MONTEREY BAY

SmileLine

The Newsletter of The Monterey Bay Dental Society

Winter 2008

Inside This Issue

MONTEREY BAY
SMILELINE

Notes From Our Outgoing President...

Dear fellow members of the Monterey Bay Dental Society,
It's 11pm and Baby Brayan, at 4 weeks of age, is crying in our bedroom, right on schedule.

As I look back on the last three years and my involvement with our MBDS, I have to say this experience has been one of growth and maturation for me in quite a few ways. First, I have had the opportunity to work with an incredibly talented group of dentists who donate their valuable time in order to make our community a better place to practice and live in. I have been humbled and blessed to work alongside all of you, and am sincerely grateful for your guidance and support.

Second, I now have a much better insight into how CDA works, and as a dues paying member, I recommend to anyone who has not had the opportunity to witness and participate in our yearly legislative sessions and in our governing process in general, to try and do so at some point in your career. The work and organization that is required to make these events function is amazing, and each year I leave proud to be a member dentist in the California Dental Association. The CDA is viewed as the gold standard across the country and for good reason. Please participate. You will not regret it.

Third, two words… Carole Hart. We are blessed to have such a skilled, hardworking and motivated executive director. The respect Carole has earned over her career is evident at our state sessions, where she is viewed as a mentor by other executive directors, and held in highest esteem throughout the ranks of the CDA. She is a fount of knowledge, and is truly the steady hand that has guided every president of this component for over twenty years. I have witnessed her ability to multitask at an almost inhuman level, yet she always managed to have a piece of dark chocolate and a smile for me during some of those long meetings. Thank you Carole for everything you do for us, and for your consistently positive, personable presence.
It was three years ago, at my first induction dinner as Vice President, that my son Jake was born. I am now the father of two beautiful boys, married to the most incredible and supportive woman I have ever known. I want to take a moment to thank my wife Jennifer for her support during the last three years. I can honestly say I am a different man since she came in to my life.
Our new President is Dr. Chad Cassady. We are in great hands with Chad. His insight and work ethic, combined with his great sense of humor, guarantees a productive year for our component.

Thanks once again for all of your support. I wish you and your loved ones a happy, healthy and blessed holiday season.

Respectfully,
William C. Francis D.D.S

Our Incoming MBDS President

Allow me to introduce myself…

My name is Chad Cassady. I am an orthodontist practicing in Carmel and Pacific Grove. I received my B.S. in Molecular Biology from San Jose State University—then moved east, and received my dental training at Columbia University. Finally I returned home to California—attended UCSF—where I received my orthodontic certificate and MS in 2002. Later that year I transitioned into practice with Dr. Gerry Tarsitano, and am here to stay. My lovely wife Rebecca and I have three beautiful children. Chad Jr. is 8, Jack is 5, and Ava is 1. We've got our hands full, but we're having a blast.

I am truly honored to be the president of the Monterey Bay Dental Society. I've always been intrigued by organized dentistry and was very excited when I was approached by one of my colleagues five years ago and asked if I would be interested in becoming a member of the board. I jumped at the opportunity and I've been actively involved ever since. Being a member of the board has allowed me to meet an unbelievably dedicated group of people who give so much of themselves to the dental society. I strongly encourage anyone who is at all interested to participate with our ongoing programs or become a board member. I know that our lives are extremely busy, but giving back to your occupation not only benefits the profession, it also benefits YOU. The Monterey Bay Dental Society is a strong group, but we always need new energetic individuals to help keep it one of the finest in the state.

I look forward to my upcoming responsibilities as dental society president. If you have any input, or questions about serving on the MBDS Board, please feel free to contact me at any time. I am very happy to discuss any suggestions you might have to enhance our society.

Thank you.
Chad Cassady DDS

From The Editor

The tumbling stock market and world economic crisis is affecting every one of us and every one of our patients. In many practices I work with as well as my own, it seems that many "ideal" treatment plans are being set aside in favor of options that will allow the patient to "get by" for the time being. Countless situations involve prioritizing—and unfortunately, dental health and its maintenance are for many consumers less of a priority than paying the mortgage, putting food on the table and allowing some cash for the holidays. It is all too easy to turn our focus on our own problems—paying our staff, our rent and dental supplies, and on our "holey" schedule.

As your editor my powers don't include an instant solution to this situation. However, I would offer this suggestion. Try looking outward. Start with Doug Carlsen's article. Among other things, he talks about sitting for a few minutes in your reception area.

Look at what your patients look at. Get the feel of your office. Think about how you can modify the atmosphere to make it perhaps a little more inviting, personable, comfortable. More so than ever, perception of connection and warmth (which hopefully is perpetuated by you and your staff) will help take focus away from monetary worries.

Look at what some of your colleagues do with their time. Alison Jackson—our MBDS "Dentist of the Year 2008", organizes and conducts education and screenings in schools throughout the Monterey Bay Area. Hugo Ferlito—2007 Dentist of the Year—helps direct activities at Dientes in Santa Cruz and started the Community Partners program (through which MBDS volunteer members see patients referred from Dientes for care in their offices). Mark Bayless, Jeff Meckler, Marc Grossman and several other active and retired MBDS members—regularly, on their own dime, fly to places like Peru, Cambodia and Tibet in order to provide dentistry for individuals who have no other access to dental care. Each one of these people provides you and your profession immeasurable quantities of good will. These people elevate the public's opinion of dentists and dentistry, and most certainly the opinion and quality of life of individuals who benefit directly from their efforts.

Look at the big picture. The way you conduct yourself—the way we all conduct ourselves—is on stage. I suggest that dentists who remain available, who are consistently professional and caring and who make a positive difference in their community will not only survive this crisis, they will prosper.

My sincerest wishes to you and your families for a joyous holiday season!

Lloyd P. Nattkemper, DDS
Editor

TDIC Insurance Solutions

Dear Component Member:

The Monterey Bay Dental Society is pleased to announce that we now endorse TDIC Insurance Solutions as our insurance broker. We know that many of our members already use Insurance Solutions and appreciate that it is a company founded by CDA and governed by dentists for dentists. For more than 25 years, TDIC Insurance Solutions has been dedicated to serving the insurance and financial needs of CDA and MBDS members and supporting organized dentistry.

We recognize that as our members move through their careers, they may wonder what insurance plans they need and how much coverage to purchase. With this endorsement, TDIC Insurance Solutions is here to offer personalized insurance practice management solutions to our members, and we are confident Insurance Solutions representatives know the needs of dentists because dentists are whom they serve exclusively.

By endorsing Insurance Solutions, our goal is to let our members know about the insurance products they offer to protect your future and the quality service you have come to expect from a full service broker.

What attracted MBDS to endorse Insurance Solutions is their support of our members and organized dentistry by providing non-dues revenue at both the local and state level.

We know that you would like to be supported by a company who truly understands the business of dentistry, and we have confidence that TDIC Insurance Solutions is ready to help when you have an insurance need. Please join us in welcoming TDIC Insurance Solutions to the Monterey Bay Dental Society and we look forward to working with our local representative, John Greene

Sincerely,
Monterey Bay Dental Society
Board of Directors

Monterey Bay Dental Society

Board of Directors for 2008

Chad Cassady, DDS	President
Marielena Murillo, DDS	President Elect
Nannette Benedict,DDS	Vice President
Mona Goel, DDS	Secretary/Treasurer
Bruce Donald, DDS	State Trustee
Bill Francis, DDS	Immediate Past President
Tim Griffin, DDS	County Director
Corrine Cline-Fortunato, 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

Safe and Effective Procedures for Dental Instrument Processing

By Rodney Stine

The Dental Board of California (DBC) requires every dental office to have infection control procedures in place to prevent the spread of infectious diseases. These procedures include the use of personal protective equipment (PPE), surface disinfection, and instrument sterilization. This article provides informational tips on how to process contaminated dental instruments safely and effectively, from chairside to the point of instrument reuse.

