THE NUGGET

A PUBLICATION OF THE SACRAMENTO DISTRICT DENTAL SOCIETY

NOVEMBER 2008

EXAMINING QUALITY OF CARE (PART 3 OF 3)

THE PEER REVIEW PROCESS

Inside:

What is peer review? How does it work?

PLUS: Now's the time to give to your Foundation!

DON'T MISS OUT ON THESE EVENTS!

MEMBER FORUM

November 20, 2008 • 6:30pm–8:30pm
Sacramento Hilton — Arden West

How to Best Handle Your Experience with Peer Review & Ethics

Michael Thomas, DDS (CDA Council on Peer Review)

Raquel Viteri (CDA Peer Review Manager)

Roya Main (CDA Judicial Council Manager)

Bryan Judd, DDS & Steve Koire, DDS (SDDS Peer Review Committee Co-Chairs)

Carl Hillendahl, DDS (SDDS Ethics Committee Chair)

Peer review is one of the most valuable SDDS membership benefits. It is an alternative to litigation for resolving disputes between member dentists, their patients and insurers, regarding the quality and appropriateness of dental treatment. Speakers will explain the overall process, the grading system applied by the committee, and how member dentists can best utilize the system.

Learn the difference between Peer Review and Ethics, how each is handled and how best to navigate (and/or avoid!) these most valuable membership benefits. Bring all your questions!

2 CE (CAT II) • Member Price: $65

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CPR BLS RENEWAL

CPR Basic Life Support (BLS) required for renewal of your dental license!

November 8, 2008
8:30am–1:30pm

Sutter General Hospital
Buhler Building (Cancer Center)
2801 L Street, Sacramento

See insert to sign up!

SDDS ANNUAL HOLIDAY PARTY

Monday, December 8, 2008 • 6:00pm–9:30pm

Del Paso Country Club
(3333 Marconi Ave, Sacramento)

Join us for a festive evening of cocktails, scrumptious hors d'oevres, dessert, silent auction, fun and games, fellowship and celebration!

NEED MORE INFO? Fliers for these events and more are available in the center of this issue or online at www.sdds.org. We'll see you there!

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NOVEMBER **2008**

VOLUME **54**, NUMBER **9**

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* *featured on cover*

THE NUGGET **IS A 2007 INTERNATIONAL COLLEGE OF DENTISTS JOURNALISM AWARD WINNER IN THREE CATEGORIES:**

GOLDEN PEN HONORABLE MENTION AWARD

OUTSTANDING COVER AWARD

OVERALL NEWSLETTER AWARD

PRESIDENT'S MESSAGE

YOU ARE NOT ALONE

By **Robert D. Shorey, DDS**

Most of us operating dental practices don't have to listen to the national news to understand our nation is in the midst of one of our most serious financial crises in decades. Keeping a financially sound practice running while dealing with our daily life challenges is common for all of us who have chosen to go into dentistry and operate our own dental practice.

It is likely that in whatever stage of life we are practicing dentistry — working as an associate, just beginning our practice, planning for retirement — we are all experiencing tougher times. It's during these times that it is very fortunate that we are a community of health professionals dedicated to a higher calling than capitalistic competition. As president of our dental society I would like to remind our members you are not alone. It is surprising how the camaraderie within our profession may be the necessary life preserver to keep our morale high, our optimism alive and our practices running.

After 25 years of dental practice, I have experienced, seen or heard about a lot that I would have never imagined when I graduated from dental school. Having colleagues like my fellow SDDS members to turn to has often provided answers that seemed hidden from my conscious mind. In these trying times, if you find your are in a situation that is difficult to overcome or you know of a dental colleague in a difficult situation, please keep in mind that you can contact your dental society and our staff will discretely find a resource to provide help.

A few people have characterized the current financial situation as a typical bump in the nation's economic road and nothing to worry too much over, while others have ominously stated we are entering uncharted territory. I'm not sure we really know for sure the depth of this current economic downturn and I don't know what the truth is concerning how much time will pass before an economic recovery will get the mood of our patients back up. I do know our profession is full of talented smart people who are willing to help each other. ■

FROM THE EDITOR'S DESK

PeerReviewGate — UNDER THE COVERS?

By **Paul P. Binon, DDS, MSD**

When I started on this issue of the *Nugget* in June of this year, it looked like a routine task. I contacted the co-chairs of the SDDS Peer Review Committee (PRC) and asked them to write two articles with different focuses regarding peer review (PR). I also called the Chair of the Peer Review Council at CDA, Dr. Humerickhouse, and he indicated that Peer Review was in the process of change and that multiple tasks (traditionally done by the individual components) were being standardized and brought to the state level, away from the local district dental societies, in order to attain greater consistency. Would he write a brief article on what is taking place and what we might expect? He agreed, as did the Co-chairs of the SDDS PRC.

In this issue you will find two articles written by Dr. Steve Koire. Dr. Koire conferred with both Dr. Humerickhouse and Raquel Viteri, the Council Manager, and they weighed in on Dr. Koire's article and made appropriate additions and corrections, as per CDA policy and procedures. This was really confusing to me since the original submitted article was a condensed version of the procedures and protocol utilized by Peer Review as stated in the Peer Review Manual. The manual can be downloaded from the CDA web site under "services." If you have trouble sleeping, I recommend starting on this as, by page 5, you will be sound asleep.

In my original request to the writers, I stated that the following would be of interest to the membership:

"Can you relate the actual mechanics involved from the time the complaint arrives at SDDS through to the end of the decision? Typically, how long does it take to go through the process (best case and worst case scenario), the pitfalls and pratfalls in the system? What are the biggest headaches? How often does the committee meet? How are the decisions made and who does the reviews? How are the examiners calibrated? Are there checks and balances in the system? Are the reviewed dentists protected from being reviewed by peers with a specific agenda or bias? When are "experts" called in for consultation on cases and why?"

A question comes to mind, since it is supposed to be a review by "peers." That means to me that you could have treatment reviewed (an implant reconstruction, for example) by dentists who have no experience in the procedure to be evaluated, or someone with a blatant dislike of the treatment plan. Furthermore, three or more reviewers may have just as little experience as the person being reviewed. (Not everything can be described in the Peer Review Manual). These are the kinds of questions that I am sure crop up. It would likely be of interest to the membership if some rationale were presented and explained. This may sound dull and boring, but many members don't fully understand the methodology and protocols. Some of these answers are in the Manual on the CDA site, but I have found it overwhelming in many respects.

> *Can the patient bring an action on the referring dentist if the specialist is not a member?*

I also requested that particular focus can be on numbers: how many claims per year for each of the specialty areas and the GPs does SDDS process? Is the number increasing? Are there currently disturbing trends, such as a notable increase in the complaints that are made based on years of practice, educational origin (U.S. schools vs. foreign), type of dentistry or level of difficulty? With cosmetics popularity on the rise, are there more problems with veneers? Are there other distinguishing characteristics like orthodontics by non-orthodontists, implant surgery and restorative, types of materials used, fraudulent charges or others? Is there a funny side to all this? Other nuances to consider: if an SDDS/CDA member refers to a non-member specialist, how does that work? Can the patient bring an action on the referring dentist if the specialist is not a member? What about laboratories that "educate and promote" some techniques — are they accountable?

With this broad base of interesting potential information regarding Peer Review, I expected that it would make interesting reading. Dr. Koire has done a masterful job of presenting much information. But just exactly what is going on? Some of this information is confidential, due to the "sensitivity and privacy issues for the dentist member and the particular peer review process." Well that sure makes me feel good. To me it means that significant protocols and decision-making processes regarding you and your patients, involving significant sums of money and emotionally charged consequences, are secretive and apparently beyond our meager mental capacity to understand. That same elitist attitude is pervasive in our government; must we also have it in our professional association? What is ironic is that everything is detailed in the Manual available online - or is it? A confidential source stated: "…this may all sound melodramatic… [but]… it is offered with the intention of maintaining the integrity of the peer review process both for our members and the public. I'm sure you would agree that discretion is well applied here."

Sounds reasonable, but how can you maintain the INTEGRITY of the Peer Review Process if it is veiled in secrecy and is about as transparent as a brick wall. Will that give confidence to our members or the public? ■

Editor's Note: Many changes, processes and protocols regarding Peer Review are being presented and considered at the November House of Delegates. A follow-up will be written in a future Nugget *issue.*

CATHY'S CORNER

AREN'T WE PROUD?

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

"Well, obviously she must not be talking about the stock market," you say. Yikes, what a scary 3rd quarter and, as I write this on October 8th, we are enduring one of the worst stock market downturns in history. While we are all thinking about our investments, our retirement, our "longer" plans to stay in the workforce and major adjustments in our lifestyle, it seems that focusing on the positive is just a little harder to do.

Oh sure, our health is primarily good. Our kids are safe. Our jobs, albeit a little more challenging, still help us through this trying economic time. I do not profess to know any of the answers, but I do know that, in this scary time, people still manage to keep smiling, keep positive and "stay the course" — for the most part.

Life in organized dentistry goes on. Thank goodness our SDDS reserves are safe in CDs and protected by the FDIC. Our volunteers continue to work on their committees and projects, and forge ahead making plans for SDDS next year. We tightened our budget a bit, we're coming up with programming that will hopefully interest you and keep you closer to the home front, and we're still planning to have a bit of fun (yes, you can still have fun!) along the way.

As November begins, the SDDS is in full swing with the activities of the CDA House of Delegates. Our 13 delegates, 2 trustees, 3 alternates and I are headed to Los Angeles in a couple of weeks to participate in the annual House. This is the main event of the year and is the place where decisions are made for you and your association: policy decisions, peer review decisions (with regard to procedures), leadership decisions and member benefit decisions. In this issue, Dr. Binon has presented a vast array of articles, history, opinions and scenarios with regard to the peer review process. This process, one of the most important member benefits, is currently going through many procedural and administrative changes. These changes, if approved, will be implemented next year. This process is not a secret process; only the names of the doctors, the patients and the results are protected. The process is transparent and has stood the test of time. Dr. Binon brings up some very salient questions and we are sure we will be receiving some response letters for future issues of the *Nugget!*

Finally, this House of Delegates is the last for our Speaker of the House, our dear member, Dr. Matt Campbell. It is with great pride and much <*applause*> that we congratulate him. We are so proud of you, Dr. Campbell! Job well done!

Have a great November and Happy Thanksgiving! ■

Cathy

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A BRIEF HISTORY OF PEER REVIEW

By **Paul Binon, DDS, MSD**

Peer review has a long standing history in the healing arts. A Syrian physician, Ishaq bin Ali al Rahwi (854-931) published *Ethics of the Physician,* in which he stated that physicians should make duplicate notes on the details of the diagnosis and treatment of their patients. In the event of cure or death, the notes could be examined by the medical council comprised of other physicians to ascertain that the proper level of treatment was rendered and, if anything, could be educational. In the event that the treatment was substandard, the physician could be sued. Other ancient Arabic medical manuals and texts suggested documentation and review of treatment as well. The first European record of the peer review process dates back to 1665 by Dr. Henry Oldenburg at the Royal Society of Edinburgh. *Medical Essays and Observations*, published in the early 1700 by the Royal Society of Edinburgh, laid the foundation for the present day peer review process. This process has been the cornerstone of the scientific method in all branches of science. Today, in order to be published in a legitimate scientific journal, all manuscripts have to be substantiated for content, validity and efficacy by a formal panel of reviewers.

