JUNE/JULY 2011

IS TECHNOLOGY ALWAYS SUPERIOR?

A LOOK INTO LASERS FOR PERIODONTAL THERAPY

Inside:

A conversation on lasers — are they superior?

PLUS: 2011 SDDF "Swing for Smiles" Golf Tournament Recap

$125 per person

$1250 per table

Silent online auction • Cocktails, dinner & live auction • Entertainment & dancing

LIVE AUCTION ITEMS:

as of June 2, 2011

- 1-week stays at:
  - Maui (Hawaii)
    donated by Dr. Dave Seman
  - Kauai (Hawaii)
    donated by Mann, Urrutia, Nelson, CPAs
  - Seascape (Aptos)
    donated by Dr. Kelly Giannetti
  - Dollar Point (Lake Tahoe)
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  - Schaeffer's Mill (Lake Tahoe)
    donated by Dr. Don Rollofson
- Golf for 4 at Cypress Point (Pebble Beach)
  anonymous donor
- $3,000 worth of concrete work & construction
  donated by Sellers Construction (Ed Sellers)

WATCH FOR SILENT AUCTION, OPENING THIS SUMMER!

MISSION OF THE FOUNDATION: The SDDF's mission is to help to improve the oral health of the community through dental education, screenings and free dental treatment to those who otherwise cannot obtain it. Currently the programs of SDDF are:

- **Smiles for Kids (SFK)** — our program that screens more than 30,000 children every year and our member dentists provide free treatment (in the dentists' own offices) to 1000 who cannot otherwise get treatment;
- **Smiles for Kids Ortho** — part of the SFK program that provides free orthodontic treatment to more than 70 children each year;
- **Smiles for Big Kids (SFBK)** — our program that provides screenings and treatment to adults, focusing on the elderly, parents of SFK patients and other patients who "fall through the cracks";
- **Emergency Treatment** — provided on a case by case basis, all provided by volunteer dentists.

SDDF is funded solely through contributions, bequests, fundraising events, donation of services by member dentists, planned giving and grants.

ABOUT THE FOUNDATION: The Sacramento District Dental Society's Foundation (SDDF) is a non-profit, 501c3 that was established in 1969 by the member dentists of the Sacramento District Dental Society (SDDS). Currently the SDDS is more than 1500 members strong and encompasses the five counties of Sacramento, Yolo, Placer, Amador and El Dorado — reaching all the way to cities of Tahoe City and South Lake Tahoe, Jackson, Elk Grove, Davis and Woodland.

Saturday: OCTOBER 1, 2011

6:30pm • Hyatt Regency Sacramento

MORE INFO ONLINE!

Check the web for more information on the SDDF Gala, including registration forms, sponsorship opportunities and auction items.

www.sdds.org/SDDF_Gala.htm

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***THE NUGGET* IS A FOUR-TIME INTERNATIONAL COLLEGE OF DENTISTS JOURNALISM AWARD WINNER:**

GOLDEN PEN (HONORABLE MENTION, 2007)
Article or series of articles of interest to the profession

OUTSTANDING COVER (2007)
Remarkable cover

OVERALL NEWSLETTER (2007)
Exceptional publication overall

PLATINUM PENCIL (2010)
Outstanding use of graphics

PRESIDENT'S MESSAGE

More than the Basics IN DENTAL SCHOOL

By **Wai M. Chan, DDS**

How things have changed over the years.

When I was in dental school, tooth color fillings were silicate fillings. The new polishable esthetic material was a resin composite filling material with only one color. It was "take it or leave it." We would carefully etch the enamel because we were told etching the dentin would kill the pulp tissue. If we accidentally placed the etching solution on the dentin (we did not have the fine needle etching gel delivery system yet), we would probably go home feeling guilty and dream of patients calling us and complaining of endodontic problem. Fast forward 35 years, we have multiple choices of colors, shades and materials. We are using enamel and dentin bonding agents. We are doing total etch technique or self-etch technique. We are moving from doing what was traditionally being done to doing procedures based on evidence and peer-reviewed research.

> *We are not tradespersons; we are healthcare practitioners who specialize in oral health. To stay on the top, we have to keep learning.*

In addition to fixed and removable prosthesis, we are now restoring patients' missing teeth with implant-supported crowns and prosthesis. We are placing hard tissue and soft tissue grafts. We are performing tissue regeneration procedures. We are also using mini-implants for anchorage in orthodontic procedures. More dentists are using loupes for better vision. Some offices are using surgical microscopes. More and more offices are using digital radiography, digital intra and extra-oral camera. Almost all offices are computerized. We are using trans-illumination to detect tooth fractures and decay. Some offices are using laser cavity detecting devices. Some are using lasers for hard tissue and soft tissue procedures in their practices.

We are not tradespersons; we are healthcare practitioners who specialize in oral health. To stay on the top, we have to keep learning. Our patients have entrusted their care to us, we have to keep improving ourselves so we can better serve our patients.

If you do not have time to read all the journals, then read the abstracts. Pierre Fauchard Academy provides their fellows a bimonthly journal, *The Dental Abstract.* It is a collection of abstract of articles from various peer-reviewed journals. The PFA Fellows find it beneficial and time saving. There are other journals like that. Check online or check with the publishers when you go to conventions.

We cannot diagnose what we do not know. Peer-reviewed journals, continuing education classes, study clubs, hands-on workshops, all these will expand our knowledge, help us and empower us to provide better care to our patients. Your peers will be more than happy to guide you and share their knowledge with you. You just have to ask. We do not know everything. Collaborating with our dental and medical colleagues who are experts in their respective specialties will help us in arriving at the proper diagnosis and best treatments for our patients. We will look like heroes when we utilize all the resources we have. ■

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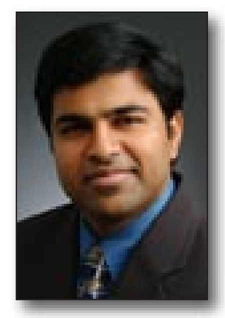
FROM THE EDITOR'S DESK



LASER IS NOT BETTER THAN A CURETTE FOR PERIODONTAL THERAPY — NOT YET!

By **Ash Vasanthan, DDS, MS**
Associate Editor

My association with lasers started in my third year in dental school. It was at that time I submitted a paper on "Lasers in Dentistry," which gave me the opportunity to present it at the national conference. It also became my very first publication. Later on, when I pursued my Masters in Dental Biomaterials, my thesis was on "Implant Surface Modification Using Lasers," which complemented my clinical periodontics residency. I followed my desire to teach periodontics and found myself at the University of Missouri, Kansas City, which is known to be the hub of laser research in periodontics. I'm not sure if I chose lasers or lasers chose me. Our association continues to grow and this issue of *Nugget* just strengthens that.

We all can agree that in our professional careers we see many things come and go, but, only some things stay. I believe laser technology is one to stay and will continue to help and modify the dentistry we practice. I use lasers in my practice quite regularly for different surgical procedures from gingivectomy to implant uncovering and many other soft tissue procedures. I have come to enjoy using it for what it does. However, I have refrained from using it in non-surgical periodontal therapy. The simple reason is that I have not seen any scientific evidence in properly designed, well presented prospective, blinded and randomized multi-center clinical trials. The mentioned type of trial is one that provides the strongest form of evidence, eliminating bias. Although lasers are easy to use and can definitely increase patient acceptance of treatment, the questions is, "Are lasers truly the factor that brings about our clinical success or is it our bias toward lasers that make us look at it that way?" In most cases the latter seems to be true and research has shown similar clinical gains without laser, which makes me feel even stronger about the way I practice my periodontics. One of my co-workers asked me, "So, should I quit using lasers for perio therapy?" and my answer to him was, "Definitely not. All I'm saying is be aware of the fact that it is a mere adjunct and is not the silver bullet."

> *We all can agree that in our professional careers we see many things come and go.*

In this issue of the *Nugget* I have tried to compile a list of articles from authors of different backgrounds and, more importantly, from different geographic locations of the country. These authors are authorities in their field in their own unique ways and I'm thrilled that I was able to collaborate with them for this issue. It is my hope, that these articles will give better clarity to our understanding of lasers and their applications. One must consider the fact that if the periodontal community, as a specialty, has not embraced lasers for non-surgical perio therapy, there definitely is a lack of evidence or a clear clinical direction to its use in our offices on an everyday basis. Although, at this point in time, the use of lasers in non-surgical perio therapy is more of an adjunct, the future definitely holds promise. I am hopeful that the LIGHT AMPLIFICATION in this issue of the *Nugget* will have STIMULATED your thoughts, focusing EMISSION of your energy in understanding this source of RADIATION called L-A-S-E-R. ▪

Dr. Ash Vasanthan is a periodontist who practices in Roseville. He is a Diplomate of the American Board of Periodontology and International Congress of Oral Implantology. He is an adjunct assistant professor at University of Missouri Kansas City, where he previously spent five years teaching periodontics and implants .

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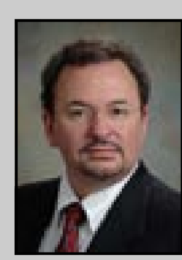

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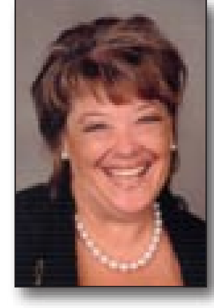

And You Think Summer is for Relaxing... REALLY?

By **Cathy B. Levering**
SDDS Executive Director

Just as I turn the calendar over to June, there seems to be no rest for the weary!

While we try to slow down a bit in our programming each summer, it's the time that we gear up, plan, schedule, contract, design, print and catch-up to get-ahead for the fall and upcoming "season."

Summer is sort of our "ALL STAR BREAK" — and our staff is certainly proving to all be "MVPs"! Just this week we sent the Directory to the printer, the master calendar to the printer, the *Nugget* to the printer, and the Program at a Glance is in final edits.

That said, a couple of notable and "HONORABLE MENTIONS" as I hurry this article off to the printer:

RIVER CATS — thanks to nearly 300 of our members and friends who will be attending our SDDS night at the Raley Field next week (June 9th). This is always a fun night and we love to offer it every year…

WICKED — It's coming to Sacramento in May /June in 2012. We've reserved 150 tickets for SDDS and, if you want to join us, make sure you watch for our ticket sales announcement. It's going to be a hard ticket to get and we have them!

JULY 6th (6:30PM) — CDA is hosting a town hall meeting in Sacramento and they want to hear from our members regarding access to care and barriers to care. Our SDDS representatives will be there so that they can hear your thoughts and viewpoints and take them further to the CDA House of Delegates in November.

SMILE SACRAMENTO — SDDF GALA, OCTOBER 1, 2011 — tables are filling up fast (tables of 10) so please send in your reservations before July 15th! (You don't have to have a full table to attend). See insert to sign up!

MEMBER MAILING / 2011-2012 PROGRAM AT A GLACE — Coming soon (August 15th)!

Have a great summer and please call us if you need us! We're here! ■ Cathy

CDA TO HOST REGIONAL ACCESS PROPOSAL FORUMS

Access to care, workforce issues, barriers to care are all issues that are facing the dental profession and our community today.

CDA, the Access Workgroup, and the Workforce Task Force (all comprised of CDA members) have been working hard to gather the information, based on knowledge-based research, so that we are prepared to address these very important issues.

CDA has scheduled regional forums in June and July for members to discuss the association's proposed strategies for reducing barriers to oral health care. This is an opportunity to engage in the discussion and ask questions about the research, process and report that has been prepared for consideration by CDA's 2011 House of Delegates. CDA will send out forum notices in the coming weeks.

