FLORIDA FOCUS
Official Publication of the Florida Academy of General Dentistry

Volume 22, No. 2 | Education ■ Advocacy ■ Excellence | Spring, 2012

Message from the Florida AGD President

by Tony Menendez, DDS, MAGD

By nature, I am not a political individual. Yet here I sit, writing to you about the inevitable political quandary we will all face in the not too distant future. I have talked with many of you, inquiring about your awareness of up and coming legislation concerning the scope of our practice and that of, as yet defined, auxiliary personnel. The FDA in conjunction with the Hygiene association has supported and promoted through our state legislature, a bill allowing hygienists the ability to deliver local anesthetics. Most of you were unaware that this measure was even in existence, let alone this far along. Believe it or not, I support this legislation on its face value. I believe the patient, hygienist and doctor all benefit from this statute. Even though there are well documented methods of providing patient comfort without local anesthesia, I believe that a hygienist's armamentarium should include the ability to provide local anesthesia for the comfort of the patient without having to wait for the Doctor. Remember, I am not a political individual but I do believe I am logical to a fault. Most hygiene appointments are less than 1 hour in length and even if this would involve root scaling and planing, I don't believe much more than infiltrations are needed to obtain good anesthesia. I asked the powers that be, why this legislation promotes the delivery of blocks without limitation to the use of vasoconstrictors by hygienists. Their reply, "Good dentists will insure the proper use of anesthesia as they are ultimately responsible for the actions of their hygienists". When questioned about the potential for abuse and misuse of this statute, specifically the wide open scope of practice issues, they restate the aforementioned statement. Mind you, I have asked this question of more than a handful of individuals and repeatedly get the same general response. As an individual whose original reason for seeking out membership in the AGD was lifelong learning, I was concerned with the limited number of both clinical and didactic hours needed for hygienists to provide local anesthesia. I remember quite well, the victim of my first injection. I was a rising junior at Emory University College of Dentistry, having completed rigorous didactic education in anatomy, physiology and pharmacology, and understanding the inherent danger of giving local anesthetics; with that I began my clinical training. Don't get me wrong, I believe that providing infiltrations with anesthetics devoid of vasoconstrictors is within the scope of dental hygienists, I don't believe that hygienists need to give blocks with the rare possibility of morbidity or mortality. When I asked about this aspect of the legislation, I was advised that 44 other states have similar legislation and none other is as restrictive as ours and they have seen no reason to become more restrictive. I agree

Menendez, *continued on page 2*

What's Inside?

President's Message, Continued from Page One

that good dentists will insure the safety of their patients and practice a "do no harm" philosophy. I also realize that there are individuals who see this legislation as a shortcut, a way to increase production and profitability by hiring a "hygiene anesthetist" that frees the Doctor to concentrate on productivity; a concern that has been verified by practitioners in those states that currently have hygiene anesthesia laws. This certainly concerns me!

As AGD members, we espouse the philosophy and adhere to our commitment of lifelong learning. We continue to build upon the basic education we received in dental school and understand that continuing education allows us to provide the finest service we possibly can to our patients. With this thought in mind, we are all well aware of the advantages of education. Why then, are we witnessing the "dumbing down of dentistry"? We ask dental students to labor through anatomy, physiology; pharmacology and occlusion prior to treating their first patient yet hygienists will only be required to take minimum didactic and have minimal clinical exposure prior to providing anesthetic blocks. Why is there such a double standard? I understand that our state will have one of the most restrictive statutes regarding the administration of local anesthesia by a hygienist, but is this realistic and what do we say to those dental students who are held to a higher standard? I recently asked a hygiene student what she thought about the law and she stated that she did not feel comfortable giving anesthesia, besides, it was hard enough learning how to place amalgams and composites. Where have I been? I was totally unaware that hygienists were being trained to place restorations. The next change on the horizon is the expanded functions duty assistant, capable of placing and finishing both amalgam and composite restorations. Once again, "good" dentists will abide by the statute and use it as it is intended, but am I the only one who sees the abuse potential in this future legislation? Unfortunately, the practice of dentistry is in most cases, a business. For most of us, morality and ethics guide us with respect to the treatment of our patients. For others, greed is the prevailing factor. I have been told by people I respect and admire that what you are seeing is our last ditch effort to control our own destiny. By having broader dental therapies provided by auxiliaries under our direct supervision, we are involved in shaping our own future. If we don't do it, somebody else will and if the Pew and Kellogg foundation have their say, mid-level providers will be the solution.

This is a very complex problem. It takes many years and much money to train a young dentist. What then is the value of a dental degree? Should we encourage these individuals to pursue a career when the value of their education is being undermined? Is the "dumbing down of dentistry" likely to increase the access to care issue, or are we looking for solutions in all the wrong places? Certainly something must be done to improve the oral health of our nation. The public must be educated in preventative care, the authorities must mediate and oversee the disbursement of care and we must do our part to make it work. Yes, if we don't do our part the authorities will find someone who will. Get involved, be aware and speak your mind.

FLORIDA FOCUS

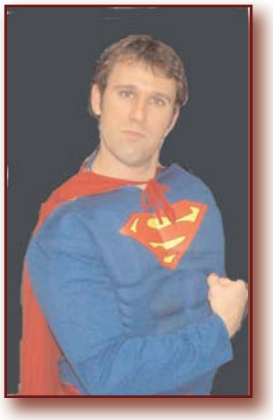
Published by the Florida Academy of General Dentistry
2372 NW 8th Street, Delray Beach, FL 33445

Tony Menendez, DDS, MAGD , President
Chris Wujick, DMD, Editor
Rosalie A. Small, Managing Editor

Send announcements and correspondence to:
Florida Academy of General Dentistry
2372 NW 8th St., Delray Beach, FL 33445
Phone: (866) 620-0773 FAX: (707) 220-2861 Email: flagd@flagd.org

Send letters to the editor to:
Chris Wujick, DMD, Editor
8475 Seminole Blvd., Seminole, FL 33772
gatorwuj@hotmail.com

Editor's Message



Dentists of Steel

by Dr. Chris Wujick
Editor, ***Florida Focus***

Few times in a dentist's career will one look around the state's dental landscape and feel a sense of parity with other dentists. Be it location and situation of employment, professional development, level of earnings, or energy for the profession; we all vary from our colleagues in many ways. But, this is one of those few times in our careers where we are all in the same boat. A new biennium has begun, and we all stand 30 CEUs away from maintaining our professional status. So, I want you think about how you plan on addressing this requirement. Are you going to wait to the last minute and quickly accumulate the requirement because you have to? Or, are you going take this requirement as inspiration to truly grow professionally and be an even better dentist than last biennium.

I see good CE as providing more than just an enhancement in our knowledge base, but also an enhancement in our energy for our career. In fact I get the same feeling from CE courses as I used to get as a child wearing my superhero underoos. With the power of those childhood protective drawers, I felt like I could fly off my bed a little higher. I could run a little faster. And I felt like no monster in my closet or under my bed could ever get me. Like the Man of Steel, I felt empowered. I was ready to tackle my challenges and succeed.

You too will feel energized back at your practice following a good CE course. With new knowledge in hand the superhero "S" on your chest will garner you the confidence to expand your treatment options. You will feel like a red cape sails you between operatories with an uplifting theme song playing in the background. Your understanding of new technologies might give you a sense of X-ray vision to avoid problems you once thought unavoidable and treatment plan better than you ever have before.