This type of critical review methodology has also been extended to clinical practice by way of the clinical audit. A review such as this is made to ensure that what should be done is being done and also provides a framework for improvements. Florence Nightingale initiated the first clinical audit during the Crimean War (1854). She changed unsanitary conditions and tracked results, resulting in the decline of mortality rates from 40% to 2%. The first formal medical auditor was Ernest Codman. His work in 1912 established quality monitoring and assurance based on surgical outcomes. His "end result" format followed every patient after surgery to help identify surgical errors and establish a reasonable level of accountability.

In dentistry and medicine there are different types of audits. There is the *Standards based audit,* which involves gathering data on current practices and comparing outcomes with a defined standard. There is the *Patient survey audit,* which collects data as to quality of care from the viewpoint of the recipient. Then there is the *Peer review audit,* which is an assessment of the quality of care that was provided by a clinical team with a focus on improving care. Typically the cases discussed are interesting and unusual, rather than problematic ones.

The first European record of the peer review process dates back to 1665 by Dr. Henry Oldenburg at the Royal Society of Edinburgh.

The last type of audit is an *Adverse occurrence review,* which is a variation of the peer review methodology applied to cases that have had an unexpected outcome or generated complaints. It is typically an anonymous review, based on specific criteria and standards. This, in reality, is the essence of the peer review system within the CDA, although it is not anonymous.

Historically, "Peer Review" referred to disagreements between dentists and Dental Insurance Companies. The Massachusetts Dental Society was recognized as being one of the first to have this system in place prior to 1967. In 1967, the ADA House of Delegates adopted a resolution (Res.30-1967-H Trans.1967:324) that dental societies should develop "*Dental Society Review Committees*" to handle disputes between dentists and third party payers. ADA's recommendations on the structure and operation of the review committees were also proposed at that time. In April of 1970, at the ADA 21st Annual Dental Health Conference, Dr. David A. Soricelli presented a paper on "Practical Experience in Peer Review: Controlling Quality in the Delivery of Dental Care." In that presentation, he suggested the radical idea that "peer review" could be extended to arbitrate disagreements between dentist and patient.[1] Shortly thereafter, various dental associations called for the setup of this type of system. In addition, numerous articles appeared in dental literature with titles such as, "The need for peer review," and "Peer review: An organizational responsibility."[2] In 1973, ADA Board Resolution #287 called for establishing a peer review mechanism in state components. Again in 1975, with Board Resolution #21, the ADA suggested the peer review mechanism to adjudicate dentist–patient disagreements. The policy making continues through the present, making revisions to the structure, operations and policies as needed. In 1977, ADA Res.91H-1 combined Dental Society Review Committees and Patient Grievance Committees to be "Peer Review Committees."[4]

In concert with the ADA, in order to achieve quality care and to resolve disputes regarding the quality of dental treatment, the appropriateness of treatment and irregular billing practices, the 1976 CDA House of Delegates passed a resolution that mandated the formation of a uniform statewide system to resolving disputes involving dental care. Following its initial implementation, the 1994 CDA House of Delegates established the Council on Peer

continued on page 21

1. Jeffrey Gartman, *ADA Reference & Resource Linrarian*
2. ibid
3. Donalda Ellek, PhD: *Early History of ADA* policy book (available through the ADA library: *www.ada.org/prof/resources/library/about.asp#contacting* — Office of Quality Assessment & Improvement, Council on Dental Benefit Program.)
4. Encyclopedia Wikipedia *(www.wikipedia.org)*
5. ibid

PEER REVIEW PROCESS

By **Steve W. Koire, DDS** (SDDS Peer Review Co-Chair)

One of the membership benefits of organized dentistry is the peer review system, which is designed to resolve disputes that arise in the delivery of dental services to the public, specifically disputes regarding the quality and/or appropriateness of dental treatment, utilization (problems related to dental insurance benefits when treatment is questioned), and/or potential irregular billing practices. The peer review system is an alternative option to the legal system, at no cost to the member or patient.

Although peer review can satisfactorily resolve the majority of disputes received, there are limitations that may make a complaint unsuitable for review. One of these limitations is that a case must fall within the time limitations of peer review. Therefore, if a complaint is received beyond the three years from the date the treatment was completed or more then one year from the date the complainant became aware of the problem, then the complaint is not reviewable.

In some cases the doctor is unaware that the patient is unhappy with the care he/she received, thus, the peer review notification can be surprising and stressful. Conflict often is emotionally charged and aggravating. Furthermore, anticipation of the review can be stressful if you are unclear of the process. It is the experience of the Peer Review Committee that many inquiries can be resolved between the dentist and patient if even a small attempt is made to rectify the problem. However, if you are unable to reach an agreement, then peer review may be an option.

How does the peer review process work? Complaints are filed with the component dental society. All necessary forms are collected by the component dental society staff. Upon receipt of all the completed forms, the case is evaluated to ensure that the peer review criteria has been met in order to proceed with the review of the case.

The peer review system is an alternative option to the legal system, at no cost to the member or patient.

Should the complaint involve treatment provided by a dentist in an ADA recognized specialty, the case will be evaluated by a specialty committee.

If the complaint meets the peer review criteria, then the case is assigned to the Peer Review Committee for review. The committee consists of volunteer dentists practicing in the community for a minimum of 5 years. The Peer Review Committee reviews all the available records, examines the patient and interviews the dentist (if applicable). Upon evaluating all the evidence, the Peer Review Committee will make a decision and forward the recommendations to CDA for review and finalization of the case. Subsequent to the resolution of the case, both parties have the opportunity to appeal the decision within a specific time frame.

The peer review process may take several months to a year, depending on the complexity of the case. As a member of CDA, you have agreed to comply with the Code of Ethics; therefore, it is expected that the dentist under review will comply with the Peer Review Committee's decision. Likewise, patients are required to provide written assurance that they will comply with the peer review decisions as well as signing a Release of All Claims form prior to receipt of any refund that might be awarded.

The members of your Peer Review Committee strive to be unbiased and thorough. During 2007, the Sacramento District Dental Society opened 34 cases. Many thanks to the dentists who volunteer their time to serve on peer review and the staff who work many hours to provide this valuable member benefit to our members.

Should you have any comments or questions, do not hesitate to contact me *(stevenkoiredds@sbcglobal.net)*. ■

PEER REVIEW — PART 2

By **Steve W. Koire, DDS** (SDDS Peer Review Co-Chair)

Having discussed the nuts and bolts of our Sacramento District Dental Society Peer Review process, curiosity naturally prompts the question, "What are these cases and how can I avoid ever dealing with peer review?" Most cases brought to the attention of peer review are the result of poor communication between the patient and doctor. Don't make promises you may not be able to keep and don't rely on boiler plate consent forms as substitutes for thorough explanations. It is generally rare for a patient to contact our committee before attempting to share their unhappiness with the treating doctor. Some complaints are completely reasonable

How can I avoid ever dealing with peer review?

and some definitely are not. Deciding to conciliate the situation depends greatly on the substance of the complaint and, as it turns out, fairness. Refunds to patients will usually take care of things but certainly come with a sour taste when you're convinced you've been wronged. Extremely difficult treatments or hard to manage patients with poor clinical results do not a silk purse make. Regardless of your effort, good will or any number of nice things about you or your practice, there will be times when a disgruntled patient shows up in your chair.

Now any of you who have a CDA Professional Liability policy and value a 5% discount have participated in a risk management course and have largely accepted the fact that CDA is there to help if a letter with "Esq." in the return address shows up in your office. While this is a small comfort, avoiding the situation altogether definitely is better. No reason to reiterate the usual things so if the dentistry is excellent, communication is the problem. But if you know the dentistry is not really good, it is likely peer review will agree so resolving the case prior to the formal review makes sense. Again, this is where doctors may feel we would be overly critical, but we're not looking for perfection; really a passing effort makes the grade. We've found undiagnosed decay, wide open crown margins, dentures with poor occlusion in addition to inadequate retention, restorations placed without decay removal, partials placed on periodontally hopeless teeth — you name it. And each of these cases in the somber light of morning could have been simply refunded and the situation defused.

When the patient has complaints that are not substantiated by the clinical or radiographic findings, their case is not refunded. For example, we've seen patients who complained of needless fillings (extensive radiographic decay), ugly teeth (looked good to us) and the inability to eat apples with their new full dentures. Most cases are screened out right at the get go. Yearly, we receive on average 220 calls to the Dental Society regarding peer review from patients, with around 70 initiated reviews, of which two thirds are referred or resolved. This leaves approximately 20 to 30 cases per year that are opened and reviewed. There seem to be more cases regarding fixed prosthodontics than other areas of dentistry but we have no hard numbers reflecting the distribution of specific types of reviews. Variations in experience and training are not correlated with an increase in complaints. If in fact there really aren't any particular trends that we can identify. I would expect complaints to increase regarding implants simply because more implants are currently being placed than in the past. But, with only a three year trailing period, things will probably stay much as they are. In general, the number of claims has remained relatively constant throughout the last few years with some small increase as patients and doctors become more familiar with the peer review process.

Overall the process works well and, although we can't find for both parties and someone is bound to be disappointed, peer review seems to be appreciated by each of the participants. ■

INTERESTING PEER REVIEW FACTS

Listed below are the statistics as to occurrence, according to the CDA database (SDDS stats in parenthesis).

2006

SPECIALTY CASES

80 Specialty Cases Closed

Decision:

- Dentist: 27 (0)
- Patient: 12 (1)
- Patient/Dentist: 5 (1)
- Inappropriate for review: 33 (0)
- Non-determination: 3 (0)

GENERAL CASES

263 General Cases Closed

Decision:

- Dentist: 50 (4)
- Patient: 56 (1)
- Patient/Dentist: 29 (3)
- Inappropriate for review: 122 (3)
- Non-determination: 6 (1)

2007

SPECIALTY CASES

66 Specialty Cases Closed

Decision:

- Dentist: 18 (0)
- Patient: 5 (0)
- Patient/Dentist: 6 (0)
- Inappropriate for review: 36 (0)
- Non-determination: 1 (0)

GENERAL CASES

289 General Cases Closed

Decision:

- Dentist: 52 (5)
- Patient: 64 (16)
- Patient/Dentist: 28 (3)
- Inappropriate for review: 143 (2)
- Non-determination: 2 (0)

For more information on the peer review process, contact SDDS at (916) 446.1227.

ON WHY PEER REVIEW & DELIVERING THE GOODS

By **Paul P. Binon, DDS, MSD**

We are frequently reminded of the benefits of the tripartite membership in ADA, CDA and SDDS, one of which is peer review. So why is this so important? I believe that most of you can easily connect the dots on this issue. The obvious is that it is a mechanism for patients and dentists to resolve issues without involving the legal system. When there is a grievance issue, instead of jumping into an attorney's office, the circumstances and the clinical performance case is evaluated by impartial peers. When attorneys get involved, resolution can take much longer and there is usually much more rancor. Typically, damages are sought to not only compensate the patient for the fees they invested, but also to pay for the attorneys fees, all of which can add up. The biggest issue is the emotional drain involved in such an experience, regardless of being right or wrong. Attorneys who specialize in malpractice evaluate cases very carefully before becoming involved to make certain that there are significant issues and compensation for both the plaintiff and the attorney. The worst scenario is when a novice attorney, who believes he is Clarence Darrow takes on a case and has no clue.

When attorneys get involved, the resolution can take much longer and there is usually much more rancor.

