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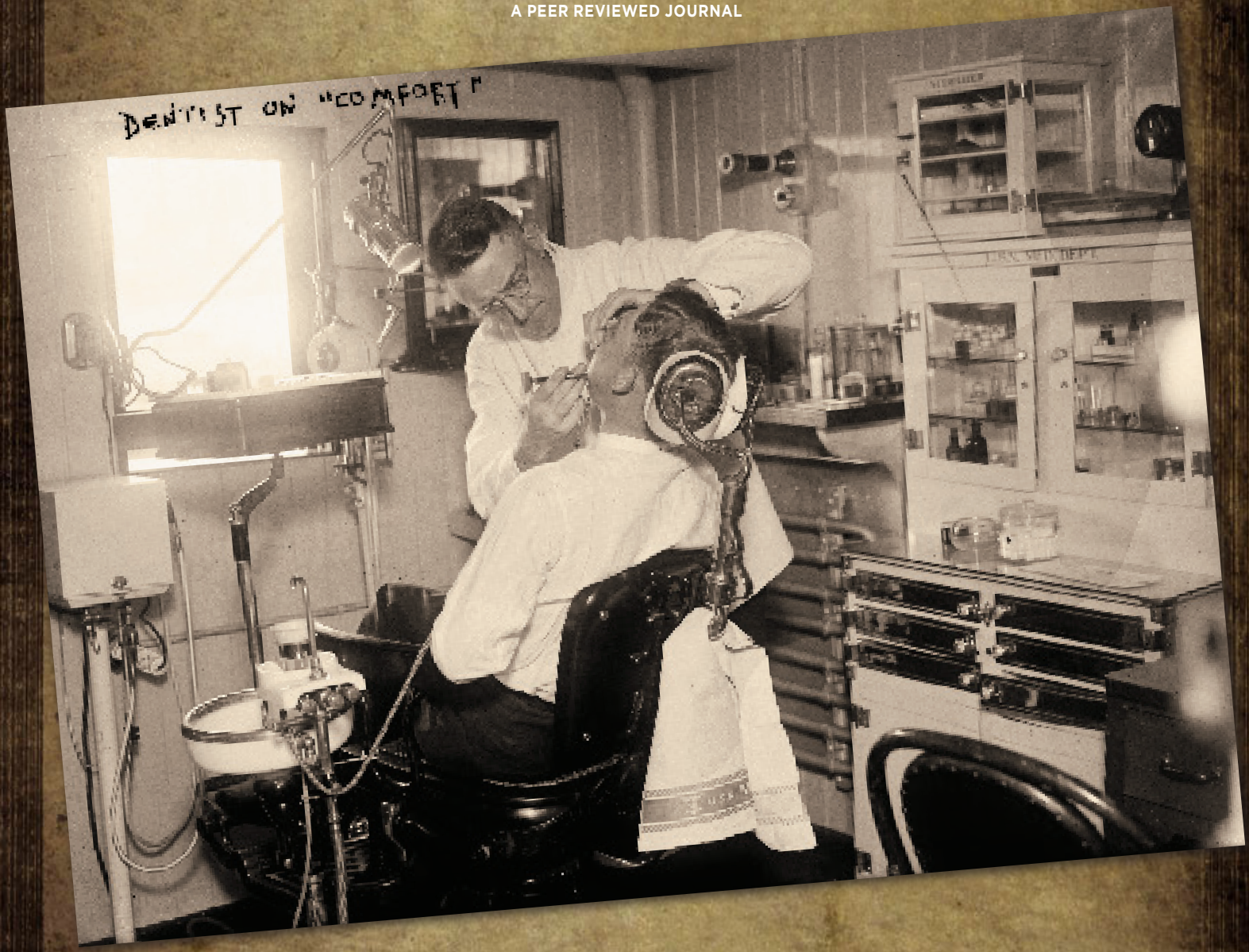
NDA JOURNAL

OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

A PEER REVIEWED JOURNAL



"Dentist on 'Comfort'" New York City, mid-1920s, Bain News Service, publisher

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NDA JOURNAL

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NDA JOURNAL

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It's *not* Easy, it's *not* Minor, *and* it's *not* Simple!

Daniel L. Orr II, DDS, PhD, JD, MD
editornda@nvda.org

Every once in a while, editors succumb to the temptation to opine a bit more openly, such as when the *Journa*l ran, "It's not Novocain, it's not an Allergy, and it's not an Emergency!"[1] Note the exclamation point. Once again, I'm giving in to the temptation to cautiously wag my journalistic finger at dental colleagues. So, consider this fair warning, as the exclamation point in the title indicates, my blood pressure may be a bit higher than normal as I write this piece directed at a common dental faux pas.

After recently reviewing a manuscript submitted for publication in a professional journal, I was reminded how doctors often foolishly sell themselves short. Avoidance of such unfitting conduct is something I learned early on in my professional career, not from studying for boards, but from my Mom.

Thank heavens for Mom, who agreed to help me get my practice started for a "few weeks" in 1980 and ended up staying over two decades. A serious argument can be made for having one's mom manage a practice, but that special circumstance isn't commonly a realistic option. I was fortunate Mom understood I needed all the help I could get. However, with regard to the subject at hand, what Mom taught me is something that can be shared, something that will benefit all health professionals.

Most of our moms observed closely what we went through to become dentists—starting with high school and undergraduate efforts made to successfully secure a coveted place in dental school, which was then arduously completed. At times, they saw the deferral of practice for a few more years to do advanced training. Moms know that the entire process of preparing to do what we do for our patients can consume nearly two decades. After all that training, going into significant debt to pay for the education, and consciously sacrificing the "good life" to study—while most in our age bracket weren't sacrificing or studying anything—it was logical for us to feel pretty good about being competent at artfully resolving a lot of difficult dental issues for patients. In fact, after a short time in practice, patients will often confirm that opinion, at times saying something like, "You're done? That was easy," after a procedure is completed. Somehow, in some dentists' minds, what had once been "difficult" when first studied morphed to "easy" after a few years. After a

Continues ➲

Dr. Orr practices Oral & Maxillofacial Surgery in Las Vegas, is a Clinical Professor of Surgery & Anesthesiology for Dentistry at UNSOM, Professor and Director of OMS at UNLV SDM, and is a member of the California Bar. He can be reached at editornda@nvda.org *or 702-383-3711.*

few such experiences, it is not surprising some doctors might even begin to advise patients scheduled for similar procedures that the future surgery, anesthetic, etc. will be "easy," "minor," "simple," or something similar.

After injudiciously opining to a patient that some procedure was "easy," "simple," "minor," or some equally inappropriate term, my good office manager/Mom, concerned about her son, gave me "the look," signifying someone had room for improvement (that would most often be me). Well, even if one is a doctor and Mom isn't, she's still Mom and needs to be respected (see the 6th Commandment). When no one else was looking, I finally asked, "What, Mom?"

Mom's invaluable pearl was that health professionals should not diminish what they can safely, successfully, and predictably do after years and years of study, training, sacrifice, and practice. If what we do was that "easy," "minor," or "simple," it wouldn't require decades to master. That Mom was right has been manifest throughout the years on several levels. Further, what good does it do to correct appreciative patients who think their doctor has done something singular and wonderful with, "Oh, it was easy?" It's much better to say something like, "We're fortunate that worked out as planned."

Plus, which cases turn out to be the most clinically, psychologically, or legally problematic? Aren't they often the ones that are seemingly straightforward, situations we have successfully completed without incident hundreds or thousands of times before?

That brings us back to the article being reviewed. Altruistic health professionals often don't naturally comprehend what Mom taught about injudicious false humility. The manuscript being prepared was by a well-know author for a major journal, but was peppered with inappropriate "easy," "minor," and "simple" type descriptors. The draft was later modified after a review questioning the potential legal considerations of using such terms. *What attorney wouldn't love to have a doctor describe something as "simple" right before everything falls apart?*

Doctors would have to look long and hard to find an "easy," "minor," or "simple" procedure that hasn't resulted in a lawsuit somewhere along the line.

And, by the way, please don't compromise a colleague's efforts by advising patients, for instance during second opinions, that something will be or should have been

Leta M. Orr, 1926–2010

"simple" for your fellow doctor to complete. Such nasty innuendo is almost always part of the genesis of health professional tort litigation.[2]

Dentists who find it is just too difficult to control their self-deprecation by continuing to denigrate years and years of sacrifice, study, and practice by dubbing their efforts "simple" are themselves in part to blame for providing fodder for the current politically correct low-level[3] dental provider paradigms being foisted upon our patients. After all, *if it's so simple, who needs a dentist? Call DentalZoom and schedule with a low-level provider.*[4]

Lastly, consider a quote learned from a non-doctor, Hall of Fame basketball player Bill Walton. A career-ending "simple" stress fracture didn't respond to usually predictable straightforward treatment in 1990. So, at age 37, Mr. Walton, who was subsequently confined to a wheelchair, wisely advised, "Minor surgery? That's when they do it on someone else."

Thanks again, Mom. ◆

Endnotes

1. Orr D, NV Dent Assn J, 11:3, 3-5, Fall 2009
2. Orr D, A Plea for Collegiality, J Oral Maxillofac Surg, 64:9, 1086-1092, 2006.
3. Personal communication with NDA President Michael Banks (thank you for correcting the Editor's previously errant description of entry level non-dentists as "mid-level")
4. Orr D, DentalZoom, NV Dent Assn J, 13:4, 3-5, Winter 2011-2012.