Your office team will feel this superhero zest and your new sense of empowerment will spread. Your office will be energized with you leading the way. Your staff will notice how your new knowledge translates into better treatment for your patients, and your staff will subconsciously raise their game as well. They will be staring at you in the morning huddle thinking "it's a bird, it's a plane, no, its Benjamins." As with this enhanced skill and confidence comes enhanced earning ability for the office.

The AGD will help you achieve this empowerment. In addition to advocacy, the Academy's mission is to provide for its members the best CE available. Convenient local and statewide monthly meetings will help keep you stimulated and engaged in our profession with topics that can be immediately integrated into your practice. The National AGD Conference will be in Philadelphia this year, from July 21st to the 24th, and will provide many opportunities to refine your skills on more targeted areas.

So, this biennium, revisit your days of underoo glory. Think of the CE requirement not as a requirement but rather as an opportunity. Take this opportunity to fly high where only dentists of steel can fly.

Finally, on a personal note, I would like to thank Dr. Elizabeth Nunez for her assistance with this issue of the ***Florida Focus***.

Update on the Central Florida AGD

The Central Florida Chapter of the AGD has a new president, Dr. Mark Falco of Lake Mary. This year we have six scholarships to award deserving dental assisting students. An AGD social event has been scheduled on March 7th at Dubsdread Country Club in Winter Park to kick off the new year. More events will follow.

Protect Yourself - Bits and Pieces of Risk Management

by Dr. Frank Recker, JD

Throughout the course of the day, general risk management questions arise which, standing alone, do not require a dissertation to answer. I would like to address a few of the many issues that can be answered in a relatively brief manner:

Q: Do I have to give a patient a copy of their records? Don't they belong to me (the dentist)?

A: A patient is entitled to receive a complete copy of their dental records, including radiographs, lab slips, chart entries, financial records, and photos. A dentist is permitted to charge a reasonable fee for making copies of those records. And no dentist is expected to 'immediately' produce such records upon demand by a patient. The original records are the property of the dental office.

Q: If a patient is unhappy and demands a refund, what should I do?

A: Each situation must be weighed on its own facts, considering the amount in question, the extent of the treatment rendered, the attitude of the patient, the patient's propensity to accept responsibility for their own role in dental health, etc. Generally speaking, I have no objection to a dentist refunding fees for services rendered as long as a 'release' is obtained from the patient. It would simply make no sense, for example, to refund $10,000, only to later face a malpractice suit by the same patient.

Q: If a patient's attitude about their dental treatment degenerates to the point of hostility with dental staff or the dentist and treatment is not completed, can I terminate the patient?

A: Yes. In virtually all circumstances a dentist can terminate the dentist/patient relationship regardless as to whether or not treatment has been completed. Doing so may involve a pro rata refund of fees paid in advance (i.e., incomplete root canal, bridge not seated, etc.) but that can be a great deal easier than continuing to treat an obviously hostile or disgruntled patient. 'Abandonment' is a legal concept that requires 'injury' to the patient and the patient has an obligation to avoid incurring any injury. Any patient termination should include a letter to the patient explaining that further treatment is necessary and that they should immediately seek the services of another dentist. The letter should also include a warning that failure to finish treatment in progress, or address a dental condition not yet treated, could result in injury to their teeth, oral tissues, and jeopardize their dental health.

Q: I have several new patients who are absolutely wonderful, but they refuse to allow me to take radiographs ostensibly because of their fear of additional radiation. They are willing to sign a chart entry stating that they refuse dental x rays and will not hold me responsible. Would this be okay?

A: No. As a matter of law, a patient cannot give valid consent to treatment (or lack of treatment) which would be below the standard of care. If the dentist believes radiographs are necessary in order to perform a competent diagnosis and assessment of a patient's dental condition, the dentist cannot avoid liability for failing to do so. The practitioner puts both his/her dental license at risk in addition to potentially assuming responsibility for any adverse consequences of failing to obtain complete diagnostic information. In such situations the real issue is often the cost of the radiographs, and the confrontation can be avoided by suggesting to the patient that you view the radiographs as being so important you would extend a professional courtesy to obtain them at no charge to the patient. Alternatively, the patient must be told that your dental license cannot be put at risk by agreeing to practice dentistry in a manner that falls below the standard of care.

Q: My patient approved the color and appearance of multiple anterior crowns. After seating them, he said the color had been changed and wanted them removed and replaced. How should I handle this situation?

A: This situation illustrates the importance of intra oral photographs, documenting the appearance of the crowns prior to their being seated, after being seated, and the patient's acceptance of the crowns/veneers being noted in the patient's chart. A dentist is not required to continue to remove and redo dental work because of a patient's vacillations. In fact, this could reflect a patient who cannot be satisfied no matter how many times the work is redone. In such a situation, continuing to attempt to appease the patient could inure to the detriment of the practitioner by inferring that the dentist is agreeing with the patient's assessment of poor treatment. And generally speaking, a patient who expresses unhappiness after approving the treatment will not become happier or more satisfied through repeated attempts by the dentist. Something else in the patient's life is usually happening and the dentist is experiencing the results of that unhappiness, rather than being the cause. This is not to say that in all situations redoing treatment is wrong. There are circumstances in which the patient is correct and 'something' changed. But the practitioner needs to be wary about immediately agreeing to redo dental treatment, especially in large and complicated cases.

Q: What should my treatment plan include?

A: First, there is most often more than one treatment plan, or should be, in any given patient encounter. Dentistry is replete with treatment options and we have an obligation to present those options to the patient, whether or not we even perform certain dental procedures. For example, a dentist who does not render implant treatment is nonetheless required to present implant treatment options if appropriate. With today's computer software, optional treatment plans should include CDT codes and UCR fees for each tooth or proposed treatment, as well as a generalized statement that any specific treatment plan may need altering based upon the clinical situation that might be

***Bits & Pieces**, Continued on page 15*

The Florida AGD and the Tampa Bay AGD Present a CE Seminar:

Bringing Sexy Back to the Posterior Composite

Academy of General Dentistry PACE Program Approval for Continuing Education

AGD Provider # 219295

Speaker:

Dr. John Gammichia, DMD, FAGD

Dr. Gammichia is a 1995 graduate of the University of Florida College of Dentistry, and and L.D. Pankey graduate. He is a full time dentist in Orlando, FL where he has practice with his father for the last 17 years. He has published articles in national magazines such as AGD Impact, Dental Practice Reports and Dental Economics and has lectured nationally at such places as the Chicago Mid-Winter and the AGD annual meeting.

When: Friday, April 20, 2012
1:00 p.m. to 4:00 p.m.

Where: Tampa, FL
Sheraton Suites Tampa Airport Westshore
4400 West Cypress Street
Tampa, Florida

Three hours of PACE Approved CE Credit

Cost:

AGD Member before April 6 - $65.00
AGD Member after April 6 - $80.00
AGD staff - $30.00
Non-AGD Member before April 6 - $95
Non-AGD Member after April 6 - $110
Non-AGD Staff Members - $50

KURARAY DENTAL **Sponsors** triodent Innovative. Simple. Smart.