Northern California Access Proposal Forum: JULY 6 (6:30pm)
CDA Building (1201 K Street, Sacramento)

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The *Nugget* is an opinion and discussion magazine for SDDS membership. Opinions expressed by authors are their own, and not necessarily those of SDDS or the *Nugget* Editorial Board. SDDS reserves the right to edit all contributions for clarity and length, as well as reject any material submitted.

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Interview with **David Hilton, MS, PhD**
Laser Physicist (left)

Interview conducted by **Ash Vasanthan, DDS, MS**
Associate Editor (right)

A Chat with Laser Physicist, DAVID J. HILTON, MS, PhD

Dr. Vasanthan (V): ***What is the physics behind lasers? What makes lasers so unique compared to any other light source?***

Dr. Hilton (H): A laser is a controlled light source. Lasers have, in most cases, fixed operating wavelengths that are determined by the specific laser type (Nd:YAG, Diode, Er:YAG, Er:YSGG, CO_2, etc.), which permit the operator to specifically target tissue that absorbs at that wavelength. They also produce light in one direction to form a beam, in contrast to a light bulb that radiates light in all directions. As a result, it is possible to focus the emitted light from a laser to a small spot using a lens and to deliver its energy to cut tissue, remove hard tissues or accretions or to kill bacteria. Finally, lasers are *coherent* sources of light; this means that two interacting laser beams form an interference pattern where two different light bulbs, in general, do not.

V: ***What is the difference between the laser used in a regular pointer for lectures compared to the one used in medicine/dentistry?***

H: The major difference is the laser power. As a laser pointer, you want a *compact* device that can be run off of AA or AAA batteries for an extended period of time. For medical/dental applications, the laser power may need to be higher to cut tissue, kill bacteria or remove dental calculus. If they are ANSI Class 3B or Class 4 lasers, you and your patient(s) will need to wear laser goggles to operate the laser safely, as these lasers are *easily* capable of causing eye damage. All lasers used in dentistry fall under class 3B and 4.

V: ***There is a big discrepancy in the size of the laser equipment with some being very small and others being quite big. Why is there a difference?***

H: Power, again, is the main difference. A laser pointer need not produce much light to do its job, while a laser that would be used to cut steel must produce a tremendous light output. For medical and dental applications, the required power is often times rather modest, especially if the beam is focused onto the tissue.

V: ***Currently there are a lot of different lasers being used in dentistry: CO_2, Diode, Nd: YAG, Er: YAG. How does each one differ?***

H: The actual atom or molecule used to generate the light determines the operating laser wavelength. For example**, carbon dioxide** lasers generate light from transitions between different molecular vibrational and rotational states and emit light at a wavelength of either 9.6 or 10.6 µm. **Diode lasers** are also very common and generally emit in the near infrared (980 nm is one common wavelength for a gallium arsenide diode laser). In a **Nd:YAG** laser, the neodymium (Nd) atom is emits laser light at 1064 nm; this wavelength corresponds to one of the atom's electronic transitions. **Er:YAG** is a similar laser that uses the YAG crystal to manage heat flow and the erbium (Er) atom to generate light emission at 2940 nm. The related Er:YSSG laser emits 2790 nm, again due to the Er atom in the YSSG host.

> *The use of lasers in periodontal treatment is also growing, primarily for the laser's ability to focus on the infected areas under the sensitive gingiva and sterilize them.*

V: ***Wavelength is always cited to be an important factor for a laser. Why is that?***

H: Materials absorb different wavelengths, depending on their chemical components. To target a specific tissue, we need to understand its chemistry and how it will absorb the laser light. The Nd:YAG laser operates at 1064 nm, which is strongly absorbed by body tissues and hence is more useful for use with soft tissues. The Er:YAG laser operates at 2940 nm and can be used to drill enamel, hydroxyapatite, or other hard tissue. The advantage over a conventional drill to prepare a tooth for filling is the ability to target a small area (the cavity) with nearby areas experiencing little to no damage. As a second effect, since the Er:YAG and Er:YSGG lasers are strongly absorbed by water, the water in bacteria will also absorb energy. The right dose will heat the bacteria to a high enough temperature where it dies, thus sterilizing the surface of the tooth while the laser drills away the damaged tissue.

V: ***Is it true that a laser can destroy bacteria only based on direct contact?***

H: The use of lasers in periodontal treatment is also growing, primarily for the laser's ability to focus on the infected areas under the sensitive gingiva and sterilize them. The Nd:YAG, Er:YAG and Er:YSGG are strongly absorbed by water, so any bacteria within the beam focus will absorb this energy. The majority of this energy would be turned into heat and, if the temperature change is large enough, kill the bacteria. This can generally be done at a laser power without much damage to the underlying enamel and bone.

V: ***Can a laser effectively remove calculus (an accretion of calcium and phosphate with bacteria) attached to the root surface of a tooth (made of calcium and phosphate with some organic matter)?***

HAVE YOU CHECKED THE WEB? The SDDS website is your source for CE, events, important announcements and more! Check it out at **www.sdds.org**

H: Well, automobile manufacturers regularly use lasers to cut steel, so the main issue is not removing calculus, but doing so in a way that preserves the existing tissue/bone. The Er:YAG laser is specifically absorbed by hydroxyapatite, so it will be absorbed by both the calculus and the tooth. However, at the right power (which may be a very narrow range) calculus would be loosened, although there is a risk of root surface damage.

> *There has been and will continue to be an enormous investment in developing laser technology for a wide range of industries.*

***V:* Based on your work with the industry and lasers where do you see the future of lasers in our applications in dentistry?**

H: There has been and will continue to be an enormous investment in developing laser technology for a wide range of industries and for a wide range of medical applications. Our ability to develop new materials that emit at specific wavelengths will allow us to more carefully target specific kinds of bacteria and surface buildup. We will also likely see increased use of lasers as *diagnostic* tools. There has been some preliminary work that uses very long wavelength lasers for caries detection (J. Biomed. Opt. 8, 303 (2003); Caries Res 2003;37:352–359). Since these long wavelengths are non-ionizing, they are safer than traditional x-rays for both patients and the dental staff. These long wavelengths have also been shown to be able to discriminate between normal and cancer cells in topical skin cancers (Brun et al. Physics in Medicine and Biology (2010) vol. 55 pp. 4615); it may be possible to apply this in the future to oral cancer detection to permit preliminary diagnosis prior to performing a biopsy. ■

Dr. David J. Hilton *obtained a B.S. and M.S. (1999) in Optics from the University of Rochester and M.S. (2001) and Ph. D. (2002) in Applied Physics from Cornell University. He is currently an Assistant Professor of Physics at the University of Alabama at Birmingham. His research focuses on the development and utilization of laser and other coherent light sources for solid-state materials characterization, quantum control, and biomedical applications.*

continuing education

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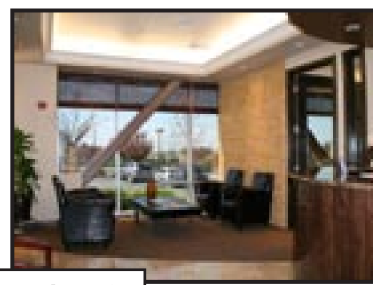

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Laser Assisted New Attachment Procedure (LANAP™)

IN THE OFFICE

By **Todd Welch, DMD**
Periodontist (Jackson, TN)

Laser assisted new attachment procedure (the LANAP™ protocol) is a patented therapy designed for the treatment of periodontitis through regeneration rather than resection. This therapy and the specific neodymium:yttrium-aluminum-garnet (Nd:YAG) laser used to perform it have been in use for more than a decade. Developed and refined in Cerritos, California, since the 1990s by Dr. Robert H. Gregg II and Dr. Delwin McCarthy to achieve consistently effective and predictable outcomes. The U.S. Food and Drug Administration approved the LANAP™ protocol for the treatment of periodontitis and gum disease, in 2004.

Early LANAP™ research showed consistent mean pocket depth reduction (40%) and improved bone density (38%) in an 8-year retrospective study of the protocol's earliest clinical results[1].

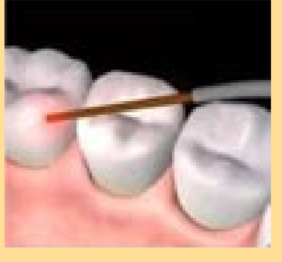
Although about 80% of Americans suffer from gum disease, approximately 97% of those with moderate to severe periodontitis refuse treatment as too invasive and painful and not achieving strong enough lasting results. Acceptance of the LANAP™ technique in periodontal treatment, introduces an option that more patients are willing to accept. There are those who debate the results of LANAP™. The American Academy of Periodontology (AAP) has yet to amend its August 1999 statement questioning the procedure. At odds with AAP's stance are subsequent peer-reviewed articles such as Raymond Yukna's manuscript of human histology published in the *International Journal of Periodontics and Restorative Dentistry* in 2007 and the article by Harris in *General Dentistry* in November 2004.[2,3]

How the LANAP™ Protocol Works:

In LANAP™ surgery, a variable pulsed (Nd:YAG laser at 1064nm wavelength) dental laser is used by a trained and certified dentist or periodontist to treat the periodontal pocket.

Steps Involved:

1. Under local anesthesia, pocket depths are probed to the level of bone.
2. The thin optic fiber is placed parallel to the root surface and a first pass with the laser, called laser troughing, is accomplished with the short duration pulse.
3. A cleaning is accomplished with an ultrasonic scaler and hand instruments.
4. A second pass with the laser is taken to finish debriding the pocket and achieve hemostasis with a thermal fibrin clot. No sutures or surgical glue is needed.
5. Occlusal adjustments are performed to remove interferences, minimize trauma, and provide balance to long axis forces and are considered an essential component of the LANAP™ protocol. Mobile teeth above class II mobility are splinted.
6. Patients are monitored at one week, 30 days and then every 3 months for periodontal maintenance. No subsequent probing is performed for at least nine months to a year to allow sufficient healing time for the cementum-fiber PDL interface



What LANAP™ accomplishes:

The tenacity of the calcified plaque and calculus adherent to the root surface is modified by the laser energy so its removal with an ultrasonic scaler is more easily accomplished. The free running pulsed Nd:YAG laser is combined with systemic antibiotics to achieve the optimal reduction of microbiotic pathogens (antisepsis) within the periodontal sulcus and surrounding tissues. Perio pathogens and pathologic proteins are selectively destroyed by the laser's light energy, providing an aseptic surgical environment that allows healing following the laser hemostasis step. Since, the laser energy is quite selective for pocket epithelium, the underlying pleuripotent connective tissue is spared, thereby permitting healing and regeneration rather than formation of a pocket seal by long junctional epithelium. Stimulation of existing stem cells permits the formation of new root surface layer (cementum) and new connective tissue (periodontal ligament) formation on tooth roots. The procedure's success has challenged the old paradigm of periodontal healing in the absence of guided tissue regeneration barriers (GTR) or bone grafting materials (allografts).

Benefits of LANAP™:

- Pocket depth reduction is comparable to that achieved by conventional resective osseous or pocket reduction surgery, but without the gingival recession normally associated with osseous surgery
- Significant post-operative reduction in gingival indices, gingival inflammation and bleeding on probing.
- Minimal post-operative recession and root sensitivity.
- Minimal pain is easily controlled with the use of non-steroidal anti-inflammatory drugs (over-the-counter NSAIDs) such as ibuprofen.

