to help you. Please consider donating functional equipment, film, developer, fixer etc.! Any such items are eligible as charitable donation income tax write-offs.

Contact Aud Kennedy at (831) 477-5269 or aukenned@cabrillo.edu

What is a Professional?

by Kenneth Jacobs, DDS

It was a Saturday night like most others during the last 7-10 years of my life. The babysitter flaked out on us for the hundredth time, so the chance for my wife and I to do something adult vanished. As I became resigned over again to catch up on some reading as my primary Saturday night activity, my son inquired why I was always reading those dental magazines that showed gross bleeding gums, black broken teeth and had a lot of big, foreign sounding words. He was also curious why I had spent the last two days attending "Dental School" (CE) instead of being at the office or hanging out at home. Well, I thought about his questions for a moment and said, "That's the difference between a job and a profession". I further explained to him that a lifetime of study, dedication to the craft and those that you serve separate professionals from those who merely go to work. He looked at me with a perplexed yet understanding expression and then went on building his 3,252 pieces Star Wars Lego Star Destroyer set.

I began to further ponder what are the elements of being a professional and realized the scope of this distinction is truly mind-boggling. A few among many elements stood out to me.

- Communication – How many times would it have been nice to receive a call from a subsequent treating dentist regarding a problem with previous treatment that you may have provided in the past. Instead, many times we hear from peer review or even worse an attorney first. Why not pick up the phone and discuss the potentially volatile situation to get all of the facts with the previous provider before making

uninformed comments or final recommendations. Our patients will always benefit if understanding comes from great communication and not accusation or assumption.

- Don't be judgmental – Now this does not mean we cannot make assessments based on hard evidence but rather not placing our own values onto someone else. How many times do patients poorly following directions regarding oral hygiene, medication dosing or treatment plan continuation? Yet, who of us is perfect in all phases of our lives? That saying about "glass houses and stones" is applicable here. We are truly professional when we can help our patients be the best that they can be.

- Place others above yourself when doing so would not cause harm to yourself – Presently, we live in an especially uncertain time. The economic pressures that face us and our patients cannot cloud our judgment. Our role is to educate, counsel and lead by example, not sell our services only for our own enrichment. Although we may feel as if we are targeted unjustly by our staff, patients and government regulations the confidence and privilege the public places with us must not be devalued or taken for granted. Our standing in the community as "Professionals" must truly be cherished.

Editor's note: Dr Jacobs is editor of the Los Angeles Dental Society's ***Explorer.*** *He graciously provided permission for reprinting of the article.*

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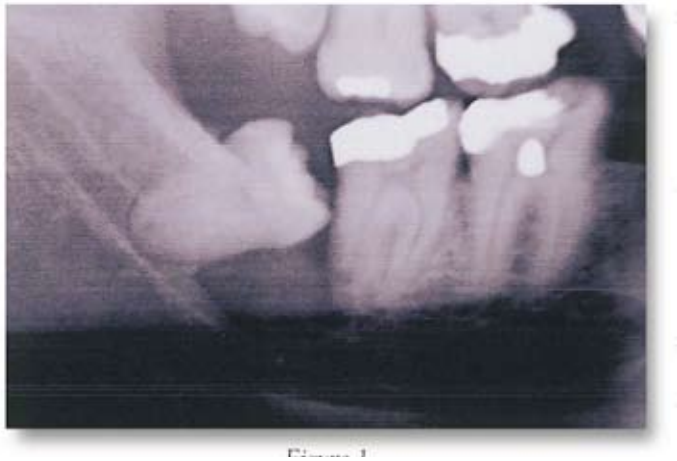
She'll be happy to send you samples.

Squamous Cell Carcinoma Radiographically Resembling a Dentigerous Cyst

By Jeffrey A. Elo, DDS, MS

A 63-year-old Hispanic male presented to the oral and maxillofacial surgeon complaining of pain in his lower right jaw that had been intensifying for 3 weeks. The lesion was initially considered an infection, and his primary care physician prescribed antibiotics, but the pain was unresponsive to a 10-day course of amoxicillin.

The patient's medical history was significant for non–insulin-dependent diabetes mellitus and hypertension; his social history was negative for tobacco or alcohol use. He reported a decrease in appetite for 3 months, but denied any significant weight changes. On extraoral examination, neither facial soft tissue swelling nor regional lymphadenopathy was observed. The patient complained of a mild, dull ache on palpation of the right mandibular angle. He denied paresthesia, dysesthesia, or anesthesia. On intraoral examination, the gingiva and alveolar mucosa in the region of the right mandibular second and third molars showed normal contour and unremarkable smooth pink mucosa with no evidence of erythema, hyperkeratosis, ulceration, induration, or swelling. The second molar exhibited no tenderness to palpation and no mobility; however, a deep periodontal pocket was observed on the distal aspect (7 mm probing depth). The third molar was not clinically visible due to complete soft tissue impaction. A panoramic radiograph revealed a 15-mm circumscribed triangular radiolucent lesion inferior to a mesioangular impacted third molar and distal to the second molar; the inferior lesional border abutted the inferior alveolar nerve canal (Figure 1).

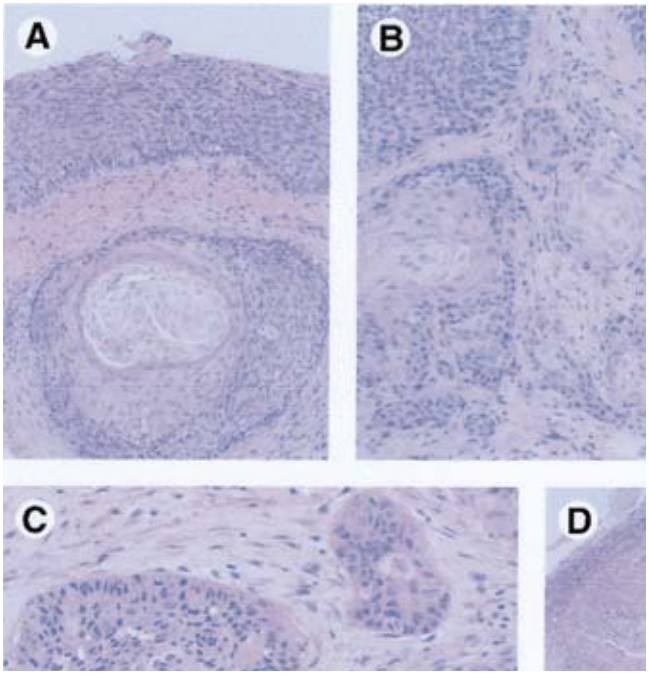


The clinical differential diagnosis included dentigerous cyst, pericoronitis/ periodontitis, odontogenic keratocyst, odontogenic tumor (e.g., ameloblastoma), and osseous lesion (e.g., giant cell granuloma). At surgery, the third molar was extracted without complications. The 1.5-cm x 1.0-cm irregular mass lesion was curetted out in multiple fragments, and the specimen was sent to an oral pathologist for histopathologic evaluation.

Histologically, the connective tissue demonstrated rather closely packed budding islands of neoplastic stratified squamous epithelium of varying size, each exhibiting peripheral disordered basal keratinocytes and central spinous keratinocytes and parakeratotic whorls (Figures 2A-D). Keratin pearls and parakeratin- filled microcysts were seen. In some areas, the connective tissue was partially covered by dysplastic epithelium (cystic lining and/or gingival sulcular epithelium) showing palisaded tall basal keratinocytes and elongated fusiform spinous keratinocytes arranged parallel to the surface.

