WINTER 2010–2011

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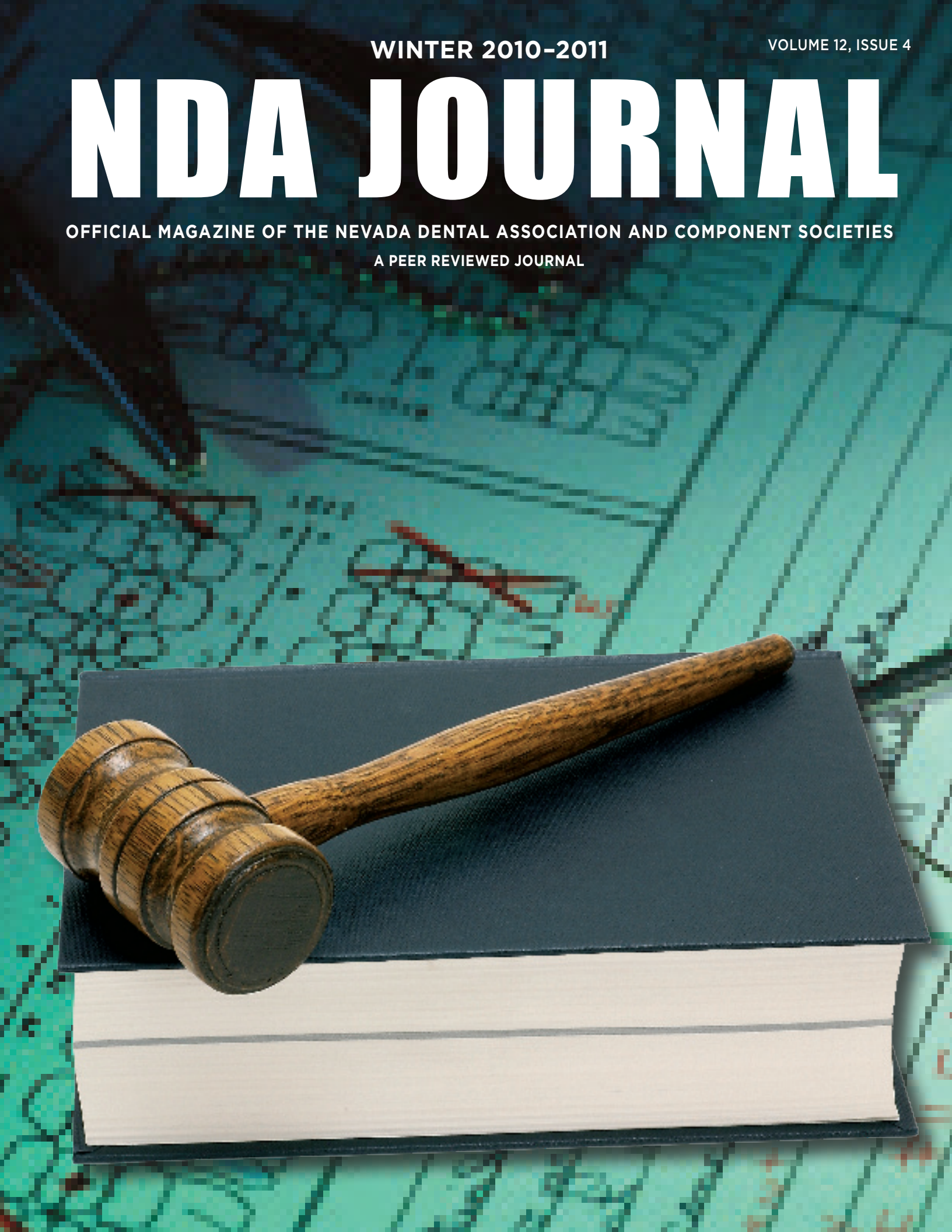

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Mom Always Wanted an Attorney

Actually, she didn't, but things don't always turn out like one plans (aye, do they ever?). Mom was always supportive of all educational goals and encouraging when I shared the goal of becoming a dentist, so inspired after an Eagle Scout career day trip to the USC School of Dentistry. Fortunately, that goal kept me pretty focused in high school and college (teenagers in the 1960's all needed to focus). However, I didn't really enjoy the pre-dental curricula as much as I could have since the "educational" objective was to successfully navigate the highly competitive and pressure-packed path to dental school acceptance. Once we were in, there wasn't any decrease in academic intensity as we all learned to implement dental school survival skills in an effort to not be forced from Mock Board Island. Upon graduation, who doesn't remember the distinctly wonderful feeling that we'd never have to go to school again? Well, one thing leads to another, and after a few years of recovery I found that when I didn't have to go to school, the process was enjoyable, even the examinations. Education of course is something one can keep long after losing just about anything else (money, family, friends, teeth…) except one's mind. Some religious persuasions state that knowledge is something you can take with you even when leaving this mortal sphere.

The sequellae of study can certainly be an asset as far as employment. The first supplemental degree option most dentists seem to discuss or consider is the MBA. At UNLV SDM, undergraduate dental students have the option to earn an MBA concurrently with their dental degree. Frankly, earning an MBA certainly involves gaining information that is extremely worthwhile for the small business dental professional niche. In fact, an MBA is probably the second most valuable supplemental degree option available to dentists.

Some dentists, such as educators or Oral and Maxillofacial Surgeons, often consider earning a supplemental PhD or MD. However, in today's world these options' usefulness overall are still at a relatively lower level.

The most universally valuable credential available today is the JD. As doctors, we can appreciate that it is a safe bet that there will never be universal legal care with the associated layers and layers of government administrators, annual reiterations of more and more confusing billing codes, etc., etc. The ADA and ABA both represent professionals, but besides fighting separate successful battles exempting the groups from Congressional red-flag rules,[1,2] don't have a lot in common. A dentist with a JD has hundreds of additional options that can be considered.

For instance, for Election Day I was asked to be part of the Election Day Operations Legal Taskforce, one of a group of about 30 attorneys (over half were flown in from Washington, DC), assigned to ride a polling place circuit and watch the poll watchers with NRS 293 as our guide. Armed with Incident Report Sheets, Declaration forms, and 800 numbers to the experts, I fortunately didn't note

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any voting shenanigans during my 12 hours. However, I did discover that one of the NV Assembly candidates claimed an NDA endorsement where none was given; this was dutifully reported to the NDA. The pay, besides the joy of helping to defend the right most mentioned in the Bill of Rights, voting, for providing service to the country, state, and NDA, was a submarine sandwich during our training.

At UNLV SDM, the option to earn a JD is now in place. There aren't a lot of dentist attorneys out there, mere hundreds out of the 175,000 dentists in the country. Although dentist attorneys are relatively rare, attorney attorneys are plentiful. There are tens of thousands more attorneys in California alone than there are dentists in the entire country. [3] It has been estimated at the current rate of growth seen in attorney censi, everyone will be a lawyer by the end of this century. And, who would want to take the chance of being the last one so certified?

It is possible to earn a JD while maintaining a private practice. Earning a JD takes a minimum of three years after matriculation. Depending on one's professional and personal commitments, the process could take a decade, but it is certainly feasible.

With all the changes being foisted on dentistry by third parties, wouldn't we all sleep a bit easier knowing that a few more of our colleagues were qualified to speak in a lawyerly fashion about dentistry to non-dentists seeking to direct our activities in one way or another?

Of course not a lot of dentists have the inclination to commit to also becoming attorneys. After all, dentistry is the optimal profession, let alone health profession, to be in. However, for those that want to explore the JD option or just get a flavor of the areas of interest in that niche, Las Vegas will soon host again the annual American College of Legal Medicine (ACLM) Conference. The ACLM has dozens of dentist attorney members and supports sessions dedicated to dental issues. This year's meeting is being held at Planet Hollywood February 25–27. A discounted registration fee has been arranged for NDA members and the dental program is reproduced in this issue of the *Journal*.

Another less intensive legal educational option is to order one of the ADA's best selling resources, *The ADA Practical Guide to Frequently Asked Legal Questions*, released in June 2010: www.ada.org/4355.aspx

This issue of the *Journal* contains an article by ADA Hillenbrand Fellow dentist attorney Quinn Dufurrena, the current Executive Director of the Idaho Dental Association, who formerly practiced in Nevada.

An article posing the option of universal legal care is broached in a work by Matthew Rice, MD.

Endodontist attorney Bruce Seidberg, Past President of the ACLM offers thoughts on dental records.

NDA President Dr. John DiGrazia submitted an interesting article from the Nevada State Historical Society about an 1890s dental legal case in which the Nevada State Dental Law was declared unconstitutional.

Finally, attorney Steve Kern offers his concerned thoughts on the popular "I'm sorry" trends seen in the health professions recently.

Enjoy, and have a judicious day. ◆

Endnotes

1. www.ada.org/3742.aspx/ Accessed 22 Nov 2010
2. www.abanet.org/poladv/priorities/redflagrule/ Accessed 22 Nov 2010
3. www.calbar.ca.gov/AboutUs/BarNumbers.aspx/ Accessed 12 Oct 2010

NDA Executive Director's Message

Robert H. Talley, DDS, CAE
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The 2011 Nevada legislative session starts February 7, 2011. This promises to be a very difficult session in which to safeguard the interests of your profession, your practice and your patients (some call these the 3–Ps). Reasons for this include: Nevada has an estimated 3 billion dollar deficit which will force legislators to make tough decisions that could result in loss of some programs that protect the profession, loss of some dental benefits for your state employee patients, and the legislators may have to introduce new taxes that would be unfavorable to small businesses. Of 63 total legislators in the House and Senate, 23 are new. Your association has a great contract lobbyist and a legislative committee that has been meeting with these new legislators all through this last interim year to educate them on your issues. So, here I am asking you again to do a few things to help us during this session.

Educate yourself as best you can by reading information sent to you by the ADA (ADA News, Legislative updates, CAPWIZ Alerts, etc.) and, of course, anything sent by the NDA as an alert. Armed with this information you become a credible advocate on behalf of yourself and the 3–Ps.

As distasteful as it can be, please read the newspaper and watch the news and help us to not miss anything that might affect the 3–Ps.

Get to know your legislators. Some say the key to success is the 3–Rs. They are relationships, relationships and yes, relationships. If you do nothing else, introduce yourself to your State Senator and Assembly-person. You can go to our website and click on the link to the Nevada Legislature and locate your legislators. Send them a note and let them know you are a constituent, that you are a dentist and that you are interested in issues that affect the 3-Ps.

During the session you may receive emails that urge you to contact your legislators. We do not send these emails to simply clutter your inbox. As best we can we limit our "calls to action" that we send you as we understand that too many emails can turn our members against the process. These calls to action are only sent at extremely critical junctures during the legislative process and only on issues of extreme importance. Honestly, the value of a solid response by the membership to individual legislators is priceless. They do listen to their constituents and they prefer personal communication instead of a "canned" or scripted email. We will always provide talking points for you to use and then ask you to please personalize the communication.

To sum it all up, even in a tough legislative year we can still be successful in protecting our varied interests. By far the most effective weapon in our NDA arsenal remains the well informed, educated members who know their state legislators and are engaged in the legislative process. ◆

NDA President's Message

John C. DiGrazia, DDS

Happy New Year! On behalf of the Nevada Dental Association, I wish each of you, your family and staff, a healthy and prosperous 2011.

Your NDA has been hard at work over the past months laying the groundwork for making 2011 a successful year. Your professional interests have been aggressively represented at both the state and federal levels.

At the annual conference of the American Dental Association in Orlando, Florida, our Nevada delegates to the ADA House of Delegates and I attended a grueling, but productive session. Delegates Dr. Jade Miller, Dr. Dwyte Brooks, Dr. Gilbert Trujillo, and I voted on a host of resolutions that affect ADA long-term policies and membership provisions. One difficult, but unfortunately necessary item, was the passage of a membership dues increase. There were many arguments for and against a dues increase, and there was concern that such an increase would send the wrong message to members. However, an increase was necessary to maintain a healthy reserve for the continued success of the ADA. In addition to the dues increase, the House of Delegates also approved a one-time $23 per member assessment to help finance a technology upgrade to the ADA infrastructure. This upgrade was necessary in order to expand upon the available membership benefits that the ADA offers to us, and we are all excited to see the new technology implemented.