For patients concerned about conventional surgery for treatment of periodontal disease,

the new laser treatment can be a totally different experience. I find this to be true in my practice where I perform both procedures and I find myself increasingly performing the LANAP™ and encouraging patients to go through the laser option more often. With this great option added to the list of services I provide, my patients are able to save their teeth, preserve their natural smile, and avoid the potentially life-threatening systemic effects of untreated periodontal disease. I'm thrilled to offer this great treatment option to my patients and enjoy seeing a greater acceptance of this successful treatment modality. ■

Dr. Todd Welch is a Board Certified periodontist who practices in Jackson, Tennessee. Laser periodontal therapy is one of his professional interests. He maintains an active blog on ***www.wtnperioblog.com***

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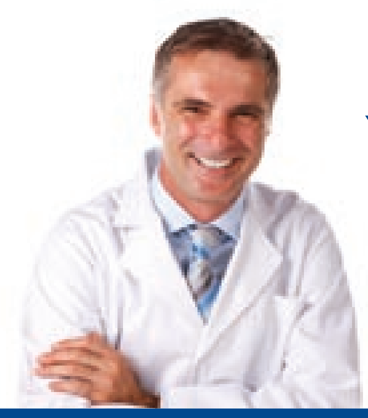

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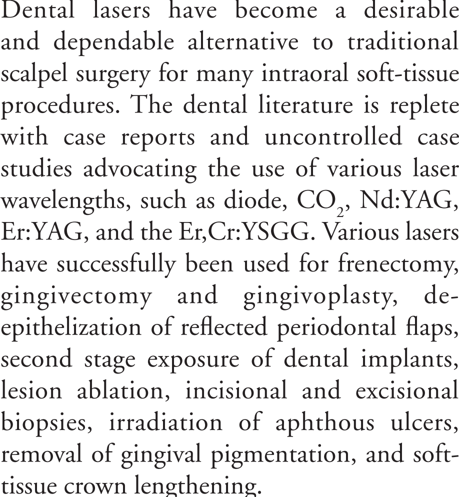
Lasers: DEMAND GOOD SCIENCE & GOOD EVIDENCE

By **Charles Cobb, DDS, MS, PhD**
Periodontics Professor (Kansas City, KS)



Dental lasers have become a desirable and dependable alternative to traditional scalpel surgery for many intraoral soft-tissue procedures. The dental literature is replete with case reports and uncontrolled case studies advocating the use of various laser wavelengths, such as diode, CO_2, Nd:YAG, Er:YAG, and the Er,Cr:YSGG. Various lasers have successfully been used for frenectomy, gingivectomy and gingivoplasty, de-epithelization of reflected periodontal flaps, second stage exposure of dental implants, lesion ablation, incisional and excisional biopsies, irradiation of aphthous ulcers, removal of gingival pigmentation, and soft-tissue crown lengthening.

Lasers easily ablate and recontour oral soft tissues. Further, when used in a cutting mode, lasers increase hemostasis which results in a clear and fully visible surgical field. Because of the intense and focused energy beam, lasers also exhibit a bactericidal effect at the target site. A few studies have reported that laser surgery, compared with traditional scalpel surgery, is less painful, exhibits less swelling and heals faster with less wound contraction. However, other studies offer conflicting opinions with respect to pain and speed of wound healing.

For almost two decades the laser has proven useful for a variety of clinical applications. However, there remains a paradox: why does the use of laser mediated periodontal therapy remain controversial? Is it because lasers challenge the traditional philosophy and modalities of treating periodontal diseases or because of a lack of hard evidence on which to make informed decisions? Many in private practice are using various types of lasers for the treatment of periodontal disease and most have expressed satisfaction with the results of therapy. Yet several recent systematic reviews of the literature have suggested there is little evidence to support the purported benefits of lasers for the treatment of periodontal disease when compared with traditional therapy. The conspicuous question then becomes, "Is laser mediated periodontal therapy based on sound evidence, i.e., peer-reviewed, randomized and controlled clinical trials (RCTs) or unconfirmed hearsay evidence?" The answer seems obvious.

In a 2008 issue of the *Journal of Dental Education* the following question was posed: "Why is it that dentists are among the very few health professionals who can ignore critical evaluation of the scientific literature and treat patients with personal experience as its equal?" The authors suggest that many dentists provide treatment without critically evaluating whether such treatment is consistent with the best evidence. The authors propose several possible reasons for ignoring the best available evidence, such as expediency, difficulty finding reliable evidence-based references, easy access to questionable information, and a desire for quick profits. Other reasons may include the introduction of new products without rigorous clinical trials. Regulatory agencies such as the U.S. Food and Drug Administration (FDA) do not necessarily require clinical research before product marketing. As an example, in the case of dental lasers, the 510K FDA premarket notification process requires only that the applicant provide evidence that its device is substantially equivalent to one or more similar devices currently marketed in the U.S. marketplace. A 510K premarket notification does not imply therapeutic equivalency or superiority. Indeed, the 510K process does not even require a clinical trial.

> *Technological change occurs so rapidly that dentistry / medicine has begun to rely on a limited number of "expert" clinicians who then present proportionately less research for us to learn from.*

A local newspaper featured an article entitled "That Surgery Might Not Be Best for You" followed by the question: "Are high-tech "keyhole" appendectomies safer than the old-fashioned operations surgeons have been doing for a hundred years?" The article noted that what is often assumed about health care – more is better, new beats old, high-tech out classes low — isn't always so. For example, research comparing drugs and treatments to discover "which have better results, fewer complications or lower costs is in woefully short supply."

As if to drive the point home, Dr. Richard P. Feynman, 1974 Nobel Laureate Physicist, stated "There is one feature I notice that is generally missing in 'cult science'… It's a kind of scientific integrity, a principle of scientific thought that corresponds to utter honesty. Details that could throw doubt on your interpretation must be given, if you know them. If you propose a theory, for example, and advertise it, or publish it, then you must also present all the facts that disagree with it, as well as those that agree with it." How many times has a sales representative offered to provide you with both a list of benefits and deficiencies associated with their specific laser? Does anyone ever discuss the lack of evidence or unbiased research regarding the application of lasers to periodontal therapy? Does this lack of discussion explain the dichotomy between practicing clinicians and published research? Are we really a profession based on science or a trade based on word-of-mouth transfer of techniques?

Given the low level of evidence, why do clinicians persist in making claims of superior results? Why cannot well designed RCTs produce the same results that are claimed by clinicians? Part of the answer may be the well researched concept of "confirmation bias."

Clinicians consistently over-estimate the benefits of their treatment due to confirmation bias. Simply put, confirmation bias is the tendency to look for and perceive evidence consistent with our hypotheses and to deny, dismiss or distort evidence that is not. Consider that in the average private practice:

- None of us does a procedure with failure as a goal;
- None of us likes to admit we made a mistake;
- The expense of investment biases opinions towards success;
- We have no placebo or positive control groups in our practices;
- We are not blinded to treatment;
- We are not calibrated for clinical measurements; and
- We do not randomized patients when planning treatment.

Thus, our bias is towards successful treatment, never a failure or partial failure, and because we see what appears to be a positive effect in some patients, it tends to become generalized to the entire practice. This is particularly true if one has just purchased a $50,000 (or more) instrument — it must work because it costs so much — otherwise I just made an expensive mistake!

In many respects development of dental lasers represents "disruptive innovation" — that may not be better than traditional therapy. When technology produces a more predictable outcome, that is more cost effective, and offers the patient greater benefits than traditional therapy, then progress has been made. Everyone wins. Technological change occurs so rapidly that dentistry / medicine has begun to rely on a limited number of "expert" clinicians who then present proportionately less research for us to learn from. Thus, the commercial side of the equation becomes dominate. In the current environment, commercial enterprise can sell their products without paying for the RCTs or being forced to justify their lack of evidence. Instead the industry buys an "expert" to market their product by presenting "the evidence."

The bottom line: be skeptical of opinions; ask hard questions; demand good science; demand good evidence; evaluate the evidence; and base your clinical decisions on scientific principles. ■

Dr. Cobb is a Professor Emeritus in the Department of Periodontics at the University of Missouri-Kansas City. He has received academic degrees in Dentistry (DDS), Microbiology (MS) and Anatomy (PhD). He is a Diplomate of the American Board of Periodontology. His career has been divided between an equal number of years devoted to full-time private practice and full-time academics.

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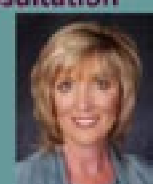

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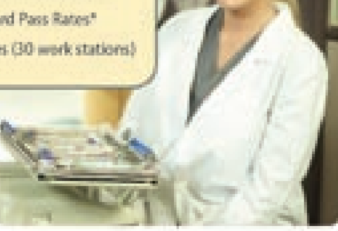

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Dental Lasers & Non-Surgical Periodontal Therapy:
SEEING THE LIGHT THROUGH SCIENTIFIC EVIDENCE

By **Nicky Hakimi, DDS**
Periodontist (Roseville, CA)

I have been following the clinical application of lasers for the treatment of periodontal disease for the past decade. My interest in dental lasers peaked when I was a CDA Delegate in 2001, where a hot and extended debate was taking place on the House floor. The issue addressed the training, education and appropriateness of the use of lasers by allied dental personnel. Despite the huge popularity of lasers in the dental community, the dental literature is still ambiguous about laser therapy as an alternative to traditional periodontal therapy. The primary purpose of this article is to provide a summary of evidenced-based findings in terms of several claims made on behalf of dental lasers and their advantages over the conventional approaches: 1. Laser mediated sulcular and/or pocket debridement; 2. Reduction of subgingival bacterial levels; and 3. Scaling and root planing.

What does the evidence show, in terms of laser mediated sulcular and /or pocket debridement?

Recently, clinical benefits (pocket depth reduction and clinical attachment gain) were reported for Nd:YAG (Neodymium: Yittrium Aluminum Garnet) laser assisted removal of pocket epithelium after scaling and root planing (SRP). These were histologically found to be due to new cementum or the attachment of new connective tissue. However, an in-depth review of the study by researchers in universities showed a flawed statistical analysis was provided to support these findings, with the sample size of specimens being quite small and there were few inconsistencies in the study design. One of the claimed advantages of applying a laser to a periodontal pocket is the laser's ability to debride the soft tissue wall since conventional tools cannot complete sulcular debridement of soft tissue effectively. The Nd:YAG laser which is delivered with a thin and flexible fiber can decontaminate and vaporize the pocket-lining tissue that it can target. The question is, how much area can a thin fiber carrying a non-bending collimated laser beam, target along the inner lining of a pocket?

If one considers the clinical parameters of reductions in probing depth or gains in clinical attachment levels, the dental literature indicates that when used as an adjunct to SRP, laser curettage has little to no benefit beyond SRP alone. The available evidence from several early studies has consistently shown that therapies intended to arrest and control periodontitis, depend primarily on effective debridement of the root surface and not removal of the lining of the pocket / soft tissue wall.[1]

Reduction of Subgingival Bacterial Levels

The laser therapy has been recommended as an alternative to traditional periodontal treatments such as scaling and root planing based on the assumption that lasers eradicate subgingival periodontal pathogen and inactive bacterial toxins from cementum. Two randomized clinical trials failed to suggest that the Erbium: YAG (Er:YAG) is superior to hand, sonic, or ultrasonic instrumentation at four and six months following treatment in regards to clinical and microbiological outcomes.[2] While laser manufacturers claim that the Er:YAG laser has the potential to eliminate subgingival microbes and remove endotoxin from root surfaces, results in this study suggest that the claim is unwarranted. Current evidence shows lasers, as a group, to be unpredictable and inconsistent in their ability to reduce subgingival microbial loads beyond that achieved by SRP alone.

