MONTEREY BAY

SmileLine

The Newsletter of The Monterey Bay Dental Society

Spring/Summer 2008

Inside This Issue

MONTEREY BAY
SMILELINE

Notes From The President...

Hello Everyone! I hope the New Year has been a healthy, happy and productive one so far. I wanted to take some time to update you on the progress we have made on a few of the action items I have been focusing on these past few months.

A little over a month ago, I met with Dr. Tom McKay, Director of Allied Health and Dr. Bridgete Clark, Program Chair for the Cabrillo College Dental Hygiene Program, regarding the status of the dental hygiene alumni association and the potential for enhancing an endowed scholarship for a local hygienist. The meeting was fruitful, and their suggestions and advice lent some good direction to the project.

Following that meeting, Dr. Clark and Debbie Reynon (head of the Santa Cruz ROP dental assisting program) came to our MBDS board meeting held the following week. Dr. Clark was able to give us a status report, and we presented our project itinerary and goals to the board for feedback. Ms. Reynon very graciously offered any assistance she and her students could give in order to bring this project to fruition. Carole Hart, in her infinite wisdom, searched her photographic memory banks and realized that the Monterey Bay Dental Society still had access to $3700.00 in funds currently in the CDA Foundation that had been previously donated by individual dentists to go towards a future hygiene program, directed as such during the time that the dental society had contributed funds to the Cabrillo Hygiene Program. Carole is at this time tracking down this money, and we will be able to put these funds to work.

The following week, the Cabrillo hygiene department graciously invited me to present at the start of their Curriculum Committee biannual meeting. I was able to update them in regards to our project goals. Our main goal is organization of a fundraiser/dinner event which will serve two purposes. First, the function will help raise funds for an ongoing endowment fund for the hygiene department and second, to directly involve the second year graduating class in what would be a graduation event/meet and greet with the local dental community. At this event, scholarships and awards for next year's recipients will be awarded, making it an event to look forward to! Debbie Reynon expressed interest in involving the ROP students as well.

The week following my presentation at Cabrillo, I was contacted by Patricia Anderson, a local hygienist, who requested a meeting between myself, Patricia, and two fellow hygienists, Cheryl Lemon (faculty member at Cabrillo) and Karine Strickland, current President of the Monterey Bay Dental Hygiene Association (MBDHA). All three were acting as representatives of the MBDHA. We met at my office and reviewed the current status of this future project. This meeting was incredibly productive, and the enthusiasm these health care practitioners exhibited regarding the future of dental hygiene around the Monterey Bay was contagious to say the least. The MBDHA is also willing to participate and incorporate their own current scholarship/award event itinerary at this upcoming function.

During all the meetings there was a general consensus that the future of any alumni association lies in the students that are currently enrolled in the program. Focusing our efforts on developing a consistent, enjoyable and enriching event where we can all gather and renew our relationships, celebrate the accomplishments of our new team members, and welcome those just starting their educational journey, will have a lasting benefit on the dental community as a whole. We have a great opportunity to create a community event that will include hygiene alumni, students, faculty, local dentists, hygienist members of the MBDHA, dental assistants and benefactors.

I feel so fortunate for the chance to work with this coalition of incredibly gifted and motivated health care practitioners. I will keep you all updated on our progress. Please feel free to contact me at any time regarding any input or suggestions you may have.

Respectfully,

William C. Francis DDS

President Monterey Bay Dental Society

From The Editor

Times are changing. Paradigms in patient care are changing. Decisions regarding what is the best treatment for a patient who presents with failing restorations, endodontic problems, periodontal disease and who is demanding whiter teeth and fresh breath are far different in 2008 than they were in 1998, and completely different than they might have been in 1988 or 1978. Economic times have changed, too. Whether an individual is working in the service or construction industries, health care or high tech, or if they are retired on a "fixed income", every one of us is feeling a pinch. Personally, even with a hybrid automobile, I cannot believe how much of my monthly budget goes towards gasoline. In my own practice folks are putting off treatment they feel is nonessential, patients are cancelling their maintenance visits, and we are hearing all kinds of new and imaginative reasons people need to postpone their dental appointments.

We may feel an urge to counter this problem by recommending more treatment for our patients, more tests (such as for periodontal microorganisms, salivary pH or metal allergies), and more expensive options for care when more economical alternatives would suffice—and insisting these be started immediately in order to avoid dire consequences. We have staff to pay, rents and mortgages, and after all we have a certain lifestyle to maintain!

I would offer a word of caution. 'Though there are exceptions, the average consumer in 2008 is wary of gimmicks. They want quality and value—and in fact it is my perception that people are looking at expenditures more as investments than purchases. They want honesty, a familiar face who they can trust, and they want their questions answered. They also are prioritizing their needs, and expect their mechanic, tax advisor, personal trainer, physician and their dentist to be up front (and, again, honest) about what matters most, what's next, and what's optional.

I always smile when remembering a plaque nailed above the private office door in the group I first practiced with up in Petaluma. There were five of us in the practice. Vince, the founding partner, was hugely popular in the community and with his patients. He had survived and thrived through tough times and invested in his practice and his family in the good times. His plaque read, "Age and Treachery will always overcome Youth and Skill". Etched into the plaque was a bent-over old man whacking a youngster on the rear with his cane. Vince put that up there just to irritate the rest of us, who were all about half his age. Vince didn't practice treachery. He practiced good quality dentistry, took good care of his patients and his staff, and he made decisions wisely after careful consideration. We all know things will get better. Cavities will get deeper. Gums will bleed. We will get a new economic stimulus package along with a new administration. For now, I would suggest we offer the finest care we can in a manner that our patients know is what they need, and will hold up with time. Offer alternatives. Explain options and risks. Don't take it personally if Mrs. Smith wants to wait. Document what you have recommended. Be available if she wants to come back in and ask a few questions. Be consistent in the care you provide—this is a time when personal and professional ethics are under close scrutiny. And maybe most important, be realistic about your own expenditures and goals.

