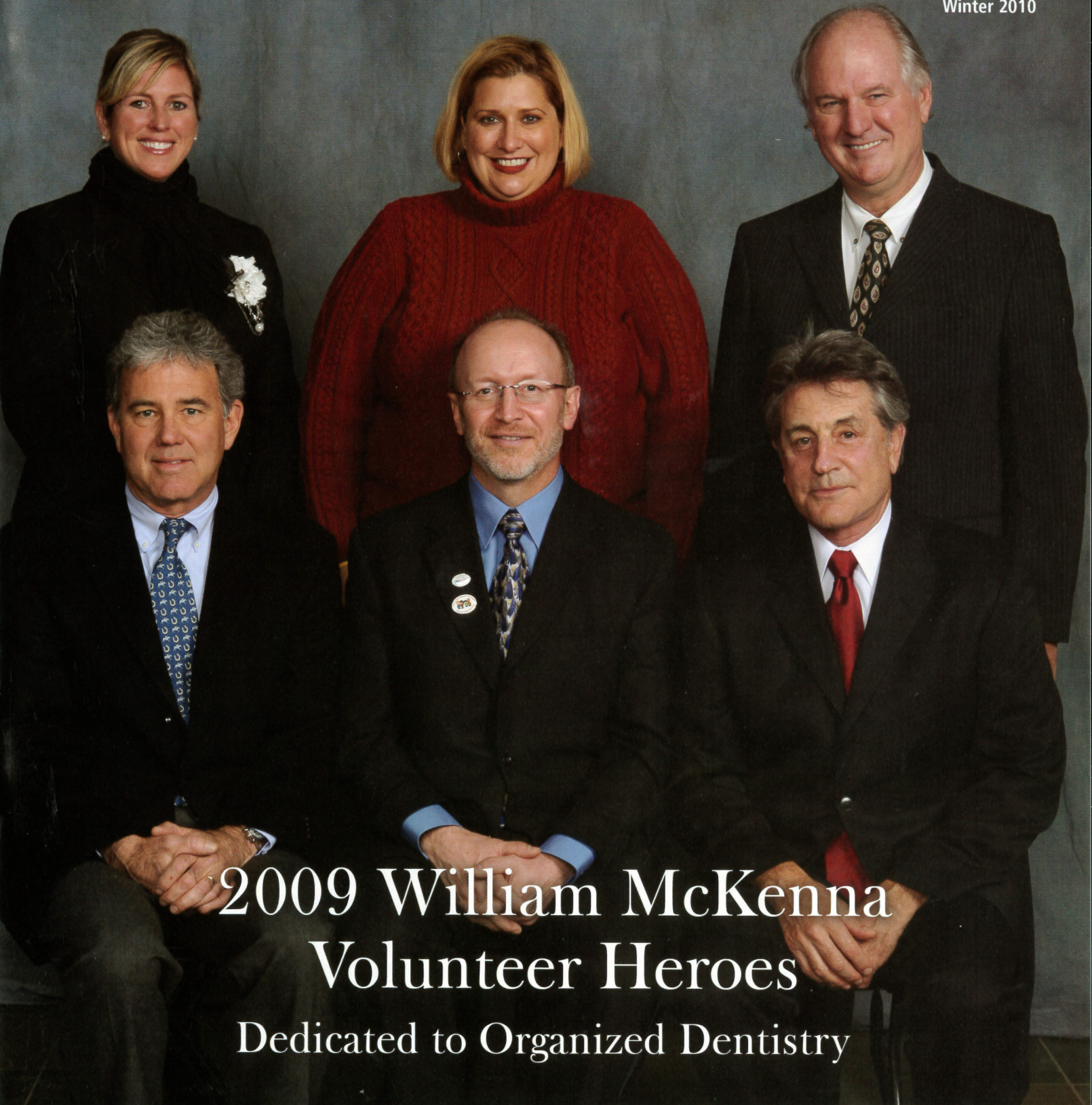


# JOURNAL *of the*

MASSACHUSETTS DENTAL SOCIETY

Winter 2010



2009 William McKenna  
Volunteer Heroes

Dedicated to Organized Dentistry

# CARPE DIEM, OR LOSE OUR VOICE

**N**ATIONAL HEALTH CARE COVERAGE—WHY IS THIS SUCH A DIFFICULT CONCEPT? NO MATTER what health care package may ultimately be passed in Congress, the model will evolve over many years. The U.S. public is clamoring for a change in the traditional provision of health care. Mainstream America cannot reasonably afford medical care. Insurance costs have skyrocketed. The percentage of a small business’s gross income that used to cover premiums and benefits has increased to the point that it has become oppressive.

Access to care used to refer to providing services to the poor. It is now a middle-class problem, for the insured and uninsured. At some point, the government, the medical establishment, and the insurance industry will have to overcome their political differences and self-interest and work together to develop a system that will provide care for everyone.

And dentistry must be part of the solution. We cannot allow the changes to occur without a strong presence at the table. The private practice of dentistry as we know it can best be protected by strengthening our voice in this changing climate. Hiding our heads in the sand will not protect us. Working with our elected officials, at all levels, is the best way to promulgate effective and positive changes. We implore you to let your state and federal officials know how you stand on issues related to dentistry and its role in the health care spectrum. Elected officials definitely take note of the volume of communication (phone calls, emails, and letters) that they receive on issues. They also look for actions: A high percentage of dentists joining MassHealth under the new program demonstrated that we are working to improve access and that we desire to be part of the process.

In order to better maintain independence and control, we need to prevent insurance companies from dictating how we practice. It is essential that Congress repeal the McCarren-Ferguson Act so that insurance companies have to abide by the same antitrust laws that we do. An immediate and pertinent issue is that Delta Dental has decided that, on a national level, it will have new policies relative to noncovered services. These policies set a cap on the amount that a participating dentist can bill a patient for services not covered by the plan. In other words, they may say “we don’t cover procedure XYZ, but if we did, this is what we’d allow and you must accept it under your contract, with no charge to the patient above what we say you can charge.” In the case where a patient has reached his or her maximum yearly benefit, this restricts you—the provider—to a capped fee rather than your usual fee. Other insurance companies will quickly follow suit.

There are many ramifications of these new policies. Costs will be shifted from insurance companies to providers, causing dentists to shift costs to other patients who are private pay or uninsured, as is common practice in hospitals and the medical profession. Cost-cutting measures, such as reducing staff as a means of dealing with the negative impact of the changes, will result. These changes are only a marketing ploy to sell “reduced-cost” plans to purchasers and do not increase care for patients, but, instead, *decrease* access to care.

The MDS has filed “An Act Relative to Financial Services Contracts for Dental Benefits Corporations” designed to protect patients from these policy changes. Please contact your elected officials in the House and Senate and talk to them about this legislation and why these changes are harmful to the profession and patients. Talking points on the matter are available at [www.massdental.org/legislation](http://www.massdental.org/legislation).

Please don’t take this lightly. If you want dentistry to remain an important part of health care and to retain some control of the way we provide dental services, you cannot sit back and hope that someone else will take care of things for you. ■



*David B. Becker*

*Arthur I. Schwartz*

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## ESTATE PLANNING OPPORTUNITIES IN A DOWN MARKET

**A** DOWN MARKET CAN MEAN TOUGH TIMES, BUT IT CAN ALSO PRESENT unique opportunities to minimize property-transfer (gift and estate) taxes. While owning assets that are losing value might seem like a bad thing, now may actually be a great time to reduce your taxable estate by gifting those assets to beneficiaries. That's because current low asset values and interest rates enable you to make gifts at a lower gift-tax cost. And if and when the market rebounds, those assets will be growing in your beneficiaries' estates and not in yours. Here are a few gift-giving techniques that take advantage of today's economic climate.

(Note: This article discusses federal tax rules only. Individual states impose their own property transfer taxes using rules that may be different from the federal rules.)

### Basic Gifting

Each year, you can make gifts of up to \$13,000 to anyone you want, to as many people as you want, tax-free under the annual gift-tax exclusion. You can give away twice that amount if both you and your spouse make the gifts together (this is called gift splitting). And you can give away an unlimited amount if you pay tuition or medical bills on behalf of another person (just be sure to make these payments directly to the school or health care provider).

### Family Loans

You can lend money to your children at the current IRS minimum interest rate (known as the applicable federal rate [AFR], which changes monthly), and then potentially forgive an amount equal to the gift-tax exclusion each year. The gift-tax exclusion amount is adjusted for inflation; the figure is \$13,000 for 2009.

### Grantor Retained Annuity Trust (GRAT)

A GRAT is an irrevocable trust with a specified term (e.g., 10 years) into which you gift assets that you expect will greatly increase in value in the future. You receive annuity payments during the trust term, and at the end, your beneficiaries receive any remaining property.

The transfer of assets to the GRAT is a taxable gift to the trust beneficiaries. The value of the gift for tax purposes is determined based on the current IRS rate (known as the 7520 rate, which also changes monthly).

Tax savings are achieved because the annuity payments are

calculated to result in a gift-tax value of zero. It's anticipated, however, that the actual interest earned will be higher than the 7520 rate, leaving a substantial value in the GRAT at the end of the term. This remaining value is passed on to your beneficiaries tax-free.

### Intentionally Defective Grantor Trust (IDGT)

An IDGT is an irrevocable trust that has a purposeful flaw (i.e., you retain some control over the trust) so that you, and not the trust entity, pay the income taxes on trust income. Thus, an IDGT is ideal when you want to transfer income-producing assets. Even though you retain some control over the trust, IDGT assets will generally not be included in your taxable estate at your death.

You sell assets to the IDGT in return for an installment note, with interest calculated based on the current AFR. There is no gift tax because it is a "sale" (except for an initial gift that "seeds" the trust). However, because you and the trust entity are considered the same taxpayer, no gain is recognized on the sale, and interest you receive under the note is not considered taxable income.

Tax savings are achieved because, hopefully, the value leaving your estate via the sale will exceed the value returned to your estate via the note. You also reduce your estate by paying the income taxes on IDGT income.

### Charitable Lead Trust (CLT)

A CLT is an irrevocable trust with both charitable and noncharitable beneficiaries. It's called a lead trust because it is the charity that is entitled to the first or lead interest from the trust property. After the specified term, the remaining trust property passes to you or another named noncharitable beneficiary.

At the time assets are placed into the CLT, you receive a current gift-tax deduction equal to the present value of the income stream that will be going to the charity. The interest rate used is based on the current 7520 rate, and the lower the interest rate, the higher the deduction. As with a GRAT or IDGT, it is hoped that the CLT assets will appreciate beyond the 7520 rate, allowing the excess to pass tax-free.

### Conclusion

These gifting strategies, and others, can turn this economic downturn into a mixed blessing. ■





**ROBIN ANASTAS AND GEORGE GONSER**

*Ms. Anastas is supervisor of sales and client services and Mr. Gonser is CEO of MDSIS-Spring Insurance Group.*

## CRACKING THE CODE TO QUARTERLY HIRD/FAIR SHARE REPORTING

WHEN IT COMES TO HEALTH INSURANCE RESPONSIBILITY DISCLOSURE (HIRD) forms, you may be asking yourself, “What are my obligations as an employer? Do I have to file a HIRD/Fair Share report with the state?” We recommend that all employers file the HIRD/Fair Share form as proof that you will not be held liable. All Massachusetts businesses with the equivalent of 11 or more full-time employees must file this form with the Massachusetts Executive Office of Labor and Workforce Development. However, what every practice should focus on is the key word “equivalent.” A common misconception is thinking that you have a hired staff head count of 11 employees, and this is not always the case. So, it’s time to play detective and do some calculations of your own.

### Number of Employees

An employer has 11 or more full-time equivalent employees if the sum of total payroll hours for all employees for a calendar quarter, divided by 500, is greater than or equal to 11. The following must be considered in calculating total payroll hours:

- For each employee with more than 500 payroll hours, the employer shall include 500 payroll hours (5,500 or more quarterly payroll hours equals 11 or more equivalent employees).
- Payroll hours include all hours for which an employer paid wages to an employee, including but not limited to regular, vacation, sick, Federal Medical Leave of Absence, short-term disability, long-term disability, overtime, and holiday payroll hours.
- An employer that is determined to be a successor under M.G.L. 151A shall include the payroll hours of the predecessor’s employee during the applicable period.
- Payroll hours include hours for which an employer paid wages to a temporary employee as defined in 430 CMR 4.04(8)(a) provided that the individual has worked for the employer for at least 150 payroll hours during the 12-month period ending with the last day of the applicable reporting period.

Who is included in the percentage calculation? Employers must include all full-time employees as defined in 114.5 CMR 16.02 to determine its percentage of full-time employees enrolled. This means that salaried owners need to be included in the calculation, as well. You need to break down your quarterly hours worked when or if you are paying yourself at year end.

Who is considered a full-time employee? An employee who works 35 hours or more per week at a Massachusetts-based business location (even if he or she lives in another state) is con-

sidered a full-time employee. This definition applies to the employees who are offered health plan benefits under the tests for a “fair and reasonable” contribution.

Who is exempt from the calculations? Independent contractors, employees under the age of 18, part-time employees averaging fewer than 64 hours per month, and students who are employed as interns or cooperative education participants do not need to be factored in when calculating your full-time employee head count.

What is a “fair and reasonable” contribution? Employers must make a “fair and reasonable” contribution to their employees’ health insurance or pay a penalty. What constitutes a fair amount? A fair amount is an employer contribution of at least 33 percent toward a health premium for all full-time employees who are employed more than 90 days. Please note that the health insurance carrier requires 50 percent of an individual premium and 33 percent of a family premium.

