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NDA JOURNAL

SUMMER 2018

On the Cover

January 01 2018—Governor Sandoval signed AB474 into law. As prescription writing doctors have always understood, this measure will have multiple negative unintended consequences.

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A Bad Rx

AB 474, Nevada's Star Chamber Solution to a Fake News Problem

The Journal has had interest in Nevada's regulatory and legislative dance regarding prescription writing for several years.[1,2] As of January 1, 2018, a serious devolution of prescription writing in Nevada was confirmed by the codification of AB474. After years of training and practice in the safe, effective, and ethical delivery of controlled substance (CS) prescriptions for our patients, many judicious doctors will now choose to opt out of CS prescription writing.

Our Nevada legislators are not the only ones to respond to the siren call of the fake news prescription opioid crisis, which postulates that doctor written prescriptions are a significant etiology in overdose death.

In Utah, Salt Lake County recently joined a cartel involving political entities in 41 other states when it filed suit against drug manufacturers and doctor prescribers[3] because of the fake news prescription opioid crisis. Such moves by overzealous politicians were predictable, and foreseen by many doctors, as legislators began to curtail our CS Rx abilities years ago, a course that ultimately frustrates patients who need these agents.[4] Nevada has been specifically mentioned as a state where doctors have been legislatively forced to deny legitimate patients access to analgesics.[5] Nevada has also jumped on the bandwagon and staked its claim via the popular theory that its ingenuous doctors were hoodwinked by tricky drug detailers.[6]

In California, legislators have been decriminalizing felony drug offenses for years…for non-doctors. Proposition 47 lead to the latest crime without consequences legislation on the left coast. Drug related crime such as diversion by drug dealers is now a misdemeanor level ticket offense, not the felony it used to be.[7] Drug crime by criminals has increased now that there are minimal or no consequences for bad behavior, but the legal hammer still falls solidly on licensed doctors.

Canada's Liberal Party is considering legislation to decriminalize all illicit drugs.[8] Of course, highly trained, law-abiding, and ethical Canadian doctors still need government permission (licenses), subject to sanctions such as revocation of course, to prescribe.

HOW DRUGS ARE CLASSIFIED IN THE US

SCHEDULE	DESCRIPTION	EXAMPLES
Schedule 1	Drugs with no currently accepted medical use and a high potential for abuse. They are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence.	- Heroin - Lysergic acid diethylamide (LSD) - Marijuana (Cannabis) - Methylenedioxymethamphetamine (Ecstasy) - Methaqualone - Peyote
Schedule 2	Drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.	- Combination products with less than 15mg of hydrocodone per dosage unit (Vicodin) - Cocaine - methamphetamine - Methadone - Hydromorphone (Dilaudid) - Meperidine (Demerol) - Oxycodone (OxyContin) - Fentanyl - Dexedrine - Adderall - Ritalin
Schedule 3	Drugs with a moderate to low potential for physical and psychological dependence. Schedule 3 drugs abuse potential is less than Schedule 1 and Schedule 2 drugs but more than Schedule 4.	- Products containing less than 90mg of codeine per dosage unit (Tylenol and codeine) - Ketamine - Anabolic steroids - Testosterone
Schedule 4	Drugs with a low potential for abuse and low risk of dependence.	- Xanax - Soma - Darvon - Darvocet - Valium - Ativan - Talwin - Ambien - Tramadol
Schedule 5	Drugs with lower potential for abuse than Schedule 4 and consist of preparations containing limited quantities of certain narcotics. Schedule 5 drugs are generally used for antidiarrheal, antitussive, and analgesic purposes.	- Cough preparations with less than 200mg of codeine per 100ml (Robitussin AC) - Lomotil - Motofen - Lyrica - Parepectolin

SOURCE: Drug Enforcement Administration — BUSINESS INSIDER

Table 1: Schedules of Controlled Substances. Source Drug Enforcement Agency[11]

Someone needs to advise our Nevada legislators that the licit and illicit CS (Table 1) issues our patients may be experiencing are now officially even worse thanks to AB474. Defining "worse" by the way includes the fact that as legislation that restricts prescription writing is codified, death rates from drug abuse, including suicide from patients enduring intolerable pain, increase.[9,10]

AB474 was foisted onto unsuspecting Nevadans after its political promotion, with the predictable spin from our elected representatives and their dutiful minions about how effective it would be.[12] Unfortunately, as the doctor prescription writers of Nevada always knew, this misguided law will do nothing to mitigate opioid addiction and will in fact exacerbate it as patients see even more legal restrictions on Nevada doctors, legal restrictions which artificially limit safe and responsible prescription writing.

What restrictions? Well, Nevada doctors are now specifically targeted with multiple potential fast-tracked regulatory, civil, and criminal penalties. The term "target" is intentional. At a 2017 CE course about the then proposed AB474 at University Medical Center in Las Vegas, **a course faculty member from Nevada's State Pharmacy Board was asked if it was possible that doctors had morphed from prescription diversion helpers to "targets." After a pause, he replied: "That is true doctor."**

In February 2018, several presentations at the American College of Legal Medicine annual meeting discussed the nationwide aggressive governmental efforts at reigning in the relatively insignificant number of malprescribing doctors. The ACLM review revealed that as far as utter senselessness, Nevada seemed to be second to none within the regulatory milieu.

NDAJ dentist readers might feel a bit grateful relatively speaking, at least compared to our physician colleagues, in that the NSBDE AB474 related Rules and Regulations allow that Dental Board disciplinarians "may" (in other words, also may not) consider mitigating circumstances before applying the full force of the law to licensed dentists. However, that the NSBDE recognizes that a literal interpretation of AB474 is problematic is evidenced by the question NSBDE Disciplinary Screening Officer Coordinator Dr. Rick Thiriot asked the NSBDE recently:

"Does a practitioner need to "obtain" patient medical records or just the patient provided information? AB474 requires the practitioner to "obtain and review a medical history of the patient" and also requires the practitioner to make a good faith effort to obtain and review the patient's medical records from any other provider of health care for the patient. How is this possible for a dentist treating emergency patients for acute pain or trauma on a daily basis when other offices are not required to send the medical records out immediately or over unsecured lines of communication?"[13]

The NSBDE attorney Melanie Bernstein Chapman responded: "AB 474, Section 54 states that the evaluation and risk assessment that is required before issuing a patient a prescription for a schedule II, III or IV controlled substance for the treatment of pain, must include "making a good faith effort to obtain and review the medical records of the patient from any other provider of health care who has provided care to the patient." The statute further states that "the practitioner shall document efforts to obtain such medical records and the conclusions from reviewing any such medical records in the medical record of the patient."

"The Nevada Board of Dental Examiners is aware that a "good faith effort" is not defined in the statute and does not differentiate between dentists and other types practitioners. Further, the statute does not give guidance as to any practical limitations on this requirement. Pending further clarification from the Pharmacy Board regulations and/or future statutory amendment, if any, the Nevada Board of Dental Examiners recommends that dentists make an effort to obtain any medical records or information that impacts the decision to prescribe (or not prescribe) a schedule II, III or IV controlled substance. To the extent that these materials are not available, it is important to document the attempt, the reason for unavailability and the rationale for determination that a prescription is being issued without the pertinent records. As a reminder, regardless of the availability of medical records from other providers, a dentist must always check the patient's PMP report and, if the patient is shown to be receiving the controlled substance from another provider, the dentist should not issue the prescription."[14]

Historically, prior to AB474, the Director of the NSB Pharmacy felt it was reasonable for dentists to not check the PMP before prescribing a CS analgesic after an emergency procedure, for instance an extraction, was completed.[15] This opinion was made in part because it is well known that the PMP frequently contains inaccurate information or is not accessible.

Ms. Bernstein Chapman further elucidated: "Section 60 of AB 474 amends NRS 639.23507(1) to state, in pertinent part, as follows:

1. A practitioner, other than a veterinarian, shall, before issuing an initial prescription for a controlled substance listed in schedule II, III or IV and at least once every 90 days thereafter for the duration of the course of treatment using the controlled substance, obtain a patient utilization report regarding the patient from the computerized program established by the Board and the Investigation Division of the Department of Public Safety pursuant to NRS 453.162.

The practitioner shall:
(a) Review the patient utilization report to assess whether the prescription for the controlled substance is medically necessary; and

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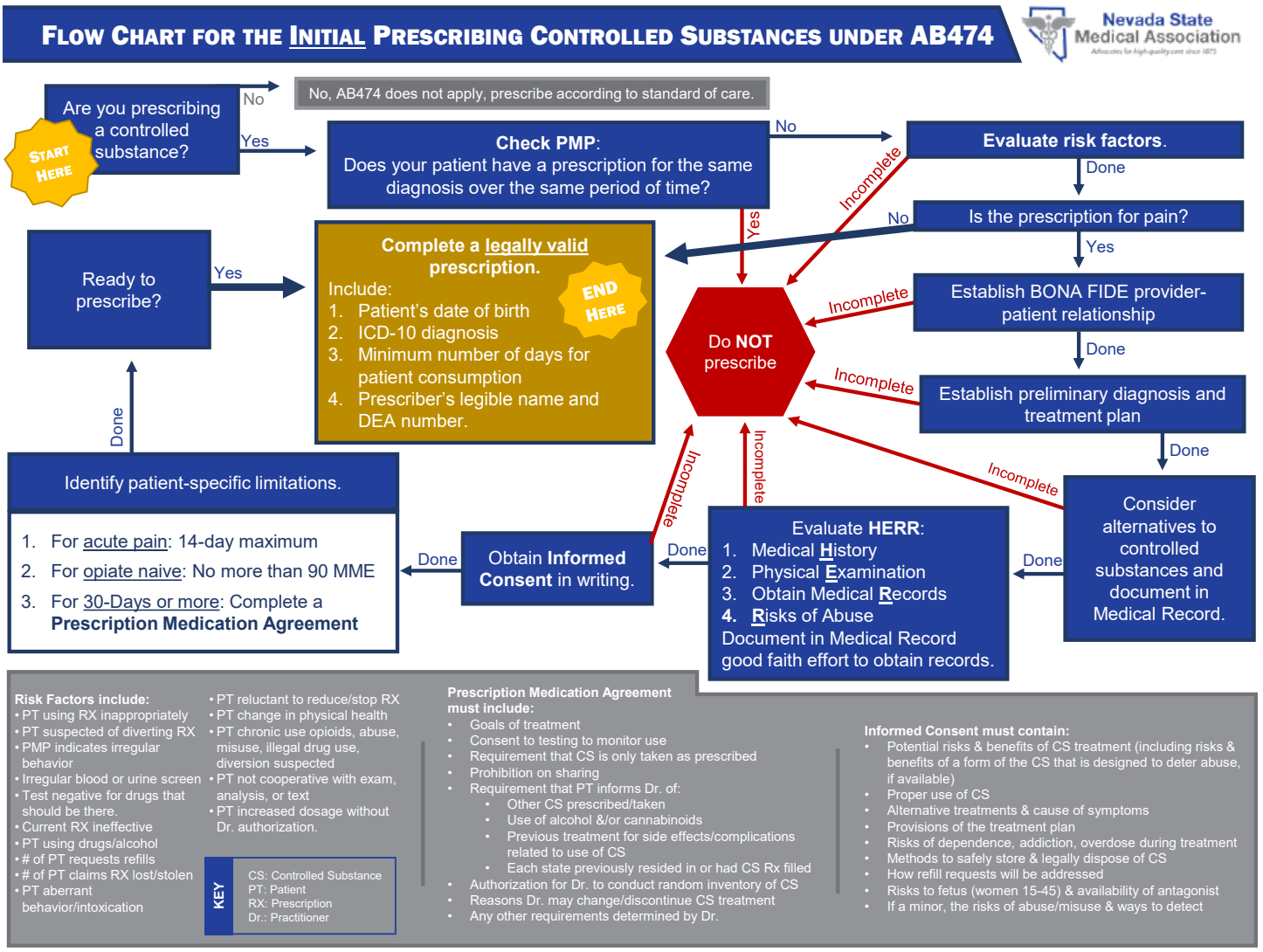

Table 2. NSBME AB474 Flow Chart

(b) Determine whether the patient has been issued another prescription for the same controlled substance that provides for ongoing treatment using the controlled substance. If the practitioner determines from the patient utilization report or from any other source that the patient has been issued such a prescription, the practitioner shall not prescribe the controlled substance.