Best wishes for a great summer

Lloyd P. Nattkemper, DDS
Editor

Monterey Bay Dental Society

Board of Directors for 2008

William Francis, DDS	President
Chad Cassady, DDS	President Elect
Marielena Murillo, DDS	Vice President
Mona Goel, DDS	Secretary/Treasurer
Bruce Donald, DDS	Trustee
Stuart Osaki, DDS	Immediate Past President
Tim Griffin, DDS	County Director
Alison Jackson, DDS	County Director
Geralyn Menold, DDS	County Director
David Shin, DDS	County Director
Robert Woolery, DDS	County Director
Lloyd Nattkemper, DDS	Publications
Bruce Donald, DDS	Fluoridation Committee
Mark Joiner, DDS	Community & Public Relations
Nannette Benedict, DDS	Legislative & Cal D Pac
Carl Sackett, DDS	New Dentist Committee
Alison Jackson, DDS	Dental Health Committee
Kenji Saisho, MD, DDS	Dental Health Committee
Al Grosnick, DDS	Ethics Committee
Nannette Benedict, DDS	Dental Care Committee
David Stein, DMD	Peer Review Committee

In This Issue

Oral Sedation Dentistry and Obstructive Sleep Apnea, Part One

By Todd Morgan, DMD

In recent years the use of oral conscious sedation in dental practice has enjoyed a sharp boost in popularity and demand among anxious consumers. The number of dentists who advertise "sedation dentistry" is increasing and holds the potential to become as common as the "cosmetic dentist." Interestingly, one can draw surprising comparisons between these two labels when you consider that most dentists are very well equipped with the basic skills needed to competently provide a wide variety of professional services, including sedation dentistry. A condition called obstructive sleep apnea (OSA), however, introduces significant risks into the sedation equation. OSA, the third most common health problem behind only diabetes and asthma, and has been proven to be a significant risk factor in cardiovascular disease and significantly contributes to complication associated with anesthesia and sedation. OSA deserves attention from dental professionals, who are in a unique position to screen, refer, and perhaps even treat patients at risk. Undetected OSA is common, and potentially leaves many of our patients vulnerable to problematic airway collapse during sedation procedures.

Last year, the Governor of California signed new legislation aimed at more closely regulating oral conscious sedation provided in the dental setting. As of January 1st, proof of competence and a permit is required of providers who deliver these services for their patients. Of interest is that no permit is required to provide a single, standard dose of a prescription sedative before treatment. But even a single dose given at bed time or for sedation purposes can aggravate pharyngeal collapse, leading to apneic events and significant oxygen desaturation. Any dentist who writes sedative-hypnotic prescriptions for their patients should be aware of OSA and take appropriate precautions in these patients.

SIGNS AND SYMPTOMS OF OSA

The hallmark symptom of OSA is snoring: a consequence of partial upper airway obstruction and dubbed "the second most obnoxious sound that comes from the human body." Snoring is common and probably benign in most cases. However, with the progression of time, the influence of gravity, and an extra 25 lbs, snoring can progress to more serious pharyngeal collapse and apnea. A typical patient with OSA that might present in our practices is a male, between 40 and 60 years old that is mildly obese and has the type of tongue and access to the oral cavity that will have us considering a new occupation. However, thin people can have apnea as well and monitoring the blood oxygen saturation of every patient before, during and after operative procedures is essential. Multiple dosing is a common practice in oral conscious sedation and this can often lead to a peak in pharmokinetic action, producing significant apnea. Under these circumstances, even healthy patients may begin to exhibit apnea and pharyngeal collapse, requiring respiratory assistance such as "chinning" (mandibular protrusion) technique or ventillation. Sedation dentists that employ longer acting agents are obliged to guard against a "peak" occurring some time after a procedure is completed and the patient is home "sleeping it off," and still susceptible to apnea. If the patient has a CPAP machine or an oral appliance, this is an important time to wear these devices.

THE ANESTHESIA EXPERIENCE

The American Society of Anesthesiologists (ASA) has already established guidelines on the management of OSA patients in hospitals, implementing special precautions and protocols such as close observation and avoidance of narcotics. Patients are instructed to bring CPAP equipment or an oral appliance with them for use post-op. A prospective study at Barnes Jewish Hospital in 2006 that looked at the incidence of OSA in the peri-operative setting found an alarming 40% at risk for moderate-severe apnea. It is known that OSA patients are at 4 times greater risk for post-op complications and by the year 2009, according to the Joint Commission on Accreditation Organization, hospitals will be required to have protocols in place that will detect and provide safety measures for undiagnosed patients, such as screening questionnaires and pre-op overnight oximetry. What lessons can we learn from our medical colleagues?

Sedation is an important service that has allowed many fearful patients access to treatment and better dental health. Careful administration of oral sedation medications is safe and effective, but the prudent dentist should be aware of the added risks associated with OSA. The undiagnosed patients are of special concern, when even appropriate doses of sedatives or narcotics can produce significant upper airway collapse. Part 2 in this series will provide physical clues and simple screening techniques that can unmask the OSA patient and reduce your risk of complications.

C. Herder, J. Schmeck, D. JK Appleboom, and N. de Vries. Risks of general anaesthesia in people with obstructive sleep apnoea. BMJ, October 23,2004

Finkel, K. L. Saager, E. Safarzedeh, M. Bottros,, and M. Avidan. OSA: The Silent Pandemic, In ASA Annual Meeting. 2006 Chicago IL.

R.M. Gupta, A.D.Hannsen and P.C. Gay. Post-operative complications in patients with OSA syndrome undergoing hip or knee replacement: a control study. Mayo Clinic Proc. 2001

Todd Morgan, DMD, is a restorative general dentist who has developed a special interest and training in sleep medicine. His early research in association with physicians has shown that snoring and obstructive sleep apnea (OSA) can be effectively treated with a new approach called oral appliance therapy (OAT).

Dr. Morgan graduated from Washington University School of Dental Medicine in 1985. He was certified in oral appliance therapy for the treatment of snoring and OSA in 1999. He is a founding member of the Academy of Dental Sleep Medicine and served on its Executive Board for several years. He lectures locally on sleep disorders and is internationally published on oral appliance therapy.

He can be reached at (760) 436-9292.