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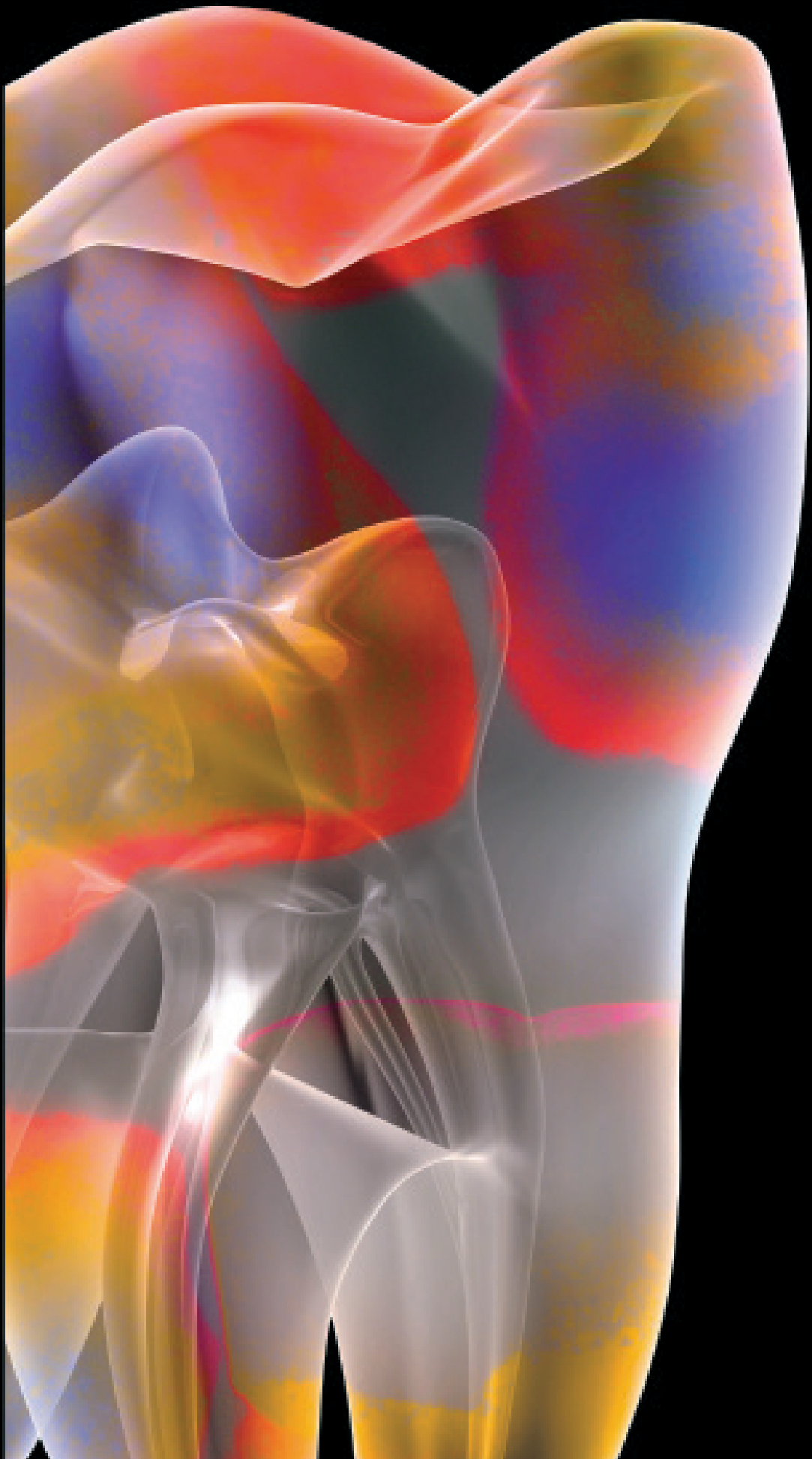

Robert H. Talley, DDS, CAE
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One of the things I don't like about writing a journal article is the fact that it is not timely. I write in March and you get it at the end of April.

In March, we lost another great NDA leader with the passing of **B.G. Smith** (*see obituary below*). B.G. served in the Southern Nevada Dental Society for many years and was a delegate to the NDA midwinter meeting this last January. He is the perfect example of a man who loved his profession and gave back to it continuously. Anyone who knew B.G. knows he was not afraid to voice his opinions, but his 'bark,' was always worse than his 'bite' and he kept us straight about how things were done in the society. He also understood the need for change.

He will be missed by me and countless others throughout the state.

Legislative Update

These are the legislative activities we are participating in:

- Interviews of candidates for State Assembly and Senate to educate them on our issues.
- Participation in selected Assembly and Senate caucus and individual functions to get to know new candidates and make some decisions on who we need to interview.
- Attendance and testimony on dental insurance for children and adults at the new Silver State Insurance Exchange meetings taking place as part of the Patient Protection and Affordable Healthcare Act.
- Development of a Patient Database form to be used by our members to sign their patients up to get information from the NDA about any legislative move to change the doctor-patient relationship.
- Development of a Dentist Pro Bono Work form for members to report to the NDA any charity work donated in a structured event or in their office so legislators know how much free work we are doing.

Annual Summer Meeting

The Annual Summer meeting is July 5–7 at the Hyatt Regency Monterey in Monterey, California. Please consider getting out of the heat and joining us in a truly beautiful part of the country. We were able to get a $199 per night rate at a great hotel. The signup sheet and details are on page 10 of this *Journal* and online at *www.nvda.org*. ◆

94th Annual Summer Meeting

July 5–7, 2012 • Hyatt Regency Monterey, Monterey, CA

In Memoriam—B.G. (Bill) Smith, DDS

B.G. (Bill) Smith, DDS, graduated from this life and into the hands of his Lord Jesus on March 9, 2012. Born in Thompsonville, Ill., in 1930, "B.G.," as his friends called him, was a veteran of the U.S. Army, serving in the 21st Infantry in Korea. Dr. Smith graduated from Loyola University Chicago School of Dentistry in 1961 and established a 42-year dental practice, but he never retired. B.G. was passionate for—and worked diligently at—the grassroots level to establish the UNLV School of Dental Medicine and was a member of the school's faculty until his passing at age 81.

He is survived by his loving wife, Barbara, of 62 years and their four children, Wally, Patti, Brad and Janeen; eight grandchildren; and six great-grandchildren.

In lieu of flowers, the family requests donations to the UNLV School of Dental Medicine.

Published in Las Vegas Review-Journal *from March 13 to March 14, 2012.*

As we prepare for the annual meeting in Monterey, my tenure as your President is coming to an end. We have charted a new course for the society that reflects our true position of being the authority on Oral Health Care. In hiring our new lobbyist, Chris Ferrari, we are positioning ourselves to gain ground in the legislature instead of retreating. Our Executive Director, Dr. Robert Talley, has been working feverishly with Chris to bring him up to speed. Chris understands our position on the issues and the executive board is very proud to have him onboard. His task is not a small one, but one that is based on the needs of all practicing dentists in the state of Nevada. We expect great things from him and he will represent us well in the legislature.

My biggest concern for the NDA is the question that was most recently asked at a Delegate meeting. The question is, "Why should I spend that amount of money for dues?" and continues with, "Am I getting anything in return?" I can honestly tell you that the price of membership is worth a lot more in terms of viability than money.

The utmost reason for membership is to retain the ability to practice in a private practice setting. This relationship is built on our ability to communicate, educate, and restore our patients to optimum dental health. It creates a relationship that is built on trust and on our ability to relieve pain, restore function and create esthetic results that our patients can only dream about. These are lifelong bonds that are forged in the true doctor-patient relationship. A bond that can never be replaced.

Also, membership in NDA brings legislative advocacy, peer review, continuing education, and a multitude of endorsed products. Yes, there is true value in membership, but only if we bond together and work through the issues intelligently and plot a course for long term viability.

I would like to thank

- The **Delegates** for their countless hours of work and dedication to our society.
- The **component presidents** have been outstanding leaders and have responded to the call of duty at a moment's notice.
- Our executive director, **Dr. Robert Talley**, who behind the scenes has built a conglomerate of positive relationships that will help us move our agenda forward.
- The **Executive Board** for their overwhelming support and understanding as we charted this new vision and a course for viability over time.
- The **legal and legislative committee** that provides fantastic insight to the political process and is courageous enough to make bold decisions!

And most of all, thanks to all of those pioneers who came before us that believed that there was no greater place to practice than Nevada! People like **Joel F. Glover, B.G. Smith**…who loved Nevada dentistry just like I do!

Your Society is in great hands! The course has been charted. The structure has been downsized for maneuverability and your new leader, **Dr. Gilbert Trujillo,** will take the society to a new level. Thank all of you for your support. As I become your past President. it will not diminish my efforts to always strive to make the society better. I will always be in the shadows offering my suggestions and help in any way to make a positive difference. ◆

Michael Banks, DDS

On the cover: The cover photo, "Dentist on 'Comfort,'" comes from the George Grantham Bain Collection, a collection that represents the photographic files of one of America's earliest news picture agencies. The photographs Bain produced for distribution through his news service were worldwide in their coverage, but there was a special emphasis on life in New York City. The bulk of the collection dates from the 1900s to the mid-1920s, but scattered images can be found as early as the 1860s and as late as the 1930s. The cover image can be found online as part of the Library of Congress Prints and Photographs Division at *http://hdl.loc.gov/loc.pnp/pp.print*.

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94th Annual Summer Meeting

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July 5–7, 2012

Schedule

Thursday, July 5

Registration	1–5 PM	
Executive Committee Meeting	3–5 PM	Oak Tree Room 1–3

Friday, July 6

Joel F. Glover Fun Run & Pizza	6 AM Run / 7 AM Breakfast	Knuckles Sport Bar
HOD I—Leadership Training	8–11:30 AM	Pebble Room
North–South Golf Tournament	1 PM	Bayonet Golf Club
President's Dinner	6:30–8:30 PM	President's House

Saturday, July 7

Pliney Phillips Breakfast	8–9 AM	Pebble Room
HOD II	9 AM–12 NOON	Pebble Room
HOD, Academy and College Lunch	12:30 PM	Pacific Room

Registration Form

NDA 94th Annual Summer Meeting, July 5–7, 2012
Hyatt Regency Resort • Monterey, California

Event	Time	Number Attending	Fee (per person)	Total payment
Registration—NDA Member/Spouse/Child		_____	$ 0	
Registration—Non-NDA member (required)		_____	$ 300	$_____
Registration—Non-ADA member (required)		_____	$ 500	$_____
Thursday, July 5				
Executive Committee Meeting	3–5 PM	_____	$ 0	
Friday, July 6				
Joel F. Glover Fun Run & Pizza Breakfast	6 AM Run 7 AM Breakfast	_____	$ 35	$_____
House of Delegates—Session 1	8–11:30 AM	_____	$ 0	
North–South Golf Tournament	1 PM	_____	$ 100	$_____
President's Reception/Dinner Adult	6:30–8:30 PM	_____	$80	$_____
President's Reception/Dinner Child (5–12)	6:30–8:30 PM	_____	$40	$_____
Saturday, July 7				
Pliney Phillips Breakfast	8–9 AM	_____	$ 35	$_____
House of Delegates—Session 2	9 AM–12 NOON	_____		
College and Academy Lunch (ACD, ICD, ADI and PFA members & spouses)	12:30 PM	_____	$ 60	$_____
Grand Total				$

Note: Registrations will be accepted until June 27, 2012.
No refunds given past June 27, 2012. Hotel reservations and pricing are only guaranteed through June 12, 2012.