Please also note that, with respect to your question about the possibility of an inability to access the PMP or correct information on the PMP, NRS 639.23507(2) states as follows:

2. If a practitioner who attempts to obtain a patient utilization report as required by subsection 1 fails to do so because the computerized program is unresponsive or otherwise unavailable, the practitioner:

(a) Shall be deemed to have complied with subsection 1 if the practitioner documents the attempt and failure in the medical record of the patient.

(b) Is not liable for the failure."

On the other hand, the NSBME appears to be developing an AB474 interpretation with a lesser level of reasonableness than the NSBDE. The NSBME Executive Director and Attorney have proposed relatively punitive Rules and Regulations secondary to AB474. The proposed Rules and Regulations have yet to be voted on by NSBME members.

The NSBME has also published a circuitous flow chart that may or may not be particularly helpful navigating the AB474 waters. (Table 2)

As referenced in NRS 639.23507(1) quoted above, there is another group of prescription writers in Nevada dentists should be a very envious of. Veterinarians successfully lobbied to have "human" written into AB474, which excludes their patients that need CS. Obviously, our legislators feel doggies won't be sharing prescriptions with their canine friends. But will they share with their owners? In fact, what is to prevent an owner that desires CS from kicking the dog and then making an appointment with the vet for the puppy's pain? No one would ever do that, correct?

Notice there is no legislative concern for the interminable extra time required to attempt to comply with the law's dozens and dozens of mandates for prescribers with the temerity to continue to try to legally prescribe CS. **It is important to understand that if a prescriber does not comply 100% with the legal requirements iterated in the new law, that prescriber has violated the law.** Further, if a regulatory, civil, or criminal investigator simply feels "good faith" has not been exhibited, the prescription writer will have the opportunity to explain in detail why that opinion is wrong. Statute violation is the best way to subject oneself to not only regulatory intervention, such as the specifically mentioned loss of one's license to practice, but also to further civil and criminal ramifications. When a disgruntled patient shows that a health professional has not complied with the law, the patient likely wins the related malpractice suit. When law enforcement convinces a jury that a health professional has not complied with the law, "beyond a reasonable doubt" becomes much easier to establish.

At least Nevada doctors won't have to worry about fraudulent billing or coding issues[16] because there is no reimbursement code allocated for the extra hours it now takes to attempt to comply with AB474.

Realistically, how much extra time does it take? Well, in the old days, including millennia from Hippocrates prior to January 1, 2018, writing a safe and functional prescription would take less than a minute after a doctor's reasonable evaluation of the patient. The NDAJ informally surveyed the UNLV School of Dental Medicine and found that writing each CS Rx takes at least 20 minutes, which means, for instance, that fewer emergency clinic patients can be seen in the allocated clinical sessions. The NDAJ then checked with Touro University School of Medicine and found that their average CS writing commitment is over 40 minutes.

Recognizing the dilemma dentists now face, Touro University has sponsored free continuing education (CE) CS courses (another requirement of AB474) specifically for dentists. (See page 25) Surreally, **it can now take more time to write a CS Rx than to take the two-hour course, and easily more time than it takes to complete most of our surgical procedures.**

Many have said that, per the actual language AB474, it is virtually impossible to fulfill all the requirements, particularly the subjective requirements, such as a "good faith" review and documentation of all the patient's prior medical records, in any time frame. Again, "good faith" will be evaluated by state apparatchiks who are paid to find noncompliance, for instance with the documented mental health evaluation according to nationally recognized standards and the unrestricted physical examination. How often do dentists identify split S2's during cardiac auscultation? Could dentists attempting to fulfill the requirements of AB474 subject themselves to sanctions for practicing outside the scope of their licensure when doing mental health screens and complete physical examinations?

It is probably safe to say that a handful of daring doctors will donate hours gratis searching the always inaccurate Prescription Monitoring Database (PMP) as part of dutifully trying to comply with that requirement in AB474. Importantly, PMP administrators have admitted that not so subtle changes to the PMP database were implemented to more easily trap suspect CS prescriber/targets.[2]

How likely is it that even one drug addicted citizen will abandon his reliable illicit drug sources to make an AB474 approved appointment for a legal Rx? Answer: not likely.[17] Will previously law-abiding patients consider illegal sources for controlled substances after being faced with the reality of AB474? Answer: yes they will.[18]

How did we arrive at our current dysfunctional prescription writing situation? In the early 2000's the nation witnessed an increase in opioid analgesic prescriptions, as well as increases in addiction, diversion, and fatal overdose.[19] The Centers for Disease Control and Prevention (CDC) noted the pattern and promptly alerted doctors back when we were considered partners in optimizing health care as opposed to our current status as targets. The Drug Enforcement Agency (DEA) and CDC closed multiple "pill mills," effectively solving the problem related to a few rogue doctors.[20] The 2011 peaks of opioid analgesic prescribing and overdose were followed by multiyear sustained declines, which continue today, but have not been publicized by the CDC bureaucracy.[21]

This is not the first time that a politicized CDC has withheld information about politically incorrect data that is contrary to a trendy cause de jour. For instance, from 1996–1998 the CDC collected data on defensive use of firearms as part of its "gun violence research." That information was only publicized this year after being accidently discovered by independent researchers. The hidden CDC studies found that Americans legally use firearms defensively at least 2.5 million times a year[22], saving millions of more lives than are lost secondary to armed criminals working the work of death in any venue, including the killing fields known as "gun free zones" such as educational institutions or health care facilities.[23] The American Dental Association (ADA) Building and the UNLV School of Dental Medicine are fake gun free zones, at least for criminals.[24] And yet, feckless and/or frankly sinister politicians seek to ban law-abiding citizens from exercising their Constitutionally confirmed right to keep and bear arms, a right proven to reduce violent crime more than any other measure.[25] But we digress, back to the denigration of doctors licensed to write prescriptions.

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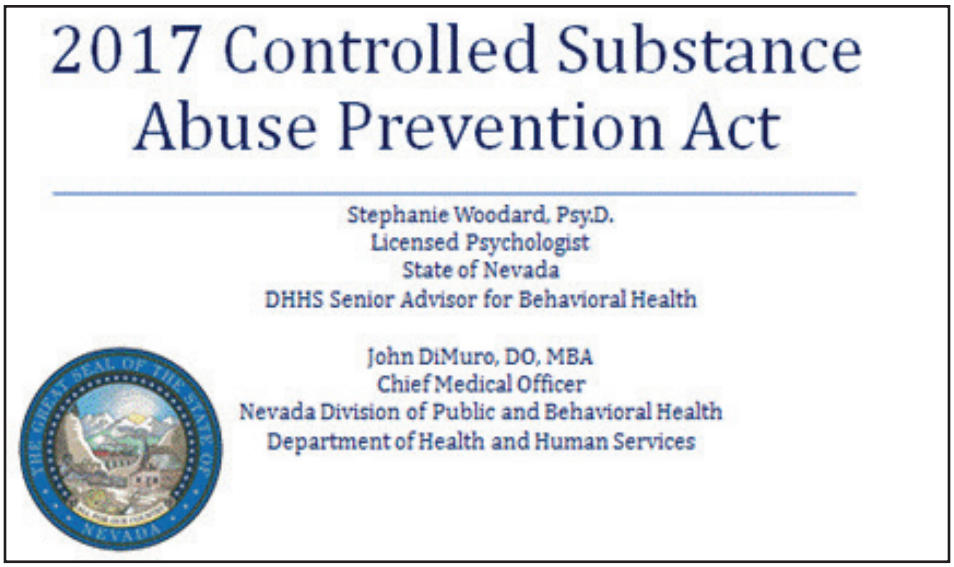
Such politically correct, but dishonest, bias has continued with regard to the illusory overuse of CS prescriptions, especially with regard to dentists. Less than forthright actions by the CDC, DEA,[26,27,28,29] and a sensationalistic media, have intensified barriers for appropriate access to CS for patients in dentistry and otherwise.[30]

The non-partisan Cato Institute opined that: "Regulators are misdiagnosing the opioid crisis as a doctor-patient problem. While raids on black market drug dealers net hauls from an endless sea of illicit drugs, including opioids, legislators accept the myth that the drug crisis is caused by doctors' prescriptions. The numbers show that isn't the case."[31]

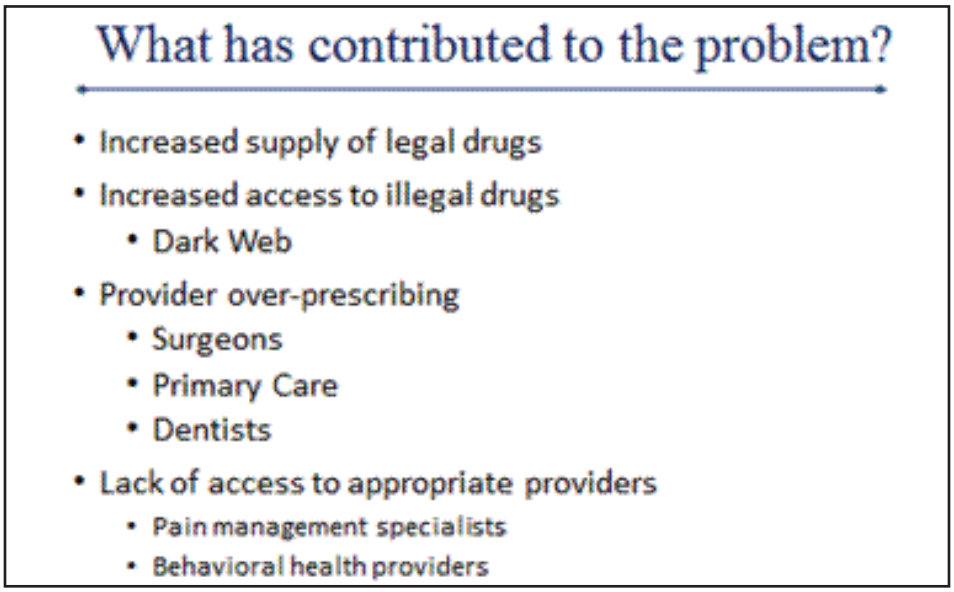
Your Editor knows from personal experience the Cato Institute is correct. In 1989 my brother (Figure 1), a former narcotics detective, helped coordinate the largest narcotics proceeds seizure in California history at that time. In this case a residential home was found to have rooms and rooms, and a garage, full of millions and millions of dollars and massive quantities of illegal drugs, probably more than all the doctors in California could write in a year. That dollars and contraband record has been surpassed many times since 1989. Dear Readers, doctors are simply not the problem.

Further, in spite of information contained in the AB474-promotional power point presentation distributed by the Governor's office, dentists are specifically not the problem relative to other sources in spite of the allegations of Nevada's Senior Advisor for Behavioral Health and former Chief Medical Officer. (Slides 1,4)

Figure 1. Narcotics Detective Orr, Halloween Seizure 1989.



Slide 1: 2017 information distributed by the Governor's Office.



Slide 4: Illusory "Over-Prescribing" Dentists targeted.