Effective January 2010, all employers filing for Quarter 1 of the filing year who were not required to file each quarter of the previous filing year will be required to retroactively provide a simple certification of liability status for the previous quarters not filed. If you are liable for payment in Quarter 1 or any subsequent quarters, you will be required to file each quarter.

There is some important information that you should have available to complete the filing. To file, you will need your Department of Unemployment Assistance (DUA) number, the number of full-time employees, the number of employees enrolled in the company health plan at the end of the applicable quarter, the calculation of all employees’ employment hours (those who worked one month or more) for the applicable quarter (you can round down the figure), the employer contribution percentage of your individual and family health insurance plan, your insurance premium (if you offer multiple plans, know all the premium costs), a qualified IRS Section 125 plan (premium offset plan) in your business, and your open enrollment date.

Once you have gathered this information and you are ready to complete the filing process, go to <https://fsc.detma.org> and read and review the “Filing Instructions.” There are four quarterly filing periods for 2010.

The most valuable piece of advice that we can give you is to write down the Re-Entry number that is assigned to you once you begin filing. Knowing this number will enable you to redo your data entry and to print all pages.

If you have any questions about the HIRD form or process, please contact MDSIS-Spring at (800) 821-6033 or visit [www.mdsis.org](http://www.mdsis.org). ■

# 2009 William McKenna Volunteer Heroes

Since 1996, the Massachusetts Dental Society and the JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY have been joining forces to honor those member dentists who have dedicated their energy, skills, and time to the profession of organized dentistry: the William McKenna Volunteer Heroes. This annual recognition is the Society's way of saying thank you to those deserving members who give so much of themselves to organized dentistry and their communities. These are members who have gone above and beyond to help the MDS achieve its goals, inspire colleagues, and advance the profession of dentistry.

On the following pages, you will meet the 2009 William McKenna Volunteer Heroes and learn their thoughts on the importance of volunteering, what they have gained both professionally and personally from their volunteer experiences, and why they think getting involved is so important to the future of dentistry. These members, who tirelessly donate their time and expertise for the betterment of the Society and the profession, give the MDS its strength.



**Standing (from left): Drs. Roland Nentwich, Amelia Grabe Lane, Richard Marchand, and Arnold Maloff. Seated (from left): Drs. Cherie Bishop and John Herzog.**



Residence: **Lexington**  
 Office Location: **Chestnut Hill**  
 Specialty: **General Dentistry**  
 Dental Education:  
**Tufts University School of Dental Medicine**  
 Number of Years in Practice: **15**  
 Number of Years of MDS Membership: **15**

*Cherie C. Bishop, DMD*

**When and why did you decide to join the MDS and become part of organized dentistry?**

I joined immediately following my graduation from Tufts University School of Dental Medicine (TUSDM) in 1994. I was then encouraged to volunteer at the Yankee Dental Congress by my friend and classmate Dr. Janis Moriarty [MDS Trustee]. That started me on my path in organized dentistry.

**Is involvement in organized dentistry important to you? If so, why?**

Organized dentistry has been incredibly important to me not only for the people I've met and friendships I've developed, but also for the confidence and leadership skills that I have developed through the MDS Leadership Institute, my Guest Board Member position, and my volunteer roles at Yankee.

**Please describe the extent of your volunteer experience in dentistry.**

I started as a volunteer at Yankee, first as a room coordinator, then as a presiding chair, and gradually moved up the ranks to day captain and then Core Committee member. I completed the MDS Leadership Institute in 2008, and then was a Guest Board Member from 2008–2009. Now, I am the secretary for the Metropolitan District, and I continue to serve on the Yankee Core Committees for YDC 35, 36, and 37. I have also participated in several Beacon Hill Days.

**Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

I think that attending the MDS Board Retreat as a Guest Board Member was a very memorable experience for me. I gained so much appreciation for what the officers and trustees of the Board, as well as the MDS staff, are doing behind the scenes to further our profession. It was impressive to see the dedication of the Board volunteers—these practicing dentists are working tirelessly to improve access to care for the public, as well as the rights and benefits of their fellow member dentists. As for a person who has made it worthwhile, [MDS Trustees] Janis Moriarty and Lisa Vouras have been role models for me in organized dentistry for sure.

**How has volunteering impacted you on a professional and personal level?**

Volunteering is my way of giving back to my profession, whether it's at the MDS or my dental school. I am so thankful for the skills that I have developed as a clinician and as a leader in my profession. I have increased confidence in my presentation skills, which is helpful not only in staff meetings in my practice, but also in talking to patients about potential treatment.

**Do you volunteer in community and philanthropic activities outside of dentistry? If so, what are they and what drew you to them?**

I am on the Tufts Dental Alumni Executive Board, as well as the Tufts Dental M Club. I co-chaired the Tufts Wide Open Golf Tournament last year, and for the past three years I have been chair of the Tufts Dental Student/Alumni Networking Session. I was also a co-chair for my 15th TUSDM reunion last spring. I guess between the MDS and Tufts, I haven't had much time for volunteering outside of dentistry, although this past September 11, my husband and I delivered donated hot meals to the firefighters in our local firehouse, an event organized by a close friend of ours.

**What do you feel are the most important issues facing organized dentistry today?**

Access to care is certainly a hot topic, as is encouraging new dentists to get involved in organized dentistry on a local, state, and national level. Helping to make the newer dentists realize that there is a strong network out there will only benefit them as they are starting out.

**In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?**

Just join, you'll find everything you're looking for . . . and more.

**What is your favorite . . .**

- ~ **Thing about the MDS?**  
The people I've met and friendships I've developed
- ~ **Word?** Beach
- ~ **Vacation spot?** St. John, U.S. Virgin Islands
- ~ **Part of your job?** My partners, staff, and patients
- ~ **Dental procedure to perform?** Smile makeovers
- ~ **Book?** I recently purchased *True Compass*, the Ted Kennedy memoir
- ~ **Sport to watch?** The Red Sox!
- ~ **Movie?** *Elf*
- ~ **TV show?** *Grey's Anatomy* and *Nip/Tuck*
- ~ **Way to unwind on the weekend?** Spending time with family at my in-laws' beach house in Buzzards Bay





Residence: **Danvers**  
 Office Location: **Danvers**  
 Specialty: **General Dentistry**  
 Dental Education: **Columbia University College of Dental Medicine and St. Luke's/Roosevelt Hospital (GPR)**  
 Number of Years in Practice: **25**  
 Number of Years of MDS Membership: **25**

*John A. Herzog, DDS*

**When and why did you decide to join the MDS and become part of organized dentistry?**

I've always been a member of the American Dental Association, but I don't remember a specific moment when I decided to join the MDS. I guess it was just the natural progression of things when I moved back here from New York after my residency in 1984. As a dental professional, I feel that supporting my professional organization just makes common sense. In addition, I value the opportunity that organized dentistry provides for me to network and share ideas with colleagues.

**Is involvement in organized dentistry important to you? If so, why?**

I think from my level of involvement, you can tell that organized dentistry is important to me. The "why" is rather simple: I feel our profession is stronger collectively than as isolated solo offices operating individually. There is strength in numbers, and organized dentistry is where the numbers are for dentists. It seems to me to be the best way that we can have input on how our profession evolves, and evolve is certainly what it is always doing.

Dentists are probably the only group that has both our profession and the interests of our patients at heart. Insurance companies and their lobbyists certainly don't. Some elected officials may try, but most, from my experience, have their finger in the air testing the public opinion and doing what's in their best interest of getting reelected. It's important that dentists have a seat at the table as decisions are made about our profession's future. Organized dentistry provides that seat.

**Please describe the extent of your volunteer experience in dentistry.**

I have volunteered in lots of different areas over the years. It's funny how many things you can get involved with if you just say yes. I've been assistant secretary, secretary, and this year I am chair of the North Shore District Dental Society. I represented the North Shore District on the Council on Dental Health and Health Planning many years ago. I began my Yankee Dental Congress experience as a member of the General Arrangements Committee for years, working at information booths and various other assignments. Then a classmate of mine from Columbia, Dr. Alan Gold, asked me to be a part of his Core Committee when he was general chair of YDC. I was hospitality chair for his Yankee, and since then have served on several additional Core Committees. I have served as allied co-chair, publicity chair, general chair of YDC 32, and this year I am exhibits chair. I also served as Steering Committee chair for 2008–2009, and I'm presently on the YDC Oversight Committee. Oh, and I guess I shouldn't leave out that I have volunteered on the Mobile Access to Care (MAC) Van.

**Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

There are many days, events, and people that stand out for me over the years. Certainly, my year as general chair of Yankee had many memorable people, days, and events. I would be hard pressed to pick just one, but if I have to, I'm going to say the Yankee Dental Congress. It is so impressive to see how many volunteers come together to make the meeting successful year after year. To see the number of dental professionals who come together in Boston and share educational and social opportunities makes me feel that it truly is worth my time and expertise.

**How has your volunteering impacted you on a professional and personal level?**

On a professional level, my volunteer activities have put me in contact with many committed people who continue to be a resource to me. It's nice to be able to look around the state and know I can reach out to someone who I never would have met if not for my volunteer activities. On a personal level, I've met wonderful people from all over the state whom I consider friends as well as colleagues.

**Do you volunteer in community and philanthropic activities outside of dentistry? If so, what are they and what drew you to them?**

In the past, I was very involved in community activities outside of dentistry. I used to be extremely involved in the Kiwanis Club of Beverly. I am a past secretary and president, and was a board member for many years. I also ran a youth basketball league in Beverly for 13- to 15-year-olds for about 10 years. We had 125 kids in the league and I was responsible for everything from uniforms to gym time to referees. Since I started expanding my involvement with organized dentistry, my time to donate to local causes such as those has dwindled. Over time, maybe I will become more involved locally. We'll see what the future brings.

*Continued on page 17*





Residence: **Brewster**  
Office Location: **Chatham**  
Specialty: **General Dentistry**  
Dental Education: **Boston University Henry M. Goldman School of Dental Medicine**  
Number of Years in Practice: **4**  
Number of Years of MDS Membership: **8**

## *Amelia Grabe Lane, DMD*

### **When and why did you decide to join the MDS and become part of organized dentistry?**

As a student at Boston University, we're automatically members of the American Student Dental Association (ASDA), the MDS, and the ADA. In 2002, my class (2005) was enrolled in the tripartite membership. I chose to get involved in ASDA and organized dentistry because my father, Dr. George Grabe, has always been involved in organized dentistry where he practices in New Hampshire, and I was able to see from his experience the benefits and camaraderie as a result of his involvement. I also wanted to give back to the field of dentistry, one that I feel so incredibly lucky to have joined.

### **Is involvement in organized dentistry important to you? If so, why?**

It is incredibly important to me because no one else is going to advocate for us and no one else knows our issues and concerns better than we, the dentists who practice on a daily basis and know our profession inside and out. I also have a big voice and am not afraid to use it for issues I believe in! I appreciate the camaraderie I have experienced for so long, from ASDA, the MDS, and the ADA in dental school, to my local Cape Cod District Dental Society (CCDDS) now as a practicing dentist. I can go to any ADA meeting now and know I'll run into many old friends from ASDA and the ADA, which is wonderful.

When I moved to the Cape in 2005, I didn't know any dentists here except those I'd met through the MDS—such as Mike Buckley on the Council on Membership during my four years in dental school, as well as Dan Mahoney, who was the secretary of the MDS, and Bob Faiella, former president of the MDS, both of whom I had met at the House of Delegates when I was a BU delegate all four years in dental school. If not for them, I wouldn't have known anyone here, and they made sure to introduce me around at my first CCDDS meeting and welcome me to the Cape dental community. From there, I've been able to get to know a lot of dentists in the area whom I would not have had the opportunity otherwise to meet, share ideas and concerns with, and get the support we all need as small business owners and solo practitioners.

### **Please describe the extent of your volunteer experience in dentistry.**

Starting in dental school in my first year, I enjoyed the opportunity of working with Kathy Lituri of BU's Community Outreach Programs office to volunteer at health fairs and talk to people in the community about the importance of regular dental care. In ASDA, we'd host local schoolchildren and provide dental examinations for them every year. I also loved ASDA's Lobby Day in Washington, DC, when we'd be able to talk with senators and congressmen/congresswomen about issues important to dentistry and students.

I've done practically anything offered to me to volunteer because I love giving my time to worthy causes, and ASDA and the ADA have always given me a reason to say yes. I held national positions in ASDA during dental

school, so I was also a student representative on three ADA councils and got to experience many facets of the ADA that most members never see; I therefore value my membership 100 percent.

More recently within the MDS, I was chair of the Cape Cod District Dental Society for 2008–2009. I was a Guest Board Member in 2008–2009, and a graduate of the Leadership Institute.

As a member of the Rotary Club and as a third-generation Rotarian, I have also volunteered extensively in areas outside of dentistry, most notably in Rotary's Eye Care for Tobago, a mission where we delivered eye care and glasses to people in need on the island of Tobago in the Caribbean.