So peer review serves multiple purposes. It is a means whereby the patient can get an unbiased evaluation. It is totally transparent and standards are applied in a fair and honest manner. It's a means of reasserting the high ethical standards that the profession upholds. It's a mechanism to limit financial exposure in settling a dispute on both sides of the issue. It also limits the amount of time involved in settling the issue. A legal action can take years and is often time intensive with respect to interviews, deposition, records, attorney meetings, expert witnesses, etc. Admittedly so, peer review can also take many months. Most of the work is done in committee and at the time of the evaluation, so there is a significant difference in time commitment.

Readers of the *Nugget* who belong to SDDS are part of the peer review system. But what if you are not a member? Typically the issue winds up in an attorney's office or, if it's a small enough case, no attorney will touch it. If that is the case, there goes another individual that will bad mouth dentistry. What may be of interest is that there could be an added level of exposure if you refer to a non-member specialist dentist. If there is an action against that specialist and it becomes a legal case, you could be drawn in inadvertently. In our litigious society, everyone involved could be sued. That is not the case with peer review.

In the Peer Review Manual it states that a dentist cannot initiate a case against another dentist. When someone comes in for an exam with recent dentistry that defies description, reporting problems and pain, asking, "Is this acceptable dentistry?" then what do you do? Without making dunning remarks against the previous treating dentist, you can explain the peer review system and ask if they would like to pursue that option to get an unbiased opinion. OK, so you dodged that bullet!

But what if you can't? One of my favorite editorialists is Dr. Norman L. Feigenbaum, who pens "Viewpoint" in the magazine PP&A. He had some interesting insight into a circumstance that has occurred to us all in some manner. As the story goes, he was at a hair salon and the stylist engaged him in conversation. When he divulged that he was a cosmetic dentist, the conversation turned to her teeth. She recently had a bridge placed in the anterior maxilla by a "cosmetic dentist" and was dissatisfied with the result, citing the teeth were sensitive as well. She wanted him to look at the bridge and render an opinion. He made every effort to avoid falling into the trap, but she persisted. He informed her that an evaluation would be improper in the salon and he was also not wearing his glasses. He was aware that the bridge was less than attractive even from a conversational distance but did not say anything. His advice, go back to the treating dentist, tell him of your dissatisfaction and the chronic sensitivity. At the next hair appointment she related that she had done what he suggested and it fell on deaf ears. He defended his bridge, told her it looked natural and offered to place composites at the gum line to deal with the sensitivity. As Dr. Fiegenbaum stated, "What could I say?" It ended up that he "… referred her to another clinician whose work I appreciate and value." That is another way of ethically dodging the bullet. The other reason for the story is that it deals with "… an issue that irritates many of my clinical colleagues. If a clinician specializes in cosmetic dentistry — and almost everyone claims to these days — then you must consider what skills are required to fulfill that verbal promise. Otherwise, the practitioner is lying to the public, making false promises to the patients and collecting fees that are unmerited." That also holds true for any area of dentistry, be it orthodontics, implant dentistry, prosthodontics, periodontics and so forth. If you talk the talk, then you have to walk the walk. You have to take the time and effort to obtain the additional skills. And if you don't, there is always peer review.

PP&A "If you promise, then you must deliver…" Feigenbaum, N, vol 12: No 8; 762 ■

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DELEGATES TAKE IT TO TO THE HOUSE!

CDA House of Delegates: November 14–16, 2008

SACRAMENTO DISTRICT DENTAL SOCIETY'S FOUNDATION

A CHARITABLE 501-C3 ORGANIZATION

NOW'S THE TIME TO GIVE TO YOUR FOUNDATION!

By **Robert E. Gillis, DMD, MSD** (SDDF President)

Every SDDS member is an SDDF member. You should all be proud of our contributions to the health of the five county region, most notably through Smiles for Kids. We can only continue programs like this with your participation and financial support. We are continuing to provide many services to the community in your name and raise the image of dentistry. **WE NEED YOUR SUPPORT!**

First: when you receive your dues statement, please include SDDF;

Second: if you are not saving and donating your scrap gold to Crowns for Kids, please get a jar and start;

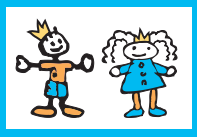
Last: although all of us are dealing with a depressed economy, we are still blessed to be able to practice this wonderful profession.

Please consider donating to the Spirit of Giving. We need your support! Thank You. ■

DUES BILL

☑ **$75 VOLUNTARY DONATION TO SDDF**

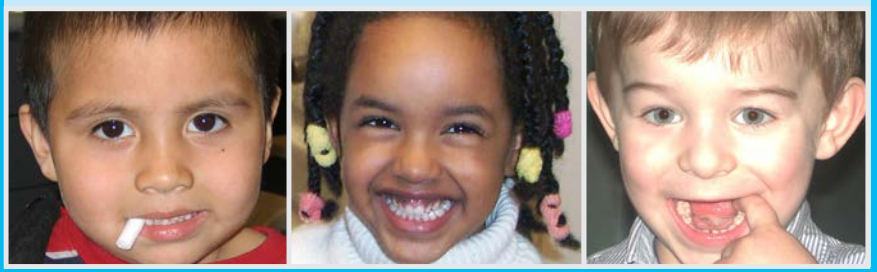
DON'T FORGET TO CHECK OFF YOUR VOLUNTARY DONATION TO SDDF ON YOUR DUES STATEMENT THIS YEAR!



Crowns for Kids: Save your gold crowns and be part of a great donation to the Foundation and **Smiles for Kids**

It's as easy as 1-2-3!

1. Fill out Crowns for Kids intro letter (available for download on www.sdds.org) and fax back to the SDDS office (916.447.3818) **OR** call the SDDS office (916.446.1227) and let us know you'd like to participate.
2. Once you've received your packet of goodies (including a jar for crown collection, an instruction sheet and a postcard), begin filling your jar with gold crowns you collect from patients.
3. When your jar is full, at the end of the year or when you have at least a couple crowns in your jar, mail the jar to **STAR REFINING** and the postcard to SDDS so you can start again!



Crowns for Kids offered through a partnership between SDDF and **STAR REFINING** (800.333.9990)

star refining® LONDON

WHAT YOU GIVE IS WHAT WE CAN DO!

Spirit of Giving

Please join our cause in any way you can — as a donor of your services or a tax-deductible contribution to the fund. Together we can make a difference. *(See enclosed flier for more information)*

TDIC INSURANCE SOLUTIONS NOW OFFERS HOME & AUTO INSURANCE

CDA members can now protect their home, car and personal belongings through the same broker that currently protects their practice and family. TDIC Insurance Solutions has now teamed up with three A+ rated insurance companies, Chubb, Safeco and Travelers to provide personal lines insurance. Each of these companies has unique products and services designed to fit the needs of CDA members, their families and employees. By offering personal lines of insurance, TDIC Insurance Solutions is furthering its commitment to be the one broker that can provide you with all of your insurance needs.

Each company selected to insure your home, car and personal belongings was hand-picked by a committee of your peers. These companies bring a wide range of products that are sure to meet your needs. While home and auto insurance are the most popular types of personal lines insurance, there are many other options. You will be able to insure boats, recreation vehicles, jewelry, artwork and just about anything else you may own and want to protect.

In addition to being able to protect your belongings, each carrier has special features not common to most insurance companies. To name just a few:

Chubb will send a local representative to your home to do a full review of your property and belongings. You will get a detailed outline, including pictures, measurements, features and special accents within your home. If you ever need to file a claim, you can use this document as a reference to have your home restored exactly as it was.

Safeco can insure a business-owned automobile through a personal policy, rather than a commercial policy. By insuring your auto through a personal insurance policy you may save as much as 50 percent when compared to a similar commercial policy. Safeco also offers a variety of discounts and credits to qualified customers including up to a 15% discount when both a home (or renter) and auto policy are purchased together.

Travelers will provide qualifying dentists with an automatic 12 percent discount on their auto policy (any car covered under the same policy will get the same discount).

Ask our agent about what special features that might be right for you. We know you will be hard-pressed to find all of these products and services at any other broker.

In addition to the specialized features listed above, all of the new carriers offer umbrella insurance. Any home, auto or watercraft insurance policy comes with set liability limits. These limits are the maximum that an insurance company will pay out on a claim. Policyholders are responsible for any amount in excess of the established limits of their policy. Umbrella insurance is designed to give you added liability protection above and beyond the limits of your homeowners, auto, and watercraft personal insurance policies. With an umbrella policy you add an additional amount of liability protection. This protection is designed to "kick-in" when the liability limit on your homeowner, auto or personal watercraft policy has been exhausted. One of the best features of the umbrella insurance is one policy will cover all three types of insurance listed above, you do not need a separate umbrella policy for your home, car or boat.

TDIC Insurance Solutions is confident they can find the right insurance plan that will meet your specific needs and provide you with the protection you deserve. For more information, call TDIC Insurance Solutions at 800.733.0633 or visit their Web site at tdicsolutions.com. ■

Western University
COLLEGE OF DENTAL MEDICINE

By **James Koelbl, DDS** (Founding Dean)

My name is Dr. Jim Koelbl, and I began my new position as the founding dean of the developing College of Dental Medicine at Western University of Health Sciences in Pomona on July 1, 2007. Before coming to California, I served from 1999-2007 as dental dean at West Virginia University School of Dentistry; and prior to that served from 1994-1999 as Associate Executive Director at the American Dental Association. I have also held faculty positions at the University of Illinois, Loyola University and the University of Louisville. I practiced general dentistry full time and part time in rural Wisconsin and in the city of Chicago. My wife, Dr. Joan Sandell, and I have six children and three grandchildren.

I am proud to be a new member of the Tri-County Dental Society, and I want to thank TCDS and CDA for the warm welcome that has been extended to me! I am a strong believer in the value of organized dentistry. I served as President-Elect of the West Virginia Dental Association and currently serve as Vice-Chair of the American Dental Association Commission on Dental Accreditation.

I also want to introduce Dr. Bob Trombly, our Executive Associate Dean, and Rosemary Monehen, our Assistant Dean for Pre-doctoral Education and Assessment. Bob joins us from the University of Colorado and Rosemary comes from the American Dental Association in Chicago. These two have already been doing exceptional work for the College. Another person who is vital to the success of our College is Betty Terrell, our Executive Assistant.

We are planning to admit our inaugural class of approximately 64 students in August 2009. As you can imagine, there is much to accomplish between now and then.

The decision to begin a dental school came from the strategic planning process conducted by the University over the past several years. This is part of the long term vision of our President, Dr. Philip Pumerantz, to develop a comprehensive Health Sciences University here in Pomona. By the year 2009, we will have nine health sciences programs on campus. This will facilitate our vision of inter-professional education and healthcare, and allow each of the students to learn more about the contributions that can be made by other members of the health care team. Of course, as dentists, we already know the importance of good oral health as part of good overall health.

To accommodate the new colleges, the University is constructing a Health Education Center and a Patient Care Center. Both buildings will house dentistry, medicine, optometry and podiatry. The Health Education Center will include large auditoriums, lecture halls, small group study rooms, faculty offices, preclinical laboratories and research space. The Patient Care Center will be a multi-professional health care facility for the previously mentioned colleges; and in addition will house a retail optic center and a pharmacy. Demolition of some of the structures on the current sites began in March and we're on schedule for completion of both buildings in June 2009.

Our application for accreditation was submitted to the Commission on Dental Accreditation in March, and has been reviewed by their staff and a team of consultants. They determined that the College had the potential for meeting all of the accreditation standards and was ready for the initial onsite visit. That initial site visit occurred on October 14 and 15, 2008. The dental accreditation process calls for two additional site visits: one in spring 2011 and a final visit in spring 2013.