Course Description: What ever happened to the filling? The plain old posterior composite, where did it go? For the last ten years or so it has been pushed aside by en vogue methods such as porcelain crowns, CAD/CAM technology and digital impressions. Companies stop advertising to dentists about the filling and then dentists start leaving them off the treatment plans and stop doing them altogether. This lecture can possibly revolutionize some practices. Imagine "wowing" every one of your restorative patients, leaving them thrilled when they leave your office. Their excitement starts to rub off on you and the next thing you know you are excited about doing fillings. This lecture will bring instant gratification and the attendees will learn things that they can bring back to their office and implement immediately. Dr. Gammichia has put together a lecture that is technologically advanced but is easy to understand. He will walk you through the steps to create a posterior composite that looks just like a natural tooth. Sounds sexy, doesn't it?

Please accept my registration for the Seminar "Bring Sexy Back to the Posterior Composite" (PLEASE PRINT)

Name_____

Address_____

City, State, Zip_____

Phone_____Fax_____Email_____

Enclosed is my check for $_____

_____ AGD members before 4/6 _____ AGD members after 4/6 _____ AGD staff members

_____ non-AGD members before 4/6 _____ non-AGD members after 4/6 _____non-AGD staff members

Registration forms with checks (only method of payment) should be mailed to:
Florida AGD, 2372 NW 8th St, Delray Beach, FL 33445

The Small Print:

Cancellations before 4/13/12 will receive full refund less a $25 processing fee.

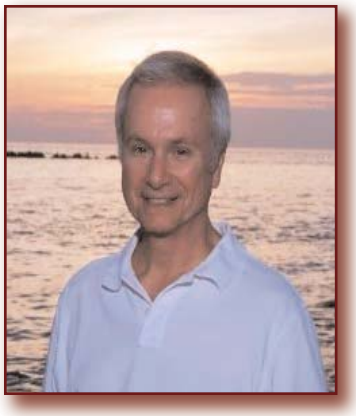
Cancellations after 4/13/12 will receive a 50% refund less $25 processing fee.

"No shows" will not be refunded.

Cancellations will only be accepted via fax (707-220-2861) or email (rsmall@flagd.org)

Legislative Notes - DEA Issues

In a recent hearing of the Drug Enforcement Agency (DEA) held in Arlington, VA., at which I represented a dentist holding two DEA registrations, some interesting issues arose that every dentist who has a DEA registration should know about.



Dr. Frank Recker, JD, Chair Legislative & Governmental Affairs Committee

Dr. Jeffrey Becker (the 'respondent'), an Ohio licensed dentist, faced DEA allegations that included not having a DEA registration/permit for both locations at which he administered and dispensed controlled substances in Ohio, and for not obtaining prior DEA permission before disposing of waste/unused controlled substances after completing an IV sedation procedure.

At the hearing held on November 8-10, 2011, the respondent acknowledged that he had two dental office locations within Ohio at which he dispensed/administered controlled substances (IV sedation), but only had a DEA registration permit for one of the two locations. The respondent had been unaware of any regulatory interpretation requiring two separate registrations within the same state. He also practiced IV sedation in Milwaukee, WI and did obtain a separate DEA registration for the Wisconsin office location (in 2010) after checking with the DEA about the need for having a separate registration for administering IV sedation in another state.

The DEA prosecutor also established (as the respondent had already acknowledged) that the respondent had failed to obtain prior DEA permission before disposing of waste/unused IV medications in a sink (squirting waste/unused meds remaining in syringes) even though that disposal process was always witnessed and verified by another dental staff member.

Disturbingly, the government presented only one expert witness, Dr. Daniel Becker (no relation to the respondent Dr. Jeffrey Becker). Although the expert's primary testimony was directed towards an issue ultimately rejected by the judge, he acknowledged on cross examination that he always disposed of his unused controlled substances/IV waste drugs into a sink without prior DEA approval, exactly as the respondent had done for over 20 years. Thus, even though qualified as an 'expert' in drug regulations, Dr. Dan Becker himself admitted that he was not following the ostensible DEA 'prior approval' process.

Similarly, the expert witness for the respondent, Dr. Joel Weaver, presented a sworn affidavit that essentially stated the very things that Dr. Dan Becker had acknowledged: Dr. Weaver was aware of no Ohio dentist or hospital that obtained such DEA 'prior approval' for IV controlled substance waste disposal. He also opined that he was aware of no Ohio dentist that registered each location at which that dentist administered or dispensed a controlled substance. In fact, Dr. Weaver stated it was common practice for oral surgeons to administer IV drugs at multiple office locations in Ohio without possessing a separate DEA registration for each office.

On that point, Dr. Dan Becker, the DEA's sole expert witness, also acknowledged that he had administered IV sedation in hundreds of different office locations throughout his career as a dental anesthesiologist, but had only one DEA registration, such being for his own office location.

However, notwithstanding the unchallenged testimony of both the government and respondent's expert witnesses, the administrative law judge concluded (among other findings) that:

1. Respondent maintained an unregistered professional practice, in violation of 21 u.s.c. § 823(e) and 21 u.s.c. § 1301.12;

2. Respondent failed to dispose of controlled substances properly, in violation of 21 c.f.r. § 1307.21(a).

Thus, in essence, the judge found that ignorance of the law -- as now interpreted and applied by the DEA-- was no excuse. He found the respondent 'guilty' of not obtaining prior DEA approval before disposing of waste/unused IV meds/controlled substances and of not having a separate DEA registration for his second office location in Avon, Ohio. Based upon these findings, the administrative law judge recommended the revocation of respondent's DEA registrations.

The respondent maintained at the hearing, and in post hearing briefs, that the 'prior approval' requirement is not a mandatory provision in the underlying federal statute or DEA regulations, and is also contrary to Ohio law.

Although the administrative law judge's findings are now subject to review by the administrator of the DEA and through subsequent appeal to the 6th Circuit Court of Appeals, the findings themselves are very disturbing. If allowed to stand, these findings represent the legal rejection of what are clearly common practices in dental offices and hospitals in Ohio, and possibly in other states.

Region 20 Report

Update on the AGD

by Dr. Richard Kanter
Region 20 Trustee

AGD 2012 Annual Meeting

The AGD's short experiment, which separated governance from the educational portion of our annual meeting, has ended. Many of our members were unhappy with the change in meeting schedule, which required some to be away from their office for a full week. They asked that the meeting be converted to the original format and the House of Delegates voted to make that change using a resolution drafted by your Florida delegation.

As you can imagine, these meeting dates and room reservations are made years in advance and usually require a few years to make any major changes. It's gratifying that the AGD was able to change the format of the meeting for the very next session.

We hope you'll join us from June 21-24 in Philadelphia to meet with friends and colleagues, visit the exhibit areas and attend our wonderful educational sessions.

AGD's Membership is Increasing!

As many of you are aware, membership in many medical and dental professional organizations are decreasing. The American Medical Association represents only 25-30% of US physicians.

We should be very proud that the total membership of the AGD is increasing. It appears our focus on lifelong education and advocacy has struck a cord with general dentists around the country. This is a marked turnaround from past years and we hope a sign that our core mission is relevant.

The AGD has enrolled 4,366 new members in 2011, up from 3,189 in 2010. Our total membership has increased from 36,126 in 2010 to 37,367 in 2012.