As you are aware, the State of Nevada employee dental benefits will expire in July 2011, which has been a significant concern of the NDA. The loss of a dental benefit plan is the unfortunate result of State of Nevada budget woes. While directed to save state resources, this benefit plan change has the potential to negatively affect many state employees as they may not seek, or may delay, seeking proper dental care. Further, this loss of benefits will likely impact our practices. On your behalf, the NDA has actively outlined the importance of oral health to Public Employees Benefit Board (PEBP) in an attempt to alter the course of this benefit plan change. In October, in a conference call inviting all NDA members to participate, Dr. Robert Talley explained the upcoming benefit plan changes, and shared how NDA members could assist in resolving this problem. Unfortunately, we did not get the response from membership that we had anticipated.

Although the October NDA membership conference call was not as well attended as I would have liked, it was an opportunity for those who did attend to participate first-hand in discussions and analysis of the issues at hand. The conference call forum is an excellent means of bringing many members together in an efficient and economically beneficial forum without having to take significant time from our practices to travel for an in-person meeting. Accordingly, we will be hosting additional conference calls in the future, and I encourage each of you to consider participating in such future conferences. If you did not get an invitation to the October conference call, please contact the NDA office to update your email address. Additionally, please make sure that the NDA is whitelisted on your servers and in your spam settings so that you are sure to receive NDA emails.

The next task for your NDA officers will be the undertaking of strategic planning. In January, NDA officers will host a Strategic Planning Conference with a goal of bringing together all branches of the NDA—including the officers, committees, and members—to develop long and short term goals for our association. I am confident this meeting will result in providing a roadmap for future leaders that will prove invaluable toward enhancing membership value.

I am excited to see many of you at our upcoming NDA meetings—the Mid-Winter Meeting at the Silverado Resort in Napa, CA on February 11–12 and the Summer Meeting at the Grand Wailea Resort in Maui, HI on July 7–9. I was recently informed that ADA President Raymond Gist will be attending the NDA meeting in Hawaii this summer. I hope that all of you consider attending both of the meetings as your participation is an integral part of making your NDA membership a success. ◆

Save the dates for our 2011 meetings!

Mid-Winter Meeting
February 11–12, 2011
Silverado Resort
Napa Valley, CA

93rd Annual Summer Meeting
July 7–9, 2011
Grand Wailea Resort & Spa
Maui, Hawaii

NDA Treasurer's Report

Dwyte Brooks, DMD

Each year at this time our thoughts turn to the holidays, the coming new year and, of course, the NDA Annual Budget. There are many people to tell you about the first two items, but it is up to Dr. Talley and me to tell you about the budget. The NDA has actually had a pretty good year considering that we are surviving in one of the five worst economies in the world (according to the Brookings Institution). For several years our budgeting has been pessimistic about income—frugal on expenses while planning for the worst and hoping for the best. The result has been modest but definite growth in financial stability in an environment where that is difficult to achieve. Our benchmark by which we measure our stability occurs on November 30 of each year since that is the time when our income for the past year is essentially complete and our remaining expenses are minimal and largely known.

Our first notable benchmark is our Reserve Calculation. The House of Delegates has set our target reserves at 40% and just a few years ago we were closer to negative 40% than the positive side. Last year our reserves were around 4% and this year they have almost doubled to 7.9%. As mentioned, in this economy that is exceptional.

Our new budget had its initial presentation to the NDA officers and is undergoing final revisions prior to the February House of Delegates meeting in Napa, CA. Our budgeted income of $521,176 for the coming year is an increase of about 4% over 2010, but is significantly less than the actual 2010 income. The budgeted expenses for 2011 are $512,641 with a projected net of $8,535. If the projections hold, this would result in another modest increase in reserves.

If the total budget and expenses seem like a large number for a small operation, remember that the total includes dues collected for the ADA and the local components. The bulk of our income is sent to the appropriate entity as soon as we receive it.

The next time you see Dr. Talley, thank him for the work he does to see into the financial future and guide our organization through the fiscal turmoil that surrounds us. ◆

Army Reserve Soldiers—Two Days of Dentistry

By Dwyte Brooks, DMD

Like many of my local colleagues, I received an interesting letter in August, 2010 from ReachOut Healthcare America. It involved providing dental care for young reserve soldiers to get them prepared for deployment. I have been doing this in my practice as a courtesy going back to my own military service many years ago. This seemed like a good opportunity to accomplish a lot in a short period of time. I made a phone call and had a nice conversation with Sergio, one of the event coordinators.

After an exchange of emails and faxes, all was set for two days at a rate of a little over $500 per day for my efforts. I was sent, upon my request, some photographs of the facilities and general description of the equipment and supplies. I was encouraged to bring any other items I might want to use.

On Saturday, the morning of the event, I arrived at the Army Reserve facility about 25 miles from my home at the assigned 7 AM start time. The group gathered for about 30 minutes before we began introductions and orientation. Each dentist was paired with an assistant and we went to our assigned areas and started to work out the logistics of treating patients. The treatment was to be done in two mobile dental treatment trailers that had three or four dental operatories. After about 15 minutes, we determined where most of the supplies and switches were located and felt that we could finally start treating patients. The one comment about mobile units is that the routine breakdown, transport and set-up takes a toll on the equipment. During the first morning, there were a series of problems that kept one or two units out of function throughout the day. By that afternoon, almost all systems were functioning normally but equipment failures occurred at an abnormally high rate.

To say that the operatories were small is an understatement. My family has often been compared to hobbits, but that did not help the tight fit of these spaces. Ergonomically, it was a disaster. As we completed the second day, I had a severe backache for the first time in over 35 years of dental practice mostly due to the configuration of the equipment. Finding specific items in the units was an adventure as it could be in any location but it was compounded when the configuration was new to both my assistant and myself. Concerning my assistant, she was a delight to work with throughout the two days and certainly made the weekend much more pleasant with her abilities, awesome personality and interaction with the patients. The soldiers were without exception a credit to the military in every way—respectful, thankful and understanding throughout the entire time. I'm quite sure that for them this was easy compared to the experiences they had during training and deployment.

As I reflect on the experience, it has positive and negatives to be sure. The service is sorely needed and just seeing the amount of treatment necessary to get these soldiers at even the lowest level of deployment-ready left me with a sense of an overwhelming task. We accomplished a lot in two days but it was definitely less than if I had been working in my office. For that reason I will continue to treat some of these soldiers in my own practice on the weekends. I'm kind of old and it was very physically challenging. In the future, I will only do one day of service at a session.

I don't know if this is a cost effective approach to preparing reserve troops for deployment, but I do know that unless there is some type of systematic follow-up and attempt to create a dental home for these soldiers, this is at best a temporary fix and the problems will probably recur by the time they return from deployment.

As far as monetary compensation goes, don't do this for the money. As for me, I donated my compensation to my favorite charity, Helping Kids, which added a lot to the value of the experience. Do it for our soldiers that give so much to our country and ask for, and get so little in return. ◆

New Dentist Committee

By David White, Nevada Chair

Wow, what an election cycle! I would like to thank Jeanette Belz and the Legislative Committee for all their hard work developing relationships and lobbying for dentistry. On behalf of the new dentists of Nevada, I would like to thank those whom contributed to the NDA Political Action Fund, which has provided an opportunity for the next generation to continue giving great patient care. *Thank you again!*

The ADA has officially changed our committee name from "Committee on the New Dentist" to "New Dentist Committee" (NDC).

We are pleased to announce some upcoming Nevada NDC events. In the north, we will be having an event at the end of January. On March 9, we will begin offering *free* quarterly CE courses to new dentists. These CE courses will be taught by local dentists and aimed at addressing common early year challenges. For those in the south, we are in discussions to have an inaugural social event. Please "Like" and check our Facebook page for upcoming events. Please plan to join us at the Mid-Winter Meeting in Napa, CA. This is a wonderful opportunity to network and witness the work being done on behalf of NDA members. Finally, the New Dentist Committee Annual Session will be held June 16–18 in Chicago.

If you have questions about the NDC, contact me at whitedav@umich.edu or 775-287-7960 cell. ◆

2011 ACLM Dental Meeting to be Held in Las Vegas

The Annual Ethics and Legal Aspects of Dentistry Conference sponsored by the American College of Legal Medicine will be held February 25 at the Planet Hollywood Hotel and Resort in conjunction with the Annual ACLM Conference, which runs through February 27.

Dental section topics are timely and the planned topics and schedule is reprinted in this edition of the *Journal (see below)*.

Registration information is available at www.aclm.org and NDA members will receive a discounted registration fee. ◆

ACLM 51st Annual Meeting—Preliminary Conference Schedule

FRIDAY, FEBRUARY 25, 2011

10:15 AM–12:30 PM	**GENERAL SESSION I – DENTAL** Licensure Providers & Malpractice Moderator: *Richard S. Harold, DMD, JD, FCLM; Tufts University SDM*
10:15–10:45 AM	Ethics of Using Live Patients for Licensure Part I *Dean Mert N. Aksu, DDS, JD, FCLM; Univ. of Detroit Mercy School of Dentistry*
10:45–11:15 AM	Ethics of Using Live Patients for Licensure Part II *Pamela Zarkowski, JD, MPH; Univ. of Detroit Mercy*
11:15–11:45 AM	Midlevel Provider Model *Dean Karen P. West, DMD, MPH; Univ. of Nevada Las Vegas SDM*
11:45 AM–12:15 PM	Dental Malpractice – What Does It Mean? *Frank J. Riccio, DMD, JD, FCLM; Law Offices of Frank J. Riccio, PC*
12:15–12:30 PM	Questions & Answers
1:30–3:30 PM	**GENERAL SESSION II – DENTAL** Liability Issues Moderator: *Douglas Wolff, DDS, JD; Northern Dental Partners, LLC*
1:30–2 PM	Referral Liability in Clinical Practice *Boyd W. Shepherd, DDS, JD; Boyd W. Shepherd, P.C.*
2–2:30 PM	Ethical Considerations in Use of Nitrous Oxide *Nickolas Levering, BS, DDS, MS; Center for Health Policy and Ethics, Creighton Univ.*
2:30–3 PM	Medico-Legal Issues Associated with Cone Beam Computerized Tomography in Dentistry *H. Clark Whitmire, Jr., DMD, JD, FCLM, FACD; Univ. of Texas – Houston Dental Branch*
3–3:15 PM	Questions & Answers
3:30–5:15 PM	**GENERAL SESSION III – DENTAL** Records – Insurance & Fraud Moderator: *Gerald Halk, DDS, MS, JD, LLM, FCLM; Sterling Endodontics*
3:30–4 PM	Ownership of Dental Records *Chester Gary, DDS, JD, FCLM; Univ. at Buffalo School of Medicine*
4–4:30 PM	Insurance Conundrum – Who Do You Trust? *Joseph Graskemper, DDS, JD, FCLM; Stonybrook SDM*
4:30–5 PM	Fraud in the Dental/Medical Office *Joseph DiDonato, III, DDS, MBA, FAGD; Olean General Hospital*
5–5:15 PM	Questions & Answers

About the

American College of Legal Medicine

Contributed by the ACLM Board of Governors

The American College of Legal Medicine (ACLM) was incorporated in 1960, with organizational roots dating back to 1955. It is the most prominent professional society in the U.S. concerned with addressing issues that arise at the interface of law and medicine. Fellows of the American College of Legal Medicine, which comprise over 50% of its membership, have degrees in law and one or another health science. The majority have both MD and JD degrees. Others are JDs with DDS, DMD, RN, or PhD degrees. College members also include physicians (MD, DO), attorneys (JD, LLB), dentists, RNs, podiatrists, scientists, and other health professionals.

Through its medical legal resources, the ACLM educates and assists health care and legal professionals, advances the administration of justice, influences health policy, improves health care, promotes research and scholarship, and facilitates peer group interaction. In addition, the American College of Legal Medicine represents the specialty of legal medicine in the American Medical Association's Specialty and Service Society.

The Mission of the ACLM is to "promote the continued professional advancement of its members, as well as non-member physicians, and other interested professionals, through education, research, publications, and interdisciplinary and collaborative exchanges of information. The educational meetings are designed to improve the professional performance of the participants and focus primarily on research, methodologies, techniques, and issues and advances in the field of legal medicine. The education activities encourage interdisciplinary exchanges of ideas and information and thereby facilitate enhanced service to society in the healing arts and legal professions."