### **Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

In dentistry, every patient on the Mobile Access to Care (MAC) Van was an experience that stands out; the patients were so wonderful and appreciative of our efforts. Outside of dentistry, the best memory was a 10-year-old boy in Tobago who was legally blind. Our opticians had examined the boy and given me a prescription with the instruction to find a pair of glasses from the donated glasses we received that matched as closely as possible to his prescription. I found them, the exact prescription. They were small frames and just looked like they were made for him. When he tried them on, I had him read my name tag, which he did. Then he looked at his mom, who was crying, and gave her a big hug. Then we brought him to the window to look out at the view from the health center, which was a big bay with aquamarine waters, palm trees, just beautiful. His face lit up like nothing I've ever seen. He could finally see. Everything had always been mostly a blur to him and now he could see clearly. There wasn't a dry eye in the health center at that moment. I will never forget it.

### **How has your volunteering impacted you on a professional and personal level?**

Being able to give back professionally as a dentist has allowed me the opportunity to really change someone's life in ways I've never experienced. It is rewarding to be able to give of my skills and make a difference that no one else was able to or willing to do. In my experience, people are very appreciative, and

Continued on page 17







Residence: **Marblehead**  
 Office Locations: **Danvers and Salem**  
 Specialty: **Endodontics**  
 Dental Education: **University of Pennsylvania and Tufts School of Dental Medicine (Certificate in Endodontics)**  
 Number of Years in Practice: **29**  
 Number of Years of MDS Membership: **29**

*Arnold I. Maloff, DMD*

**When and why did you decide to join the MDS and become part of organized dentistry?**

I joined the MDS right after graduation from the endodontic program at Tufts School of Dental Medicine (TUSDM). Initially, it was a wonderful way for me to meet my professional peers. It was quickly apparent to me that dentists need a unified voice to advocate our concerns and issues. The MDS and American Dental Association are excellent forums to represent our profession.

**Is involvement in organized dentistry important to you? If so, why?**

In this age of health care reform, it is so important for us to be an organized force to help our cause of providing dental care to as many people as possible. We need qualified people to represent us at all levels, and organized dentistry gives us that ability. Strength comes in numbers, with contract negotiations, legislative initiatives, insurance-related matters, and many other issues. Organized dentistry gives us an opportunity to represent ourselves and promote our best interests. This involvement also gives me the opportunity to interact with many of my wonderful colleagues.

**Please describe the extent of your volunteer experience in dentistry.**

I've been involved with the North Shore District Dental Society (NSDDS) for 29 years. I've done everything from serving on numerous committees and being our district secretary for more than 10 years to holding the position of chair. It has also been my pleasure to lecture at our local dental societies and study groups, as well as serve as assistant clinical professor at TUSDM. I have also been a delegate to the MDS House of Delegates. Presently, I am a member of the MDS Peer Review Committee. A new experience for me at the moment is being a board member of Eastern Dental Insurance Agency (EDIA), an offshoot of Eastern Dentists Insurance Company (EDIC).

**Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

During my tenure as NSDDS secretary, I mediated numerous disputes between patients and dentists in the district. To the best of my knowledge, I was able to mediate and resolve every single dispute. What gave me enormous satisfaction was that, when needed, I was able to be an advocate for one of my colleagues.

**How has your volunteering impacted you on a professional and personal level?**

Volunteering has enriched my life and my practice in many ways. On a professional level, I have had the opportunity to meet and interact with so many talented doctors, some of whom have acted as mentors to me throughout my career. I feel this has raised my level of dentistry. On a personal level, volunteering has opened up a whole network of interesting and exciting colleagues to interact with, and many of these relationships have developed into lifelong friendships.

**Do you volunteer in community and philanthropic activities outside of dentistry? If so, what are they and what drew you to them?**

My most memorable activity, which has touched me deeply, was being involved with the Big Brother Program. So many people need help on so many levels, and this gave me the opportunity to become involved with a youngster who desperately needed a helping hand.

**What do you feel are the most important issues facing organized dentistry today?**

At this juncture, health care reform may not affect dentistry, but who knows what the future holds. We need to be organized as governmental issues start to impact us more. Insurance companies seem to want to dictate treatment and fees for our patients. Access to care for the underserved is a big issue. Poor dental care results in lost school days and lost work hours, and burdens hospital emergency rooms. Graduating college students carry a tremendous debt burden, which lessens the desire for a dental education. We need to continue to stress oral health as a part of overall health. Lastly, communication with our members and the need for them to participate is an ongoing concern.

**In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?**

As graduation from dental school was approaching, it became apparent to me how little I really knew in regard to dentistry, and the MDS will allow you to further your education by interacting with people who have been in your position.

**What is your favorite . . .**

- ~ **Thing about the MDS?** Friendships
- ~ **Part of your job?** Being able to work for my staff—my bosses away from home!
- ~ **Book?** Books on history
- ~ **Sport to watch?** Basketball and football
- ~ **TV show?** *House*
- ~ **Way to unwind on the weekend?** Playing golf and torturing my friends!





Residence: **Barnstable**  
 Office Location: **Yarmouth Port**  
 Specialty: **General Dentistry**  
 Dental Education: **Tufts School of Dental Medicine**  
 Number of Years in Practice: **31**  
 Number of Years of MDS Membership: **31**

*Richard D. Marchand, DMD*

**When and why did you decide to join the MDS and become part of organized dentistry?**

I joined the Massachusetts Dental Society when I first opened my practice in 1978 to meet local dental professionals for support and to develop a network for reliable, quality patient referrals.

**Is involvement in organized dentistry important to you? If so, why?**

I believe involvement in organized dentistry is important for many reasons, perhaps the most important being able to talk with trusted local professionals about day-to-day patient care issues. Also, over the years I have become increasingly aware of the many areas in which both the MDS and the ADA represent the profession and protect it from government intervention.

**Please describe the extent of your volunteer experience in dentistry.**

I have volunteered on the local and state level for many years. On the local level, I have held various offices in the Cape Cod District Dental Society. On the state level, I have volunteered in many capacities at the Yankee Dental Congress, including serving as presiding chair, room coordinator, and member of the Hospitality Committee. I've participated in the Council on Access, Prevention, and Interprofessional Relations (CAPIR) and the MDS House of Delegates, as well as attended Beacon Hill Day. Lastly, I've volunteered on the Mobile Access to Care (MAC) Van.

**Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

One time, a young patient on the MAC Van asked for a second toothbrush to take home with her so she would not have to share her new toothbrush with her sibling. That made me realize how needy some families really are and how we have a responsibility to do as much as possible to help.

**How has your volunteering impacted you on a professional and personal level?**

I feel that volunteering helps me stay current with changes in the profession.

**What do you feel are the most important issues facing organized dentistry today?**

In my mind, government and insurance company pressures on private practitioners is the most important issue we face as a profession.

**In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?**

Organized dentistry is our best chance as private practitioners to maintain the ability to control our destiny and not be overwhelmed by government regulation.

**What is your favorite . . .**

- ~ **Thing about the MDS?** Staff efficiency and organization
- ~ **Vacation spot?** Cape Cod
- ~ **Part of your job?** Getting to know my patients
- ~ **Dental procedure to perform?** Good old-fashioned all-gold crowns
- ~ **Sport to watch?** Football
- ~ **Movie?** *Goldfinger*
- ~ **Way to unwind on the weekend?** Sailing





Residence: **Worcester**  
 Office Locations: **Shrewsbury and Holden**  
 Specialty: **Orthodontics**  
 Dental Education: **State University New York at Buffalo (DMD and MS in oral medicine) and University of Rochester (Orthodontic Certificate)**  
 Number of Years in Practice: **26 (14 years as a general dentist and 12 years as an orthodontist)**  
 Number of Years of MDS Membership: **26**

## *Roland G. Nentwich, DDS*

### **When and why did you decide to join the MDS and be part of organized dentistry?**

While I was in dental school, I joined the American Dental Association. Upon graduating and settling in Central Massachusetts, I proceeded to join both the MDS and the Worcester District Dental Society (WDDS).

### **Is involvement in organized dentistry important to you? If so, why?**

I have never viewed involvement in organized dentistry as a burden or a chore. Rather, I have viewed it as a privilege. Having the opportunity to share my thoughts and concerns with colleagues, to learn, and to have the support of fellow professionals was critical. The Massachusetts Dental Society has always been ready and willing to provide insight and assistance to fledgling practitioners, assisting us all in the achievement of our goals.

### **Please describe the extent of your volunteer experience in dentistry.**

Over the years, I have had the pleasure of serving on a number of different boards alongside many very fine practitioners. I have worked with the Nursing Home Commission, been a mediator for the MDS Peer Review Committee, served on the MDS Council on Membership, and am past president of the WDDS. I have been associated with various dental residency programs, including the UMass Memorial Medical Center, and with the Worcester City Hospital Program. I have also had the pleasure of being associated with the Tufts University School of Dental Medicine Orthodontic Program as a lecturer on facial growth and development and as a clinical orthodontic instructor for the past 10 years. I served as the chair of the UMass Temporomandibular Disorder Study Group for three years. I have worked with some extremely dedicated individuals—some of whom have also been honored as Volunteer Heroes—to provide evaluations for underserved individuals at the St. Ann’s Free Clinic in Shrewsbury.

Additionally, I have been a delegate to the MDS House of Delegates. These experiences have provided me with many opportunities to see up close the wonderful services and experiences that can be found through active participation in the organizational aspects of dentistry.

### **Is there one volunteer experience that stands out in your memory? One day/event/person that made you know it was worth volunteering your time and expertise?**

I find that any time that I have a chance to share information about the practice of dentistry makes me feel more accomplished. In every teaching experience that I have been involved with, my personal growth and education has been greater than anything I may have provided to the student. The profession’s progress is predicated upon our ability to share and receive knowledge.



### **How has your volunteering impacted you on a professional and personal level?**

Volunteering has made me more aware of the needs out in the community. The ignorance regarding the importance of good oral health is staggering. There is a prevailing belief among the public that “I only worry about what affects my appearance.” I feel that the greatest service we can provide is educating the public about the importance of good dental health care.

### **Do you volunteer in community and philanthropic activities outside of dentistry? If so, what are they and what drew you to them?**

Yes. I have volunteered at a rape crisis center in Worcester and am presently involved in an advisory capacity for the evaluation and treatment of facial deformities in association with UMass Memorial Medical Center.

### **What do you feel are the most important issues facing organized dentistry today?**

First would be the commercialization of dentistry, followed by the need for determining a way to provide for the underserved segment of the population not qualifying for state assistance. We need to create a smoother transition for dentists new to the field to become part of the dental community. Also, we have large segments of the population that feel disenfranchised both within our profession and outside within the general public. This need has to be addressed, not only through volunteerism but also through government action. And last, but not least, we need to determine ways to limit the debt for our dental school graduates. This debt is crippling the graduates’ flexibility to move forward and limiting their ability to choose certain career paths.

### **In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?**

You cannot complain about your future if you are unwilling to be involved in your present.

### **What is your favorite . . .**

- ~ **Thing about the MDS?** The advocacy for the profession
- ~ **Word?** Adversity—from this can come greatness
- ~ **Vacation spot?** Anywhere on the water
- ~ **Part of your job?** Working with children
- ~ **Dental procedure to perform?** Nonsurgical correction of an orthopedic problem in a child through the use of functional appliances
- ~ **Book?** *The Foundation Series* by Isaac Asimov
- ~ **Sport to watch?** Football
- ~ **Movie?** *Remember the Titans*
- ~ **TV show?** *The Daily Show*
- ~ **Way to unwind on the weekend?** Skiing, playing golf, reading





John A. Herzog, DDS, continued from page 12

### What do you feel are the most important issues facing organized dentistry today?

Access to care and legislative issues are the two biggest concerns, in my opinion. The access issue is relatively constant, but the legislative issues change from year to year. The actions of the MDS and MDS-PAC in the legislative arena are probably the single biggest benefit to membership in the MDS.

### In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?

You will make lots of decisions throughout your professional life, but no single decision will have a more profound effect on your profession over the course of your career than the decision to be a part of organized dentistry.

### What is your favorite . . .

- ~ **Thing about the MDS?** Certainly, not that it's in Southborough! Honestly, I think I would have to say the staff. They are a great group of hardworking, committed people who have our best interests at heart.
- ~ **Word?** Yes.
- ~ **Vacation spot?** I don't have a single favorite. I view vacation spots like I view golf courses: I'd like to experience as many as possible over the course of my lifetime. I've enjoyed wonderful times in many places, but it's the variety of experiences that I cherish.
- ~ **Part of your job?** The people. It's the question I ask a young person if he or she is thinking about going into dentistry and asks me my opinion of it as a career. I ask them, "Do you like people? If you aren't a people person, then dentistry is probably not the best choice of careers for you."
- ~ **Dental procedure to perform?** Root canals. That may seem strange, but taking a person out of pain is one of the most gratifying experiences. It is tremendously rewarding and, in many cases, will win you a patient for life. When I was in dental school, one of my professors liked to tell us, "Learn how to get people out of pain. If you can do that, it will be the single biggest practice builder you'll ever need."
- ~ **Book?** Don't really have one, although my favorite magazines to read are *Esquire* and *Rolling Stone*.
- ~ **Sport to watch?** This used to be a toss-up between basketball and football. To my own amazement, I'd have to say that it's now golf. When I was younger and before I had taken up golf, I felt it was the most boring sport in the world to watch. Now that I golf, I appreciate the skill level of professional golfers. The consistency and accuracy of their games is something I could never understand until I tried to do it myself. However, I've quickly learned that, for me, golf will be a life-long pursuit of mediocrity.
- ~ **Movie?** There are many. To name a few would be easier. Ones that come to mind are *Chinatown*, *L.A. Confidential*, *Star Wars*, *Goodfellas*, *The Godfather*, and *The Matrix*. Hard to find a common theme running through there.
- ~ **TV show?** Once again, hard to pick one. Three that jump right out are *24*, *Law and Order: SVU*, and *NCIS*, which I only discovered fairly recently.
- ~ **Way to unwind on the weekend?** It used to be golf and/or the gym before we welcomed the newest addition to our family, our daughter, Emma, two years ago. Now, it's time with the family and yard work. I still love golf and working out; it's just finding the time that is difficult.