The initial site visit report will be reviewed at the Commission's January 2009 meeting, at which time the Commission has the authority to grant "initial accreditation" status. Initial Accreditation is the classification granted to any dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation, the developing program has the potential for meeting the accreditation standards.

Progression from "initial accreditation" to "full approval" takes place after the program is fully operational and has graduated its first class. Students who enter and graduate from a dental education program with "initial accreditation" status are considered to be graduates of an accredited program, and are eligible for licensure in all 50 states, Puerto Rico and the District of Columbia.

As you know, there is strong interest in the dental profession on the part of college students. Faculty and staff from the College and University have participated in eleven pre-dental programs at colleges all over California which have been attended by over 500 students. We have also hosted five admissions information sessions on our Pomona campus, which have been attended by an additional 300 students.

Positive feedback was received from both the offices and the students.

We joined the national application service (AADSAS), and began to accepting applications in May 2008. At the end of June, we received our first mailing of applications, and as of July 21, we have received over 800 applications for our inaugural entering class. We will conduct our initial review of applications shortly and proceed to conduct personal interviews for selected candidates beginning in September.

We have made recruitment presentations to various colleges in northern and southern

continued on page 21

THANK YOU 2008 PAC CONTRIBUTORS

106
CONTRIBUTORS IN 2008!

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WHAT IS SACPAC?

The Sacramento District Dental Society Political Action Committee (SacPAC) was created in 2001 for the purpose of establishing a fund to make contributions to candidates for local and state office. SacPAC contributes to those candidates and incumbents who support the concerns, beliefs and issues of the Sacramento District Dental Society and its members.

HOW CAN I CONTRIBUTE?

Contributions to SacPAC are voluntary. To donate, please check the box on your next dues statement, or send a separate check to the SDDS Office (make check payable to SacPAC). You can contribute in any amount, even if you've already paid your dues this year!

HOW CAN I HELP?

Follow the elections, candidates and issues this coming election year. If you feel that SacPAC needs to support a candidate or an issue, let us know. Together, we can show our support!

THE RIBBONS ARE COMING! THE RIBBONS ARE COMING!!!

At the last General Meeting, you may have noticed some SDDS members wearing SACPAC Ribbons on their nametags. These are the people who have contributed to our Political Action Fund (either through the dues check-off or by just making a contribution).

Our SACPAC supports local candidates, local races and dentists who are running for office. We make donations to both sides of the aisle and help support candidates who are friends of dentistry. Please consider making a contribution to our Sacramento PAC — either through your next dues check-off ($30 or more) or by just sending a contribution!

Some campaigns that we have contributed to over the past few years:

Ted Gaines for Assembly

Larry Masuoka, DDS for San Juan School Board

Bill Marble, DDS for Woodland City Council

Tim Herman, DDS for Roseville Joint Union High School Board

Dave Cox for Assembly

Jan Scully for District Attorney

Roger Niello for Supervisor, Assembly

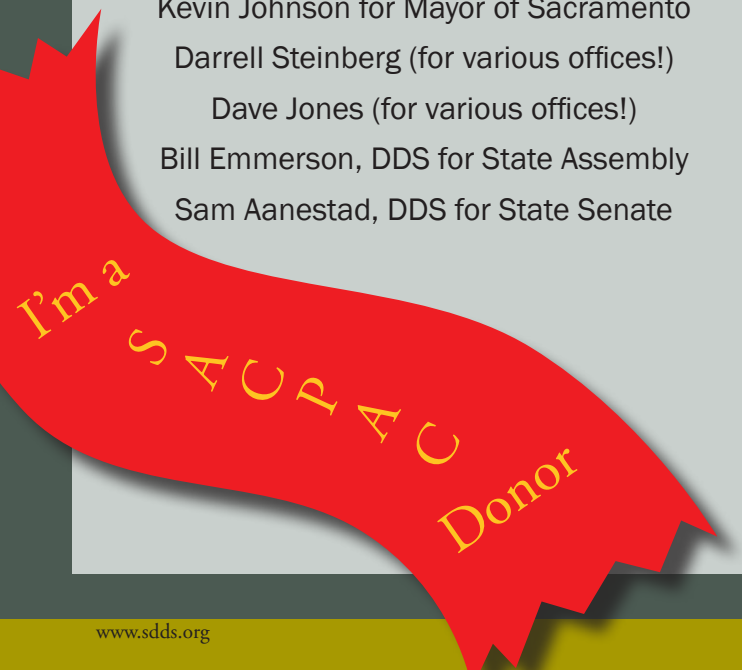
Kevin Johnson for Mayor of Sacramento

Darrell Steinberg (for various offices!)

Dave Jones (for various offices!)

Bill Emmerson, DDS for State Assembly

Sam Aanestad, DDS for State Senate



YOU
THE DENTIST, THE EMPLOYER

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.

IMPROPER BILLING: *Recovering from the Loss*

By **Robyn Thomason (Risk Management Analyst, TDIC)**

Once you suspect or discover that billing irregularities have occurred in your office, you must act quickly. Arrange to meet with all staff involved with the practice's billing. Discuss the situation, and let them know that you will be conducting an audit. If computers are used for billing, let staff know that use of the computer will be limited or suspended until the audit is completed.

Advise the employees that as a provider and business owner, you are obligated to report billing discrepancies to all insurance carriers and correct the errors. Reporting billing errors to an insurance company may lead to refund requests from the insurance company. This may necessitate charging a patient's account resulting in a balance due. Send a letter with the patient's billing statement explaining that there was an error in the insurance billing and the new balance is reflected. Suggest patients contact the office if they have additional questions. While this is uncomfortable, it is still money that the practice is entitled to collect.

In the event the audit uncovers issues that can be linked to an employee, discuss this with him or her privately, but be sure to have a witness in the meeting. Keep in mind that some discrepancies may not be intentional but a matter of misinformation. If the billing errors were due to a misunderstanding, discuss this with the employee and provide additional training and guidance. However, if the employee's billing errors were intentional, consider disciplinary action including possible termination.

> *If you discover any discrepancies, initiate an audit immediately, and inform the staff.*

Many dentists believe they can use Employee Dishonesty coverage of the TDIC Building & Business Personal Property policy to recover these losses. Employee Dishonesty only provides coverage to the named insured for loss sustained due to employee theft of the **dentist's** money or property. It does not cover money or property the employee wrongfully or mistakenly takes from a third party, such as an insurance carrier.

Stay abreast of the billing practices in your office. If you discover any discrepancies, initiate an audit immediately, and inform the staff. If you discover staff made an honest mistake, give additional training. For the employee who acted intentionally, act swiftly and take disciplinary action up to and including termination. ■

STAFF SALARY & BENEFITS SURVEY
ARE YOU IN THE BALLPARK?

Watch your email for the SDDS 2008 Salary Survey. Conducted by California Employers Association, this survey will provide to you information on salary ranges, benefits, vacations, holiday pay, medical & dental benefits & much more.

Participants in this survey receive a FREE copy of the results! Don't miss out!

A Brief History of Peer Review

CONTINUED FROM PAGE 7

Review as an independent council. Since then CDA has continued to refine the operational format of the peer review system.

Membership in CDA requires compliance with the association's code of ethics. Part of the code is that it is unethical for a dentist to render substandard care. Since the "standard of care" or the "quality of service" is not defined by state or federal law, the standard of care will be defined by the California Dental Association. In tort law, the standard of care is the degree of prudence and caution required of an individual who is under a "duty of care."[5] The standard of care for medical (dental) treatment is a guideline that can be general or specific. It specifies appropriate treatment based on scientific evidence. In legal terms, it is the level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. Specific guidelines for a plethora of dental considerations and procedures are detailed in the CDA Peer Review Manual. The manual can be viewed and downloaded online at www.cda.org under membership benefits. ■

Western University...

CONTINUED FROM PAGE 17

California and have several more scheduled in the coming months. Just recently, I spoke to a group of over 120 pre-dental students at the University of California, San Diego. The students there run three free health care clinics in the San Diego area and I was extremely impressed with their dedication to dentistry and their commitment to the underserved. The University sponsored a program for pre-health advisors in February, and we also planned four admissions workshops for college students here on campus in May and June. We have already received over 750 inquiries from potential applicants.

We have attended several meetings of the California Dental Association and local dental societies and have begun to visit the other dental schools in the area. I have also had the opportunity to make presentations about our new college to the California Oral Health Access Council and the California Endowment Pipeline Group. We have visited a number of individual dentists in the community and Dr. John McGwire, a member of the Western University Board of Trustees, has been very instrumental in facilitating many of these contacts.

One of the most significant challenges for any dental school is the recruitment of qualified faculty. We are pleased to say that we have received over 50 inquiries to date from prospective faculty members for both full- and part-time positions.

Our newest faculty member is Elizabeth Andrews, DDS, MS. Upon graduation from the University of the Pacific Arthur A. Dugoni School of Dentistry, Liz practiced general dentistry in Merced, California, for ten years. She then attended the University of North Carolina — Chapel Hill School of Dentistry where she earned her Certificate of Specialty Training in Oral and Maxillofacial Pathology and a Master of Science degree. Dr. Andrews officially joined the College of Dental Medicine on August 1, 2008. In addition to her duties in teaching and research, Dr. Andrews plans to establish an oral pathology biopsy service at the college.

In conjunction with our College of Osteopathic Medicine of the Pacific (COMP), we have also recruited a DDS / PhD faculty member whose primary role will be in research. This individual has been the recipient of a National Institutes of Health training grant, and has conducted significant research in the areas of cancer and genetic markers of systemic disease.

The College continues to receive tremendous support from the University, from administration, deans and faculty of the existing colleges. Individuals and colleges have been very open to working with the new colleges and are looking forward to incorporating oral health into the current mix. The proximity of all the colleges on one campus and the culture of openness and collaboration will allow us to do things in new and exciting ways.

We will continue to be in touch, and always welcome any thoughts/ideas/advice you are willing to share. I can be reached at jkoelbl@westernu.edu, and you can visit our website at www.westernu.edu for continued updates about the University and the College of Dental Medicine. ■

ABSTRACTS

Effects of rapid maxillary expansion on conductive hearing loss

N. Kilir, et al
Angle Ortho 78:3 2008

Results of the study showed that hearing levels of patients with conductive hearing loss (CHL) were improved and middle ear volume increased during active treatment and in the retention period. The authors concluded that the RME procedure provides positive and stable effects on hearing and Eustachian tube functions of growing children who have CHL and transverse maxillary deficiency.

Success of pulpotomy with zinc oxide-eugenol vs. calcium hydroxide/iodorm paste (Vitapex) in primary molars: A clinical study

C. Trairatvorakul, et al
Pediatr Dent 30:4 2008

The authors state that ZOE is the most popular root canal filling material for primary teeth. However, studies have reported chronic inflammatory reactions and slow resorption with its use. Results of the study show that Vitapex appeared to resolve furcation and periapical pathology at a faster rate than ZOE at 6 months, but at 12 months both materials had similar success rates.

Oral manifestations of diabetes mellitus in complete denture wearers

D. de Lima, et al
J Pros Dent 99:1 2008

Results of the study showed a slight reduction of salivary flow in the diabetics and a corresponding slight reduction in denture retention was observed. However, there was no significant difference in the self-reported denture retention or the prevalence of mucosal lesions.