Fiscal Comments

The national AGD does a remarkable job managing and investing its monies. The budgetary process is thorough and exhausting. There are many contingency funds and protocols to ensure that we meet our income and expense goals. Our external audits over the last few years have certified the accuracy of the bookkeeping and financial protocol of the organization .

The investment committee has done an outstanding job in maximizing our investment returns throughout these volatile years. Our reserve ratio hovers between 45-55%; making us a financially conservative and healthy organization.

Internet Access

As many of you are aware, the AGD was offline for a few days. This was the result of a crash of multiple servers in the main office. While the headquarters had prepared for such a "crash" contingency, this was "the perfect storm". We have purchased new equipment and are working on a master plan to ensure there is no repeat of this disruption.

Stay current on AGD activites at www.agd.org

Keep up with the FLAGD at www.flagd.org

The Florida AGD 2012 General Assembly

Friday, June 15, 2012
at the Gaylord Palms Resort
Orlando
in conjunction with the FNDC
12:00 Noon to 1:00 p.m.

Agenda:

Introduction of Board of Directors and Special Guests

Pledge of Allegiancer/Convocation

Approve Minutes of 2010 General Assembly

Councils/Committees/Officers Reports

Old Business

New Business

Report of the Nominating Committee
Dr. Tony Menendez
(Nominees to be announced)

Award Presentations

Installation of New Officers and Board

Sadly, it's the end of the free lunch!

Attendance at the 2012 General Assembly is limited to 60

Therefore, in order to confirm attendance, there will be a charge of $15 for the luncheon at the 2012 General Assembly

Awards to be Presented:

Dr. J. Frank Collins Lifetime Achievement Award
Distinguished Service Award
Humanitarian Award
Continuing Education Awards

Mail this form with your check to FLAGD, 2372 NW 8th St., Delray Beach, FL 33445

Name_____AGD #_____

Phone #_____ Email_____

Enclosed is my check for $_____ for _____ reservations for the FLAGD General Assembly Luncheon

ADVOCACY , KELLOGG FOUNDATION , MID-LEVEL PROVIDERS, 1,023, PUBLIC APPROVAL 76%, DT, IOM, BOD, PEW FOUNDATION, WOOD JOHNSON FOUNDATION, ACA, HRSA, $4.9 MILLION, HOUSE, ADEA, ADHA, WHITE PAPER ?????

by Dr. Mel Kessler

What does all this mean to me? Can I just stay in my office, work on my own patients, enjoy my family and not be involved?

Yes you can, but then dentistry of the future will not be like dentistry of today. Change is always happening, some good, and some bad. Let me explain the title to this article. Today the number one reason to belong to the AGD is advocacy. We have to be aware of our own surroundings. Part of the AGD mission is to serve the needs and represent the interests of General Dentists (Google AGD Mission for the rest).

The W. K. Kellogg Foundation released a national survey titled "New Survey: Majority of Americans Support Mid-level Providers to Expand Access to Dental care." They stated that millions cannot find affordable dental care. True! We do need solutions. One solution given was the training of mid-level dental providers, such as dental therapists (DT), to provide preventative routine dental care to people without care. In the survey of 1,023 adults, 76% of the public approved the concept. Are you in agreement with their conclusion, that we need mid-level providers? Did they properly state that they are not like nurse practitioners, who work directly under physicians?

IOM, The Institute of Medicine, has published a 280 page report on strategies for "Improving Access to and Health Care for Vulnerable and Underserved Populations." While tremendous time and effort has gone into the reports, several things come up that may be of concern. They recommend that state legislators should amend existing state laws, including the Board of Dentistry practice acts. They want to change the laws to allow allied dental professionals to practice to the full extent of their education and training in a variety of settings and allow technology in a variety of settings and allow technology-supported remote collaboration and supervision. Their committee is made up primarily of professors, educators, members in public health and representatives from the PEW and Wood Johnson Foundations. They did not have a practicing general dentist on the committee. They did, however, question many different venues and very seriously study the problems involved with delivering care. The report fully supports the mid-level provider concept, however without direct supervision of a trained dentist. My concern is that there is an orchestrated unified campaign against individual state boards and allowing lesser trained individuals to work independently on the public.

ACA, The Affordable Care Act, is our current health care bill. Through HRSA, Health Resources and Services Administration, for 2012, it requests more than $4.9 million to train or employ alternative dental health care providers. This is authorized in section 5304 of the bill. The House of Representatives recently denied this funding for 2012. So we see there are battle lines developing regarding this program. We feel further study is needed. In government-speak, when you start to fund a study, in essence you are implementing a program!

ADEA, the American Dental Education Association, is also interested in programs to train mid-level providers. There is a flurry of efforts to expand the use of new oral health professionals in the US. Metropolitan State University, in Minnesota, graduated their first class of dental therapists in June of this year. ADHA, the American Dental Hygiene Association, is working with several schools to restructure their curriculum. Dental hygiene wants to start focusing on public health, rather than strictly in private practice. They also want to have a roll in the new model of care. The executive director of the ADEA closed an article on this subject with, "I am heartened by the level of activity within our professional association, state legislature, and within many of our own institution, and by a growing willingness of all to embrace innovation."

Change will be coming. By establishing a new set of independent mid-level providers, will we be setting up a second level of care? Or will this lower level of care lead to the destruction of quality care in dentistry? Will the public and the insurance industry instead seek services from providers with two years of training after high school? (The public and insurance industry are only driven by dollars, the idea that quality is cheaper in the long run is too abstract). These programs all have their origins in the New Zealand dental nurse school program. So is the New Zealand model successful or not? The AGD and ADA want further investigation before we endorse rushing into a lower level of care in this country.

The AGD has their "White Paper on Access to Care". We need to work with all groups to find the best solutions for the public. Please go to www.agd.org and search "White Paper" to find further information. What we need from you is involvement. Help us with advocacy by being informed on the issues, and above all, contact your legislators to let them know what you think on the issues that will affect our future in dentistry. Good luck, and may your years in dentistry be as gratifying to you as my 45 years have been to me.

INCORPORATING ORAL SEDATION TECHNIQUES INTO THE FLORIDA DENTAL PRACTICE SETTING

A Clinical Article in Two Parts

By K. David Stillwell, DDS, MAGD, FAAHD
Associate Professor and Assistant Director, University Hospital General Practice Residency, University of Alabama at Birmingham

PREAMBLE

Phobic, elderly, physically disabled, or emotionally challenged patients present unique challenges in the dental operating environment. Reducing stress during the dental appointment allows for improved cooperation, safety and clinical efficiency. There is an increased need for dentists who are able to confidently and competently render care to these patients. Adult oral conscious sedation at the minimal level is a valuable way to more effectively manage the specific dental needs of this growing population. In this two-part series, information and procedures will be outlined to assist the dentist with incorporation of sedation techniques into daily practice.

INTRODUCTION

Reminder: Rules governing the administration of anesthesia in the state of Florida are contained in the Florida Administrative Code, Chapter 64B5-14. Florida dentists considering the use of in-office sedative techniques should carefully review FAC rules related to additional training and education, issuance of permits, and requirements for administration of oral conscious sedation. Florida's rules and regulations have not been standardized to the 2007 ADA Guidelines, so each dentist should review and understand the differences in terminology that currently exist.