Amelia Grabe Lane, DMD, continued from page 13

to know that I was able to help them is a wonderful feeling. People are too selfish in our society, and they need to learn that we need to help each other in any way we can. I do whatever I can to help my fellow community members.

### Do you volunteer in community and philanthropic activities outside of dentistry? If so, what are they and what drew you to them?

As I mentioned earlier, as a third-generation Rotarian, I have volunteered a lot in my dad's Rotary Club. Even now that I've moved to Cape Cod, I still love to help them out with their big fundraisers whenever I can. Here, I try to help out whenever I'm asked, be it with the Chatham High School Athletic Fund or the Chatham Anglers of the Cape Cod League or any student interested in dentistry. I'm always happy to help out personally or, if possible, with a financial donation—every little bit of effort always helps in one way or another.

### What do you feel are the most important issues facing organized dentistry today?

Without a doubt, access to care and the various subissues of licensure, expanded function auxiliaries, etc., are at the forefront of our profession. Having lived in the sticks of New Hampshire where my dad was the only dentist in a town of about 3,000 people, I grew up in such an area where access to any type of medical care was at the forefront of the community issues. However, I strongly feel that the largest concern in providing access to care should be the quality of care provided—the philosophy should not be "it's good enough" or "anything's better than nothing." If it was your mother or even your own family who was in an area without much access to health care, would you feel it appropriate to hear that "anything's better than nothing"? It's appalling how people forget that one of the basic rights is to have access to quality health care, not just "good enough" health care. Any health care providers who feel that "good enough" is clinically acceptable need to reevaluate their ethical and moral standards and why they're in the medical field to begin with. It's called the Hippocratic Oath, we've all taken it, and we need to really determine how the "non-maleficence" (i.e., "do no harm") section of that oath is applied to the care we provide. There's no such thing as "good enough" in my book. People deserve better.

### In one sentence, what would you say to a recent dental school graduate to convince him/her to get more involved in organized dentistry?

You'll never regret it—where else can you find the same camaraderie, access to information, and support in anything regarding our profession? Nowhere.

### What is your favorite . . .

- ~ **Thing about the MDS?** All the wonderful people I've met—both at the MDS and other MDS members
- ~ **Vacation spot?** My junior year in college, I lived with a host family in Paris. So, it's my former hometown, the "City of Lights." Best food, people, and culture. Everything's pretty, and art is everywhere you look.
- ~ **Part of your job?** Hearing "Thank you, Dr. Lane."
- ~ **Dental procedure to perform?** Crowns and esthetic work—the artist in me loves being able to make things pretty and functional
- ~ **Book?** My guilty pleasure: the *Twilight* saga. Who can resist?
- ~ **Sport to watch?** Football. Go Patriots!
- ~ **Movie?** *Monty Python and the Holy Grail*
- ~ **TV show?** *The Big Bang Theory*. It hits a little too close to home sometimes, as a fellow geek.
- ~ **Way to unwind on the weekend?** Take my dog to the beach to run around and go for a walk and enjoy the beauty of life on Cape Cod

# Who Was Using Dental Services Just Prior to the Recession and How Do We Plan for the Recovery?

recession  
spending

**H. BARRY WALDMAN, BA, DDS, MPH, PHD**  
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## Abstract

Since the start of the current economic recession in December 2007, the number of unemployed persons has increased by 7.6 million to 15.1 million (as of October 2009), and the unemployment rate has doubled to 9.8 percent.<sup>1</sup> The economics of dentistry during the 2007–2009 recession are considered from the perspective of earlier recessions. The eventual turnaround in the economy is considered in terms of the need for dental practices to be extended to serve the multitude of underserved individuals in our communities.

## Regarding a Recession

A recession is a significant decline in economic activity, often reported as lasting at least two calendar quarters of negative gross domestic product (GDP). A recession begins just after the economy reaches a peak of activity and ends as the economy reaches its trough. Expansion is the normal state of the economy; most recessions are brief and they have been rare in recent decades.<sup>2</sup>

From 1945 to 2007, the National Board of Economic Research (NBER) has identified 11 recessions; their average duration was 10 months (peak to trough).<sup>3</sup>

It is during these recessions when workers lose their jobs, leading also to the loss of the health insurance that covers them and often their families. The loss of income and health coverage associated with rising unemployment causes more families to turn to safety-net programs like Medicaid and the State Children's Health Insurance Program (SCHIP) for health coverage.<sup>4</sup> The Medicaid Program provides health coverage and long-term support to 44.5 million low-income families, as well as nearly 14 million elderly people and people with disabilities.<sup>5</sup>

Many of the families recently seeking safety-net programs had a secure workforce attachment, steady income, and health coverage until they lost their jobs in the recession. Most who lose their jobs cannot afford the premiums to extend their employer-based health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their health plan for limited periods of time under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, and transition between jobs. Qualified individuals may be re-

quired to pay the entire premium for coverage—up to 102 percent of the cost to the plan.<sup>6</sup> Many families report that their lack of health coverage has serious adverse consequences on their already strained finances and deters them from obtaining health care because they cannot afford it.<sup>4</sup>

The Medicaid Program is feeling the strains of increased demand, while states have fewer resources available to support the program as revenues come in lower than projected. Unfortunately, the outlook is that FY2010 almost certainly will be a very difficult year, with the potential for widespread cutbacks and provider rate cuts that will affect millions of Medicaid beneficiaries.<sup>7</sup> (Note: The federal fiscal year is the accounting period of the federal government. It begins October 1 and ends September 30 of the next calendar year. Each fiscal year is identified by the calendar year in which it ends. For example, FY2010 begins October 1, 2009, and ends September 30, 2010.<sup>8</sup>)

### Planning for the Recovery

A previous review of dental economics during past recessions and the following years of economic expansion considered the reality that, in the short run, patients may delay elective dental procedures—such as esthetic procedures, replacements of the posterior dentition, and minor orthodontic procedures—or settle for less-expensive reparative and replacement procedures.<sup>9</sup> Based upon the review of health care expenditures in general, and specifically spending for

**Table 1. Length of Time Since Last Contact With a Dentist or Other Dental Health Professionals by age: 2007<sup>11,12</sup>**

Age (in years)	Less than 1 year	1–2 years	More than 2 years*
2–4	47.2%	3.2%	49.8%
5–11	64.6%	8.0%	7.3%
12–17	82.5%	9.9%	7.5%
<b>2–17</b>	<b>77.1%</b>	<b>7.9%</b>	<b>15.1%</b>
18–44	60.8%	14.9%	24.2%
45–64	65.4%	11.7%	22.8%
65–74	58.8%	10.7%	30.4%
75-plus	56.4%	8.7%	35.0%
<b>18-plus</b>			
Male	58.1%	13.4%	28.4%
Female	65.1%	12.7%	22.2%

\*Includes those who never visited a dentist

physician and dentist services, during the years following the recessions in the 1980s, 1990s, and 2001–2003, the study concurred with an earlier report from the American Dental Association (ADA) that “. . . because patient loads will increase over the long run, an economic recession should prove to be a minor interruption in improving practice conditions.”<sup>10</sup>

### Overall Use of Dental Services

An assessment of the use of dental services in the final period before the onset of the 2007–2009 recession would seem to confirm this optimistic perspective. The majority of individuals age 5 years and over were reported to have used dental services in the past year, ranging

from 56.4 percent of persons 75 years and over to 82.5 percent of older children ages 12–17, as well as 47.2 percent of children ages 2–4. In addition, almost two-thirds (65.1 percent) of adult females and more than half (58.1 percent) of adult males reported a dental visit in the past year. (See Table 1.) In the 10-year period since 1997, there was an ongoing increase among children and individuals 65 years and over in reported use of dental services during the previous year. While the proportion of adults between 18 and 64 years with a reported visit in the past year decreased slightly during this period, the number of those reporting a visit in the past 12 months remained over 62 percent just before the onset of the recession. (See Table 2.)

**Table 2. Dental Visit in the Past Year by Selected Characteristics: 1997, 2002, 2006<sup>13</sup>**

Age	2–17 years			18–64 years			65 years and over		
	1997	2002	2006	1997	2002	2006	1997	2002	2006
<b>Total</b>	<b>72.2%</b>	<b>74.2%</b>	<b>75.7%</b>	<b>64.1%</b>	<b>62.6%</b>	<b>62.4%</b>	<b>54.8%</b>	<b>55.5%</b>	<b>58.0%</b>
<b>Race/ethnicity</b>									
White	74.0%	76.3%	76.4%	65.7%	64.5%	63.3%	56.8%	58.0%	59.5%
African American	68.8%	68.8%	72.4%	57.0%	53.5%	55.6%	35.4%	33.9%	40.7%
Asian	69.9%	66.8%	75.5%	60.3%	62.7%	68.7%	53.9%	45.4%	66.0%
Hispanic (any race)	61.0%	62.5%	66.5%	50.8%	49.2%	47.2%	47.8%	47.9%	44.2%
<b>Economics</b>									
Poor	62.0%	64.4%	67.5%	46.9%	44.3%	44.8%	31.5%	35.0%	36.9%
Near poor	62.5%	66.9%	68.4%	48.3%	47.5%	46.8%	40.8%	43.0%	44.5%
Not poor	80.1%	79.6%	81.5%	71.2%	68.9%	69.6%	65.9%	64.7%	67.3%

## Use of Dental Services by Different Populations

General population averages tend to mask differences in varying segments in our communities. For example, reporting the national average that:

- 75 percent of the general population of children visited a dentist in the past year overshadows the reality that only 69.6 percent of children in poor families and 51.6 percent of uninsured children visited a dentist in the past year;
- 62 percent of individuals 18–64 years of age visited a dentist in the past year takes the limelight from the reality that only 47.2 percent of Hispanic individuals, 44.8 percent of individuals in poor families, and 34.8 percent of the uninsured in this age group visited a dentist in the past year;
- 48 percent of the uninsured population 18–64 years of age had no dental visit in more than two years de-emphasizes the fact that 22 percent had no dental visit in more than five years and 4 percent never had a visit. (See Tables 2 and 3.)

## National Health Insurance

As this material is being written during fall 2009, legislative decisions in Washington regarding national health insurance, and the host of related issues of general health services and specifically dental care, are far from completion—if, in fact, they will be completed during the present congressional session. In the interim, the dental profession (including individual practitioners) should consider those options that will encourage the demand for services to reach prerecession levels.

The usual series of suggestions to offset economic difficulties include highlighting preventive services (at home and in the practice), providing stepwise treatment planning with emphasis on “essential” services, as well as implementing alternative treatment modalities, limitations on elective procedures, and the delay of payment for services over an extended period of time.

The review of “who was using dental services just prior to the recession” offers an additional long-term strategy well beyond the immediacy of the period after

**Table 3. Length of Time Since Last Contact With a Dentist or Other Dental Health Professionals by Selected Characteristics: 2007<sup>11,12</sup>**

	Less than 1 year	1–2 years	More than 2 years*
<b>AGE 2–17 YEARS</b>			
<b>Race/ethnicity</b>			
White	77.5%	7.5%	14.9%
African American	75.3%	9.8%	14.9%
Asian	71.1%	7.8%	21.1%
Hispanic (any race)	72.0%	10.4%	17.6%
<b>Economics</b>			
Poor	69.6%	11.1%	19.3%
Near poor	70.3%	11.5%	18.3%
Not poor	81.4%	5.8%	14.7%
<b>Health insurance coverage</b>			
Private	81.8%	5.3%	12.9%
Medicaid or other public	74.5%	10.0%	15.6%
Uninsured	51.6%	20.1%	28.0%
<b>Region</b>			
Northeast	79.6%	5.2%	15.1%
<b>AGE 18 AND OVER</b>			
<b>Race/ethnicity</b>			
White	63.1%	12.5%	24.3%
Black	52.4%	16.4%	31.2%
Asian	62.2%	14.4%	23.4%
Hispanic (any race)	49.2%	16.9%	33.9%
<b>Economics</b>			
Poor	42.5%	14.4%	43.0%
Near poor	45.4%	14.9%	39.8%
Not poor	68.9%	12.3%	18.8%
<b>Health insurance coverage</b>			
Private			
18–64 years	72.2%	12.6%	15.1%
65-plus years	65.2%	8.8%	26.0%
Medicaid or other public	49.8%	15.2%	35.0%
Uninsured			
18–64 years	34.8%	17.2%	48.0%
<b>Region</b>			
Northeast	68.1%	14.1%	21.0%

\*Includes those who never visited a dentist

the recession: the need to reach the millions of underserved individuals in our communities. For example, in the period before the recession:

- Nearly 4 million children had unmet dental needs, including almost 1 million Hispanic children (of any race), more than one-third million African American

children, and 3.4 million Caucasian children;<sup>11</sup>

- The service most commonly reported as needed by children with special health care needs but not received was dental care;<sup>14</sup>
- More than 3.4 million adults have never had a dental appointment, including 1.7 million His-

panics (of any race), more than one-half million African American adults, and 2.4 million Caucasian adults.<sup>12</sup>

(Note: There is no doubt that these numbers increased markedly during the period of the recession. Specific information for this period should be available in forthcoming months.)