Scaling and Root Planing

Erbium lasers show the greatest potential for effective root debridement (SRP).

Clinical trials involving Er:YAG laser in treatment of chronic periodontitis are better designed and yield consistent result. This is because the majority of the clinical trials come from the same group of investigators. There is the potential for root surface damage during the process of in vivo calculus removal since the Er:YAG is a hard tissue laser and the operator would not be able to visualize what is being lased (calculus or root surface cementum). Clinical data on attachment level changes when compared to SRP alone is conflicting with some studies showing a slight benefit while others showing no benefit.[3] Further studies are needed to determine if laser assisted SRP has a statistically significant beneficial effect compared to the traditional SRP or SRP with Arestin.

> *Given the apparent use of the laser, why does use of dental lasers in periodontal therapy remain a controversy?*

Does product regulation matter?

Given the apparent use of the laser, why does the use of dental lasers in periodontal therapy remain a controversy? Why is it that the laser has not the received the American Dental Association's highest endorsement, the ADA Seal of Acceptance, which indicates a product is safe and effective. For many laser applications, the ADA awaits further evidence.

Conclusion and bottom line

In reality, dental lasers are fantastic devices for many intraoral soft-tissue procedures. In our periodontal practice we use a diode laser for many procedures such as frenectomy, gingivectomy, implant uncovering, soft tissue biopsy, etc. In regards to the use of laser for periodontal therapy, I am cautious as to its efficacy, safety and effectiveness when direct scientific and clinical evidence is lacking. As dentists and hygienists we must continually assess our decisions about providing appropriate and effective care to patients, as

new technology and devices enter the market. Clinicians are often faced with claims that sound exciting and promise "best outcome" without solid scientific evidence. We as clinicians and practitioners should apply the same standards for evidence-based decision making with new therapies and devices. Let's not forget to include clinical judgment, expertise and patient care, as in ***The Art and Science of Dentistry.*** ■

Dr. Nicky Hakimi completed her postgraduate residency in Periodontics with a Master's Degree in 1993 at the University of Kentucky, Lexington. She is currently a third term Director for the California Society of Periodontists and a Past President of Sacramento District Dental Society. She currently has her private practice in Roseville and Auburn.

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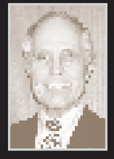
IN MEMORIAM



PETER LAURENDEAU, DDS

Dr. Peter Laurendeau passed away suddenly on the morning of May 2, 2011 at his home in Sacramento. Dr. Laurendeau was a graduate of Christian Brothers High School, St. Mary's College and Loyola University Dental School, where he graduated second in his class. For the past 40 years, he practiced as a General Dentist in Sacramento. He loved sports and was an avid skier, golfer, runner and cyclist, as well as Tang Soo Do. Dr. Laurendeau was a member of SDDS for 39 years. *(See right for more about Dr. Laurendeau)* ■

OUR CONDOLENCES

Dr. Nancy Archibald's mother-in-law and Dr. Glen Tueller's father-in-law recently passed away. Our thoughts are with both families.

SPREAD THE WORD!
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IN MEMORY OF A CLOSE FRIEND

While reflecting about my friendship with Peter Laurendeau, DDS, I cannot remember when we first meet over 35 years ago. We both started our dental practices in 1972 and probably ran into each other at a Dental Society meeting or doing some work for a committee. His charming smile and personality could capture you immediately and we soon found common interests such as skiing, rollerblading or golf. As the years passed, we became involved in a dental study group, would go to CE courses or just go out to lunch to discuss the current politics. Our friendship crystallized while I was going through a tough divorce. Here was someone who could listen and give good solid advice. If I was down or felt anxious, he always had a positive attitude and a great sense of humor about life that could bounce a person back.

Peter truly loved dentistry and his solo practice. In recent years, we would talk over the phone or meet for a quick lunch on a weekly basis. He was always trying to figure out how to do things better. We could discuss a new book, current events, investment ideas, employee issues, dental materials or any subject under the sun. We could celebrate our successes and laugh at the stupid mistakes we made when life would throw us a curve.

It has truly been a pleasure to have shared so many good times together. Our profession has lost an outstanding dentist and I will miss a true friend.

— *Glen A. Tueller, DDS*

My Experience WITH 10 YEARS OF LASER DENTISTRY

By **Timothy Herman, DDS**
General Practitioner (Roseville, CA)

In the spring of 2001, I attended an advanced restorative dentistry hands-on course and witnessed the use of dental lasers for the first time on a live patient. The results were remarkable and the finished cosmetic treatment resulted in a very satisfied patient and dental team. In June of 2001 we purchased our first lasers, two diode lasers and two water lasers from Biolase. At the time we did not realize how far out on a limb we were going with these purchases. Lasers were used by a small percentage of dentists and an even smaller percentage with hard tissue lasers. Over time, Biolase developed and provided better cutting tips and techniques which were aided by a surge in users demanding better equipment. The water laser quickly became my favorite instrument in the office. I was able to comfortably perform treatment I would not have thought about doing in the past. We had TV stations wanting to do stories on us being able to fix cavities without using a drill or Novocain.

When I first started using the waterlase I tried to do all treatment without anesthetic. However, I found this was not feasible in my practice. Over the last ten years I have developed a good understanding of when and which patients I can treat with or without anesthesia. At this time in my practice, I can treat about 90% of primary teeth lesions without anesthesia and get very good cooperation from my patients in the chair. I can also treat most senior citizens for different filling classifications without the need for anesthesia. My partners and I have a very senior laden practice and many of these patients feel immense relief when they are told, "there is no need for a shot" and "you will probably not feel anything during the treatment." I routinely prepare class 1 cavity preparations with the laser and find that molars are slower than bicuspids. As for Class II, III, IV and many class V lesions, it would be very difficult for me to treat them with any success if it were not for the water laser. I find the prepared surface is not smooth and I believe this aids in bond strength and success of the final restoration. When I treat long standing class five lesions with stained affected dentin the staining is removed and the surface area in my opinion and experience is much better for bonding the final restoration.

Technical Information:

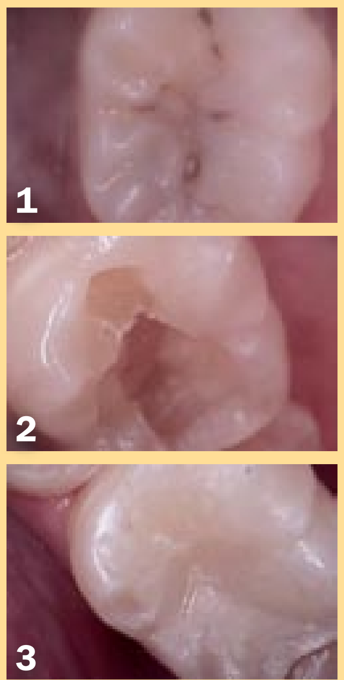
The Biolase water laser uses a trunk fiber and a hand piece that is shaped like a high speed hand piece. In that hand piece we use an assortment of laser tips depending on the procedure we are performing. The tip I use most often for soft tissue procedures is the T4 tip. This tip is tapered down to 400 microns from 600microns and with practice can cut a very fine line. To prepare teeth for fillings, I find the most durable and well rounded tip is the G6 (4mm). These tips were not even available when we first purchased the lasers and preparing teeth now is twice as fast as the best tip that was available in 2001.

Clinical Experience:

The procedures I am confidently performing now, that I was not doing before the laser, are mainly soft tissue procedures. I routinely remove hyperplastic gingival tissue to aid our orthodontic patients in being able to fully clean their teeth. Although I can use either of our lasers, I generally use the water laser to perform gingivectomies, frenectomies, shrinking of herpetic lesions and apthous ulcers. In most of these situations it is faster and I get the same results with the water laser as with the diode laser. In addition to the preceding procedures, I am very comfortable using the laser to uncover dental implants. In my experience, using the laser allows me to make my impressions for the custom abutment and final restoration on the same day as I expose the implant. One of the most important procedures I am able to perform now that I could not without the laser is boney clinical crown lengthening. I am now able to remove the necessary bone through the gingival sulcus without the need for incisions, sutures or recovery time before the final restoration. I am able to complete the crown preparation, impression and temporary crown all in one visit.

Over the last ten years I have come to rely on our lasers to treat our patients in a way we could not have before. There are many more lasers on the dental market than there was in 2001 and many of them can perform faster than the lasers we now have. In the coming years we will have to evaluate what these new lasers can do and when it will be the right time to upgrade from our current laser models. I will continue to be a "laser dentist" now and for the future. ■

Dr. Herman graduated from the UCSF School of Dentistry in 1988. He has been practicing in Roseville since then and is the managing partner of Personalized Dental Care of Roseville and Lincoln. He is an elected member of the Roseville City Council since Nov 2010. His area of interest includes laser dentistry.



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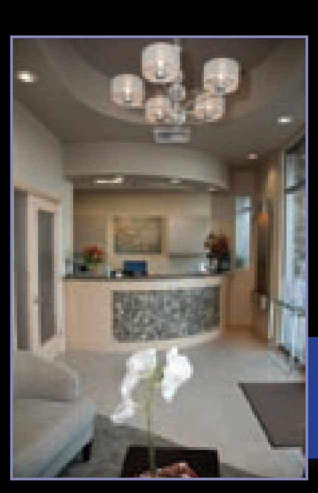

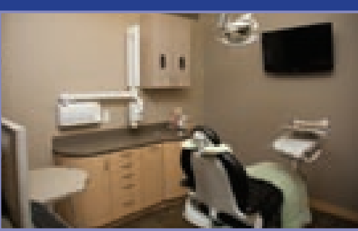

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SPOTLIGHT ON CCMP
How Can You Help?

By **Ed Gilbert**
Coalition of Concerned Medical Professionals

Coalition of Concerned Medical Professionals, (CCMP), is a private, all-volunteer non-government funded membership association of medical and dental professionals and others concerned about the lack of access to vital medical and dental resources needed by a growing portion of our workforce to stay healthy. CCMP organizes a free-of-charge preventive medical and non-emergency dental benefit available to the membership of organizations of low-income workers in our community, while fighting for a comprehensive approach to the health care needs of these workers. CCMP coordinates their work under the criteria and direction of the Sacramento County Workers Benefit Council, a delegate body representing the membership of low-income worker organizations including service workers, domestic workers, temporary workers, seasonal workers and their families.

CCMP's unique approach involves the patient, general dentist, and a CCMP volunteer dental advocate working together to develop a treatment plan and to garner all of the resources needed, whether the need be to recruit specialists, labs, pharmacies, etc., to carry out the plan of action for each CCMP patient who would otherwise have no access to preventive or restorative care.

CCMP needs volunteer general dentists and specialists in every area of dental care, including RDA's and hygienists to assist with the growing demand for dental care as the county and state have completely abandoned their legal responsibility and most low-paid service workers have no medical or dental benefits on their jobs. CCMP also needs dental labs and dental supply companies to participate with CCMP and donate exhaustible dental supplies to facilitate the ability of volunteer dentists to run CCMP general dental sessions at their offices and to provide patients with supplies to maintain home hygiene.