Lesional keratinocytes displayed moderate variation in nuclear size, shape, and chromaticity (moderate cytologic atypia).

These histological findings were interpreted as moderately differentiated squamous cell carcinoma arising either from gingival sulcular epithelium or odontogenic epithelium (dental



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Oral and Maxillofacial Surgery: continued

follicular epithelium showing squamous differentiation or dentigerous cyst lining). This pathology report was discussed with the patient, who was immediately referred to his primary care physician for a complete oncology workup. A dental cone beam computed tomography scan revealed a 30-mm (anteroposterior) x 21-mm (superoinferior) moderately well-defined lesion with relatively smooth, partially corticated, and mildly scalloped margins. The lingual, crestal, and superior aspects of the buccal cortical plate were locally destroyed with relatively smooth margins. A repeat biopsy from the right mandibular third molar area confirmed the presence of moderately differentiated squamous cell carcinoma. Magnetic resonance imaging (MRI)

studies demonstrated abnormal enhancement of the inferior alveolar nerve subjacent to the right mandibular premolars, suggesting perineural invasion; however, no evidence of proximal perineural invasion was seen.

The patient's surgical therapy included composite resection of the right posterior mandible from the angle to the mental foramen, supraomohyoid neck dissection, and reconstruction with a fibular osseocutaneous free flap. Dental implants were eventually placed, and a removable partial overdenture was made. Follow-up evaluation 30 months after the resection revealed no evidence of recurrent carcinoma.

Important Note: This case highlights the importance of prudent patient history and examination. It also highlights the importance of submitting any tissue which is removed from the oral/maxillofacial region for

histopathologic examination by an oral pathologist. This pericoronal tissue could have easily been discarded, thinking it was just inflammatory material secondary to the impacted tooth. There was nothing present in this case that was out of the ordinary to suspect malignancy.

Carcinoma rarely arises directly adjacent to an impacted tooth; however, because follicular tissue remains around impacted teeth, the potential for malignancy is present. As such, any impacted tooth with a questionable appearance ought to be referred to an oral and maxillofacial surgeon and considered for removal/treatment and biopsy.

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Children's Toothbrushes

and Other Hygiene Aids Needed

Dominican Hospital in Santa Cruz provides a number of outreach services for the community, including basic pediatric dental screenings, oral hygiene instruction and emergent care. Marcene Saxman, a nurse practitioner with Dominican's Hospital-Community Health Integration Services, contacted me recently asking if members of the Monterey Bay Dental Society might be able to assist their program.

Their current needs:

500 children's toothbrushes

Up to 350 adult toothbrushes

Floss

Toothpaste

She commented that State agencies have cut back on support, and none of the manufacturers/vendors who she had contacted were able to help. The patient population she serves has a high incidence of baby-bottle and sippy-cup tooth decay. She feels there is a great opportunity to educate entire families and make a real difference in children's lives.

Dominican's Pediatric Clinic is providing screening for caries/strep mutans for children under 5 years and their mothers, OHI and fluoride application to the kids' teeth.

Can you help? If so, contact Marcene:

Marcene.saxman@chw.edu

DH Rehabilitation Services

1555 Soquel Drive

Santa Cruz, CA 95065

Office: 457-7174

Clinic: 457-7181

Thank you!!

Lloyd P. Nattkemper, DDS

Editor

Compounding Corner with David Smith

By David Smith

Compounding for Dental Problems

I would like to share a few new facts and formulas that I picked up at a recent seminar for Dental Compounding. I hope a few of my Pearls can help you in your practices.

As we know, Dentists and Dental Hygienists may be the first to see patients and diagnose health problems. Obtaining an in-depth history of the problem can often times provide a diagnosis or potential diagnosis.

Glutamine is an essential amino acid and is important for tissue repair. This amino acid will be depleted by radiation and several chemotherapeutic agents, especially Taxotere.

A solution to this could be a Mouth Rinse of Glutamine 100mg/ml combined with Folic Acid 1mg/ml and to rinse and swallow 5ml tid to qid. Selenium 400mcg daily can be very helpful during radiation.

I have some treatments for Oral Candidiasis:

Antifungals: Clotrimazole 100mg and Ibuprofen 10mg Lozenges. (Flavored to suit the patient) Suck 1 lozenge four times daily for 7 – 14 days.

Ibuprofen will aid the effect of the –azole antifungal.

Nystatin Suspension has been used for years. The manufactured suspension is 50% sugar. A compounded suspension of Nystatin can be made Sugar-Free.

Probiotics can help the balance of good bacteria in the body and mouth. Many times it may be the bacteria in the stomach that has some effects on the mouth. I might recommend two widely used probiotics.

VSL-3 and Florastor 250mg to be used bid to tid. Empty the contents of the capsule on the tongue and swallow three times daily.

Here is a very inexpensive treatment for Xerostomia.

Pilocarpine 2% Ophthalmic drops

- 1 drop sublinqually up to four times daily as needed. This creates moisture in the mouth and each drop gives a patient 1mg of instant saliva.

We can compare Pilocarpine Ophthalmic drops at the price of $15- $20 per bottle to Salagen Tablets which cost about $150 per 100 tablets.

Bruxism may be due to an imbalance of Calcium and Magnesium which causes excessive muscle tension. Instead of using a benzodiazepine for muscle relaxation, try Magnesium (Chelate) 100mg. Take 2 capsules at bedtime to promote muscle relaxation and of course this may also require appliances.

Herpes cold sores generally respond well to oral treatments of Valtrex or Acyclovir. I have an alternative topical therapy that can be compounded called Vira Cream (2-Deoxy-d-Glucose 0.19%/ Pramoxine 1%/Diphenhydramine 1%) . The active ingredient is 2-Deoxy-d-Glucose which is found in Alaskan Red Algae and has wonderful healing properties against the Herpes virus. The Pramoxine and Diphenhydramine are combined for their anesthetic properties. This cream not ointment may be applied 5 to 6 times daily. We also make an acyclovir 5%/Lidocaine 2% applied as a lip balm, dispensed in a chapstick applicator.

Varicella Zoster Mouth Rinse also contains 2-Deoxy-d-Glucose and Lidocaine and is useful in the oral cavity and/or throat. Rinse and gargle tid – qid.

PCCA Plasticized Base: This is a great improvement over Orabase as a vehicle. Plasticized Base is a polyethylene and mineral oil base commonly used for topical or oral preparations. It has a soft elegant feel and is completely anhydrous. Plasticized Base is great for water sensitive actives. It is used for topical application.

Please call us if you have any questions.

David can be reached at (831) 758-0976.

Red Flags Rule on the Horizon

By John S. Findley, DDS (President, ADA)

On March 4, representatives of the American Dental Association met by telephone for more than an hour with staff of the Federal Trade Commission (FTC) responsible for implementation of the "Red Flags Rule." That Rule will require all covered entities, including every dental office in America, to put in place a program designed to detect identity theft.

According to the published regulations, each dental office will have to adopt and maintain a written policy for addressing identity theft, train its staff on the policy and follow up on any incident involving suspected identity theft. The Rule is scheduled to go into effect on May 1.

Speaking for the ADA, I urged the FTC staff not to apply the Red Flags Rule to dentists. I pointed out that identity theft is generally not a problem in dental offices and also noted that more

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Red Flags Rule on the Horizon: continued

than 80 percent of U.S. dental practices comprise only one or two dentists. In these circumstances, enforcing the Rule would have very little benefit but would add significant costs to the delivery of dental care.