In Part Two, a short list of well-studied sedative and anxiolytic drugs (Table One: Drug Armamentarium for AMOS Procedures) will individually be discussed to highlight their indications and usage. Appropriate monitoring, documentation, and recovery of the sedated patient will also be covered. When properly structured and administered, minimal sedation of the adult patient is a safe, effective professional service to be integrated into the dental office.

STRATEGICALLY SELECTED SEDATIVE AGENTS (THE AMOS ARMAMENTARIUM)

Many agents are available to clinicians to aid in sedation and anxiety control of the adult patient. A short list of well-studied sedative and anxiolytic drugs has been identified as predictable and effective in the author's practice and educational setting. *Part Two* will focus on a select few medications from three drug classes (see Table One). Information on the formulations, dosage range, onset, half-life and precautions found in Table One was compiled from numerous reference documents[8-16] with emphasis on Malamed's text.[17] In general, the most significant factors that will dictate the appropriate AMOS medication selected are: 1) age, 2) weight, 3) concurrent medications, 4) anxiety level, and 5) length of procedure to be performed.[18]

ANTIHISTAMINES

The antihistamine class includes a number of H_1 antagonists that possess sedative, antiemetic, antispasmodic, and anticholinergic properties. As a clinically useful histamine blocker, hydroxyzine is classified as a diphenylethane and offers an excellent sedative choice to patients who are heavy smokers or asthmatics (it has been reported that benzodiazepines have not been as effective in patients who smoke due to up regulated liver enzymes that speed up benzodiazepine metabolism). Hydroxyzine's sedative actions are not produced by cortical depression but through suppression of hypothalamic nuclei and by peripheral actions on sympathetic pathways. Hydroxyzine's anticholinergic effects are useful in dentistry through its antisialogogue action (reduces salivary flow) and its antiemetic action (reduces nausea and vomiting). Asthmatic patients and those with COPD often benefit from these supplemental actions as well as the sedative effect.

Some precautions should be observed with antihistamine sedatives. They are known to potentiate opioids, barbiturates, sedative-hypnotics, and anti-anxiety drugs. Malamed[17] has suggested that dosages of all CNS depressants be reduced by 50% when administered concurrently with hydroxyzine. This drug does not reduce seizure threshold. Blurred vision, dizziness and xerostomia are commonly reported side-effects. Yagiela[9] has indicated the need to decrease dosage in the elderly due to exaggerated effects or extrapyramidal reactions. Hydroxyzine is metabolized in the liver and excreted in the urine. Fatal overdose is extremely rare and withdrawal reactions after long-term therapy have never been reported.

Hydroxyzine (Atarax©, Vistaril©) Dosing

Although it cannot be reversed after administration, hydroxyzine enjoys a wide therapeutic range, a reasonably short onset, and a manageable half-life. Use should be avoided in early pregnancy. Two forms of this drug are available: hydroxyzine hydrochloride (Atarax) and hydroxyzine pamoate (Vistaril). It is available as syrup, capsules, or oral suspension. Hydroxyzine combined with

inhalation sedation (N_2O-O_2) is more effective in severe anxiety than as a sole agent. For AMOS, we administer 50-100mg as a single dose (100mg maximum) with dose determined by age and weight; supplemental nitrous oxide-oxygen inhalation analgesia can provide an excellent additional benefit.

BENZODIAZEPINES

The benzodiazepines are the most commonly used medications for adult oral sedation. The benzodiazepine mechanism of action resides in the ability to slow the uptake of the inhibitory neurotransmitter GABA (gamma amino butyric acid), which causes muscle relaxation, anxiolysis, and an anticonvulsant effect. This drug class has a wide therapeutic dosage range which reduces unwanted side effects and toxicity. Even acute overdose situations do not affect the respiratory system like barbiturates, opiates, or alcohol because the GABA-benzodiazepine receptors are located in the limbic system rather than in the respiratory control centers of the brain stem.[12]

Biotransformation of the benzodiazepines occurs in the liver but without induction of hepatic microsomal cytochrome P450 enzymes, so patients with hepatic dysfunction may receive the benzodiazepines without increased risk of side effect. Many long-acting benzodiazepine drugs have biotransformation products that are pharmacologically as active as the parent compound. Selecting a benzodiazepine without intermediate metabolites for use in AMOS will reduce the potential for over-sedation or re-sedation.[12, 17]

Certain precautions should be observed with this drug class: 1) exercise caution with concurrent use of antifungals, macrolide antibiotics (erythromycin, others), proton pump inhibitors, protease inhibitors, SSRIs, oral contraceptives, and grapefruit juice with benzodiazepines, as sedative clearance time can be significantly increased; 2) powerful anterograde amnesia effects are generally helpful to minimize memory of the dental interventions but restricts the capability for patients to recall important postoperative instructions; 3) benzodiazepines are contraindicated with acute narrow angle glaucoma; 4) there are reports of relatively high addictive liability for patients prone to psychological dependence; and 5) rebound anxiety, amnesia, confusion, and psychiatric symptoms have been reported (especially with triazolam). Overt medical complexity and poor reserve capacity warrants a reduction in the maximum cumulative doses in the elderly (*50% reduction over age 65 judged to be ASA 3*).[8,12,17] Strong inducers of the P450 CYP3A4 hepatic enzyme (phenytoin, rifampin, barbiturates, St. John's Wort) have the potential to cause therapeutic failure by increasing the metabolism of BZ while decreasing serum concentrations.[12]

Even with certain precautions noted, the benzodiazepine compounds continue to represent the most nearly ideal drugs for the management of anxiety. Importantly, all benzodiazepines can be reversed with flumazenil (Romazicon©).

Midazolam (Versed©) Dosing

This short acting benzodiazepine has a rapid onset, short duration and inactive metabolites. It is available as syrup or by ampule. For AMOS, we prepare and administer midazolam as an oral cocktail in apple juice, liquid Tylenol©, or liquid Advil©. Apple juice is an effective taste-masking agent and provides a low pH that has been suggested to increase absorption and bioavailability of orally administered midazolam.[18] Suspensions of acetaminophen or ibuprofen provide the benefit of supplemental pain control related to intraoperative trauma. Initial oral dose of midazolam is 10-15 mg, with one incremental dose as needed up to maximum dose of 20 mg.

Triazolam (Halcion©) Dosing

This benzodiazepine is good for short to moderate cases of 2- 4 hours and produces no active metabolites. For AMOS, we administer triazolam at an initial dose of 0.125-0.375mg (1-3 tabs), with one incremental dose up to a maximum dose of 0.5mg when needed. For re-dosing, sublingual administration produces faster onset and increased bioavailability by avoiding the first-pass hepatic effect.[11] However, triazolam is bitter and may not be well tolerated sublingually by some special needs patients.

Lorazepam (Ativan©) Dosing

Lorazepam is a highly effective, moderately long acting benzodiazepine with excellent anti-anxiety and hypnotic properties which provides a rapid oral onset (30 minutes) and produces no active metabolites. Hepatic dysfunction (hepatitis, cirrhosis) does not alter the biotransformation, making it a good choice for patients with active liver disease and smokers. For AMOS, we use lorazepam for longer cases, administering a single 2-4mg dose depending on age and weight; no supplemental intra-operative doses are used. The amnesic properties of lorazepam are impressive and include anterograde and a degree of retrograde amnesia. Some ambulatory patients may not be comfortable feeling like they have "lost a day".[17] Due to its excellent anxiolytic properties, administration of the same dose (2-4mg) the evening before treatment can ensure a restful night's sleep.