Types of Dental Instruments

The DBC's Infection Control Regulation (Section 1005 of the Dental Practice Act) classifies reusable dental instruments as critical, semicritical, or noncritical. Critical instruments penetrate soft tissue or bone, i.e. scalpels, scalers, and burrs. Semi-critical instruments contact oral tissue without penetration, i.e. dental mouth mirrors and dental impression trays. Both critical and semi-critical instruments require sterilization after use.

Instruments that contact intact skin are referred to as non-critical items and may be wiped down with an EPA-registered surface disinfectant.

Sterilization Methods

The DBC allows four acceptable sterilization methods:

Steam sterilization, which uses pressure to produce steam that is hotter than 212˚F up to 260˚F with a cycle that generally runs 15 to 20 minutes.

Dry-heat sterilization, which requires a higher temperature, 300˚F and up, and a longer cycle time since dry air contains less heat than steam.

Chemical vapor sterilization, when a liquid chemical, usually formaldehyde, is heated to produce a chemical vapor.

Chemical sterilants, often referred to as cold sterile solutions, for use on heat-sensitive items only, for the required time duration, often eight to ten hours, followed by sterile water rinse.

Processing Contaminated Instruments

Transporting - Care should be taken when transporting contaminated dental instruments to the central processing area. The instruments should be containerized, and dental staff should never handle the instruments with their hands.

Cleaning the Instruments - According to the DBC's Infection Control Regulation, "critical and semi-critical instruments shall be cleaned and sterilized before use…" If instruments are not cleaned before being sterilized, debris on the surface can prevent heat or chemical vapor from contacting the surface area, thereby hindering sterilization.

Reusable instruments should be cleaned with hands-free, automated cleaning equipment such as an ultrasonic unit. If manual scrubbing is necessary, a long-handled brush should be used to keep hands away from the contaminated sharp instruments. Dental personnel should NEVER reach hands into containers holding contaminated instruments. If instruments cannot be cleaned immediately, pre-soaking them can improve the cleaning process.

Packaging the Instruments - After cleaning, instruments should be packaged or wrapped before sterilization using pouches of plastic/paper and woven or nonwoven sterilization wraps. Materials should be designed for the type of sterilization process being used.

Sterilizing the Instruments - All sterilization must be performed using sterilization equipment cleared by the FDA. The sterilization times, temperatures, and other operating parameters recommended by the equipment manufacturer, as well as proper instrument processing should always be followed.

Because neither steam nor chemical vapor can penetrate plastic, packages should be positioned to maximize the exposure of the paper portion of the package. The sterilizer must not be overloaded, with as much space as possible between pouches.

Before unloading the sterilizer, the wrapped packages must be visibly dry. If packages are wet, they may draw bacteria into the packaging material, which could contaminate the instruments. Wet packages may indicate a problem with the sterilizer.

Common factors for improper sterilization include chamber overload, low temperature/pressure, inadequate time, failure to preheat sterilizer, cycle interruption, expired chemical (chemiclaves).

Storing the Sterilized Instruments - Sterilized instruments should be stored in a clean, dry environment to maintain the integrity of the package. It is good practice to rotate the packages so that those sterilized first are used first. However, instruments remain sterile until the package is opened or compromised. If packaging is compromised, instruments should be recleaned, repackaged, and sterilized again.

While not required, it is recommended that all packages be marked with the date of sterilization and the sterilizer that processed the package to facilitate easy identification and recall of affected packages should there be a sterilization failure.

Sterilizer Monitoring

Biological monitoring is the standard for assuring proper sterilization of dental instruments. The DBC's Infection Control Regulation states that "proper functioning of the sterilization cycle shall be verified at least weekly through the use of a biological indicator (such as a spore test)."

Biological test strips should be placed within a wrapped set of instruments in the most difficult area to be sterilized, normally the lower front of the sterilizer. Placing the spore test strip in a different location of the sterilizer each week can help identify

Safe and Effective Procedures

"cold spots" within the sterilizer. If the sterilizer is operating properly, the spores should not survive the sterilization process.

Chemical indicators, recommended within each load, should be placed next to the instruments inside each package. If an indicator is not visible on the outside of the package, an external process indicator should be placed on the package.

Other Considerations

Single-use, disposable dental instruments – Disposable items labeled for single use only, such as high-speed suction tips and saliva ejectors, must not be used on more than one patient.

Training – All staff members who operate the sterilizer should receive training about proper sterilizer operation procedures and instrument processing techniques in the office.

Maintenance – General maintenance consists of periodically checking door gaskets, vents, and internal/external surfaces. Refer to the sterilizer manufacturer's instructions for maintaining and cleaning the sterilizer.

Conclusion

Understanding and correctly implementing the factors that lead to successful instrument processing and sterilization results in a significant achievement toward an overall effective infection control program in the dental office.

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.

What Caused Claims?

By TDIC Risk Management staff

A review of all 2007 claims

Each year, TDIC reviews all of its closed claims to identify emerging trends. A review of TDIC's 2007 closed professional, business and employment practices liability and property claims revealed that the frequency and severity of claim types remains consistent with previous years' experience.

For the past five years, restorative procedure claims (treatment involving composites/amalgams and single or multiple crowns) were the most frequent, representing 29 percent of all professional liability claims. Over 50 percent of the claims involved allegations of failure to treat properly, need for retreatment and treatment failure due to clinically unacceptable results. Interestingly, this year 8 percent of these claims involved swallowed or aspirated objects.

Endodontic treatment and extractions rounded out the top three claim types. The most common allegations for endodontic treatment continue to be failure to treat properly, separated files, perforation of the root and treatment failure. This year, paresthesia was the most common allegation of extraction claims. Fifty-four percent of the extraction claims involved third molars, a 20 percent increase over last year.

Claims involving extraction were the most severe due to the allegations of inferior alveolar and lingual nerve injuries. In one claim, a general dentist, just two years out of dental school, extracted all four third molars of a 27-year-old female. She reported lingual paresthesia a few days later. The subsequent treating oral and maxillofacial surgeon and TDIC consultant both opined the lingual nerve had been transected. Further complicating the case, the dentist admitted to altering the patient's chart by adding information to "clarify his entries."

Other noteworthy information includes:

- The frequency of employment practices liability claims remains stable. Wrongful termination claims continue to be the most frequent.
- Treatment issues comprise the majority of claims involving dental board investigations. Allegations include substandard restorations, excessive treatment and failure to treat properly.
- Water damage to dental offices tops the list of most-frequent property claims, as it has over the past seven years. These claims involve overflowed, cracked and leaking toilets; burst, broken or leaking pipes; broken dental unit lines; and sewer backup.
- The number of policyholders reporting stolen copper piping, wiring or flashing has increased significantly.

Look to TDIC to help mitigate these and other types of claims by using the resources available at thedentists.com, or calling the Risk Management Advice Line at 800.733.0634.

Registered Dental Assistant Program

By Karoline Grasmuck, RDA, CDA

I have been in dentistry for 28 years with ten of those years spent in education. My vision for the Monterey Peninsula College Registered Dental Assistant Program is to implement all of the resources available in the Modern Dental Assisting textbook. The resources are online and on the included CD-ROM. X-ray mounting, charting, flash cards, practice exams and many more items are included. My students have begun taking online exams to help prepare them for the California RDA exam.

Many changes are coming to the RDA Programs in 2010 and MPC has to implement them. Pit and Fissure Sealants is a new requirement for the program. It must be implemented by 2010; students taking the RDA exam after January 1, 2010 must be certified in Pit and Fissure sealants as well as traditional categories such as radiology and coronal polish in order to be eligible for the exam.

I need volunteers to help me with the program. Two immediate needs are Advisory Committee members (dentists as well as RDAs) and offices to place students for internship.