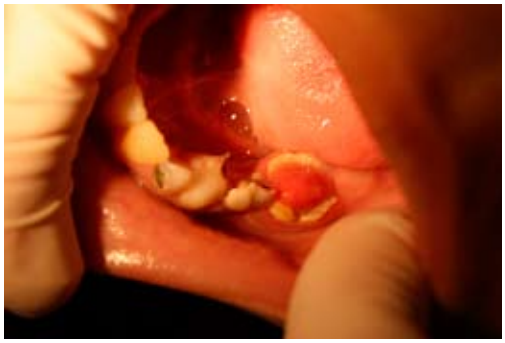
Editor's Note:
This article is provided with kind permission of the author and the San Diego County Dental Society.

Dental Volunteer Trip to Cambodia 2008 - International Health Emissaries

By J. Mark Bayless, DMD

Our first clinic is about to begin, and we are bouncing down a rutted dusty road deep in rural Cambodia. Our destination is the Sras School, where there are over 500 Cambodian elementary students waiting for us to arrive. We pass carts being pulled by a double team of oxen, young shaven head smiling monks clad in orange robes wielding shovels filling potholes. The young monks wave and stare curiously at our two vans packed with supplies as our group of 13 dentists and volunteers pass by leaving a cloud of dust billowing behind. The "houses" along the road are all built on stilts to stay above the water line during the rainy season, and what little water is left from the past rains fills the ditch between their stilt shacks and the road. In the muddy water the naked kids swim, net half-dollar size fish, wash their dishes, and even drink. No wonder some 30,000 Cambodian children die each year from dysentery.[1]

Cambodia lost 2 million souls during the reign of the Khmer Rouge, which ended in 1979. Nearly all the dentists, doctors, and anyone suspected of having any intelligence about the Khmer Rouge were killed, died of disease, or starved to death in Khmer work camps. As a result, Cambodia is one of the poorest nations on earth, with a per capita income of only $300.



In the developed, industrialized world, many people take access to medical and dental care for granted. They might only briefly encounter the misery of a lack of access to care when they are away on vacation or visiting a remote area. For many people, however, lack of access to care is an everyday experience. High-income countries (like the United States, United Kingdom, Japan and Australia) have a dentist-to-population ratio of about one dentist to every 1,600 people. By contrast, countries in the low-income group (like Cambodia, Nigeria, Togo and Mongolia) have, on average, a dentist-to-population ratio of about one dentist to every 119,000 people. Clearly, the major oral health problem for people living in low-income countries is a shortage of dentists and other trained personnel capable of delivering oral health care. This problem is exacerbated by the fact that nearly all dentists in poorer countries are located in the larger urban areas, while much of the population lives in rural areas. Thus, the results of a simple dental abscess can be catastrophic. In poor communities and countries (that is, lower-middle-income and low-income countries), where there is no dentist within easy access, the delay before seeking any form of treatment frequently is long, thus exacerbating the damage caused and the dangers of all oral diseases. People simply have to endure the symptoms, which often include severe pain and disability, and alleviate the major symptoms as best they can. The result is that the natural history of the oral disease is played out to its fullest: teeth develop abscesses, which go untreated, and what appeared initially as minor ulcers and painless swellings progress to untreatable carcinomas and massive cysts and other tumors.[2]

This is why we have chosen to spend the time, energy, and resources to lend a hand in Cambodia. Our group consisted of the following dentists from the Monterey Bay Dental Society: Walt Kitagawa, Marc Grossman, Jeff Meckler, Mark Bayless, and our families. Our organization is International Health Emissaries [3] (IHE) (www.internationalhealthemissaries.org), and in Cambodia we work with Angkor Hospital for Children (www.angkorhospital.org), who arranges the schools where we work. We bring portable lights, dental units, operative boxes, surgical supplies, clothes and toys.

On our past trip to Cambodia, we stayed in Siem Reap, the gateway to the fabled ruins of Angkor Wat. We worked

Dental Volunteer Trip to Cambodia 2008

four and a half days in the schools, seeing approximately 300 patients-- doing 403 extractions and 102 restorations in difficult conditions. We pay for our own travel, lodging, and food expenses, as all donated monies to IHE goes 100% to buying equipment and supplies. We typically work for one week, then the second week we travel throughout Southeast Asia.

It sounds like hard work, and it is! However, the great joy of being able to provide pure dental care without all the paperwork, insurance and hassles of running our day to day offices is very refreshing, particularly when our patients, the Cambodian children, are so appreciative and so poor that they never have seen a dentist and have absolutely no access to dental care at all (not even emergency rooms).

As I look up from my little Cambodian patient to the windows and doorways of our school room converted into a dental clinic, and see the hundreds of kids watching our every move, it's like the circus has come to town. We are dental rock stars for once. As dental professionals, there are many ways to volunteer our services to the needy, and our way is no better than yours. However, the need is massive as there is a worldwide bottomless pit of decay. My consolation when thinking about the magnitude of needs is simple: if I can help get just one child out of pain, it has been worthwhile. There is an old Hindu saying; "How do you eat an elephant? One bite at a time…..".

Dr. Bayless has volunteered his time with The Flying Doctors since 1985. He has traveled to Mexico, Nicaragua, Honduras, Guatemala, Nepal, Cambodia and Peru providing dental care at no cost to children. He now serves as a board member of International Health Emissaries, an organization that provides dental care to the needy in developing countries around the world. He maintains a full time pediatric dental practice in Monterey.

[1] WHO Factbook. In addition to our dental clinic, the four families on this trip we also paid for four water wells (drilled 30 meters deep) for four families in order to provide potable water.