Apart from the financial burden, I advised the FTC staff that the requirements of the Rule are contrary to the atmosphere that dentists strive to establish in their offices. I made clear that most dentists want to create a friendly environment which helps to promote the doctor-patient relationship. Some of the bureaucratic requirements that are made necessary as a practical matter by the Rule, such as demanding a photo ID from every new patient or checking Social Security numbers, tend to cut directly against that objective.

Fellow ADA representatives also explained the special problems that dentists and physicians will face under the Rule. In particular, they may have to report any suspected identity theft both to the patient whose identity is at issue and to law enforcement officials. Reporting of this nature could raise issues under the HIPAA privacy regulations. Determining how to harmonize the Red Flags Rule with HIPAA requirements in any given case could result in yet more costs for our members in terms both of their own time and in connection with obtaining legal advice.

In response, the FTC staff expressed its intention to enforce the Red Flags Rule with "flexibility." It assured the ADA that it sought only "reasonable compliance." However, I countered that, no matter how reasonable the FTC may be, the Rule still exposes dentists to substantial costs and requires them to take measures that are in tension with the relationship that dentists try to establish with their patients.

For all these reasons, the ADA made a number of specific requests:

- The Red Flags Rule should not be applied to dentists. In this connection, the ADA stressed that many laws have exceptions for small businesses.
- If the Rule is applied to dentists, the FTC should publish formal guidance, including templates that would minimize the costs and other adverse consequences on dental offices.
- At the very least, the effective date of compliance with the Rule by dentists should be postponed until the FTC reconsiders whether the Rule should be applied in dentistry and until the FTC issues guidance that will help to mitigate the effects of the rule on dental offices.

FTC staff made no commitments on any of these requests. However, they promised to get back to the ADA. In the meantime, the Association will continue to work against imposition of needless regulatory burdens on our members.

Dental Administrative Assistant Program

Meeting the Needs of the Dental Community

On Friday, August 21, 2009 at 11:00 am, the first orientation for the start of the new Dental Administrative Assistant Program (DAAP) at Cabrillo College (Aptos, CA) will embark in opening its doors to prepare and train dental front office personnel! Through the combined efforts of Dr. Bridgette Clark, Tom McKay, and Stephanie Leech a (three-year) grant has been received through the states "Workforce Investment Act" via a fifteen percent discretionary fund. The "DAAP" program is considered to be a "capstone" project including didactic, clinical, and work experience requirements for those students participating in the program. Currently, there are no other certificate programs specifically designed for dental front office personnel only in this capacity.

As part of receiving this grant, a market survey will be completed upon completion of the first group of students completing the program, and subsequent classes over the next three years. In order to maintain this grant, a minimum of 18 students will be required to participate in this program as part of the grant study of meeting the employment needs of providing educationally qualified front office personnel.

Currently, the EDD (Employment Development Department) does not have any resources regarding the current statistics of employment needs in this area of training. However, the initial responses received from the surveys sent out to our local dental communities; indicate there is a definite need for training personnel in front office skills.

This is truly an exciting time for those of us involved in beginning this new program! Amongst our resources of teachers involved in this program, Shirley Brush, former general manager for Dr. David Okuji, and Kim Anders (Certified Dentrix Trainer) will be assisting us in developing this program further.

Did you know there is a national certification offered through the Dental Assisting National Board (DANB)? By passing a comprehensive written examination from DANB, specialized certification can be obtained in the area of Certified Dental Practice Management Assistant (CDPMA). For those employees who wish to develop or enhance their current front office skills, especially those clinical dental auxiliaries who wish to be cross-trained and multi-skilled (a great resume builder); we encourage you to attend our first orientation on August 21, 2009.

It is with great honor to be working with a great team of educators in establishing this new program! Dr. Bridgette Clark has worked tirelessly to get this program off the ground to soar to new heights! If you have any interest in serving this program in any way, please contact us!

Respectfully,

Debbie M. Reynon, CDA RDA AA AS
Instructor
Cabrillo College, Dental Hygiene Department
6500 Soquel Drive
Aptos, CA 95003

For more information refer to website: Cabrillo.edu
Dental Hygiene Department Phone: (831) 479-6471
Personal Email Address: alliemae1956@aol.com or (831) 262-8617 cell

Malpractice: A Plaintiff's Perspective

By Edwin J. Zinman, DDS, JD

Translated from Latin, primum non nocere means "above all, first do no harm." This principle is the cornerstone of both dental ethics and tort law principles. A continuing thread, woven through the fabric of dental ethical codes and layers of law, is the fiduciary obligation of the dentist to the patient (Willard v. Hagemeister, 1981). As a fiduciary, the dentist's primary obligation is to protect and preserve the patient's best interests irrespective of the dentist's financial interest. The same fiduciary obligation applies to other professionals such as physicians or attorneys.

By contrast, the business community's interest is often dictated by its stockholders' desire to maximize profits. If not balanced with the protection and preservation of the patients' interests, harm to public health results.

The tobacco industry, for example, recently agreed to a $368 billion dollar settlement of 40 state attorney generals' class actions. The proposed settlement included payments for a multitude of medical injuries caused by profitable sales of a public-health endangering product (New York Times, 1997). Similarly, managed care organizations run the risk of liability for fiduciary failure if only the fiscal, rather than patients' needs, are fulfilled by discouraging needed referrals (Shea v. Esenstein, 1997).

Standard of Care v. Customary Care

The standard of care to which all dentists must adhere is ordinarily established through dental expert testimony. Occasionally the court will intervene and affirm the appropriate standard of care if testifying experts confuse a negligent custom with the legal standard of reasonable care. If an entire industry or profession lags behind what reasonable care is or ought to be, the courts will judicially pronounce the correct standard (Barton v. Owen, 1979). For instance, jaywalking, speeding or not wearing a seat belt is neither legal nor reasonable but instead represents customarily negligent practices. Similarly, absence of full mouth radiographs for a comprehensive dental exam, not probing or recording periodontal pockets and not diagnosing caries susceptibility exemplify negligent customs rather than reasonable standards of care.

Comparative or Contributory Negligence

Fundamental to protection of a patient's rights is the patient's right to a jury trial, which determines the relative responsibilities and obligations of both dentist and patient (see, for example, the California Dental Association Patient Bill of Rights). If the dentist breaches the fiduciary obligation to care for the patient's best dental interest, a finding of professional negligence may result. On the other hand, if the patient's negligence contributes to the patient's injury, the patient's recovery may be denied or reduced in proportion to the relative degree of patient fault.

When compared to a patient who does not follow instructions to brush, floss or maintain recall visits, a dentist who negligently fails to periodontally probe may yet be judged with comparatively less fault, depending on whom the jury decides was a greater cause of the patient's injuries. Thus, the American system of justice contemplates balancing the relative responsibility of dentist and patient. If the patient acts irresponsibly, the civil suit will either be lost or severely compromised, depending upon the comparative degree of any patient irresponsibility. For instance, in most states with comparative fault tort law, if the patient is 40% negligent, but the dentist is 60% negligent, the patient's total damage award is reduced to 40% rather than eliminated entirely (California Book of Approved Jury Instruction, 14.90).

Investigating a Dental Negligence Claim

Since lawyers usually handle dental negligence claims on a contingency fee contract arrangement, the lawyer's fee, if any, is contingent upon achieving a satisfactory out-of-court settlement or jury verdict. 40% of a defense verdict is still zero. The plaintiff's lawyer will have invested time and legal costs to no avail if the case is lost. Therefore, the plaintiff's lawyer screens cases to assess the relative risk of trial success versus failure. Assessment factors follow.

Records: As a practical matter, juries generally conclude that food dentists keep good records and poor dentists maintain poor records. Accordingly, the best defense to dental negligence claim is patient records that document the SOAP (Subjective, Objective, Assessment and Plan) principles of recording as well as any patient failures in oral hygiene, taking prescribed medications or keeping appointments.