RTB

Lesion Sterilization & Tissue Repair: AN EMERGING MODALITY & PULP THERAPY OPTION FOR NECROTIC PRIMARY TEETH

By **Chester Hsu, DDS**

A common and undesirable end result of dental caries in the primary dentition is pulpal pathology that sometimes results in the need for extraction, and thus premature loss of primary teeth. Left alone, this situation would inevitably result in space loss and adverse effect on the eruption of permanent successors.

An artificial space maintainer is a compromised solution for a missing primary tooth; particularly in a child whose poor hygiene and/or dietary habits led to the need for space maintenance in the first place. They can come loose, and fall off, etc. Long term, space maintainer devices can be uncomfortable and problematic. Furthermore, if the tooth lost is a primary second molar prior to the eruption of the permanent first molar, the currently accepted method of space maintenance, the feared distal shoe, is generally considered to be an undesirable option.

It has been said, the best space maintainer is the primary tooth itself. Thus, primary endodontics or pulpectomy has long been the treatment of choice for second primary molars that have undergone pulpal necrosis or irreversible pulpitis extending beyond the coronal region, particularly when six year molars have yet to erupt. Although this procedure itself has a guarded long-term prognosis under these circumstances, and is a bit heroic and challenging for the provider (especially on an apprehensive child), the idea is to preserve the tooth in the mouth long enough to act as a guiding plane for the permanent firsts, which it often does adequately.

Even this procedure has its limitations, though. Teeth with resorbed roots, significant mobility, or where furcal bone loss extends to the succedaneous premolar would not be candidates even for a pulpectomy. There is an exciting new option that seems to reliably save even those teeth that cannot be pulpectomized.

So, without further ado, I'd like to share this promising pulp therapy with my fellow SDDS colleagues. It is known as Lesion Sterilization and Tissue Repair (LSTR) and also Non-Instrumentation Endodontic Treatment (NEIT). This concept is new here in the U.S. but has been available as an apexogenesis treatment for necrotic immature premolars in Japan for some time. In fact, the concept was originally developed by the Cariology Research Unity of the Nigata University School of Dentistry in 1988.

This concept is new here in the U.S. but has been available as an apexogenesis treatment for nectrotic immature premolars in Japan for some time.

In a Japanese research article published in 2004 in the *International Endodontic Journal* entitled, "Endodontic treatment of primary teeth using a combination of antibacterial drugs," the authors (T. Takushige, E.V. Cruz, A. Asgor Moral, E. Hoshino) reported treating 87 primary teeth that had either physiologic root resorption, periradicular radiolucencies, or both with this technique which involved placement of a triple antibiotic/propylene glycol paste (3-Mix MP) on the bottom of the pulp chamber. Of those 87 treated teeth; 83 were deemed successful outright, and the other four were deemed successful after retreatment. The criteria for success included firm attachment to the jaw, the absence of pain and infection, successful replacement by permanent successors, and reduced or resolved furcation radiolucencies. It is important to note that these LSTR treated teeth were followed during the study up until they naturally exfoliated, and presented no ill-effect to the succedaneous premolars during and after eruption.

Approximately three years ago, a forward thinking pediatric dentist in Louisiana, Dr. Leslie Jacobs, came upon the aforementioned article in the *International Endodontic Journal* and called up one of the leading researchers involved in the study to discuss and learn more about LSTR and the 3-Mix MP compound. Then she coordinated a phone meeting between the researcher and Professional Arts Pharmacy, a compounding pharmacy in Louisiana (which is the same one I use and how I heard about this product), to directly communicate with each other in order to precisely formulate a 3-Mix MP kit for dentists based upon the criteria of the research article. The kit comes as a jar of combined powder of three antibiotics (metronidazole, minocycline, and ciprofloxacin), and a syringe filled with propylene glycol that is to be mixed immediately prior to application.

As far as I am aware, the Professional Arts Pharmacy is the only place presently in the U.S. to obtain this dental-ready preparation of 3-Mix MP. After initially hearing about 3-Mix

MP from one of the pharmacists at Professional Arts Pharmacy, I was referred to call Dr. Leslie Jacobs to answer some questions I had about the product and the technique involved in its use. Dr. Jacobs graciously explained her 3-Mix technique to me and provided answers to some questions I had.

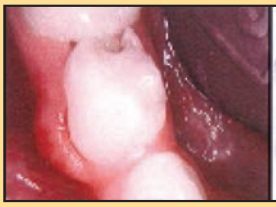
Over the course of the last two years that I have been using this product on my patients in my office, I have learned even more about this promising new pulp therapy from my continued correspondence with Dr. Jacobs, the internet, and also from some text sources. It was also mentioned as a way to promote revascularization of necrotic immature permanent teeth at a recent American Academy of Pediatric Dentistry (AAPD) and American Association of Endodontists (AAE) joint symposium on pulp therapy. I have been in periodic phone contact with Dr. Jacobs to compare notes and share stories of its clinical use. We have both, thus far, had great success with 3-Mix MP on our perspective patients in our perspective offices.

The technique involved in using the 3-Mix MP kit prepared by Professional Arts Pharmacy on an actual dental office patient is fairly simple; and the steps involved are detailed below. These are the same steps currently employed by myself, and by Dr. Leslie Jacobs in her office according to phone conversations with her:

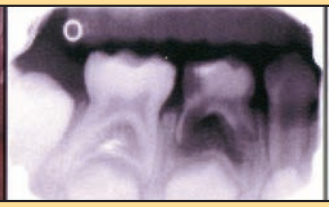
1. Have 3-Mix powder jar and propylene glycol syringe set aside and ready to go. Remove cap on propylene glycol syringe and replace with syringe applicator tip.
2. Also have a sterile cement mixing spatula and Woodsen instrument in an un-open sterilization bag in your set-up.
3. Use a rubber dam whenever possible during this procedure. It is important to have good isolation for this technique.
4. After removing the decay and debriding the pulp chamber (ala pulpotomy) using your current method of choice on the tooth being treated, irrigate the pulp chamber with peridex (chlorhexidine solution) using a small syringe. Then air dry or thin only using gentle off-angle bursts of air from the air/water syringe. The pulp chamber need not be dry to continue; peridex and even some bleeding in the pulp chamber is ok. If there is excessive hyperemic bleeding from the pulp orifices, a cotton pellet can be condensed and placed on the floor of the pulp chamber and left there for a few minutes while you do something else, perhaps an exam on another patient, or chart write-up. Hopefully the bleeding will be significantly diminished upon returning to the patient and removing the cotton pellet. Remember, some bleeding is not a problem.
5. You're now ready to mix and prepare the 3-Mix MP compound. Change gloves first. Shake the 3-Mix powder jar to ensure even distribution of antibiotics. Open the lid of the jar and set aside. Place a drop or two of propylene glycol on a mixing pad. Open the sterile bag containing the mixing spatula and woodsen and remove the spatula, then use the tip of the spatula to scoop out a small mound of 3-Mix powder about 3 times the size of the drop of propylene glycol. Then thoroughly mix the powder and liquid with your spatula until a thick rollable putty is formed. This may take some practice at first to get the right consistency. Too much liquid and it will be sticky and difficult to handle, too much powder and the putty will be crumbly and not roll into an easy to handle ball. Your assistant can be easily trained to mix the 3-Mix MP for you.
6. Using the spatula end of the Woodsen instrument, carry the 3-Mix MP putty to the target tooth and place the putty into the pulp chamber. Using the condenser end of the Woodsen, gently tamp down the 3-mix MP putty to cover the floor of the pulp chamber. You only need enough to thinly cover the pulp floor (~1mm).
7. Next, carefully place your IRM, Temp-It® or other filler of choice to obturate the remaining coronal space. Take special care to, as much as possible, avoid displacement of the 3-Mix medicament on the pulp floor.
8. Being careful to not dislodge the pulp chamber contents (the propylene glycol in the 3-Mix MP mixture makes it slippery and easy to inadvertently get sucked out by a high speed evacuator — it's happened to me), prepare the tooth as you normally would and fit and cement your stainless steel crown. You are done!
9. Alternatively, you can place glass ionomer or resin-modified glass ionomer over the 3-Mix MP, and then composite resin on top of that, to do an esthetic "tooth-colored" sandwich restoration.

Be sure to cap both the 3-Mix jar, and propylene glycol syringe, tightly after use and seal inside a zip-lock bag (included in the kit), and store in a cool dry place. It is important to keep the powder moisture-free.

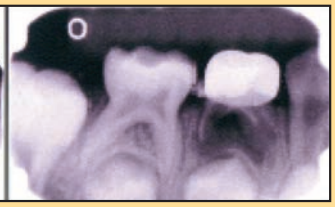
Below are some radiographs and intraoral photos from an early case I documented *(patient's name has been omitted for privacy):*



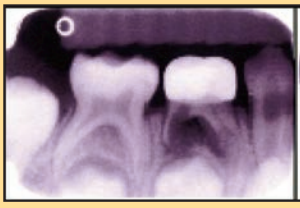
Tooth #S intra-oral photo taken on 11/22/06, showing distal caries lesion and parulis on buccal gingiva



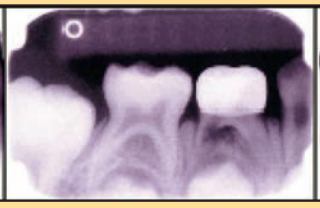
Tooth #S periapical radiograph taken on 11/22/06, showing deep distal caries lesion, pathologic root resorption and bifurcation radiolucency



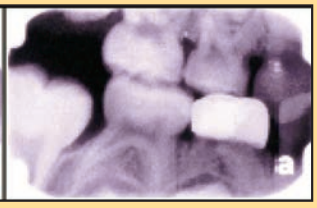
Tooth #S periapical radiograph taken same day, immediately post-treatment with 3-Mix MP



Tooth #S radiograph taken on 12/11/06. Parullis is gone, gingiva appears healthy and patient is no longer in pain.



Tooth #S radiograph taken on 1/18/07. Furcation radiolucency substantially diminished in size.



Tooth #S radiograph taken on 5/7/07 (nearly six months post-treatment). Bone has completely regrown in bifurcation area. Gums are healthy and patient reports no pain.

Sounds great so far, but how does it work?

For most of us, it is likely not vital to have more than a cursory understanding of how our products and techniques work. It simply suffices that they work. After all, we're dentists, not biochemical engineers. That said, a deeper understanding may be essential for wider acceptance of such an avant-garde treatment. Therefore, I will share my limited knowledge with you, my fellow SDDS brethren, the best I can.

Breaking it down into its components; Metronidazole (Flagyl) is an anti-bacterial drug that was chosen due to its effectiveness against anaerobic bacteria, particularly those found in oral infections. However, some microbes are resistant to the Metronidazole; so two additional antibacterial drugs, Minocycline and Ciprofloxacin, are included to eliminate bacteria that are left over. The result is a "slam dunk" effect that essentially kills all of the anaerobes present in and around the infection. This *lesion sterilization* allows the body's own natural wound healing process to occur (ie- *tissue repair*). Once the inflammatory pathogens are eliminated, the necrotic pulp itself acts as a scaffold of extracellular matrix that facilitates the re-growth of cells into the area. In theory, nearby cells such as fibroblasts, odontoblasts, ameloblasts, osteoblasts, endothelial cells, and perhaps dental stem cells are cued by the extracellular matrix (calcium, phosphate, proteins) to repopulate the region of damaged tissue.

For most of us, it is likely not vital to have more than a cursory understanding of how our products and techniques work. It simply suffices that they work.