This is achieved through a diverse array of scholarly and professional endeavors that are nationally and internationally recognized. The *Journal of Legal Medicine* is one of the leading internationally circulated journals in its field. The *Journal* includes articles and commentaries on topics of interest in legal medicine, health law and policy, professional liability, hospital law, food and drug law, medical legal research and education, the history of legal medicine, and a broad range of other related topics. Indexed in national and international databases, the Journal is circulated throughout the world. Complementing the scholarly work contained in the *Journal of Legal Medicine* is the further body of medical legal knowledge that appears in the ACLM's recently published monograph, entitled *Legal Medicine*. The Seventh Edition was released in February 2007 and has sold over 1,000 copies nationally and internationally. Published by Mosby/Elsevier, *Legal Medicine Seventh Edition* is one of the leading textbooks in the field of legal medicine. The publication features 75 chapters that focus on the most important topics in the field, including professional medical liability, confidentiality and privacy, the business aspects of medical practice, patents and intellectual property, access to health care, ethical and legal issues in life-care planning, pain relief and pain management, legal aspects of bioterrorism, public health law, and forensic science.

The ACLM's newest monograph, *Medical Malpractice Survival Handbook*, also released in 2007 by Mosby/Elsevier, contains 43 chapters authored by a renowned field of experts. Four sections focus, respectively, on physicians and malpractice, the etiology of malpractice, malpractice lawsuit resolution, and liability of specialists and subspecialists in medical malpractice cases.

The ACLM produces two other significant publications. One is *Legal Medicine Perspectives*, which offers a bimonthly analysis of recent developments in federal and state courts, as well as recent statutory enactments by Congress and throughout the states. The other is *Legal Medicine Questions & Answers*, a case-based bimonthly publication offering answers to complex medical legal and medical ethical issues arising in clinical situations. Both of these publications, along with the *Journal of Legal Medicine*, can be readily accessed and reviewed online by ACLM members.

The medical legal advocacy and scholarship of the ACLM is reflected in other important activities. At the national level, the work of the ACLM Amicus Curiae Committee has continued to showcase the College's efforts to participate in the administration of justice at the state and federal level. Amicus briefs have been filed in cases that were pending before various state supreme courts, United States Courts of Appeal, and the United States Supreme Court. A copy of these briefs may be reviewed at the ACLM website (www.aclm.org).

Additionally, at the national level, the ACLM is a co-sponsor, since 1995, of the National Health Law Moot Court Competition—one of the nation's highly regarded law student competition addressing issues at the interface of medicine and law. This competition, which began in 1992, is held each year in November at Southern Illinois University School of Law.

Consistent with these efforts of the ACLM to recognize and reward oral advocacy in the area of legal medicine, the ACLM is also committed to recognizing written advocacy and written scholarship on the part of law students, medical students, and allied health professions students. The ACLM annually sponsors a student writing competition open to students in multi areas of legal medicine including bioethics. Authors of winning papers not only receive a generous honorarium but their award-winning manuscripts may be published in the *Journal of Legal Medicine*, following peer review. Through this writing contest, efforts of the ACLM to promote research and scholarship are highly visible at law schools, medical schools, and health professions education programs.

Perhaps of greatest significance, is the excellent record of achievement held by the American College of Legal Medicine in sponsoring successful scientific meetings and conferences in multiple venues throughout the U.S. Since its inception, the ACLM has sponsored annual meetings, each lasting approximately three days and focusing on current and critical issues confronting the field of legal medicine. Each annual program showcases an internationally recognized panel of expert faculty who address a diverse and compelling array of medical legal issues that challenge health care professionals in virtually every arena of medical practice and research. At the 2010 annual meeting, the ACLM celebrated its 50th anniversary since incorporation. ◆

LegalCare

It is Time to Lower Legal Costs *AND* Ensure Affordable, Accessible Legal Coverage for All

By Matthew S. Rice, MD

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According to the American Bar Association, thousands of innocent working Americans are wrongfully convicted of crimes every year, in part due to negligent or poorly trained lawyers, careless judges, and prosecutorial misconduct.[1] Samuel R. Gross, Professor of Law at University of Michigan, estimates that between 3.3 percent and 7 percent of convictions are erroneous, meaning that between 60,000 and 140,000 innocent Americans are incarcerated.[2]

With attorney-legislators scrutinizing and planning the reform of medicine and the health insurance industry, it is only fitting that physicians apply the most current progressive healthcare reform principles to the legal profession. Attorney-legislators and other politicians and appointees are strongly encouraged to use the present healthcare reform momentum to simultaneously reform the legal profession. Doing so would greatly add to their credibility among constituents and other stakeholders, since they know essentially nothing about medicine and everything about law. Legal reform: it is time.

Illustrative Anecdotes

- Cameron Willingham was convicted of murdering his children by arson in 1992. Due in part to poverty, inadequate representation by legal counsel, and an inefficient, haphazard, paper-dependent legalcare system based on medieval principles and practices, he was executed in 2004.[3] The Texas Forensic Science Commission has been examining the flawed investigation that contributed to the execution of this man, thought by many arson experts to be innocent.
- Jimmy Bromgard's public defender failed to investigate the facts of his client's case, filed no motions on behalf of his client, failed to give an opening statement, failed to prepare for closing arguments, provided no expert witnesses for his client, and failed to file an appeal. As a result of our two-tiered legalcare system, Bromgard languished for 15 years in prison for a rape he did not commit.[4]
- Eddie Lloyd was wrongfully convicted of rape and murder in 1985. Contributing factors to this tragic injustice included representation by a court-appointed attorney, poor hand-off between defense attorneys prior to trial, and the fact that another state-appointed attorney failed to meet with Lloyd or file a claim of ineffective assistance of counsel. Lloyd was exonerated after spending 17 years in prison, and died two years later.[5]

Scope and Severity of the Problem

Legalcare costs in the U.S. are skyrocketing, with tort costs alone draining Americans of $865 billion dollars annually, a sum greater than the entire combined gross domestic products of New Zealand, Hong Kong, Ireland, Vietnam, Qatar, Ecuador, and Luxembourg.[6] Billions more are wasted by fearful business owners complying with dubious regulations drafted by lawyers. Are we getting our money's worth? Is the United States any more safe, just, or lawful than Japan or Great Britain, where the legal-cost burden is half of what we pay? According to *The Times* of London, our legal system is worse than that of either Russia or China.[7]

The prohibitive costs of lawsuits and liability insurance are smothering small business owners and working Americans, who bear almost 70 percent of business tort liability costs.[8]

Class-action lawsuits result in multi-million dollar payouts to lawyers while consumers end up with nothing of value. David de Alba, a California Superior Court Judge, awarded attorneys who filed a class-action lawsuit against Ford Motor Company $25 million. What did the plaintiffs receive? *Coupons* they could apply toward the purchase of a new vehicle.

Expenses related to defensive medicine practices add $124 billion annually to healthcare costs, more than enough to give a $10,000 health insurance premium to each chronically uninsured American.[6,9]

The burden of lawsuits in America is an unseen "tax" of $9,827 on each working family of four.[6] Unless you're Warren Buffett or Bill Gates, your family or small business is just one serious legal bill away from bankruptcy, and all bankruptcies in America involve at least one expensive legal bill.

A large percentage of all legal spending goes to administrative and overhead costs, needlessly increased by reliance on antiquated paper-based records and information systems typified by the 8 ½ x 14-inch yellow legal pad.

While half of all Americans will require legalcare services in any given year, almost 280 million Americans lack legal insurance. For those few Americans who do have legal insurance coverage, most plans only cover a limited number of attorney visits and fail to provide coverage for preexisting situations such as divorce proceedings, custody cases, bankruptcy, or cases involving alcohol or drugs, thus exposing hardworking families to unlimited financial liabilities.[10] Even those Americans with coverage are struggling to cope with soaring legal expenses. As a nation we can no longer afford to accept the status quo. The cost of inaction is simply too much to bear.

Lack of affordable legalcare is compounded by serious flaws in our legalcare delivery system. Limited access to legalcare by the uninsured poor and racial minorities results in unacceptable sentencing and incarceration disparities. It is critical that we close these gaps in legalcare for all Americans, but particularly for blacks and Latinos, where the incidence of conviction and incarceration is disproportionately high. More than 60 percent of inmates are racial minorities, and one in eight black males in their 20s is in jail on any given day.[11]

Racial minorities, the poor, non-citizens, and men receive longer prison sentences than whites, the wealthy, citizens, and women, respectively.[12] Recent studies by the American Bar Association estimate that half of all poor Americans suffer from at least one serious legal problem each year, but 75 percent of them have no access to legalcare services. While the average profit per partner of the most successful law firms soared to $755,000 annually over the past 10 years, these same attorneys only provided eight minutes per day of pro-bono legalcare services to the needy and helpless who suffer from serious legal conditions.[13] Clearly, perverse profit motives have hindered the ability of many attorneys to reach their potential in providing low-cost or free legalcare services to the poor. Imagine an America in which disenfranchised socioeconomic groups and disparity ethnic groups had access to the same quality legalcare afforded to the wealthiest Americans!

Too many Americans go without high-value preventive legalcare services such as professional income tax preparation and reviews; estate, will, and trust planning; legal risk reviews; precrime legal mitigation assessments; and other critical legal services available only to the wealthiest Americans. Routine use of preventive legal services could help Americans avoid future liabilities, but owing to prohibitive costs, many working American families forgo such counsel only to suffer the far greater consequences of future legal or regulatory noncompliance. Our legal *care* system has become a criminal and civil *punishment* system, and the time for reform is well overdue.

Lower Costs to Make Our Legalcare System Work for People and Businesses— Not Just for Lawyers

Inefficient and poor-quality legalcare costs the nation hundreds of billions of dollars every year. Billions more are wasted on administration and overhead, and this problem will only worsen as legal spending increases over the next decade. We must redesign our legalcare system to reduce inefficiency and waste, and improve legalcare quality, driving down costs for families and businesses. We can do this by: (1) adopting state-of-the-art legal information technology systems; (2) ensuring that clients receive, and attorneys deliver, the best possible counsel, including preventive legal services and chronic-offender management services; and (3) liberating attorneys from perverse profit incentives by implementing a national single-payer legalcare system.[14]

Legal costs and quality can vary tremendously among firms and attorneys; however clients have limited access to this information. We must require firms and attorneys to collect and publicly report measures of legal costs and quality, including data on hourly fees, legal errors, miscarriages of justice, attorney-to-client staffing ratios, overruled motions, reversed verdicts, and conviction rates.[14]

We must align incentives with excellence. Sadly, many attorneys collect fees based on the *volume* of services provided rather than on the *quality* of those services.[15] For example, a working parent might take her obese child to an attorney to sue a school for damages arising from chronic illnesses caused by the federally funded school lunch program. The attorney might think to himself, "I could make a lot more money by taking this case and billing

Continues ➲

LegalCare

from page 13

these people $400 per hour, rather than telling them that the case is futile."

Enter LegalCare, a national single payer legal system that would set reimbursement rates for attorneys and link quality legal counsel with incentives. LegalCare would cover all Americans and drive down legal costs across the board. LegalCare would be administered by a Department of Legal Services (DLS). Reimbursement rates would be modeled on the highly successful Medicare program, and would range from $12.56 to $170.65 per attorney-client session, based on coded documentation of the complexity and quality of legalcare services provided.

Tackling the Disparities in Legalcare

Although all Americans are affected by this crisis in our legalcare delivery system, an overwhelming body of evidence indicates that certain populations are significantly more likely to receive lower quality legalcare than others.

Do not all Americans deserve access to the best available legalcare? Could a poor, working minority group member accused of drug possession simply walk into the office of a politically connected trial lawyer and receive the legalcare he needed and deserved at an affordable price? Of course not! Lawyers demand cash retainers, ranging in the thousands to tens of thousands of dollars for criminal defense. He would likely end up with a poorly trained, non-connected public defender, and spend years languishing in prison. According to a damning 2002 report, many public defenders are "unqualified, irresponsible, or overburdened and do little if any meaningful work for [their] clients."[16] It is our nation's moral duty to ensure that attorneys and law firms provide affordable counsel to all Americans, especially our most vulnerable and disenfranchised; and to end the practice of "cherry-picking" easy clients or lucrative cases.