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Letters to the Editor

Dear Dr. Orr,

It has come to our attention that if an office is not contracted for the "plan" offered by some carriers (i.e. some Delta, Blue Cross and Blue Shield contracts), the carrier will pay benefits directly to the patient in spite of a valid assignment to the dentist. We did some research and found NRS 689A.135, which states that if the patient has assigned benefits, the insurer is obligated to pay the benefits to the person designated by the insured. If the insurer still pays the benefits to the insured, they must also pay the benefits to the assigned dentist upon receipt of a copy of the assignment.

We have experienced incidents where we are assigned benefits, but the insurer has paid the patient directly. The patient cashes the check, and we are then told by the carrier that their obligation has been fulfilled. We then are forced to try to do the most difficult extraction of all....extracting the payment from the patient! We have considered attaching a copy of NRS 689A.135 to our claims submitted to these particular carriers. Please comment on this situation.

Very sincerely,
Karen Lasiter

Editor's Note: *The* Journal *thanks Mrs. Lasiter once again for her input regarding issues of concern to dentists. The* Journal *has also included a sample assignment of benefits, developed from several sources including Dr. Lasiter's own form, for use by the membership prn.*

When an insurer illegally pays someone other than the assigned, the law is clear that the assigned must also be paid directly by the insurer. The insurer may then seek reimbursement from the assigning patient. Any insurer operating under the authority of the Nevada Insurance Commission (NIC) should be responsive to the NRS. If the payer is not functioning via the NIC, such as a private trust, the assignment is still valid but the NIC will not likely be a resource when controversies arise.

Sample assignment of benefits letter

ATTENTION INSURER

Please be advised that our patient has assigned benefits to be paid directly to:

_____

Per Nevada Revised Statute 689A.135 and 629.031:

NRS 689A.135 Assignment of benefits to provider of health care.

1. A person insured under a policy of health insurance may assign his or her right to benefits to the provider of health care who provided the services covered by the policy. The insurer shall pay all or the part of the benefits assigned by the insured to the person designated by the insured. A payment made pursuant to this subsection discharges the insurer's obligation to pay those benefits.
2. If the insured makes an assignment under this section, but the insurer after receiving a copy of the assignment pays the benefits to the insured, the insurer shall also pay those benefits to the provider of health care who received the assignment as soon as the insurer receives notice of the incorrect payment.
3. For the purpose of this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.
(Added to NRS by 1983, 879)

NRS 629.031 "Provider of health care" defined. [Effective January 1, 2012.]
Except as otherwise provided by a specific statute:

1. "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, physician assistant, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, podiatric physician, licensed psychologist, licensed marriage and family therapist, licensed clinical professional counselor, music therapist, chiropractor, athletic trainer, perfusionist, doctor of Oriental medicine in any form, medical laboratory director or technician, pharmacist, licensed dietitian or a licensed hospital as the employer of any such person.
2. For the purposes of NRS 629.051, 629.061, 629.065 and 629.077, the term includes a facility that maintains the health care records of patients.
(Added to NRS by 1977, 1313; A 1983, 1492; 1987, 2123; 1991, 1126; 1993, 2217; 1995, 1792; 1997, 679; 2003, 904; 2005, 69; 2007, 3041, 3050; 2009, 2942; 2011, 1092, 1510, 2678, effective January 1, 2012)

Release and Assignment:
I hereby authorize Dr. _____ to release to your company records of any information regarding my diagnoses and treatment during the period of care.

I also assign to Dr. _____ the amount due to me in my claim and direct your company to pay Dr. _____ directly the amount due me in my claim for services Dr. _____ has provided.

Patient: _____

Signature: _____

Date: _____

Dear Mr. Kellogg

By Ken Jones, DDS, JD • Reprinted with permission of the Ohio Dental Association and Dr. Jones

To those who run the Kellogg Foundation:

Okay, let's talk. Maybe we can find some middle ground. Or maybe we can't. Maybe we can figure out a way to do what you think you want to do —provide dental care for everyone— and also to do what I think needs to be done to do just that—and do it the right way.

Do we need Alaska-style DHATs as Mid-level Providers in Ohio and the few other target states where you're pushing the legislatures to do the dirty work? Maybe, maybe not. Will they solve all the dental care and access woes in Ohio? Not in my lifetime. Will they provide care—whether good, bad or indifferent—in the areas that actually need more dentists and dental care? Don't make me laugh.

Here's what I said in August 2005. Sometimes you have to say something a number of times before the message sinks in. So let me say it again in January 2011 and tell you that it's even truer and more relevant today than it was five and a half years ago.

> "I've been a member of organized dentistry for over three decades, and I'm tired of wearing sack cloth. My fault? I don't think so.
>
> Dentistry has worked its collective butt off for years to "solve" the problem of access to dental care. We've worked at prevention and education and charity since dentistry evolved from bloodletting and barbershops. It hasn't worked to date, and, unless fundamental changes are made in our society's attitudes, access will remain a bone of contention and controversy forever.

The view that isn't often publicly espoused is one with which I agree — specifically, that there is a segment of the population that must change its psychological and sociological perspectives in order to improve its own fortune. I'll help, but I can't [and won't] try to do it alone. They need to accept some of the grass-roots views of us grassroots dentists as valid. Like these, that show how priorities are getting out of whack:

1. At least three-fourths of my Medicaid patients use only cell phones. I stood behind a patient at Verizon while she discussed her $235 monthly phone bill.
2. Money spent for tongue studs, body piercing, tattoos, smokes, soda and bottled water should instead be used to support the family.
3. Ortho, implants, bleaching, and crowns for esthetics are a privilege, not a right. And if Medicaid patients offer to pay for them out of their pockets, why am I doing their discounted dentistry that they get for nothing?
4. Fluoride is still the best preventive tool we've found. It needs to be in every water supply, and it's not.
5. Learn to think beyond the next half hour. Show up for appointments with those who are trying to help you. I'm told that a lot of Medicaid recipients don't even bother to pick up their monthly benefit cards.
6. Pain meds are not definitive dental care. Don't ask for [or demand] them from me. Ibuprofen works wonders.
7. Parents need to teach their kids it's not okay to be 15 [or any age, for that matter], never married, and have multiple kids that society pays for. Parents need to accept more responsibility for their kids' actions."

So what else can make the difference? How about putting everyone on the same fee schedule? Some of us get our whole fee by qualifying for federal funds to supplement state funds. Others can't get that special, preferential treatment. Maybe some of that $16 million that you're holding out to grease the legislative wheels could convince me to do more if it actually would end up in my pocket, hmmm?

Then, how about requiring Medicaid recipients to get dental treatment (at least for the kids) in order to get their monthly check? That might solve a lot of the "chronic need" problem. Acknowledge the fact that I will *not* take the blame for others' poor choices in life. Require changes in those poor choices or remove the state's support system. Support a return to the ability of the U.S. Public Health Service to provide care for those who can't afford the basics. Maybe we could use those facilities to actually do some dental service instead of allowing the leadership and care providers to drop to a level that puts us to shame.

Then, maybe we can solve that "access" problem. Maybe we could even solve it and stay a profession that I'd be proud of.

And then, Mr. Kellogg, maybe I will eat a bowl of Corn Flakes again. ◆

Master Shifu

By Drew Jones, DMD, Utah Dental Association • Reprinted with permission from Utah Dental Association, Nov/Dec 2011

Recently I was at a restaurant with my family. A mother with a five- or six-year old daughter came in. As we were standing in line, I had a brief conversation with the woman and her daughter. I mentioned how dressed up they were and the little girl said that they had been to a wedding. I figured it must have been a regular Utah wedding where only punch, cake and a few nuts had been served. That explained why they were at the restaurant.

The little girl was dressed immaculately. She was wearing a new dress. Her black hair was all combed and held back with fancy pins. She had big brown eyes that sparkled. She looked like a kid on her way to Easter—when kids got really dressed up for Easter. She had white socks and shiny black shoes. Everything about her looked perfect except for her shoes. They were on the wrong feet. She had her right shoe on her left foot and her left shoe on her right foot. I didn't say anything to her mother as I am sure it would have embarrassed the little girl and spoiled her day.

How many times do we do everything right and then make one small mistake that we may not even know we have made? I know I make small mistakes in dentistry every day. With 10X magnification, who doesn't? I can even find mistakes with no magnification. Everything about dentistry is in millimeters and fraction of millimeters.

How many times have I done a root canal only to take an x-ray and see the fill is 1 mm short or long? How many crowns have I put on with "open margins or ledges" when I enlarged the tooth with my digital x-rays? How many composite fillings have had recurrent decay only a year or two after I placed them? Did I make a mistake, or was it the patient's neglect? How many amalgams (yes, I still do them) have I discovered overhangs on with my six-month recall x-rays? A lot of times I do my dentistry and I am like that little girl with her shoes on the wrong way—I didn't even know I had made a mistake. I went on my way, thinking everything was great.

Most of the time when I see a mistake, I fix it free of charge. But I don't have a set policy. There are too many factors—the patient's personality, the patient's homecare, the patient's age and health, how bad the problem is, and

Illustration credit: Erin S. Tripp with permission from Mills Publishing, Inc.

Drew Jones, DMD is the Editor of UDA Action, *the official publication of the Utah Dental Association. He can be reached at drdukejones@hotmail.com.*

many other factors. **I guess I have two rules. First, treat your patients the way you would want to be treated. Second, don't let money determine your decision.** It can be hard to tell the patient that the crown you put on last year needs to be replaced—and you will do it free of charge. But it is harder if the patient goes to another dentist who tells the patient that the crown you put on last year needs to be replaced and the new dentist will do it for $800.