Nationally, in 2018 dentists prescribed only 2% of all opioid prescriptions.[33] Here in Nevada, the NDA, led by the research of our Executive Director Dr. Robert Talley, actually evaluated the evidence. Out of 1,500 dentists in Nevada, only two prescribers were identified as "possibly" over prescribing CS. Upon further investigation, no action whatsoever was taken. There simply was not an issue with Nevada dentists as of 2017.

Further further, opioids, and the fake news prescription opioid crisis, are not even the cause of the overdose problem. A study presented for the keynote address of the PAINWeek annual meeting in 2017 revealed that the average number of toxic substances found in overdose victims was 6. Alcohol was present 47% of the time and amphetamines were identified 25% of the time. However, if just 1 of the 6 toxic substances found in the deceased was an opioid, the case was signed out as a "prescription opioid death."[33] We do not have a prescription opioid crisis, but a polypharmacy crisis in non-compliant victims. Polypharmacy

brews include a mixture of legal and illegal agents such as alcohol, amphetamine, cannabis, cocaine, lysergic acid diethylamide, ketamine, fentanyl, heroin, etc. Only a miniscule amount (0.6%) of initial legal prescriptions for CS are misused.[34] The CDC has acknowledged that it is not predictably possible to differentiate between legal and illegal opioids, such as the enormous amounts of fentanyl imported from China,[35] found in fatal overdose.[36]

We are now constantly lectured that studies have shown that various combinations of ibuprofen and acetaminophen are actually superior to opioid based medications. While these studies confirm doctors have analgesic prescription writing wiggle room, there are indeed cases when our patients' acute or chronic intractable pain will not be relieved sufficiently by non-opioid medications… problem not solved. By the way, did our legislators consider the ramifications to our patients' kidneys and livers as they are force fed Motrin® and Tyelenol®? No they did not. Some cardiac patients have been advised to avoid ibuprofen altogether.

Intentional political legerdemain specifically excluded doctors from meaningful input during AB474 machinations, so the Rx morass we find ourselves in is not surprising.

So why in the world are legislators, regulators, and law-enforcement now admittedly targeting doctors in Nevada? Well, which group is easier for legislators, regulators, and law-enforcement to control, government permitted/licensed health professionals or the true bad guys, unlicensed and unregulated drug dealers?

Sadly, as evidenced by the ADA[37] and other professional societies, some doctors can hardly wait to get in line to voluntarily abrogate more and more of our professional privileges and responsibilities by means of our political, regulatory, and criminal justice antagonist betters…none of whom has ever treated a patient or written a prescription.

As explained by Jerry Rogers of RealClearPolicy, legislators need a "boogeyman," some group to blame and from which to extract recompense, during crises…enter the doctors via the fake news prescription opioid crisis.[38]

But, as our elected officials always explain when urgently legislating: "We have to do something!" Too bad for Nevada's patients the AB474 something does nothing to solve the misdiagnosed problem, and actually makes it worse.

We were trained that circumspect prescription writing is a duty we owe our patients. That is not the case in Nevada as of January 1st as our professional privilege and responsibility is now legislated to a tortuous cookbook of rules more suited for technicians.[39,40]

Many responsible professionals have the opinion at this time that it is virtually impossible to comply with AB474, particularly since those judging our prescriptions are our antagonists and are armed with AB474, another political solution looking for a problem.

The question Nevada dentists must ask themselves is if they are willing to risk their licenses to regulatory foes, their assets to civil plaintiffs, and their freedom to criminal prosecutors by trying to comply with the malum prohibitum (bad because we say it is) Catch-22 mandates of AB474. (Table 3)

We can still safely offer our sympathy to patients who will continue to find it much more difficult, if not impossible, to legitimately access prescription based CS pharmaceuticals from doctors in Nevada in a timely fashion. Dear patients, our hands are legally tied. Call your legislators; maybe they will rethink the issue.

Some of the requirements iterated in the now codified AB474 are reviewed in the supplement following this editorial.

The NDAJ appreciates the assistance of Dr. Rick Thiriot, Ms. Shaffer Kugel, and Ms. Bernstein Chapman of the NSBDE for helping the *Journal* navigate a small portion of AB474. In addition, the Journal is appreciative of the NSBDE release regarding Fraudulent Google Reviews contained in this issue. (See page 13.) As always, the Journal thanks its peer reviewers and welcomes comments from NDA members.

Catch-22

1. A problematic situation for which the only solution is denied by a circumstance inherent in the problem or by a rule

2. An illogical, unreasonable, or senseless situation

3. A measure or policy whose effect is the opposite of what was intended

4. A situation presenting two equally undesirable alternatives

Table 3. Catch-22, courtesy of Joseph Heller and Miriam-Webster. [41]

References

1) Orr D, A Good Rx, NV Dent Assn J, 12:2, Summer 2010.
2) Orr D, A Good Rx Redux, NV Dent Assn, 17:3, Fall 2015.
3) Lockhart B, "Enough is enough," Salt Lake County sues pharmaceutical firms, doctors over opioid crisis, Deseret News, 10 APR 2018, https://www.deseretnews.com/article/900015451/enough-is-enough-salt-lake-county-sues-pharmaceutical-firms-doctors-over-opioid-crisis.html, assessed 11 APR 2018.
4) Chambers J, Gleason R, Kirsh, K, et al, An Online Survey of Patients' Experience Since the Rescheduling of Hydrocodone: The First 100 Days, Pain Medicine 2016, 17:1686-1693, https://www.ncbi.nlm.nih.gov/pubmed/26814291, accessed 11 APR 2018.
5) Investigative Report on patients Denied Access to Pain Medicaiton 2014, National Fibromyalgia and Chronic Pain Association, https://www.fmcpaware.org/investigative-report-on-patients-denied-access-to-pain-meds.html, accessed 11 APR 2018.
6) Rindels M, Snyder R, Laxalt files lawsuit targeting Oxycontin maker for "massive deceptive marketing campaign," NV Independent, May 15, 2018, https://thenevadaindependent.com/article/laxalt-files-lawsuit-targeting-oxycontin-maker-for-massive-deceptive-marketing-campaign, accessed 18 MAY 2018.
7) Sandberg E, After Proposition 47: Crime and no Consequences in California, National Review, Jan 30 2018, https://www.nationalreview.

com/2018/01/californias-proposition-47-crime-and-no-consequences/, assessed 15 APR 2018.
8) Kassam, A, Canada's Liberal party considers decriminalization of all illicit drugs, The Guardian, Apr 16, 2018, https://www.theguardian.com/world/2018/apr/16/canada-liberal-party-considers-decriminalization-all-illic-it-drugs, accessed 16 APR 2018.
9) Gutfeld G, Opioids—Facts and Fallacies, Fox News, 25 APR 2018.
10) Kertesz S, The Opioid Crisis and Addiction in Our Society, U of AL School of Medicine, Div Preventive Med, 2017, https://www.uab.edu/medicine/dopm/dr-stefan-kertesz-s-commentary-about-opioid-prescriptions, accessed 30 APR 2018.
11) Jacobs H, Business Insider, May 22, 2016, http://www.businessinsider.com/us-drug-scheduling-system-heroin-marijuana-2016-5, accessed 21 APR 2016.
12) Woodard S, DiMuro J, Sandoval B, 2017 Controlled Substance Abuse Prevention Act, Power Point presentation released by Governor's Office, 2017.
13) Shaffer-Kugel D, email May 17, 2018.
14) Thiriot, R, personal communication, May 16 2018.
15) Orr D, Why We Love Coding, NV Dent Assn J, 20:1, Spring 2018.
16) Pinson L, Letter to the Editor, NV Dent Assn J, 14:1, Spring 2012.
17) Mitchell, CA, From Dark Dens to Suburban Townhouses, J Legal Med, 38:1, APR 2018.
18) Lilly D, Estimating the Actual Death Rate Caused by Prescription Opioid Medication and Illicit Fentanyl, J Am Phys and Surg, 23:1, 20-22, Spring 2018.
19) Rudd RA, Aleshire N, Zibbell JE, Gladden RM, Increases in drug and opioid overdoes deaths-United States, 2000-2014, Am J Transplant 2016:164:1323-1327.
20) Fudin J, Atkinson TH, Opioid prescribing levels off, but is less really more? Pain Med 2014:152:184-187.
21) Fenk SM, Porter KS, Paulozzi LJ. Prescription opioid analgesic use among adults: United States, 1999-2012. NCHS data brief 198, 2015.
22) Doherty B, CDC, in Surveys It Never Bothered Making public, Provides More Evidence That Plenty of American innocently Defend themselves with Guns, Reason, Apr 20, 2018, https://reason.com/blog/2018/04/20/cdc-pro-vides-more-evidence-that-plenty-o, accessed 28 APR 2018.
23) Edeen, J, In the crosshairs: are our hospitals targets for terrorist attacks? Concealed Carry Magazine 2016, https://drgo.us/?p=3480 accessed 18 AUG 2016.
24) Orr, D, Amendment II, NV Dent Assn J, 18:3, Fall 2016.
25) Lott J, More Guns Less Crime, University of Chicago Press, 1998.
26) Federal Register, Jeffery J. Becker, DDS Affordable Care Decision and Order, 77:234, 72387-72408, Dec 5, 2012.
27) Akers, E, Letter to Honorable Kurt Schrader from the Drug Enforcement Administration, May 8 2013.
28) Orr D, Letter to James Arnold and Drug Enforcement Administration, Sep 24, 2016.
29) Cote L, Letter to Demetra Ashley and Drug Enforcement Administration, Nov 13, 2017.
30) Atkinson TJ, Schatman ME, Fudin J. The damage done by the war on opioids: The pendulum has swung too far. J Pain Res 2014:7:265-268.
31) Singer JA, Cato Institute, Misdiagnosing the opioid crisis, Inside Sources, Sep 27 2017.
32) Axeen, S, Seabury S, Menchine M, Emergency Department Contribution to the Prescription Opioid Epidemic, Annals of Em Med, Sep 12 2017, http://www.annemergmed.com/article/S0196-0644(17)31969-8/fulltext, accessed 11 APR 2018.
33) Schatman M, Keynote Address, PAINWeek 2017, Las Vegas, NV. https://www.painweek.org/scrapbook/keynote.html, accessed 11 APR 2018.
34) Brat G, Agniel D, Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study, Brit Med J, 2018:360:j5790, https://www.bmj.com/content/360/bmj.j5790, accessed 29 APR 2018.
35) Tanebaum M, Authorities seize massive amount of Chinese fentanyl on Main Line, Phylly Voice, March 28, 2019, http://www.phillyvoice.com/authorities-seize-massive-amount-chinese-fentanyl-main-line/, accessed 18 MAY 2018.
36) Puja S, Rudd R, Noonan R, Haegerich T, Quantifying the Epidemic of Prescription Opioid Overdose Deaths, Am J Pub Health, April 2018, https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304265, accessed 30 APR 2018.
37) Garvin J, ADA adopts interim opioids policy, Supports prescription limits and mandatory CE, ADANews, Apr 07 2018.
38) Rogers, Jerry, Is the Opioid Crisis Too Complicated for Our Political Elites?, RealClearPolicy, April 12, 2018, https://www.realclearpolicy.com/articles/2018/04/12/is_the_opioid_crisis_too_complicated_for_the_political_class_110593.html, accessed 15 APR 2018.
39) Orr D, Dentistry, Honored Profession or Self-Serving Trade? NV Dent Assn J, 15:1, Spring 2013.
40) Orr D, Dentistry Is _____?, NV Dent Assn J, 10:4, Winter 2008-2009.
41)Merriam-Webster, Catch-22, 12 MAY 2018, https://www.merriam-webster.com/dictionary/catch-22, accessed 23 May 2018.