We must challenge the legal system to eliminate inequities in legal outcomes by requiring law firms, attorneys, and judges to collect, analyze, and report legal outcome inequalities for disparity populations, and we must hold them accountable for any differences found. We must also diversify the legal workforce to ensure culturally effective legal counsel.[14]

Attorneys must be required to keep electronic legal records (ELR) for their clients, the benefits of which are substantial: improved administrative efficiencies, improved quality of legalcare, and elimination of legal errors, reduction of redundancies and paperwork, and lower legalcare costs, among others. The ELR should be modeled after the functional and efficient Department of Defense electronic medical record, AHLTA, which is arguably the "Porsche" of electronic medical records.[17] The National Coordinator of Legal Information Technology would ensure that attorneys who fail to be meaningful users of the approved ELR (Attorney Hypermetric Longitudinal Technology Application) by 2015 face reduced payments and other financial penalties from the DLS. In a general sense, meaningful users of the ELR are defined as attorneys who demonstrate to the government that they are using electronic documentation, that their technology is connected in a manner that provides for electronic exchange of legal data to improve quality of legal services, and those attorneys who submit information to the government on legal outcome measures.[18]

The National Institute of Comparative Legal Effectiveness would monitor attorney-client decisions via the ELR to make sure that lawyers do what the DLS deems appropriate, fair, and cost-effective. The goal is to reduce costs and guide attorneys' decisions, with the aim of standardizing and improving legal outcomes for all Americans.

Lawyers, judges, and other legalcare providers will have to adjust to a values-oriented system. In too many cases legal professionals are providing legalcare that doesn't reflect the latest laws, societal norms, or sentencing guidelines. That will have to change. They will have to learn to operate less like solo professionals and more like team members, working with attorneys in other practices, state bar associations, and the DLS to optimize legalcare. In return, they will enjoy the benefits of working in a simpler, seamless system that emphasizes and rewards excellent performance and fair legal outcomes.[19]

We must guarantee affordable and accessible legal counsel for all Americans. Currently, with nearly 280 million Americans lacking legal insurance, rising costs are a burden on working families and small businesses. It is simply too expensive for individuals and families to buy the legalcare they need and deserve on the open market, and is impossible for many with ongoing or preexisting legal problems.

Affordable, Accessible Coverage for All

We must require law firms and attorneys to accept clients with pre-existing legal problems (to include recalcitrant criminal behavior, drug and alcohol addictions, and civil problems such as complicated divorce and custody battles), at fair reimbursement rates set by the DLS. We can no longer allow attorneys and firms to accept easy or lucrative cases while dismissing those who cannot pay, or who suffer from challenging legal conditions.

LegalCare would be budget-neutral if it were funded with a small addition to the existing Federal Insurance Contributions Act tax (FICA), and a federal tax of 75 percent on all tort awards and on all court filing fees. LegalCare will enable all deserving Americans to get the comprehensive and quality legal benefits they need and deserve at a fair and stable price. It will eliminate the two-tiered legalcare system currently in place, keeping courthouse doors open for all, regardless of economic status or race. ◆

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Editor's note

Access to an online petition requesting Federal implementation of single-payer legal care can be found at www.petition2congress.com/2/2817/go/818003/ linked from www.singlepayerlegal.org.

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Ethical Dilemma with the Refusal of Radiographs

By Quinn Duferrena, DDS, JD, Executive Director, Idaho Dental Association

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This article addresses the ethical issues surrounding a patient's refusal to have radiographs taken.

We have all had it happen. Mr. Smith refuses to have "x-rays" taken. We have let it slide before but now we realize that it has been four years since the last radiographs. Our stomach knots up as we realize we are walking a fine line between possible negligence and the patient's right to choose their own treatment. Usually a little one-on-one discussion will uncover our patients fear about x-rays, which more often than not solves the dilemma. Not Mr. Smith. We have gone over the risks and benefits of radiographs before with the resultant "I don't want x-rays."

As we know, without complete radiographs our ability as healthcare professionals is compromised. Without the information provided by radiographs we are unable to provide a comprehensive and accurate treatment plan. So what do we do?

The crux of the tension lies in the dentists' professional responsibility to provide dentistry within the standard of care. Meanwhile, the patient is exercising their autonomy with regards to their protected right to control their own bodies. It is a well-settled law that a competent adult has a legal right to refuse medical treatment. [1]

It would make our dental decision about radiographs easy if it were set in stone that patients shall have complete full mouth radiographs every five years and bite wing x-rays every six months. A patient's refusal to have these radiographs would automatically prevent any patient from receiving any type of dental service.

There are no such engravings. Dentistry is not a black and white science. The gray area makes up what's called professional judgment. To assist in this area the ADA set out guidelines for radiographic exposure. These guidelines help only as an adjunct to the dentist's professional judgment, however. The dentist must weigh the benefits of taking dental radiographs against the risk of exposing a patient to the inherent radiation, the effects of which accumulate from multiple sources over time. By the very nature of this guideline it indicates that certain radiographs are not mandatory on all patients all the time. Radiographs should be taken only when there is an "expectation" by the dentist that the "diagnostic yield will affect patient care."[2] This allows and demands that the dentist use his professional discretion to determine if there are reasonable articulate indications for x-rays. These are guidelines only and serve as a resource for the practitioner and are not intended to be the standard of care. [3]

So, in the case of Mr. Smith, we look at the guidelines, and weigh those guidelines against such factors as previous periodontal disease, medical history considerations, nutritional changes indicating an increase in caries susceptibility, and all the other elements needed to form that elusive gray area of professional judgment.

Okay, so we have used the guidelines to determine what type of x-rays and how often to take them. Now we feel more comfortable with our professional judgment in how often Mr. Smith should have the radiographs taken. That confidence can also translate to how we will handle Mr. Smith's refusal to have those necessary x-rays.

Now we need to deal with the concept of informed consent. Actually a more appropriate term, in this instance, would be informed refusal. This concept states that in order to make an intelligent decision a patient must be told of the possible consequences in refusing the requested treatment. [4] A case analogous to Mr. Smith's was decided in a medical malpractice case where the woman was advised to have a Pap smear test. She refused the test and later died from cervical cancer. The court held the opinion that informed refusal is like informed consent. Even though a patient refuses to follow the recommendation of the treating doctor they must be advised of the consequences of that refusal. [5]

Consequently, after a full disclosure with Mr. Smith, we are left with three treatment and documentation options. We won't even consider the failure to document. The risks are too high.

1. Treat him but document in his chart that he again refused x-rays.
2. Treat him but only after having him sign a release form indicating that he has been informed of the risks and benefits of radiographs and the possible sequelae in failing to consent to the taking of those radiographs.
3. Refuse to treat Mr. Smith unless he consents to the radiographs that you feel necessary.

How much risk are you willing to take? An important factor to consider, in a dental malpractice suit, is that a document that leaves little to interpretation or ambiguity has more credibility. As such, a jury may view, as more credible, a written release signed by the patient. Signed consent forms are used routinely for more invasive procedures like Oral Surgery and Endodontics. Perhaps there would be less liability and more cooperation from patients if they were forced to take the time to read a written consent form. As with any legal document a patient is more likely to think twice about their refusal before applying their signature.

So we have had Mr. Smith sign our "radiographic refusal consent form" and everyone is happy. But what happens down the road, when Mr. Smith's teeth become loose due to the undiagnosed periodontal disease? Now you are sitting on the stand being judged by twelve of your peers, none of whom are dentists and none of whom have read about proper informed consent and documentation. How do you respond when the plaintiff's attorney points out that you are the professional, not Mr. Smith, it was your job to use your professional judgment and now Mr. Smith is losing his teeth.

At this point, if you look back, you may have chosen the third option and refused to treat Mr. Smith. Winning or losing a negligence case may not be the issue. With proper informed refusal the professional may have protected themselves from successful litigation. Maybe a more important issue is that you did not want to end up in that situation in the first place. So consider again.

If after a careful discussion of the risks and benefits the patient still refuses to the appropriate radiographs and you don't feel comfortable with that decision, perhaps you are falling below your own standard of care or professional philosophy in the treatment of your patients.

By using the ADA guide and your professional judgment you can arrive at a reasonable articulate criterion in determining the appropriate radiographs for our patients. Once you are comfortably within that "standard of care gray area" you may feel more comfortable and more assertive in how you deal with Mr. Smith and his refusal.

Maybe that knot in your stomach will go away. ◆

The table below compares our estimated exposure to radiation from dental X-ray with other various sources. As indicated below, a millisievert (mSv) is a unit of measure that allows for some comparison between radiation sources that expose the entire body (such as natural background radiation) and those that only expose a portion of the body (such as X-rays).

	Source	Estimated Exposure (mSv)
Man Made	Dental X-rays	
	Bitewing radiographs	0.038
	Full-mouth series	0.150
	Medical X-rays	
	Lower gastrointestinal tract radiography	4.060
	Upper gastrointestinal tract radiography	2.440
	Chest radiograph	0.080
Natural	Cosmic (Outer Space) Radiation	
	Average radiation from outer space in Denver, CO (per year)	0.510
	Earth and Atmospheric Radiation	
	Average radiation in the U.S. from natural sources (per year)	3.000

Source: Adapted from Frederiksen NL. X-Rays: What is the Risk? Texas Dental Journal. 1995;112(2):68-72.

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Saying *I'm Sorry* May *Make You* Sorry

By Steven I. Kern, Esq.

Lately, dentists are seeing a lot of information advising them to admit their errors and apologize if they've made a mistake. But sometimes, saying you're sorry is the worst thing you can do. Before relieving your conscience, here are a few things to consider.

Admitting errors can lead to loss of reputation, legal entanglements, and economic ruin. Unlike in church, confession doesn't necessarily lead to absolution in our highly litigious society. While saying I'm sorry may well be morally correct and soothing to the psyche, our legal system provides little reward for contrition.

One major concern with admitting errors is that many malpractice insurance policies include a clause which allows the carrier to deny coverage to the policyholder if he or she does anything that adversely affects its ability to provide a defense. As a result, saying "I'm sorry" can lead to the loss of malpractice insurance coverage. That's because saying I'm sorry is considered an admission. An admission is an exception to the hearsay rule, so anyone who hears it can be called to testify against you, should legal action ensue.

As one example, in a case that I'm currently defending, a psychiatrist is battling for his career and his livelihood because he chose to say "I'm sorry," in an effort to appease a client. But for this "admission," the evidence against him would have been slim to none, and no one would have even considered bringing a case against him. Instead, the doctor has not only been sued for malpractice, but criminal and license revocation actions were brought against him. While a jury acquitted him, before the acquittal, an administrative law judge found him guilty in a separate administrative disciplinary action, using a lower standard of proof—"preponderance of the evidence"—rather than the "beyond a reasonable doubt" required for a criminal conviction. As a result, his licensing board suspending his license to practice for a year. That decision is now on appeal.

The case involves a patient, addicted to Percocet, with diagnosed borderline personality traits, accusing the doctor of touching her breast for one second. The patient had also been diagnosed with fibromyalgia and during the doctor's palpation of her tender points she flinched and arched her back. This may have caused the one second touching, but the doctor is unsure even of this. The patient subsequently called him on the phone, accusing him of wrongdoing. Rather than argue with her, he repeatedly told her he was sorry, in an effort to placate her, calm her down, and get her to return to the office for continued treatment (he was treating her with Soboxone for her drug addiction).

The telephone conversation, unbeknownst to the doctor, was being taped and monitored by the police, and the apology was used as an admission against him. If not for the apology, this case would never have gotten anywhere. Instead, the doctor is now fighting for his professional life, and he has lost his hospital privileges and managed care contracts, pending resolution of the litigation. This has also caused him near financial ruin.

A good number of groups are advising the apology approach. It appears that a number of these groups, however, have either a financial stake in this effort, are backed by plaintiffs' law firms, or to be less cynical, have a good, moral perspective which ignores the economic and professional reality of the problem. Many of these groups are relying on one case study involving a Veterans' hospital in Kentucky, which showed an apology, offered along with a financial settlement, and ended up costing less per claim. But the patients in Kentucky were older veterans whose penchant for litigation was, most probably, very different than the average patient in Nevada. In fact, no similar results have been reported in highly litigious patient populations.

So while apologizing may be morally right, or may purge the doctor's guilt or help alleviate the guilt, an apology can also create major problems.

If you're in a situation where you realize you've made an error, before you even consider apologizing, check with your malpractice insurance carrier. As discussed above, many policies include a clause stating that the carrier can disclaim coverage if your actions adversely affect the carrier's ability to provide a defense. Unless your carrier gives you written permission to apologize, your apology could cause you to lose your malpractice coverage.