The reality is that the profession should not anticipate a major infusion of government financial resources for dental services from any national health insurance program, considering the fact that while federal, state, and local government support for total personal health services in 2007 represented 45 percent of costs (55 percent of hospital costs, 34 percent of physician service costs, and 62 percent of nursing home costs), government support for dental services amounted to 6 percent of costs, with projections that government support would reach 7.3 percent of total costs in 2011.<sup>15</sup>

While an economic recovery will assure the return of many of the ongoing patients who had to defer dental services for economic reasons, the need is to expand the population base served by dental practitioners. The profession and individual practitioners must be able to reach many of the underserved populations in our communities with necessary services. Dentists have a long history of tailoring the care for individuals with limited financial and/or disabling conditions. Planning for the recovery after the recession requires a broader perspective to include individuals who historically had limited contact with the profession. Individual practitioners provide services for patients who enter their practices, but they may have only a passing awareness of the hundreds or thousands of children and adults in their communities with unmet needs.

A previous presentation in the JOURNAL OF THE MASSACHUSETTS DENTAL SOCIETY cited examples of community pressure to develop solutions for the delivery of services that ran counter to efforts by the organized profession.<sup>16</sup> These included the passage of legislation (by an affirmative vote of three-quarters of the electorate) in the state of Oregon to legalize denturists to fabricate and provide dentures for older patients without the supervision of a dentist and efforts to provide dental services for residents in nonmetropolitan areas

of Alaska. Currently, other programs are being considered in various states to develop mid-level providers to meet the care needs of the underserved.<sup>17</sup>

The long-term efforts to recover from the recession may well combine renewed services to past patients of record and needed efforts to reach the underserved populations, rather than continuing the expansion of efforts to develop new cadres of lesser-trained individuals. And your suggestions? ■

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# New Guidelines for the Use of Minimal and Moderate Sedation by Dentists

*Editors' Note: This article was originally produced as a Clinical Dentistry Advisor for the Eastern Dentists Insurance Company (EDIC). It is being reprinted with EDIC's permission.*

*Author's Note: The opinions expressed in this article are those of the author and do not represent the official opinions of the American Dental Association, although they do reflect a summary of the 2007 Guidelines.*

In October 2007, the House of Delegates of the American Dental Association (ADA) overwhelmingly approved new guidelines regarding the teaching and use of sedation and general anesthesia by dentists and also reiterated the policy statement endorsing the use of sedation and anesthesia by educationally qualified dentists. The policy statement affirms that the delivery of sedation and anesthesia care is an integral part of dentistry. These guidelines provide guidance and direction to state boards of dental registration, malpractice and dental insurance carriers, the profession, and the public. They offer a uniform standard for the practice of sedation/anesthesia in dentistry and set forth an educational framework for the teaching and use of sedation and anesthesia for all dentists.

The new guidelines are a dramatic departure from the previous guidelines that have been evolving since 1972. The writing group (Committee H—Anesthesia) of the Council of Dental Education and Licensure was composed of experts representing the ADA, the American Association of Oral and Maxillofacial Surgeons (AAOMS), the American Academy of Periodontology (AAP), the American Academy of Pediatric Dentistry (AAPD),

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the American Society of Anesthesiologists (ASA), the American Dental Society of Anesthesiology (ADSA), and the American Society of Dentist Anesthesiologists (ASDA), as well as ADA staff members. After receiving input from communities of interest and incorporating further suggestions, the guidelines were presented at a reference committee hearing and at a unique town meeting prior to their adoption by the ADA House of Delegates.

## **Major Changes**

- Conceptually older versions did not comport with current dental practice, and significant changes in practice since the last revision, especially in the areas of minimal and moderate enteral sedation, were recognized and addressed.
- Reorganization of the documents based on the depth of sedation and anesthesia within the sedation–anesthesia continuum rather than the route of administration.
- The use of the American Society of Anesthesiologists' definitions in whole or part with these new definitions applicable to the practice of sedation and anesthesia in dentistry to unify medical/dental sedation providers.
- Endorsement of the American Academy of Pediatrics/ American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures for pediatric patients receiving sedation by dentists.
- Recommended development of a new emergency management course more relevant to the practice of sedation and anesthesia in the profession of dentistry.

## Definitions

Sedation and anesthesia is a continuum and it is not always possible to predict how an individual patient will respond. It is imperative to practice within one's educational qualifiers and state permitting. The most important concept of this continuum is that the ability to rescue a patient who enters a deeper level of sedation than initially intended is the key to safe practice. For all levels of sedation, the practitioner must have the training, skills, and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

## Levels of the Continuum

- **Minimal Sedation**—A minimally depressed level of consciousness, produced by a pharmacological method that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.
- **Moderate Sedation**—A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interven-

tions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

- **Deep Sedation**—A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- **General Anesthesia**—A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

## MINIMAL SEDATION

### Adults

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

## Children (Aged 12 and Under)

Children are at special risk for respiratory depression and airway obstruction during sedation. For that reason, the use of pre-operative sedatives for children (aged 12 and under), except in extraordinary situations, must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals. Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the ADA supports the use of the AAP/AAPD's *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

## Dosing Guidelines for Minimal Sedation

- **Maximum Recommended Dose**—Maximum Food & Drug Administration-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.
- **Incremental Dosing**—Administration of multiple doses of a drug until a desired effect is reached, but not to exceed the MRD.
- **Supplemental Dosing**—During minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for

**Table 1. Continuum of Depth of Sedation—Definitions of Levels of Sedation and General Anesthesia**

	Minimal Sedation "Anxiolysis"	Moderate Sedation "Conscious Sedation"	Deep Sedation	General Anesthesia
<b>Responsiveness</b>	Normal* response to verbal and physical stimulation	Purposeful* response to verbal or physical stimulation	Purposeful response following repeated or painful stimuli	Unarousable—even with painful stimuli
<b>Airway</b>	Unaffected	Unaffected	Intervention may be required	Intervention often required
<b>Spontaneous Ventilation</b>	Unaffected	Adequate	May be inadequate	Frequently inadequate
<b>Cardiovascular Function</b>	Unaffected	Usually maintained	Usually maintained	May be impaired

\*In accord with these particular definitions, the drug(s) and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of either minimal or moderate sedation.

Adapted from American Society of Anesthesiologists (ASA), *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*.

prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined that the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5 times the MRD.

### Education Requirements

To administer minimal sedation, the dentist must have successfully completed:

- Training to the level of competency in minimal sedation consistent with that prescribed in the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced; or
- An advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines.

and

- A current certification in basic life support (BLS) for health care providers.

Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia health care provider requires the operating dentist and his/her clinical staff to maintain current certification in BLS for health care providers.

### MINIMAL ENTERAL SEDATION

Education requirements for training to competency in minimal enteral sedation:

- A minimum of 16 hours.
- Clinically oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated.
- May include group observations on patients undergoing enteral

and/or combination inhalation-enteral minimal sedation.

- Clinical experience in managing a compromised airway is critical to the prevention of life-threatening emergencies.

### The Use of Minimal Enteral Sedation

A dentist, or an appropriately trained individual at the dentist's direction, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment.

The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist. The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge.

### Clinical Guidelines for Minimal Sedation

#### *Patient Evaluation*

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist. (See Table 2 for ASA Physical Status Classification.)

#### *Preoperative Preparation*

- The patient, parent, guardian, or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents, and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.

- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian, or caregiver.

### *Personnel and Equipment Requirements*

#### *Personnel*

At least one additional person trained in BLS for health care providers must be present in addition to the dentist.

#### *Equipment*

A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm. An appropriate scavenging system must be available if gases other than oxygen or air are used.

### *Monitoring and Documentation*

#### *Monitoring*

A dentist or an appropriately trained individual, at the dentist's direction, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

- Oxygenation—Color of mucosa, skin, or blood must be evaluated continually. Oxygen saturation by pulse oximetry may be clinically useful and should be considered.
- Ventilation—The dentist and/or appropriately trained individual must observe chest excursions continually. The dentist and/or appropriately trained individual must verify respirations continually.
- Circulation—Blood pressure and heart rate should be evaluated preoperatively, postoperatively, and intraoperatively, as necessary (unless the patient is unable to tolerate such monitoring).

### Documentation

An appropriate sedative record must be maintained, including the names of all drugs administered, detailing local anesthetics, dosages, and monitored physiological parameters.

### Recovery and Discharge

Oxygen and suction equipment must be immediately available if a separate recovery area is utilized. The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist. The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge. Postoperative verbal and written instructions must be given to the patient, parent, escort, guardian, or caregiver.

### Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administra-

tion of minimal sedation, and providing the equipment, drugs, and protocols for patient rescue.

### MODERATE ENTERAL SEDATION

The use of moderate enteral sedation for dentistry is a unique paradigm. These techniques rely upon either larger-than-maximum recommended doses or multiple doses titrated to effect. Titration is difficult due to inability to reliably predict absorption of these drugs from the gastrointestinal (GI) system.

Titration is the administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response, and duration of action is essential to avoid oversedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation, one must know whether the previous dose has taken full effect before administering an additional drug increment.

*(Author's Note: The teaching guidelines contained in this section on moderate sedation differ slightly from documents in medicine to reflect the differences in delivery methodologies and practice environment in dentistry. For this reason, separate teaching guidelines have been developed for moderate enteral and moderate parenteral sedation.)*

### Education Requirements

To administer moderate sedation, the dentist must have successfully completed:

- A comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced; or
- An advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines.

and a current certification in:

- Basic life support (BLS) for health care providers, and
- Advanced cardiac life support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.

Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia health care provider requires the operating dentist and his/her clinical staff to maintain current certification in BLS

**TABLE 2. ASA Physical Status Classification**

ASA Class	Description	Examples
<b>I</b>	A normal, healthy patient, without organic, physiologic, or psychiatric disturbances	Healthy with good exercise tolerance
<b>II</b>	A patient with controlled medical conditions without significant systemic effects	Controlled hypertension, controlled diabetes mellitus, cigarette smoking without evidence of COPD, anemia, mild obesity, age less than 1 or greater than 70 years, pregnancy
<b>III</b>	A patient having medical conditions and significant systemic effects intermittently associated with significant functional compromise	Controlled CHF, stable angina, poorly controlled hypertension, morbid obesity, bronchospastic disease with intermittent symptoms, chronic renal failure
<b>IV</b>	A patient with a medical condition that is poorly controlled, associated with significant dysfunction, and a potential threat to life	Unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
<b>V</b>	A patient with a critical medical condition that is associated with little chance of survival with or without the surgical procedure	Multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulation

for health care providers. This includes 24 hours of instruction and at least 10 adult case experiences by the enteral and/or enteral-nitrous oxide/oxygen route are required to achieve competency. These 10 cases must include at least three live clinical dental experiences managed by participants in groups no larger than five. The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep-to-moderate sedation.

Participants should be provided supervised opportunities for clinical experience to demonstrate competence in airway management with participant-faculty ratio of not more than five-to-one.

Courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals, and surgical centers.

### **Clinical Guidelines for Moderate Sedation**

A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness. The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge.

#### ***Patient Evaluation***

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

#### ***Preoperative Preparation***

- The patient, parent, guardian, or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents, and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Preoperative verbal and written instructions must be given to the patient, parent, escort, guardian, or caregiver.

#### ***Personnel and Equipment Requirements*** *Personnel*

At least one additional person trained in BLS for health care providers must be present in addition to the dentist.

#### *Equipment*

A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen, or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm. An appropriate scavenging system must be available if gases other than oxygen or air are used. The equipment necessary to establish intravenous access must also be available.

#### ***Monitoring and Documentation*** *Monitoring*

A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level, a qualified auxiliary

may be directed by the dentist to remain with the patient and continue to monitor him or her as explained in the guidelines until the patient is discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Consciousness—Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.
- Oxygenation—Color of mucosa, skin, or blood must be evaluated continually. Oxygen saturation must be evaluated by pulse oximetry continuously.
- Ventilation—The dentist must observe chest excursions continually. The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds monitoring end-tidal CO<sub>2</sub> or by verbal communication with the patient.
- Circulation—The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record). Continuous electrocardiogram (ECG) monitoring of patients with significant cardiovascular disease should be considered.

#### *Documentation*

An appropriate time-oriented anesthetic record must be maintained, indicating the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters. Pulse oximetry, heart rate, respiratory rate, and blood pressure must be recorded continually.