[2] Poverty, oral health and human development, Contemporary issues affecting the provision of primary oral health care , J Am Dent Assoc, Vol 138, No 11, 1433-1436. © 2007

[3] IHE also provides dental care in Guatemala, Honduras, Nicaragua, Ecuador, and Peru. For more information or to donate, please visit our website or call our President Jack Faia D.D.S. at (831) 647-8742

MBDS Calendar of Events - 2008

June 12, 2008
Kent Williams, DDS
"Embezzlement in the Dental Office"
General Membership/Dinner Meeting
Bittersweet Bistro, Aptos
6:00 PM – 9:30 PM
1.5 CEUS in Category Two

June 27, 2008
Dennis Tarnow, DDS
"Controversies and Innovations in Implant Dentistry"
Embassy Suites Hotel
9 A.M. – 5 P.M.
7 CEUS in Category One

July 18, 2008
Art Curley & Eve Cuny
"Dental Practice Act & Infection Control" (Dental Board Mandated Course)
Embassy Suites Hotel
8 A.M. – 1 P.M.
4 CEUS in Category One

August 15, 2008
Van Haywood, DMD
"Tooth Bleaching & Esthetic Information to Make Everyone Smile"
Embassy Suites Hotel
9 A.M. – 5 P.M.
7 CEUS in Category One

September 12-14
CDA Scientific Sessions
San Francisco

October 24, 2008
General Membership Dinner/Meeting
Installation of Officers
Pasadera Country Club
7:00 P.M. – 10:00 P.M.

Personal Finance 2008

By Doug Carlsen, DDS

One of my primary goals is to simplify the dentist's financial life. Unfortunately, we often tend to believe that finance is much more complicated than it need be. Below are some tips gleaned from Consumer Reports, American Association of Individual Investors (AAII), and Burton Malkiel's A Random Walk Down Wall Street.

Personal Planning

Use Quicken at home for budgeting, retirement planning, even on-line bill paying. It is extremely sophisticated, yet easy to follow. You, or your partner, will need to spend several hours setting it up, yet those hours will pay off handsomely over the years---especially if your partner sets it up. Both of you need to view frequently---once a quarter---yes, frequently---no cheating!

Place all the investments possible into one financial institution for tracking and reallocation ease. Many brokerages, such as Vanguard, Fidelity, and Schwab, are able to track outside accounts as well. If this is not possible, QuoteTracker can track online for free---www.quotetracker.com.

Make sure all stock certificates are held at a financial institution. Any trades must be done with the brokerage in possession of the certificates, and if you ever lose the stocks, you will pay a 4%-6% fee to replace. I learned this the hard way last year.

Use Its Deductible (itsdeductible.com) to track clothing and monetary gifts to charity. You receive fairly generous deduction allotments for items donated to Goodwill, Salvation Army, etc. The service costs $20/year and is connected to TurboTax, so is IRS-friendly.

Home, auto, and umbrella insurance policies need to be with the same company for ease of tracking and lower rates.

Safeguard your financial identity by having your name removed from all those pesky, and potentially ruinous, preapproved credit cards and insurance. Yes, you do need to shred the junk mail! Go to www.optoutprescreen.com. You will have to provide your social security number, but the service, operated by the major credit bureaus, is legitimate.

Asset Allocation

Changes have been in the wind since 2004. The large financial institutions' analysts now feel that stocks should comprise 90% of one's portfolio up to age 40. This percentage of stocks will gradually lower to between 50%-60% by retirement. Analysts previously recommended 20%-30% stocks and 70%-80% fixed income (bonds and cash) in an early-retirement (age 60-70) portfolio. They are now recommending 50%-60% stocks, and 40%-50% fixed income in early retirement. Why? Actuaries have found that retired couples often live 30 years or longer in retirement. Stocks have historically performed much better than fixed income investments over an extended time frame. Furthermore, investors of most ages are now directed to invest 15%-30% in international funds---up from 0%-5% three years ago. Why? International funds are considered safe and sophisticated havens today with the flattening of the world economy and the rapid dissemination of large corporations into all corners of the world. International funds often do not move in tandem with US funds, reducing overall portfolio risk.

Below are averaged asset allocations from the January 2007 AAII Journal. They are taken from allocations used for Life-Cycle Funds of large brokerages. Life-Cycle Funds are intended as an all-in-one investment vehicle. For those having a defined benefit pension and/or those seeking to leave an estate, a different overall allocation may be indicated. Please check with your financial adviser for proper allocation. All assume a retirement at age 65.

Age 40	Age 55	Age 65	Age 75
US Stocks 72%	US Stocks 53%	US Stocks 45%	US Stocks 28%
International Stocks 20%	International Stocks 15%	International Stocks 12%	International Stocks 6%
High-Grade Bonds 7%	High-Grade Bonds 27%	High-Grade Bonds 35%	High-Grade Bonds 40%

continued on page 8

Personal Finance 2008

Cash, Short Term Bonds 1% Cash, Short Term Bonds 5%
Cash, Short Term Bonds 8% Cash, Short Term Bonds 26%

Consumer Reports, in January, 2007, further simplified with the following "no-nonsense" asset allocation for investors of all ages:

Large-Cap Stock Fund 30%
Small-Cap Stock Fund 30%
Foreign Stock Fund 30%
Money Market Fund 10%

Consumer Reports further related that it may be prudent, if concerned about short-term loses when nearing retirement, to increase your holding to 30% bonds and asset-allocation funds, while lessening the stock funds to 60% total. This advice is similar to the above AAII broker's recommendations.

Gold? Since it always comes up---yes, a modest amount in an ETF, such as iShares Comex Gold Fund (IAU), may reduce the variability of your total portfolio if you feel that inflation may increase. None of the analysts I have read indicate a probability of inflation rearing its ugly head in the foreseeable future and nearly all feel that metal-free dental portfolios are considered most prudent. If you must, keep metals to 5% or less of your total allocation.

Happy planning!

About Doug Carlsen

Doug Carlsen, DDS, retired at age 53 from private dental practice in Albuquerque and clinical lecturing at the UCLA. He is a feature writer for Dental Economics. He currently lectures on Your Number Now, a retirement workshop for dentist and spouse, and Secrets to Wealth Building, 2007. He lectures, writes, and consults dentists on business and personal finance with emphasis on cash flow. Contact at 760-798-0886 or drcarlsen@gmail.com. Dr. Carlsen generously offers his insights to those of us practicing around the Monterey Bay.