NON-BENZODIAZEPINE HYNOTIC "Z-DRUGS"

The relatively new non-benzodiazepine hypnotics (the "Z-drugs") have hypnosedative actions comparable with the benzodiazepines yet they display specific pharmacokinetic and pharmacodynamic properties. These agents are selective compounds that interact preferentially by binding to neural transmembrane chloride channel subunits known as omega-1 receptors to produce their sedative effects (BZ binds to omega-1, but also to omega-2 receptors which generates adverse effects on cognitive performance and memory).[16]

***AMOS**, Continued on page12*

The "Z-drugs" are strong sedatives but only exhibit mild anxiolytic, muscle relaxant, and anticonvulsant properties. This drug class better preserves psychomotor tasks and memory capacities than the benzodiazepine compounds. These drugs have fast acting clinical onsets, relatively short half-lives, and limited duration of action making them a good choice for short appointments. Caution should be exercised for patients with impaired renal or hepatic function. If concurrently administered with other drugs that inhibit the CYP3A4 liver enzyme metabolic pathway, expect elevated blood levels for Zolpidem and Zaleplon. Increased CNS depression occurs when the "Z-drugs" are given with benzodiazepines. It has been recommended to decrease dosage in elderly patients (50% reduction over age 65). These drugs are not contraindicated in pregnant patients or in narrow angle glaucoma.[9, 15]

Zolpidem (Ambien©) Dosing

As an imidazopyridine, zolpidem tartrate has a short half-life (1-3 hours) and no active metabolites, making it an excellent choice for short to moderately long dental appointments. Occasional side effects reported include headache, nausea, and muscle pain. Flumazenil will reverse the sedative effects, so observe the same precautions as with benzodiazepine reversal. For AMOS, we administer 5-10mg of Zolpidem, with one incremental dose if needed up to a maximum dose of 10mg.

Zaleplon (Sonata©) Dosing

Also an imidazopyridine, zaleplon has an ultrashort half-life (0.5-1 hours) and no active metabolites. This gives us an oral agent that can be effectively employed for those short dental appointments (crown delivery/soft tissue management, etc.) when the patient must be sedated but when other AMOS agents would over-sedate and result in an extended monitoring period prior to discharge. For our AMOS patients, we administer a single dose of 5-20mg depending on age and weight. Flumazenil will reverse the sedative effects.

RESPIRATORY SUPPORT AND SUPPLEMENTAL INHALATION ANALGESIA

There are very few patient conditions that contraindicate the use of supplemental oxygen administration during dental care. As part of our AMOS protocol, we set up and deliver 100% oxygen by nasal hood or cannula at the beginning of the induction of the sedation. Later, co-administration of nitrous oxide during local anesthesia and during more challenging portions of the dental procedure can effectively utilize the analgesic properties of N_2O-O_2 which will assist in preserving the sedation result. At appropriate points in time, the treating dentist can revert back to 100% oxygen. This process of intermittent nitrous oxide administration will decrease the risk of nausea often associated with the length of time an individual is carried on N_2O-O_2 . The use of nitrous oxide-oxygen analgesia as a supplement to any one of the medications on the *AMOS Drug Armamentarium List* will convey additional levels of anxiety relief with minimal effects on respiration, consciousness, and cardiovascular stability. At the conclusion of the active dental treatment, we administer 100% oxygen for five minutes in preparation for evaluation of discharge readiness.[11]

RECOVERY AND REVERSAL OF THE AMOS PATIENT

The selective employment of sedative drugs from the AMOS Drug Armamentarium List, in a patient who has been properly assessed for sedation reliability prior to administration and with dental treatment sequenced and executed to effectively coincide with the duration of the sedative agent, will routinely exhibit a routine and uneventful recovery. Patients will be normally observed to emerge from sedation in a timely fashion, free from major anxiety and fully capable of preparing themselves for departure from the operating environment.

By limiting the duration of our dental treatment to four hours and by specifically limiting the type and amount of sedative agent employed in our practice, it is a rare occurrence to find a patient in an over-sedated state and unable to meet discharge criteria. Therefore, it is also rare to consider the administration of a reversal agent. Reversal is contemplated when a patient moves out of a minimal sedation state into undesired deeper planes of anesthesia, necessitating discontinuance of the dental procedure or delaying full recovery following completion of treatment. Avoidance of over-sedation is the paramount goal but safety is enhanced due to the availability of a highly effective reversal method.

Flumazenil (Romazicon©) is a specific benzodiazepine receptor antagonist. Upon administration, it causes a rapid reversal of unconsciousness, sedation, amnesia, and psychomotor dysfunction. Onset is rapid with the peak effect occurring in 1 to 3 minutes.[9]

For the reversal of sedative effects from benzodiazepine or "Z-drug" administered for AMOS, the recommended initial dose of flumazenil is 0.2mg IV (2ml) over 15 seconds. If the desired level of consciousness is not obtained after 45 seconds, a second dose of 0.2mg IV is delivered and repeated at 60 second intervals where necessary up to a maximum dose of 1.0mg. The dosage should be individualized based on the patient's unique response.[19] Delivery of 0.2mg flumazenil sublingual via 16 gauge needle has been personally observed to produce effective and rapid benzodiazepine reversal for situations when an IV port is not available. The effect of flumazenil administered by this route is not well studied (intramuscular, subcutaneous and sublingual routes of flumazenil injection have been studied in dogs). There is some evidence that the onset of reversal by the sublingual or intramuscular route is sufficiently fast to manage acute emergencies.[11]

Initiation of convulsion is the most common serious adverse event associated with flumazenil reversal. This is frequently observed in patients relying on benzodiazepine effects to control seizures, who are physically dependent on benzodiazepine, or

who have ingested large doses of other drugs (mixed-drug overdose). Seizures are generally reversible with standard antiepileptic therapy including benzodiazepines, phenytoin or barbiturates. Severe adverse effects, including fatalities related to development of cardiac arrhythmias, have been reported following reversal procedures in patients taking large quantities of tricyclic antidepressants.[19]

Withdrawal symptoms may occur following rapid injection of flumazenil in patients with long-term exposure to benzodiazepines. Withdrawal symptoms have been reported following flumazenil treatment in patients receiving chronic (and rarely, acute) benzodiazepine therapy. Although benzodiazepine withdrawal symptoms have been reported, symptoms are generally mild and transient.

After reversal, residual un-metabolized benzodiazepine in the circulation can reengage GABA receptor sites as the effects of flumazenil wanes, leading to the potential for re-sedation. In all reversal cases, the patient must be monitored during an extended in-office recovery period and the transporting guardian/companion must be informed to observe the patient for re-sedation following discharge. The half-life for the benzodiazepine or the "Z-drug" used for AMOS must be known in order to anticipate the likelihood of re-sedation following reversal.[9] Long acting benzodiazepines may predispose certain patients to extended recovery periods and re-sedation after reversal. Selecting agents from the AMOS Drug Armamentarium List will assist in avoiding over-sedation by employing only those medications with short half-lives and inactive metabolites.