#### ***Recovery and Discharge***

Oxygen and suction equipment must be immediately available if a separate recovery area is utilized. The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness. The qualified dentist must determine and document that the level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge. Postoperative verbal and written instructions must be given to

## Additional Sources of Information

**American Academy of Pediatric Dentists (AAPD).** Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures: an update. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available from: <http://www.aapd.org/media/policies.asp>

**American Academy of Periodontology.** Guidelines: in-office use of conscious sedation in periodontics. Available from: <http://www.perio.org/resources-products/posppr3-1.html>

**American Dental Association.** American Dental Association policy statement: the use of sedation and general anesthesia by dentists. Available from: [http://www.ada.org/prof/resources/positions/statements/statements\\_anesthesia.pdf](http://www.ada.org/prof/resources/positions/statements/statements_anesthesia.pdf)

**American Dental Association.** American Dental Association guidelines for the use of sedation and general anesthesia by dentists. Available from [http://www.ada.org/prof/resources/positions/statements/anesthesia\\_guidelines.pdf](http://www.ada.org/prof/resources/positions/statements/anesthesia_guidelines.pdf)

**American Dental Association.** American Dental Association guidelines for the teaching of pain and anxiety control to

dentists and dental students. Available from: [http://www.ada.org/prof/resources/positions/statements/anxiety\\_guidelines.pdf](http://www.ada.org/prof/resources/positions/statements/anxiety_guidelines.pdf)

**American Dental Association.** American Dental Association Commission on Dental Accreditation. Accreditation standards for predoctoral and advanced dental education programs. Available from: <http://www.ada.org/prof/ed/accred/standards/index.asp>

**American Dental Association Council on Scientific Affairs.** Acceptance program guidelines: nitrous oxide-oxygen conscious sedation systems, 2000. Available from: <http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada>

**American Association of Oral and Maxillofacial Surgeons (AAOMS).** Parameters and pathways: clinical practice guidelines for oral and maxillofacial surgery (AAOMS ParPath o1) anesthesia in outpatient facilities. Contact the AAOMS at (847) 678-6200 or visit [www.aaoms.org/index.php](http://www.aaoms.org/index.php).

**American Association of Oral and Maxillofacial Surgeons (AAOMS).** Office anesthesia evaluation manual, 7th edition. Contact the AAOMS at (847) 678-6200 or visit [www.aaoms.org/index.php](http://www.aaoms.org/index.php).

**American Society of Anesthesiologists.** Practice guidelines for preoperative fasting and the use of pharmacological agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. Available from: <http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperativefasting.aspx>

**American Society of Anesthesiologists.** Practice guidelines for sedation and analgesia by non-anesthesiologists. Available from: <http://www.asahq.org/publicationsandservices/practiceparam.htm#sedation>. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to [www.asahq.org/publicationsandservices/sgstoc.htm](http://www.asahq.org/publicationsandservices/sgstoc.htm).

**Dionne RA, Yagiela JA, et al.** Balancing efficacy and safety in the use of oral sedation in dental outpatients. *JADA*. 2006;137(4):502-513.

**National Institute for Occupational Safety and Health (NIOSH).** Controlling exposures to nitrous oxide during anesthetic administration. NIOSH Alert. 1994. Publication No. 94-100. Available from: <http://www.cdc.gov/niosh/noxidalr.html>

the patient, parent, escort, guardian, or caregiver. If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

### Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation,

and providing the equipment, drugs, and protocol for patient rescue.

### Conclusion

There are millions of Americans in need of dental care who cannot or will not access dental care without the use of minimal, moderate, or deep sedation, or general anesthesia techniques. These patients include the mentally challenged, preoperative pediatric patients, and patients with motor dysfunction or other preexisting medical conditions where stress levels are important to attenuate. The high incidence of fearful, anxious, and phobic dental patients makes the use of sedation

an important tool in assuring these patients comprehensive dental care.

Guidelines are dynamic and reflect best practices over time. Increased educational offerings at all dental educational levels, adherence to proper patient selection, the use of appropriate monitors, and an understanding of the pharmacology of these sedative drugs will all increase patient safety. Rescue from unintended deep levels of sedation for minimal/moderate sedation providers and attention to the airway at all times will reduce the main causes of mortality and morbidity that center around hypoventilation, apnea, and airway obstruction. ■



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# The Eight Pillars of Perfect Record Keeping

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**A**s practitioners, we all find ourselves being challenged daily by hectic schedules, numerous patients, and difficult cases—not to mention life in general. One way to make your professional life easier is by demystifying the process of accurate and thorough record keeping. Modern-day record keeping should not elicit the anxiety that can accompany the word “modern.” In fact, modern-day record keeping is actually an instinctive composite (no pun intended) of the time-proven, classical diagnostic and treatment planning process that we were all taught, with a healthy dose of informed consent added in for good measure.

This article contains a comprehensive and easy summary of what thorough documentation and record keeping in today’s environment should look like. These “eight pillars” of realistic record keeping will prove invaluable for the continuum of care of your patients and will be a primary source of help and protection to you if your dental records ever need to appear before a critical insurance or regulatory auditing board.

## **First Pillar: Patient Information and Demographics**

This is basic patient information that must be contained in all records. Basic patient information includes the patient’s address, Social Security number, all relevant phone numbers, physician’s name and contact information, insurance information, and emergency contact information. If the patient is a child, then

the custodial parent contact information should be indicated. The signed Health Insurance Portability and Accountability Act (HIPAA) waiver should be included in this section as well.

## **Second Pillar: Medical and Dental History**

The information to be gathered from the patient’s medical history does not differ from what we originally learned in dental school. The record should contain a comprehensive review of past and present illnesses, any systemic diseases that may affect the oral cavity, as well as a review of systems. There should also be a screening of significant diseases, including, but not limited to, hypertension, diabetes, cancer, and allergies. A listing of any prescriptions and nonprescription medications utilized by the patient should be present as well. Finally, the medical history should be updated yearly by the patient and reviewed and documented by the practitioner. All previous medical histories should also be incorporated into the patient’s chart. Although this sounds overwhelming, we are lucky in the sense that there are many preprinted questionnaires available to us from many agencies that are inclusive of all the information required.

The patient’s dental history should pattern closely to the information gathered on the medical history form. The dental history should include any common problems that the patient has experienced in the past or is currently experiencing, as well as any condition that could adversely affect the patient’s dental treatment, such as syncope, general anxiety, xerostomia, or any reactions to particular anesthetics or drugs. Documentation should also include whether the patient is seeing a specialist for any dental treatment and whether there is tobacco and alcohol abuse. It is also extremely important to document the frequency of dental visits, the date of the last dental examination, and the current home-care regimen.

### **Third Pillar: Record of Examination**

This takes place when the patient is in the chair. Once a thorough intraoral and extraoral exam is performed, documentation in the chart should always include the findings of the physical exam, which would encompass intraoral and extraoral soft-tissue examination (oral cancer exam), examination of teeth, periodontal charting in full, and a record of the radiographic examination, including number of radiographs taken and type of radiograph (bitewings, full-mouth X-rays, etc.).

### **Fourth Pillar: Diagnosis**

A written diagnosis can take many forms. A diagnostic list occurs naturally when a complete record of examination is documented. Formulating a problem list based on a complete exam leads automatically to the organization of the patient's treatment, which in itself leads to the precursor of the treatment plan. The problem list can be defined as a differential diagnosis, which then should be followed by a definitive diagnosis. If a referral to a specialist is needed to determine a definitive diagnosis, then the referral should also be documented.

### **Fifth Pillar: Treatment Plan**

There must *always* be a documentation of the treatment plan in the patient's record. A treatment plan must outline the proposed treatment, prognosis, risk analysis, and anticipated outcomes. Historically, the treatment is documented in a stepwise process encompassing all phases of treatment: the initial exam, hygiene, Phase 1 treatment, Phase 2 treatment, and plans for recall.

The importance of a documented treatment plan cannot be overemphasized, as it serves so many functions. A formalized treatment plan enhances communication and forces a necessary dialogue between the practitioner and the patient, and clears up any misconceptions that the patient might have about his or her existing conditions and treatment. In addition, it ensures patient education. For the practitioner, the development of a formalized treatment plan ensures documentation of both the proposed treatment and the patient agreement, thereby eliminating future difficulties; it also serves to ensure that patient care is delivered in an organized manner by the practitioner and support staff.

### **Sixth Pillar: Informed Consent**

Informed consent is a natural segue from the treatment plan and an equally important part of the patient's record. The informed consent document ensures that the patient is well educated in the details of the proposed treatment plan; in addition, it prepares the patient for treatment. This process also serves to bring a clarity and openness to the practitioner-patient relationship, thereby helping to reduce complaints of inappropriate care as well as malpractice claims.

The document used to obtain informed consent must disclose in writing the nature of the condition being treated and the diagnosis. The document must also list the proposed treatment and any associated risks, as well as potential complications, side effects, and projected outcomes. In addition, the consequences of not undergoing proposed treatment, as well as any alternative treatments, must be disclosed.

One must bear in mind that all such documents must be signed by patients who are mentally competent and of legal age. Consent cannot be obtained fraudulently or under duress. It is not acceptable to have a patient give his or her informed consent while undergoing treatment (i.e., in the middle of a procedure), as that can be considered "duress."

### **Seventh Pillar: Progress Notes**

Although every pillar already listed in this article is an important part of the patient's record, the progress notes are by far the most crucial. It cannot be emphasized enough how important a detailed and thorough documentation of the patient visit can be. It is not enough to simply enter a one-line written note that lists what area was treated and what material was used. The progress notes are the only written recollection and documentation of treatment and interaction between the practitioner and patient at any given visit.

The question that occurs to all of us practitioners as we try to navigate a very busy workday is "How much do we write . . . or don't write?" The answer, although complex, can be simplified by following these tips:

- Always update. Check to make sure the medical history is current (within one year); ask the

patient if there have been any changes, and make a note in the progress notes as to whether there were changes or no changes. Either way, it must be documented.

- Document any medicaments used during the treatment procedure by amount and type.
- Document an objective account of what treatment was delivered and where. Also include a diagnosis of what you treated. Document the patient's reactions—negative and positive—during the procedure and after. Make sure the progress notes also include what instructions (if any) were given to the patient; these can range from home care to postoperative instructions. Indicate plans for the next appointment.

After the progress notes are thoroughly checked to make sure they contain all the above, it is imperative that they be signed by the practitioner. Initials or signature by anyone other than the practitioner is not acceptable.

### **Eighth Pillar: Miscellaneous**

Although it may seem by now that all relevant areas have been covered and that the patient's record contains an overabundance of information, this is not the case. A patient's record is an accurate composite of all information relevant to that patient. In addition to the above information, the patient record must also include any written exchanges with the patient, information of patient compliance (or noncompliance), and information exchange with other specialists or practitioners pertaining to the patient. Also, copies of laboratory slips, biopsy result slips, photographs, and the like are also considered to be part of the patient's record.

### **Conclusion**

Building on these eight pillars should make record keeping a little bit easier as we continue to navigate the waters of an increasingly complicated world. With time, these should become second nature. When all else fails, it is best to hearken back to the days of dental school and the standard of care we were taught there. ■





# A Clinico-Pathologic Correlation

**DANIEL OREADI, DMD**  
**MARIA B. PAPAGEORGE, DMD, MS**

*Dr. Oreadi is chief resident and Dr. Papageorge is professor and chair of the department of oral and maxillofacial surgery at Tufts University School of Dental Medicine.*

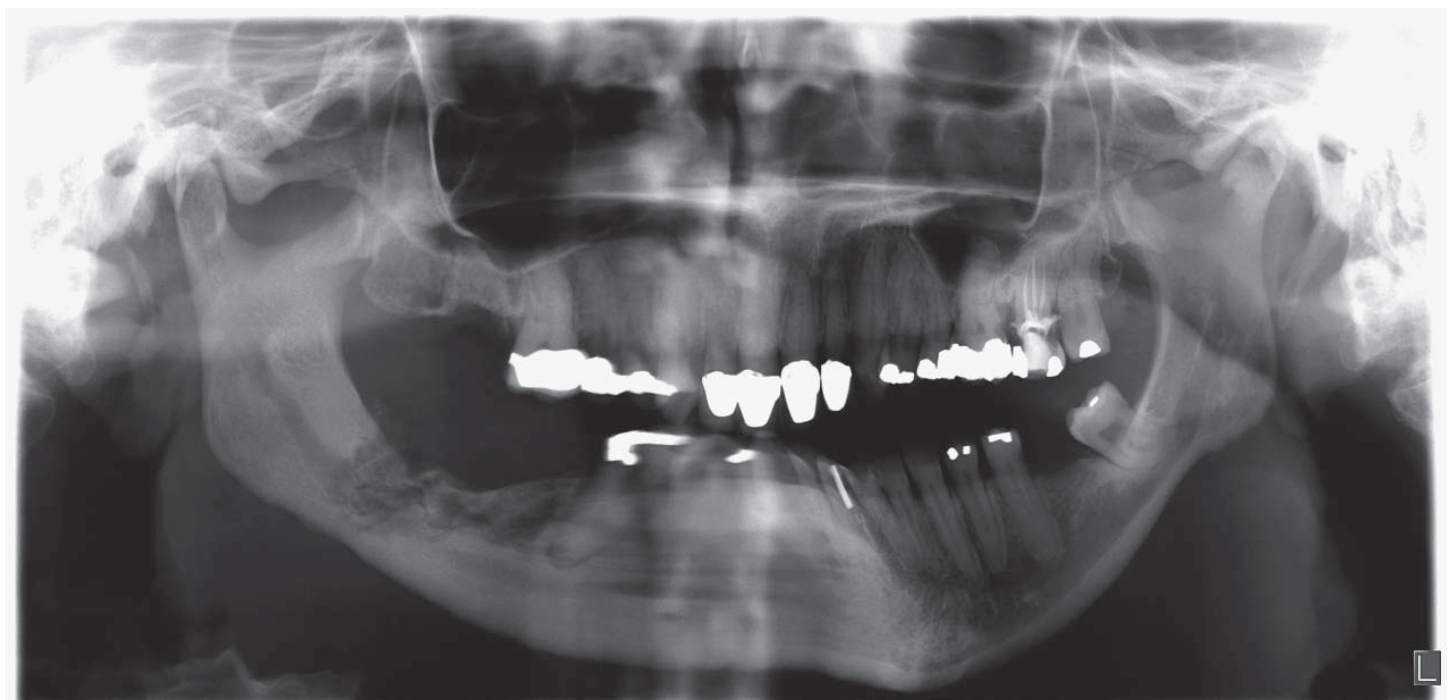


Figure 1. Panoramic radiograph showing the radiolucent "moth-eaten" appearance of the right mandibular body.