AB474 Requirements

Before prescribing a CS (II, III, or IV) a practitioner must consider the following factors, when applicable:

1. Whether there is a reason to believe that the patient is not using the CS as prescribed or is diverting the CS for use by another person.

2. Whether the CS has had the expected effect on the symptoms of the patient.

3. Whether there is a reason to believe that the patient is using other drugs, including alcohol, Schedule I CS or prescription drugs that:

- a. May interact negatively with the CS prescribed; or
- b. Have not been prescribed by a practitioner who is treating the patient.

4. The number of attempts by the patient to obtain an early refill of the prescription.

5. The number of times the patient has claimed that the CS has been lost or stolen.

6. Information from the PMP that is irregular or inconsistent or indicates that the patient is inappropriately using a CS.

7. Whether previous blood or urine tests have indicated inappropriate use of CS by the patient.

8. The necessity of verifying that CS, other than those authorized under the treatment plan, are not present in the body of the patient.

9. Whether the patient has demonstrated aberrant behavior or intoxication.

10. Whether the patient has increased his or her dose of the CS without authorization by the practitioner.

11. Whether the patient has been reluctant to stop using the CS or has requested or demanded a CS that is likely to be abused or cause dependency or addiction.

12. Whether the patent has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner.

13. Whether the patient has a history of substance abuse.

14. Any major change in the health of the patient including pregnancy, or any diagnosis concerning the mental health of the patient that would affect the medical appropriateness of prescribing the CS for the patient.

15. Any other evidence that the patient is chronically using opioids, misusing, abusing, illegally using or addicted to any drug or failing to comply with the instructions of the practitioner concerning the use of the CS.

16. Any other factor that the practitioner determines is necessary to make an informed professional judgment concerning the medical appropriateness of the prescription.

Practitioner must obtain a PMP utilization report on the patient before issuing an initial prescription for a CS (II, III, IV) and at least every 90 days thereafter.

The practitioner shall;

- a. Review the PMP report to access whether the prescription for the CS is medically necessary, and

b. Determine whether the patient has been issued another prescription for the same CS for ongoing treatment; if so, the practitioner shall not prescribe the CS.

Each prescription for CS (II, III, IV) must include:

1. DEA number of the prescriber

2. ICD 10 diagnosis

3. Fewest number of days to consume the quantity of CS prescribed; number of refills, and

4. Each state in which the patient to whom the CS was prescribed has resided or filled a prescription for CS II, III, or IV (see AB474 Sec.7€(2); however, this is not required in Sec. 61 of AB474 which amends NRS 639.2353, of the Board of Pharmacy statutes; but it is required in the prescription medication agreement nevertheless)

Before issuing an initial prescription for CS (II, III, IV) for the treatment of pain, a practitioner must:

1. Perform an evaluation and risk assessment which must include;

- a. Obtaining and reviewing a medical history
- b. Conducting a physical examination
  - i. Physical examination is not limited
- c. Make a good faith effort to obtain and review the medical records from other providers who have provided care to the patient
  - i. Practitioner shall document efforts to obtain such medical records
  - ii. Practitioner shall document the conclusions from reviewing such medical records
- d. Assess the mental health and risk of abuse, dependency, and addiction of the patient.
  - i. Using methods supported by peer-reviewed scientific research and validated by a nationally recognized organization.

2. Establish a preliminary diagnosis of the patient and a treatment plan tailored toward treating the pain of the patient and the cause of that pain

3. Document in the medical record the reasons for prescribing the CS instead of an alternative treatment that does not require the use of a CS

4. Obtain informed consent to use a CS for the treatment of pain from:

- a. The patient, if the patient is 18 years of age or older or legally emancipated and competent to give such consent;
- b. The parent or guardian of a patient who is less than 18 years of age and not legally emancipated; or
- c. The legal guardian of a patient of any age who has been adjudicated mentally incompetent

5. The informed consent must include information concerning:

- a. The potential risks and benefits of treatment using the CS
  - i. Including if a form the CS that is designed to deter abuse is available
  - ii. The risks and benefits of using that form
- b. The proper use of the CS
- c. Any alternative means of treating the symptoms of the patient and the cause of such symptoms
- d. The important provisions of the treatment plan established for the patient
- e. The risks of dependency, addiction and overdose during treatment using the CS
- f. Methods to safely store and legally dispose of the CS
- g. The manner in which the practitioner will address requests for refills of the prescription
- h. If the patient is a woman between 15 and 45
  - i. The risks to a fetus of chronic exposure to CS during pregnancy
  - ii. The risks of fetal dependency on the CS and neonatal abstinence syndrome
- i. If the CS is an opioid
  - i. The availability of an opioid antagonist without a prescription and
  - ii. If the patient is an unemancipated minor
    - 1. The risks that the minor will abuse or misuse the CS or divert the CS for use by another person and
    - 2. Ways to detect such abuse, misuse or diversion

For treatment of acute pain, a practitioner shall not prescribe a CS for more than 14 days and if the CS is an opioid or it has been more than 19 days since initial prescription for an opioid, the prescription may not exceed 90 MMEs per day.

If a practitioner prescribes a CS (II, III, IV) for the treatment of pain the practitioner shall not issue more than one additional prescription that increases the dose of the CS unless the practitioner meets with the patient, in person or using telehealth, to reevaluate the treatment plan.

Robert H. Talley, DDS, CAE
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Executive Director's Summer Message

Some of the legislative concerns from members that are being discussed by the NDA legislative committee are: Providing TMJ coverage as a Medicaid benefit, requiring insurance companies to provide a dental loss ratio which would show how much premium is going toward care of the patient, student loan forgiveness for underserved areas in Nevada, adding a time limit for insurance companies to recover funds from providers when they find a patient was not eligible for treatment, requiring all dental consultants to insurance companies to be licensed dentists in Nevada, requiring insurance companies to create web portals for information on eligibility, asking for an increase in the Workman's compensation fee schedule and determining if anything can be done about fictitious reviews on any medical office when the person is not a patient of record at the office. These issues are being discussed thoroughly by the legislative committee and the contract lobbying firm. It will be determined whether each issue can be moved forward and the best way to do so. Then they will be prioritized as we can only bring a few using legislation. Many of these issues might be able to be addressed through adding to bills brought by other entities. We have had some success this way in the past.

We must also be ready to defend against any intrusion into the practice of dentistry such as mid-level provider and dental practice ownership. These are real threats that could come to Nevada at any time.

This brings me to the NDA's new Advocacy Tool. There is no better way to defend against an intrusion like mid-level provider than to get your patients educated, mobilized and on your side in an issue like this. I for one am afraid that members will tend to put off getting their patients signed up for this until the crisis is here and guess what—it might be too late. Please call the NDA office and we will help you with this program. We know a gentle message to your patients about this from you will get them moving to sign up.

I want to say a few words about membership. No matter what you hear from a loud few, membership is up. This is due to some really good work from NDA Membership Committee comprised of staff and members from all the components. There has also been significant help from the ADA. This work will continue and it will take time. Please stay positive.

We must also be ready to defend against any intrusion into the practice of dentistry such as mid-level provider and dental practice ownership.

President's Summer Message

George McAlpine, DDS

I am amazed how fast my year as NDA President has passed. Having been involved with Nevada organized dentistry for almost 20 years, I can say, currently, we seem to be more at odds than at any time in our history! This last year can definitely be described as "interesting times"! We have, historically, always come together, North and South, and worked through any differences we had to do our best to protect our patients and our profession. We all want to be able to pass the torch to the next generation of dentists, often our sons and daughters. Our wish for them is to love the profession as much as most of us do plus be able to make a comfortable living while repaying their considerable school loans. Now, more than ever, is the time for our profession to come together and work for the greater good! I believe we all want the same thing for the dental profession in Nevada although we may differ as to how we get there. It is essential that we continue to recruit our colleagues to join with us to protect and strengthen organized dentistry for current and future generations. If we fail to do this, we will see the continued growth of corporate dentistry, treatment being driven more and more by what insurance companies will authorize and, sooner or later, the addition of midlevel providers to the mix. I do, however, remain optimistic that we can come together and ultimately save our profession.

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Bob Randolph
Corporate Broker

With over 45 years of experience in the Dental Industry, we have the knowledge, experience, and connections to make your dreams a reality. Dental Practice Sales, LLC has been helping to educate, finance and successfully transition Buyer's and Seller's for over 15 years in Nevada. We are the busiest we have ever been with motivated Buyer's and Seller's. We are happy to explain the process and get you on the path to where you want to be.

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ADMC The Academy of Dental Management Consultants

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BULLETIN

FRAUDULENT GOOGLE REVIEWS

The Nevada State Board of Dental Examiners has been contacted concerning recent Google "reviews" regarding at least two Nevada licensees. These reviews have been posted from April 5, 2018 through the date of this Bulletin (April 9, 2018), and may continue into the future. In the instances about which we have been contacted, several reviews are posted under different names within minutes or hours of each other, all give "one star" and all describe alleged dissatisfaction with the practitioner.

Please be advised that it has been confirmed that the alleged reviewers are **NOT** patients of the practitioner being "reviewed" and that no one by any of these names has treated with the practitioner at any time. It is believed that the negative posts submitted during this time frame are **fraudulent** posts generated with the intention of damaging the reputation of the targeted dentist.

We wish to make the dental community aware of these incidents and encourage all Nevada dentists to check their own Google and Yelp reviews for similar posts. If you find that similar "reviews" have been posted about you, and you can confirm that the "reviewers" are not actual patients in your practice, in addition to reporting the posts to Google or Yelp, please also report these instances to the Board as we have an ongoing investigation into these matters.

Should it be determined that these posts were submitted by, at the direction of, or with the knowledge of, any Nevada Dental Board licensee, the Board will take appropriate action.

If you have any information concerning these fraudulent posts, or have any additional questions, please contact the Dental Board office at (702) 486-7044.

Thank you.
The Nevada State Board of Dental Examiners

Outcomes and Impact of Playing Music in Operating Rooms

Is it Time for Clear Standards?

By Joy Phan, BA, OMS-II; Lance Truong, BS, OMS-II; Chutima Phongphua, MD, MPH, MBA

Introduction

Noise has been cited as being distracting to both patients and providers, but is music considered "noise"? Could music actually mask noisy distractions? The ubiquity of music played in the operating room is clear; recent surveys have found that music is played in approximately 53–72% of surgical operations.[1] Newer surgical suites now have docking stations for mobile devices, Bluetooth-equipped wireless speakers, and radios, making it easier for music to be played in the operating room (OR) than ever before.[2]

Studies have shown positive effects of music on patients preoperatively, but there are much fewer studies assessing the opinions of the surgical team regarding the playing of music intraoperatively and the resulting patient safety implications.

The type of music listened to in ORs is not standardized and is largely dependent on personal preferences —music can vary from classical to heavy metal. The decisions of whether music is played or not, what type, and how loud are made by the surgeon, and occasionally, anesthetists. The views of nurses, technicians, students, and others often receive less if any attention.[1] There is evidence to suggest that surgeons significantly benefit from self-selected music, but at what cost? Studies show communication within the surgical team being negatively affected by background music.[3] A hearing-impaired scrub technician was even awarded $100,000 in a settlement involving hospital's failure to reasonably accommodate the employee's requests to turn down the music in the OR.[4]

As healthcare providers, we have a duty to ensure the safety of the patient. To accomplish this, established protocols and circumstances in healthcare must always be examined with the goal of preserving the patient's well-being. In the light of recent studies suggesting that playing music during surgery may both positively and negatively affect the performance of the surgical team, it is necessary to highlight and limit the potential negative effects of music by formally addressing the use of music either as part of 'time-out' before the start of surgery or through future regulations and recommendations.