MBDS Trustees Report

The CDA Leadership Conference was held in La Jolla Feb. 29 - Mar. 1 followed by the CDA Board of Trustees meeting Mar. 1 - Mar 2. The Leadership conference was a huge success. Not only was there good information on Surviving & Thriving as a Volunteer in Organized Dentistry, but also there were several other topics of great interest for your practice. Subjects covered were: Communication - Delivering your message, Effective Recruiting & Hiring, and Practice Management. One of the great benefits of volunteering at MBDS or at CDA is meeting with your colleagues and sharing and learning ways to better provide dental care and improving our leadership skills. Please call Carole Hart if you'd be interested in volunteering.

In addition to other actions the Board of Trustees has the job of evaluating the Executive Director of CDA each year. We have found that Peter DuBois is doing an excellent job for CDA and our organization is thriving, fiscally sound, and striving to provide better benefits to our members. Our staff at CDA, under his direction, is functioning well and efficiently. The CDA building which we own is nearly 100% leased, and we approved some remodeling to the entry foyer to keep it attractive and competitive as a prime downtown business building. We also approved action items, which will streamline our Peer Review system. These action items will be submitted to the CDA House of Delegates in September for their ratification.

Bruce Donald DDS, Trustee

Community Partners to Help Patients in Need

By Kathleen McCarthy

An exciting new partnership has been formed between Santa Cruz County's two safety net dental clinics (Dientes Community Dental Care and Salud Para La Gente), a local foundation (Pajaro Valley Community Health Trust), and members of the Monterey Bay Dental Society. These partners are working together to expand upon Dientes' successful Dental Affinity Program (DAP) to reach low-income, uninsured patients in need throughout Santa Cruz County.

The Need: Many people believe that the need for dental services among low-income people is being addressed by government sponsored programs. This is simply not the case. While lack of dental insurance is one of several barriers to regular dental care, even those with public insurance are many times unable to access dental care due to the limited number of providers participating in publicly funded programs, such as Denti-Cal. Unfortunately with few private practitioners currently available to treat underserved populations, the local safety net programs are being inundated with patients and are not capable of filling all the gaps.

The goal of DAP is to help connect low-income uninsured adults with access to quality, affordable dental care. DAP is a collaboration between the local safety net clinics and local dentists to provide pro bono dental care to uninsured adults.

Patients are carefully screened at Dientes Community Dental Care and Salud Para La Gente before being referred to volunteer providers. These providers see patients in their office for the period of time required to complete the dental treatment plan and then redirect clients back to the referring clinic for their on-going care.

The Call to Action! DAP needs the help of local dentists willing to donate their time to provide pro bono dental care to low-income Santa Cruz County adults without health insurance. Dental volunteers have the option to accept referral calls only when it is convenient for them and their staff. Care will be taken to rotate referrals among all volunteer dentists to ensure that no individual provider is overburdened. DAP will be publicized through various media outlets. In addition, participating volunteers will be recognized publicly and acknowledged in writing for their generous in-kind contributions (which are tax deductible).

Please partner with us to improve the health of those in greatest need in our community by volunteering your time to see patients in need. For more information about volunteer opportunities with the Dental Affinity Program, please contact Kathleen McCarthy Program & Grants Manager at the Pajaro Valley Community Health Trust at (831) 761-5695.

Dientes Community Dental Care Update

By Hugo J. Ferlito, DDS

In the last issue of the SmileLine I discussed the concept of the "Dental Affinity Program". The concept was that I (as Clinical Director of Dientes) would select and screen a patient for a participating Dentist to treat. The treatment would be pro bono with the patient paying all lab fees to the dentist directly.

I am happy to tell you that we have moved beyond the concept phase into the implementation of the program. Thanks to six practitioners—Drs. Thomas Young and William Francis of Santa Cruz, Drs. Dave Montgomery and Ballan Tuck of Aptos, Dr. Nannette Benedict of Scotts Valley and the Central Coast Pediatric Group, we are beginning to see the program take off. Patients are receiving the type of care that they could not obtain under normal circumstances.

Dr. Gerald T. Kondo of Watsonville has not only become a Dental Affinity program participant, he is taking charge to make Dental Affinity program happen in South County .

Dientes will provide the participating dentist with IRS documentation for the value of the treatment rendered.

This is truly a "win-win" situation. The patients are so thankful! One young woman who is working and going to school told us that this is the first time in her life someone has extended a hand to her.

So, want to get involved? Would you see one patient and make a contribution of the incredible gift you have as a healer? With one patient at a time we can make a difference, a significant difference in the life of an individual.

If you want to participate please contact me.

Warm Regards,

Hugo

Dr. Ferlito is Clinical Director of Dientes Community Dental Care, 1830 Commercial Way, Santa Cruz 95065. His direct line is (831) 464-5422. Fax (831) 464-5415 and e-mail drferlito@dientes.org

Editor's Note:

For those of you who are confused, both Kathleen and Hugo are hard at work in efforts to make the Dental Affinity Program become a viable ongoing reality in the Santa Cruz/Watsonville area. Dr. Ferlito sincerely desires dentists in ALL regions of the Monterey Bay Dental Society to participate.

How Many Ways?

By Virenchandra R. Patel, DDS

Private Practitioner

When was the last time you thought about your dental license and what you went through to get it? How much thought have you given to the process for our newly graduating colleagues? For us, getting licensure was simple: Pass the Dental Board of California exam. Today, however, there are a few more routes to licensure available and a new one on the horizon.

Following the enactment of SB 1865 (Aanestad), the Western Regional Board Examination (WREB) was approved by the Dental Board of California as equivalent to The Dental Board of California Exam (DBC). The WREB is now available to graduates as an alternative to the DBC. The introduction of the examination in 2006 resulted in some graduates taking the WREB and some taking the DBC. There were some difficulties with the scheduling of the California law and ethics exam for those that took the WREB and this led to a delay in getting licensed. The Dental Board of California added many more dates for the law and ethics exam the following year and as such the vast majority of candidates chose to take the WREB in 2007. The WREB exam is perceived as being easier by most candidates as it has a historically higher pass rate. The fact that there is no time limit for the clinical portion of the exam may also be a contributing factor to this perception.

Other differences exist between the WREB and the DBC, the biggest one being that the WREB is accepted by the licensure agencies approximately 25 states. The fees for the examinations also differ, with the DBC exam costing approximately ⅓ less than the WREB.