Many states have now passed "I'm sorry" legislation which provides some degree of protection for the physician. Unfortunately, most of these laws do not go far enough. The laws may limited the admissibility of the apology, but rarely make the apology inadmissible in all circumstances. If Nevada were to pass an appropriate law enabling you to say you're sorry without the risk of destroying your career, then I'd give different advice. But absent a law which makes the apology non-admissible in all circumstances, the apology is deemed an admission, an exception to the hearsay rule, and, depending upon the scope of the law, may be used against you in a civil, administrative and criminal proceeding.

If you've made an error, before deciding to apologize, your best course of action is to first contact your personal healthcare attorney and get his advice. With your attorney's concurrence, contact your carrier and let them know what happened. Let them decide whether an apology is appropriate and then, together, establish a plan for how to apologize, and what to apologize for. As part of that plan, decide how that apology is to be communicated, so that there is no chance of misunderstanding. Consider whether to simply communicate regret for an unfavorable outcome, and explain why the outcome occurred, or whether to admit that the unfavorable outcome was your fault. Since an injured patient may not appreciate the nuance between the two, and, therefore, when relating the conversation, claim that you admitted wrongdoing, any apology should either be recorded or witnessed by a neutral third party.

In short, while an apology may help you purge your guilt it could harm your career and be financially ruinous. So be careful about what you say and how you say it. Don't rush to alleviate your guilt at risk of losing your career. ◆

Steven I. Kern, Esq, is a principal at Kern Augustine Conroy & Schoppmann, PC in Bridgewater, NJ.

Editor's note

The last session of the Nevada Legislature had an "I'm Sorry" law proposed which contained some immunity for those who apologize. This bill never made it out of committee and currently Nevada has no protection for those who apologize.

Legal Importance and Content of General Dental Records

This article is a summation from a portion of the Risk Management seminar presented by the author.

By Bruce H. Seidberg, DDS, MScD, JD, FACD, FPFA, FAAHD, DABMM

Introduction

Dental records serve at least two major purposes. Primarily, they are practice records that tell a story about a patient's dental health and treatment in order to help the dentist deliver care. They are also legal records which are used forensically to help reconstruct diagnoses and treatments. Accurate records can be relied upon to help exonerate a practitioner from allegations of wrong doing. Failing to maintain a written record can be construed as unprofessional conduct in many jurisdictions. Accurate records reflect well on the practitioner and office when reviewed by either a patient, an investigator from the state licensing bureau, a plaintiff's attorney, a judge, or a jury.

Patient records should demonstrate that necessary information is recorded with consistency from appointment to appointment and from patient to patient. Records remain a strong basis of a defense against claims. A practitioner should be able to show that the same forms are used and that the same information is recorded in the same place for every visit and for every patient. Patient charts should be reserved for informed consent documentation, dental and medical information concerning the evaluation process, treatment and patient responses to treatment proposals and/or treatment. Other items not directly related to patient care may be kept outside the patient care jacket of information.

Content

Basic patient records often include, but may not be limited to, demographic information, medical and dental history, diagnostic information, radiographs, study models, informed consent documents, progress notes, copies of pharmacy and lab prescriptions, and all written consultation and referral reports.

Demographics

The obvious information required to locate the records are the patient's name, address, phone numbers, date of birth, and occupation. Middle initials or names can help identify patients with similar names. Occupation can be valuable for some diagnostic issues. In addition, the general physician's name and phone number, any medical or dental practitioner's information and an emergency contact number can be helpful. (Table 1.)

TABLE 1. Demographics

Patient name, address and phone numbers
Date of birth
Occupation
Physician's name and phone number
Emergency contact and phone number
Informed Consent

Informed consent is initiated during the conversation a dentist has with the patient prior to examination. It is continued once the diagnosis and treatment is proposed during which the benefits, possible risks of the projected treatment and options, including no treatment, are explained and discussed in terms the patient can understand. The consent form is memorialized by a document dated and signed by the patient. When completed, it can help avoid informed consent allegations as part of a claim. Most state laws require a form of informed consent for any non-emergency treatment or diagnostic procedure. It is mandatory for all invasive procedures. In addition, there are forms designed to be used for the use of local anesthetics, nitrous oxide, biopsies, specialty-type treatments and for the refusal of treatment proposals and referrals.

Medical History

A standardized medical history form should be completed by the patient that includes the date of the last physical examination, a check off list of systemic issues, several defined sections for patients to write explanatory issues, i.e. hospitalizations, medications being taken inclusive of recreational drugs (dosage and purpose), herbal remedies, diet drugs, chronic ailments, prosthetic joint replacements, immunosuppressive disorders, allergies (antibiotics,

analgesics, latex and/or local anesthetic reactions) and for women, current pregnancies or the use of birth control medications. It is important to ask if the patient is taking one of the bisphosphonate drugs and warn them about the risks affecting dentistry. Obtaining vital signs completes the medical history. Once completed, all positive responses should be discussed. There is no substitute for the chairside review with the patient or guardian prior to furthering the diagnostic process. (Table 2.)

TABLE 2. Special Medical Conditions

Allergies
Hypertension
Immunosuppressive issues
Bleeding disorders
Anticoagulant therapy
Prosthetic joint replacement
Mitral valve prolapse
Diabetes (type and control)
Heart issues
Dental History

A thorough dental history can be very beneficial. The universally accepted diagnostic method follows the acronym "SOAP". (Table 3.) The dental history should include the patient's description of their dental status, previous dental records and radiographs if available, current radiographs, pulpal testing results, periodontal status, oral hygiene habits, history of bruxing, orthodontic treatment, history of traumas, TMJ issues and any known problems with local anesthetics. Some patients may complain about the affect of epinephrine, and that should be explored with them. Once a diagnosis and treatment plan is determined, the informed consent process continues and is documented. The elements for an appropriate development of a complete record are in place. (Table 4.)

TABLE 3. S.O.A.P.

S	Subjective findings—referred to as the chief complaint of the patient
O	Objective findings—what the practitioner finds during the physical and radiographic examination
A	Assessment—what the diagnosis is compiled from looking and listening to the patient and testing and viewing diagnostic aids
P	Plan—Development of a treatment plan to address diagnostic findings

Diagnostic Information

In addition to the patient's descriptions and the histories noted, it is important for the dental practitioner to have clear and properly positioned radiographs as part of the examination. It is important to chart caries, restorations, missing teeth, periodontal pocketing and other findings, prior to comprehensive care, to establish the basis of the diagnosis. If the patient has a complaint of dental pain, pulpal testing should be done and recorded in a diagnostic workup sheet. These factual findings all become a part of the legal dental chart.

TABLE 4. Diagnosis and Treatment Plan

Both must be fully explained to the patient in terms they understand
Pre-treatment changes to a plan must be discussed and patient consent noted
Consent to treatment plans must be recorded and dated in the progress notes

Progress Notes

The primary focus of a dental chart should be the progress notes, which also become the main line of defense for any allegations regarding the dental care. When appropriate, the notes include but are not limited to the date and time that services were provided, the amount and type of local anesthetic used, the procedure(s) and the materials. Instructions to the patient, drugs administered or prescriptions written, and as well as cancellations, missed appointments, referrals made, referrals refused (noncompliant patient), important patient comments or complaints, consultation and biopsy reports. (Table 5.) Vital signs should be obtained and recorded, especially when using analgesic agents, i.e. nitrous oxide. The main rules governing progress notes are listed in Table 6.

TABLE 5. Progress Notes

Date and time of services rendered
Amount and type of local anesthetic administered
Use of Nitrous Oxide if applicable; who monitored patient
Procedure(s) accomplished
Material used (sedative, filling and/or temporary material)
Instructions to the patient
Cancellations or missed appointments
Referrals made and reports received
Refusal for Treatment and/or Referrals (noncompliant patient)
Patient complaints
Telephone conversations with patient, physician or another provider

Continues ➲

TABLE 6. Rules to Follow for all Progress Notes
Progress notes are for services rendered and pertinent communications
Use a consistent style of entry for all patients
Record similar information in the same way for accuracy and completeness
Use blue or black ink (red does not reproduce)
Never alter a record
Never alter a record by using white-out, black out, erasures
Any correction must be made with a single line through an erroneous entry
Initial and date any additional after the fact entries
Write legibly so entries are clear and unambiguous
Express concern rather than negativity
Never write derogatory comments or acronyms that can be misinterpreted
Maintain a separate record for billing and fee information
Do not ignore patient complaints that have merit
Record and explain resolution of any complaint rather than make no entry
Date and initial every entry
Never part with the original record, only provide copies when requested

Access to Records

The dental practitioner owns the custodianship of the physical record but the patient owns the dental/medical information contained in the documents. The patient has the right to receive her/his records upon request. When a patient requests a record, it is recommended that only copies of records be given. Requests should be in writing. The same applies to an attorney or any other third party request. Always retain the original record and radiographs. They are the single most important item of evidence that a dentist has in any alleged action case. Never part with the original documents! Records cannot be withheld from a legitimate written request because of a financial balance due for services rendered. Before a copy of the record is provided to a requester, make a last entry stating "copy of records were made and transmitted to…(whomever) and date and in initial the entry.

Retention of Records

For adult patients, records must be kept safe for a minimum of six years from the last treatment date in most jurisdictions or for an adequate period of time after the statute of limitations expire in any individual state. For minors, most states require six years from the last treatment date or until the patient is twenty-two years of age, whichever is longer. It is best to keep the records forever in a dry storage area. In rare circumstances, the normal dental malpractice statute of limitations can be extended for a lengthy time, i.e. the foreign object doctrine or the doctrine of continuous treatment. Usually there is no statute of limitations for professional discipline cases, therefore, keeping the records available if necessary, a line of defense is maintained.

Electronic Records

The health professions are leaning toward electronic records and many practitioners now use them. If and when ER become a part of office documentation procedures, a record keeping program should be used that "locks" all entries within a reasonable time to prevent alteration. In a legal proceeding, there must be confidence that records are authentic, unaltered and reliable.

Summary

The purpose of record keeping has not changed over the past decades, but the methodology has. Because records are the primary line of defense, documentation has been held to a high degree of scrutiny in cases of dental malpractice and professional negligence. A summary of the elements for documentation are found in Table 7. Bottom line is that records must be legible and proven to be accurate, complete and authentic. ◆

TABLE 7. Summary of the Elements for Documentation
Patient Demographics
Medical History
Dental History
Signed Informed Consent Forms
S.O.A.P. Details
Progress Notes × record information immediately to avoid "memory distortion" × record positive and negative findings × use standard abbreviations × do not alter records × avoid subjectivity
Lab and Pharmaceutical Prescriptions
Referral Prescriptions
Consultation Reports, Biopsy Reports, Referral Reports
All Written and Email Communications
Keep Billing and Fee Information Separately

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Dentures in the OR—Is Removal a Must?

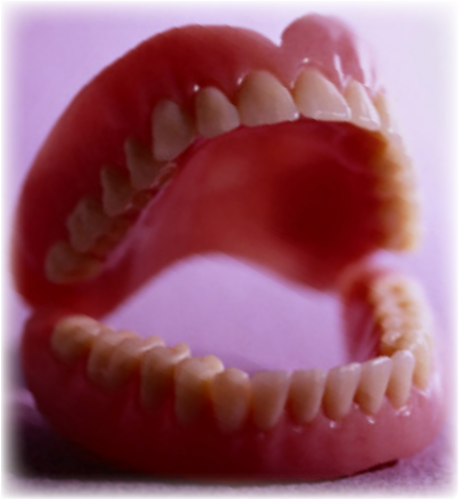
Survey Suggests Younger Docs More Willing to Be Flexible

By Larry Beresford

Reprinted with permission from Clinical Anesthesiology, *Issue 9/2008, Volume 34:09*

Most anesthesiologists grown long in the tooth were taught that dentures and other removable oral appliances must come out of the patient's mouth before surgery. That was particularly true for procedures involving endotracheal intubation, with its potential to dislodge or break off pieces of the appliance and damage soft tissue in the mouth or lead to aspiration of a foreign body.

But this historical standard is far from universally practiced in U.S. hospitals, judging from a recent survey of residency programs in anesthesia. More than 17% of institutions tolerated the presence of removable dental appliances (RDAs) for oral intubation; more than 60% during regional anesthesia; and more than 80% for cases performed under local anesthesia, the researchers found.



Nearly half of surveyed programs allowed exceptions to removal requirements of RDAs based on patient preference, and one-fourth allowed exceptions based on surgeon preferences. More than one in five programs that responded to the survey acknowledged that adverse outcomes related to RDAs had occurred at their institutions.