Methods

We performed a review of publications focusing on the effects of music on members of surgical teams and surgical outcomes. A text search of English language articles and abstracts in the PubMed database was conducted using the words "Music" and "Surgery." Ten articles were included in this review including the World Health Organization (WHO) Surgical Safety Checklist and Occupational Safety and Health Administration (OSHA) Technical Manual.

Results and Discussion

Perspectives on the Issue:

Arguments in favor of music being played in the OR often highlight benefits from the surgeon's perspective: Music has been shown to increase the speed and accuracy of task performance, especially for surgeons.[3] Most of the surgeons (63%) stated that music had a positive effect on staff interaction, 80% claimed music made people calmer and more efficient.[3] Music can have a calming impact on teamwork and is therefore different from other noise considered irritation.[5] Surgeons play music often report doing so to relieve stress, reduce white noise, and enhance performance and concentration during surgical procedures.[6]

Conversely, arguments in opposition of music being played in the OR are often framed from the perspective of other team members within the OR: Anesthesiologists report that music is associated with difficulties communicating and offering a stable level of sedation.[3] In one study, 26% (of surgical staff) felt music reduced their vigilance and impaired communication, 11.5% stated that music might distract their attention from alarms, and 51% declared music was distracting when difficulties and problems occurred.[3] From 2005–2008, the Food and Drug Administration (FDA) reported 566 alarm-related deaths attributed to alarms not being heard by members of the surgical team.[7] Intraoperatively, repeated requests were five times more likely to occur in cases that played music than those that did not. These repeated requests can add between 4–68 seconds each to operation time and increased tension due to frustration with ineffective communication.[1] Additionally, anesthetized patients are at increased risk of Noise Induced Hearing Loss

(NIHL) because the stapedius muscle is paralyzed as a result of anesthetic agents.[2] Recommendations have already been made to safeguard the hearing of patients under anesthesia during dental surgeries and for patients undergoing Magnetic Resonance Imaging (MRI) because of previous examples of exacerbated or acquired tinnitus; by comparison, noise levels in the OR during orthopedic procedures frequently exceed both cases.[8]

Additional Issues to consider:

To date, there are no reported policies prohibiting the playing of music in ORs, leaving the decision at the discretion of the OR staff.[2] Given the dearth of discussion of the subject in current literature, we can begin by examining several basic questions on this issue:

- Should we continue to allow music to be played in the operating room during surgery without patient consent?
- Should consensus be gathered from the members of the surgical team in order to play music during surgery?
- Furthermore, if there is a personal preference by the surgeon to play music in the OR, how can the views of the surgical team as a whole be considered?

It is important to recognize that in answering these questions, a compromise between safety precautions (that protect both patients and providers) and medical team autonomy may still be realized. Failure to address these questions, however, will allow a continued health risk for patients and legal vulnerability for providers and medical institutions to remain.

To start, there exists research to support at least preliminary guidelines in regulating decibel levels. According to Shambo et al. (2015), clear speech requires a 15-dB signal-to-noise ratio from the ambient noise. In some ORs, clear speech required 70 to 80 dB of sound, which far exceeds normal speaking levels of 55 to 65 dB. For safe listening, the OSHA recommends no more than 85 dB for eight hours a day.[9] If music is to be permitted in the setting of an OR, a compromise in the form of decibel restrictions can serve to protect hearing and communication during surgeries.

Because playing music intraoperatively may negatively influence the outcomes of surgery from safety and logistical perspectives, including surgical time overruns and costs. Establishing a process to gain consent from either patient, surgical staff, or both may work not only to improve the safety of patients but

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also to reduce the liability of involved stakeholders. Without certain precautions, it can be argued that playing music intraoperatively is unethical, presents a legal liability, and can negatively influence the performance of the surgical team as a whole by impairing communication and endangering the patient and entities involved in the patient-provider relationship.

Conclusion and Recommendations

Common sense workplace etiquette and legal considerations suggest that music should have volume restrictions and be considered part of the surgical safety checklist.

If music is to be played intraoperatively to help aid performance, the following ethical and logistical recommendations should be considered:

- The patient should provide consent to having music played during their operation.
- There should be consistent monitoring of sound levels within the OR to keep noise within existing Occupational Noise Exposure limits as mandated by OSHA.[9]
- The Joint Commission, the accrediting body for a majority of health care establishments and organizations, should adopt guidelines that add surgical staff music consent as one of the checklist items during 'time-out' to ensure equal representation for all staff.[1,10]

Until the use of music in the operating room is addressed in a formal manner, safety and liability concerns will remain. As such, more medical centers should adopt regulations to facilitate the proper use of music during surgery.

Acknowledgement

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Disclaimer

The opinions expressed in this article do not in any way reflect those of Touro University Nevada.

References

[1] S. M. Weldon, T. Koriakangas, J. Bezemer and R. Kneebone, "Music and communication in the operating theatre," Journal of Advanced Nursing, vol. 71, no. 12, pp. 2763-2774, 2015.
[2] L. Shambo, T. Umadhay and A. Pedoto, "Music in the Operating Room: Is It a Safety Hazard?," American Association of Nurse Anesthestists Journal, vol. 83, no. 1, pp. 43-48, 2015.
[3] D. N. Moris and D. Linos, "Music Meets Surgery: Two Sides to the Art of "Healing"," Surgical Endoscopy, vol. 27, pp. 719-723, 2012.
[4] U.S. Equal Employment Opportunity Commission, "St. John Health System Settles EEOC Disability Discrimination Lawsuit," [Online]. Available: https://www.eeoc.gov/eeoc/newsroom/release/11-18-09.cfm.
[5] Y. Ullman, L. Fodor, I. Schwarzberg, N. Carmi, A. Ullmann and Y. Ramon, "The Sounds of Music in the Operating Room," International Journal of the Care of the Injured, vol. 39, pp. 592-597, 2006.
[6] C. Conrad, Y. Konuk and P. Werner, "The effect of defined auditory conditions versus mental loading on the laparoscopic motor skill performance of experts," Surgical Endoscopy, vol. 26, no. 6, pp. 1347-1352, 2009.
[7] B. Stringer, T. A. Haines and J. D. Oudyk, "Noises in the operating theatres: Nurses' perceptions and potential difficulty communicating," Journal of Perioperative Practice, vol. 18, no. 9, pp. 386-391, 2008.
[8] M. R. Nott and P. D. West, "Orthopaedic theatre noise: a potential hazard to patients," Anaesthesia, vol. 58, pp. 784-787, 2003.
[9] Occupational Safety and Health Administration, "OSHA Technical Manual," [Online]. Available: https://www.osha.gov/dts/osta/otm/new_noise/index.html#standards.
[10] World Health Organization, "WHO Surgical Safety Checklist and Implementation Manual," 2008. [Online]. Available: http://www.who.int/patientsafety/safesurgery/ss_checklist/en/.

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Convicted for Treating Pain

Lessons to Be Learned

By Samuel Nigro, MD

On June 26, 2013, the Cleveland Plain Dealer carried a story headlined "Cleveland Heights Doctor Sentenced to Prison for Selling Painkillers." It tells how I was sentenced to nine months in prison, at age 76, for illegally prescribing painkillers and receiving cash in return. It stated: "He prescribed large doses of painkillers at patients' requests without performing medical treatment or testing. In exchange, he would receive $100–$200 in cash per visit from these patients."

The article states that detectives with the Cleveland police department and Ohio pharmacy board agents began receiving tips concerning my prescribing from several pharmacists and former patients.

The article notes that I pleaded guilty to one count of attempted engaging in a pattern of corrupt activity, one count of tampering with drugs, two counts of attempted drug trafficking, and four counts of trafficking. Besides the jail term, it said I must also pay a $250,000 fine.

Sequence of Events and My Guilty Plea

Beginning about 2004, I began to complain to the Ohio State Board of Pharmacy about pharmacists mistreating my patients by making crude, non-therapeutic remarks; asking inappropriate questions; assuming an arrogant and capricious level of responsibility; and at times refusing to fill my prescriptions. If I were willfully doing anything criminal, I certainly would not have repeatedly complained to the pharmacy board for more than 10 years.

I noticed some improvement in the treatment of pharmacy customers, but inappropriate events still occurred. I was informed that Ohio law gave pharmacists (most with only a high school diploma before their pharmacy school) a level of responsibility equal to that of physicians with respect to prescription drugs—without any documentation of training in patient evaluation and decision making. Pharmacists were found to rely on the Physician's Desk Reference, a book usually containing only the original studies that qualified a medicine to be listed in the PDR, with little to no information about subsequent findings for use of the medicine. Thus, I did not think pharmacists were qualified to be making treatment decisions about the use of medications. Instead, I thought they needed directions on how to handle concerns about filling prescriptions without mistreating patients or slandering prescribers.

I presented my comments, findings, and a proposed "Pharmacy Customer Rights" law to replace Ohio Administrative Code 4749-5 to the Ohio General Assembly, medical groups, and others. About three months after that, my home and both of my offices were suddenly the object of search warrants by the pharmacy board and prosecutor's office, falsely accusing me of running "pill mills" and having $40,000 in cash, among other trumped-up exaggerations. I called my attorney, who advised me to say little or nothing because all would likely be used against me. Fifty counts from nine patients were used, and of the nine, seven had been terminated by me for misuse of medications. Then, again without intervention-like efforts to explore and correct fairly, the state medical board asked for records also, confirming Machiavelli's assertion that power corrupts and metastasizes in government to destroy those who criticize.

Without offering any explanations, clarification opportunities, or fact-finding due process, the State Medical Board of Ohio was apparently co-opted by the pharmacy board into compounding the accusations.

My attorneys, shocked at the application of an obscure law (Ohio Revised Code 4731-21-02) to the extraordinary volume of complaints, told me to retire and surrender my license, which, with a plea bargain, would likely result in a minimal sentence for a 76-year-old man, first offender, with no charges of violence. They said, "You will not have any money left after fighting all this maliciousness. Cut your losses!" My attorneys told me that the police state has arrived and fighting the government is a bad way to end my career, especially since I had been considering retirement for the past five years anyway. Several emphasized that I already was flooded with accusations and would face an extremely costly fight, and extreme punishment if I lost.

After being told that government workers including judges are very sensitive, and generally tend to retaliate for public explanations and complaints, I withdrew a comprehensive explanation to the Ohio inspector general that requested an investigation of the Ohio pharmacy board for "false accusations, malicious prosecution, prevarications, ignoring exculpatory evidence, witness coaching, false evidence creation and retaliation." Self-censorship seems to be required. I felt that the reporters asking for responses were hostile and had already assumed that

I was guilty. The fact that prosecutors make false statements to the press and defendants cannot present facts without adverse consequences is a sign of tyranny.

The aggressive prosecution ignored the mitigating finding that I never earned a criminal dime and that all cash had been recorded and deposited into my corporate bank account. Also given no mitigating influence was the fact that I had terminated all three of the patients used for the initial plea-bargained prosecution, one each in 2008, 2009, and 2010. Hoping to give notice to other physicians, I, ignorant of doing anything criminal, reported the facts of each termination to the pharmacy board and medical board. Yet these were the three cases used to over-criminalize me at sentencing.

Truth and justice are seemingly irrelevant; judges, prosecutors, and investigators take no oath to tell the truth when presenting evidence or communicating with the judge. As David Brock explained, "The Supreme Court has ruled that unsworn statements made to a Court or Congress are not covered by criminal statutes prohibiting false statements."[1]

I found that my attorney's "cut your losses" advice seems to be the current meaning of equality before the law. Believing an attorney's advice should be followed, and being ready to retire, I did retire and then completed the license surrender form to the medical board. There was a plea bargain between my attorneys and the prosecutor, which reduces the work of the prosecutor as the right to expensive jury process is bargained away to reduce the number of counts. As part of the plea bargain, the defendant's speaking out to explain his position likely violates the agreement—but the prosecutors can continue to provide defamatory and inflammatory information as they

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did in my case, even though they had agreed not to do so.