- The Advisory Committee meets only once a year and it will need equal numbers of dentists and RDAs.
- Internship offices are required by the state for students to complete their studies. I will need offices for three separate rotations.
    - The first session begins January 19, 2008, and will need to be at a General Dentistry office. The students will need to work in the office full time for the entire two weeks.
    - The second and third rotations are each eight weeks long. The students will be in the offices on only Mondays and Tuesdays. The second and third rotations can be in General Dentistry or any dental specialty office.

I need offices that are willing to help train these students, not just let them observe or take out the trash. Students need to know what it is like to work as a dental assistant.

I am also looking for dentists willing to take time out of their very busy days and come in as guest speakers and/or to help when the students are doing their practical exams for coronal polish and Pit and Fissure sealants. Dentists are also needed to check over patient paperwork for the radiology, coronal polish and Pit and Fissure sealants.

I know I am asking for a lot, but this is an excellent opportunity for dentists and dental assistants to give back to the dental community as well as an excellent resource for offices to find new, well trained employees.

Karoline Grasmuck, RDA, CDA
Program Director/Instructor
Monterey Peninsula College

Editor's note: Karoline brings a wealth of experience to our community. She also brings a sincere enthusiasm--please, if you are able to help as an advisor or if you need a "free" assistant who is learning their profession, help her maintain and grow that enthusiasm. We will ALL benefit! Contact her at <kgrasmuck@mpc.edu>, or call Karoline at 831.646.4137

Grey Bears Prowl the Streets of Santa Cruz!

Grey Bears has been assisting seniors and feeding the needy in Santa Cruz County for over 34 years. Their membership is over 3000 and growing, and so is the need for help.

Grey Bears asks that you offer a discount of 5% to card carrying Grey Bears members. They also ask that you give a donation of $100-250, if possible.

In return, Grey Bears will list you in their newsletter as discounters/donors and provide you with a certificate for your premises attesting to your assistance to seniors. They will also put you on their web site, when it is complete. They encourage you to use your support for Grey Bears in your advertising.

Donations should be sent to Lynda Francis, Executive Director Grey Bears, 2710 Chanticleer, Santa Cruz, CA 95065-1812. Information can be obtained from Lesly Sweet Miller, Director Senior Resources Grey Bears, 831-423-0906.

Thank you for your help!

Lesly Sweet Miller

What's a Dentist To Do?

By Doug Carlsen, DDS

On October 2, someone took Wall Street's pin stripes, private equities, derivatives, and short sales to the cleaners. After a week on the hot cycle, things looked a bit cleaner, yet someone connected the tumble dry to the Hanford site, leaving all greenbacks in the trousers. I think we're all a bit nervous to open that toxic dryer these days, as what's left may look a bit tattered and much smaller.

What can the dental practitioner do to protect his practice and his family these days? The following thoughts have been harvested from top academic and dental minds.

Practice

- Get the maximum credit line possible. It may be tougher in the future to secure a loan. This is not to purchase cone beam radiography, but is for an office emergency, such as a fire or computer theft. In other words, use only as a contingency fund.
- Do not finance major treatment yourself. If the patient has trouble with payments now, things may become even more difficult later. Use Care Credit or a bank still in business.
- Offer a one time 10% to 50% discount on long term receivables. Michael Shuster recommends 10%--- I've had clients offer 50% to accounts over one year in arrears. Your chances are probably better to collect now than in the coming months.1
- Turn your eye on your practice. Doctor, set up a hygiene visit for yourself and become a patient. Actually walk into the reception room as patients do. Yes, there is another door into the office. Announce your arrival to the front desk and sit down and wait, just like the patients. Take a look around and use all your senses. Is the reception area cluttered, are you greeted warmly, are things bright or dingy? Visit the patients' bathroom. This is how they decide about your cleanliness and thoroughness, not by the plaques on your walls. Patients love seeing the doctor evaluate his practice this way.
- Be honest with patients about the financial scene today. Everyone is worried; to cover up that money is tight won't help your treatment plan acceptance. Realize that everyone is cutting back on discretionary expenses. Stage your treatment plans if necessary.

Personal

- Get the maximum credit line possible. This is not for home improvements or college. This is for unexpected disasters, such as accidents, illness, or loss of income. As above, this is a contingency fund – what's good business practice is good personal practice!
- Please don't sell all your equities now that prices are low. That's the biggest mistake individual investors make.
- Pay off your short term debt. Pay credit cards off now! You realize a return of 15%-24%. Nothing on Wall Street currently pays over 5% without huge risk.
- Please watch it with commodity investments---gold and oil have extremely high risk now.
- Plan on a future big loss of income: cut your personal expenses 20% in the next two years. I'm not sure things will become dire, yet to be ready for the worst is prudent and will prepare you for when the kids come back home at age 30. As I've extolled in the past, delay new auto purchases for a couple years, stage home improvements or use sweat equity, and pare down family gifts. Additionally, dining out once a week vs. twice saves an average of $200 per month, and a driving vs. flying vacation visiting relatives instead of Frankie Valli will save an additional $5,000 per year. Combined, you could save up to $1,500 per month, or about 20% of your average family budget after taxes and savings.

Warren Buffet and John Bogle (Vanguard founder) are back in the market as of November 1. Economist Harry Dent and others

continued on page 9

Waste Management 2008: Useful Information For Your Office

By Celia Brown

What to do with sharps, bio-hazardous waste, pharmaceutical waste, and hazardous waste in California? Garbage has gotten very complicated over the last 20 years and keeping up with the regulations is a chore; however, the payoff, a cleaner environment, is well worth it. Science is just beginning to show us how nature is being affected by our waste pharmaceuticals and so disposing of them properly is becoming more important every day.

A small dental clinic will have three waste streams: sharps waste, regular waste, and hazardous waste. A larger dental surgery practice could have up to five separate waste streams, adding pharmaceutical waste to the four already mentioned. Four of these waste streams are regulated by the California Medical Waste Management Act and require registration with the local enforcement agency

Here are some of the finer points of Dental Clinic Waste Management that your local Medical Waste inspector will be checking. If you haven't already implemented them, do so as soon as possible to avoid potentially costly follow-up inspections and/or issuance of deadlines for compliance.

Pharmaceutical waste must be segregated from sharps and bio-hazardous waste and labeled "For Incineration Only". Special sharps-approved pharmaceutical waste containers are available, as well as those with absorbent padding for disposing of liquid pharmaceuticals – empty vials can then be placed in the regular garbage.

Some pharmaceutical agents are actually hazardous waste (eg. epinephrine), are regulated by the Federal Resource Conservation and Recovery Act (RCRA) and cannot be mixed with pharmaceutical waste. Every generator of RCRA waste is responsible for categorizing their own waste stream and disposing of it properly. If RCRA wastes are minimal, permitting is not required. RCRA wastes are categorized as ignitable, corrosive, reactive, or toxic and include insulin, epinephrine, thimerosal, and nitroglycerin. Your pharmaceutical provider, professional organizations, MSDS information, and local waste hauler can help get you started in categorizing this waste stream.

In order to have a hauler pick up your hazardous waste, you will need to obtain an Environmental Protection Agency (EPA) number. Handlers of RCRA waste, who need a U.S. EPA ID Number, must send a "Notification of Regulated Waste Activity", form 8700-12, to the U.S. EPA contractor at the address given in its instructions. You can request this form by calling (415) 495-8895 or you can download it from the U.S. EPA web site.

In addition to your waste, if you have in excess of 200 cubic feet of compressed gas or other hazardous materials, you will need a Hazardous Materials permit – please contact your local Environmental Health Agency for more information regarding this requirement.

Last but not least, although you probably don't receive used sharps from patients that administer their own injections, it's useful to know that there are now over twenty household sharps collection sites and 10 household pharmaceutical waste collection sites throughout the county. You can find the nearest location at www.sharpmedsolutions.org.