Lawyers typically review dental records to not only identify potential defendants as well as subsequent treaters, but also to determine evidence of documented diagnostic or treatment errors.

Negligence: Even if a dental procedure is performed in a technically flawless manner, the dentist may still be liable if the treatment was either unnecessary or lacking adequate disclosure to the patient of the informed consent principles of risks, benefits and reasonable alternatives (California Book of Approved Jury Instructions, 6.11).

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Defense attorneys would rather defend poor records than falsified records. In a poorly documented records case, the dentist may have exercised good judgment, but failed to record findings or recommendations, and may still win the case. Thus, the jury must decide if the dentist's negligence was an oversight in recording, rather than poor judgment. Dentists who create records for litigation, rather than contemporaneously with treatment, lack credibility that proper judgment was exercised. Instead, dental deceit, if proven, subjects the dentists to Dental Board discipline (California Business & Professions Code 1680(S)) and punitive damages. Professional liability insurance defends but does not indemnify for proven fraud, since fraud damages are regarded as evidence of intentional misconduct. Professional negligence insurance policies cover careless mistakes but do not indemnify deliberate deception designed to consciously mislead or misrepresent a patient or misrepresent anticipated treatment results (California Insurance Code 553).

Defenses: Honest mistakes are defensible as a judgment call in which reasonable dentists may differ. Even if only a dental minority would have done what the defendant dentists did, nonetheless such conduct is not negligent, provided it was a reasonable minority school of thought. However, if the members of the contrary school of thought promote a dangerous or controversial methodology, the contrarian school may be unreasonable and therefore represent an unacceptable substandard practice. For example, paraformaldehyde-containing endodontic sealants, cementing an excessively over-contoured but esthetic crown or acquiescing to managed care plans that unreasonably delay or deny referrals represent unreasonable minority schools of thought that, therefore, do not represent a defensible alternative method.

Causation: Despite the dentist's negligence, if no harm resulted, no liability results. If a non-periodontally probing dentist can demonstrate that no worsening of the patient's periodontal disease resulted, despite the absence of recorded pocket measurements, then the failure to probe caused no damage or injury. Conversely, if the radiographs demonstrate progressive bone loss where no pocket measurements were ever done, then the presence of deep pockets implies that, earlier in time, the pockets were shallower. Consequently, periodontitis, had it been treated earlier, would likely have had a better prognosis.

Damages: Prognosis is essential to determine present and future damages. Loss of a single tooth can result in a plethora of damages. If the tooth was unopposed or otherwise non-functional, little damage may have resulted in its loss except for any value as a future abutment, should any adjacent teeth be lost. Maxillary incisor tooth loss is significant, since arguably the patient's proud smile is lost and the prosthodontist usually can not esthetically match God-given natural enamel.

Current treatment costs alone may not be the true or total measure of damages. If a lost tooth is replaced with a bridge, the average longevity of a bridge is approximately ten years. Especially in the maxillary anterior region, due to esthetic matching to adjacent teeth as the patient ages, the esthetic life may be reduced several years from the ten year average longevity for bridges. Accordingly, juries consider present as well as future replacement costs resulting from teeth lost.

Additional damage to be considered are transportation costs to obtain corrective care, lost wages uncompensated by sick leave, the pain of corrective dental procedures and the mental suffering to have undergone corrective care and permanent loss of a vital natural part of one's body caused by another's carelessness.

Mitigation

Dentists often mistakenly believe that the corrective care should be delayed until examined by others, such as delaying removal of defective restoration so peer review examiners can independently examine.

A patient has a legal obligation to mitigate or lessen damages, if reasonable to do so (California Book of Approved Jury Instructions, 14.67). Accordingly, delaying corrective care potentially damages the patient both dentally and legally. Thus, a crown or bridge patient with open crown margins risks decay, endodontics and periodontal disease, unless the crown or bridge is promptly replaced.

Evidentiary Proof

Diagnostic quality radiographs, recorded chart entries documenting chief complaints, differential diagnoses, clinical findings, diagnostic testing, informed consent, recommended therapy and prognosis represent baseline benchmarks for comparison with prior or subsequent care. Some examples of evaluating negligent dentistry follow:

Prosthodontics: Was the crown necessary? Was a radiographic artifact mistaken for decay, which instead required either no treatment or only monitoring and observation (Benn & Meltzer, 1996)? Do radiographs or chart entries of subsequent treating dentists document crowns that have open or short margins, overcontour, closed embrasure spaces, malocclusion or biologic width invasion?

Endodontics: Was the post adequate in length, type and direction? If a perforation occurred, is it also observable in any prior treaters' radiographs? Was pulpal testing done to document necessity for root canal therapy? If endodontics failure occurred, was a substantial contributory cause due to failure to use a rubber dam, short root canal fill or a missed root canal?

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Exodontics: Was the extraction necessary, or should the tooth have been saved by endodontics? If left alone, was the extraction risk greater than retention, such as in the case of an older patient with an asymptomatic impacted third molar? When performing the extraction, did the dentist have available a complete periapical view, or was the dentist operating blind with either no radiograph or a cut off view? Did a new systemic disease affecting the post-operative course recently manifest, which an outdated medical history failed to detect?

Emerging Litigation

Newer technologies and materials require careful study and strict scrutiny of manufacturer's directions before use. Restorative composite materials are technique sensitive and may predispose to increased need for endodontics if improperly used. When safety margins are narrower, opportunities for operator error increase.

Dentists adhering to the standard of care must also adhere to manufacturer inserts. For instance, certain buildup materials require at least two-thirds remaining tooth structure. Thus, failure to follow manufacturer's recommendations exposes the patient to tooth fracture and the dentist to a professional negligence suit, since reasonable dentists usually follow manufacturers' recommendations.

Informed Consent: Representing prognosis for any new material or technique requires the dentist to advise the patient that long-term results are unknown. Even representing the national statistics for a procedure's success may constitute a negligent misrepresentation or even fraud, if the practitioner knows or should know that the dentist's own success rate is poor when compared to the national statistics (Hales v. Pittman, 1978). Stated otherwise, informed consent requires the dentist to advise a patient of all material risks. One material risk that a reasonable patient would want to know is that a greater risk of failure or complications may result with the dentist whose therapeutic track record falls substantially below the national median success rate.

Record Keeping Fraud

Evaluating dental records for assessing the presence of dental negligence analysis requires the evaluating dentist to determine if the records were altered. One hallmark of altered records is that the records appear too good to be true. In this author's experience, added falsified entries in dental records have included (a) additions to an oral surgeon's records advising of post-operative pathological fracture, (b) a general dentist's referral to a periodontist, (c) patient's refusal of recommended radiographs, (d) backdating insurance forms, and (e) post-operative antibiotics following extractions. Altered records expose the dentist to risk of a separate tort termed spoliation (California Book of Approved Jury Instructions, 7.95).

Conclusion

Pursuing only profits rather than patient welfare pushes the liability envelope to the open position. Dentists tempted to increase patient volume by discounting not only fees, but also discounting quality of care, increase the risk of professional negligence litigation if professional quality is also discounted. Patient protection remains the paramount principle that professional negligence suits strive to uphold.

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Dr. Zinman is a periodontist and attorney specializing in dental jurisprudence and personal injury. He is a former lecturer at the School of Dentistry, University of California at San Francisco and practices in San Francisco.