Volunteers are urgently needed to help CCMP grow! General dentists do exams and treatment; dental professionals make presentations to CCMP membership organizations of low-income workers on topics of dental education and information. Volunteers coordinate all aspects of the dental benefit including arranging transportation for patients as needed, accompanying patients on each dental visit as a dental advocate (a lay position that is responsible for coordinating between the dentist and the patient to ensure that all the steps are carried out for a successful outcome). Volunteers are also needed to interview those who have been denied access to preventive care by public or private programs to determine how to overcome the economic and political obstacles to good oral health.

CCMP is open seven days a week, year-round, and CCMP volunteer organizers will arrange with each volunteer dental professional how much time he/she can donate, when and how often. Call CCMP today about how you *can* make a difference in the lives of low-income workers and their families in Sacramento. Ask for Ed at CCMP, (916) 925-9379. ■

VOLUNTEER Opportunities

CCMP

DESCRIPTION: Association of medical and dental professionals concerned about lack of access to care (private, all-volunteer, non-government funded)

PATIENT BASE: Low income workers.

SERVICES PROVIDED: Free preventative medical and non-emergency dental care.

VOLUNTEERS NEEDED: General dentists, specialists, assistants and hygienists.

ALSO NEEDED: Dental labs and supply companies to partner with; home hygiene supplies

CONTACT INFO:
Ed Gilbert (916.925.9379 • ccmp.pa@juno.com)

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PATIENT BASE: South Placer County homeless men, women and children.

SERVICES PROVIDED: Social, health and case management services to help individuals become active participants in our community.

VOLUNTEERS NEEDED: Dentists, dental assistants, hygienists and lab participants for onsite clinic expansion.

OPEN HOUSE: July 26, 2011 (5:30–7:30pm)

CONTACT INFO:
Ann Peck (916.296.4057 • annpeck49@aol.com)
Volunteer Coordinator

WILLOW DENTAL CLINIC

Located at the Sacramento Salvation Army

A student run, free dental and medical clinic, started by UC Davis students

DESCRIPTION: Dental clinic currently operates at the Sacramento Salvation Army approximately once a month on Saturdays from 8:30am-12:30pm, but would like to offer services more frequently. There are also volunteer physicians on staff and medications available through the Willow Medical clinic which operates weekly in the same building at the same time.

PATIENT BASE: Homeless men and women in Sacramento, some of whom are currently receiving aid at the Salvation Army; they are all very appreciative of our time and service.

SERVICES PROVIDED: Most of the work involves extractions and amalgam restorations.

VOLUNTEERS NEEDED: Dentists and hygienists (equipment not needed to volunteer)

EQUIPMENT NEEDED: Mobile equipment to loan or donate – currently limited to using the mobile equipment and instruments brought in by Dr. Alex Tomaich and Dr. Dagon Jones

CONTACT INFO:
Michael Robins (530.864.8843 • marobbins@ucdavis.edu)
volunteering or donations

SACRAMENTO DISTRICT DENTAL SOCIETY FOUNDATION

A CHARITABLE 501-C3 ORGANIZATION

SDDF RELEASES ITS 2011–12 BROADWAY SELECTIONS!

GALA UPDATE

Thank you to the following sponsors for our GALA:

$10,000 GOLD SPONSOR: PATTERSON DENTAL SUPPLY

$5,000 TABLE SPONSORS

Kids Care Dental Group
Dr. Aaron Reeves

Morgan Stanley
John Bolter, Tim McDonald, Jeff Won, David Fritz

These confirmed sponsors are as of June 2nd.
THERE IS STILL TIME TO SPONSOR!
www.sdds.org/SDDF_Gala.htm

$2,500 SPONSORS

Anonymous *(Gotta' love them!)*
Capitol Periodontal Group
Endodontic Associates
Elk Grove Orthodontics
Dr. Don Rollofson
Drs Jackson, Heise & Alpha Oral & Maxillofacial Surgery

SACRAMENTO DISTRICT DENTAL FOUNDATION DOES…

broadway

2011–12 SELECTIONS RELEASED!

DATE TBA
during the week of Sept 27–Oct 2, 2011

DATE TBA
during the week of Jan 24–29, 2012

DATE TBA
during the week of Mar 13–18, 2012

DATE TBA
during the week of Apr 17–22, 2012

WICKED DATE TBA
during the weeks of May 23–June 17, 2012

This year's tourney raised

$15,000

for the Foundation!

THANK YOU, SPONSORS!

HOLE 1
Blue Northern Builders, Inc.

HOLE 1
Drs. Cas, Jonathan & Damon Szymanowski

HOLE 2
Komet

HOLE 3 — HOLE IN ONE
DEXIS Digital X-Ray

HOLE 4
Jackson, Heise & Alpha Oral & Maxillofacial Surgery

HOLE 4
Andrews Construction, Inc.

HOLE 5
Carestream Dental (Kodak)

HOLE 6
Olson Construction, Inc.

HOLE 7 — LONGEST DRIVE
Kids Care Dental Group

HOLE 8 — CLOSEST TO THE PIN
Mann, Urrutia, Nelson, CPAs

HOLE 9
Union Bank

HOLE 10
Ronald T. Blanchette, DDS

HOLE 10
Wells Fargo Bank

HOLE 11
Patterson Dental Supply

HOLE 12
Tekfix Team

HOLE 13
Prosthodontic Dental Group: Drs. Nordlander, Hinton, Dyal, Alvarado & Angel

HOLE 14 — CLOSEST TO THE PIN
Delta Dental of California

HOLE 15
Ameriprise Financial

HOLE 16 — LONGEST DRIVE
Burkhart Dental Supply

HOLE 17
Paramount Lab

HOLE 18
Supply Doc, Inc.

HOLE 18
Sacramento Coca-Cola Bottling Company

PUTTING CONTEST
Northwestern Mutual
Adam Miller & Mike Welch

BEER CART SPONSOR
Levering Company *(Bruce Levering)*
Commercial Real Estate

BEER CART SPONSOR
Dental Management Solutions *(Gayle Suarez)*

DONATIONS FROM

A-Dec
Blue Northern Builders, Inc.
Empire Ranch Golf Course
Endodontic Associates Dental Group
(Drs. Whitnack, Keating, Greene, Bal & Opp)
Komet
Procter & Gamble Oral Health
Sacramento Coca-Cola Bottling Co.
Signature Smiles
(Dr. Scott Szotko)
Sybron Endo
Teal Bend Golf Course
Turkey Creek Golf Course

CONTEST WINNERS:

LONGEST DRIVE (HOLE # 7)
Sponsor: Kids Care Dental Group
Winner: **DR. SCOTT SZOTKO**

CLOSEST TO THE PIN (HOLE # 8)
Sponsor: Mann, Urrutia, Nelson, CPAs
Winner: **ED COLLINS**

CLOSEST TO THE PIN (HOLE # 14)
Sponsor: Delta Dental of California
Winner: **RYAN HUGHES**

LONGEST DRIVE (HOLE # 16)
Sponsor: Burkhart Dental Supply
Winner: **JIM FISHER**

PUTTING CONTEST
Sponsor: Northwestern Mutual (Adam Miller & Mike Welch)
Winner: **CHRIS BAILEY**

1ST PLACE FOURSOME *Competitive*
Winners: **DR. MIKE WARD**
STEVE BRAND
DR. CAS SZYMANOWSKI
DR. HARRY VIANI *(Nice hat!)*

1ST PLACE FOURSOME *Recreational*
Winners: **JIM CHO**
STEVE LOVE
DR. SCOTT SZOTKO
DR. STEVE KIM

2011 SDDF GOLF TOURNAMENT COMMITTEE

Dr. Damon Szymanowski
Chair

Dr. Todd Andrews

Dr. Daisuke Bannai

Dr. Matthew Comfort

Dr. Jeffrey McComb

Philip Kong
Union Bank

Thank you for a great tournament!

CONGRATULATIONS,

MANN, URRUTIA, NELSON, CPAs

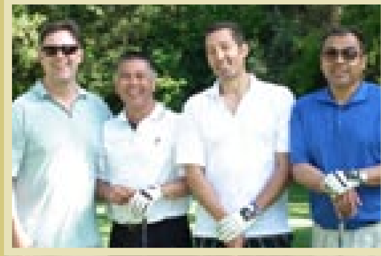
VOTED MOST CREATIVE HOLE SPONSOR

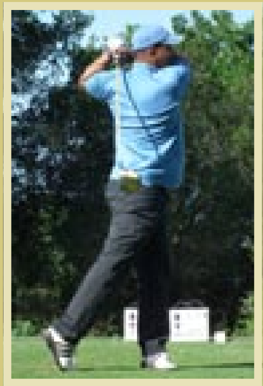
Fore!

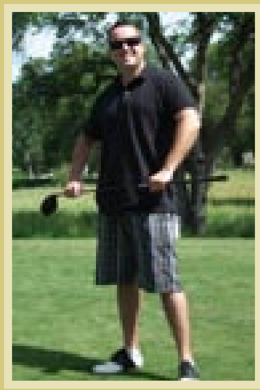
PHOTOS:

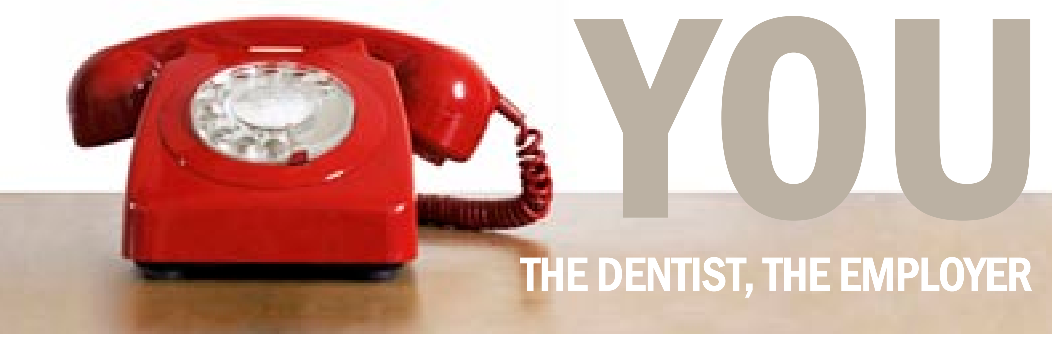
(clockwise from top right)

- Drs. John Oshetski, Steve Longoria, Jeff Martin and Stan Arellano enjoy a great day on the course.
- Sherry Everhart and Gayle Suarez (Dental Management Solutions) had a blast running their beer cart!
- Drs. Greg Nahorney and Paul Johnson take off for their first hole.
- Dr. Ryan Higgins shows off his golfer chic attire.
- Dr. George Mayweather sends hopes for a good shot.
- Bob Edwards (DEXIS Digital X-Ray) offers $5,000 cash for a hole-in-one!









YOU ARE A DENTIST. You've been to school, taken your Boards and settled into practice. End of story?

Not quite. Employee evaluations, hiring and firing, labor laws and personnel files are an important part of being an employer. Are you up on the changes that happen nearly EVERY January 1st?

In this monthly column, we will offer information pertinent to you, the dentist as the employer.

What You Said IS NOT WHAT I HEARD

By **Access Human Resources**

Generational Crosstalk and Why You Should Care

In the past — you, as the Doctor, may have paid little or no attention to the age span of employees working for you. With four generations in the workplace, circumstances have changed. Generations are pushing each other's communication hot buttons.