DISCHARGE AND POSTOPERATIVE MANAGEMENT OF THE AMOS PATIENT

AMOS patients can present a challenge in determining when they have made sufficient recovery from the sedation and are ready to be discharged. Assessing the patient's alertness and orientation to person, place, and time ("alert and oriented x 3") is an important discharge criterion. Establishing that proper orientation existed at the time of discharge should be documented in the anesthesia record or progress notations; some mentally challenged patients may not be aware of the answers to these classic questions which may prompt the dentist to note that the patient was "alert, vital signs were stable, able to ambulate with assistance, with no apparent distress observed at the time of discharge to responsible guardian". Some additional discharge criteria are:

- Normalization of vital signs
- Breathing unassisted with no potential for airway obstruction
- Patient is fully responsive and alert, ambulatory without assistance, and able to verbalize appropriately
- Following NPO, hydration has been reestablished
- Patient has responsible companion for transportation
- Postoperative instructions are provided in writing and reviewed with patient and companion; emergency number are given to the companion [18]

Aside from the many advantages of AMOS, erratic and unpredictable gastric absorption can occasionally occur which may lead to delayed onset or prolonged recovery.[11] Ultimately, the treating dentist must be satisfied with the patient's level of recovery before discharging. Often, the elderly are unable to ambulate effectively after AMOS and should be assisted out of the office. Per the preoperative arrangements, the patient is escorted and driven home by the responsible companion who has already been properly informed of the postoperative care. The written postoperative instructions should include the recommendation for all patients to avoid operation of cars or machinery for the remainder of the day following surgery.

CONCLUSION

In the U.S., 80% of dentists are generalists; less than 10% are either oral surgeons or dental anesthesiologists. These statistics indicate that there are not enough anesthesia-trained dentists to treat all of the patients who desire to receive treatment under sedation.[7,11] General dentists should strive to incorporate an efficacious in-office sedative technique in order to assist this underserved portion of the population. A growing volume of research and clinical experience has shown that the administration of adult minimal oral sedation (AMOS) by properly trained providers can provide a safe and effective means for treating many special needs patients in an outpatient dental setting. This allows a population that has historically had limited or no routine dental care a much needed opportunity to access treatment that will improve their health and quality of life.

Incremental oral dosing, also known as titration, is an example of a commonly employed off-label practice which has grown in popularity. Quarnstrom and Donaldson[13] employed oral triazolam in 270 cases over a course of 15 years in a dosage range of 0.125-0.5mg and only resorted to supplemental doses for 17 (9.0%) of their 188 patients, yet achieved a published success rate for a satisfactory level of sedation of 98.4%. They concluded that the justification for using intravenous agents for patients requiring sedation was difficult when oral medication could provide such an excellent alternative, particularly in light of the increased cost of malpractice insurance and the difficulty and expense involved in obtaining IV sedation certification. Some controversy remains regarding titration when employing the oral sedation route. Repeated oral administration of a benzodiazepine like triazolam has been reported to result in that medication reaching a constant blood-level after it is administered over the course of three to five half-lives (which achieves a *steady-state* condition) when the amount of drug that is accumulated equals the amount that is eliminated.[3] Many feel that this phenomenon produces the intrinsic safety mechanism of the benzodiazepine class and allows for the safer administration of two smaller doses over time based on observation of patient response rather than one large dose at the onset.

However, there is a delay in drug equilibration between the plasma and the effect site which can predict possible overdose if

***AMOS**, Continued on page14*

additional doses are administered only on the basis of periodic intraoperative reassessment of the patient's anxiety level, since the plasma concentration may still be rising after the prior dose. Certain key attributes of the benzodiazepine class suggest that administering additional amounts of the drug at time points *less than one hour* on the basis of the patient's sedative response can result in additional dosing while the central effects of the original dose still are increasing. This can lead to overdose. This consideration has accounted for our AMOS protocol to include a single supplemental intraoperative dose at hour two of the procedure, to limit operating time to four hours, and to avoid multiple incremental dosing techniques.

There is fairly strong opinion that the oral route is inherently the safest and most practical route for drug administration.[3,11] Protection is provided against foreign substances by the vomiting mechanism, first-pass elimination and a muted anaphylactic response. The relatively slow absorption reduces distributional influences and allows for recognition of deleterious trends and the possibility to prevent further absorption. The oral route also avoids local damage associated with needle puncture, ischemia from intra-arterial injection and venous irritation leading to thrombophlebitis. The use of an orally administered drug also avoids exacerbating anxiety in patients who are fearful of venipuncture. The cost of care also is substantially less for an orally administered agent compared with that involving a parenterally administered sedative. When employing AMOS in the context of appropriate standards of care, the interests of the public and the profession are well served by providing a cost-effective service that can be made widely available.

See APPENDIX, PART TWO at www.FLAGD.org

REFERENCES: PART TWO

9. Yagiela JA, Neidle EA, Dowd FJ. Pharmacology and Therapeutics for Dentistry, ed 4. St. Louis: Mosby;1998.

10. Donaldson M, Gizzarelli G, Chanpong. Oral Sedation: a primer on anxiolysis for the adult patient. *Anesth Prog* 2007;54:118-129.

11. Berthold C. Enteral sedation: safety, efficacy, and controversy. *Compendium* 2007;28(5): 264-272.

13. Quarnstrom FW, Donaldson M. Triazolam use in the dental setting: a report of 270 uses over 15 years. *Gen Dent* 2004;52:496-501.

14. Feck AD, Goodchild JH. The use of anxiolytic medications to supplement local anesthesia in the anxious patient. *Compendium* 2005;26(3):183-190.

15. Wynn RL, Bergman SA. The new Z-drugs as sedatives and hypnotics. *Gen Dent* 2005;53:174-177.

16. Terano MG, Rossi M, Palomba V, Smerieri A, Parrino L. New drugs for insomnia: comparative tolerability of zopiclone, zolpidem, and zalephon. *Drug Saf* 2003;26:261-282.

17. Malamed SF. Sedation: A guide to patient management, ed. 3. St. Louis: Mosby; 2003.

18. Goodchild JH, Dickinson SC. Anxiolysis in dental practice: a report of three cases. *Gen Dent* 2004;52:264-269.

19. Romazicon Side Effects. Drug Information Online at Drugs.com. Available at:http://www.drugs.com/sfx/romazicon-side-effects.html?printable=1. Accessed January 11, 2011.

20. Boynes SG, Moore PA, Lewis CL, Zovko J, Close JM. Complications associated with anesthesia administration for dental treatment in a special needs clinic. *Special Care Dentist* 2010; 30(1):3-7.

Update on the Gold Coast AGD

Dr. Robert J. Fish, President

The **GOLD COAST** component is celebrating its twenty-fourth anniversary during 2012 and continues to attract new members.

The **GOLD COAST** component is a Florida Board of Dentistry CE Broker-approved and a Florida AGD PACE approved provider of continuing dental education.