Propylene glycol is an organic, water-soluble, clear viscous liquid that is widely used commercially and pharmaceutically in a wide range of products as a lubricant, moisturizer, emulsifier, solvent, and/or carrier. An example of its use is the thin green lubricating strip on a disposable shaver. Its function in 3-Mix MP (the"P" in MP) is as an effective carrier that has been demonstrated *in situ* to quickly and reliably deliver the 3-Mix medicament through the dentine and kill all cultivable bacteria within 24 hours. The "M" portion of 3-Mix MP is macrogol which generally used as a laxative. I have not yet been able to determine its purpose in the 3-Mix MP medicament.

It would not be fair to present this article without sharing the views of its detractors. The Philippine Pediatric Dental Society has released a position paper against the LSTR technique. I have had the opportunity to consult a friend, Jeff Gruneich Ph.D., a biochemical engineer and co-founder of Store-A-Tooth™ (a dental stem cell banking service) in Boston, MA. Based upon my conversation with Dr. Gruneich and the knowledge that I have gathered, I will list and try to address each of its stated concerns.

- **Potential toxicity and allergic reaction.** *The amount of 3-Mix MP medicament used is very small, and is sealed within the coronal pulp chamber either with a stainless steel crown, or a glass ionomer/composite resin sandwich restoration. Even though it is carried and diffused into the periradicular area, the amount is still fairly minimal and would not likely elicit a threshold allergic or toxic response even in an individual with such sensitivities. There were no reports of side-effects in any of the patients in the Japanese study; nor have I or Dr. Leslie Jacobs had any such issues in our perspective offices. Of course a good history should always be taken on the patient to mitigate risk.*
- **Inappropriate use of antibiotics and ecologic potential for selective pressure.** *Selective pressure is the phenomenon where susceptible bacteria are destroyed but more resistant bacteria survive, resulting in a population of more resistant bacteria. Once again, the amounts used are small and there is a "slam dunk" effect that kills off all cultivable bacteria in the region. There are essentially no survivors. Also when you consider that dentists often employ widely accepted antibacterial techniques such as Arrestin™ (minocycline microspheres) for local periodontic therapy, which ostensibly have the same issues as 3-Mix MP therapy. In addition, Systemic antibiotics are prescribed relatively freely in the medical/dental community for a bevy of ailments; at times with reckless abandon. The real question is whether the benefits outweigh the risks. In the case of LSTR therapy; the risk appears small, and the potential benefits are great.*
- **The possible of leakage of 3-Mix MP paste into the oral cavity and its effect on microflora.** *The encapsulated nature of the 3 mix once the tooth is restored, and the small amount used in the first place should make this proposed effect negligible. When you consider that Peridex is commonly used for, among other things, treating bad breath. The effect of a small amount of antibiotic paste sealed within the tooth by the restoration seems overstated.*
- **Antibiotics should not be used topically.** *Topical antibiotics are prevalent and widely used in the United States for a multitude of conditions.*

A recent USC School of Dentistry Pediatric Residency Department study on 3-Mix MP (which they obtained from Professional Arts Pharmacy) found that it was quite effective in treating teeth with necrotic and irreversibly inflamed pulps, which would support the study done in Japan. They further tested the 3-Mix MP medicament on primary teeth with reversible pulpitis and pulp disease not extending to the radicular region as an

UPCOMING SDDS EVENTS

For more information on Sacramento District Dental Society events, visit www.sdds.org or call us at (916) 446-1227.

November 11 • 6:00pm
GENERAL MEETING • 3 CE
The Five Things Everyone Wants from Their Job
Virginia Moore & Debbie Castagna (The Practice Source)

November 21 • 9:00am
CONTINUING EDUCATION • 2 CE
Nightguards Made Easy
Jim Hillier (Dentsply Caulk)

November 20 • 6:30pm
MEMBER FORUM • 2 CE
How to Best Handle Your Experience with Peer Review & Ethics
Panel of Experts
Peer Review & Ethics Committee

December 8 • 6:30pm
SDDS Annual Holiday Party
Silent auction, installation of officers, great food & moore!

alternative to the formocresol vital pulpotomy technique and was found, thus far, to produce better results and less failures than the traditional method using formocresol. They do state in their conclusion that they feel more research needs to be done before broadly recommending its use.

I personally find it interesting to note that formocresol (which is extremely caustic, tissue toxic, and mutagenic) is the widely accepted standard of care for the vital pulpotomy technique, worldwide, at this time. Ferric sulfate, and electrosurgery are the two other accepted pulpotomy modalities as stated by the American Academy of Pediatric Dentistry in the latest edition of their annually updated reference manual, but have their downsides as well, and do not have success rates significantly different from formocresol.

The LSTR-NEIT technique appears to be useful in a broad range of pulpal disease states. Panacea of pulp therapy? Perhaps not. There are some concerns about its use that warrant further evaluation, and more research. Though it certainly seems to be a promising approach to treating pulpal pathology in primary teeth. The benefits seem to outweigh the risks thus far. At this time, I am only offering this service to patients when their tooth cannot be saved by other means or as an alternative to a pulpectomy. As mentioned earlier, checking the child's health history for drug allergy and sensitivity is an important first step. I explain to the parent that this is a very new therapy that involves the use of an antibiotic paste that is placed within the tooth itself. I also tell them that recent research using 3-Mix MP have yielded great results, and that I have had excellent success on my own patients as well. I offer the LSTR therapy as an alternative to extracting the tooth and placing a space maintainer. I then explain that the baby molar is the best space maintainer. If they choose to go ahead with the 3-Mix MP technique, I only charge it out as a traditional pulpotomy and stainless steel crown fee.

I personally do not feel comfortable replacing traditional vital pulp techniques with 3-Mix MP until more research data to support it becomes available.

At this time, I personally do not feel comfortable about replacing traditional vital pulp techniques with 3-Mix MP until more research data to support it becomes available. I do feel that it is a great option for teeth that cannot otherwise be saved and therefore have nothing to lose, as long as the parent is given the associated risks, benefits, and alternatives as we customarily do with the dental services we provide. At this time, the mixture of the three aforementioned antibacterial drugs with propylene glycol may be considered an off-label use of these pharmacological agents, which, individually, are commonly known and widely used for other therapeutic purposes. Fluoride itself is routinely used off-label to augment enamel caries resistance, although, it is currently only approved by the FDA for desensitization. It is generally considered acceptable to use drugs off-label when there is a body of evidence to support it, and the evidence for 3-Mix MP and LSTR is growing. ■

Dr. Chester Hsu is an SDDS member dentist practicing in Lincoln, CA. In his article he refers to Professional Arts Pharmacy, which is located at 620 Guilbeau Rd., Suite A Lafayette, LA 70506. (888) 237-4737

VENDOR MEMBER SPOTLIGHTS

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2008 SDDS COMMITTEE MEETINGS:

Auxiliary Advisory • SDDS • 6:30pm
Future meetings TBA

Board of Directors • SDDS • 6:00pm
Nov 17

CE Committee • SDDS • 6:30pm
Nov 18 — **NOTE CHANGE**

CPR Committee • SDDS • 6:30pm
Completed for 2008

Dental Health Committee • SDDS • 6:30pm
Dec 9

Ethics Committee • SDDS • 6:00pm
Completed for 2008

Foundation (SDDF) • SDDS • 6:30pm
Nov 19

Golf Committee • SDDS • 6:30pm
Completed for 2008

Leadership Dev. Committee • SDDS • 6:00pm
Completed for 2008

Legislative Committee • SDDS • 7:00pm
Completed for 2008

Mass Disaster / Forensics Committee • 6:30pm
Dec 2 (yearly calibration) — **NOTE CHANGE**

Membership Committee • SDDS • 6:30pm
Dec 1

***Nugget* Editorial Committee • SDDS • 6:15pm**
Completed for 2008

Peer Review Committee • 6:30pm
Nov 13 • Dec 11

SacPAC Committee • SDDS • 6:00pm
Completed for 2008

For dates & times not listed above, visit the SDDS calendar at www.sdds.org/calendar.htm

LINK OF THE MONTH

Having trouble communicating with your patients?

Yahoo Babel Fish is a free online translator. Get your point across at:

http://babelfish.yahoo.com/

Stumbled upon a great link?
Email it to melissa@sdds.org, to submit it as a possible link of the month!

ADVERTISER INDEX

COMMITTEE CORNER

By **Victor L. Hawkins, DDS**
Chair

CPR Committee:
CPR BLS MANDATORY FOR DENTAL BOARD LICENSURE RENEWAL!

THE SDDS CPR COMMITTEE IS READY TO SERVE YOU!

The twenty four CPR BLS instructors of our CPR Committee are "up to the moment" current with American Heart Association (AHA) knowledge and are eager to keep YOU current when renewing your dental license. Every two years when you renew your license to practice, you are signing a statement that you have, within the previous two years, taken a *hands-on* renewal course in Basic Life Support as approved by the Red Cross or the AHA. No other courses are valid and even if you take an approved online course, you will still have to attend a hands-on course to get your skill check (with mannequins) signed off.

Margaret Delmore, MD, DDS and I attended an all day AHA update course for the Western Region on September 12, 2008. Many statistics were given to show how the new protocol changes have improved the survival rate. The improvement is impressive even though the numbers are small. Before the recent changes, the survival rate was 5.0% and after the changes it went to 6.4%. The AHA goal is 15% by 2025.

To accomplish this the AHA is currently working on a Hands Only CPR protocol for LAY PEOPLE to help take away some of the confusion associated with giving CPR Every community in America has the potential to be what the AHA calls "Heart Safe" by teaching basic "HANDS ONLY" CPR to as many folks as possible. Making CPR proficiency a contingency for high school graduation has even been suggested. These changes are NOT in effect now and will not include Professional Providers.

Please sign up and include your staff members for one of our up coming courses. For 1.5 hours homework and 3.5 hours at the course you pay only $55 each and receive 5 units of Category 1 continuing education credit. Courses will be conducted at Sutter General Hospital Buhler Building, Saturday mornings at 8:30am. Upcoming courses are: November 8, 2008, April 4, 2009 and August 1, 2009. ALSO, a course will be offered at the 2009 MidWinter Convention on Friday, February 20, 2009 from 1:30pm–5:30pm at the Sacramento Convention Center.

See you there! ■

WE'RE BLOWING YOUR HORN!

CONGRATULATIONS TO...

Dr. Rex Favero and his newly licensed daughter, **Dr. Tiffany Favero Holladay** — another dentist in the family of dentists!

Dr. Priya Puelicher and her husband, Reed, on the birth of her fourth child, Naina Catherine on September 20, 2008 (7 lbs, 8.5 oz). *(photo at right)*

Drs. Maryam Saleh and **Ashkan Alizadeh,** on their marriage Sunday, September 28, 2008. *(photo at right)* ■

Naina Catherine Puelicher, born to Dr. Priya Puelicher and her husband, Reed, on September 20, 2008.

Drs. Maryam Saleh and Ashkan Alizadeh celebrate their marriage on September 28, 2008.

Have some news you'd like to share with the Society? New babies, achievements, retirements, new offices — we'll report them all! Please send your information to SDDS via email (melissa@sdds.org), mail (915 28th St, Sacramento, CA 95816) or fax (916-447-3818). Call SDDS at (916) 446-1227 for more information.

WELCOME

to SDDS's new members, transfers and applicants.

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

NEW MEMBERS

NOVEMBER **2008**

Nahid Afshari, DDS
General Practitioner
6406 Sunrise Blvd
Citrus Heights, CA 95610
(916) 727-1880
Dr. Nahid Afshari graduated from Babol University of Medical Sciences in 2001 with her DDS. She is currently practicing in Citrus Heights and lives in Folsom with her husband, Cyrus Jahani.