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Technician Certification, What it means & Why you should care

By Ricki Braswell, CAE
National Association of Dental Laboratories

Many dentists are unaware that, in 47 states, dental technicians work without minimum standards and governmental regulation. Most dentists have a reasonable expectation that the professionals who they work with are competent. But how can you be sure? How do you determine competency?

Assessing skill and competency

Dentists use different measures to determine a dental technician's skill. Some consider the fit of the final prosthesis, some consider the function, and still others consider the form—but, most dentists consider all of these. Yet, regardless of the importance of these three variables, they only measure skill, not competency.

A skilled technician has the ability to create a prosthesis with an appropriate look and fit, which are good traits for a restoration. However, a competent technician incorporates those necessary skills with the ability to work with the appropriate materials for the prescribed restoration, the knowledge to critique the process along the way and the means to provide quality control. The competent technician knows not only how a prosthesis is created, but why certain materials are used, and under what circumstances the materials will best perform.

The combination of competency and skill is invaluable to you. Having your reasonable expectations confirmed can only come in one of two forms—either through trial and error on your part or by working with a certified dental technician (CDT).

What is certification?

Currently there are nearly 7,000 CDTs. The CDT designation awards a national certification that meets international standards through the American National Standards Institute (ANSI). Technicians are required to meet prerequisites, including education or an equivalent amount of training, in order to even sit for the CDT examinations.

The certification process is comprised of three tests:

1. A written comprehensive examination that tests the technician's knowledge and broad-based comprehension of all disciplines, including anatomy, vocabulary, occlusion, material science and morphology.
2. An in-depth, written specialty examination on one of the five areas of specialty: crown and bridge, ceramics, partial dentures, complete dentures, or orthodontics.
3. A hands-on practical examination, which tests the technician's skill level and his or her ability to manufacture a specific prosthesis in a sequence and in a predetermined amount of time. This examination tests the technician's knowledge of his or her discipline and knowledge of working with appropriate materials and devices. It also assesses the technician's understanding and recognition of developing successful processes in order to achieve predictable results.

CDTs commit themselves to career-long learning by meeting the requirement of completing 12 hours of continuing education each year, which enables them to retain the knowledge and skills that helped them achieve certification. In addition, certified dental technicians build new knowledge and work to master new techniques to stay ahead of the curve and provide you with the most reliable restorations.

Utilizing a competent, skilled, certified technician can save you time and money. The more knowledgeable a technician is, the more likely it is that he or she will manufacture a quality restoration and select the appropriate materials for long-term wear. This results in fewer remakes and happier patients for you.

Myths about certification

Certification is not the same as licensure or registration. The CDT program is a voluntary certification program that is not required in most U.S. states. The certification of dental technicians is required in Kentucky, South Carolina, and Texas, where certification programs are mandated to provide the dentists with the reassurance that they are working with a competent dental technician.

While other states have considered requiring certification for dental technicians, it is often an emotional topic. Many dental organizations equate mandated certification with licensure or registration and are concerned that requiring dental technicians to become certified will raise laboratory prices or reduce the number of technicians. In fact, neither is the case—the three states that have mandated certification are proof positive.

The primary reason for the emotional response to mandated certification is likely the friction that organized dentistry has had with the dental hygiene profession over the years. Dental technician certification is different for two main reasons: dental laboratory technicians are not seeking to practice dentistry and they are not seeking to work autonomously with the patient without a licensed dentist. Certified dental technicians recognize and respect dentists and their practices, and the vast majority of dental laboratory technicians work in independent dental laboratories and not in a dentist's office.

Although dentists write the prescriptions, many dentists do not specify the materials, leaving it to the discretion of the dental technician. Working with a certified technician is the only way to ensure competency. Certified dental technicians are dedicated to working for you and with you to improve the health and image of your patient. CDTs allow you to save time and money, and they act as a knowledgeable resource on new technology and a wide array of ever-changing materials.

To located a Certified Dental Technician in your area, or a Certified Dental Laboratory which employs a CDT visit www.nbccert.org.

Ricki Braswell, CAE, serves as the co-executive director for the National Association of Dental Laboratories (NADL). Her career in association management began in 1992. Ricki can be reached at Ricki@nadl.org.

Reversal of Dental Local Anesthetics

By Nicolas Veaco, MD, DDS, MS

Overview:

In May of 2008, the Food and Drug Administration approved the use of phentolamine mesylate for the reversal of soft tissue anesthesia caused by dental local anesthetics. The product is sold as OraVerse TM and is supplied as dental cartridges. Each cartridge contains 1.7 ml of solution with a dose of 0.4 mg of phentolamine. The dosage for adults and children weighing more than 30 kg (66 lbs) is one cartridge of OraVerse TM per cartridge of local anesthetic given, up to 2 cartridges or a dose of 0.8 mg. The recovery time of sensation and function is roughly half that of the standard vasoconstrictor containing local anesthetics used in dentistry.

Although the manufacturer indicates that the mechanism of action is not fully understood. phentolamine is an alpha-adrenergic blocker. The alpha-adrenergic receptors of vascular smooth muscle cause vasoconstriction. Alpha blockade would lead to vasodilatation and an increased blood flow in the oral soft tissues more rapidly eliminating the local anesthetic. Both the vasodilatation and the increased blood flow effects of phentolamine have been demonstrated in animal studies. The use of phentolamine injection to reverse the soft tissue anesthesia of local anesthesia works by reversing the vasoconstrictor and therefore is only effective for vasoconstrictor containing local anesthetics. The dental local anesthetics used in the clinical trials were lidocaine 2% with epinephrine 1:100,000, articaine 4% with epinephrine 1:100,000, prilocaine 4% with epinephrine 1:200.000, and mepivacaine 2% with levonordefrin 1:20.000.

The technique is simple. The dentist or hygienist administers the vasoconstrictor containing local anesthetic either as a nerve block or as local infiltration. When dental or gingival anesthesia is no longer required, the injection is repeated with a cartridge or cartridges of the phentolamine solution. Using this technique, about half of the patients will have normal soft tissue sensation and function in an hour or so, others will take longer, but will have a shortened recovery. The recommended dental procedures for local anesthesia reversal are routine restorative and simple scaling and root planing. Patients undergoing these procedures reportedly have no increase in post-procedure pain.

OraVerse TM is not indicated in children younger than age 6. The close for children weighing between 15 and 30kg (33 to 66 lbs) is 0.2 mg or 1/2 cartridge. It is unknown whether or not phentolamine so administered is excreted in breast milk and it is classified as pregnancy category C. In clinical trials, the most common adverse reaction was injection site pain. Other rare, adverse events occurred including tachycardia, bradycardia, headache, post-procedure pain, diarrhea, facial swelling, hypertension, jaw and facial pain, paresthesia, pruritis, abdominal pain and vomiting. Most resolved within 48 hours. Of special note were mild, transient paresthesias which also resolved within a day or two.