I have seen *Kung-Fu Panda 2* three times. I like Master Shifu. I have the McDonald's Happy Meal version of him on my desk. He is a wise teacher, kind of like Yoda from *Star Wars*. He teaches Po, the dragon warrior panda, that you need inner peace to be successful at kung fu. **I have found that making mistakes destroys the inner peace of a dentist, but that fixing them builds inner peace.**

As dentists we try to do everything perfectly. But it is just not possible. Someone described dentistry as trying to build a Swiss watch in a small, dark cave while it is being spit on all of the time. Surprisingly, most of the time we are successful, even when everything is measured in millimeters or less. But sometimes, even when we think everything is great, we find out later that we made a small mistake. Our shoes were on the wrong feet and we didn't know it at the time. But we know that we can correct those mistakes—sometimes free of charge—and find inner peace. I just checked Master Shifu's shoes and they are on the right way. Inner Peace. Inner Peace. ◆

"Administer" or "Dispense" a Medication—*What's the Difference?*

By Larry L. Pinson, Pharm. D., Executive Secretary, Nevada State Board of Pharmacy

The Nevada State Board of Pharmacy is often queried by practitioners about the "dispensing" of medication to their patients. The ensuing discussions frequently often reveal confusion as to just what "dispensing" actually means, as practitioners may interchange "administering" and "dispensing." In actuality, the two acts are completely different, one (dispensing) requiring a license from the Board of Pharmacy. To clarify:

1. The act of "administering" a medication to a patient in your office is perfectly legal; within your scope of practice; and requires no special licensure.
2. The act of "dispensing" a medication from your office to a patient for his or her self-administration away from your office requires registration with the Board of Pharmacy because you are now acting as a pharmacy by dispensing, not prescribing for a pharmacy to dispense, and must abide by rules that mimic requirements for a Nevada pharmacy:
   a. You must hold a "dispensing practitioner" license.
   b. Your dispensing site needs a pre-opening inspection by a Pharmacy Board Inspector and will be inspected annually thereafter.
   c. You must properly store and secure your stock.
   d. You must properly label anything dispensed as does a pharmacy.
   e. You must dispense in a "child proof container" as does a pharmacy (the "little brown envelope" of the past is unacceptable!).
   f. You must personally counsel the patient as to the use of the medication, side effects, warnings, etc. as does a pharmacist.
   g. You must keep records as does a pharmacy.
   h. You must report your dispensing of any controlled substances to the Controlled Substance Prescription Abuse Prevention Task Force by computer.

The bottom line is that anything that walks out of your office that requires a prescription, which is indicated by an "Rx Only" on the label, is considered "dispensing" and would include such things as prescription toothpaste, chlorhexidine, and many fluoride preparations. OTC products, such as ibuprofen, are no problem. Whether you charge or not for a dispensed medication has no bearing. ◆

Any questions regarding the dispensing of prescription medications can be directed to Larry Pinson, Executive Secretary of the Board of Pharmacy, or to Carolyn Cramer, General Counsel, at 775-850-1440.

Editor's Note: *The NDAJ thanks Drs. Dwyte Brooks and John DiGrazia for bringing this issue to our attention.*

Larry L. Pinson, Pharm. D., is the Executive Secretary to the Nevada State Board of Pharmacy. He can be reached at 775-850-1440.

NRS 639.23507—Rx Check…

NRS 639.23507

Patient utilization report required before writing prescription for controlled substance.

A practitioner shall, before writing a prescription for a controlled substance listed in schedule II, III or IV for a patient, obtain a patient utilization report regarding the patient for the preceding 12 months from the computerized program established by the Board and the Investigation Division of the Department of Public Safety pursuant to NRS 453.1545 if the practitioner has a reasonable belief that the patient may be seeking the controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition and:

1. The patient is a new patient of the practitioner; or
2. The patient has not received any prescription for a controlled substance from the practitioner in the preceding 12 months.

The practitioner shall review the patient utilization report to assess whether the prescription for the controlled substance is medically necessary.

(Added to NRS by 2007, 735) ◆

Editor's Note: *The NDAJ took advantage of Pharmacy Issue I in this issue to query Dr. Pinson about NRS 639.23507, thus generating the following e-mail correspondence. Also, the NDAJ is on record supporting Dr. Pinson's feeling that dentists would be well-served by accessing the PMP databank.*[1]

In addition, as noted in the Editor's e-mail below, and in "A Good Rx,"[1] *there are frequently errors in government databases and doctors are likely not indemnified when relying on such faulty data.*

February 3, 2012

Dear Dr. Pinson,

How would you interpret NRS 639.23507? For instance, if a dentist performs surgery that will predictably result in post-operative pain, is he/she mandated to access the databank, or does the treatment legitimize the Rx? No matter what the databank says (which may or may not be accurate), is it appropriate to deny a patient an Rx for a painful procedure because the patient may coincidentally be listed in the databank?

Thank you,
Dan Orr

February 3, 2012

Dear Dr. Orr,

In response to your question, I am no attorney, however my take is one of common sense (whatever that is) which would absolutely allow a dentist to treat the pain post painful procedure, regardless of what the PMP reports. Note the verbiage states " a reasonable belief that the patient may be seeking the controlled substance…for any reason other than the treatment of an existing medical condition." It then goes on to talk about "medical necessity." The procedure just completed would be the "existing medical condition" and the treatment of pain certainly a "medical necessity," so I am not feeling that accessing the database would be mandated. Having said that, I do feel that having the PMP data would be helpful to the practitioner regardless; knowing the "narcotic naivety" of your patient often dictates how you will deal with that patient's pain.

Larry L. Pinson, Pharm. D.

Endnotes

1. Orr, DL, "A Good Rx," NV Dent Assn J, 12:2, Summer 2010, pp 4-5.

A Simple Technique for Opening the Vertical Dimension of Occlusion as an Aid in Solving Challenging Restorative Problems

By Joseph C. Tomlinson, DMD

Abstract

The technique presented in this paper allows general dentists and specialists to more effectively treat a wide variety of conditions in a simpler and far more affordable manner, bringing better dentistry to more patients than ever before. The technique itself is very simple. It consists of applying a composite build-up to the occlusal surfaces and cusps of two or more teeth on each side of the mouth. The teeth I recommend selecting for this procedure are the four lower premolars. However, variations of the technique are acceptable, and are discussed later in this paper.

Introduction

Many times during the course of a typical week in the dental office, we are faced with a situation where the patient's teeth are heavily worn, either in the molars and premolars, or the upper and lower anteriors, or both. If the teeth have not passively erupted to compensate for that wear, we may be faced with a difficult challenge in restoring any one of the teeth, especially if the patient needs crowns but can't afford full-mouth reconstruction, or can't afford more than one or two crowns at a time over the course of a year. In such cases, gaining an extra two to three millimeters of inter-occlusal space can make a huge difference in allowing us to accomplish something that will be durable over time and acceptable in function and appearance. In these situations of excessive wear, utilizing the technique presented in this paper can facilitate achieving a positive solution for both the patient and the dentist.

Technique

This can be performed with any type of durable, tooth-colored composite material. I prefer to use a three-step (etch, prime, bond and composite) technique using Kerr Optibond. More specifically, I etch the enamel, rinse and dry, prime and dry, bond and cure, reapply bonding, and then apply a composite buildup to the cusps and occlusal surfaces of at least two teeth on each side of the mouth to a height of two to three millimeters. I overbuild the teeth slightly so that, as the bite is checked and adjusted for balance, and polished for smoothness and comfort, the end result is a total height increase of two to three millimeters. This can be reduced if less space is needed, or if the patient doesn't tolerate this amount of opening. While I haven't tried using a two-step or one-step product for this procedure, manufacturers of those products indicate that they bond as well as a three-step technique.

For many patients, the four lower premolars are selected for this procedure. (*See Figure 1*)

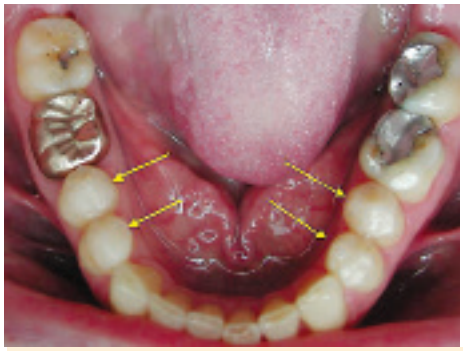

Figure 1: *Four lower premolars have been built up two to three mm with composite. Photo was taken more than two years after procedure was initially performed.*

For others, the four upper premolars are selected; and for some, the buildup is divided between upper and lower premolars. In some cases, the procedure may involve using one or two molars, especially if the cusps are heavily worn or cupped out, or show signs of excessive wear and would benefit from being restored to their original unworn shape and contour. This is particularly helpful when some of the premolars are crowned or otherwise unavailable for this purpose. Regardless of whether the teeth selected are in the lower arch, the upper arch, or a mix of upper and lower arches, **what matters most is that there are at least two teeth on each side of the mouth, resulting in**

occlusal contact on at least four teeth in each arch. This is to prevent overloading any one tooth with an excess of occlusal stress and possibly damaging it.

Another important factor in deciding which teeth to bond is the effect created on the esthetic transitions from the anterior teeth to the built-up premolars and/or molars. In other words, this procedure should be planned to provide the best esthetic enhancement (*See Figure 2*), rather than creating a cosmetic problem.

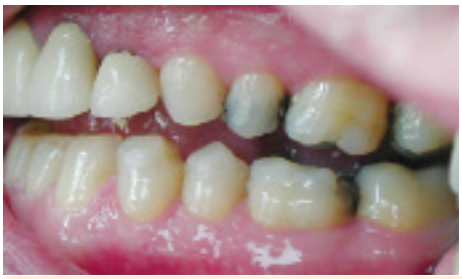

Figure 2: *Side view of build-up on teeth #20 and #21 reveals harmony in appearance with nearby teeth.*

Obviously, it is important to avoid creating any new problems, such as abnormal lateral shifting of the bite, which could lead to stress or strain on one or both TM joints, or an uneven function of the muscles of mastication, resulting in fatigue and muscle spasm, or to cause a hypersensitive tooth. To minimize problems with the bite, the modified teeth on both sides of the mouth must contact at the same instant when the teeth are closed together. In addition, the patient must be able to move the lower jaw and teeth freely from side to side and forward and back. If new occlusal contacts turn out to be heavier on one side than on the other, or if a "slide" is created, or if muscle tightness occurs, or if any soreness develops in the joints or in the teeth, appropriate adjustments must be made until those problems are corrected. Urge the patient to call the office for minor reshaping (or major reshaping if necessary) if contact problems are noticed, and for relief of any soreness that may have developed in the teeth, muscles or joints. It has been my experience that most patients undergoing this procedure have reported being able to relax more, breaking up their patterns or habits of chronic clenching or grinding. This is borne out by the fact that they rarely wear down or chip off the composite material.

Educating the patient is a big part of this technique. This should always precede performing the procedure. The patient must be educated as to why their condition causes concern, and how utilizing this technique could help solve these difficult and challenging problems. In addition, the patient should be shown how the treatment will help to improve the long-term prognosis for the subsequent restorative treatment. This will make the patient's investment in his or her teeth more predictable, both initially and in the long-term.

The patient must also understand that this procedure will not harm the teeth by applying this material, nor will it cause them to need crowns or other treatment they didn't already need. The molars, which are initially left out of contact after the composite is applied to the premolars, tend to passively erupt into contact over a period of four to six months. For some patients, passive eruption of the molars does not occur. In those cases, the molars will need to be restored with onlays, crowns, or composite build-ups, or repositioned orthodontically to establish normal occlusal function. This potential need for crowns, even

Continues ➲

on otherwise healthy molars, should be discussed in advance with the patient.