Training Taboo

Dennis Hall, MD, of Robert Wood Johnson University Hospital in New Brunswick, NJ, who led the study, said that in his anesthesiology training, leaving dentures in place for surgery was taboo.

"I know of at least one case of a patient dying of an aspirated tooth, and dental appliances are not as strong as natural dentation," Dr. Hall said. "So I surveyed residency programs—hospitals where future anesthesiologists are trained—to determine to what extent other anesthesia programs tolerate the presence of RDAs perioperatively. Frankly, I was surprised to find a lot of hospitals bending or not following the letter of the rules. That's why we didn't include a question asking why in the original survey," he said.

Dr. Hall, who presented his group's findings at the 2008 annual meeting of the International Anesthesia Research Society (IARS; abstract S-87), and colleagues surveyed 145 residency training programs in anesthesiology approved by the Accreditation Council for Graduate Medical Education about RDA practices in their institution. Program administrators were asked if RDAs are removed prior to taking the patient to the OR under a variety of surgical circumstances, with possible responses ranging from always to never; 32% responded to the survey, showing significant variation in practice patterns.

Dr. Hall said this survey grew out of a case with which he was involved several years ago. A patient scheduled for elective cosmetic surgery with orotracheal intubation refused to remove her dentures before the surgery. Dr. Hall refused to perform the procedure; the surgeon refused to insist on the dentures' removal; the hospital assigned another anesthesiologist; and the operation proceeded as scheduled.

"I understand there are financial pressures on hospitals, and they don't want to challenge surgeons in cases like this. Perioperative practice is becoming more competitive, with an ever-greater focus on customer-friendliness," Dr. Hall said. Hospital personnel may also fear dropping and breaking dentures, or losing them perioperatively, with no family member on hand to take them.

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Old Joint Commission Standard No Longer Applies

A requirement to remove RDAs was referenced in a 2003 "Wrong Side Surgery" brochure issued by the Joint Commission. Current Joint Commission hospital standards require a preanesthetic assessment but do not specifically address handling of dental appliances. The patient's right to refuse treatments is covered in Standard RI.2.70.

Ervin Moss, MD, who recently retired after 52 years as a New Jersey anesthesiologist but continues to serve as medical executive director of the New Jersey State Society of Anesthesiologists, said he belongs to the old school when it comes to RDA policies. "I strongly feel that these appliances should be removed. You can leave them in and, in most cases, you'll probably get away with it, but I don't really see what is being accomplished by bending the policy."

Dr. Moss is active in hospital standards and quality improvement initiatives. For him, the issue of RDA removal is one more example of the principle, "Why do anything that presents any kind of unnecessary risk? I admire Dr. Hall for saying no [to the procedure], even though the likelihood of an adverse event is small."

For Dr. Hall, the bottom line is this: If removing dental appliances is a requirement of hospital practice or policy, then it should be observed—or else the standard should be changed. "It was dogma when I was trained 25 years ago, but it seems it's not a clear-cut standard anymore," he said.

Dr. Hall said he sees overlap with OR practices regarding jewelry, rings, tattoos, piercings and any metal objects not of a medical nature. He plans to do follow-up research looking at some of these issues. "The issues involved are not life-shattering…but there is a real liability risk involved, especially if you have a written standard and then don't adhere to it."

David Wax, MD, anesthesiologist at Mount Sinai Medical Center in New York City and co-moderator of the abstract panel at IARS at which the RDA data were presented, called the study "novel and interesting, but not surprising." RDAs can present a safety hazard for patients "and can be a source of liability if they lead to an adverse event or if they are damaged during anesthesia," Dr. Wax said.

On the other hand, Dr. Wax said, some anesthesiologists may feel that RDAs can facilitate mask ventilation. More important is the overriding directive from the Joint Commission recognizing the patient's right to refuse treatment.

"Therefore, if a patient insists on retaining their dentures after being adequately informed of the risks of doing so, then we are obliged to abide by their wishes," Dr. Wax said.

Dr. Wax said that, because the incidence of serious adverse outcomes from RDAs being left in probably is quite low, refusing to provide care to patients under these circumstances probably is not warranted. However, having the patient sign an assumption-of-risk document may be advisable. ◆

Editor's note

This article could easily be titled "Dentures in the Dental Operatory", which in reality is an OR. The primary concern with regards to this clinical controversy is, of course, airway protection. Dental patients, including those being treated with local agents only, are not in any way immune from airway compromise. Aspiration or ingestion of dental prostheses, instruments, restorative materials, fluids (introduced or the patient's own saliva, blood, or vomit) have all compromised treatment in Nevada dental offices.

The too often repeated "humorous" story about patients having to sift through their own feces to find a dental foreign body may be the best result of being unable to retrieve material inadvertently moving into the hypopharynx. When foreign material enters the airway, significant morbidity or mortality can be reasonably expected.

What is a reasonable course for Nevada dentists?

There is no hard or fast rule about removal of prostheses or other removable or semi-removable (i.e. lip rings, tongue bars) oral foreign bodies. In fact, in contradistinction to Dr. Moss' quote in the article, at times removable prostheses may need to be retained in the dental OR for treatment, such as in establishing vertical dimension. In addition dental treatment is most often carried out within the oral cavity, the anatomical entrance to the pulmonary and GI systems, and the dental surgeon is in a singular position to optimize airway control relative to surgeons operating anywhere else in the body. Active dental treatment involving the use of local anesthetics, placement of dental instruments into the mouth, etc., can compromise airway function and limit a patient's own airway protective ability.[1]

Ideally, dentists will not have to deal with admitting a patient to the hospital for pulmonary and GI screening films to identify where a misplaced foreign body has gone. But, if such a complication occurs, besides being prepared to provide appropriate initial emergency treatment, one should be able to effectively articulate habitual, procedure specific, airway protection measures routinely taken.

Endnote

1. Orr, DL, Airway, airway, airway, the protection mantra in the dental surgery suite. Anesthesiology News. http://www.anesthesiologynews.com/index.asp?section_id=449&show=dept&issue_id=669&article_id=15899. Accessed November 12, 2010.

The Practice of Dentistry and Law in Cherry Creek

By B. F. Miller

For many years, residents of Cherry Creek had to be satisfied with the crudest sort of surgery and medical attention, the nearest doctor being located at Ely, while dental work had to await the arrival of traveling dentists who made periodical visits to the camp. In case of a violent toothache, however, Pete Cannon, who ran the drug-store and had a pair of pliers in lieu of forceps, gave heroic emergency relief. In fact Pete Cannon and an old man by the name of Leonard were the only toothpullers in the county for years.

Leonard had no home in particular, traveling over the country in a house built on four wheels and drawn by a span of small mules. Leonard, a well-known character in his day, was an atheist and in his wagon home carried a lot of snakes, lizards, scorpions, tarantulas and similar things as companions on his wanderings.

Along in the early '90s the Nevada legislature passed what was known as the dental law, whereby all new-comers to the State who wished to practice dentistry were compelled to go to Carson and undergo an examination as to their fitness and in addition had to pay a $10 license fee before starting to practice in the State. By the terms of the law residents of the State who had been pulling teeth, whether or not they were graduates of a recognized dental college, were exempt from the examination and license fee, but in lieu of this were compelled to file an application to practice with the county recorder of the county in which they resided and to pay a $1 fee for filing a certificate entitling them to practice. This law, coupled with the monopoly of dental work enjoyed for years at Cherry Creek by Pete Cannon and Leonard, was responsible for a queer trial which later furnished a great deal of fun for the entire camp.

Shortly after the enactment of the state dental law a young man by the name of McCaffery, a graduate of a California dental college, who had the finest team, rig and dental equipment ever seen in the State, arrived at Carson to take the required exam. The new dental board was not in session, but the secretary, who was busily engaged in playing poker, told the young student that it would be all right for him to go ahead and practice. The young dentist remained in Carson 10 days but was unable to get the dental board together to give him an examination, though he meanwhile had engaged in practice. Despairing of ever getting a chance to take the exam, the young dentist drove to Elko, continuing to practice all the time.

While at Elko Mr. McCaffery met Leonard, who asked him if he had a license to practice. McCaffery replied in the negative and then, becoming suspicious of Leonard, he sent a $10 money order to the state board at Carson retaining the stub as proof. Leaving Elko he struck out through the valleys, visiting Lamoille, Huntington, Butte valley and then on to Cherry Creek. A few days after he reached Cherry Creek Leonard arrived and at once swore out a warrant for the arrest of McCaffery on a charge of practicing dentistry without a license.

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Pete Cannon, the other official toothpuller, was also justice of the peace and he at once appointed John Wearne to prosecute the case, the trial being fixed for the second day following the arrest. Wearne at once visited the prisoner and advised him to settle the case, explaining that the penalty on conviction was a $250 fine or six months in prison or both at the discretion of the court, but that they were not disposed to be severe and he would be released if he agreed to pay the $250 fine.

McCaffery had plenty of money and could easily have paid, but he realized that if he admitted his guilt the same thing would happen again and again, as Leonard had then trailed him for 300 miles. There was no lawyer in the county at the time except the district attorney at Ely, so McCaffery wired Attorney Ed Farrington at Elko, now federal judge at Carson. Farrington replied that he could not afford to come for less than $600 and advised McCaffery to pay the fine, as the case against him seemed clear.

McCaffery, who was unwilling to admit himself beaten and was determined to fight the case, had become quite friendly with Ira J. McKnight, and when the writer came in on the stage from Wells at 10 PM on the night preceding the trial he was met by the two men. McKnight, a close friend of the writer, at once proposed that I try to help McCaffery out of his troubles. While having had considerable experience in civil court procedure, the writer was unversed in criminal law, but Ira, being a county commissioner at the time, had all the statutes and the three of us at once began to study up every aspect of the case and by 4 AM the next morning when we parted were agreed that we had learned enough law to make Hearne, who was not a lawyer, sit up and take notice. At 10 AM the next morning, when the case was set for trial, we appeared in Justice Cannon's court and moved for a postponement for four days. The motion was promptly overruled by his honor, whereupon the writer, having been selected as chief counsel for the defense, produced the necessary affidavit and cited the law in the case, proving to the justice that it was mandatory on his part to give the defense a continuance of two days at a time for three consecutive times if necessary to secure counsel. We agreed, however, that if he would grant us four days we would then be ready to proceed with the trial.

The continuance was granted by the justice, and the doctor was then advised to at once get busy among the boys about town, making acquaintances and setting up the drinks occasionally, while the writer went to Ely to gather further legal ammunition. This trip proved fruitful, for an examination of the county records showed that neither Justice Cannon nor Leonard, the prosecuting witness, had filed the required certificates to entitle them to practice dentistry. While the writer knew that a simple affidavit from the clerk or recorder was inadmissible if objected to by the State, he believed that he could at least get the facts before the jury.

For three days the writer diligently studied the statutes and discovered a number of laws that few people knew about and which had never been enforced. One of these provided that a wood hauler or woodchopper was subject to a fine of from $250–500 for cutting or hauling wood on the hills without first buying the land on which the wood grew. Another provided that no saloon-keeper could keep his bar open after noon on Sunday or after midnight at any time under heavy penalties; further, no married man was allowed to play cards in a saloon provided his wife or dependents filed

an objection. Likewise, under the Hamill anti-treating law no man was allowed to treat another over the bar. Violation of these statutes carried fines of $250–500 with imprisonment of six months.

Armed with all this legal lore the writer returned to Cherry Creek and demanded a jury trial for the defendant, passing every wood hauler, married man and saloonkeeper as jurors. The jury box was soon filled and the veniremen ready for peremptory challenges, but the defense regularly passed its peremptories. The prosecution, ignorant of the number allowed the State, had soon exhausted its quota, and then, falling into the trap as the defense had hoped for, attempted to challenge one more juror. This venire-man was Charles Phalan, and when defense counsel explained that the State had no right to challenge Counsel Wearne at once apologized to the juror. The defense was well satisfied, however, that Mr. Phalan, who had just become of age, would feel resentful toward the prosecution for challenging him on account of his youth, and that the worst that could be expected was a hung jury.

When the jury was sworn in the defense counsel at once began to read the old statutes which proved that three-fourths of the jurors were lawbreakers and that both the judge and the prosecuting witness, who had been practicing dentistry without filing the necessary certificates, had violated the very law for which they were prosecuting McCaffery. Counsel also proved that the prosecuting attorney, who had been cutting wood and hauling timber for years, was criminally liable under the statutes. After stressing the penalties provided for violations of these laws counsel for the defense insisted that not only should the jury find the defendant not guilty but that it should also find the dental law of the state unconstitutional and authorize the defendant to practice his profession without further molestation.