Discussion:

While researching the manufacturer's website, novolar.com, OraVerse TM was presented as though dentistry has, at long last, found the solution to a problem that plagues millions of longsuffering patients. In my opinion, dentistry has more probably found a Rube Goldberg solution to something that can be a problem for a few patients. Reuben Goldberg was a cartoonist who created complicated machines that performed simple tasks by convoluted, indirect means. By that I mean patients requiring simple restorative procedures unable to tolerate prolonged soft tissue anesthesia can have those procedures easily completed using local anesthetic without vasoconstrictor, the duration of which would be even shorter. The worst that would happen is that a reinjection is necessary, a situation no different really from the subsequent injection of phentolamine. Certainly in patients undergoing periodontal surgery, endodontic or oral surgical procedures, local anesthesia is part of comprehensive pain management and longer duration of anesthesia is welcomed. I saw no study discussing increased bleeding after anesthetic reversal, but theoretically it is an issue. In my opinion, dentists should not use pregnancy category C drugs on pregnant patients. Also, in my opinion, the benefit of anesthetic reversal does not outweigh any risk for a mother whose child is breast feeding when the easy alternative use of vasoconstrictor free anesthetics is possible. Patients with cardiac arrhythmias and problems controlling blood pressure are probably not good candidates for phentolamine reversal, but neither are they good candidates for the use of epinephrine. Patients that have health issues that might contraindicate anesthetic reversal are also patients for whom vasoconstrictor use should be limited if used at all. So if OraVerse TM is not suggested for surgery patients, patients for whom the use of vasoconstrictor is limited, children under age 6, and pregnant or nursing women. Who might benefit? A patient for whom local anesthesia without vasoconstrictor is insufficient to achieve profound anesthesia or is of inadequate duration undergoing a restorative or simple gingival maintenance procedure who wants the soft tissue effects to resolve in an hour or two instead of three to four hours. Maybe your patient is an auctioneer. A special needs patient who bites his or her lip or tongue would benefit from anesthetic reversal if the use of local anesthesia without vasoconstrictor is not feasible.

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Reversal of Dental Local Anesthetics

Summary:

The FDA has recently approved phentolamine mesylate, OraVerse TM, for the reversal of local anesthetics containing vasoconstrictor used in dentistry. It is simple to use and well tolerated. It is indicated for children ages 6 and older and dosage adjustments are necessary for children between 15 and 30 kg (33 and 66 lbs). It is intended for patients undergoing restorative and gingival maintenance procedures. The author has offered opinions regarding the usefulness of such an agent and favors the use of local anesthetic without vasoconstrictor as an easier, more effective alternative when possible.

This article is intended to introduce the subject of local anesthetic reversal. Each individual dentist is responsible for becoming completely knowledgeable about any drug prior to using it.

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Reversal of Soft-Tissue Local Anesthesia with Phentolamine Mesylate in Adolescents and Adults. Hersh EV, Moore PA, Papas AS, Goodson JM, Navalta LA, Rogy S, Rutherford B, Yagiela JA. JADA 2008; Vol 139, No 8, 1080-1093 OraVerse. Package insert. Novalar, July 2008 www.fOvalaccom/oraverse

"Somehow I can't believe there are any heights that can't be scaled by a man who knows the secret of making dreams come true. This special secret, it seems to me, can be summarized in four C's. They are Curiosity, Confidence, Courage, and Constancy and the greatest of these is Confidence. When you believe a thing, believe it all the way, implicitly and unquestionably."

"I have been up against tough competition all my life. I wouldn't know how to get along without it."

Walt Disney

Peri-Implant Biotype Enhancement

By Nicholas Caplanis, DMD, MS

Following tooth extraction, physiologic wound healing leads to alterations in gingival architecture including alveolar bone resorption, gingival recession and papilla loss. This is especially common in patients with thin periodontal biotypes. These alterations very often compromise tissue morphology and lead to esthetic challenges with implant restorations. Numerous surgical techniques are available to reconstruct post extraction defects. However, the old cliche "An ounce of prevention is worth a pound of cure" very much applies to the extraction defect and all efforts should be made to minimize these morphologic changes. It is technically easier and less costly to preserve the alveolus at the time of tooth extraction as opposed to enhancing it following physiologic remodeling. Therefore, various procedures and materials have been recommended to preserve, maintain and re¬establish ideal gingival architecture. The most common include placement of bone grafts within the extraction sockets, the use of membranes and connective tissue grafts as well as placement of immediate implants.2,4

In addition, patients who seek dental implants to replace failing teeth often present with pre¬existing hard and soft tissue defects which can potentially lead to esthetic disasters if not managed appropriately. These types of clinical conditions are extremely challenging to treat and require ancillary procedures either prior to or concurrent with implant placement to improve the final esthetic result.

Strategies to manage the extraction defect have been previously published which provide algorithms to help guide implant treatment procedures immediately following tooth extraction.3 This article presents three clinical case reports using these guidelines and demonstrates the benefits of using large, thick interpositional connective tissue grafts in conjunction with tooth extraction as during immediate implant placement to enhance the peri¬implant biotype and improve soft tissue architecture.

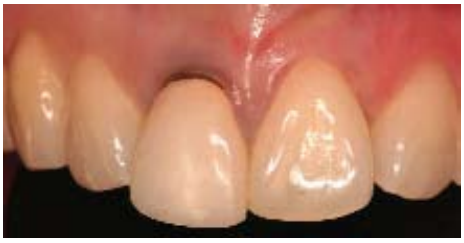

Figure 1A Clinical presentation of failing restoration with recurrent decay tooth #8.

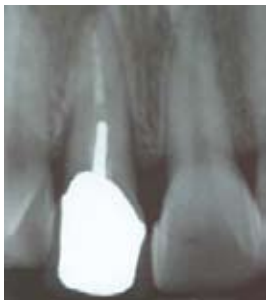

Figure 1B Failing post and core with peri-apical radiolusency.

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Patient 1

A 32 year old female patient presents with recurrent decay and a failing post and core restoration on tooth #8 (Figures 1A¬B). A thin periodontal biotype was recognized as noted by the tapered tooth form and long slender papillae1 and a high smile line further challenges esthetic management. Immediately following extraction, the socket was categorized as an EDS Type II defect3 due to the thin periodontal biotype despite that the bony socket was completely intact. Therefore, a staged implant approach was chosen per published guidelines.3 The extraction defect was grafted with a composite anorganic bovine bone matrix (Bio¬Oss, Osteohealth®) and a demineralized bone allograft.4 A large, thick autologous connective tissue graft was harvested from the palate and placed beneath full thickness buccal and palatal tunnels adjacent to the socket in order to enhance the periodontal biotype as well as to contain the bone graft within (Figures 1c¬d). Vascularity to the soft tissue graft is achieved given the greater graft dimension beneath the tunnel flaps in comparison to the exposed area over the crest (Figure 1C). Approximately 75% of the total soft tissue graft is beneath the full thickness tunnel flaps and therefore no effort is made to achieve primary closure. The soft tissue graft is positioned using buccal and palatal purse string sutures and secured on the crest using a single chris¬cross overlay suture (Figure 1D). The bone and soft tissue graft complex is allowed to heal for approximately 12 weeks prior to implant placement and results in improved soft tissue architecture with an improved biotype (Figure 1E). A flapless surgical technique utilizing a surgical template, is then used to place the implant including the healing abutment, in order to minimize soft tissue recession often accompanied with a conventional incision and flap exposure (Figure 1F). The implant is allowed to heal for an additional 16 weeks and restored with a screw retained single tooth porcelain fused to metal restoration (Figures 1G¬I). An ideal restorative outcome was achieved by the maintenance of the gingival margin and papillae.

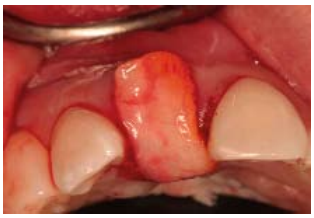

Figure 1C Connective tissue graft draped over the crest, demonstrating large size required for vascularization prior to placement beneath tunnel flaps.

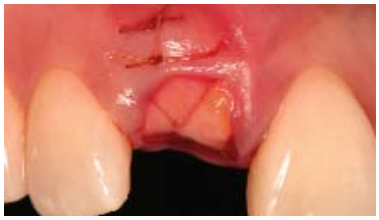

Figure 1D Interpositional connective tissue graft placed over socket graft and secured with sutures.