Patients must be informed that the *bite will feel strange* for the first week or two, possibly as long as a few months, and they will have difficulty eating some foods. In addition, they may find their speech affected slightly, at least initially, until the anterior teeth are restored, or realigned, if orthodontic treatment was planned.

In addition to educating the patient, a **trust level** must be established with the patient before this procedure is performed. It is best to offer this service only to patients you have known awhile, people who already trust your skills and clinical judgment.

Discussion and Application

This technique allows the opening of the Vertical Dimension of Occlusion (VDO) in a simple, straightforward manner. It has a variety of applications across several disciplines. One such application is the restoration of difficult and challenging conditions such as an edge-to-edge anterior bite, which has resulted in excessive wear and chipping of the upper and/or lower anterior teeth. (*See Figure 3*)

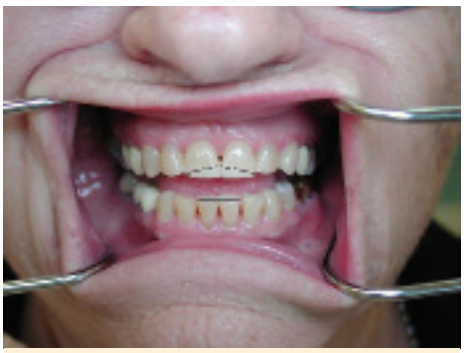

Figure 3: *Black lines across the upper and lower incisors depict the pre-treatment level of wear of these teeth. Upper and lower incisors were edge-to-edge prior to opening VDO, leaving no space to add restorative material to develop a normal shape and contour. Photo was taken more than one year after procedure was performed.*

It is impossible to restore teeth in this condition to a normal incisal-gingival length without opening the vertical dimension of occlusion, or undertaking a major treatment alternative.

Common treatment alternatives to create inter-incisal space, to permit teeth in this condition to be restored, are orthodontic realignment, surgical repositioning of the lower jaw, or surgical repositioning of the upper anterior segment of teeth and the alveolar process. All three alternatives are costly and constitute a major undertaking, something that many patients will refuse to consider.

Traditionally, opening of the VDO usually means placing crowns on most of the teeth (full mouth reconstruction), an area generally reserved for prosthodontists, or others with special advanced training. In addition, such treatment is limited to a select few patients who have substantial financial resources.

Another application of this technique for opening the vertical dimension is to create inter-occlusal space in the posterior regions, making it easier to place crowns on teeth with short clinical height, or on teeth with heavily worn chewing surfaces. Teeth in that condition have inadequate inter-occlusal space available for a normal thickness of material. In addition, the risk of pulpal exposure is high and retention can be a problem due to the shortness of the walls retaining the crown. By opening the vertical dimension of occlusion, it is possible to restore the molars with minimal to no occlusal reduction during crown preparation. The space gained from opening the vertical dimension allows us to achieve an adequate thickness of material on the occlusal aspect of the crown and avoid exposure of pulp horns lying close beneath the heavily worn surface. In addition, the retentive walls will be shortened much less than they otherwise would be, resulting in far better retention of the crown.

More importantly, some of the molars and premolars may not be as heavily worn, and will not require crowns at all, especially if passive eruption is allowed to occur, as it often does in these cases. For those teeth that need to be crowned, this can be staged over time so that patients who need assistance from their dental insurance plans, or who simply need to pay for the treatment over time, can end up with an outstanding result. For those patients in need of full mouth reconstruction, and who have committed to paying for it, this technique can serve to test the patient's tolerance for the new position of the mandible before commencing with the major reconstruction procedures. This testing of the opening of vertical dimension may uncover previously unknown sub-clinical TMJ issues.

I have been reluctant to recommend this procedure for patients with known TMJ signs or symptoms. However, I did recommend it to one of my TMJ/TMD patients for several reasons. First, I thought it might actually help reduce her muscle spasm problems. Secondly, we agreed that if, at minimum, it didn't make her TMJ muscle problems worse, her other malocclusion conditions would greatly benefit from this procedure. To the delight and amazement of both of us, it actually provided almost immediate, profound, and permanent relief from chronic muscle symptoms and spasms thought to be TMJ related. This patient was so pleased by the results she asked why more dentists didn't provide this service, and why we didn't do this years earlier. When told that no one was teaching this technique in 2003, she insisted that it should be more widely taught. She remarked that if no one else was teaching this technique, then I should be the one to teach it to other dentists,

as she was sure there were a lot of people out there who would benefit from this. I promised her I would look into it, but only after something was published on the subject.

Benefits

The greatest benefit of this technique is to gain space inter-occlusally and inter-incisally for obvious reasons already discussed. Another benefit of this technique is to be able to test a patient's tolerance and adaptability to an increased vertical dimension of occlusion before commencing with more involved restorative treatment. A reasonable time period for most patients to decide if they are going to find this new position agreeable and either comfortable or at least tolerable, is three to five weeks after the composite buildups are completed.

No tooth preparation is required for this technique, making it *completely reversible*. This is important in case the patient should decide that he/she doesn't find this change to be acceptable or tolerable. For many patients, after a period of four to six weeks, passive eruptive movement by the molars will have begun to occur, making it less possible to fully reverse this procedure. Since passive tooth eruption is a desired result for many of the patients, this should be viewed as a positive effect (benefit). However, if it is desired to utilize the inter-occlusal space for achieving an adequate thickness of material for new crowns that are planned, it is best not to wait much longer than six weeks to commence with the crown treatment, or the space created may be lost due to the passive molar eruption. (*See Figure 4*) If it is desired to prevent passive molar eruption, this can be accomplished by applying composite to the occlusal surfaces of those teeth within a few days or weeks of initiating treatment, if it hasn't been done in the beginning.

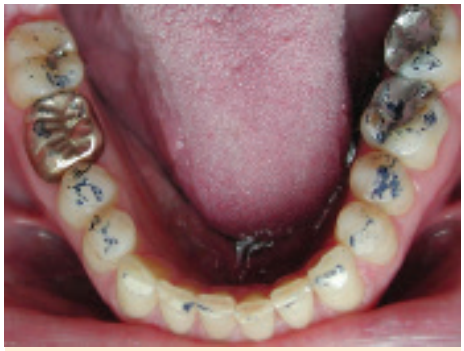

Figure 4: *Blue marks on occlusal surfaces of this patient's molars confirm they have passively erupted into occlusal contact over time. The gold crown was made prior to opening of the VDO. The two molars on the right have been crowned since this photo was taken.*

Of all the patients treated to date by the author, which includes about 25 during the past 10 years, a few in the five years prior to that, and the very first one over 25 years ago, none have requested reversing this procedure. None have wanted to end the quest to achieve the goal that was established. None have ever expressed dissatisfaction with the overall outcome. In fact, all have been pleased that it has corrected a long-standing problem.

History

The genesis of this concept came about while I was evaluating and treating an unusual anterior cross-bite condition that my mother had developed early in my dental career. I determined that this patient needed to see an orthodontist to correct this, or else have her lower incisors extracted and replaced with a removable partial denture. Neither option was acceptable to her, and she challenged me to think of a better solution. The only idea I could think of was one based on certain principles I had learned during orthodontic classes taught by Dr. William Proffit, professor of orthodontics and department chair, when I was a student at the University of Kentucky. I decided that a temporary bite opening procedure using a composite material fixed to the lower premolar teeth might be a solution. It was at least worth a try. What started out as a temporary bite opening for my mother, to help in the correction of her late onset anterior cross-bite, evolved into a permanent and stable new Class I bite relationship for her, without the help of orthodontic treatment. The results were so astounding and unexpected, that it took me awhile to comprehend just what we had accomplished so serendipitously. Gradually, I gained confidence that I could incorporate this concept into my treatment protocol for other patients with worn dentition problems without causing them harm. I began to offer it to more and more of my patients with heavily worn dentitions, especially those with heavily worn incisors. It has also been used for other conditions, such as flared upper incisors, and even for sagging faces that I determined were the result of a loss of vertical dimension of occlusion.

Untoward outcomes or results

So far as I know, there have been no untoward outcomes. Most of the patients treated with this technique continue to see me for regular cleaning and check-up visits. If there is any dissatisfaction, and this is rare, it is that the composite material is wearing down, and they need a little supplemental treatment to re-establish the vertical dimension again. Most patients, however, do not lose the vertical dimension gained as it becomes stabilized by the molars that have passively erupted into occlusion, or have been restored with crowns.

Summary

The chief advantage of this technique is to create an adequate amount of space between the upper and lower anterior and posterior teeth so those that are most in need of restoration may be properly restored, achieving

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more ideal proportions for cosmetic and functional results, as well as greater durability. In many cases, only a few teeth will need to be crowned, rather than all the teeth in the mouth. While full mouth reconstruction will still be necessary for some patients, this technique will greatly assist in the transition, both functionally and financially.

The second major advantage is that, for patients with otherwise healthy posterior teeth (not otherwise in need of crowns), the potential for passive molar eruption is high. When it occurs, it eliminates the need to restore them while correcting problems in the anterior part of the mouth, greatly reducing the costs for these patients compared to the cost of full mouth reconstruction. ◆

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Editor's Note: *Dr. Tomlinson's 2007 article above is reprinted with the permission of the* Colorado Dental Association Journal. *At the NDAJ's request, Dr. Tomlinson submitted the supplemental report to the NDAJ.* *(See page 23.)*

Utilizing a Simple Technique for Opening Vertical Dimension of Occlusion

A discussion of two cases treated since 2007

By Joseph C. Tomlinson, DMD

Since writing and publishing my article, "A Simple Technique for Opening Vertical Dimension of Occlusion as an Aid in Solving Complex Restorative Problems" in 2007, I have continued to recommend and practice this technique on a number of patients. There seems to be so many useful applications, even beyond restorative considerations. For example, in one rather simple case, a long-time female patient in her early 50s was experiencing a common aging phenomenon of down turning of the corners of her mouth. In addition, she was developing increased spacing of her upper anterior teeth. It was determined that the spacing of these teeth was resulting from increased pressure exerted against their lingual surfaces when making contact with the lower incisors over time. This was the result of a slight loss of vertical dimension of her posterior teeth over a few decades in function. After explaining the procedure that I planned to use to attempt to correct this, or to at least improve it, and obtaining the patient's consent to treatment, I applied a 2–3 mm layer of composite to all four of her lower premolars as explained in the technique described in my 2007 paper. The immediate effect was that the corner of her mouth became better supported and no longer turned down, resulting in a happier and brighter looking expression, as well as a younger looking appearance.