I was told that judges resent being challenged in their planned prejudgements as orchestrated by the prosecution. I am certain the pharmacy board investigator maliciously provided "evidence" to the judge, never presented to me or my attorney but mentioned at sentencing by the judge! I concluded that "plea perjury" is a more accurate description of the proceedings.

Plea bargains generate quick fees and enhance the conviction rate by flooding the court with counts rapidly created to pressure defendants' acquiescence, and then discarded. I understand that 90% of convictions are based on plea bargains now.

In my opinion, plea bargaining should be prohibited as a legal miscarriage or abortion because it excludes the jury and makes a travesty of the concept of being held innocent until proven guilty. Multiplying counts that cannot be proven increases the perception that the accused must be guilty, and serves to coerce him to forgo his right to a jury trial.

At my sentencing, the young new judge, personally touched by the government's continuing reaction against practices previously encouraged, and influenced by the retaliatory magnifications of the pharmacy board investigator, admitted to using me as "an example" beyond objective judicial prosecutorial plea bargain routines. I felt that the judge was being manipulated into non-judicial emotionality by prosecutorial propaganda.

My Medical Practice

I had been in practice since 1961 and full-time psychiatry practice since 1969. Around 2005, after bilateral knee replacements and a terrifying laryngospasm problem, I began to consider retiring, and I cut back somewhat on my practice. I did not accept new patients except for select referrals. However, about that time, a government-supported "Help Pain Medication Patients" initiative occurred. Originating from the White House and Congress, it was named "The Pain Decade 2000–2010" and promoted, among other things, the use of old and new pain medications; added "pain scales" to routine "vital signs"; and required pain assessment in each hospital shift's notes. Also, methadone was released for general use. Naïvely, I felt I should help out—but only with my known patients.

Consistent with unforeseen consequences of laws, by 2008 an opiate epidemic reportedly began, doctors were being falsely accused of misprescribing, and the reaction to the Pain Decade promotions was launched.

Among my 400 chronic polysyndromic atypical medication-dependent patients (not an unusual accumulation over 40 years of practice), there were about 100 who had gone to pain centers for years. About half of them had complained to me that pain centers had become injection sites, getting much more in fees for giving injections than from cheaply prescribing pain medications that worked as well or better. Because this was nationwide, pain patients and their families had organized and implemented the Pain Decade programs. Hearing this from my patients and nurses, I decided to stay in practice without new patients, in order to help my chronic longstanding psychiatric patients remain well, but also to assist those with chronic pain who had repeatedly spoken of their dissatisfaction with their treatment by pain specialists. I did not take any new pure pain patients—only my old patients already on several psychiatric medications. Reasonable successes occurred with a few high-dose patients, who were grateful to be at maximum benefit most of the time by visits to me for all care rather than an expensive, ineffective, or unwanted pain visit elsewhere.

All my 50 pain-also patients (the other 50 remained with their pain specialists because they were content with them) continued on treatment of their chronic atypical anxiety, depression, attention deficit, bipolar disorder, psychotic condition, developmental disorder, and so forth, all reasonably stable on an atypical mixture of medications that were well-tolerated and closely monitored. All I did was add a pain medication effort to what I had been doing for a long time. There was no fee increase or change in frequency of office visits, and I continued to charge $50 to $150 a visit, as I had for years. I did not start a "pain clinic." I just added pain treatment to my evaluation-and-management sessions. Some higher dosing occurred, consistent with patient need and variability. These patients had all failed routine dosing and care for years from pain specialists.

Naturally, a few drug abusers/drug seekers were identified and terminated as patients. I was surprised and grieved by the need to terminate about 15 of these longstanding patients, nine of whom were used by the pharmacy board to attack me. I am certain that at least one, caught selling, turned against me to mitigate any charges against himself, for he had made veiled threats against me when I discharged him.

Unfortunately, having prescribed only propoxphene (Darvon) for pain for 40 years, I overlooked Ohio Revised Code 4731-21-02 on utilizing stronger drugs for treatment of intractable pain. The law was effective in 2008, after a prior more limited promulgation in 1998, before the pain injection procedures took over. This old, largely ignored law required acute physical examination reports and a pain specialist confirmation of

pain medication dosing every three months. Prescribing without these was "misprescribing" by law, and applicable to most of my chronic atypical patients. Like almost all laws regulating medical care, it was well intended, but quickly became unreasonable because medicine is not an exact science. Giving pain specialists such a semi-monopoly on routine pain medications was unique. The procedures and monitoring used by specialists are not imposed on all physicians in any other area of medicine (not in cardiology, psychiatry, infectious disease, etc.). Routine medications have always been available to all physicians competent to use them. When pain specialists moved to injections, many patients had difficulty getting prescriptions for pain medications, leading to the Pain Decade 2000-2010, which resulted in opiate and drug misuse, which was followed by over-reaction and attack on physicians recruited, as I was, into the original Pain Decade campaign against the inadequate treatment of chronic pain. Nevertheless, I discovered that I had broken the law requiring concurrence with pain specialists' procedures—a law that no one seemed to know about until it was used against me. It was not mentioned in the "Pain Decade" advertising.

No acute physical examination was ever needed for my patients, whose surgery was decades healed. I would never have started pain medications had I known that a pain specialist consultation was required, especially when pain specialists had already failed these patients.

My treatment agreement, signed by all patients, had a "self-termination" section, which states that the patient has terminated me as his doctor if he misuses pain medications. Thus, if any of these patients did misuse my medications for non-medical purposes, they were technically, according to this agreement, not my patients any longer. My attorneys said my contract did not matter.

I have always provided evaluation and management services, of which, as I discovered from original code books, time is the least important component. With that discovery, I developed templates from Medicare guidelines for evaluation- and-management (E&M) codes so that I could comply with the intensity requirements in short periods of time. Time was not a factor for these codes unless formal counseling was involved, and it was not. I was able to see a high volume of patients for psychopharmacologic care. Patients were seen to their satisfaction in an effective, brisk manner appropriate to a physician who knew them well for several years at least, almost all starting before 2008. And no reviewer from Medicare, Medicaid, Workers Compensation, or others ever faulted the absence of law-required pain specialist review in my records.

Apparently, however, the law requires pain-center doctors to judge all others. Also, contrary to common sense, it applies retroactively, requiring evaluations of hundreds of old patients who had been stable on medications for years.

The Oath of Hippocrates

At this time, the Oath is no longer taught and is as dead as the traditional collegiality of the medical profession itself.

The "family" of physicians no longer exists, as many self-righteous mercenary physicians eagerly provide paid testimony against those who were once their "brothers." The concept of looking to other physicians for help and offering help to other physicians when requested is deformed by payment and program factors, which often result in abandonment of patients, especially those who are stigmatized as drug abusers. This is worse than the rejection of AIDs patients 30 years ago. No doubt, drug dealing should be criminalized, but patients do need care that is now being denied. The lack of an intervention process to help rather than destroy allegedly wayward physicians is an outrage symptomatic of a punitive, power- corrupted society, estranged from real treatment, mercy, and forgiveness.

Refusing to divulge information that should remain private, as required by the Oath, is now an anachronism. The 5-year-old movement to electronic records means that documentation as treatment is replacing the Oath's priority of patient as the main object of medical care. Global misappropriation of medical records has created a medical bureaucracy of third-party payers, costing more than $800 billion annually. For the ruling bureaucracy, records now primarily exist to deny payment, control physicians, prevent long-term care—and "document" activity that can later be considered criminal. This inflates cost, violates ethical standards, affects access, is often unreasonable for improperly stereotyped patients, scapegoats medical professionals, is burdensome to say the least, and has made paperwork more important than the patient. The doctor no longer has patients, just medical records—which had better be legally exact. Unlike bureaucratic rules, which may change at a glacial pace, major changes occur every five years in scientific concepts, every three years in medical procedures, and as often as every few days in patients. The law might, just as appropriately, try to regulate the weather.

The massive, corrupt medical-records industry imposes pseudo-medical supervision, including that by medical boards, which no longer primarily protect physicians or patients. Doctors have become mostly indentured servants of the state, which displays spurious, grandiose idealism, almost always counterproductive

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in the long run. Medical boards and pharmacy boards need ethics and professionalism to help correct wayward physicians and patients, rather than the exercise of punitive power reminiscent of Communist China's treatment of dissidents.

Freedom and Independence

If freedom means anything, it means free speech. If independence means anything, it means individuals taking free steps as "a minority of one," as defined by Stanley Milgram[2] in his study on how ordinary citizens could be co-opted by evil by the Nazis and how a minority of one could at times prevent this. My first dissent, on the first nuclear missile submarine, resulted in the prohibition of all evaporating solvents on submarines, no doubt preventing many illnesses. Over the years, many were unhappy with my frequent dissents, but generally all were accepted as the give-and-take of free-spirited citizens living their independence. There was no open personal retaliation until I dissented about the Ohio State Board of Pharmacy.

I have concluded that the only real medical professionals left are independent practitioners belonging to the Association of American Physicians and Surgeons or possibly the Catholic Medical Association. To allow politicians, law enforcement agencies, third-party bureaucracies, and pharmacists to run medicine is to have the ticket agents and baggage handlers fly the plane in which technology is always changing.

One part of the Oath of Hippocrates still applies: the Curse. "If I keep this Oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

Having abjured the Oath, medicine has become a cursed bureaucracy that poorly serves physicians, patients, and society.

Samuel Nigro, MD, is a psychiatrist residing in Cleveland Heights, Ohio. Contact sam@docnigro.com. Article courtesy of the American Association of Physicians and Surgeons.

REFERENCES

1. Brock D. The Seduction of Hillary Rodham. Free Press; 1996:409.
2. Huntoon LR. Sham peer review: the psychology of obedience and social influence. J Am Phys Surg 2012;17:99-101.

Northern Nevada
DENTAL HEALTH PROGRAMS

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Northern Nevada Dental Health Programs/Joel F. Glover, DDS

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FRIENDS OF NNDHP GIFT (can't attend tournament but want to support) **$250**
BBQ LUNCH SPONSOR with foursome.....$2,400
BBQ LUNCH SPONSOR.....$1,800
BREAKFAST SPONSOR.....$1,100
ADDITIONAL GUEST FOR BBQ.....$40
(We welcome spouses/friends/family to join you at BBQ)

EVENT DETAILS

Lakeridge Golf Club
Friday, September 21, 2018

7 A.M. Breakfast & Golfer Check-in
7:45 A.M. Shotgun Start/Tee Time
12:30 P.M. BBQ Lunch, Beer, Raffle Winners & Awards *(est. time)*

Format: Scramble
Mulligans: Available for purchase
(Collared shirt, please. No denim.)

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Controlled Substance Use and Abuse in Nevada - Implementing AB 474

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Approved by the Nevada State Board of Dental Examiners (Course #18-001)

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Wednesday, June 6, 2018 or Wednesday, June 20, 2018

6:00 pm - 8:00 pm

Sign-In Commences at 5:30 pm

PRESENTERS

Joseph Hardy, MD
Associate Professor of Primary Care
Touro University Nevada
College of Osteopathic Medicine

Weldon (Don) Havins, MD, JD
Director and Professor of Medical Jurisprudence
Touro University Nevada
College of Osteopathic Medicine

This live educational course is designed for health care professional prescribers to understand and comply with the new Nevada mandates for misuse and abuse of controlled substances, the prescribing of opioids and addiction. Following this activity, participants should be able to:

- Enumerate the requirements to be completed before prescribing any controlled substance, any controlled substance for treatment of pain, and the use of opioids for the treatment of pain.
- List the new required elements of an informed consent for controlled substances prescribed for the treatment of pain.
- Discuss the elements mandated in a prescription medication agreement.
- Distinguish between prescribing for acute and chronic pain treatment.
- Know options for treating substance abuse disorders.