With the addition of the WREB, some of the dental schools have made changes to the preparations they offer to candidates. USC continues to offer mock boards based on the DBC, whereas Loma Linda offers a full WREB qualifying exam that uses WREB forms and criteria. UCSF has made no alterations to its curriculum in light of the WREB introduction. However it does offer its students mock examinations of both the DBC and WREB variety. No students at UCSF chose to take the DBC exam this year, a fact that is of no real surprise. UCSF does not officially recommend one board exam over the other, however graduating students are like water in that they will find the path of least resistance when it comes to licensure.

The question to be asked is whether the primary function of the Dental Board of California, ensuring the safety of the public, is still being fulfilled by the introduction of the WREB. Are the graduates being held to the same standard or are we allowing individuals who should not be practicing dentistry to slip by. There are some members of the examinations committee who feel that over the years the competency level has dropped and that the WREB has further lowered the standards.

Even more recently SB 683 allowed another route to licensure via completion of an Advanced Education in General Dentistry (AEGD) or advanced education in General Practice Residency (GPR) program. This route allows individuals to bypass the examinations route entirely via further education.

Another alternative portal for licensure has been proposed by the Dental Board of California. It involves a standardized portfolio of clinical achievements during the candidate's dental school education. In addition, the schools competency examinations would also be the basis on which the candidate would be determined competent for licensure. My own experience with the portfolio system in the UK was a positive one. The requirements were quite stringent and the competency level of the graduates was very high. One difficulty with this system may be that the demographics of patients who present to dental schools have changed. Ensuring that each student has sufficient experience in carrying out the necessary procedures may, therefore, become difficult. If a portfolio system is to be put in place the dental schools will have to ensure that sufficient experience was gained by the candidates. For example, patients that required root canal treatment are commonly funneled into the post doctoral programs and pre-doctoral candidates have limited experience in carrying out these procedures.

(Editor's note: Does that infer that California Schools are graduating dentists with limited or no CLINCAL experience in areas such as Endodontics, Orthodontics, Prosthodontics and perhaps even Restorative, who will then be licensed?)

The Portfolio proposal needs to be examined very closely. We need to ask whether the institutions that educate and train dentists should also be the ones determining licensure. There may be a conflict of interest in this scenario if the proper safeguards are not in place.

As it stands today the Dental Board of California has little say in who is fit to practice in our state as the net effect of SB 1865 was to outsource the clinical exam to WREB and introduction of SB 683 allows candidates a route to licensure bypassing examinations entirely.

This article was provided with the kind permission of the author and the Sacramento Dental Society

What to Expect When You are Inspected by Cal/OSHA

By Rodney Stine

Cal/OSHA, also referred to as DOSH, is California's occupational safety and health enforcement agency, covering nearly all employees in the state, except federal employees who fall under the jurisdiction of Federal OSHA. Cal/OSHA conducts workplace inspections to determine whether employers are complying with Cal/OSHA requirements. In the dental industry, most Cal/OSHA inspections are triggered by complaints, most often made by disgruntled employees who feel that their overall concerns at work have not been adequately addressed.

Initial Contact

When a Cal/OSHA inspector makes initial contact at a dental office, he will request permission from the employer to conduct an inspection. You will not receive advance notice of the inspection. If you are busy with a patient when the inspector arrives, you can request that the inspector wait or return at a more convenient time. However, an inspector can refuse this request and demand to see the office immediately.

Important: Be sure to check the inspector's credentials and request a DOSH business card from the inspector. Prior to the inspection, the inspector should immediately identify himself by showing the State of California photo identification card and DOSH business card.

Opening Conference

The inspector will begin by explaining the reason for and scope of the inspection to the employer, and will then request required documentation and records– permits, registrations, proof of workers' compensation coverage, required posters, training records, employee exposure records, required plans - Injury and Illness Prevention, Bloodborne Pathogen Exposure Control, Hazard Communication, MSDS binder, inventory list of hazardous chemicals, hepatitis B vaccination records, exposure incident documentation (if applicable), sharps injury log, etc. If the inspection is the result of an imminent hazard, the inspector will immediately ask to be taken to the imminent hazard.

The scope of the inspection can range from a partial inspection, which is limited in scope, to a comprehensive one, which encompasses the entire worksite. In dentistry, partial inspections are generally conducted based on compliance with the Bloodborne Pathogens Standard - Title 8 CCR Section 5193.

The Walkaround

The inspector will conduct a walkaround to check work areas for safety and health violations, gathering physical evidence and examining required records. Such activities include observing safety and health practices, talking with employees or conducting formal interviews, taking photographs, and testing air and noise levels. Make sure an office representative accompanies the inspector at all times during the inspection.

During the walkaround, each complaint item will be evaluated to determine if the alleged hazard exists. Make sure safety policies and procedures are well documented, as Cal/OSHA personnel keep track of an employer's good faith effort to comply with Cal/OSHA regulations. Additionally, it is to the employer's benefit to be helpful, courteous, and responsive throughout the walkaround. However, when answering direct questions, take care not to volunteer too much information, as "anything you say can be used against you".

Closing Conference

A closing conference is held to discuss any alleged violations observed and requirements for abatement, the proposed penalties for each citation, the possibility of a follow-up inspection, the employer's rights to appeal, and the employer's responsibility to post citations in the workplace.

Proof of violations abatement must be submitted to Cal/OSHA within no more than 30 days for general violations and seven days for serious violations.

After the Inspection

Following the inspection, employers have ten days to request an informal conference with Cal/OSHA, during which employers can request extensions on abatement dates, present evidence contesting a citation, or express concerns that the proposed penalties are inappropriate.

Penalties can range up to $70,000 per violation. A willful violation that causes death or permanent damage or prolonged impairment of an employee can result in, upon conviction, a fine of up to $250,000 or imprisonment up to three years, or both. Upon receipt of the citation(s), an employer has only 15 working days to file a written appeal with the Cal/OSHA Appeals Board.