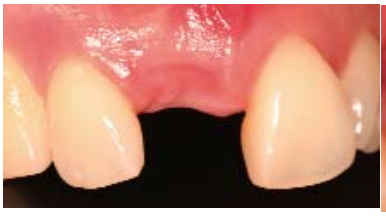

Figure 1E Periodontal biotype enhancement with favorable gingival margin and papilla preservation

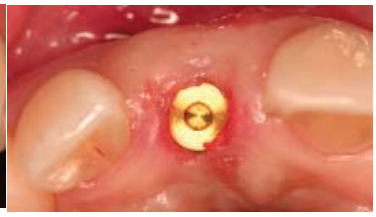

Figure 1F A flapless surgical approach was used to minimize tissue trauma.

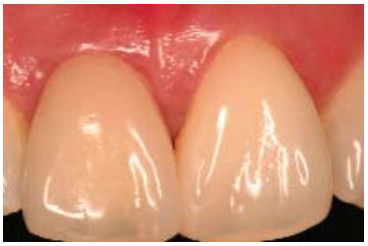

Figure 1G Ideal soft tissue esthetics achieved (restoration by Dr. Glenn Bickert).

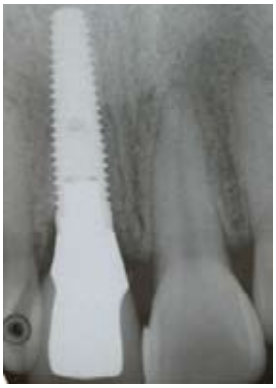

Figure 1H Radiograph of final screw retained, UCLA restoration.

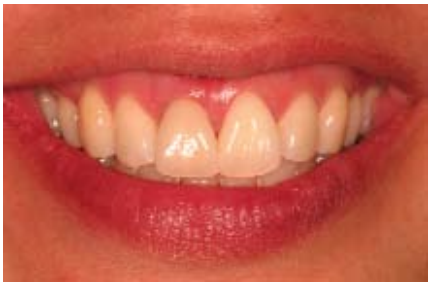

Figure 1I One year post op demonstrating stable results.

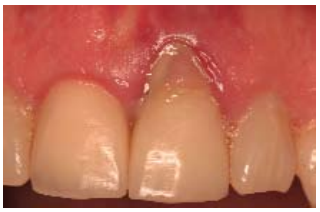

Figure 2A Severe periodontal abscess secondary to root resorption on tooth #9.

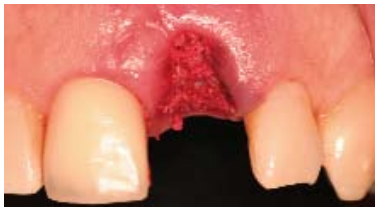

Figure 2B Site preservation using anorganic bone mineral and demineralized bone matrix graft.

Patient 2

A 54 year old male patient presents with a hard and soft tissue deficit associated with a periodontal abscess secondary to root resorption on tooth #9 (Figure 2A). An identical treatment approach was followed as with the previous clinical situation. Immediately following extraction, the socket was categorized as an EDS Type III defect3 due to the more severe buccal bone loss and therefore, a staged implant approach was necessary. The extraction defect was grafted

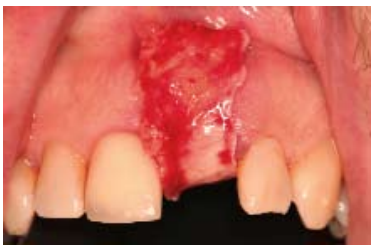

Figure 2C Connective tissue graft draped over the crest, demonstrating large size required for vascularization rior to placement beneath tunnel flaps.

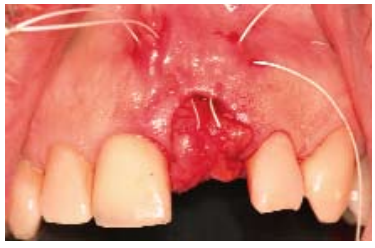

Figure 2D Purse string sutures on buccal and lingual used to position tissue graft through tunnel flap.

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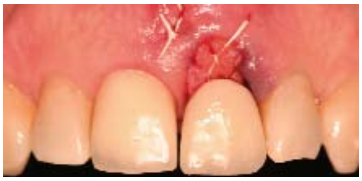

Figure 2E Site provisionalized with removable appliance using ovate pontic.

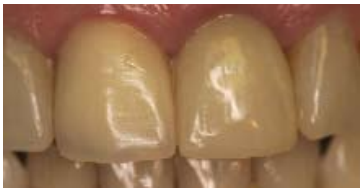

Figure 2G Provisional restoration in place demonstrating reconstruction of gingival margin.

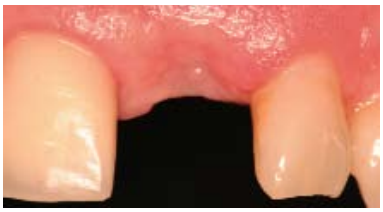

Figure 2F Soft tissue deficit completely repaired in preparation for ideal implant placement.

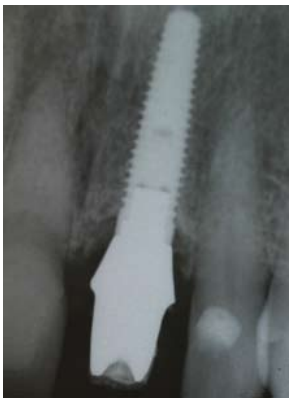

Figure 2H Six month post operative radiograph with provisional in place demonstrating stable outcome.

with a composite anorganic bovine bone matrix (Bio¬Oss, Osteohealth®) and a demineralized bone allograft4 (Figure 2B). A large, thick connective tissue graft was harvested from the palate and placed beneath full thickness buccal and palatal tunnels adjacent to the socket. The great majority of the soft tissue graft is beneath the full thickness tunnel flaps (Figure 2C) in order to promote graft vascularization and the soft tissue graft is positioned and secured as previously described (Figure 2D). A removable partial denture was used as a provisional appliance (Figure 2E) and the bone and soft tissue graft complex was allowed to heal for approximately 4 months prior to implant placement. The site preservation procedure in conjunction with the interpositional connective tissue graft, results in improved soft tissue architecture with complete repair of the pre¬existing soft tissue deficit (Figure 2F). A flapless surgical technique is then utilized to place the implant. The implant is allowed to heal for an additional 6 months and will be restored with a porcelain fused to metal restoration cemented onto a custom lab fabricated abutment (Figures 2G¬H).

Patient 3

A 42 year old female patient presents with a chronic endodontic abscess and buccal fistula involving tooth #10. A thin periodontal biotype was noted along with a high smile line including pre¬existing papilla loss between the central incisors (Figures 3A¬B). The tooth was extracted atraumatically and the socket debrided, irrigated and evaluated with a periodontal probe.3 The extraction defect was categorized as an EDS Type II defect3 due to minor fenestration of the buccal plate. The adjacent socket walls including the buccal crest were otherwise intact; therefore the defect appeared amenable for immediate implant placement in conjunction with ancillary procedures2 (Figure 3C). Following implant placement the residual socket defect was grafted with a composite anorganic bovine

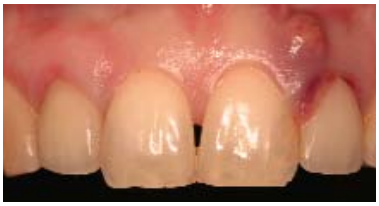

Figure 3A Endodontic abscess with buccal fistula over tooth #10.