So strongly was the jury impressed that the first ballot was eleven for acquittal and for declaring the law invalid. W.A. Watson, while strong for acquittal, somewhat doubted the jurisdiction of the talesmen in declaring the law unconstitutional. However, after considering the matter Mr. Watson, who was a true son of his father and strongly opposed to seeing the under dog get the worst of it, decided that he would take a chance and the second ballot was unanimous for declaring the law invalid.

The verdict of the jury was returned at 7:30 PM and thereafter began a celebration which was noteworthy in the annals of Cherry Creek. So pleased was McCaffery that he spent the two hundred and fifty dollars which he would have been fined in entertaining the town and every man in camp got drunk except the judge and the prosecuting attorney. Even Leonard, the prosecuting witness, who had passed his allotted three-score years and ten, in the midst of the celebration jumped on a billiard table and offered to bet Billy Bassett his favorite rattlesnake against a round of drinks for the town that McCaffery could put a better polish on a set of teeth than any other dentist in the State.

McCaffery was a great mixer and could play any kind of a musical instrument, could sing and call out dances and was popular in any company in which he found himself. He was still making his annual visits to White Pine county when the writer left the county in 1904. ◆

Editor's note

Thank you to NDA President DiGrazia for submitting this paper from *The Nevada State Historical Society Papers* (vol. IV 1923-1924, pp. 255-474).

SNDS Executive Director's Message

Robert Anderson

Happy New Year to all of our members! 2010 certainly had its share of challenges, but, as the saying goes, tough times never last, but tough people do! Let's hope that 2011 is better and more prosperous for us all.

Your society is keeping busy. Since the holiday party, we've been working on our annual Give Kids A Smile event. We are blessed to have so many resources, and so many committed people here in our valley, who join forces and make miracles happen. Last year we treated 174 children, delivering well over $100,000 in oral health care, in just 5 hours! Certainly, and sadly, the need has not diminished in the last year, so the importance of this event continues to grow.

I can't say enough about the generosity of our partners, including the folks at Henry Schein, who are not only national sponsors, but local sponsors as well. They even send a crew of volunteers to help out! And of course, the UNLV School of Dental Medicine, their faculty, administration and students are first rate, providing us with a hundred dental chairs, hundreds of volunteers and a great experience. And a new key to last year's success was the addition of the Ortho Residency at the University of Southern Nevada, who were gracious enough to host our pre-screening. Add in the dentists and residents from Nellis Air Force Base, and the Dental Hygienists' Association and the hygiene students from CSN, and you see that this is a rare event, with everyone in the dental community working together. The core of this, of course, is the participation of our members. Your expertise, and experience, make a huge difference and make the commitment of all these resources worthwhile. I hope you'll contact the SNDS office and volunteer!

And speaking of Nellis AFB, our colleagues at the 99th Dental Squadron have once again invited us to join them for our February meeting. They are working on getting a top notch speaker, and we'll once again be meeting at the Officers' Club on the base. You'll have to RSVP, as always, to ensure that we can get your through security, but it should be a great evening. Be sure to join us on Tuesday, February 8!

Our Membership Committee also wishes to remind you that we're in the middle of renewal time. Thank you to the many, many members who have already renewed, but as the deadline is approaching, our Membership Committee suggests you send in your renewal. If you didn't receive your notice, or are not sure if you've sent it in or not, please call Anthony at the NDA at 702-255-4211 for help.

And as our members know, we have two more installments of our CE Café series coming, dinner meetings in January, the Nellis meeting in February, then back to the Gold Coast for dinner meetings in March and April, and two outstanding CE speakers in March and April. We hope you can take advantage of all of these opportunities, we'd love to see you there! ◆

SNDS President's Message

Evangeline Chen, DDS

Happy New Year to all of our members! Let's all hope for a great, more prosperous 2011!

We had a busy December, and I was happy to speak with so many of our members at the CE seminar early in the month, as well as greeting you at our holiday party at Trump Tower. I think it's good to get together and share some collegiality and fellowship. As dentists, we are part of a unique profession, so it's nice to be able to relax and share the company of colleagues who speak the same language, have the same concerns, the same interests. We are part of the American Dental Association, the world's largest dental professional organization, yes, but we are also part of a local society. To me, a society is an organization that not only conducts business but has a social side as well.

This time of year is a good example of that. As a society, we have come together for our Operation Dental Elf project. Our members, some of their team members, and even some patients, all come together to gather toys and gifts for the families of deployed service men and women at Nellis Air Force Base. These are then turned over to our colleagues in the 99th Dental Squadron, stationed at Nellis, for distribution on the base. What a wonderful way to come together as dentists, in the community and at the Air Force Base, and make difference for people!

At the same time, we're working on the plans for Give Kids A Smile, being held on Saturday, February 5. Give Kids A Smile is a national event of the ADA, bringing volunteer dentists together to help children who have no access to oral health care. While most events around the country do exams only, we are fortunate to be hosted by the UNLV School of Dental Medicine, where we can do restorative work, and the Hygiene Association and Hygiene School can provide cleaning as well. Last year we treated 174 children, delivering more than $150,000 worth of treatment… all in FIVE hours! Of course, this is only possible with the many, many volunteer dental students, and by the residents at the University of Southern Nevada who host us for a pre-screening day, the residents from UNLV, and even the dentists and residents at Nellis Air Force Base. There is no other event in southern Nevada that brings every oral health education program together in one effort, all working together, and the children in our community are the beneficiaries.

Preparations are also underway for our February dinner meeting at Nellis Air Force Base. Despite their operations and deployments, they will once again be hosting us on Tuesday, February 8. The SNDS office staff will be sending out reminders and taking RSVPs, but this is always one of our best attended meetings. We'll have just worked together on Give Kids A Smile, so this really does provide a sense of community and inclusiveness. I know they are working on bringing in an outstanding speaker for us, so I hope you'll all be able to attend.

As events are planned, I'm often struck by two things. First, of course, is the outstanding value that membership represents. Dinner meetings and other society events are included in your membership dues, as are the CE Café seminars. A member can acquire 15 CEUs just by attending dinner meetings and the CE Café seminars. Add into that the discount on our mainline CE series, with outstanding speakers right here in Las Vegas, and the benefits provided for you and your practice by the ADA and NDA, and membership is an excellent value.

But the other aspect that is not spoken of is the value of fellowship and collegiality. As I've said earlier, we dentists don't get many opportunities to gather and mix and socialize with each other. The social aspect… the "society"… provides a richer opportunity than only the CEUs that might be provided. Chatting during cocktail hour at a dinner meeting, attending the holiday party, mixing with the military dentists at Nellis, and especially working together with your colleagues during Give Kids A Smile keeps us fresh and lets us feel connected.

So just as I hope to meet you at our meetings and events, I hope, too, that you'll join us in renewing your membership. As we so often say, together, we can put a smile on southern Nevada! ◆

NNDS Executive Director's Message

Lori Benvin

As we close 2010 with economic uncertainty, I think we can all be certain that 2011 will be better; we have to be grateful for all our friends and family and be thankful for our health when others met health challenges this year. We hope the New Year brings wellbeing to all.

Pro-Bono Dentistry

Even during the struggling economy in Nevada we need to thank the MANY volunteer dentists who have donated their time and their profession to help others. Some of you have graciously chosen to continue to participate as a NNDHP provider; we thank you again. We'd also like to applaud Sala Family Dentistry for their "Dentistry from the Heart" day. What an incredible day of free dentistry Dr. Jason, Dr. Todd and their dental team along with Oral and Maxillofacial Surgeon Dr. Scott Boyden did for our community on November 12. We also take our hat off to those of you who close your normal office hours to volunteer a partial day or full day of pro-bono treatment for those in need; a selfless act of kindness when you may be challenged with paying your practice overhead. You rock!

If you are treating patients' pro-bono in your office, we need to report that information to the NDA. Your NDA Legislative Committee wants to inform our Nevada legislators that dentists ARE giving back. If you are a NNDHP provider, please continue to fax your superbills after treating a NNDHP child to the NNDHP office fax directly 775-770-6375. If you are providing any other pro-bono dentistry please fax directly to the NDA at 702-255-3302. Thank you all for your extreme generosity to this community!!

Do you need Continuing Education?

Well we have it! For 2011 please watch for flyers and emails regarding some great presentations and continuing education opportunities. See highlighted Save the Date info below. Please remember that our general membership monthly dinner meetings include continuing education units. All of our dinner meetings are sent via email only. If you have an email address and you have not been receiving emails from the NNDS, please contact me at 775-337-0296 so I can be sure your address is included. ◆

NNDS 2011 Save the Date

All of our events are updated on our website at www.nndental.org.

January 13: NNDS General Membership Dinner Meeting.
Mike Sullivan, Esq., "Legal Presentation"

February 10: NNDS General Membership Dinner Meeting.
Thunder Canyon Country Club, Washoe Valley.
Jeanette Belz, NDA Lobbyist, "Legislative Update"

March 10–11: NNDS General Membership Dinner Meeting.
Dr. Richard Williamson, "Update in Contemporary Removable Prosthodontics"

March 11: Continuing Education Course. Dr. Richard Williamson

April 21: The 9th Annual Mario Gildone Lifetime Achievement Award Dinner

May 6: Annual OSHA & CDC Guidelines Continuing Education course

May 20: Mystery Bus Trip

November 11: Dr. Stanley Malamed, "Emergency Medicine in Dentistry"

WELCOME NEW NNDS MEMBERS

Jessica Clausen, DDS – General

Lily S. Kwee, DMD – General

Keith D. McGruder, DDS – General

NNDS President's Message

Mark J. Handelin, DDS, MSD

As you read this the snow will most likely be falling, the holidays will have passed, and we are dutifully pursuing our New Year's resolutions. In writing this article I became intrigued with the history of New Year's and traced the origins to the Romans, who dedicated January 1 to Janus, the god of gates, doors, and beginnings. Janus had two faces, simultaneously looking forward into the future and backwards into the past. It was customary for the Romans to ask their enemies for forgiveness and to exchange gifts representing good fortune to come, thus Janus became the symbol for resolutions.

Strike ahead 2,200 years and the traditions are still loosely in place, with more focus on self improvement and goals. The amazing part is New Year's resolutions are attained by a mere 12% of people that have them. Not being one to be outdone, I resolve in 2011 to: wear matching socks, eat more bacon, and finally learn the Macarena. Should any of you find me in violation of these resolutions, please remind me of this (we succeed 10% more when our goals are made public and we have the support of others).

Now back to our regularly scheduled ranting. The two faces of Janus remind me of the current status of dentistry. For the last decade we have seen the same two barriers to all Americans who are trying to obtain adequate oral health care—access and cost.

One approach to combat the access issue that has gained momentum is the use of auxiliary dental personnel. The last few of months of 2010 were rife with articles and information about alternative oral health care providers. As I'm sure many of you are aware, the W.K. Kellogg Foundation, the Rasmuson Foundation, and the Bethel Community Services Foundation commissioned an independent report by RTI International to assess the work of Alaskan dental health aide therapists (DHATs) in five communities in rural Alaska. The DHATs in the study underwent two years of training—one year of clinical training and one year of didactic training. Once training was completed, they worked under the general supervision of a dentist performing sealants, composite and amalgam restorations, stainless steel crown placement, extractions, and oral health instruction. The aforementioned report had small sample sizes of both DHAT providers (only five providers) and population served (300 patients, about 400 procedures). The report found that "therapists were technically competent to perform procedures included within their scope of work and were doing so safely and appropriately."

This report may indeed be the tipping point for mass introduction of DHATs throughout the US. Someone outside our profession is measuring our performance and evaluating and rewriting the standards we practice. Since the report was released, the W.K. Kellogg Foundation has given an additional 16 million dollars to community organizations in five states (Kansas, New Mexico, Ohio, Vermont, and Washington) to develop ways of adding dental therapists to dental teams that provide care in under-served areas. This is concerning because they are setting up dentistry to follow medicine, with a caste system of treatment and care where patients may not be given the opportunity for the best comprehensive diagnosis, treatment, and appropriate alternatives. As we've all seen before, a piecemeal approach to oral health rarely yields any long term results.