Celia Brown is a Senior Registered Environmental Health Specialist for the Santa Cruz County Department of Environmental Health. She can be reached at
701 Ocean St., RM. 312 Santa Cruz, CA 95060: (831) 454-2752

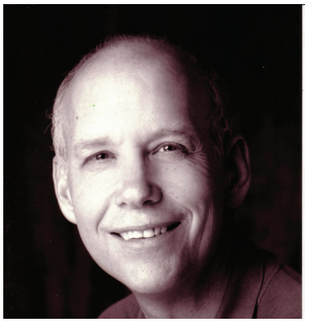
What's a Dentist to Do? continued

predict a major depression by 2010. Who do you believe? Watching your wallet may in these times may save your practice.

(Endnotes)
1 First three bullets from: Michael Schuster, DDS, "Recession Proofing Your Practice," Dental Economics, September, 2008.

About Doug Carlsen

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



The Tooth Fairy: What Is The "Going Rate"?

By Dr. Randy Ligh, Kayla Schmitz & Dr. Joseph Fridgen

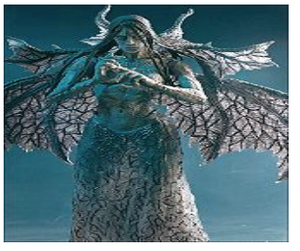
lklore or mythology of such household favorites as: Santa Claus, the Easter Bunny, Cupid, the Jack O' Lantern, Lenny O' Shea and of course, the Tooth Fairy. Whether we believe in it or not, it is a part of our profession.

Just as we embrace our profession and accept our responsibilities as a dentist it behooves us to have an understanding and knowledge of this affectionate aspect of growth and development for children and our role in this. As we become more internationally exposed and our patient populations more diverse it is prudent to at least have an awareness of the Tooth Fairy and its foreign counterparts.

"Seeing is Believing," is not always true; especially in regards to the imagination of a child. For centuries, children across the world have believed in figments and characters of their imaginations. In general, children detest the aspect of moving on to different stages in their lives. To transform this sense of loss into a feeling of accomplishment, parents and children have contrived the tooth fairy.

Originating with the earliest American Indians, the tooth fairy was actually an animal. Tribes would have a specific, designated animal; and when the Indians lost their teeth, they would regain a tooth resembling that animal. Later, when settlements were being established in the New World; Englishmen instituted their religions and folklore into every colony, birthing the tooth fairy.

From the early to middle nineteen hundred's, the earliest known rituals for the tooth fairy in the United States was essentially designated for the home. When a child lost a tooth, he would drop the tooth in various places such as: the attic, a crack, the hearth, or his birthplace. If a child was careless in the disposal of his tooth the consequences were quite preposterous. The aftermath could, in fact, result in eternal damnation or perpetual exploration during the entire extent of the afterlife. As time progressed, the home was being altered into a more convenient way of life, and so were the tooth fairy rituals. Children were now planting their teeth deep in the ground hoping that it would result in a flourished plant, or a new tooth, but once farmland was becoming sparse children could no longer "plant" their teeth. Through many alterations, the tooth fairy is now leaving treats and treasures for



Our premise is to base a value taken from the literature and extrapolate by using an Inflation Calculator to come up with a value for the primary tooth. Provided is a range for the years: 1960, 2000, 2008, 2009, and 2018.

United States Dollars
1940 - $.10
1960 - $.25
2000 - $3.75
2008 - $6.71
2009 - $7.08
2018 - $10.41

Because of the diversity of our population it is proper to be aware of international differences and currencies; therefore, we have also used a Currency Exchange Chart along with the Inflation Calculator to become more knowledgeable with a cast variety of cultures.

China: Yuan Renmimbi
2000 - 25.73
2008 - 46.08
2018 - 71.48

Japan: Yen
2000 - 410.92
2008 - 702.87
2018 - 1090.45

India: Rupees
2000 - 156.97
2008 - 289.03
2018 - 448.41

Mexico: Pesos
2000 - 37.56
2008 - 297.83
2018 - 104.27

Vietnam: Dong
2000 - 62,193.75
2008 - 111,285.35
2018 - 172,649.85

Philippines: Pesos
2000 - 166.45
2008 - 297.83
2018 - 462.05

South Africa: Rand
2000 - 28.27
2008 - 50.63
2018 - 78.55

Russia: Ruble
2000 - 88.90
2008 - 158.89
2018 - 246.50

The Tooth Fairy: continued

children to find underneath their very own pillow every time they lose a tooth.

Have you ever been asked by a parent: "My child just lost one of his baby-teeth, what's the going rate from the Tooth Fairy?"

Losing a primary tooth is an exciting developmental milestone for a child and offering a professional opinion of value based on research is helpful. Not offering an opinion closes the avenue of discussion and has overtones of not participating with the childhood whimsical myth that this parent and child obviously subscribe to.

In 2003, Dr. Songtao Shi while working at the National Institute of Health discovered the untapped potential of primary tooth stem cells. He has now left the NIH and continuing his research at USC.

Stem cells are nonspecific cells that can continue to develop and form many other cell types. Totipotent stem cells can produce any type of cell; whereas, multipotent stem cells develop into specialized groups like hematopoietic stem cells. Hematopoietic stem cells form blood cells and neural stem cells, and can also form nerve cells and nerve tissue. Progenitor stem cells are more limited and can produce only one cell type. Tissue isolated from the pulp of baby teeth has about 12-20 stem cells that are multipotent.

Tooth collection, stem cell isolation and harvesting are still under research. The future of medical applications holds quite an optimistic specter. It is especially exciting since autologous stem cell transplantation has advantages over allogeneic stem cell applications.

It is interesting to reflect that the origins of the Tooth Fairy history were partially based on thoughts of the primary tooth being saved to insure the future permanent tooth transition. The future reality is that primary tooth stem cells may indeed contribute towards the growth and development of future needed dental tissues.

This has been an enlightening opportunity for us to delve into a more lighthearted whimsical aspect of our profession so it is "food for thought" or should I say "tooth for thought"!

The Allied Dental Student Scholarship

The California Dental Association Foundation (CDA Foundation) firmly believes that by working together we are able to create an environment where success with any project can be achieved, improved, and maintained. An example of this cooperative effort is seen in the four-part collaboration between the Foundation, California Dental Association (CDA), TDIC, TDIC Insurance Solutions, and the Monterey Bay Dental Society. The Allied Dental Student Scholarship Program is sponsored by the Foundation, generously funded by CDA and TDIC Insurance Solutions, and distributed by all of the 32 CDA component dental societies.

Student achievement plays a crucial role in our efforts to expand the availability of oral health services to all Californians. Through this valuable scholarship program, each component is able to distribute $1,000 in scholarships to deserving students enrolled in a state-approved dental hygiene, dental assisting or dental laboratory technology program.

The Monterey Bay Dental Society is pleased to award this year's scholarship to Maria Isabel Nakamura and Fabian Orta. Isabel and Fabian were chosen for their demonstrated leadership, outstanding achievements, community service and a desire to obtain a career in the dental field. Isabel is enrolled in the Registered Dental Hygiene Program at Cabrillo College and Fabian is enrolled in the Salinas ROP Dental Careers Program. The Monterey Bay Dental Society is pleased to support such dedicated students as they complete their education and enter the dental profession.

To access and view other Foundation programs, please visit the CDA Foundation Web site at www.cdafoundation.org.

When You Appear Before the Peer Review Committee

By David Stein DMD

Should the situation arise where you are called upon to appear before the peer review committee there are a number of things that would be helpful to know before that time. Anyone would agree they would rather be anywhere else other than to come before a committee of 16 of their peers that are reviewing treatment they rendered to a patient. Members of the committee fully recognize you will be nervous and will feel like you are in the "hot seat" for that meeting. It may be futile to say, 'Try to relax!' but that will always be in your best interest and helps you to think clearly. Just to review what has happened before this interview, three members of the committee have examined the patient at a previous time, the full committee has heard the report of their clinical findings, and now it is your time to review the facts of the case from your perspective.