## History

The patient is a 55-year-old female who was referred to our department for evaluation and treatment of chronic pain associated with exposed bone in her right posterior mandible. Her medical history is significant for hypothyroidism, cholecystectomy, and breast cancer, which was first diagnosed 16 years ago. At that time, she was treated with chemotherapy and radiation therapy. Ten years later, in 2003, she was diagnosed with metastatic cancer to the liver and bones. This was followed with a four-year course of chemotherapy with zoledronate (Zometa®)

The patient developed pain in the right mandible and the right side of the face in August 2007. Tooth #31 was symptomatic and was removed by her oral surgeon. The pain did not sub-

side but instead became worse, and bone exposure of the right mandible developed. The oral surgeon prescribed hyperbaric oxygen in January and February 2008, but two weeks later the patient developed a localized infection in the same area. She was then treated with oral penicillin and referred to our institution for treatment. The patient complained of significant on-and-off pain to the right side of her face, although the pain was well controlled with ibuprofen. As the pain progressed, an opioid (Oxycodone) was prescribed.

On clinical examination during her initial visit, a large necrotic bone exposure of the right posterior mandible was noted, extending approximately 5 cm x 2 cm. There was sensitivity to the area with evidence of poor hygiene, but no significant soft-tissue swelling or active drainage. A panoramic radiograph revealed a "moth-eaten" appearance of the mandibular body on the right side (see Figure 1).

A virgin culture was obtained for microbiologic evaluation and a CTX laboratory study was ordered. The culture grew mixed aerobic and anaerobic flora. The results of the CTX were 175 pg/ml, which placed the patient within the minimal risk group. Based on such findings and her symptomatology, the de-

cision was made to continue with palliative care by managing her pain and preventing any overlying infection from developing. She was referred to our pain clinic for evaluation and better control of her pain and was started on antibiotics (Penicillin VK 500 mg by mouth every six hours for seven days).

## Differential Diagnosis

Bisphosphonate-related osteonecrosis of the jaws  
 Osteoradionecrosis  
 Osteomyelitis

## Diagnosis

Bisphosphonate-related osteonecrosis of the jaws

## Symptoms Course

The patient's symptoms improved for a few weeks. During her continuous follow-up appointments, it was noted that the bone necrosis was slowly progressing. The area started to swell and a chronic infectious process began to institute. In addition to the Penicillin, she was treated with different antibiotics, including Clindamycin and Augmentin.

Three months after her initial diagnosis, the patient presented to our clinic with complaints of increasing pain and severe swelling extending to the right side of her neck. A computed tomography (CT) scan revealed a pathologic fracture of her right mandible with an associated infection involving the submandibular space. The patient was taken to the operating room for incision and drainage and was kept on oral antibiotics for the next 20 days. Once the infection resolved, she was taken back to the OR for resection of the necrotic right mandible (see Figure 2) and stabilization of the remaining mandibular segments with external pin fixation.

The patient remained on external fixation for approximately three months, after which she underwent mandibular reconstruction with autogenous nonvascularized bone graft harvested from the patient's anterior iliac crests. Her postoperative course was uneventful and she is currently six months post-reconstruction, free of pain, and without any evidence of exposed bone or infection (see Figures 3 and 4).

## Discussion

The final diagnosis for this patient is consistent with her history of present illness and her symptoms. The fact that the patient never received radiation therapy to the head-and-neck region makes it unlikely for the development of osteoradionecrosis (ORN), and the clinical and radiographic findings exclude the possibility of osteomyelitis, although the necrotic bone was evidently infected at some point.

Physicians and dentists are now keenly aware of bisphosphonate-related osteonecrosis of the jaws (BRONJ) from the intravenous nitrogen-containing bisphosphonates that include pamidronate (Aredia®) and zoledronate. Oral nitrogen-containing bisphosphonates such as alendronate (Fosamax®) and risedronate (Actonel®) and possibly the more recently introduced ibandronate (Boniva®) demonstrate a risk for osteonecrosis as well.<sup>1</sup>

Bisphosphonate-related osteonecrosis of the jaws was first reported by Marx in 2003.<sup>2</sup> This severe complication occurs most frequently in patients on intravenous bisphosphonate treatment



Figure 2. Resected specimen showing the fracture, along with the necrotic bone in the superior border.



Figure 3. Two months' postreconstruction showing intact mucosa without graft exposure.

for malignant diseases, such as multiple myeloma or metastatic disease, and breast cancer. Bisphosphonates prevent, reduce, and delay cancer-related skeletal complications. Many authors, however, consider that the benefits of bisphosphonate treatment in malignant disease generally outweigh any risks.

Some cases of BRONJ have also been reported in patients on oral bisphosphonates. Millions of patients are on oral bisphosphonate treatment for osteoporosis; however, the risk of BRONJ is very low with these patients. The overall incidence ranges from 1/10,000–1/100,000 treatments, and these oral drugs are helpful in preventing hip fractures in older women in particular.

Bisphosphonates inhibit the enzyme 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase, block osteoclast protein phenylation, and thus block osteoclast-mediated bone resorption. This predisposes to BRONJ. There is an inhibition of osteoclast development from monocytes, increased osteoclast apoptosis, and prevention of osteoclast development and recruitment from bone marrow precursors. Other possible mechanisms include an anti-angiogenic effect and a suppressive effect on en-

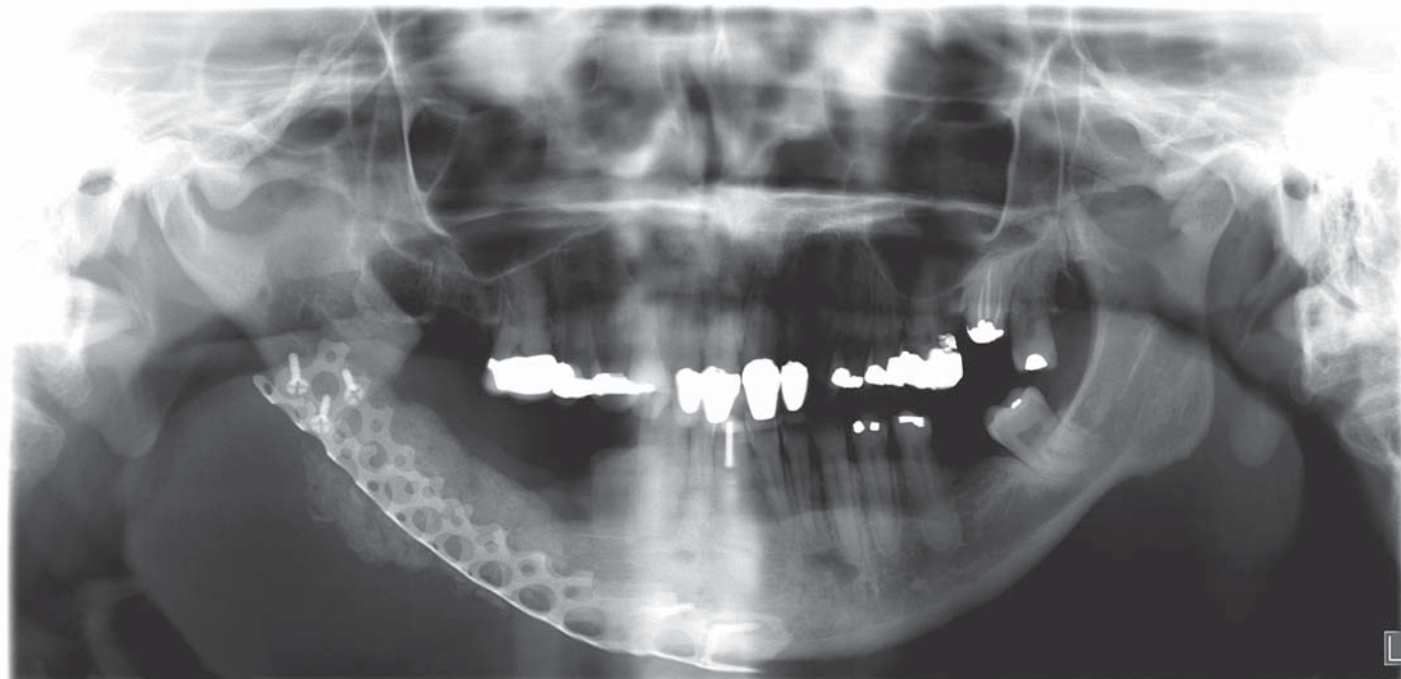


Figure 4. Panoramic radiograph two months after reconstruction.

endothelial cells with no effect on vascular endothelial growth factor receptor but reduced serum levels of interleukin 17.

Ruggiero and Drew described the elective involvement of the jaws compared to other bones.<sup>3</sup> It is suggested that it may be due to the healing of an open wound and that bisphosphonates are preferentially deposited in bones with high turnover rates like the maxilla and mandible. BRONJ is far more frequently induced by intravenous bisphosphonates than by oral bisphosphonates. Hoff et al. found that 16 out of 1,338 patients with breast cancer (1.2 percent) and 13 out of 548 with multiple myeloma (2.4 percent) on intravenous bisphosphonate treatment developed BRONJ.<sup>4</sup> Wang et al. reported a slightly greater incidence in multiple myeloma (3.8 percent), prostate cancer (2.9 percent), and breast cancer (2.5 percent),<sup>5</sup> but Mavrokokki et al. reported a lower overall incidence.<sup>6</sup>

In the original American Association of Oral and Maxillofacial Surgery (AAOMS) position paper,<sup>7</sup> BRONJ risks were categorized as drug-related, local, and demographic or systemic factors. Other medications, such as steroids, thalidomide, and other chemotherapeutic agents, were thought to be risk factors, but no measurable associations were identified. Subsequently, two new sets of factors, genetic and preventative, are available to report.

#### I. Drug-related risk factors include:

- A. Bisphosphonate potency: Zometa is more potent than pamidronate, which is more potent than the oral bisphosphonates; the IV route of administration results in a greater drug exposure than the oral route.<sup>4,5,8,9</sup> Using a number of different risk measures, the BRONJ risk among cancer patients given IV bisphosphonate exposure ranged from 2.7 to 4.2, suggesting that cancer patients receiving IV bisphosphonates have a 2.7- to 4.2-fold increased risk for BRONJ than cancer patients not exposed to IV bisphosphonates.<sup>6</sup>

- B. Duration of therapy: Longer duration appears to be associated with increased risk.

#### II. Local risk factors include:

- A. Dentoalveolar surgery, including, but not limited to:
  1. Extractions
  2. Dental implant placement
  3. Periapical surgery
  4. Periodontal surgery involving osseous surgery

In the original AAOMS Position Paper, local factors such as dentoalveolar procedures, local anatomic structures such as tori, and concomitant dental disease were hypothesized to increase the risk for BRONJ in the setting of IV bisphosphonate exposure. Patients receiving IV bisphosphonates and undergoing dentoalveolar surgery are at least seven times more likely to develop BRONJ than patients who are not having dentoalveolar surgery. In the setting of IV bisphosphonate exposure, four studies reported that dentoalveolar procedures or concomitant dental disease increased the risk for BRONJ between 5.3 (odds ratio) and 21 (relative risk). In other words, cancer patients treated with IV bisphosphonates who undergo dentoalveolar procedures have a 5- to 21-fold increased risk for BRONJ than cancer patients treated with IV bisphosphonates who do not undergo dentoalveolar procedures.

#### Conclusion

Bisphosphonates have shown great benefits for the cancer patient, and their indications outweigh the possible risks associated with their use. BRONJ has been reported with a relatively low overall incidence; however, it remains a difficult condition to treat. Therefore, prevention is the most important action we must take when treating patients with a history of any condition treated with such medications. Our understanding of this disease has improved over the past few years. The American As-

Table 1. Staging and Treatment Strategies

BRONJ* Staging	Treatment Strategies**
<b>At-risk category:</b> No apparent necrotic bone in patients who have been treated with either oral or IV bisphosphonates	<ul style="list-style-type: none"> <li>• No treatment indicated</li> <li>• Patient education</li> </ul>
<b>Stage 0:</b> No clinical evidence of necrotic bone, but nonspecific clinical findings and symptoms	<ul style="list-style-type: none"> <li>• Systemic management, including the use of pain medication and antibiotics</li> </ul>
<b>Stage 1:</b> Exposed and necrotic bone in patients who are asymptomatic and have no evidence of infection	<ul style="list-style-type: none"> <li>• Antibacterial mouthrinse</li> <li>• Clinical follow-up on a quarterly basis</li> <li>• Patient education and review of indications for continued bisphosphonate therapy</li> </ul>
<b>Stage 2:</b> Exposed and necrotic bone associated with infection as evidenced by pain and erythema in the region of the exposed bone with or without purulent drainage	<ul style="list-style-type: none"> <li>• Symptomatic treatment with oral antibiotics</li> <li>• Oral antibacterial mouthrinse</li> <li>• Pain control</li> <li>• Superficial debridement to relieve soft-tissue irritation</li> </ul>
<b>Stage 3:</b> Exposed and necrotic bone in patients with pain, infection, and one or more of the following: exposed and necrotic bone extending beyond the region of alveolar bone (i.e., inferior border and ramus in the mandible, maxillary sinus, and zygoma in the maxilla) resulting in pathologic fracture, extraoral fistula, oral antral/oral nasal communication, or osteolysis extending to the inferior border of the mandible of sinus floor	<ul style="list-style-type: none"> <li>• Antibacterial mouthrinse</li> <li>• Antibiotic therapy and pain control</li> <li>• Surgical debridement/resection for longer-term palliation of infection and pain</li> </ul>

Source: Adapted from the AAOMS Task Force on BRONJ Position Paper

\*Exposed bone in the maxillo-mandibular region without resolution in 8–12 weeks in persons treated with a bisphosphonate who have not received radiation therapy to the jaws.