To better understand the communication disconnects that are occurring in your workplace it is important to recognize why each generation communicates as they do. To help facilitate this understanding, let us review each generation and what influenced them during their formative years.

TRADITIONALISTS
Born 1900 to 1945

Traditionalists have worked longer than any of the other generations. They were influenced by the great depression, which instilled in most members of this generation the ability to live within limited means. Traditionalists are loyal, hardworking, financially conservative and faithful to their employers. They represent about 13% of the workplace. This generation is most comfortable with face-to face communication. They are more formal in their communication style than the other three generations.

BABY BOOMERS
Born 1946 to 1964
Influenced by President Kennedy's assassination, Vietnam and the "pill"

Upon entering the work force, Boomers felt compelled to challenge the status quo. As a result, they are responsible for many of the rights and opportunities now taken for granted. Because of their large numbers, Boomers faced competition from each other for jobs. They all but invented the 60-hour workweek, figuring that long hours and hard work was one way to get to rise above the pack and get ahead. Their sense of who they are is deeply connected to their career achievements. Boomers prefer verbal over written communication; call them on the phone rather than sending an email.

GENERATION X
Born 1965 to 1980

Generation X'ers were influenced by divorce rates that tripled when they were children, both parents working and being the first latch key kids. They are technologically savvy. Watching their parents being laid off after years of dedicated service instilled a sense of distrust of employers. Because they do not expect employer loyalty, Gen X'er's see no problem changing jobs to advance professionally.

In contrast to the Baby Boomers' overtime work ethic, Generation X'ers believe that work is not the most important thing in their lives. They are resourceful and hardworking, but once 5 o'clock hits, they would rather pursue other interests. An X'er is very comfortable communicating with technology such as email and text messaging.

GENERATION Y
Born 1981 to 1999

This generation has had access to cell phones, pagers and personal computers all their lives. They have also been influenced by watching natural disasters, riots and other tragedies occurring all over the world live and in color right from the comfort of their living room. Generation Y's are eager to learn and enjoy questioning things. They are confident and have high self-esteem. They are collaborators and favor teamwork. They reject the notion that they have to stay within the rigid confines of a job description. Generation Y's will think nothing of making career changes and/or building parallel careers. If you call them instead of emailing or text messaging them, you are wasting their time. These folks are excellent at multi-tasking, they are most comfortable answering an email while working on a spread sheet and listening to their iPod.

> *The most successful employers find a way to let every generation be heard.*

One-size-fits all communication and leadership is not effective given this new paradigm in the workplace. Here are some tips to effectively communicate and lead each generation.

TRADITIONALISTS

They appreciate information given to them in person. **Leadership tips include:**

- Acknowledge experience and expertise
- Provide them opportunities to mentor younger employees
- Discuss how their contributions affect the organization
- Focus on the personal touch

BABY BOOMERS

While they are most comfortable with face-to-face communication, a phone call is usually

preferable to an email. They differ from the traditionalists in that they want to be part of the decision making, not just given direction. **Leadership tips include:**

- Discuss how they're making a difference
- Assign challenging projects
- Provide public recognition and perks for performance

GENERATION X

They are used to getting feedback quickly by communicating through emails and text messaging. One of the common complaints we hear from Generation X'ers is they do not feel they are listened to in the workplace. **Leadership tips include:**

- Do ***not*** micromanage
- Give candid, timely feedback
- Encourage informal, open communication
- Use technology to communicate
- Provide learning opportunities and mentoring

GENERATION Y

This generation has grown up with cell phones, text messaging, emails and live electronic chats. Generation Y'ers are most comfortable with communication they can conduct while taking on two or three other tasks simultaneously. **Leadership tips include:**

- Provide good supervision and structure
- Communicate clear objectives and expectations
- Emphasize their ability to make a difference
- Use technology to deliver information
- Assign work that is interesting, meaningful, and important
- Assist them with career planning

The most successful employers find a way to let every generation be heard. They recognize that no one has all the answers. This appreciation of generational diversity allows each group to contribute and be a part of the growth of the office. Once employers understand this, it can help open up communication at all levels of the office and can contribute to the overall success of the office. ■

Bill Bolding and Jane Lopez of Access Human Resources, Inc. offer creative HR solutions for successful practices. Reach them by email at info@accesshumanresources.com; or by phone at (916) 396-3598 or (209) 329-4442.

HAVE YOU CHECKED THE WEB? The SDDS website is your source for CE, events, important announcements and more! Check it out at **www.sdds.org**

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BOARD REPORT

Respectfully Submitted by **Kelly Giannetti, DMD, MS**
Secretary

MAY 3, 2011

President's Report

Dr. Wai Chan welcomed the Board to the last meeting before the summer break. He thanked all participants in the RAM event and all the support for SDDS activities.

Secretary's Report

Dr. Kelly Giannetti reported that SDDS is back up to almost 80% of the market share and that drops for members who have not paid their 2011 dues were the lowest in years (only 27 dropped for non payment of dues).

Treasurer's Report

Dr. Gary Ackerman reported that the current financial status is good; income and expenses are in line with budget. **It was M/C to accept and extend the current financial and investment policy for another year.**

Executive Director's Report

Cathy Levering reported on the following:

- ***1st Tooth 1st Birthday Campaign update:*** We opted for another month on the buses (April and May). Great results thus far. First 5 Napa is going to have a similar campaign; our office will help with design.
- ***Foundation Gala, October 1st, 2011:*** Tables are filling up fast and auction items are needed.
- ***Goal update — re: speaker ratings:*** Our speaker feedback was very positive for Midwinter. We are collecting/keeping ratings for speakers (MF/GM/MW) to plan future meetings.
- ***Goal update — re: market share:*** Our ADA grant application for membership recruitment and retention was submitted; we continue to define stage 1 and stage 2 dentists and why they do not join organized dentistry. The SDDS Staff is concentrating on those recruiting areas and opportunities.
- ***Midwinter final recap:*** Very successful this year; numbers were up in all areas; the Expo was sold out by October; currently selecting topics for next year based on HR hotline calls, questions and requests, and MW evaluations.
- ***Amalgam Separators:*** Sac Regional Water and Sewer District announced that separators will be mandatory by 2013. SDDS will help provide advisory committee members to help strategize the implementation process.

Unfinished Business

- ***RAM recap and update:*** Drs. Webb and Rollofson thank all for participating; RAM will be April 19-22nd 2012; venue not confirmed. CDA is working with Mission of Mercy for another event in the Central Valley next year.
- ***Fluoridation Advisory Committee report***: Drs. Wallace & Jones reported that a favorable vote was received at the Sacramento City Council meeting. Many people were at the meeting to show support for fluoridation.
- ***General Meeting Speakers and Topics:*** Dr. Ackerman reported that the agenda is set for next year. However, if anyone has ideas for 2012-2013, please let us know.

New Business

- ***Leadership Development Committee nominations***: **It was M/C that we accept the LDC slate of officers as presented by Dr. Jones. It was further approved to implement last year's task force's recommendation to reduce the Board one additional member, to 8 at large directors.**
- ***Award nominations:*** Approved for presentation. ■

Next Board Meeting: **September 6, 2011 at 6:00pm**

Need a job? • Need an associate?
Looking to sell? • Looking to buy?

The SDDS Job Bank is your go-to place to connect with fellow members.

CDA member dentists only. Confidential and public lists available.

www.sds.org/JobBank.htm

SDDS JOB BANK

SACRAMENTO DISTRICT DENTAL SOCIETY BYLAWS REGARDING ELECTIONS…

CHAPTER VI — ELECTION PROCEDURES

Section 10. NOMINATION BY COMMITTEE: The Board of Directors shall appoint a Leadership Development Committee to nominate qualified candidates for election to all offices including Secretary, Treasurer, President-Elect, Directors, Trustees and Delegates. The Leadership Development Committee shall make its report to the Board of Directors at least 45 days before the date of the election, or at such other time as the Board of Directors may set, and the Secretary shall forward to each Member, with the notice of meeting required by these Bylaws, a list of all candidates nominated by committee.

Section 20. ADDITIONAL NOMINATIONS: Any active or life Member in good standing who meets the qualifications of the office he/she is seeking may be nominated by filing with the Secretary at least 30 days prior to the annual meeting a written nomination signed by at least ten (10) active or life Members in good standing.

Section 30. THE BALLOT: The Board of Directors shall approve the ballot for all offices, including Officers, Directors, Trustees, and Delegates to be voted upon at the annual meeting. All nominees shall be listed in alphabetical order. There shall be no changes to the ballot after approval by the Board of Directors unless a special Board meeting is held to discuss such changes.

Section 40. NOTIFICATION OF MEMBERS: The ballot shall be published to all Members at least ten (10) days prior to the election pursuant to the Notification Requirements of Chapter III, Section 50.

Section 50. THE ELECTION: The ballots shall be secret and shall be cast at the annual meeting of Members. The Secretary shall oversee the casting and counting of ballots. There shall be no campaigning whatsoever for any candidate the evening of the election.

Section 60. COUNTING THE BALLOTS: The Secretary shall select an appropriate number of Members to act as clerks and count all ballots, including mail ballots. The candidate receiving the highest number of votes for any office shall be declared elected.

I. TIES: In case of candidates receiving equal number of votes, a second ballot will be cast. If that ballot results in a tie, the Secretary shall have the candidates draw straws.

II. ANNOUNCING RESULTS: The results of the election will be announced as soon as possible and the list of successful candidates shall be published in the next periodic publication of the Society.

III. DELEGATES AND ALTERNATE DELEGATES: The Secretary shall list the names of the candidates receiving the highest total number of votes to fill the Delegate list. Those candidates receiving the next highest number of votes shall fill the Alternate Delegate list in the order of votes received.

IV. CHAIR OF DELEGATION: The President of the Society shall be Chair of the delegation.

Section 70. ABSENTEE BALLOT: Any Member eligible to vote may request an absentee ballot. The ballot must reach the Society office by 5:00 p.m. of the evening of the election meeting. The Secretary shall make a record of all those requesting absentee ballots and they will not be permitted to vote the night of the general election regardless of whether or not they returned their absentee ballot.

Section 80. INSTALLATION OF OFFICERS: The newly elected officers, Board Members, Trustees and Delegates shall be installed at a date and time designated by the Board of Directors, and shall assume their duties January 1st of the year following their election. ▪

NOTICE OF ANNUAL MEETING & ELECTIONS

Elections to be held at General Meeting September 13, 2011

SLATE OF NOMINEES • SLATE OF NOMINEES

SDDS EXECUTIVE COMMITTEE

President: Victor Hawkins, DDS
President Elect / Treasurer: Gary Ackerman, DDS
Secretary: Kelly Giannetti, DMD, MS
Immediate Past President: Wai Chan, DDS

BOARD OF DIRECTORS

Nancy Archibald, DDS *(2012–2013: 1st term)*
Carl Hillendahl, DDS *(2012–2013: 2nd term)*
Beverly Kodama, DDS *(2012–2013: 1st term)*

EXISTING BOARD MEMBERS CONTINUING 2011–12 TERM:
Wallace Bellamy, DDS • Jennifer Goss, DDS
Dan Haberman, DDS, MS • Viren Patel, DDS
Kim Wallace, DDS

TRUSTEE

Robert Gillis, DMD, MS *(1st term, 2012–13)*

EXISTING TRUSTEE CONTINUING 2011–13 TERM:
Kevin Keating, DDS, MS

DELEGATES TO THE CDA HOUSE OF DELEGATES (2 year term, 2011–12):

Nancy Archibald, DDS
Adrian Carrington, DDS *(2nd term)*
Beverly Kodama, DDS
Viren Patel, DDS

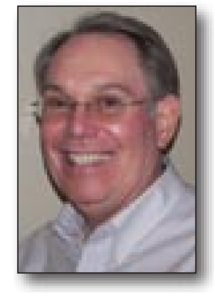
EXISTING DELEGATES CONTINUING 2010–11 TERM:
Gary Ackerman, DDS • Wai Chan, DDS
Matthew Comfort, DDS • Kelly Giannetti, DMD, MS
Victor Hawkins, DDS • Terrence Jones, DDS
Craig Johnson, DDS • Kenneth Moore, DDS
Kim Wallace, DDS

Congratulations and thank you to all candidates!