Please understand that the peer review committee and CDA must deal with facts. What we are looking for are the facts of the case that are documented by your clinical notes. The committee would like to hear a brief synopsis of your treatment of this patient. Start with what treatment the patient presented for. Did they request certain treatment or did you do a comprehensive examination and present your treatment plan to the patient? Was there a discussion regarding treatment options with risks and benefits explained? Was there a discussion of fees involved so the patient was aware of their financial obligations (although fees are not an area peer review will review except regarding refunds, it is an area where patients become unhappy with treatment rendered if they did not understand their financial obligations before treatment started). Were there issues that arose during treatment that relate to the patient's complaint? While giving your verbal synopsis of treatment, please stick to the facts. It is not germane, for example, to discuss with the committee how a dentist may think their dental assistant has it out for them and was discussing certain issues with the patient behind the dentist's back. Although this may affect the case with regard to patient/dentist relationship, these are issues that peer review cannot deal with. We are concerned with your treatment of the patient, the formulation of your treatment plan and reasons for the treatment, how treatment progressed, discussions you had with the patient and the final result or quality of the treatment.

Peer review exists to evaluate appropriateness and quality of treatment. We do not deal with such things as the patient did not like the way the dentist talked to them, if the staff was rude, if the patient felt the fees were too high, or treatment took longer than the patient felt it should. What would constitute inappropriate treatment? An example: a dentist places a 12 unit fixed bridge on 4 periodontally compromised teeth. That is a recipe for disaster and would be considered inappropriate treatment and would fail based on a failed treatment plan. Quality of care I believe is obvious. For example, if 6 upper anterior veneers were done, are the shade, contours, contacts, margins, and occlusion correct? Even if esthetics are fabulous but the contacts are open and food packs interproximally, the case fails due to the poor contacts. If any one category fails, the entire restoration fails.

Let's get back to the interview. Again, please keep your discussion as it relates to the facts of the case. Remember that if it is not written down, it is considered as if it did not happen and now it is your word against the patient's. You may certainly tell the committee things that you recall occurred during your visits with the patient but know that the final decision in all cases is made by the council on peer review at CDA. They will review the case based on the patient's request for review, treating dentist reply which includes the clinical treatment notes, subsequent treating dentist reply, and the clinical examination sheets completed by the peer review examiners. They make the final determination so if there are facts pertinent to the case that do not appear in the records, it is as if they did not happen.

Once you have completed your presentation regarding your treatment of the patient in question the floor is open for questions. In most cases members of the committee will have questions for you but please do not feel like this is an inquisition. We are doing our best to get to the bottom of the issues to make a fair decision for both parties involved. We do not want a dentist appearing before the committee to feel that they are going to be grilled and bloodied once they leave. The more information we have the greater the likelihood of a fair determination of the case.

Once your session is complete the committee will spend as much time as necessary discussing the facts of the case to come to a conclusion. The entire committee of 16 members will vote on a determination and the case captain will write up the necessary paperwork that will be sent to CDA. CDA will go through a similar process as the local committee to review the facts of the case. Depending on the complexity and the thoroughness of the local committee the council may review the case as well. Any changes that are made are sent back to the local committee chairman and case captain for their review before anything is sent out to the dentist or the patient. This can be a lengthy process with many back and forth sessions between CDA and the Monterey Bay Dental Society. These wheels grind very slowly as we all do our best to cover all the parameters of the case. We

Peer Review Committee, continued

want the patient and the dentist to feel we have covered every detail involved before a final decision is rendered. When the final determination is made the patient and dentist are notified by mail. The patient will receive a Resolution Letter stating the decision in the case. The dentist will receive the Resolution Letter and an Addendum Letter as well. The Resolution Letter is states in general terms the decision but the Addendum Letter states in detail the clinical aspects of the case. Each restoration (or aspect of treatment) is evaluated and the results are spelled out so that the dentist may understand how the decision was reached. There should be little question regarding the final result; however if either the dentist or the patient disagree with the decision each party has the right to appeal the case within 30 days from the date of the letter. All appeals are handled by CDA and the MBDS is notified of their decision as well as the parties involved.

Hopefully having some idea of what to expect when or if you are asked to appear before the peer review committee will help to alleviate some anxiety. Fear of the unknown is always lessened by knowledge of what is to come. It is our intention that you never have to see the peer review committee, but if you do remember it is better there than a court of law. And remember, write it down!

David Stein DMD
Chairman, Committee on Peer Review

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

Great Things are Happening at the ROP Center!

Mission Trails ROP consists of eight school districts in Monterey County, offering training opportunities for high school juniors and seniors as well as adults. ROP provides year-round day and evening, full and part-time technical courses at a variety of locations and times.

I am happy to announce that once again the Dental Careers Class is starting off strong this school year. Currently there are a total of 85 students enrolled and attending the program. These students are learning the fundamentals of Dentistry as well as the qualities required to be successful dental professionals.

For those of you that are not aware, in addition to the Dental Careers Class we also have a Medical/Dental Receptionist class now being offered as well. This class has been very popular and our Dental Careers students are encouraged to take the two classes consecutively when possible.

In September we began our Fall RDA Review Course. In order to qualify for this class these students must be working or interning a minimum of 15 hours per week in a dental office. These students are being prepared to successfully complete both the practical as well as the written State Board Examinations.

Mission Trails ROP is also offering the Dental Radiology Course as well. This class will be offered in October of this year as well as January, March, May and July of 2009.

Something new……Soledad ROP will be offering a new class starting in January of 2009! This will be an "Introduction to Dental Careers" class which will introduce students to the exciting career of Dentistry! Unlike our current Dental Careers class held in Salinas which is a 10 month program, this class will be limited to one semester only. This class was designed to spark interest into the dental field and will serve as a precursor to the more advanced class held currently in Salinas.

Because the Soledad program is just getting off the ground I am asking for donations of ANY KIND to help get us started. Some of the items needed include; New or used scrubs, dental materials, dental instruments, typodonts, visual aids, paper products and/or monetary donations. The dental community has always been so supportive and I am very appreciative! If you would like to make donations, monetary or otherwise please contact me. Any donation is tax deductible.

If you have any questions regarding our classes please feel free to call me. I will be happy to answer any questions you may have.

I would like to take the time to thank those of you who are already employing many of our students. Because of the successful collaboration we have together we can assure the success of these individuals.

Leslie Ochinang

Dental Careers Instructor 753-4209, ext. 121

Compounding Corner with David Smith

By David Smith

Recurrent aphthous stomatitis (RAS; aphthae; canker sores) is a common ulcerative condition of the oral mucosa. Round, or ovoid ulcers with erythematous haloes and yellow or grey floors, aphthae usually present first in childhood or adolescence. The etiology and pathogenesis of RAS is not clear. Diagnosis is on clinical grounds alone, and must be differentiated from other causes of recurrent ulceration, particularly a systemic disorder known as Behcet disease. Management of RAS remains unsatisfactory as there is no uniformly effective therapy for this disease.[1]

In a clinical randomized crossover trial, minocycline 0.2% aqueous oral rinse was assessed in patients with frequent episodes of RAS. Minocycline mouthwashes resulted in significantly improved pain control, by reducing the severity and duration of pain. Topical minocycline rinse may be a potential treatment for other non-infectious inflammatory ulcerative oral mucosal diseases. [2,3]

A single-blind controlled study evaluated the therapeutic efficacy and safety of lactic acid 5% mouthwash, one teaspoonful three times daily before meals, in the treatment of patients with RAS. The response rates after 3 days and 7 days of therapy were 63.6% and 90.8% for lactic acid versus 8.8% and 35.7% for placebo. No significant side effects were noticed apart from mild irritation in 2 of 36 patients using lactic acid. The study concluded that lactic acid 5% mouthwash is an effective mode of therapy for patients with RAS and had significantly reduced the signs and symptoms of the disease, especially when compared with placebo. [4]

1 Br J Oral Maxillofac Surg. 2008 Apr;46(3):198-206. Epub 2007 Sep 11.
2 Dermatol Online J. 2007 May 1;13(2):1.
3 Spec Care Dentist. 2008 Jan-Feb; 28(1):27-31.
4 Dermatol Online J. Dec 10;12(7):2.