Rodney Stine is the president of OSHA Review, Inc., which provides the Spore Check System, a weekly spore testing service endorsed by CDA, and SUV Disinfectant, an effective surface disinfectant and cleaner. OSHA Review, Inc. also publishes OSHA Review, a bimonthly continuing education subscription service for California dentists. For information about Spore Check, SUV, or OSHA Review, call toll free 800-555-6248.

Dental Treatment and Hypertension:

Blood Pressure Guidelines

Systolic Pressure	Diastolic Pressure	MRF	Guidelines
120-139	80-89	Y/N	Routine treatment OK: Discuss High BP Guidelines
140-159	90-99	Y/N	Routine treatment OK: Consider sedation for complex dental or surgical procedures; refer for medical consult
160-179	100-109	N	Routine treatment OK: Consider sedation for complex dental or surgical procedures; refer for medical consult
160-179	100-109	Y	Urgent dental treatment OK: Refer for medical consult
180-209	110-119	N	No dental treatment without medical consult
180-209	110-119	Y	No dental treatment: Refer for emergency medical treatment
>210	>120	Y/N	No dental treatment: Refer for emergency medical treatment

MRF: Medical Risk Factors (such as previous myocardial infarction, angina, high coronary disease risk, recurrent stroke prevention, diabetes, kidney disease)
Source: Herman WW, Konzelman JL Jr, Prisant LM: New national guidelines on hypertension: A summary for dentistry JADA 2004; 135:576-84

Editor's Thoughts For The Day..

The whole earth is the tomb of heroic men, and their story is not graven only on stone over their clay, but abides everywhere, without a visible symbol, woven into the stuff of other men's lives.

Thucydides

The greatest men have been those who have cut their way to success through difficulties.

F. W. Robertson

Whatsoever in my practice or not in my practice I shall see, or hear, amid the lives of men which ought not to be noised about, as to this I will keep silence, holding such things unfitted to be spoken.

Hippocratic Oath

The man, whom I call deserving the name, is one whose thoughts and exertions are for others rather than himself.

Sir Walter Scott

….and on a slightly less serious note…

I'm living so far beyond my income that we may almost be said to be living apart.

Hector Hugh Munro

New Antibiotics Protocols - Less Liability of More of The Same?

By Arthur W. Curley, Esq.

For a number of years the standard of care for medically compromised patients was to look to the medical community for guidance as to prophylactic application of antibiotics. When the American Heart Association set forth guidelines for patients undergoing dental care and the application of antibiotics, a standard of care was created. A prudent dentist, once determining a potential cardiac issue based on a health history, was required to either follow those guidelines or consult with the patient's family physician. In either case, careful documentation was essential.

As a result of recent studies looking back over a number of years outpatient treatment, the AHA guidelines have recently been change to narrow the circumstances where in antibiotics should prophylactically be prescribed before dental treatment.

The AHA now says that patients at the greatest danger of bad outcomes from infective Endocarditis and for whom preventive antibiotics prior to a dental procedure are worth the risks include those with:

Artificial heart valves.

A history of having had Infective Endocarditis

Certain specific, serious congenital (present from birth) heart conditions, including un-repaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits

A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure

Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device

A cardiac transplant which develops a problem in a heart valve.

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of congenital heart disease.

More importantly this change in policy creates the potential for new liability. That is because the new guidelines regarding antibiotics also say 'Drugs carry risks, including fatal allergic reactions and possibly making the bacteria that cause Infective Endocarditis to become resistant to antibiotics. Although allergic reactions are minimal, new evidence shows the risks outweigh the benefits for most patients receiving these antibiotics.'

Therefore, unnecessarily prescribing antibiotics creates a liability for the potential reactions a patient may have to medications that were not needed. Unfortunately, it is not merely a matter of reducing the amount of prescriptions. Many physicians are not current on this change in the guidelines and may advise the patient that they still need antibiotics before dental treatment. While that advice may be wrong under the current guidelines, a dentist can not override the advice of a physician because to do so would be practicing medicine without a license.

Accordingly we offer these guidelines. The patient is seen with traditional cardiac issues that no longer require antibiotic coverage: The dental practitioners should follow the new AHA guidelines. On the other hand if the patient or their physician insist on prophylactic antibiotics the dentist is left with two choices. First, obediently follow those demands but carefully document that the decision was that of the family physician. This can be documented with a confirming letter, or better yet a confirming fax sent to the position confirming the mandate for medication. Many dental malpractice insurance companies have pre-drafted forms for just these occasions. Be sure to use the 'activity report' setting on your fax machine to print out proof of the transmission and receipt. Second, the dentist can decline treatment and request the patient get a second opinion from another physician.

In other circumstances, when the dentist believes that antibiotics should be prescribed and the physician refuses, the dentist is left with the same choices as noted above. Either follow the advice of the physician and carefully issue confirming documentation or decline treatment.

Lastly, in an emergency situation and the patient is in pain: What happens if the dentist can not get a hold of the family physician to confirm the need or lack of need for antibiotic coverage? Interestingly, that situation often dictates an independent need for antibiotic application because the pain could be due to a dental infection and such infections could be more troublesome for the patient's oral and cardiac condition. In such cases the doctor needs to carefully document the degree of the emergency in the clinical findings associated with the pain such as periodontal pockets, tooth mobility, fever, swelling, or other signs and symptoms of infection before performing treatment and providing antibiotics.

In any case it is the requirement of all dentist today to stay current with the standard care and changes in guidelines. It is not a defense for a dentist to be uneducated. The American Dental Association and local component dental societies frequently distribute updates. ADA members often get news updates of such changes, there thereby creating the atmosphere for a change in the standard of care. Location is less of a defense these days because everyone, urban or rural, can access the Internet and receive e-mail.

Staying current, documenting the patient's condition, and making written confirmation of communications with family physicians and the reason for the decision related to antibiotics will protect the prudent dentist from claims of malpractice or substandard care.

Full AHA text: http://www.americanheart.org/presenter.jhtml?identifier=3047083

ARTHUR W. CURLEY

Mr. Curley is a senior trial attorney in the San Francisco based health care defense firm of Bradley, Curley, Asiano, Barrabee & Crawford, P.C.