SACRAMENTO DISTRICT DENTAL FOUNDATION

Slate of nominees for SDDF will be listed in the August / September 2011 issue of the *Nugget* and voted on at the November General Membership Meeting.

COMMITTEE CORNER



Fluoridation Advisory Committee: FLUORIDATION UPDATE

By **Kim Wallace, DDS**
Fluoridation Advisory Committee Chair

The SDDS Strategic Plan emphasizes our commitment to advocating for municipal water fluoridation and the Fluoride Advisory Committee has been busy this spring. With the help of our staff, our members, community members and allied healthcare professionals, Sacramento County has voted unanimously to fluoridate the Zone 41 water district for the first time. Additionally, the City of Sacramento has resolved to maintain water fluoridation in spite of looming budget concerns.

We hope to have many of you come forward with letters of endorsement or testimony.

We will continue to advocate for fluoridation of other Sacramento County water districts, but the process will be much more difficult if Governor Brown successfully transfers $48.5 million from First 5 Sacramento, much of it earmarked for fluoridation, to help balance the state budget.

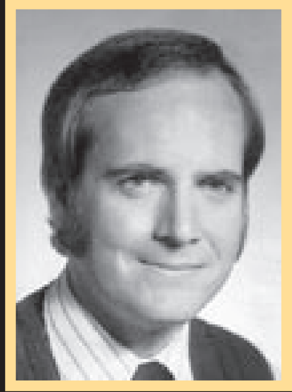
The Fluoride Advisory Committee is currently active in Davis and Woodland, where we hope to receive positive City Council decisions to fluoride. Council actions may be taken as early as July and we hope to have many of you come forward with letters of endorsement, give testimony before the City Council or even just sit in the audience at a council meeting while wearing a pro-fluoridation sticker. Please contact us with your support and many thanks to those who have supported us in our recent activities.

Back in time...

CAN YOU IDENTIFY THIS SDDS MEMBER?

The first SDDS member to call the SDDS office (916.446.1227) with the correct answer wins **$10 OFF** their next General Meeting registration.

Only the winner will be notified. The member cannot identify himself.



WATCH FOR THE ANSWER IN THE AUG/SEPT 2011 *NUGGET!*

2011 SDDS COMMITTEE MEETINGS:

Board of Directors *(SDDS / 6:00pm)*
Sept 6 • Nov 1

CE Committee *(SDDS / 6:00pm)*
Sept 20 • Nov 29

CPR Committee *(SDDS / 6:30pm)*
Future meetings TBA

Dental Health Committee *(SDDS / 6:30pm)*
Sept 12 • Nov 14

Ethics Committee *(SDDS / 6:30pm)*
Sept 28 • Nov 16

Foundation (SDDF) *(SDDS / 6:00pm)*
Sept 12 • Nov 17

Golf Committee *(SDDS / 6:00pm)*
Completed for 2011

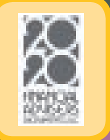
Leadership Dev. Committee *(SDDS / 6:00pm)*
Completed for 2011

Mass Disaster / Forensics Committee *(Location TBA / 6:30pm)*
2011 Meetings TBA

Membership Committee *(SDDS / 6:00pm)*
Sept 20 • Nov 15

***Nugget* Editorial Committee** *(SDDS / 6:15pm)*
Sept 27

SacPAC Committee *(SDDS / 6:00pm)*
2011 meetings TBA



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Violetta Sit Terpeluk, CFP®, MBA, CRPC®
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since 2009

MEDICAL GASES
Analgesic Services

Geary Guy, VP
Steve Shupe, VP
916.928.1068 www.asimedical.com

since 2004

CONSTRUCTION
Andrews Construction, Inc.

Todd Andrews
916.743.5150
www.andrewsconstructioninc.com

since 2002

FINANCIAL SERVICES
Banc of America Practice Solutions

Phil Hoover • 415.891.8789
www.bankofamerica.com/practicesolutions

since 2011

CONSTRUCTION
Blue Northern Builders

Marc Davis • Morgan Davis • Lynda Doyle
916.772.4192
www.bluenorthernbuilders.com

since 2007

HUMAN RESOURCES
California Employers Association

Kim Parker, Executive VP
Mari Bradford, HR Hotline Manager
800.399.5331 www.employers.org

since 2004

DENTAL SUPPLIES
Crest / Oral B

Lauren Herman • 209.969.6468
Kevin McKittrick • 916.765.9101
www.dentalcare.com

since 2002

FINANCIAL SERVICES
Dennis Nelson, CPA, APC

Dennis Nelson, CPA
916.988.8583
www.cpa4dentists.net

since 2011

JOB PLACEMENT
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dentassist

Lisa Saiia, Director
916.443.1113 www.dentassist.com

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DENTAL SUPPLIES
DESCO Dental Equipment

Tony Vigil, President
916.624.2800
www.descodentalequipment.com

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FINANCIAL SERVICES
Eagle West Group, Inc.

Chris Nunn
916.367.4540
www.eaglewestgroup.com

since 2010

FINANCIAL SERVICES
Fechter & Company

Craig Fechter, CPA
916.979.7671
www.fechtercpa.com

since 2009

FINANCIAL SERVICES
First US Community Credit Union

Gordon Gerwig, Business Services Manager
916.576.5650 www.firstus.org

since 2005

DENTAL SUPPLIES
Henry Schein Dental

Nicole Lena, Regional Manager
916.626.3002
www.henryschein.com

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John Urrutia, CPA, Partner
Chris Mann, CPA, Partner
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David Olson
209.366.2486
www.olsonconstructioninc.com

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DENTAL SUPPLIES
Patterson Dental

James Ryan
800.736.4688
www.pattersondental.com

since 2003

FINANCIAL SERVICES
Principal Financial Group

Lucas Rayburn
916.773.3343
www.principal.com

since 2010

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RelyAid

Jim Alfheim, President of Sales & Marketing
800.775.6412 916.431.8046
www.relyaid.com

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Becki Bell, Marketing Director
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since 2002

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Star Refining

Jim Ryan, Sales Consultant
800.333.9990 www.starrefining.com

since 2009

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WE'RE BLOWING YOUR HORN!

CONGRATULATIONS TO...

Dr. Gabrielle Rasi, for being awarded the Harry Wong Community Service Award for her exceptional volunteer work through her participation in Smiles for Kids.

Dr. Brian Orcutt, who participated in the Sacramento Susan G. Komen Race for the Cure, to benefit breast cancer research.

Drs. Paul Binon and Michael Forde, on their lecture presentations at the Western States Conference of Dental Laboratories in Reno in April.

Dr. Peter Worth, for receiving "Samir Bishara Award of Merit" from the College of Diplomates of the American Board of Orthodontics. As the first time recipient of this award, Dr. Worth was honored for his long time contributions to helping candidates with courses to prepare them for taking the Board exam.

Dr. (Capt) Vincent Chiappone, on his completion of three humanitarian missions with the USAF Reserves in the past year: Operation Arctic Care 2010 (Northwest Alaska), Operation Medflag 2010 (Congo) and Operation Medrete 2011 (Belize). During this time, Dr. Chiappone was promoted to Major and awarded an Air Force Achievement Medal for Arctic Care. *(photos below)*

Beth Gaines, daughter of **Dr. Robert Burkhard,** for her election into the State Assembly.

Dr. George Koch, former marathon runner who, at age 84, is still cycling 40–50 miles, 2–3 days per week, at 15–16 miles per hour, as part of the group "Sacramento Wheelmen." Dr. Koch tells us that when he was younger, he was faster!

Greg Maroni, son of **Dr. Gregory Maroni,** for his success as a baseball agent, representing such clients as Neftali Feliz, the closer for the Texas Rangers.

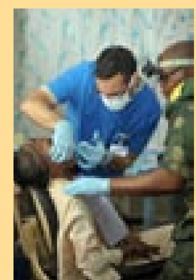
Drs. Robert Meaglia and **Kevin Keating,** for their recognition by CCMP (Coalition for Concerned Medical Professionals) as dental care providers for the working poor. Both Drs. Meaglia and Keating have volunteered days in their offices for patients obtained through CCMP. *(photo below)*

Dr. Herbert Yee, for receiving the Community Service Award at the OCA (Organization of Chinese Americans) 2011 Dragon Boat Festival.

Dr. Linda Rafferty, on her retirement!

Patrick McCurry, son of **Dr. Kevin McCurry,** for his achievement of Eagle Scout in May. Patrick joins his father, grandfather and great grandfather in the Eagles Nest — four generations in all! ■

Have some news you'd like to share with the Society? Please send your information (via email, fax or mail) to SDDS for publication in the *Nugget!*



Left to right: Dr. Chiappone at Operations Arctic Care, Medrete and Medflag • Drs. Meaglia and Keating at CCMP

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LETTER TO THE EDITOR

MUTUAL AID REVISITED

Editorial Note: Following the passing of his wife, Nelva, on March 11, 2011, Dr. Bevan Richardson invited the Nugget *to share his thoughts during her illness, and his gratitude for his mutual aid group. The following is a letter he wrote on February 28, 2011.*

Last November I directed an issue of the Nugget focusing on the concept of being part of a mutual aid group. I have participated a number of times in helping members of my own group and I have also assisted outside of my group. These experience have made me sensitive to the need to be prepared. There was one potential mutual aid scenario that I had never considered. And just now I am personally involved in it.

My wife has been in treatment for multiple myeloma for a year and a half with no significant resolution, on January 25th I took my wife to Salt Lake City, to the Huntsman Cancer Treatment Hospital, for a two hour consultation. Due to a number of significant considerations, it was decided to put her into the ICU immediately and to start treatment for her condition. It was to be a two and a half week treatment schedule. I had to stay the first two weeks. Then my sister relieved me on Sunday and I returned home. On Monday I had an urgent call directing me to return to Salt Lake City. There had been a dangerous turn of events. At this writing, I am still in Salt Lake City, going on week six and with four separate trips to the ICU. If it wasn't for my mutual aid friends, my office staff would have been at a total loss regarding what to do. Our group stepped up unquestionably and have been there to take care of my patients and staff. This is the purpose of mutual aid. And this is another reason, besides our own death or disability, that we should all be involved in such a group. Believe me, I can't thank these guys enough.

Bevan Richardson, DDS (SDDS Member)

Our condolences once again go out to the Richardson family. (See April 2011 Nugget)

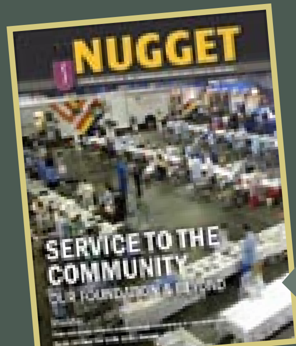
Do you want to form a

MUTUAL AID GROUP?