Compounding for Dental Problems involves The Triad which is the relationship
between the Dentist – Pharmacist – Patient. Improving therapeutic outcomes can be accomplished by solving many of the following problems:

- Avoidance of dyes, preservatives, fillers, actives
- Palatable liquid medications
- Administrable dosage form
- Avoidance of side effects
- Dose, dosage form, or medication is commercially unavailable
- Cost effective therapy
- Unique dosage form designed for specific problem

Editor's Note:

A local pharmacist, David Smith (of A & O Pharmacy in Salinas) contacted me recently about contributing to the MBDS SmileLine. David is a rare breed—one of a handful of local pharmacists expert at compounding medications—a common practice perhaps 100 or more years ago (and in fact the "state of the art" in ancient times) but unique in our day of multi-billion-dollar pharmaceutical companies and mass-produced medications.

In my own practice, there have been times when patients were unable to take or tolerate certain medications, when they were trying to avoid taking certain medications, and when they have presented with frustrating situations involving a mucosal disorder or surgical complication—when pharmaceutical compounding came to the rescue. As an example, many years ago I treated a gentleman who had several abscessed anterior teeth. Treatment involved removing the teeth, debriding the region and grafting the area so as to preserve the anterior ridge, allowing for fixed bridge placement later. This gentleman had a history of IV drug and alcohol abuse, and sincerely wished to avoid narcotic medication. He also had a history of duodenal ulcers and had significant difficulty tolerating NSAID's. A local pharmacist in Pacific Grove was able to compound a preparation that worked perfectly for this patient, who had moderate pain lasting several days after his surgery. It consisted of a locally-acting analgesic/anti-inflammatory with an agent that allowed uptake directly through the mucosal tissues of the mouth, thus avoiding any systemic effect.

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

Hand Hygiene Guidelines Fact Sheet

- Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms (e.g. methicillin resistant staphylococcus aureus) and reduce overall infection rates.
- CDC is releasing guidelines to improve adherence to hand hygiene in health care settings. In addition to traditional handwashing with soap and water, CDC is recommending the use of alcohol-based handrubs by health care personnel for patient care because they address some of the obstacles that health care professionals face when taking care of patients.
- Handwashing with soap and water remains a sensible strategy for hand hygiene in non-health care settings and is recommended by CDC and other experts.
- When health care personnelís hands are visibly soiled, they should wash with soap and water.
- The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. Handrubs should be used before and after each patient Just as gloves should be changed before and after each patient.
- When using an alcohol-based handrub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.
- Alcohol-based handrubs significantly reduce the number of microorganisms on skin, are fast acting and cause less skin irritation
- Health care personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. Patients in intensive care units or in transplant units)
- When evaluating hand hygiene products for potential use in health care facilities, administrators or product selection committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of hand hygiene products by personnel. Characteristics of a product that can affect acceptance and therefore usage include its smell, consistency, color and the effect of dryness on hands.
- As part of these recommendations, CDC is asking health care facilities to develop and implement a system for measuring improvements in adherence to these hand hygiene recommendations. Some of the suggested performance indicators include: periodic monitoring of hand hygiene adherence and providing feedback to personnel regarding their performance, monitoring the volume of alcohol-based handrub used/1000 patient days, monitoring adherence to policies dealing with wearing artificial nails and focused assessment of the adequacy of health care personnel hand hygiene when outbreaks of infection occur.
- Allergic contact dermatitis due to alcohol hand rubs is very uncommon. However, with increasing use of such products by health care personnel, it is likely that true allergic reactions to such products will occasionally be encountered.
- Alcohol-based hand rubs take less time to use than traditional hand washing. In an eight-hour shift, an estimated one hour of an ICU nurseís time will be saved by using an alcohol-based handrub.
- These guidelines should not be construed to legalize product claims that are not allowed by an FDA product approval by FDAís Over-the-Counter Drug Review. The recommendations are not intended to apply to consumer use of the products discussed

CDC protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Reprinted with permission from the Centers for Disease Control and Prevention and the Harbor Dental Society.

Dientes Community Dental Clinic Gains County-Wide Support

By Milena Friend

A new program at Dientes makes it possible for patients to get much-needed treatment for complex dental problems, without the long wait usually associated with a busy clinic environment.

The Dental Affinity Program, introduced this year by Dientes' Clinical Director Dr. Hugo Ferlito, provides referrals for Dientes patients from across the county, and of all ages, to see area private dentists at no charge to the patient.

"With dental care, as well as any other health care, time is of the essence," explains Ferlito. "If the treatment plan is not completed in a reasonable time, you may lose the ability to carry out the plan as things change and get worse. This is the real aim [of the program]. It permits the timely completion of a complex treatment plan to the great benefit of the patient."

The program arose from the "clinical need to expedite treatment", adds Executive Director Will Hahn, but "the program will also help to increase the amount of uninsured patients who receive care throughout the community."

The need arose for Dientes to be able to send certain patients to dentists who have agreed to do the work pro bono, besides lab fees, which the patient pays for and are just a fraction of normal prices – even compared with Dientes' already discounted rate. Patients are chosen for the program, who have a good history at Dientes and are compliant, ideal patients. After the work to be done has been identified with an exam and full set of x-rays, a dental affinity dentist is contacted to take over that patient's treatment.

Currently, there are about 9 patients in the process of receiving treatment from several of our dental affinity partners.

The approximately 12 dentists who are involved in the program so far have volunteered to provide care to Dientes patients in need. Some of them may be seeing one or two patients a year, and some perhaps every month or so.

Dientes has recently partnered with Salud para la Gente, a health clinic in Watsonville, and the Pajaro Valley Health Trust, to provide patients throughout the county with this service. Patients can be referred from either clinic by a dentist who sees that they could benefit from the program.

From there, Dr. Ferlito explains, the clinic "will contact the [Pajaro Valley Health Trust] through the Monterey Bay Dental Society, who will keep a list of participating dentists and patients who have been approved for the program". The program aims to make getting extensive dental work as easy as possible for the patient, so ideally the dentist assigned is close and accessible to the patient.

Since the start of the program earlier this year, we now have several participating dentists in Santa Cruz, Watsonville, Freedom, and Aptos. Carole Hart, with the Monterey Bay Dental Society, assists in maneuvering patients to the closest offices. In one case, however, a patient was referred to an oral surgeon in Watsonville who could not see the patient right away; the patient was able to drive to Hollister for an immediate appointment.

When the affinity dentist is finished with the treatment of the referred patient, he or she will confirm with the program that the patient has received all the work he or she needs, and the patient will continue getting their regular treatment at Dientes. The dentist will then communicate when they will be ready for the next patient; whether in several months, or as soon as a patient match is found.

Currently, there are 8 general practitioners participating in the program, two oral surgeons, an endodontist, and a pediatric dentist. "I'm actually going to be one of the dental affinity providers, right here," Dr. Ferlito adds. "If I see someone that I could get through treatment fairly quickly, then I'll go ahead and do [the procedures] here."

The Dental Affinity Program through Dientes has already taken off and gained the support of two of our most valued partners in the county. We have already been able to complete life-changing treatment for several patients, and know that with your support, this program will continue to grow and thrive!