The delayed effect was that the upper incisors began to upright and move in a lingual direction toward a more favorable position from which they had been forced to move slowly over many years. This allowed the spaces between these teeth to close slightly, enough to improve the overall appearance—to the patient's great satisfaction. This resulted from altering the balance of forces on these teeth as follows: by increasing the VDO, the pressure on the lingual surfaces of these teeth placed on them by the lower incisors was eliminated. She could still get them into contact for eating but they were not in contact when she closed her teeth together. This allowed daily light pressure from the upper lip to slowly press these teeth lingually until they were in balance with other forces, including the tongue, from the lingual side. No other restorative treatment was needed in this case as the molars passively erupted into full occlusion within six months—typical with this VDO procedure.

In these challenging economic times it is amazing what great improvements we can achieve for our patients with simple procedures and very little cost. In this case, the cost was limited to charges for placement of composites on four lower premolars. Since this involves no anesthetic and no removal of tooth structure, I typically charge for a two or three-surface composite, even though the composite covers the entire occlusal surface and involves some shaping of the newly elevated buccal and lingual cusps and the occlusal grooves between them. The bond to enamel is, of course, the best and strongest of all. With such a strong, reliable bond, and easy access to all margins for cleaning, recurrent caries is not an issue. The durability of the material is amazingly excellent. This material commonly remains intact for well over 15 years. When it does chip or break off, it can be repaired; or, a decision might be made to leave it off and allow the tooth to passively erupt into occlusion with its neighboring molars.

Another patient of interest that I have treated with this technique in the past five years is also a female in her early 50s. This new patient who first came to my office about three years ago presented with a deep anterior overbite resulting in an uncomfortable fit of her teeth; in maximum intercuspation position, she felt uncomfortable strain to her jaw muscles and TM joints. She informed me that the bite hadn't always felt this uncomfortable. She added that the anterior teeth didn't overlap in the past as much as they did when I first evaluated her. I found that the lower incisors were causing impingement and chronic irritation of the gingival tissue behind her upper incisors. Other findings included missing upper second molars, a failing upper

Continues ➲

right first molar, and a very mobile upper left first premolar. It was determined that tooth #3 was hopeless and must be extracted. Tooth #12 was thought to be too mobile to be saved, but a decision was made to retain it to occupy the space, to maintain an acceptable appearance, until much later in the treatment plan. Lower second molars were very close to the upper soft tissue ridges where teeth #2 and 15 were missing leaving insufficient space to place implants, or even a removable partial denture in those positions. In my opinion, I believed I could offer her the best service by first restoring her collapsed vertical dimension. I explained that by restoring her vertical dimension, it would provide immediate relief for the soft tissue behind the upper anteriors. In addition, it would create enough space to place some type of teeth in the positions of missing #2 and 15. In addition, it would relieve occlusal stress on hypermobile tooth #12. She consented to treatment and we proceeded to apply composite to at least two posterior teeth on each side of her mouth. This included teeth #4, 5, 13 and 14. Tooth #12 was not included as it was not expected to be retained much longer.

After this initial step, we followed up with extraction of tooth #3 and appointed her with hygiene for a complete periodontal scaling and root planing to eliminate other local factors contributing to the gingival irritation. Our next planned step was to take impressions for some sort of interim partial denture to replace missing teeth #2, 3 and 15, as well as #12. It would be removed when the appliance was seated. However, at the time of impression taking for that appliance, I noticed that tooth #12 was no longer mobile, at least not enough to be easily detected. This was primarily the result of completely relieving all occlusal stress on this tooth for a period of about six weeks following the opening of her vertical dimension of occlusion. I made a decision to not extract #12 but to retain it indefinitely. It is obvious that this would save the claimant a significant expense in replacing #12 with either an implant or bridge.

Another factor I considered in what type of appliance to make was that I wanted to prevent the lower incisors from passively erupting. I decided a thin platform should be incorporated that would fit against the palate behind the upper incisors. The lower incisors could then rest against this platform, or function against it, and the soft tissue would be protected from a return of the initial problem of impingement. Another factor in my decision was that the upper incisors were somewhat misaligned and would benefit from minor realignment that might not occur on its own as in the previous patient. I planned to correct this with minor orthodontic treatment. Thus, I chose to make a hybrid provisional RPD/Hawley retainer that incorporated all of these elements. This was seated and the patient is currently wearing it and functioning now on a full complement of posterior teeth, including denture teeth in the sites of #2, 3 and 15, as well as on an anterior platform of acrylic positioned behind the upper incisors.

The patient is currently stable and much improved at this point. At every visit, she has stated that her bite feels more and more comfortable, and she is becoming more accustomed to the changes. She is emphatic that it is much improved from the way it was before she came to see me. When she is ready to move forward, we will discuss progressing to the following long-term goals: enhancing the alignment of her

upper incisors with the Hawley facebow. If this is insufficient she might later be referred to an orthodontist. However, before that occurs, I would like for her to have teeth #2, 3 and 15 replaced with implants. Once those are placed and restored, she should be in a better position to consider more definitive orthodontic treatment for her anterior teeth. As is obvious, this case involved occlusion, periodontal issues, extraction of a tooth, implant possibilities, a removable prosthodontic appliance and orthodontic considerations. Although it may have seemed complex in the beginning, by restoring this patient's VDO to a more ideal position before doing anything else, it greatly simplified all aspects of the case, allowed her to retain tooth #12 which I had considered hopeless and would have been extracted; and all this was accomplished for very reasonable and affordable costs. To date, no teeth have been crowned and no crowns are planned other than following implant placement, which is now possible due to inter-arch space created by increasing the vertical dimension of occlusion. ◆

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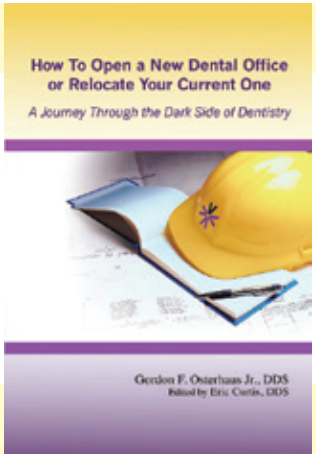


Book Review

How to Open a New Dental Office or Relocate Your Current One

by Gordon F. Osterhaus, Jr., DDS • Edited by Eric Curtis, DDS

A book review in two parts

Review #1—The dental student

By Michael Lloyd, UNLV SDM DS III

How to Open a New Dental Office or Relocate Your Current One is a text book written to successfully accomplish what the title states. As a third year dental student, I have spent most of my educational career studying science and health courses, but not many in business, including in dental school. I, like many of my dental student peers, can benefit from the step by step process Dr. Osterhaus presents to open and manage a new dental office efficiently. "It is imperative that you have a clear understanding of every aspect…in order to attain your goal of completing the project relatively on time, and most important, on budget."

Gordon Osterhaus is a dentist who, after practicing for 20 years, began a career in dental office practice management. The reader can really appreciate the ease in reading as it is conversational and flows well. The most valuable aspect of this book is how it provides tips and hints of which short cuts to avoid and which short cuts to take. The gems are real life experiences of common pitfalls to look out for at each step when planning and building a new office. He states that "There are inherent flaws built into the process of dental office development, flaws that have been repeated and reinforced for years." These experiences are condensed into a form that the novice dental entrepreneur can understand and apply.

There may be bias at times, however. After years of dental practice, Dr. Osterhaus participated in dental equipment sales. This book puts heavy emphasis on the dental equipment planning aspect as being the cornerstone of building a successful new dental office. Although this may arguably be a downside to the book, one must remember Dr. Osterhaus' background and track record in developing 80 new dental offices, which should restore trust in the wisdom he shares in his book.

Dr. Osterhaus' book is a recipe for success. I recommend this book to any dental student or practicing dentist who sees themselves opening or relocating their practice in the future. ◆

Review #2—The veteran dentist

By Dr. Dwight W. Meierhenry

After reading many similar texts over the years, what a pleasure it was to review a fresh new book on practice transitions. *How to Open a New Dental Office or Relocate Your Current One* is a must read for anyone involved in any part of dental delivery—from care, sales, providing reality service, renovating, converting, to providing space for future dentists.

This book is especially necessary to read and absorb by dentists. Planning and comprehension coupled with knowledge of construction and proper sequence of conversion of space to a dental office is very dangerous to leave in the charge of the inexperienced. Costs can easily exceed 30–50% in extras to original estimates. As with all professions, there are many small nuances that run into significant additional costs if not taken into consideration. The book is written in a plain, accurate, and informational style. As many are aware, most dentists have little if any

Author Gordon F. Osterhaus, Jr., DDS

construction or business experience. This book provides the dentist with the complete rules of the road. Do not attempt to do any dental office construction without a careful reading and understanding of all, and I do mean all, chapters. The warnings for the inexperienced are clear and concise.

If there is any criticism, it is with the lack of discussion of the ergonomics of a dental office. Dentists spend half their lives in the office and ergonomics are vital to one's health. Location of operatories, staff break room, sterilization area, adequate storage, etc., must be carefully thought out. Planning the placement of a convenient front desk ensures repeated visits which add up over the years. The layout of operatories and their use need to be carefully thought out. While working, seating placement of staff and dentist is crucial in order to maximize efficiency. Long halls are to be avoided. Select a square foot print and then go to a planning stage. I was trained before sit-down dentistry. Back issues have ended a lot of dental careers. Operatory ergonomics often are poorly thought out. Extra effort needs to be placed here.

In general, the book is outstanding with nothing left out. As I mentioned, anyone involved in a dental space from reality agent to dentist should thoroughly read and understand every page. There is information that will save many thousands of dollars. Having practiced dentistry for 50 years, I can recommend this book to any dentist contemplating a new or renovation project as a must read. It should be required reading for all dental students.

This is definitely a 5-star book. ◆

For more information on Dr. Osterhaus' book, see www.valleydentalconsulting.com

William B. Daugherty, Lost His Teeth

Reno Evening Gazette, February 19, 1891

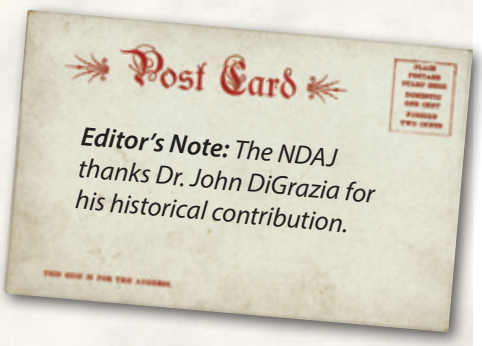
Lost His Teeth

Two attractive and gentlemanly looking emigrants sat the other day on the depot steps sunning themselves and making classic observations on Reno and her people, when one remembered suddenly an amusing incident which occurred just beyond Wadsworth and broke into a hearty laugh. Says he, "Do you remember those teeth which that tall Missourian lost?"