Contact SDDS (446-1211) for guidance.

remember...

THE *NUGGET* IS AVAILABLE ONLINE!



YOU ASKED FOR THIS!

Nugget Survey 2009

www.sdds.org/NUGGET.html

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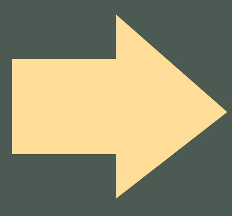
WELCOME

to SDDS's new members, transfers and applicants.



IMPORTANT NUMBERS:

SDDS *(doctor's line)* . . . . (916) 446-1227

ADA . . . . (800) 621-8099

CDA . . . . (800) 736-8702

CDA Contact Center . . (866) CDA-MEMBER *(866-232-6362)*

CDA Practice Resource Ctr . . *cdacompass.com*

TDIC Insurance Solutions . . (800) 733-0633

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Central Valley Well Being Committee . . . . . (559) 359-5631

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Share your information with the Society!

We can only refer you if we know where you are; and we rely on having your current information on file to keep you informed of valuable member events! Give us a call at (916) 446-1227.

The more accurate information we have, the better we can serve you!

NEW MEMBERS

JUNE/JULY **2011**

Martin Kerzie, DMD
General Practitioner
4970 Rocklin Rd, Ste 100
Rocklin, CA 95677
(916) 626-5525
Dr. Martin Kerzie graduated from the Temple University School of Dentistry in 1990 with his DDS and completed a residency there in 1991. He is currently practicing in Rocklin with his wife and fellow SDDS member, Dr. Lura Orsino, and lives in Granite Bay.

NEW TRANSFER MEMBERS:

Maha Almusawi, DDS
Transferred from San Francisco Dental Society
General Practitioner
3838 Watt Ave, Ste A100
Sacramento, CA 95821
(916) 482-8082
Dr. Maha Almusawi graduated from the UOP Arthur A. Dugoni School of Dentistry in 2010 with her DDS. She currently practices in Sacramento and lives in Roseville.

Jack Gorman, DDS
Transferred from San Francisco Dental Society
General Practitioner
5899 Sunrise Blvd
Citrus Heights, CA 95610
(916) 967-7766
Dr. Jack Gorman graduated from the UOP Arthur A. Dugoni School of Dentistry in 2010 with his DDS. He currently practices and lives in Citrus Heights.

Mark Pacheco, DDS
Transferred from San Francisco Dental Society
General Practitioner
Pending Office Address
Dr. Mark Pacheco graduated from the UOP Arthur A. Dugoni School of Dentistry in 2010 with his DDS. He is currently seeking employment in the greater Sacramento area and lives in West Sacramento.

Gregory Peterson, DDS
Transferred from Orange County Dental Society
General Practitioner
Pending Office Address
Dr. Gregory Peterson graduated from the University of Colorado in 2008 with his DDS. He is currently seeking employment in the greater Sacramento area and lives in Loomis.

NEW APPLICANTS:

Bijan Aflatooni, DDS
M. Franklin Godfrey, III, DDS – WELCOME BACK!
Emerson Lake, DDS
Leo Townsend, DDS – WELCOME BACK!
Blain Jacobson, DMD

THE SDDS ANNUAL MEMBERSHIP DIRECTORY HAS GONE TO PRINT!

WATCH YOUR MAILBOX!

Going on Vacation?

Remember... SDDS is not your emergency contact!

You must be available to render emergency care to patients of record currently under your treatment or make available to such patients through your outgoing voice mail / answering service a list of colleagues who are aware and willing to render care at times when you are not available. ***DO NOT USE THE SACRAMENTO DISTRICT DENTAL SOCIETY REFERRAL SERVICE AS YOUR "ON CALL" COVERAGE.*** *Failure to provide care can place a dentist in violation of ADA Principles of Ethics and the CDA Code of Ethics.*

CLIP OUT this handy NEW MEMBER UPDATE and insert it into your DIRECTORY under the "NEW MEMBERS" tab.

TOTAL MEMBERSHIP (AS OF 5/31/11): 1,550

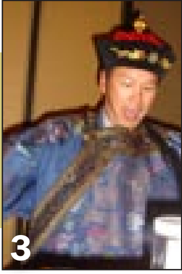
TOTAL ACTIVE MEMBERS: 1,289
TOTAL RETIRED MEMBERS: 203
TOTAL DUAL MEMBERS: 2
TOTAL AFFILIATE MEMBERS: 11
TOTAL STUDENT/PROVISIONAL MEMBERS: 3
TOTAL CURRENT APPLICANTS: 5
TOTAL DHP MEMBERS: 37

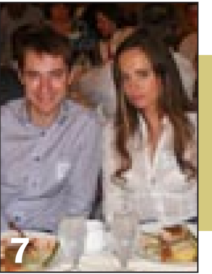
TOTAL NEW MEMBERS FOR 2011: 28

EVENT HIGHLIGHTS

MAY GENERAL MEMBERSHIP MEETING

May 10, 2011 — Foundation Night





***1:** Dr. Bev Kodama (center) finds herself surrounded by men! (left to right: Drs. Glen Tueller, Kent Daft, Bevan Richardson, Jason Roth, Jeff Rosa and Walt Skinner) **2:** Dinger helps Executive Director Cathy Levering promote the RiverCats game on June 9th! **3:** "Emperor Yee" gets the crowd's attention to promote the SDDF Smile Sacramento Gala. **4:** Smiles for Kids 2011 site hosts in attendance (left to right): Drs. Kim Wallace, Michael Boyce, Erin Carson, H. Scott Thompson, Sutter Terrace Dental Group, Christy Rollofson, Vic Hawkins, Dean Ahmad, Chester Hsu, Don Rollofson, Gabrielle Rasi, Robert Daby and Matt Comfort. **5:** Dr. Gabrielle Rasi receives the Harry Wong Community Service Award for her exceptional volunteer efforts. **6:** Cindy Nguyen and Erin Hart receive CDA Foundation Allied Dental Health Student Scholoarship Awards, presented by Dr. Don Rollofson. **7:** Dr. Alex Antipov and his wife Natalie enjoy dinner.*

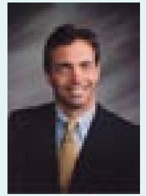
LINK OF THE MONTH

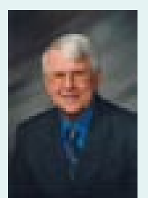
SDDF Gala information

Keep up with the most current info at:

www.sdds.org/SDDF_Gala.htm

WESTERN PRACTICE SALES
John M. Cahill Associates


Tim Giroux, DDS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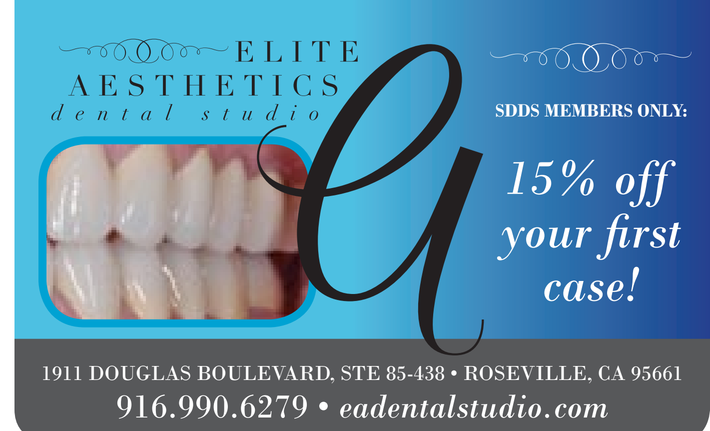

Nugget Classifieds

For Lease

DESIGN YOUR OWN DENTAL SUITE offering generous tenant improvements for this 800 sq ft office space. Rent negotiation is available. The suite is in a three story mid-town dental complex. (916) 448-5702. *11-10*

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OFFICE SPACE SHARING ROSEVILLE / GRANITE BAY. 1250 sf modern facility, digital/paperless, in a prof'l one-story office w/ street signage. Currently used 3 days/week. Ideal for mature, low-volume, high-end practice. dmd@surewest.net. *05-11*

FREE RENT — Fully equipped, 4 ops, Dentrix software, Arden area, great for starting new practice. Former location of 35 year practice. Contact Douglas Yee (916) 801-1707. *05-11*

BRAND NEW BUILD-TO-SUIT OFFICE. 1500 sq ft. Next to GP, great for specialist. Rent / T.I. negotiable. Located South Sacramento / Elk Grove. (916) 525-3200. *06/07-11*

DENTAL OFFICE. 1355 Florin medical-dental building. 850 sf, 3 operatories, $1,200 monthly. Includes all utilities and janitor. Ample parking. (916) 730-4494. *06/07-11*

OPERATORY SPACE TO SHARE in Roseville. Contact Dr. Alan Pan at (916) 781-6688 to discuss details if interested. *06/07-11*

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LOCUM TENENS — I am an experienced dentist, UOP graduate and I will temporarily maintain and grow your practice if you are ill / maternity leave or on extended vacation. (530) 644-3438. *04-10*

LOCUM TENENS — Loma Linda grad, 1980. Temporary dentist for emergencies, vacations and maternity leaves. (530) 823-0502. *02-11*

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Nugget Survey 2009

NEW CLASSIFIED SECTIONS!

Vacation homes • Misc items for sale • Home rentals / sales • Tickets

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Vacation Trade

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Selling your practice? Need an associate? Have office space to lease? Place a classified ad in the *Nugget* and see the results! SDDS member dentists get one complimentary, professionally related classified ad per year (30 word maximum; additional words are billed at $.50 per word). Rates for non-members are $45 for the first 30 words and $.60 per word after that. Add color to your ad for just $10! For more information on placing a classified ad, please call the SDDS office (916) 446-1227. Deadlines are the first of the month before the issue in which you'd like to run.

SACRAMENTO DISTRICT DENTAL SOCIETY

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SDDS CALENDAR OF EVENTS

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JUNE

16–18 **ADA New Dentist Conference**
Chicago, IL

25 **CPR BLS FULL COURSE**
Sutter General Hospital
8:30am–1:30pm
CANCELLED

30 **DMD Early Bird Deadline**

JULY

14 **Peer Review Committee**
6:30pm

AUGUST

5 **Executive Committee Meeting**
7:00am / Del Paso Country Club

6 **CPR BLS Renewal**
Sutter General Hospital
8:30am–12:30pm

11 **Peer Review Committee**
6:30pm

19 **Peer Review Chair Calibration**
9:00am / CDA Office

SEPTEMBER

6 **Board of Directors Meeting**
6:00pm / SDDS Office

8 **Peer Review Committee**
6:30pm

9 **Continuing Education**
Lasers & Minimally Invasive Dentistry
Douglass Young, DDS, MS, MBA
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
8:30am–1:30pm

12 **Foundation Board Meeting**
6:00pm / SDDS Office

Dental Health Committee
6:30pm / SDDS Office

13 **General Membership Meeting**
Treating Trauma Without Drama
Kenneth Tittle, DDS, MS
New Member Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

15–17 **Board of Directors Retreat**
Carmel, CA *(tentative)*

20 **Member Forum**
HR Audio Conference
Alternative Work Week,
Wage & Hour Issues
Noon–1:00pm

CE Committee
6:00pm / SDDS Office

Membership Committee
6:00pm / SDDS Office

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DMD EARLY BIRD DEADLINE: JUNE 30, 2011