Veronica Alvarado, DDS
Prosthodontist
4944 Windplay Dr, Ste 300
El Dorado Hills, CA 95762
(916) 941-2333
Dr. Veronica Alvarado graduated from the UCLA School of Dentistry in 2005 with her DDS and completed her specialty certification in prosthodontics at the VA Medical Center in Long Beach, CA earlier this year. She is currently practicing in El Dorado Hills with fellow SDDS member, Dr. Gene Gowdey, as well as in Elk Grove. Dr. Alvarado lives in Elk Grove with her husband, Mark Armstrong.

Samuel Chung, DDS
General Practitioner
4355 Golden Center Dr, # 4
Placerville, CA 95667
(530) 622-3430
Dr. Samuel Chung graduated from the Loma Linda University School of Dentistry in 2006 with his DDS. He is currently practicing in Placerville with fellow SDDS member, Dr. Injoo Han, and lives in Pleasant Hill.

Jennifer Gee Schoon-Tong, DDS
General Practitioner
Pending Office Address
Dr. Jennifer Gee Schoon-Tong graduated from the New York University School of Dentistry in 2007 with her DDS and completed a residency at the VA Medical Center in East Orange, NJ earlier this year. She is currently seeking employment in the greater Sacramento area and lives in Sacramento.

Brenda Herrera, DMD
General Practitioner
Pending Office Address
Dr. Brenda Herrera graduated from the University of Nevada, Las Vegas School of Dentistry earlier this year with her DMD. She is currently seeking employment in the greater Sacramento area and lives in Sacramento with her husband and fellow SDDS new member, Dr. Jeron Winslow.

Sheila Inalou, DMD
General Practitioner
Pending Office Address
Dr. Sheila Inalou graduated from the Tufts University School of Debtistry earlier this year with her DMD. She is currently seeking employment in the greater Sacramento area and lives in Sacramento.

Michael Narodovich, DMD
General Practitioner
6994 Sunrise Blvd
Citrus Heights, CA 95610
(916) 723-8900
Dr. Michael Narodovich graduated from the Temple University School of Dentistry earlier this year with his DMD. He is currently practicing in Citrus Heights with fellow SDDS members, Drs. Richard Smith and Tigran Vardanian, and lives in Sacramento.

Joseph Rawlins, DDS, MS
Pediatric Dentistry
5420 Park Dr
Rocklin, CA 95765
(916) 435-5230
Dr. Joseph Rawlins graduated from the Baylor College of Dentistry in 2005 with his DDS and completed his specialty certification in pediatric dentistry at Ohio State University earlier this year. He is currently practicing in Rocklin with fellow SDDS member, Dr. Dennis Peterson, as well as in Yuba City. Dr. Rawlins lives in El Dorado Hills with his wife, Julie.

Christy Rollofson, DDS
General Practitioner
9727 Elk Grove Florin Rd, Ste 270
Elk Grove, CA 95624
(916) 685-2105
Dr. Christy Rollofson graduated from the USC School of Dentistry in 2007 with her DDS and completed a residency at Cedars Sinai Medical Center earlier this year. She is currently practicing in Elk Grove with fellow SDDS member, Dr. Roger Reich, and lives in Rancho Murieta.

Amir Shad, DDS
General Practitioner
8759 Center Pkwy
Sacramento, CA 95823
(916) 525-5600
Dr. Amir Shad graduated from the University of Toronto School of Dentistry in 1996 with his DDS and later completed a residency at Rochester General Hospital, NY in 1997. He is currently practicing in Sacramento and lives in Elk Grove with his wife, Dr. Shirin Ahmad.

MORE

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

TOTAL MEMBERSHIP (AS OF 10/3/08): 1,535

TOTAL ACTIVE MEMBERS: 1,305
TOTAL RETIRED MEMBERS: 180
TOTAL DUAL MEMBERS: 2
TOTAL AFFILIATE MEMBERS: 8
TOTAL STUDENT MEMBERS: 2
TOTAL CURRENT APPLICANTS: 9
TOTAL DHP MEMBERS: 29

TOTAL NEW MEMBERS FOR 2008: 76

Huai Xu, DDS
General Practitioner
4561 Mack Rd
Sacramento, CA 95823
(916) 422-2171
Dr. Huai Xu graduated from Nanjing Medical University in 1987 with her DDS. She is currently practicing in Sacramento and lives in Gold River with her husband, Qiang Jin.

NEW TRANSFER MEMBER:

Jeron Winslow, DDS
Transferred from San Francisco Dental Society
General Practitioner
3428 Watt Ave, Ste B
Sacramento, CA 95821
(916) 489-9990
Dr. Jeron Winslow graduated from the USCF School of Dentistry earlier this year with his DDS. He is currently practicing in Sacramento and lives in Sacramento with his wife and fellow SDDS new member, Dr. Brenda Herrera.

NEW STUDENT MEMBER:

Madeline Majer
University of Michigan/2008
UOP Arthur A. Dugoni School of Dentistry/2009

NEW APPLICANTS:

Susan Abeldt, DDS
Mohamed El Sayed, DDS
Teresa Hall, DDS
Tiffany Favero Holladay, DMD
Ellen Mark, DDS
Lisa Ngo, DDS
Navdeep Sandhu, DDS
Ryan Wittwer, DDS, MS
Anna Zee, DDS

Place this page in the "New Members" section of your 2008 SDDS Directory

ELECTRONIC DUES PAYMENT

Pay your dues over 6 months in 6 equal payments!

This year members will be able to enroll in the EDP program online at cda.org. The online renewal and EDP will open **NOVEMBER 30, 2008.**

December 22, 2008 is the last day to mail or fax EDP enrollment forms

January 11, 2009 will be the last day to enroll for EDP online

The first withdraw will be **January 23, 2009**

These dates are based on the bank calendar, so they will not change.

Contact SDDS (916.446.1227) with any questions. ■

ELECTRONIC DUES PAYMENT

RETIRING ANY TIME SOON?

If you plan to retire between now and the end of December, please call the SDDS office so that you can officially change status before the next dues year.

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MEMBERSHIP REPORT

CONGRATULATIONS! MEMBERSHIP MILESTONES FOR 2008

The following members celebrated significant membership anniversaries in 2008:

SIXTY YEARS

Kenneth H. Fox, DDS
Mitsuho A. Sato, DDS

FIFTY YEARS

Wayne D. Benson, DDS
Ronald E. Buhler, DDS
E.J. Chase, DDS
Robert G. Corcoran, DDS
Daniel J. Corrigan, DDS
C. John Cox, DDS
James W. Elliot, DDS
Earl L. Hummell, DDS
W. Kenneth Miller, DDS
Andre J. Monier, DDS
William S. Owens, DDS

FORTY-FIVE YEARS

Richard M. Alexander, DDS
Lee F. Crane, DDS, MPH
Chung H. Fong, DDS
M. Franklin Godfrey, Jr., DDS
Harvey S. Greer, DDS
Walter L. Griffin, DMD
Donald M. Hagy, DDS
Victor L. Hawkins, DDS
Bruce E. Horrigan, DDS
Kenneth J. Law, DDS
William W. Maddox, DDS
Alan H. McDowell, DDS
James L. Peck, DDS
Russell L. Perpall, DDS
John O. Riebe, DDS
James R. Silverman, DDS
Kay G. Smith, DDS
Ersic Wing, DDS

FORTY YEARS

John B. Childers, DDS
Thomas J. Chin, DDS
Thomas B. Holloway, DDS
Theodore T. Krysinski, DDS
Carl R. Rodegerdts, DDS
Melvin W. Walters, DDS

THIRTY YEARS

Ron M. Ask, DDS
Maureen Brandman, DDS
Fredrick A. Correa, DDS
Louis G Cuccia, DDS
David Feder, DDS
Ronald G. Fong, DDS
Harold R. Hanefield, DDS
Kenneth B. Hashimoto, DMD
Rodger S. Kampf, DDS
Richard C. Kennedy, Jr., DDS
Geoffrey J. Lukes, DDS
Kenneth R. Marti, DDS
Kris W. Martinson, DDS
Robert L. McClurg, DDS
Lloyd R. Price, DDS
Judson R. Roberts, DDS
Richard A. Silva, DDS
David C. Sorensen, DDS
Jeffrey C. Vernon, DDS
Edward R. Weiss, DDS
Ernest W. Westover, DDS
Mark E. White, DDS
Mark A. Wiest, DDS
Alan R. Williams, DDS
Bingson W. Wong, DDS
H. Wesley Yee, DDS

TWENTY YEARS

Terry M. Adair, DDS
Jed G. Anderson, DDS
Kreston Anderson, DDS
Ronald E. Cogburn, DDS
William B. Couch, DMD
John C. Fat, DDS, MS
Bradley M. Fralick, DMD
Steven F. Higashi, DDS
Brock E. Hinton, DDS
Dennis W. Hiramatsu, DDS
Richard F Jackson, DDS
Nelson A. Johansen, Jr., DDS
Paul E. Johnson, DDS
Richard C. Keilson, DDS
Gertrude Y. Lee, DMD
Ronald C Lee, DDS
James M. McNerney, DMD
Mark A. Rademacher, DDS
Thomas J. Schlehofer, DMD
Daniel K. Woodson, DDS
James P. Zimmerman, DDS, FAGD

TEN YEARS

Debra Baker-Parachou, DDS
Mohammad I. Beddawi, DDS
Jonathan K. Chan, DDS
Allen E. Chantry, DDS
Steven R. Fife, DDS
Debra S. Finney, DDS
Paul R. Genasci, DDS
Ralph I. Jacobs, Jr., DDS
Pieter J. Linssen, DDS
Lisa A. Mayeda, DDS
Jeffrey S. McClure, DDS
Robert J. Meaglia, DDS
Kevin M. O'Dea, DDS, MS
Michael H. Payne, DDS, MSD
Quynh-Trang N. Pham, DDS
Ronald P. Pisciotta, DDS
Richard H. Portalupi, DDS, MSD
Priya P. Puelicher, DDS
Moji G. Radi, DDS
Ronald D. Rasi, DDS
Jared W. Ruminson, DDS
Alvin Seevers, DDS
Sherry D. Shapiro, DMD
Lee Anne Stigers, DMD
J. Alex Tomaich, DDS, MD
Michael M. Uzelac, DDS, MS
Whitney T. Vu, DDS
David W. Wistrom, DDS

SCHEDULED TO RECEIVE LIFE MEMBERSHIP IN 2009

Awarded at SDDS Holiday Party (Dec 8, 2008)

Carl V. Broden, DDS
George R. Burger, DDS
Matthew J. Campbell, Jr., DDS
Hugh M. Charles, II, DDS
John B. Childers, DDS
Peter D. Duisenberg, DDS
Kenneth B. Frostad, DDS, MS
George A. Gould, DDS*
Carl M. Griffith, DDS
Stephen E. Haun, DDS
Leslie A. Hoenig, DDS
Thomas B. Holloway, DDS
Gilbert H. Larsen, DDS
Priscila M. Linsao, DMD
Richard A. Mandelaris, DMD
Stephen C. Ott, DDS
James F. Peters, DDS
Richard A. Smith, DDS
Michael D. Weideman, DDS
Kenneth G. Whitnack, DDS

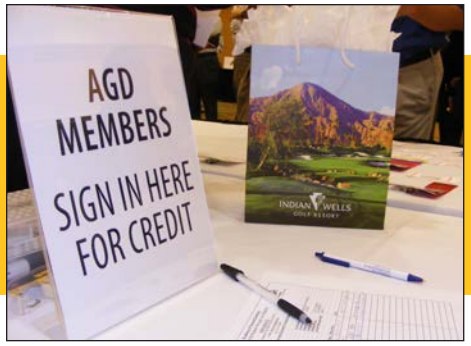
Note: Life membership is granted to an active or retired member who has been a member for 30 consecutive years and has attained the age of 65. It is effective the calendar year following the year in which requirements are fulfilled.