Melina Friend is the Development Coordinator at Dientes Community Dental Clinic

If you are interested in participating in the Dental Affinity Program, please contact Dr. Hugo Ferlito at (831) 464-5422 or drferlito@dientes.org

The California Society of Pediatric Dentistry Presents Online Continuing Education

Press Release:

The California Society of Pediatric Dentistry (CSPD) is proud to announce the addition of lectures to fulfill sedation CE requirements to the online continuing education, which is now available on its website (www.cspd.org/oce).

- Medical Emergencies in the Pediatric Dental Office (Dr. Bart Johnson)
- Sedation and General Anesthesia Updates for the Pediatric Dental Office (Dr. Douglas Jackson)

A wide variety of lectures pertaining to pediatric dentistry are also offered:

- Restorative Dentistry for Children: One Clinician's Approach (Dr. William Waggoner)
- 25 Things That Have Changed the Way I Practice (Dr. William Waggoner)
- Review and Analysis of the Literature on Amalgam (Dr. William Waggoner)
- Basic Principles of Pharmacology and Sedation Pharmacology (Dr. Thomas Lenhart)
- Difficult Pediatric Patient Sedation Group (Dr. Thomas Lenhart)
- Management of Sedation Emergencies (Dr. Thomas Lenhart)

Also offered as part of the continuing education series is access to the Pediatric Oral Health Access Program (POHAP) lectures:

- Behavior Management Group (Dr. Barbara Sheller)
- Diagnosis and Treatment Group (Dr. William Waggoner)
- Intervention and Restorative Group (Dr. Kevin Donly)
- Prevention Group (Dr. Steve Adair)
- Special Needs (Dr. Paul Casamassimo)

The above presentations cost $35.00 for each hour of continuing education. Once purchased, each lecture may be viewed for 2 weeks and the viewer can print an online certificate upon completion of a short test.

Payment for these lectures may be paid by Visa, MasterCard, Discover, American Express or PayPal.

These eleven lectures are the basic course work required for practitioners who seek to improve their skills in the treatment of children under the POHAP protocol. These lectures are delivered using the MediaMosaic Library software developed by the Vodium Corporation. This software provides a rapid loading time and graphical user interface and runs on almost any platform or browser. The video stream cannot be blocked by firewalls, it allows fully synchronized and searchable video, loads almost instantaneously and boasts a resizable browser window.

CSPD continues to lead the way in producing pediatric dental online training using video, audio, scrolling text and PowerPoint slides on a single screen … under the watchful eye of the MediaMosiac software. All of the lectures are ADA CERP qualified.

California Society of Pediatric Dentistry

The California Society of Pediatric Dentistry (CSPD) was founded in 1975 and represents the specialty of Pediatric Dentistry in California. It is dedicated to education, practice and research in the specialty of pediatric dentistry. CSPD is comprised of over 700 California pediatric dentists along with a number of associate colleagues from other states.

The society provides liaison with other health care organizations, government entities and private agencies concerned with the dental health of children, adolescents and individuals with special health care needs.

CSPD is the California state component of the American Academy of Pediatric Dentistry (AAPD) and is currently the largest state component, representing almost 10% of AAPD membership.

For more information contact:
Lonnie Lovingier, DDS lrlov@aol.com
Steve Niethamer, DDS sniethamer@cspd.org
Roland Hansen, DDS rhansen@cspd.org

Members of your MBDS Board at the November 2008 CDA *House of Delegates*

Dealing with Employment Issues

By TDIC Risk Management Staff

Harmony among the office staff, common goals, established rules and good communication are essential to a smoothly functioning dental office. Without these, an office can be an uncomfortable place to work, as well as a breeding ground for liability.

Every dental office has its own culture, conditions of employment and benefits. Clearly communicated workplace standards prevent surprises and false expectations among management and employees. Established office guidelines protect you from potential employment practices liability claims and foster a more productive and creative team. When employees know what to expect and what is expected of them, you will have fewer complaints and less absenteeism and turnover. Having a written employee manual is the starting point to implementing effective employment practices.

Your employee manual should reflect your employment practices. It is important for your manual to address office policies, procedures and protocols, including the administration of benefits and pregnancy leave. To prevent allegations of wrongful termination or discrimination, establish guidelines for disciplinary actions and terminations, and include them in your employee manual. Additionally, every office should have a written policy prohibiting on-the-job harassment, including sexual harassment, with an internal complaint procedure that an employee can use to file a confidential complaint. This policy should be included in your manual as well.

Once you begin using an employee manual, adhere to it strictly. Disseminate the employee manual to all employees, and obtain a signed acknowledgment that each employee received and read it. Keep the signed acknowledgement in their personnel file. A copy of the manual should always be accessible for employee access and review. To gauge how closely you are following the guidelines outlined in your employee manual, conduct a periodic audit of your day-to-day operations. Regularly review and update your manual to accommodate new laws and changes in your office. When you make changes to the manual, distribute those changes to all employees and obtain a signed acknowledgment that they received the changes.

It is also important to clearly designate whether your employees are at-will or for cause. With at-will employment, either the employer or the employee may lawfully terminate the employment relationship at any time as long as the termination does not violate a specific law or is not discriminatory. However, if the employment relationship is for cause then the specific terms of that agreement control the situations in which the termination is lawful. That is, employment can be expected to continue unless there is "cause" to terminate it. Cause can include inadequate or substandard work performance and inability to do the job, as well as gross misconduct, embezzlement, violation of a stated office procedure or reduction in work force.

Further, employers may not base employment decisions on an individual's age, race, sex, national origin, religious beliefs, color or ancestry, physical or mental disability, medical condition, marital status, sexual orientation, political beliefs, or any other basis protected by federal, state or local law, ordinance, or regulation. Basing employment decisions on the above factors would expose employers to liability for wrongful termination.

The growth of federal and state legislation dealing with employee discrimination and sexual harassment, the changing legal views on wrongful termination, and the increasing tendency of disgruntled employees to turn to the courts for retribution, have created a need for employment practices liability (EPL) insurance. Your professional liability carrier may offer EPL coverage. The Dentists Insurance Company offers such coverage as an additional endorsement. As long as you have employees, you risk facing allegations of wrongful employment practices.

For Immediate Release

Distinguished Local Oral & Maxillofacial Surgeon Opens State-of-the-Art facility in Scotts Valley

September 12, 2008 (Scotts Valley, CA) It is with great pleasure that Corrine Cline-Fortunato, DDS announces that her new 2,300 square foot facility located at 223 Mount Hermon Road, Suite B has opened for patient treatment.

Throughout its spacious surroundings and state-of-the-art equipment, the new facility will allow Dr. Cline-Fortunato to better accommodate and serve patients who are referred to her office. The reception area was designed for convenience and comfort for patients and their families. In addition, Scotts Valley Oral and Maxillofacial Surgery is easily accessible from Scotts Valley, the San Lorenzo Valley, downtown Santa Cruz, the west-side of Santa Cruz and Los Gatos.

For the past eleven years, Dr. Cline-Fortunato had been serving both the Santa Cruz and San Jose dental communities in group partnerships. She is delighted to be bringing high caliber Oral and Maxillofacial Surgical care to Scotts Valley, an area known for its five-star medical, esthetic and wellness facilities. Her special brand of oral surgical care combines form and function for beautiful and healthy smiles with "from the heart" patient care. About Dr. Cline-Fortunato:

A native Californian, Dr. Cline-Fortunato was born in southern California, but raised in Pismo Beach. She returned to Southern California to further her education graduating from UC Riverside, Summa Cum Lade in 1988, receiving her Doctorate of Dental Surgery from the University Of Southern California School Of Dentistry in 1993 and completing her residency in Oral and Maxillofacial Surgery from Los Angeles County/ USC Medical Center in 1997. While in residency she was awarded both the Marsh Robinson Academy Fellowship and the Southern California Academy of Oral Pathology Fellowship. Dr. Cline-Fortunato is a member of many international, national, state and local dental organizations. She is especially active in the California Association of Oral and Maxillofacial Surgeons (CalAOMS) where she served as the editor of the state newsletter, The Compass, for several years. She has lectured both locally and abroad on various topics related to Oral and Maxillofacial Surgery for several dental organizations, as well at Cabrillo College. Currently she serves the State Board of California as an Ambulatory Anesthesia office evaluator. She continues to travel nationally and internationally to stay abreast of the most current topics in her field.