"No."

"Well, Bill Smith, who is only 35 and who lived in Osage County for just 35 years, had several bad teeth as well as several places where a number of tusks once had flourished. A traveling tooth carpenter happened along one day and showed Bill a set or two of newfangled teeth. He told Bill that tobacco would not stain store tooth, and that if he would have his remaining teeth drawn out and allow a set to be made for him, that he could go to California and marry a rich California girl and live like a Bonanza king. Bill could not stand any further melting arguments, and raised up the top of his head for the dentist to insert his machinery. The base man soon got in his work, Bill bearing the agony with a Piper's fortitude. The usual results followed. Bill lived on spoon stuff and unchewed grub for two weeks; then his mouth was filled with soft white paste and the shape of the biggest mouth in Old Missouri drawn out. Bill himself, after he got both parts of his head together, was scared at the impression. Well, he finally got the teeth; but to have seen him use the things would have made you laugh your buttons off. He stuck to these teeth, though. The day came for starting, and Bill wiped the tears from his eyes with a big cotton handkerchief that was colored and had pictures all over it, wrapped his teeth carefully in it, put on a white shirt he bought from a Jew peddler, and set sail for the West. Well, he didn't want to use his teeth too much, and they weren't very good things to use at the table, any way. He had put them in his mouth a few times along the route and gone into the air castle business with great success, and then he would slyly take them out and tie them up. In answer to an inquiry, the conductor told him that he was nearing California. So just beyond Wadsworth, Bill took out the treacherous things and placed them in position. This time he thought that he would go out on the platform and see how they would act in the fresh air. But Bill began to catch cold and reached over to sneeze, and, by golly, do you believe me, his second story teeth dropped out. Bill knew that the future was a blank unless he got those teeth, so he jumped off and rolled down the bank after them. After looking around for a few minutes, the torments were found and shoved into his mouth and it tightly shut. Then he started on a fast walk, overtook the train and got aboard. I believe that he would have walked into Wadsworth a half an hour ahead of the train, but the engineer told him the company didn't allow opposition on their track, so Bill not being well acquainted with Nevada roads, jumped on."

The conductor called "all aboard," the men brushed their pants, took passage, and the train moved slowly out of town. ◆



Southern Nevada Dental Society

February 2012 • UNLV School of Dental Medicine

Give Kids A Smile 10th Anniversary

10 Years of Give Kids A Smile

= 1,500 children treated

= Care valued at more than $1,000,000 !

Thank You!

Richard Kohlmeyer, DDS, GKAS Chairman
99th Dental Squadron at Nellis Air Force Base
College of Southern Nevada's Dental Hygienist Program
Helping Kids
Henry Schein
Dr. Jaleh Pourhamidi, Roseman University
Roseman University Orthodontic Residency Program
Southern Nevada Dental Hygienists' Association
SR Construction
UNLV students, administration, staff, residents & faculty
Dr. Karen West, Dean, UNLV School of Dental Medicine
Dr. Woyda, Colorado Springs, Colorado

SNDS Member Volunteers

Christine Ancajas, DDS | Peter Balle, DDS | Michael Banks, DDS | Ilya Benjamin, DMS | Marshall Brownstein, DDS | Joel Casar, DMD | Cher Chang, DMD | Evangeline Chen, DMD | Arnold Collum, DDS | Michael Duboff, DMD | Stephen Fleming, DDS | Barry Frank, DDS | A. Gomez, DDS | Blair Hale, DMD | Jaren Jensen, DDS | James Jones, DDS | Stanley Kaufman, DDS | AnnaLee Kruyer DDS | Robin Lobato, DDS | Ronrico Mangapit, DMS | George McAlpine, DDS, MS | Jaleh Pourhamidi, DMD | George Rosenbaum, DDS | James D. Smith, DDS | William (B.G.) Smith, DDS | Robert Talley, DDS | Richard Thiriot, DDS | Franson Tom, DMD | Kenneth Tracht, DDS | Karen West, DMD, MPH | Joseph Wineman, DMD | Wendy Woodall, DDS | Charles Woyda, DDS | Lydia Wyatt, DDS

SNDS Executive Director's Message

Robert Anderson

The Southern Nevada Dental Society celebrated the 10th anniversary of Give Kids A Smile with our best event yet. The event ran in two stages, with **Roseman University's Orthodontic Residency** program stepping up to provide exams and x-rays for 160 underprivileged children. This gave us a great head start.

The following week, about 200 volunteers gathered at UNLV's School of Dental Medicine for the main Give Kids A Smile event. With so many children pre-screened, we were able to fill all 90 chairs very quickly, with some patients starting their treatment in less than ten minutes after the volunteer briefing. Five hours later, 220 children received exams, x-rays, and hygiene and restorative treatments valued at approximately $150,000.

Naturally, an event like this is only possible with *great* partners. We cannot overstate the value of the pre-screening event hosted by **Dr. Jaleh Pourhamidi** at Roseman University. And as always, **Dr. Karen West**, Dean of the UNLV School of Dental Medicine rolled out the red carpet and made us all welcome. We also need to thank **Helping Kids** for working with their families to bring the patients in for both events. They have been with us from the very beginning and did a super job this year, as always!

Henry Schein stepped up as both a national sponsor and more importantly to us, as a local sponsor. They provided unwavering support to both events, brought in members of their own network, equipment, supplies—even to the point of their staff volunteering on the day of the event.

The **Southern Nevada Dental Hygienists' Association** came out in force, as did **College of Southern Nevada's Dental Hygienist program**, with students, staff and faculty. It was significant that the first three Give Kids A Smile events here in southern Nevada were hosted by CSN! This cooperation between the SNDS and the Hygienists' community is unparalleled and much appreciated.

They joined members of the **UNLV student body, UNLV administration, staff, Residents and faculty,** who worked tirelessly to make the event a success. Even our colleagues from the **99th Dental Squadron at Nellis Air Force Base** joined us with some of their dentists, hygienists, assistants, and their Residents, making this once again the only event in southern Nevada to have every oral health education program working together in one cause. We were even fortunate to have **SR Construction** pay for lunch for the volunteers.

We would like to particularly thank SNDS members who attended and gave their time to make a difference. This includes **Richard Kohlmeyer, DDS**, our GKAS Chairman, and our other great member volunteers:

Christine Ancajas, DDS
Peter Balle, DDS
Michael Banks, DDS
Ilya Benjamin, DMS
Marshall Brownstein, DDS
Joel Casar, DMD
Cher Chang, DMD
Evangeline Chen, DMD
Arnold Collum, DDS
Michael Duboff, DMD
Stephen Fleming, DDS
Barry Frank, DDS
A. Gomez, DDS
Blair Hale, DMD
Jaren Jensen, DDS
James Jones, DDS
Stanley Kaufman, DDS
AnnaLee Kruyer DDS
Robin Lobato, DDS
Ronrico Mangapit, DMS
George McAlpine, DDS, MS
Jaleh Pourhamidi, DMD
George Rosenbaum, DDS
James D. Smith, DDS
William (B.G.) Smith, DDS
Robert Talley, DDS
Richard Thiriot, DDS
Franson Tom, DMD
Kenneth Tracht, DDS
Karen West, DMD, MPH
Joseph Wineman, DMD
Wendy Woodall, DDS
Charles Woyda, DDS
Lydia Wyatt, DDS

Of particular note, we want to thank **Dr. Woyda**, who travelled from Colorado Springs, Colorado to volunteer for our event. This was his third year of supporting GKAS in southern Nevada. I should also add that over the ten years of participating in Give Kids A Smile, this year's event brings a total of about 1,500 children treated with care valued at more than $1,000,000!

Future events

Looking ahead, we have several sessions of our popular CE Café coming up, as well as our main-line CE Series, which will run through May. We are also already planning for our annual Community Night on September 11, so be sure to check the SNDS activity calendar elsewhere in this issue. We hope to see you there!

One year ago, I took the "Oath of Office" as President of the Southern Nevada Dental Society. My predecessor, Dr. Chen, guided our organization through some of the worst financial times and the hardest situations that the Las Vegas area had seen in years. But we remained solvent and we still had a cadre of members who understood the importance of organized dentistry.

Today, the outlook is better. While we look around us and continue to see high unemployment and vacant homes, the picture has brightened a little. As dentists, we can see that a corner has been turned, and little-by-little we have become generally busier. Patients who were once AWOL are slowly returning. New patients numbers are increasing and many patients are requesting more cosmetic treatment instead of the "...just patch it, Doc" that we heard for a few years.

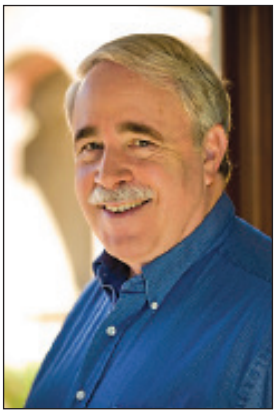
On an organizational level, we have also seen improvement. Membership numbers are up, our Continuing Education programs have produced more non-dues income, and attitudes have begun to change for the better.

We have worked through the NDA's decision to reduce by half the total number of Delegates with a SNDS Board evaluation that will eliminate the election of new Delegates this year and to allow the necessary reduction from twenty to ten to occur by attrition. While this is less than ideal, it makes the most sense to proceed in this manner.

One of the next tasks for the SNDS is to revise some of our Bylaws. For example, we currently follow Robert,s Rules of Order as our Bylaws state. However, both the ADA and the NDA (and most of organized dentistry) follow Sturgis. If you don't know, the Sturgis sisters re-wrote a set of rules that are simpler to follow and understand.

Other goals that the SNDS should strive to reach are to both increase membership and to improve our Continuing Education programs—a major source of funding to our Society. Our current SNDS dues can remain low and our membership benefits can continue to increase with a membership boost and a greater participation in our programs like the CE Cafe, reasonably priced all-day CE courses, and courses needed to maintain our Nevada licenses.