\*\*Regardless of the disease stage, mobile segments of bony sequestrum should be removed without exposing uninvolved bone. The extraction of symptomatic teeth within exposed, necrotic bone should be considered, since it is unlikely that the extraction will exacerbate the established necrotic process.

\*\*\*Discontinuation of the IV bisphosphonates shows no short-term benefit. However, if systemic conditions permit, long-term discontinuation may be beneficial in stabilizing established sites of BRONJ, reducing the risk of new site development and reducing clinical symptoms. The risks and benefits of continuing bisphosphonate therapy should be made only by the treating oncologist in consultation with the oral maxillofacial surgeon and the patient.

\*\*\*Discontinuation of oral bisphosphonate therapy in patients with BRONJ has been associated with gradual improvement in clinical disease. Discontinuation of oral bisphosphonates for 6–12 months may result in either spontaneous sequestration or resolution following debridement surgery. If systemic conditions permit, modification or cessation of oral bisphosphonate therapy should be done in consultation with the treating physician and the patient.

sociation of Oral and Maxillofacial Surgeons Task Force on BRONJ has developed a series of recommendations that are worth reviewing in an attempt to prevent and/or manage this condition. The literature is extensive but the knowledge of it is lacking. Education among physicians, dentists, and patients is important in order to avoid treatment delay and poor outcomes. Future research in the development of novel strategies for the prevention, risk reduction, and treatment of BRONJ is needed in order to decrease risks of development and improve care for patients suffering from this disease. ■

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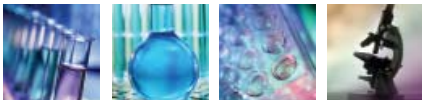
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## PATHOLOGY SNAPSHOT

**VIKKI NOONAN, DMD, DMSC**  
**SADRU KABANI, DMD, MS**

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# MEDICATION-INDUCED HYPERPIGMENTATION OF THE ORAL MUCOSA

**N**UMEROUS MEDICATIONS HAVE BEEN IMPLICATED AS THE CAUSE of intraoral hyperpigmentation. Several mechanisms by which medications act to induce oral hyperpigmentation have been identified and include the stimulation of melanin production by melanocytes, the deposition of pigmented drug metabolites within the soft tissues, chelation of hemosiderin to the medication, and the synthesis of other pigments such as lipofuscin.<sup>1,2</sup> While the clinical presentation of medication-induced intraoral hyperpigmentation varies, such pigmented changes are often multifocal and diffusely distributed within bound-down mucosa. This condition may arise at any intraoral site; however, the hard palate is the most common location with sharp demarcation at the soft-palate junction.<sup>3,4</sup>

The reason behind this preferential localization of medication-induced hyperpigmentation to the hard palate is unclear. Two commonly prescribed medications notable for inducing intraoral hyperpigmentation are minocycline and antimalarial medications. Intraoral minocycline-induced hyperpigmentation often involves the teeth and bone. These pigmented changes are clinically visible due to the relative translucency of the overlying mucosa;<sup>5</sup> however, bona fide soft-tissue minocycline-induced hyperpigmentation has been described and is characteristically limited to the bound-down mucosa.<sup>2</sup> Antimalarial medications, frequently prescribed for the management of lupus, also induce pigmented changes of the bound-down mucosa, most notably the hard palate.

The differential diagnosis for diffuse and multifocal pigmented intraoral lesions includes physiologic (racial) pigmentation,<sup>6</sup> postinflammatory hyperpigmentation such as smoker's melanosis,<sup>7</sup> and systemic conditions associated with diffuse oral and cutaneous hyperpigmentation. Although in some instances such changes are esthetically displeasing, medication-induced



**Figure 1. Diffuse pigmentation of the hard palate in a patient with lupus managed with anti-malarial medication.**

hyperpigmentation is benign and there are no long-term complications associated with this condition. Early recognition and discontinuance of the medication may cause the pigmentation to diminish with time. Typically, a thorough history will uncover the underlying nature of the process; however, a biopsy with submission of lesional tissue for histopathologic evaluation may be indicated to exclude the possibility of a melanocytic malignancy. ■

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**NORMAN BECKER, DDS, EDITOR EMERITUS**

## My Stroke of Insight

**JILL BOLTE TAYLOR, PhD**

*A Plume Book of Science—Penguin Publishers*

By a stroke of luck, I was introduced to *My Stroke of Insight*, Harvard neuroanatomist Dr. Jill Bolte Taylor's personal journey after suffering from a massive stroke in the left hemisphere of her brain. A personal account into the beauty and resiliency of the human brain as seen through the eyes of a neuroscientist, *My Stroke of Insight* is more a guide with hints on how to control emotions and enjoy life.

After detailing the anatomy and functions of the human brain, Dr. Taylor describes the stroke she experienced: "Feeling detached from normal reality, I seemed to be witnessing my activity as opposed to feeling like the active participant performing the action." The rest of that chapter describes her experience with the plea, "Remember, please remember everything you are experiencing! Let this be my stroke of insight into the disintegration of my own cognitive mind."

The remainder of the book, which reads like a novel, does more than describe her efforts toward recovery. Dr. Taylor uses her thoughts and experiences to teach caregivers their important role while at the same time offering positive reflections of a patient's feelings and comprehensions:

"I desperately needed people to treat me as though I would recover completely."

"Offer me multiple-choice questions and never ask me Yes/No questions, but at the same time, give me time to try to understand the answer. For example, 'Do you know the name of the President of the United States?' may require time to try to remember what is meant by 'Name'?, then what is meant by 'President'?, 'what is the United States?'"

"Be patient with me even if a question must be repeated 20 times. Each may be the first for me."

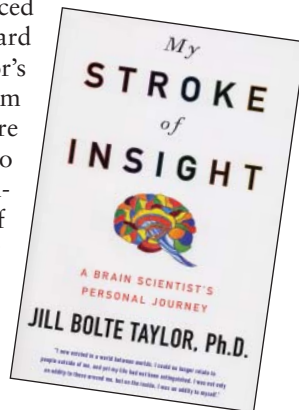
Although the descriptions of the stages of recovery were compelling, I was most impressed by the philosophy of living that Dr. Taylor teaches throughout her story:

"The more aware I am about how I am influencing the energy around me, the more I have a say in what comes my way."

"I am in control of how I choose to think and feel about things. Even negative events can be perceived as valuable life lessons, if I am willing to step to the right and experience the situation with compassion."

"Be grateful for all that is."

If you choose to read this account of Dr. Taylor's venture, you may just become a better caregiver and a better diagnostician.



## The Practitioner's Credo—10 Keys to a Successful Professional Practice

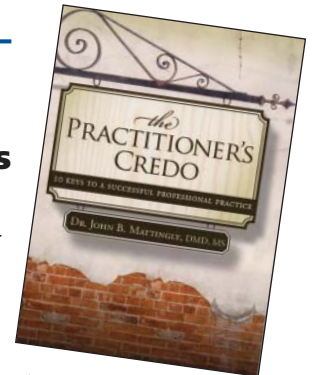
**JOHN B. MATTINGLY, DMD, MS**

*Morgan James Publishing*

Dr. Mattingly has included practical and often wise hints within his "10 keys" that may seem like common sense but bear repeating. It's all too easy to forget the basics.

His 10 keys include the following: There should never be a time when respect is taken for granted and common courtesy is not extended; successful practices all enjoy the stability of happy, secure, hardworking staff; the words "please" and "thank you" go a long way to showing respect and appreciation; stress is self-induced . . . each unfair, unjust action that we are responsible for adds a layer of stress; and the pursuit of excellence should be a major objective of every practitioner.

In addition to the philosophical advice that appears throughout the book, Dr. Mattingly offers practical examples of implementation of the keys, such as patient letters, office manuals, marketing, and practice management. ■



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## ART OF DENTISTRY

### ERIC K. CURTIS, DDS, MAGD, ELS

Dr. Curtis is past president of the American Association of Dental Editors. In 2006, he received the American Dental Association's Distinguished Editor Award.

## HABLANDO ESPAÑOL

THERE ARE DEFINITE ADVANTAGES TO SPEAKING SPANISH. I REALIZED it in dental school, when I was assigned interesting cases simply because no one else in my work group could figure out what those patients from San Francisco's Mission District were complaining about. Spanish rescued me when I graduated; while many of my classmates stressed over finding people with that perfect Class II board lesion, the patients who spoke Spanish came looking for me.

My background in Spanish helped me learn French during my dental residency in a Swiss hospital, and it has deepened my enjoyment of English. These days, my wife and I use Spanish as a convenient secret code to say things to each other we don't want our kids to understand—which is motivating them to want to learn it themselves. My patients who overhear me speaking Spanish think I'm a genius (a misunderstanding I am slow to correct).

People who know I speak Spanish are often envious. Every week someone else tells me, "I wish I could learn Spanish." Given the number of Spanish-speaking patients all across the United States, dentists *should* learn it. Knowledge of Spanish is becoming not just a question of convenience, but of pressing practicality. The United States has the world's fifth-largest Spanish-speaking population, after Mexico, Spain, Argentina, and Colombia. And the numbers are growing. According to 2008 American Community Survey demographic estimates, 15.1 percent of the U.S. population is Hispanic, and the U.S. Census Bureau predicts that in 2050, that figure will rise to 24 percent.

Understanding Spanish is a matter of cultural sensitivity. Spanish speakers will also take your attempts to communicate as a sign of personal sensitivity, as well as a clear compliment. Acknowledging your patients' cultural background can reduce fears and build trust and confidence. Speaking one-on-one also helps preserve patient confidentiality. What's more, patients will more likely follow treatment plans they understand.

How should a dentist go about picking up some useful Spanish? How-to books can lend a hand. There are a variety of volumes that cover health care-oriented Spanish. Many are grammar books, attempting to teach the basics of Spanish by means of medical terminology, and most of those, such as Janet E. Meizel's *Spanish for Medical Personnel* and Ana Malinow Rajkovic's *Manual for (Relatively) Painless Medical Spanish* include only a very little dentistry.

Two useful volumes that I keep on my office bookshelf are dictionaries: Marcos Freiberg's *Bilingual Dictionary of Dental Terms, Spanish-English* and *Dental Lexicon, 2nd ed.*, a listing of English dental terms with their equivalents in Spanish, German,

and French. You might also want to look for useful phrases in Spanish-language American Dental Association or Massachusetts Dental Society brochures.

But the truth is, you will get only limited Spanish from words on a page. And self-study courses, even the ones with tapes and interactive CDs, are helpful only if you are really, really motivated. Just as you learned dental surgery primarily by taking a bur to enamel, you absorb Spanish mainly by getting practice speaking it. So take a class. Better yet, take an immersion class, such as the one my family and I enrolled in a few years back.

We flew to Mexico City, then drove an hour south over the mountain to Cuernavaca, where we each enrolled in the Centro Bilingüe, a language school affiliated with the University of Morelos. Nestled in a lush garden setting, the Centro's cafeteria sells electric orange mango slices and blood-red hibiscus tea, while its skilled teachers proffer equally colorful and invigorating language lessons. While my kids conjugated verbs, I punched up my conversational flow discussing literature and current affairs. When I mentioned I wanted to review some dental terminology, the Centro arranged for several private tutoring sessions with a local nurse whose father was a dentist. We lived with a local family, so when we went home we continued to practice the target language. After two weeks, my kids weren't fluent, but they were confident about expressing themselves using their newfound vocabulary.

You don't have to speak Spanish perfectly—or even very well—to communicate effectively. There are three things to remember about learning Spanish: (1) Grammar and pronunciation don't have to be flawless to be understood; (2) Spanish is a Latin-based language, so many words are similar in both Spanish and English, which makes remembering vocabulary easier; and (3) a lot of information can be conveyed with a few simple expressions.

Let me start you out. *Mucho gusto* means "Pleased to meet you." *¿Qué pasa?* means "What's going on?" or "What's the problem?" *¿En que le ayudo?* translates to "How can I help you?" *¿Dónde le duele?* is "Where does it hurt?" *Diente* is a tooth, *hueco* is a cavity, *relleno* is a filling, and *piquete* is the shot (the "qu" is pronounced "k"). *Sacar* means "to pull," if it has to come out. *Abra* means "open," and *cierre* means "close." There you are. You're ready for your next patient. And your next lesson.

"A different language," filmmaker Federico Fellini once said, "is a different vision of life." In treating our patients, knowing some Spanish can result in a more sensitive, profound vision of dental care. And it's one practice builder you can enjoy after hours, too. ■