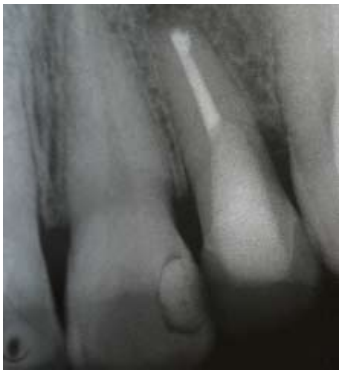

Figure 3B Failing endodontic therapy with peri-apical radioluscency tooth #10.

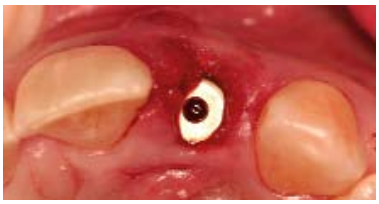

Figure 3C Immediate implant placement following socket degranulation and detoxification.

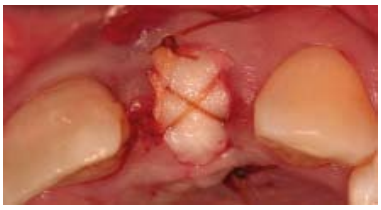

Figure 3D Criss-cross overlay suture secures interpositional connective tissue gaft over crest.

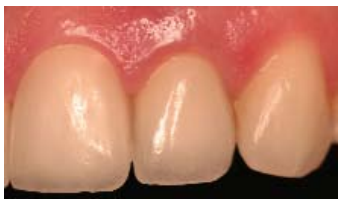

Figure 3E Ideal soft tissue esstheticsachieved

bone matrix (Bio¬Oss, Osteohealth®) and a demineralized bone allograft. Similar to the previous two patients, a large, thick autologous connective tissue graft was harvested and placed beneath the full thickness buccal and palatal tunnels adjacent to the socket as well as over the implant. Once again, vascularity to the soft tissue graft is achieved given the greater graft dimension beneath the tunnel flaps and therefore primary closure is unnecessary. The soft tissue graft is

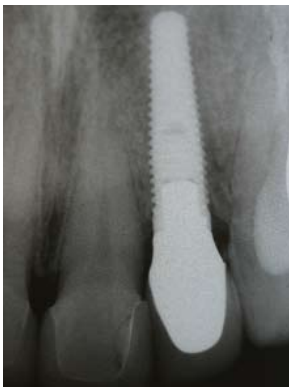

Figure 3F Radiograph of final cement retained implant restoration supported by custom abutment.

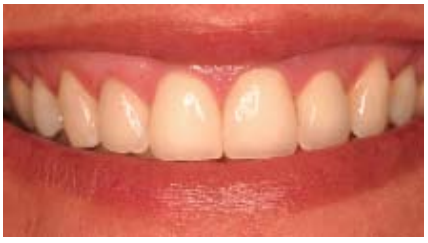

Figure 3G Cosmetic dentistry included anterior porcelain veneers (restoration by Dr. Jon Marashi).

positioned and secured using the previously described technique (Figure 3D). The bone and soft tissue graft complex is allowed to heal for approximately 4 months prior to uncovery. The final restoration of the implant was achieved using a custom gold abutment (Figure 3E¬F) and porcelain veneers were placed on the

continued on page 24

Peri-Implant Biotype Enhancement: continued

maxillary anterior teeth (Figure 3G). An excellent esthetic outcome was achieved. (Restorations by Dr. Jon Marashi San Clemente, CA).

These three clinical situations demonstrate the clinical benefits of incorporating large thick, interpositional autologous connective tissue grafts during site preservation and immediate implant placement surgery. When used appropriately, these grafts vascularize completely, even without complete primary closure. The grafts seem to improve the soft tissue biotype and enhance soft tissue esthetics adjacent to implant restorations by minimizing gingival recession and interproximal papillae loss.

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RM Matters

By Taiba Solaiman
Risk Management Analyst, TDIC

Allowing staff to practice outside their licenses increases liability exposure

"Dentists shall be obligated to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obligated to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction." (ADA Principles of Ethics and Code of Professional Conduct, Section 2.C.)

A serious problem among dental offices occurs when dentists allow staff to practice outside the scope of their licenses. The practice owner is responsible for the actions of all employees. This includes ensuring licensed staff possess and maintain current licenses and that they practice within the parameters of those licenses.

Many practice owners intend to expand their practice not only financially, but also its ability to provide dental services for the community. To do so effectively, the practice must increase its total productivity. This may tempt some dentists to have their staff perform duties for which they are not licensed. Allowing staff to practice a level of dentistry beyond their scope exposes both the dentist and the employee to disciplinary actions by the state dental board not to mention placing patients at-risk. In the event the dentist terminates the employee for refusing to practice beyond his or her scope, this may lead to the employee filing a claim for wrongful termination. If a professional liability claim arises out of a situation where the treatment performed is outside the scope of the auxiliary's duties, the case will be difficult to defend.

An example of allowing a staff person to practice outside the scope of his or her license is delegating hygiene duties such as scaling or root planing to a dental assistant. The dentist often bases the decision to delegate such duties on the dental assistant's experience or skill. He or she reasons that the dental assistant has been practicing for many years and is more than qualified to perform scaling and root planing. While the assistant may have the skills, he or she is not licensed to do so. Dental assistants who have not received the proper training and credentialing to perform hygiene duties are in violation of state dental board regulations. Breaching these statutes may result in disciplinary actions against the dentist and employee in the form of fines, suspension or license revocation.

The dental board defines the allowable duties for all licensed professionals and dictates the type of supervision required while staff performs the duties. These duties may vary from one state to another. For a copy of allowable duties and settings, contact your state dental board. A link to your state dental board can be found on thedentists.com under the Risk Management section.

RM Matters: continued

When delegating tasks to staff:

- Know the scope of practice for each employee under your supervision.
- Do not delegate duties to staff that are not within the scope of their license.
- Do not allow staff to practice without a current license. Require staff to provide you with a copy of their license after each renewal.
- Ensure licensed staff maintains their license by completing continuing education requirements.
- Hold regular staff meetings to discuss the work flow in the office and how everyone is doing as a way to spot check that staff is staying within the scope of their licenses.

If a staff person allows his or her license to lapse, do not allow that person to work in current duties until the license is current again.

Some states mandate posting a list of allowable duties in the dental office. Even if your state does not mandate posting the list, it is good risk management to post a list of allowable duties in a common area such as the break room. Additionally, have a copy on hand for reference if a question arises pertaining to which procedures are permissible for each staff position. If everyone has access to knowing what they can and can not do, the likelihood of someone practicing beyond the scope of his or her license diminishes. For more information or advice on how to handle your particular situation, call a TDIC risk management analyst at 800.733.0634.

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Azael F., MPhT, Scotts Valley

I am a 2nd year dental hygiene student and I think this class would be an excellent class to take for anyone entering the Dental Hygiene program. It is a great overview of the first semester of the DH program. It would prove to be an excellent foundation for anyone interested in the dental field. Also it was a good review for the DH National Board Exam.
Kristy C., Morgan Hill

I really enjoy taking the Dental Terminology class. I've been learning a lot more terms that I have been using in my dental assisting job. I definitely recommend this class to anyone who needs helps or want to learn more about the dental field. LeVon S., Hollister

As a student on the DH waitlist, the Dental Terminology class couldn't be more helpful. It's great preparation for the program and it's a great companion or prerequisite for BIO7 Head and Neck Anatomy, which is a requirement for the program. I find that studying and reading for one course helps me get ahead for the other! Jennifer M., Soquel

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