For Immediate Release, continued

Dr. Cline-Fortunato (a.k.a. "Corry") spends most of her free time hiking, swimming, wine tasting and entertaining family and friends. They are avid sponsors and supporters of the Gorilla Foundation, American Musical Theater of San Jose, Scotts Valley/ San Lorenzo Valley Soccer Club and the San Lorenzo Valley Cheer Squad.

"Developing my 'dream practice' in my own community, among colleagues, friends and neighbors who I respect and want to serve has been a great blessing both professionally and personally."

Contact Information:
Dr. Corrine Cline-Fortunato
223 Mount Hermon Road, Suite B
Scotts Valley CA 95066
(831) 430-9910

A Recalled Childhood Memory:

This is a true story, written by a friend who has since passed away. Before he died he put this down on paper so all his friends could share in HIS Christmas story after he left us. This took place about three years after his mother kicked out the father of their seven children when she learned that he was money laundrying for the mob. With in months of him leaving, the family had to move out of their home and in with her parents until she found a job. She finally rented a house and raised seven children by herself. Five of the kids graduated from college, two with master's degrees. But that is now. Kevin is gone. But this story is of a special Christmas where Santa was dressed in overalls and rode a big gas truck...

A recalled childhood memory: As told and written by Kevin Bitting 2007

Christmas Day I was grade school age (3rd or 4th, I believe). It was a terribly cold morning, freezing in fact! It had snowed through the night so there were snowdrifts clean up to our living room and first floor windows.

I was all excited about the presents Santa may have left me and the tremendous amount of snow I would later go out and play in. There was no school with presents and fun in the snow later, to sled and toboggan in, it was dreams come true.

It was so very cold in our house that morning when we woke up, I could see my breath (indoors!). By the time I was down stairs with my brothers and sisters to open presents, my mom was already on the phone. She was trying to explain to someone on the other end of the line, that she had seven children, it was Christmas morning and we had no heat in our house. None of us dared move to open presents as we listened to our mother on the phone. We all knew this was important, more important than rushing to open the gifts Santa brought. Yet there those present stood, gleaming under the tree, just begging to be opened!

After what seemed to be a very long time, my mom finally hung up the phone. She had just given the person on the other end of the phone her name and our address. My mom sat us all down, even the little ones, they being the two youngest boys and myself, then proceeded to explain the situation as best as we could understand.. My older brothers and sisters already understood the situation, even before my mom began her explanation. I could tell by the worried expression on their faces they had from my mom.

In those days, our house was heated by oil. Every once in a while a big truck would pull up and a man would pull a hose with a nozzle on the end, like you see at a gas stations, from the truck all the way up the front door practically. Near the front door, next to some bushes, there was a pipe with a cap on it that stuck out of the ground. He would just pop off the cap, stick the nozzle in and pump oil into the pipe. It seemed that we never really saw him much in the summer, if at all: so I figured out that as long as he pumped oil occasionally in that pipe, we'd have heat in the winter.

My mom explained that because it was Christmas Day, the oil company's employees were off celebrating Christmas with their families too and no one could come to our house. The snow storm made it even more difficult because the roads weren't plowed yet, so even if the Oil Company was open that day, they couldn't make it through the snow. While this was very true, it wasn't the whole reason, either.

What she didn't tell the little ones was, that we owed a good deal of money to the Oil Company and that we owed it for quite sometime. The Oil Company wanted our balance paid before getting any more heating oil. She didn't have any money to pay them toward the balance that we owed. She didn't tell the little ones that she spent it all on Christmas that year and even extended herself (on what little credit she had); but my older brothers and sisters somehow knew. They knew that my mom was trying to make a Christmas for her kids, especially the little ones.

Sometimes my mom would see something months in advance, she knew that one of us really wanted and she would put it on "layaway." She was hoping to pay it in full before Christmas. Or she'd buy it now, on credit, and literally take to the following Christmas to pay if off. For her, life was just a series of sacrifices that moved from one to another in order to provide for her children. Somehow we seemed to get through, though sometimes just barely.

That morning she told us to run upstairs, put on a lot of clothes, one over the other in order to keep warm; because we may not have heat for a while and she didn't know when we would get more oil. Now we were all worried for my mom, even the little ones! I didn't want to open any gifts until I could take away the worry on my mom's face. I wanted to see the worry on my older brothers and sisters faces lifted also. I didn't seem very likely though.

Now being just a little kid, I still pined for my presents, naturally, but I knew that I couldn't enjoy getting them as long as I saw the worried expression across my mother's Face. She didn't try to conceal this growing up, put on a pretend happy face. When it came down to just plain day to day and week to week survival, concealment, now that I look back, would have seemed absurd. To hide the constant and tremendous effort it took her to provide even the essentials (food, clothing and a roof over our heads) would have been a disservice to us, if not impossible. (My mom raised all seven of us children by herself. She had asked my dad to leave just after the last child was born, and never be a part of this family. Never! This needless to say is another story for another time)

As is our family tradition, one of the kids gets to play Santa! "Okay, kids; who gets to be Santa this year," mom would say. Usually, with the seven of us, bright and quick of mind, we'd all have that one figured out based upon years past. Even the little ones could figure who's turn it was, in a flash. If there was disagreement, a brief review of years past would be exchanged amongst us kids, like some genealogy. "Let's see, well Bonnie was last year and Linc was the year before and Jim did it before that …" and so it would go. If it wasn't figured out, then general consensus ruled. Every one of us would agree to who would play Santa. Some of us, me especially, would agree outright, because it was the quickest solution to getting the presents. NOW!!!

Here we were, layer upon layer of clothing, sitting around the Christmas tree with little piles of presents placed before each of us by the brother or sister chosen to play Santa,. The excitement was definitely there in each of us, naturally being just kids. But it wasn't quite like years past. I suppose that worry on my mom's face, she just couldn't hide from us, took precedent. Kids are resilient, we were going to be out in the freezing weather anyway, playing in a couple of hours… so what if you could make ice cubes in our living room. But to my mom, one of the essentials was being denied her children: a warm roof over their heads.

I think we had just got to the point of having all the presents doled out when we all heard a rumble that shook the windows and rattled the doors. Then the high squeal of air breaks. We all abandoned our piles of presents, rushing to the living room windows. There, before us, stood an oil tank truck snow piled all around it. Its wheels having made fresh tracks in the snow where the street should be under the high white blanket that hid sidewalks and curbs. A man, in uniform no less, was dragging a hose that unwound from the under belly of the tanker. And he was dragging himself and the hose through knee deep snow to our front door.

He struggled through the snow, to find the pipe with the cap on it. He looked up toward the window where we all were staring out at him. All of us immediately pointed to where the pipe usually is, near the bushes, by our front door. He found it right away being directed by seven pairs of hands and popped that cap off and proceeded to pump heating oil in the pipe. I remember turning to look at my mom's face as tears welled in her eyes, transfixed at the deliveryman. She mouthed the words, "Thank You" to the man as he looked up while pumping the oil. He nodded as if he knew how terribly important this was to a single mom, with seven kids. As a kid back then, I only knew that this kind act brought relief to her. As an adult, I get my own tears at the memory of it.

Kevin's Christmas Gift to you, for always…

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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

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