CME Accreditation and Designation

This Live activity has been reviewed and is acceptable for up to 2.0 Prescribed credit by the American Academy of Family Physicians. AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 credit™toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1. Two (2) hours of Controlled Substance Use and Abuse CME can be claimed for this activity. Attendees should only claim credit commensurate with the extent of their participation in the activity. ***Course evaluations will be collected and CME certificates issued at the end of the program.***

Jessica Beason
jessica.beason@sndsonline.org

SNDS Executive Director's Message

I recently heard an office manager describing her expectation that she gave her staff saying, "When you walk through that door I own your smile." She went on to say she wanted them to leave their personal drama at the door. When I taught dental assisting, I would talk to my students about personal space and that they were invading the patients personal space and that they needed to earn their trust. I'm sure when you were in dental school your instructors spent time talking about how to address the fearful patient. I think we would all agree creating a positive emotional experience is essential in the dental office.

Most of you have probably taken an IQ test but have you ever taken an EQ test? It is probably fair to say that your high IQ helped get you through dental school. I would venture to say that EQ is what will make you stand out as a dentist. Unlike IQ, EQ can be developed. EQ is one's ability to identify, evaluate, control and express emotions. A person with high EQ has a high awareness of self and others. Emotional intelligence is made up of four skills and falls into two categories. Personal competence consisting of self-awareness and self-management and social competence including social awareness and relationship management. Having a better understanding of these areas and having the control to manage them can improve your relationships and your ability to interact with others. These skills are so important that 75% of fortune 500 companies utilize EQ testing before hiring. It appears that how you communicate and collaborate with others is just as important as the other skills you will offer.

Emotional intelligence in the dental office could be the most important tool your office could use. Knowing that emotions are heightened when sitting in a dental chair and having a team that is sensitive to these needs is the social awareness needed to have a successful service model. Your patient can't always identify the quality of your work but I guarantee they will have a very clear understanding of how they were treated. I've seen this first hand from taking numerous calls from patients wanting to make a peer review complaint, I can tell you many of the statements are focused on how they were treated rather than the treatment received.

In the routine and busyness of your day how would you judge your emotional intelligence?

My daughter a seventh grader was telling me the other day how one of her teachers was always grumpy, she went on to tell me that this class was her last class of the day. She also noticed when they had a reverse schedule her first period teacher who is always nice was a little grumpy when she had her at the end of the day. She deduced that having to work with students all day by the end of the day any teacher would be grumpy. This seems to be understandable but does that justify the actions.

How are you and your team at the end of the day? You have had difficult patients, no shows, denied insurance claims and soccer practice to get to at five. Do your patients get the same emotional treatment that they would if they were the first patient? Maybe it is the self-awareness we need at the end of the day that acknowledges

we need to catch our breath and walk into that operatory fresh for that 4 PM patient.

From my experience in the dental office the most important skill your team can poses is emotional intelligence. Have you taken the time to help them develop this? I believe the first step in developing this is an awareness of one's self. I first became aware of emotional intelligence when I took a class on it in business school. I would have your team take a test and share their results with each other. They will have fun learning about themselves and their co-workers and it serves to improve your culture and interaction with your patients.

Resources:
Emotional Intelligence 2.0. Travis Bradberry
Emotional Intelligence for Sales Success: Connect with Customers and get Results. Colleen Stanley
https://www.forbes.com/sites/travisbradberry/2014/01/09/emotional-intelligence/#55d450311ac0

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Joseph Wineman, DMD

None of us is as Smart as all of us

Many of you know I am a retired military officer. As a senior leader in the US Army Dental Corps, I had my share of leadership training and was fortunate to work for some of the brightest and charismatic Army leaders of my time. Leadership in the military is top down driven: "This is my plan, you execute it." That style leadership may work in some organizations in the civilian sector (think Ford Motor Company assembly plant) but usually does not work for a group of diverse people working on a common task (think Zappos). As our local dental society and our practices are surrounded by an increasingly complex and uncertain environment, I feel that I have a great responsibility as the incoming President to lead an increasingly diverse SNDS Executive Committee and transform it into a collaborative team.

Building coalitions and working collaboratively becomes even more important as the local dental grows in complexity and increases its membership. As we look toward building our "bench of future leaders," collaboration is no longer optional. Our local component officers and delegates need to develop this leadership trait to obtain results and hopefully advance into our tripartite leadership positions.

Recently through my LinkedIn connections, I came across a great article by Dan McCarthy.[1] Here are the ten things a great collaborative leader should do according to him.

1. Forget about being the expert and having all the answers. Let's face it, when was the last time you knew everything? We are challenged by our patients who read something about their condition on Google and they know everything. Complex business decisions require the collective input of many stakeholders. Leaders who cling to the old concept of having to be the expert on all things leads to two negative outcomes: burnout and a perception of arrogance from others. You can remain prepared for anything but forget about being "Right all the time." Allow yourself to listen and learn from others.

2. Learn to listen. Active listening is a skill that involves focus, energy, and commitment. Look at the speaker, lean towards them, ask questions. If you want to be open to new ideas and other opinions, listen with your two ears and shut your one mouth.

3. Lead sideways, not just up and down. Leading sideways means being a leader—and sometimes follower—amongst your peers. It means understanding what your peers think is important while looking for ways to help them achieve their goals. Collaboration isn't just about trading favors. It is about looking for ways to combine resources and talents to achieve extraordinary results for the organization that cannot be achieved individually.

4. Build personal relationships. Get to know your fellow leaders personally, when you do it is much easier to build trust, resolve conflicts, and collaborate. Regular coffee, lunch, or discussion over an adult beverage will help lay the foundation for collaboration. Teambuilding events or activities can build relationships in the group or team by allowing everyone a chance to get to know each other better.

5. Establish trust. Trust is built over time and based on many interactions. Every day is filled with opportunities to build or break trust

with fellow members. You have a thousand opportunities every single day to engender or endanger trust. Work hard to win each one of these small but important moments of trust. Remember trust can be destroyed in a matter of a few seconds. Your word is your bond.

6. Keep your commitments. When you walk out of a meeting or end a phone call, and you say you're going to do something, make sure you do it by agreed to deadline. No excuses. Missing deadlines and ignoring others is a surefire way to erode trust and respect. Collaboration requires extra effort to not only do your own work on time but to provide information and resources to somebody else so they can do their work.

7. Embrace diversity. Our target audience for membership has become more diverse. It's easy to collaborate with people who are "PLUs" (people like us). It gets tougher when "PNLUs" (people not like us) are part of the process. However, when you get people with different perspectives together to solve a problem, your efforts will frequently lead to bolder, more creative solutions.

8. Learn the art and skill of asking questions. Asking, instead of telling (see number one) is a great way to engage and involve others. The simple question: "What do you think (insert name here)?" is a great way to get input from your fellow collaborators.

9. Learn to resolve conflict. Collaboration is hard work. When multiple people work together towards a common goal, conflict is inevitable. Conflict is not necessarily bad. Disagreement is not disrespect. Conflict can create the opportunity for others to share their opinions and may lead to a better outcome. If there is no conflict, perhaps you are not collaborating at all.

10. Learn how to make consensus decisions. Involving others in the decision-making process can harness the collective wisdom of talented individuals and gain critical buy-in through ownership of the decision thereby speeding up implementation.

I will do my best to follow these ten tips. I encourage all current and future leaders within our state's dental components to share these recommendations to become a collaborative leader—a leader who can produce extraordinary results by leveraging the collective talent of the entire membership…so all members succeed.

References

1.https://www.thebalancecareers.com/how-to-be-a-collaborative-leader-2275830

Lori Benvin
nnds@nndental.org

News from the Northern Nevada Dental Society

June 1 marks the day we welcome our new NNDS Executive Board members into office and some new faces to the Executive Committee that deserve our thanks for volunteering their time in taking over these leadership roles.

On behalf of the NNDS I'd like to thank those leaders who are stepping down this year. Thank you for your volunteerism and dedication to the NNDS and to your association; Dr. Eric Pendleton, Dr. Ryan Falke, and Dr. Maggie Heinen who has taken on a new role representing Nevada at the ADA level.

We welcome your fellow colleagues to these very important leadership roles and please support them in their efforts this year for the betterment of your profession:

Executive Board
President
Adam Welmerink, DDS

Immediate Past President
Spencer Fullmer, DDS

Vice President
Craig Andresen, DDS

Secretary/Treasurer
Erin (Brosy) Anderson, DMD

Members at Large
Jason Doucette, DMD
Benjamin Brooks, DDS

Executive Committee:
CE/Monthly Dinner Meetings
Nick Anastassatos, DDS, Chair

Temporary Dentist Network
Craig Andresen, DDS, Chair

Northern NV Dentist Health & Wellness
Eric Dean, DDS, Chair

Peer Review
Paul Brosy, DMD, Chair

Emergency Referral Service
Gerald Hansen, DDS, Chair

Chief Delegate Stephen Sims, DMD

Delegates
Troy Savant, DDS
Tom Melendrez, DDS
Ben Salar, DMD
John Eric Cercek, DMD
Aimee Abittan, DMD

Membership Chair
Troy Savant, DDS

New Dentist Committee Chair
Benita Ng, DDS

Give Kids A Smile Chair
Trent Gookin, DDS

NDA Legislative Committee & ADA Delegates
David White, DDS, *Chair*
Maggie Heinen, DMD

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Welcome Newest NNDS Members

Dustin Harrington, DMD – General

Yeganeh P. Jewell, DDS – Orthodontics

Christine Lewis, DDS – General

NNDS President's Summer Message

Spencer Fullmer, DDS, MS
nnds@nndental.org

"Time flies when you're having fun"…the saying holds true for me as my year as NNDS president comes to a close. I feel, however, that this is a beginning for me. I've come to appreciate the NNDS, NDA, ADA, and organized dentistry as a whole.

From my earlier days in dental school, I knew that I would want to be involved in organized dentistry, but it wasn't until moving to Nevada and becoming a tripartite member that I really gained my appreciation for these organizations. They are not just important; they are quite literally our life-blood. From researching products for the safety of our patients to creating standards of care and recommendations for patients and providers to promote increased oral health in communities, state, and country. Importantly, the NNDS helps us network as dentists to look out for each other, and mentor new incoming dentists. Legislatively our profession is protected and defended by these organizations. I could go on and on!

My message today is short and sweet…organized dentistry is strong! I'm grateful to be a part of it, and I pledge to support it as best I can, moving forward. If any of you are "on the fence" about becoming a member of these organizations, or would like to become a leader…please call me, I'd love to share with you why I feel these organizations are so great. Warmest regards.

NNDS Executive Director's Message continued

Mario Gildone Lifetime Achievement Award Selection Committee
Nick Furchner, DDS, Chair

Northern Nevada Dental Health Programs
Greg Pisani, DDS, President
Joel T. Glover, DDS, Vice President
Gilbert Trujillo, DDS, Secretary
Robert Barone, Treasurer
Tom Myatt, DDS
Kathy Peak
Arnie Pitts, DDS
David Russell, Esq.

We have some great continuing education and dinner meeting opportunities lined up again this year to include top-notch presenters and topics for all dentists and dental teams with significant discounts for our valued members. Watch for flyers and notifications in your mailbox, email and on the NNDS Facebook. If you are not receiving these notices please check your spam folder or contact the NNDS directly at nnds@nndental.org and I will make sure you are added.

Finally to all our NNDS members only, we will be offering Amalgam Separators bundled at $298; a $900 savings off suggested retail pricing. Watch for information soon!