This article first appeared in the Santa Clara Dental Society's Cutting Edge. Our thanks to Kathleen Cooper, SCDS's exec. director, and to Mr. Curley!

Dr. Ron Wickum remembered—

By Gary Klugman, DDS

The Monterey Bay Dental Society lost one of it's most enthusiastic and optimistic members on Dec 9, 2007. Even as he battled with his cancer, he remained optimistic. He would even play golf after treatment. A setback that meant more metastases were found only meant that he needed more treatment for a cure. He celebrated his birthday with his twin brother and friends and patients just a couple of weeks before he passed away. He was upbeat, bald, articulate, and happy to see everyone.

Ron once said he enjoyed his profession so much, it was his hobby. He always stayed current or a little ahead of the curve with his education and equipment. Dentists from all over the country would seek his advice and enjoy being around him at meetings. He worked with the Santa Cruz Coroner's office for 35 years. He was a Charter Member of the International Academy of Laser Dentistry, a Fellow of the Royal Society of Medicine, a Member of the Dental Organization for Conscious Sedation, a Fellow of the American Academy of Forensic Sciences, a Life Qualified Member of the Crown Council, a Member of the Academy of Cosmetic Dentistry, and a Life Member of the American Dental Association.

He loved the outdoors especially hunting, fishing, and golfing. He is survived by his wife of 43 years Bunny; children Jeff and Dr. Suzanne Wickum; and brothers, Tom and Dr. Don Wickum.

Abstracts

Immediate dentin sealing supports delayed restoration placement

P. Magne, et al
J Pros Dent 98:3 2007

The authors state that the results of the in vitro study indicate that freshly cut dentin surfaces (inlay, veneer, and crown preparations) may be sealed with a dentin bonding agent immediately following tooth preparation, prior to impression making. Three-step etch rinse or 2-step self etching DBA's are recommended, and the bond of the definitive restoration to the resin-coated dentin can still be obtained following extended placement of provisional restorations up to 12 weeks. Also, the sealed dentin is protected from bacterial leakage and the risk for postcementation sensitivity is reduced.

Efficacy of an automated flossing device in different regions of the mouth

A. Hague & W. Carr
J Perio 78:8 2007

The study found that the automated flossing device (Ultra Flosser, William Getgey Co.) removed significantly more interproximal plaque in molar, premolar, and anterior teeth compared to manual floss at days 15 and 30.

Current ceramic materials and systems with clinical recommendations: A systematic review

H. Conrad, et al
J Pros Dent 98:5 2007

Results of the study indicate there is not a single all-ceramic material or system for all clinical situations. The successful application is dependent upon the clinician to match the materials, manufacturing techniques, and cementation or bonding procedures with the individual clinical situation.

GOT X-RAY STUFF?

If you are converting to digital radiography and have analog equipment or supplies no longer being used, Cabrillo College Dental Hygiene is looking to help you. Please consider donating functional equipment, film, developer, fixer etc.! Any such items are eligible as charitable donation income tax write-offs.
Contact Aud Kennedy at (831) 477-5269 or aukenned@cabrillo.edu

Dental Administrative Assistant/Dental Front Office Skill Certificate

Interested in a career in Dental Administrative Assistant/Dental Front Office?
Need a couple extra units for a full load to keep financial aid?
Brush up on your dental/medical terminology.
New certificate program coming to Cabrillo soon!

Available Spring 2008	Units	Courses Coming Soon	Units
DH155 Dental Terminology	3	DH157 Beginning Law & Ethics	2
CABT103A Data Entry	1	DH159 Dental Insurance	2.5
MA172 Medical Office Procedures	3	DH 199 Career Work Experience Education	1
MA184 Health Care Com. & Etiquette	2		
RECOMMENDED COURSES			
ENGL 100 or 1A	3	MA178 Medical Spanish	3

New Course: **DH155 Dental Terminology**
Instructor: **Bridgete Clark, RDH, DDS**
Starting February 22, 2008
Fridays 9:00 am-12:00 noon
3 units; 3 hours Lecture
Teaches fundamentals of dental/medical word building. Provides a background for any dental or medical course. Great class for anyone interested in the dental profession. Credit/no credit grade.

The Smileline is published by the Monterey Bay Dental Society, 8 Harris Court, #A2, Monterey, CA 93940 (831) 658-0168. This newsletter solicits and will publish, space permitting, signed articles relating to dentistry but will assume no responsibility for the opinions or validity of the theories contained therein.

Subscription rate for non-MBDS members is $15.00 per year. Acceptance of advertisements in no way constitutes professional endorsement by the MBDS.
This publication is printed by Sir Speedy, Monterey, CA 93940.

Cover photo by Bruce Donald
Design by Robert Packard

Dr. John H. Newman, Jr. died unexpectedly on May 2, 2008 after a year long struggle with severe anxiety and depression. He was 48 years old.

John was born in San Mateo, CA and grew up in Santa Cruz. He graduated with honors from Harbor High and UCSF, majoring in chemistry. He completed his education with a doctorate degree from UCSF School of Dentistry, where he met his wife to be, Len Vita. He had a very successful family dental practice in Scotts Valley and Santa Cruz for the past 21 years. His practice was characterized by a thoughtful, patient-centered approach to dental care popular with children, adults and seniors alike. John also enjoyed teaching dental hygiene at Cabrillo College.

John was a talented singer and musician. He had a James Taylor-quality to his voice which brought him invitations to sing at weddings and local social events. He took special pride in his involvement with Holy Cross music ministry where he was a parishioner, choir member and cantor.

John had an engaging, enthusiastic personality. He loved traveling with family and friends, playing high level tennis, downhill skiing, sushi and Mexican food. He has left an ever lasting impression as a dedicated professional, great friend, loving father, husband, brother and son.

John is survived by his wife, Len Newman; daughter, Lindsay; son, Mitchell; parents, John Sr. and Jean Newman, sisters Judy Newman Rakela and Jenny Newman Stockford, brother, Jeff Newman.

MONTEREY BAY
SMILELINE

8 Harris Court, #A2
Monterey CA 93940

NON-PROFIT
ORGANIZATION
US POSTAGE
PAID
PERMIT #152
SALINAS, CA