Our monthly continuing dental education meetings continue to focus on the specific needs of our members and cutting edge dentistry. We have sponsored the following continuing dental education programs:

December, 2011 - DOMESTIC VIOLENCE (BOD MANDATED CE)

January, 2012 - CLINICAL HYPNOSIS IN DENTISTRY

February, 2012 - BRUXZIR SOLID ZIRCONIA

The **GOLD COAST** component will again this year award two deserving graduating senior dental students from Nova Southeastern University College of Dentistry its Certificate of Excellence along with a monetary gift.

Our monthly C.E. meetings take place on the last Wednesday of every month except July, August, and December. We continue to attract new members at monthly meetings held at the Private Dining Room at the Links Restaurant at the Marriott Resort Hotel at Heron Bay TPC in Coral Springs.

All are encouraged and welcome to attend.

Tips to Maximize the Business of Your Practice
Control Your Stress in the Workplace

from Dale Carnegie Training

Pressure situations are present during both good and bad economic times. However, when times are tough the situations can be magnified. Problems at home can directly influence issues in the workplace. It is your job to create an environment that reduces stress and promotes engagement. Here are 8 tips to help you and your team control stress and worry in tough situations:

1. **Live in a compartment of the present.** The professional with a commitment to service seals off each interaction with a customer so that negative experiences don't poison future interactions. When it comes to customer service, live in the moment.

2. **Don't fuss about trifles**. A "trifle" is something that is insignificant in comparison to other things in your life. Keep the big picture in mind. Doing so will help you objectively sort out the small stuff from the important issues.

3. **Cooperate with the inevitable.** Realize when your situation is inevitable. If you can learn to recognize situations where you have no control, you can gain some control over the emotional aspects of the situation.

4. **Decide just how much anxiety a situation is worth and refuse to give it any more of your energy.** Once you make this decision, it is easier to find ways you can improve on the situation or let it go and move on.

5. **Create happiness for others.** It is difficult to sustain a negative attitude when you are doing something good or helpful for someone else. Simply put: Doing good for others makes you feel better.

6. **Expect ingratitude.** In your practice, you provide many diverse services. When you do so, you probably expect in return some signal of gratitude for your assistance. This expectation is rarely met. If you do receive heartfelt thanks from someone, you should count yourself lucky. Don't let ingratitude deter you from providing top-quality service.

7. **Put enthusiasm into your work.** Enthusiasm is the positive energy and sustained effort that keeps you driving toward your goals. Making a decision to have a positive outlook can be critical in enjoying your job and working with your internal and external customers.

8. **Do the very best you can.** It can be difficult to deal with criticism, especially if you feel it is undeserved. One way to put criticism in perspective is to ask yourself if you are doing the very best you can with what you know and are able to do. If you are, then you can avoid taking the criticism personally. If there is room for improvement in your performance, take responsibility and improve it.

Take action and take control. Stress visits us all, but it doesn't have to move in for good!

For more free Dale Carnegie E-Tips to build the business of your practice go to: www.dalecarnegie.com. For effectiveness training for yourself, your staff or your organization contact Robert Graves 813-966-3058.

***Bits & Pieces**, Continued from page 4*

encountered by the dentist. For example, a tooth 'treatment planned' for a crown may require endodontic therapy after the clinician removes the existing restoration, decay, or visualizes pulpal pathology. In short, no treatment plan should be presented as imposing a limitation on what might also be necessary based upon clinical judgment at the time treatment is rendered.

Q: I have several patients who routinely cancel their appointments and their treatment is always delayed, or not performed at all. Should I charge them a fee for each missed appointment?

A: While it is appropriate to charge a fee for a missed appointment if a patient is so advised of the policy at the initial appointment, it is often better to consider terminating such a patient. Such a patient's dental condition often deteriorates and becomes more complicated, or the dentist encounters a series of 'emergency' appointments rather than being able to complete the treatment plan in a methodical manner. The patient ultimately puts the dentist at greater risk of liability and should probably be terminated from the dental practice through written correspondence.

The Florida Academy of General Dentistry
2372 NW 8th Street
Delray Beach, FL 33445

2011-2012 Executive Council

Officers

President
Tony Menendez, DDS, MAGD
4120 Tamiami Trail, Suite A
Port Charlotte, FL 33952-9241
Work: 941-624-4575
Fax: 941-624-4587
Email: smilesdds@comcast.net

President-Elect
vacant

Vice-President
Jason D. Lewis, DDS
130 Gateway Circle
Saint Johns, FL 32259
Work: 904-201-6000
Fax: 904-201-6004
Email: jlewisdds@bartramdentalcenter.com
Vice-President

Secretary
Laurence A. Grayhills, DMD, MAGD
250 Professional Way
West Palm Beach, FL 33414-6391
Work: (407) 798-1600
Email: drgrayhills@grayhillsdental.com

Treasurer
Harvey P. Gordon, DDS, MAGD
4949 SW 33rd Way
Ft. Lauderdale, FL 33312
Phone: 954 618-9982
Email: flashfl@earthlink.net

Immediate Past President
E. Donald Thomas, DMD, FAGD
201 N Lakemont Ave Ste 300
Winter Park, FL 32792-3211
Phone: 407-644-1455
Fax: 407-644-0592
Email: dt2thfxr@embarqmail.com

Editor
Chris Wujick, DMD
8475 Seminole Blvd.
Seminole, FL 33772
Phone: 727-393-6024
gatorwuj@hotmail.com

Delegates at Large

Bipin J. Sheth, DDS, MAGD
5239 Coconut Creek Pkwy
Margate, FL 33063-3964
Work: 954-979-8631
Fax: 954-979-8651
Email: bipinsheth@msn.com

Jeff Oppenberg, DMD
11935 85th St
Largo, FL 33773-2718
Phone: 727-442-2358
Email: j3j2j1us@yahoo.com

Pedro A. Castro, DMD
7313 W Flagler St.
Miami, FL 33144-2505
Phone: 305-264-3905
Fax: 305-262-7082
Email: pacr108@aol.com

Frank Recker, DDS, JD
1850 San Marco Rd, Ste A
Marco Island, FL 34145-6709
Phone: 239 642-4704
Fax: 888-469-0151
Email: Recker@ddslaw.com

Region XX Director
Robert Gehrig, DMD, FAGD
1405 South 25th Street, Suite B
Fort Pierce, FL 34947
Work: 772-465-4545
Fax: 772-465-5869
Email: rdgehrig@bellsouth.net

Region XX Trustee
Richard M. Kanter, DMD, FAGD
801 W. Fletcher Avenue
Tampa, FL 33612
Work: 813-961-1727
Fax: 813-968-7220
Email: RKanter48@aol.com

Region XX Secretary/Treasurer
Patrick P. Shepherd, DDS
10748 Saint Andrews Rd
Boynton Beach, FL 33436-4711
Email: ToothFxr1939@bellsouth.net

Council & Committee Chairs

Membership Council
Dr. Tony Menendez, Chair

Legislative Council
Dr. Frank Recker, JD, Chair

PACE Council
Dr. Bipin Sheth, Chair

Continuing Education Committee
Dr. Mel Kessler, Chair

Public Information Council
Dr. Rod Shaw, Public Information Officer

Budget and Finance Committee
Dr. Harvey Gordon, Chair

Constitution & Bylaws Committee
Dr. Tony Menendez, Chair

Nominating Committee
Dr. Michael Badger, Chair

Awards Committee
Dr. Rod Shaw, Chair

Audit Committee
Dr. John Joffre, Chair