Surgery First Shows Better Survival than Chemo for Tongue Cancer

For the treatment of cancer, many would consider chemotherapy to be the best option. But for tongue cancer, new research suggests that surgery may be the most effective primary port of call. This is according to a study published in the journal JAMA Otolaryngology Head and Neck Surgery.

According to the American Cancer Society, approximately 36,000 people will have been diagnosed with oral cavity or oropharyngeal cancers, which includes tongue cancer, in the US throughout 2013.

The main treatment options for people with oral and oropharyngeal cancers include surgery (partial or full removal of the tongue for tongue cancer, followed by extensive reconstruction), radiation therapy, chemotherapy, targeted therapy and palliative treatment. These can be used alone or in combination.

But researchers from the University of Michigan Comprehensive Cancer Center, including Dr. Douglas Chepeha of the University of Michigan Medical School, say patient outcomes may be improved if surgery was used as the first treatment option.

"To a young person with tongue cancer, chemotherapy may sound like a better option than surgery with extensive reconstruction," says Dr. Chepeha.

"But patients with oral cavity cancer can't tolerate induction chemotherapy as well as they can handle surgery with follow-up radiation. Our techniques of reconstruction are advanced and offer patients better survival and functional outcomes."

Poor patient outcomes with induction chemotherapy

To reach their findings, the researchers first analyzed 19 patients who had advanced oral cavity cancer.

All of the patients had induction chemotherapy. Patients with a poor response to the chemotherapy then had surgery followed by radiation treatment, while patients whose cancer reduced by 50% had additional chemotherapy in combination with radiation treatment.

Of 10 patients who had a response to chemotherapy, only three had a full response and were free of the cancer five years after treatment.

Of the other nine patients who received surgery following induction chemotherapy, only two were free of the cancer and alive after five years.

The investigators then analyzed a comparable group of patients, all of whom had surgery as their initial treatment followed by radiation therapy. This group saw much better survival rates and functional outcomes, according to the researchers.

The research team says the findings oppose protocols for treatment for laryngeal cancer, in which they say one dose of chemotherapy can help doctors find out which patients respond better to chemotherapy and radiation, and which patients may have better outcomes with surgery.

The investigators note that for laryngeal cancer, induction chemotherapy usually leads to better patient survival and functional outcomes, as discovered by their own previous research. But they say their findings show this is not the case for tongue cancer.

Dr. Chepeha explains: "The mouth is a very sensitive area. We know the immune system is critical in oral cavity cancer, and chemotherapy suppresses the immune system. If a person is already debilitated, they don't do well with chemotherapy.

Despite the proven success of this strategy in laryngeal cancer, induction chemotherapy should not be an option for oral cavity cancer, and in fact it results in worse treatment- related complications compared to surgery."

Medical News Today reported on a study suggesting that people with dental cavities have a lower risk of being diagnosed with head and neck cancer, compared to those with few or no dental cavities.

The mouth is a very sensitive area. We know the immune system is critical in oral cavity cancer, and chemotherapy suppresses the immune system. If a person is already debilitated, they don't do well with chemotherapy.

Event Calendars

Nevada Dental Association

2018			
June 21–23	NDA Summer Meeting	Mandalay Bay Resort	TBA
July 9	NDA Executive Meeting	Video Conference	6pm
August 6	NDA Executive Meeting	Video Conference	6pm
September 17	NDA Executive Meeting	Video Conference	6pm
October 15	NDA Executive Meeting	Video Conference	6pm

Southern Nevada Dental Society

2018			
June 27	Dr. Brian Mantor "Current Bone Augmentation Procedure"	8840 W Russell Rd, Clark, Nevada 89148	6pm–8pm
July 25	Dr. Victoria Woo "Oral Pathology CPC"	8840 W Russell Rd, Clark, Nevada 89148	6pm–8pm
August 22	Dr. Matthew Cox "Endodontic Miscellany"	8840 W Russell Rd, Clark, Nevada 89148	6pm–8pm
October 4	SNDS Community Night	11011 W Charleston Blvd, Las Vegas, Nevada 89135	5:30pm–8pm
October 5	Dr. John Molinari "Infection Control"	TBA	8am–12pm

Northern Nevada Dental Society

2018			
July 10	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
July 17	NNDHP Advisory Board meeting	5605 Riggins Court, #101A, Reno	5:30pm
August 7	NDA Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
August 9	NNDS Open House BBQ Picnic	Bartley Ranch Regional Park, Reno	5pm
September 11	NNDS Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
September 21	Nndhp/Joel F. Glover 16th Annual Charity Golf Tournament to Benefit the Adopt A Vet Dental Program / NNDHP	Lakeridge Golf Club, Reno	7:45am
October 9	NDA Executive Committee Meeting	5605 Riggins Court, #101A, Reno	5:30pm
October 11	NNDS General Membership Dinner Meeting with Ira Victor, "Cyber Security"	Atlantis Casino Resort Spa, Reno	6pm

Obituary

Dr. Joseph M. Hanson passed away May 15, 2018. A native Nevadan, he graduated from UNR and went on to study dentistry at Emory University, receiving his DDS in 1976. He served for 20 years in the United States Air Force Dental Corps and retired as a full Colonel. He then worked for 15 years for the State of Nevada Department of Corrections as well as teaching at the UNLV School of Dental Medicine in the Emergency/Oral and Maxillofacial Surgery clinic. Dr. Hanson was a valued peer reviewer for the NDAJ. Joe had a larger than life personality and enjoyed hunting in his free time. He passed peacefully as Jan, his wife of over 40 years, held his hand. Any donations should be directed to the Nathan Adelson Hospice in Dr. Hanson's name. God bless.

KAREN P. WEST RECEIVES AWARD

Karen P. West, DMD, MPH, dean of the University of Nevada, Las Vegas, School of Dental Medicine, received the American Dental Education Association's premier award—the ADEA Distinguished Service Award—at the 2018 Annual Session & Exhibition in Orlando, FL (March 19, 2018). The ADEA board of directors presents this award when an ADEA member has made an extraordinary contribution to dental education through research, teaching, or service. According to Dr. Leon Assael, ADEA Chair of the ADEA board of directors, "All of us in this room have been helped by the work of Karen West," referring to her long tenure with and varied leadership roles and accomplishments on the Commission on Dental Accreditation (CODA), within ADEA and dental education, as well as her inestimable qualities as a person, and as an academic dentist.

ADMISSIONS AND STUDENT AFFAIRS

The Class of 2018 held its Senior Gala at the Four Seasons on May 9. The 13th School of Dental Medicine Commencement took place on May 11. There were a total of 78 graduates, which brings the number of alumni to 967. Twenty-three percent of graduates are going into specialty or residency programs, or the military. The remaining class members will be going into associateships/private practice in the following states:

Nevada: 30
Texas: 12
California: 7
New Mexico, Utah: 3 each
Oregon: 2
Alaska, Arizona, Hawaii, Connecticut, Florida, Washington: 1 each

We wish them all the best in their future endeavors.

The School also accepted eight students into the second cohort of the Doctor of Dental Surgery program. These four women and men, all of whom originally received their dental education degree outside the United States, are scheduled to graduate during 2020.

Important dates:

Summer Semester Begins
May 14

Application Cycle 2018–19 begins
May 15

ADEA Simulation Course
June 1–2

Summer Semester ends
August 17

Class of 2022 Orientation
September 4–7

Fall Semester Begins
September 10

Class of 2021 White Coat Ceremony
September 28

ADVANCED EDUCATION IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS RESIDENCY PROGRAM

This semester, the school graduated six residents who successfully completed the Advanced Education in Orthodontics and Dentofacial Orthopedics Residency program, and earned a certificate in orthodontics and a master's in oral biology.

The graduating residents are:

Dr. Vincent Khang

Dr. Satya Nayak

Dr. Anh Nguyen

Dr. Amy Tam

Dr. Suzanne Wen

Dr. Adam Whiteley

Three of the graduates will be practicing in California; one in Hawaii; one in Texas; and one in North Carolina.

FACULTY NEWS

UNLV School of Dental Medicine and UNLV Military & Veteran Services Center received the $10,000 first-place prize in the NV Energy Foundation's "Power of Good Giveaway" competition. More than 110 nonprofits statewide that support active duty military or military veterans participated in the contest. Nevada residents voted to determine the top three organizations in the northern and southern regions. The dental school will use its half of the award to support the Sgt Clint Ferrin Memorial Veterans Dental Clinic, which serves the dental needs of underinsured and uninsured veterans.

Dr. Antonina Capurro created the Medical Miles for Rural Smiles program that provides residents of rural Nevada towns much needed dental services and immunizations. Earlier this spring, Dr. Capurro and her team provided care to residents in Pahrump, Tonopah, and Goldfield.

The Las Vegas Review-Journal ran a video story on its website about Dr. Tina Brandon Abbatangelo that touched on her role within the dental school, her work with the Peter Emily

Foundation, her Ms. Nevada crown, and her new children's book.

FACULTY PUBLICATIONS

Faculty within the departments of Biomedical Sciences and Clinical Sciences published seven articles and accepted five presentation invitations since last noted in this journal.

STUDENT RESEARCH

Student research yielded 19 published abstracts, 19 presentations during the school's Student Research Day, and 15 presentations during the annual American Association for Dental Research meeting.

Students mentored in research:

DMD Students: 52

PROMOTIONS/FACULTY RECOGNITION AWARDS

Dr. Christina Demopoulos received the "Community Partner" award from Acelero Learning for her commitment and advocacy to children, families, and Acelero Learning Clark County Head Start programs. Dr. Demopoulos also received the Las Vegas Morning Blend and America First Credit Union "Give Back" award for her community engagement and her role as a foster parent.

Dr. Robert Lockhart received the American Academy of Periodontology's 2018 Outstanding Teaching and Mentoring in Periodontics award, which recognizes an educator who demonstrates a commitment to excellence in providing education in the full scope of clinical periodontics, and relays that enthusiasm to students.

COMMUNITY SERVICE REPORT

UNLV School of Dental Medicine had a very productive start of the new year with community outreach events. From January 1, 2018 to April 30, 2018, the community outreach team offered just over 950 screenings and 726 dental sealants to underserved patients in Nevada. The team also provided over 850 applications of fluoride varnish. With the assistance of dental students, they offered oral hygiene instruction to almost 12,000 students. The school's newest project, the Early Childhood Caries Prevention Project (ECCPP), reached patients in Clark, Lyon and Washoe counties. The ECCPP team just returned from a trip across northern NV starting in Elko, NV and ending in Reno, NV. The value of the donated services for this time period was more than $450,000 using an average summary for the ADA fees.

DEVELOPMENT NEWS

To learn more about supporting the UNLV School of Dental Medicine, please contact Nikki Khurana-Baugh at 702-774-2362 or via email at nikki.khurana-baugh@unlv.edu.

Infection Control. October 5, 2018, 8–12 noon. 4 CEU's. Red Rock Resort. Continental breakfast served.
Speaker: Dr. John A Molinari, PhD
Purchase your tickets by calling the office 702-733-8700 Or Visit: https://snds.ticketspice.com/infection-control-ce

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Wells Fargo Practice Finance
888-937-2321 www.wellsfargo.com/dentist

NDA-Affiliated Products

These companies and their products have been evaluated by the NDA and are recommended for use in running your practice. Let us know if you have any feedback or would like to recommend a product or service for affiliation. For a weblink to each company, go to www.nvda.org/affiliatedproducts.shtml.

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TDIC
Professional liability
800-733-0633 www.tdicsolutions.com

NDA Supplies
Save up to 35% on dental supplies
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Wint '18-'19	**Nov 12**
Spring '19	**Feb 13**

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