Our profession is filled with many of the best and brightest minds in this country. We are all extremely creative and ingenious individuals with an entrepreneurial flare. We must use our wisdom and intelligence to formulate new and alternative plans for caring for the underserved, which will take sacrifices from all of us if it's to work in the grand scheme. On a local level the NNDHP has done a wonderful job, and the volunteerism of the dental community has been tremendous. The framework of our program is a model for the rest of the country and has been copied repeatedly to provide comprehensive care to underserved children. This incredibly valuable service helps a tremendous amount of children, but is not the all-age long-term solution given the magnitude of the need that has been identified.

We have a very difficult road ahead of us. A solution to the access to care and the cost of care won't be found overnight, nor will the first option necessarily be the best option. However, if we put blinders on and continue with the status quo, change will be thrust upon us. The importance of solidarity and our organized components of dentistry are critical for our voices to be heard. There may be differences in opinion as to how we should retain ownership of our profession, but we all agree that the dentist should remain the diagnostician, surgeon, and operator for intraoral procedures.

I don't anticipate having the same conversation 10 years from now on the eve of 2021. Dentistry must change or offer solutions for the problems being presented. Please remain informed and actively participate in the process by attending NDA and NNDS functions, our patients and the citizens of Nevada deserve it. ◆

THE JOEL F. GLOVER, DDS MEMORIAL GOLF TOURNAMENT

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Karen P. West, DMD
UNLV SDM Dean

Hello from the UNLV School of Dental Medicine!

We are in full swing here at the dental school with students preparing for finals and trying to finish up patient care procedures before the holidays! It has been an exciting fall semester with senior students interviewing for residency positions and the newbie first years getting adjusted to the 8–5 (plus studying until midnight) routine. We are very pleased with our first year classes' academic and preclinical performance this year. They are an enthusiastic and highly motivated group of students.

We were also quite excited to receive notice that three of our students were just awarded Predoctoral Dental Student Scholarships from the ADA Foundation.

The Admissions Committee has been very busy this year; interviewing students for the 2011 entering class at UNLV SDM. As of December 1, 2010, we will have sent out acceptances to 98 students for the 75–80 slots available. Four of those accepted will also be awarded the Regents Higher Education Opportunity Award which will be given to outstanding Nevada residents and is a renewable monetary award based on academic performance and professionalism. Thus far, we have received over 2,200 applications for next year's first year class. We will continue to interview until the class is filled.

Residency programs in Orthodontics, Pediatric Dentistry and General Practice have all been interviewing prospective candidates for positions as well. Ortho has four new residents starting the program on July 1, 2011. This year they were extremely lucky to get their top four choices who will come to us from a variety of dental schools located across the country. The other two programs won't know their outcomes until next semester, but we are sure that their accepted residents will be highly qualified and an asset to our school.

We have searches ongoing for four faculty positions—one opening in Endodontics, two openings in Orthodontics and an opening for a dental hygienist who will provide instruction in the Periodontics area of the Clinical Sciences Department. We hope to be able to hire the full-time Endodontist within the next month. Dr. Ron Lemon, our Associate Dean for Advanced Education has gone above and beyond the call of duty as he is currently doing all of the teaching and clinical coverage along with our part-time instructors until that hire is made. We would love to have additional part-time instructors in all areas from the community, so if you are interested, please contact Dr. Michael Sanders, Chair of Clinical Sciences at 702-774-2650.

Our part-time and adjunct faculty dinner was a huge success again this year. On November 18, we had a delicious dinner and celebration for part-time faculty members who give their time and energies to the School of Dental Medicine. They bring a wealth of knowledge and experience to our school, whether it be in the classroom, preclinical laboratories or the clinics. Thirty plus faculty members were honored that night with many more receiving their certificates and gift later. We were pleased to have Dr. Michael Bowers, Interim Executive Vice-President and Provost, with us that evening to bestow greetings from President Neal Smatresk.

Students are continuing their service activities with Saturday Morning Children's Clinic, the Sergeant Clint Ferrin Dental Clinic and the Huntridge Teen Clinic, just to name a few. In addition to these student-operated clinics, the School of Dental Medicine was honored to receive the Silver Syringe Award for outstanding outreach activities from the Southern Nevada Immunization Coalition for the oral screening, education and nutritional instruction provided to school age children in Southern Nevada through the work of Dr. Millie McClain.

The mentorship program with the Southern Nevada Dental Society is up and running with over 30 interested students and dentists participating. Finally, a big thank you to the NDA and the SNDS for their generous donations toward the senior students' membership in the American Student Dental Association. Their partnership with the SDM will allow 100% of the Senior Class to be involved in organized dentistry! ◆

NDA Annual Mid-Winter Meeting

February 11–12, 2011

Silverado Resort, Napa, CA

SILVERADO

REGISTRATION

Event		# Attending	Fee	Total Payment
Registration – NDA Member			$ 0	—
Registration – NDA Spouse/Child			$ 0	—
Registration – Non-Member			$ 100	
FRIDAY, FEBRUARY 11	**Time**			
Golf	10AM–3PM		$ 70	
President's Reception	6:30–8:30PM		$ 60	
SATURDAY, FEBRUARY 12	**Time**			
Breakfast	8AM		$ 25	
House of Delegates	9AM–12 NOON		$ 0	—
Dinner at Markham Winery	6–9PM		$ 100	
			GRAND TOTAL	

Registrations will be accepted until January 28, 2011. **Registrations after this date will be onsite only.**
NO REFUNDS WILL BE GIVEN PAST JANUARY 28, 2011.

Name _____

Guest(s) _____

Address _____

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Accepted forms of payment are:

( ) Check payable to NDA

( ) Credit card (Visa, MasterCard and AMEX)

( ) Online at www.nvda.org

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Silverado Resort, 800-532-0500
Group – Nevada Dental Association
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8863 W. Flamingo Rd Ste 102
Las Vegas, NV 89147
702-255-4211 • Fax: 702-255-3302

Calendar of Events

JANUARY–MARCH 2011

JANUARY 2011

JAN 11	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
JAN 11	SNDS Dinner Meeting	5:30 PM	Gold Coast Hotel, 4000 W Flamingo Rd
JAN 12	SNDS Dentist Health and Wellbeing Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
JAN 13	NNDS General Membership Dinner Meeting	6 PM	The Grove at SouthCreek
JAN 19	SNDS Peer Review Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
JAN 20	CE Café, Dr. Dean Mersky (presented by SNDS)	*Contact the SNDS office at 702-733-8700 for time & location*	
JAN 20	AGD General Membership Dinner Meeting	6 PM	*Location tba*
JAN 25	SNDS Executive Committee Meeting	6 PM	SNDS office, 8863 W Flamingo Rd, Ste 101
JAN 26	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Dr, Reno

FEBRUARY

FEB 5	Give Kids A Smile	All Day	UNLV SDM
FEB 8	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
FEB 8	Nellis AFB Member Dinner Meeting	5:30 PM	Nellis AFB
FEB 9	SNDS Dentist Health and Wellbeing Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
FEB 10	NNDS General Membership Dinner Meeting "Legislative Update"	6 PM	Thunder Canyon Country Club 19 Lightning W Ranch Rd, Washoe Valley
FEB 11–12	NDA MidWinter Meeting & House of Delegates	9 AM	Silverado Resort & Spa, Napa, CA
FEB 16	SNDS Peer Review Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
FEB 17	AGD General Membership Dinner Meeting	6 PM	*Location tba*
FEB 23	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Dr, Reno

MARCH

MAR 8	NNDS Executive Committee Meeting	5:30 PM	161 Country Estates Cir, #1B, Reno
MAR 8	SNDS Member Dinner Meeting	5:30 PM	Gold Coast Hotel, 4000 W Flamingo Rd
MAR 9	SNDS Dentist Health and Wellbeing Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
MAR 10	NNDS General Membership Dinner Meeting	6 PM	The Grove at SouthCreek, Reno
MAR 11	All Day CE Course—"Update in Contemporary Removable Prosthodontics" with Dr. Richard Williamson (presented by the NNDS)	8 AM	The Grove at SouthCreek 95 Foothill Rd, Reno
MAR 16	SNDS Peer Review Committee Meeting	*Contact the SNDS office at 702-733-8700 for time & location*	
MAR 18	All Day CE Course—"Pearls for Your Practice" with Dr. Joseph Blaes (presented by the SNDS)	9 AM–4 PM	Gold Coast Hotel & Casino 4000 W Flamingo Rd, Las Vegas
MAR 18	AGD General Membership Dinner Meeting	6 PM	*Location tba*
MAR 29	SNDS Executive Committee Meeting	6 PM	SNDS office, 8863 W Flamingo Rd, Ste 101
MAR 30	NNDS Peer Review Committee (if clinical)	5:30 PM	3575 Grant Dr, Reno

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www.adaceonline.org

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www.dentalcare.com

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www.kerrlearningsource.com

AFFILIATED PRODUCTS

The following companies are NDA affiliated products. These products have been evaluated and are recommended for use in running your practice. Please let us know if you have any feedback or would like to recommend a product or service for affiliation.

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Collegiate Funding Services	*Student Financing*	**866-312-7227**
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NDA PAST PRESIDENTS

1922 George H. Marvin	1952 Clifford A. Paice	1982 Clair F. Earl
1923 John V. Ducey	1953 Walter R. Bell	1983 R. D. Hargrave
1924 Thomas H. Suffol	1954 Raymond J. LaFond	1984 James L. Davis
1925 George A. Carr	1955 Jack E. Ahlstrom	1985 N. Richard Frei
1926 Samuel T. Spann	1956 J.D. Smith	1986 Lloyd Diedrichsen
1927 Bruce Saulter	1957 Kern S. Karrash	1987 Gerald Hanson
1928 Frederick H. Phillips	1958 Vincent J. Sanner	1988 Gerald C. Jackson
1929 Frederick J. Rulison	1959 Wallaxe S. Calder	1989 James C. Evans
1930 William H. Cavell	1960 John B. Hirsh	1990 Whit B. Hackstaff
1931 Harold E. Cafferata	1961 David W. Melarkey	1991 William E. Ursick
1932 Louis M. Nelson	1962 David W. Melarkey	1992 Dennis J. Arch
1933 Carlton E. Rhodes	1963 Fae T. Ahlstrom	1993 A. Ted Twesme
1934 Pliney H. Phillips	1964 Morris F. Gallagher	1994 Bruce Pendelton
1935 Harold R. McNeil	1965 Wayne L. Zeiger	1995 J. Gordon Kinard
1936 Lawrence D. Sullivan	1966 Mario E. Gildone	1996 Joel F. Glover
1937 Alexander A. Cozzalio	1967 William D. Berry	1997 Rick Thiriot
1938 Charles A. Cozzalio	1968 James F. Archer	1998 Jade Miller
1939 George A. Carr	1969 Philip J. Youngblood	1999 Patricia Craddock
1940 George A. Steinmiller	1970 Carl M. Hererra	2000 William C. McCalla
1941 George A. Steinmiller	1971 George P. Rasqui	2001 Robert H. Talley
1942 Omar M. Seifert	1972 William H. Schaefer	2002 Susan Jancar
1943 Stephen W. Comish	1973 Robert L. Morrison	2003 Dwyte Brooks
1944 Quannah S. McCall	1974 John S. McCulloch	2004 Peter DiGrazia
1945 Oliver M. Wallace	1975 James M. Jones	2005 Robert Thalgott
1946 Gilbert Eklund	1976 Harry P. Massoth	2006 Arnie Pitts
1947 Robert H. Gatewood	1977 Leeland M. Lovaas	2007 George Rosenbaum
1948 E. Ross Whitehead	1978 Blaine R. Dunn	2008 Joel T. Glover
1949 Howard W. Woodbury	1979 Louis J. Hendrickson	2009 Peter Balle
1950 Roy P. Rheuben	1980 Duane E. Christian	2010 John C. DiGrazia
1951 Leonard G. Jacob	1981 Dwight Meierhenry	

Save the Date! *Nevada Dental Association 2011 Meetings*

Mid-Winter Meeting

Silverado Resort, Napa Valley, CA
February 11–12, 2011

Silverado Resort: 800-532-0500

www.silveradoresort.com

Group Name: Nevada Dental Association

93rd Annual Summer Meeting

Grand Wailea Resort & Spa
Maui, Hawaii
July 7–9, 2011

Group Name: Nevada Dental Association
Grand Wailea: 800-888-6100
www.grandwailea.com

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