** 2009 life member for ADA; already a life member with SDDS and CDA.*

EVENT HIGHLIGHTS

OCTOBER GENERAL MEMBERSHIP MEETING

October 14, 2008 — CDA Night



Did you know? *Academy of General Dentistry (AGD) members get credit for attending SDDS meetings! If you're an AGD member, look for the sign in sheet at the main table.*

The 50/50 raffle made over $1000, awarding a $500 cash prize to Dr. Dave Feder!

The brothers Roth (Drs. Sean and Jason) enjoy the pre-program social hour.

Are you a SacPAC donor? Please check off a PAC donation on your dues statement — it will help our legislative efforts.

Philip Kong (Citibank — SDDS Vendor Member) addresses the group.

Crowns for Kids is an easy way to donate to the Foundation by recycling your old crowns. Contact SDDS for more details. Save your crowns — every crown helps!

CDA Foundation's Michele Flynn (Marketing and Communication Specialist) and Jennifer Stolo (Associate Executive Director) attended the meeting to explain how SDDS members can help the cause.

New Members *(left to right): Drs. Caton State, Prabhdeep Grewal, Angel Sun, Kevin Chang, Kimberly Wong and Hoang Truong are welcomed by Dr. Wai Chan.*

Dr. Marjorie Jara (SDDS New Member for October) and her husband, Christopher, settle in to their first meeting.

Dr. Kevin Keating addresses SDDS membership as this month's speaker.

Thank you for supporting SDDS continuing education programs. For each course, name tags are printed to help you network with your peers. BUT did you know that SDDS uses this as our tracking system for attendance? If you don't pick up your tag, we mark you as a "No Show." If you are ever audited by the Dental Board of California and they ask you for your CEUs, there's a chance that they may check to confirm you actually attended those classes and that you didn't just bum a CE card from your buddy. So… remember to ALWAYS pick up your nametag.

CONTINUING EDUCATION UNITS!

Nugget Classifieds

Practices For Sale

EAST CONTRA COSTA COUNTY, CA — Beautiful, four op (3 equipped) GP located in professional building. Collections in 2007 exceeded $340,000 on a part-time schedule. Practice Transition Partners, (888) 789-1085, www.practicetransitions.com. 06/07-08

UPGRADE YOUR OFFICE! Doctor moving to new location, to sell all equipment and leasehold in Campus Commons area. Turnkey: 6 operatories, 2 in-office restrooms, pano, intra-oral camera, artwork. Please contact John Pacelli at Patterson Dental (916) 595-3005. 08/09-08

GREAT OPPORTUNITY IN A GROWING AREA for a new dentist! I am selling my dental office and building a new practice to accommodate the growth of my practice. The office includes everything except the patients. The office has three fully-equipped operatory rooms that have computers in each and digital x-rays. Also, has comfortable reception area, front desk space, bathroom and lab area. For more information, please call Dr. Peliks (916) 933-7401. 11-C1

SOUTH SACRAMENTO: GP, FFS, no capitation, no PPO. Quality, caring practice in Greenhaven/Pocket area. 27+ yrs of goodwill. Owner retiring. 4 op high tech practice with stable staff. Digital x-ray, intra-oral camera, Global microscope, Kavo electronic handpieces, Adec lights and new x-ray machines. 4 days of hygiene. Looking for capable, experienced, caring dentist to take over. Average yearly collection of $600,000 in the last 4 years. Asking $435,000. Call (916) 682-9361. 11-C1

Equipment For Sale

USED EQUIPMENT FOR SALE. Air-Techniques vacuum unit. Pelton & Crane rear delivery cabinets with handpiece delivery units. Adec overhead track light. Metal locking chart cabinet, 7 tiers, and 3 cabinets on a track. KelCom communication light system. Contact Jemaxco@aol.com for pictures and more information. 10-08

SIEMENS OP-10 PANO FOR SALE! — Excellent condition. 2K. Please call Nancy at (530) 756-0262. 11-C1

Employment Opportunities

A GREAT OPPORTUNITY! If you are planning or considering opening a practice in El Dorado Hills, give me a call!!! Dr. Linssen (916) 952-1459. 02-07

ORTHODONTIST — Help!!! Too many patients!!! Kids Care Dental Group is looking for an orthodontist to help with our huge patient base. More consults than you could ever imagine. Seeking a long-term commitment and a dedicated individual. Great private practice with unlimited potential. Call Derek at (530) 263-2454 or fax your resume to (916) 290-0752. 06/07-08

PEDIATRIC DENTAL PRACTICE located in Folsom seeks dentist. Excellent opportunity for skilled dentist to join our practice. Please fax resume to (916) 983-9012. 08/09-06

1–2 FULL TIME ASSOCIATE DENTISTS NEEDED for busy Stockton practice that does 1.5–1.7 million in collections per year. Very competitive salary/bonus. $200k–$300k/yr potential. Fax resume to (916) 929-5848. 10-08

GENERAL PRACTICE LOOKING TO SHARE OR SUBLEASE space to endo, OS, periodontic or pedo specialist in Roseville. Please contact Mike at (916) 787-0631. 11-08

Positions Wanted

ENDODONTICS: In your office 2–3 days/month or ? 30+ yrs experience. References upon request. Contact Dr. Koett, Sr. (916) 337-6202. 02-07

GP LOOKING TO RENT A CHAIR in Sacramento area 2–3 times/month. Please contact @ (917) 749-3410 or vadim_s@comcast.net. 06/07-08

STOP THE SCREAMING! In-office sedation services by MD anesthesiologist • Pedo/Adults • Medi-Cal Provider • 20 years experience • Call (800) 853-4819 or info@propofolmd.com. 05-07

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. 10-08

ASSOCIATE INTERESTED IN TRANSITIONAL PURCHASE of busy foothill practice needed in beautiful community 45 minutes from Sacramento. Low crime rate and traffic congestion. Great place to live and work. FAX resume to (209) 267-1538. 11-08

Positions Wanted *(cont)*

GP 19 YEARS EXPERIENCE in cosmetic, restorative, endo (anteriors & molars), OS (uncomplicated & complicated), ortho (conventional & invisalign), implants (surgery & prostheses). Team oriented. Great with patients and staff. Available 1-3 days/week. Cell: (916) 730-4122. Email: betile@yahoo.com. 11-C1

For Lease

SUITE FOR LEASE — 2 OPERATORY: Sacramento Dental Complex — Midtown. Possible to purchase existing equipment. Great for new practice. Please call (916) 448-5702. 03-07

HIGHLY VISIBLE LINCOLN OFFICE SPACE — Divisable up to 8,000 sq ft for lease or purchase. Ground up built by a dental contractor specialist. Call (916) 772-4192 for details. 01-08

DENTAL OFFICE SPACE AVAILABLE FOR LEASE in professional building. Located in Elk Grove. 1800 sq feet, 5 operatory spaces, large reception room, business office, laboratory and private office. Ph Mel Bell (916) 479-1827. 03-08

DENTAL SPACE FOR LEASE —Nicely appointed space in established Carmichael dental building. 820 sf with 3 patient areas, reception, waiting, and private office/break room. $1.35 psf plus utilities. Agent (916)443-1500. 08/09-08

HIGH VISIBILITY TURNKEY OPPORTUNITY — Office located in North Natomas in Natomas Marketplace Shopping Center with 4 operatories fully equipped with ADEC Cascade Planmeca xrays, Miele Dental Disinfector and other top of the line equipment. 1600 sq.ft. (916) 928-9212. 08/09-08

SPACE FOR LEASE — Are you a specialist looking for a space to lease in Lincoln? If so, our new state of the art office may be the place for you. Our attractive upscale general practice is located in a professional building with plenty of patient parking. For more information, please call (916) 434-1400. 08/09-08

FOR LEASE: NEW DENTAL OFFICE scheduled to open in El Dorado Hills Oct 08. Facility has four ops with digital x-ray, paperless Dentrix software, electronic registration, intra oral camera. Newly furnished. 893 Embarcadero Suite 101 (916) 933-3787. 11-08

MERCY SAN JUAN HOSPITAL LOCATION — High visibility, Coyle Avenue. 1400 sq ft, 4 ops, 2 baths, business & private office. Share waiting room with high quality GP dentists. (916) 961-1111. 11-08

SDDS Members Can Place Classified Ads For FREE!

Selling your practice? Need an associate? Have office space to lease? Place a classified ad in the *Nugget* and see the results! SDDS members 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.

SDDS CALENDAR OF EVENTS

NOVEMBER

3 **NorCal Caucus for HOD**
6:30pm / Spataro

10 **SDDF Executive Committee**
Noon / SDDS Office

11 **General Membership Meeting**
The Five Things Everyone Wants from Their Job
Debbie Castagna & Virginia Moore (The Practice Source)
Staff Night
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:00pm Social
7:00pm Dinner & Program

12 **Alliance Board Meeting**
Noon / SDDS Office

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

14–16 **CDA House of Delegates**
6:00pm / Beverly Hills

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

18 **CE Committee**
6:00pm / SDDS Office

19 **Foundation Board Meeting**
6:30pm / SDDS Office

20 **Member Forum**
How Best to Handle Your Experience with Peer Review & Ethics
Panel of Experts
Peer Review & Ethics Committee
Sacramento Hilton — Arden West
2200 Harvard Street, Sacramento
6:30pm–8:30pm

21 **Continuing Education**
Nightguards Made Easy… In Your Office
Jim Hillier (Dentsply Caulk)
Sutter General Hospital Buhler Building
Cancer Center — Rooms 3 & 4
9:00am–11:00am

DECEMBER

1 **Membership Committee**
6:30pm / SDDS Office

2 **Forensics/Mass Disaster Committee**
Calibration
6:30pm / Sac County Coroner's Office

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

8 **Holiday Party**
6:30pm / Del Paso Country Club

9 **Dental Health Committee**
6:30pm / SDDS Office

10 **Alliance Board Meeting**
Noon / SDDS Office

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

15 **President's Thank You Dinner**
6:30pm / Sutter Club

24–26 ***Christmas Holiday***
SDDS office closed

ROUND UP YER POSSE FOR THE 29TH ANNUAL MIDWINTER CONVENTION
FEBRUARY 19 & 20, 2009 WE RECKON YOU'LL ENJOY IT. NOW, DRAW.

loads of ceu!

EARN **3** CE UNITS!

November 11, 2008:
The Five Things Everyone Wants From Their Job

Presented by:
Debbie Castagna & Virginia Moore
(The Practice Source)

Job satisfaction . . . loving the work you do is the wonderful result of having your personal needs met. Those "5 Things" may surprise you and will be revealed on Staff Night!

Our speakers promise to send you back to your practice feeling invigorated and excited about your potential for even greater work days!

6pm: Social & Table Clinics
7pm: Dinner & Program

Sacramento Hilton, Arden West
(2200 Harvard Street, Sac)

NOVEMBER GENERAL MEMBERSHIP MEETING: STAFF NIGHT

SACRAMENTO DISTRICT DENTAL SOCIETY

915 28th Street
Sacramento, CA 95816
916.446.1211
www.sdds.org