And one last thing…we need to have committed members give their time and willingly serve on committees and to act as our Delegates to the NDA. We need people who are not looking for a line to add to their CVs but to honestly work for the membership. We need people who are willing to educate themselves as to both the "how" and the "why" of organized dentistry. As my dental mentor once said to me, "This is your career. You either help direct where it goes or you have to follow someone else's orders. The choice is yours." ◆



Joel Casar, DMD

NNDS Executive Director's Message

Lori Benvin

Since winter never really arrived as much as it could have this year, we plan on "spring"ing right into our 2012 NNDS year for events and news. We have had some exceptional guest speakers thus far for our members to obtain continuing education, including Dr. Stanley Malamed. His presentation was one of the best attended general membership dinner meetings and continuing education courses we have hosted in several years. Thanks to all that attended. We hope you enjoyed this 2-day conference event.

Our 2011–12 Continuing Education Chair, **Dr. Maggie Heinen**, has done a fantastic job in coordinating top-notch speakers. Dr. Jose-Luis Ruiz will join us in March 2013 (and possibly Dr. Joseph Blaes in November 2012).

On May 11, our OSHA Update course will be presented by William Carpenter, DDS from UoP. He will present an update on OSHA compliance in conjunction with the required CDC course all dentists and hygienists must take prior to their licensing renewal years. The 5-hour course will include four hours of Regulation #R201–09 for dentists and hygienists entitled, "Infection Control & OSHA Today." We are keeping the cost down—since this course is mandatory, your Executive Board feels that making a profit is not a concern. We are offering it to our members at a reasonable price. We are also offering a further reduction in price if any of your hygienists attended our 2-hour CDC course last May. Call the NNDS at 775-337-0296 for details. You can register online at *www.nndental.org*.

We have decided to put our annual Mario Gildone Lifetime Achievement Award Dinner on hiatus for 2012. The MGLAA Selection Committee decided to postpone the nomination of the award until 2013 because we had no strong candidates who met the criteria this year and who would bring about attendance at a dinner. In lieu of this event, we are hosting a Legislative Dinner Meeting on Thursday, April 26.

The advocacy you receive as a benefit of your membership is working diligently to create relationships with Nevada legislators and candidates. Building relationships with legislators and your patients on important health issues and on issues that could greatly impact your profession when potential bills are introduced will be the focus of the meeting. *All* of you need to be informed. We strongly encourage you to come to the dinner meeting and voice your opinion, ask questions, and listen to your NDA legislative committee colleagues share their predictions and information. They will be calling on you to talk to your patients about these important issues.

Finally, as the NNDS 2011–12 year comes to a close on May 31, I thank our hardworking committees and Executive Board members. The passion through volunteerism you put forward for this society and dentistry is remarkable. I hope more of our young dentists step up and get involved—they are the future of our strong society.

I especially thank our President, **Dr. Quincy Gibbs,** for a job well done this year. Quincy will be leaving northern Nevada this June to further his educational career and we wish him and his family the best. Thank you, Quincy, for your hard work, your incredible dedication to the society, and for your unwavering stability and sensibility on doing what is right for your profession. We will all miss you.

Please continue to check our website at *www.nndental.org* for upcoming continuing education courses and events, including collaboration with Henry Schein Dental on June 29 with our guest presenter Dr. Charles Blair. We have some great opportunities for CE units along with opportunities to experience the camaraderie that makes the Northern Nevada Dental Society unique. Come share practice pearls, meet new friends, and we hope to see you this coming year! ◆

Dental History Bank of Nevada

Make a rewarding investment, deposit your history with us.

If you have something to share, then *deposit* your historical stories of dentistry in Nevada with us. Email your submission to *nnds@nndental.org* or call 775-337-0296 for more information.

Welcome New NNDS MEMBERS

Donald Christiansen, DMD – General

Kaveh "Kevin" Kohanof, DDS – General

Well, here is my last editorial of the year. As my NNDS presidential term ends, I think of all the issues we are dealing with in our profession and wish they were ending as well. Unfortunately, issues such as mid level providers, non-covered services and access to care will persist. It is up to our members to take on these issues and educate our patients about them, much like we do about dentistry. An informed patient base can only help our legislators to make the right decisions affecting our profession and ability to provide proper dental care to Nevadans.

Without being involved and representing my colleagues, I would not have known about these dangers and how so many in our profession are working to maintain a high level of dental care for all. I encourage all of you to be involved, whether it is attending monthly meetings or volunteering for a delegate position or the board. Even reading the *NDA Journal* shows your involvement!

We have great people that stepped up to the plate, both with the NDA and your NNDS. I thank the executive board for their dedication and time spent away from their families to provide excellent leadership with society matters. I thank Vice President **Dr. Jason Ferguson**; Treas/Secretary **Dr. Frank Beglin**; Members-at-Large **Drs. Brandi Dupont** and **Perry Francis**; and Immediate Past President **Dr. Mark Handelin**. I also thank **Dr. Rick Dragon**, Membership & Recruitment Chair and **Dr. Maggie Heinen**, Continuing Education Chair.

A very big thanks to our Executive Director **Lori Benvin,** who seems to be in three places at once and always with a smile. Thank you for your expertise, opinions and hard work, our society is well to have you!

In closing, I thank the membership for their dedication to our profession and community and taking time to attend meetings and functions. On more than one occasion, I have been

Quincy L. Gibbs, DDS

stopped by presenters and others outside of our society and they have commented on what a great group of doctors we are, in our cohesiveness and dedication to the profession and our patients. This is great to hear and so true! In the upcoming year, our challenges remain and I am confident our society and leadership can take them head on and propel dentistry forward in the image that we want. ◆

Congrats Oklahoma State University Football

By NDA Journal FBS/D-1 Championship Committee

It is well accepted that dentists are among the most trusted professionals in society.[1] The precepts of the ADA Code of Professional Conduct mandate that dentists put the welfare of society ahead of self-interest.[2] Dentists, as well-trained and educated citizens who support concepts of fair and ethical behavior, have an obligation to exhibit intelligent leadership and aid the community with issues not necessarily related to dentistry.[3]

These attributes are absent in one program affiliated with higher education today, the BCS, a self-serving faction that selects its Football Bowl Subdivision (Division I) champion primarily on the basis of maximizing remuneration for BCS member entities and individuals,[4,5] while ignoring well-established, logical, and time-proven options (i.e. playoffs) to reward achievers in America.[6]

For these reasons, and in keeping with our iterated core values:

The Nevada Dental Association Journal is pleased to announce, in the inexcusable absence of a playoff, the Dentist Determined Subjective Champion Has Absolute Merit Poll (DDS CHAMP) selection for college football's 2011 National Champion:

Oklahoma State University

12–1 Oklahoma State Cowboys
2011 NDAJ National Champions

NDAJ BCS Era Champions:

2002	Ohio State	14–0
2003	USC	12–1
2004	USC	13–0
	Utah	12–0
2005	Texas	13–0
2006	Boise State	13–0
2007	USC	11–2
2008	Utah	13–0
2009	Boise State	14–0
	Alabama	14–0
2010	TCU	13–0
	Auburn	14–0
2011	Oklahoma State	13–0

Endnotes

1. Harris Pole #37, Most Trusted Professionals, May 2006
2. www.ada.org/194.aspx, Accessed 20 Jan 2012
3. American College of Dentists, Ethics Handbook for Dentists, 2010
4. Wetzel D, Peter J, Passan J, Death to the BCS, *The Definitive Case Against the Bowl Championship Series*, Gotham Books, 2010.
5. Bennett D, The Arizona Republic takes on the corruption of the BCS, Sep 26, 2011
6. Wetzel's Playoff Plan, http://rivals.yahoo.com/ncaa/football/news?slug=dw-playoff120208&prov=yhoo&type=lgns, Accessed 20 Jan 2011

Calendar of Events

APRIL–AUGUST 2012

APRIL

TUE 10	SNDS Member Dinner Meeting	5:30 pm	Gold Coast Hotel, Las Vegas
TUE 17	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
WED 18	*SNDS presents:* CE Café—"Using 3D Radiology in Diagnosis"	6 pm	*Please RSVP to SNDS at 702-733-8700*
WED 18	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
THU 19	AGD General Membership Dinner Meeting	6 pm	location: tbd
FRI 20	*SNDS presents:* CE Seminar, Dr. James E. Jacobs	9 am – 4 pm	Gold Coast Hotel, Las Vegas
THU 26	NNDS General Membership Dinner Meeting "Legislative"	6 pm	The Grove at SouthCreek, Reno

MAY

FRI 4	*SNDS presents:* CE Seminar with Amy Logan Parrish, Carrie Jameson Webber	9 am – 4 pm	Gold Coast Hotel, Las Vegas
7–9	Washington Leadership Session (Exec. Director, Legislative Team)		Washington D.C.
TUE 8	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
FRI 11	*NNDS presents:* CE Course, "CDC Infection Control & OSHA Today"	7:30 am	Atlantis Hotel Resort Spa, Reno
SAT 12	2nd Annual Joel Bowl Scholarship Fundraiser	6 pm	Coconut Bowl, Sparks
WED 16	*SNDS presents:* CE Café—"Bone Grafting and Implants"	6 pm	*Please RSVP to SNDS at 702-733-8700*
WED 16	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
THU 17	NDA Exec. Committee Videoconference (Officers, ADA Delegates)	5:45 pm	Videoconference
TUE 22	SNDS Executive Committee Meeting	6 pm	SNDS Office

JUNE

FRI 1	New 2012/13 NDA, NNDS and SNDS Executive Board officers take office		
TUE 12	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
WED 20	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
FRI 29	*NNDS presents:* CE Course with Dr. Charles Blair	8 am	Atlantis Hotel Casino Spa, Reno

JULY

5–7	NDA Summer Meeting & House of Delegates (All Officers, ADA Delegates)		Hyatt Regency, Monterey, CA
TUE 10	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
16–19	ADA Management Conference (NDA Exec. Director)		Chicago, IL
WED 18	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*

AUGUST

TUE 7	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
THU 9	NNDS Open House BBQ	5 pm	Bartley Ranch Park, Reno

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Southern Nevada Dental Society's
CE Café Series

Wednesday, April 18

▸ ***"Using 3D Radiology in Diagnosis"***

LOCATION Nevada State Bank, 3688 S Jones Blvd, Las Vegas (Jones & Twain)

TIME 6:00 pm dinner, Seminar 6:30–8:30 pm. 2 CEU.

Wednesday, May 16

▸ ***"Bone Grafting and Implants"***

LOCATION Nevada State Bank, 1501 W Warm Springs Rd, Henderson (Warm Springs & Stephanie)

TIME 6:00 pm dinner, Seminar 6:30–8:30 pm. 2 CEU

Free for SNDS members
RSVP Required
Email: s_nds@hotmail.com

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