



Contact Point



Volume 33, No. 2 Utah Academy of General Dentistry Fall 2008

"In Pursuit of Excellence Through Continuing Education"

President's Message

I just want to write a President's message to all of the members of the Utah AGD. I thought it might be nice to show a snapshot view of how far the UT AGD has come since I was last given the opportunity of being the president. This past year, under the leadership of Dr. Ruedi Tillman we have been able to have excellent CE courses. The last CE Course with Dr. Stanley Malamed was one of the best courses that I have attended. If you have not had the opportunity to hear and learn from some of the people that we have had present to the UT AGD, you have missed out on becoming a better dentist for your patients. We had Dr. Marty Zase, the past president of the Academy of Cosmetic Dentistry talk to us. We have had Dr. Karl Korner, Dr. Jamison and Dr. Brian Le Sage present on Implants, Sleep Disorders and Anterior Restorative Dentistry respectively. To Dr. Stobbe, Dr. Scoville, Dr. Maxfield and Dr. Tracy I want to say thank you for all your time and effort in getting us such courses in such good locations (along with good food) for such a great price.

I am proud to be a member of the Academy of General Dentistry. I know of no other organization that will speak for me, a general dentist, with such a clear and concise mission. When I attended the regional meeting this past year in Colorado, Dr. Bruce Burton, a past president of the AGD mentioned that we should always think of how our current learning will help our patients. I see the changes that are happening in Alaska and wonder how is this going to help our patients. I will not go into all the details, and I hope that if you do not know what is happening in Alaska that you will become interested and in turn become involved with general dentistry and do what can be done to protect our profession. In short, Alaska now has what is known as "Mid-level providers" that can provide basic dental care, including restorations to patients. Some dental schools have seen this as an opportunity to increase their student base and has given their support to this undertaking. For me, this is the first step in having dentistry return to its early days before the Baltimore College of Dentistry started. It was more of a mentorship and on the job training and anyone could set up a dental office without standardization of training or licensure. I am also a proud member of the American Dental Association, but I am aware of the limitation that the ADA has toward general dentists. The ADA has to be the umbrella over all of dentistry and has to represent the specialists as well.

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Dr. JC Cheney receives the UAGD Dentist of the Year award from Dr. Dan Boston 2008-09 UAGD President at the September business meeting

2008 Dentist of the Year

Dr. JC Cheney, long time member and supporter of the AGD, was awarded as the 2008 Utah AGD Dentist of the Year. Dr. Cheney was joined by his wife and daughter for the award reception and offered some words to those in attendance concerning the recent push for mid-level provider recognition. See other articles in this newsletter for additional information or visit agd.org. JC Practices in Salt Lake City and attended the University of Washington School of Dentistry. He has been an active member of the AGD for 12 years. Congratulations JC!

Also at the September Business meeting, the UAGD Board was recognized. The Board warmly thanks the following members for their service to the UAGD and wishes them well as they move on to other opportunities. These AGD members have served for many years in most of the positions on the board including President and merit our thanks.

Dr. David Powell
Dr. Duane Callahan
Dr. Lynn Walker

Malamed Sedation Course

The recent course held at the downtown Marriott was a marvelous success. Dr. Stanley Malamed, noted author, speaker and guru of local anesthesia and emergency medicine presented on the topic of oral sedation protocols or "moderate sedation" as is becoming more preferred. Dr. Malamed joked with the audience and entertained with video and wit as he outlined the big reasons why people have a fear of dentists. The presentation was designed to help participants become more comfortable with the *science* of sedation in order to go and learn the *art* of sedation.

Dr. Malamed's wealth of knowledge became especially apparent as questions were asked on related topics. When asked specific questions about the use of articaine and paresthesias, he cited articles found on his website www.drimalamed.com which can be downloaded as pdf files. He suggested that the use of articaine infiltrated in the mandibular buccal fold could increase the success rate of the IANB by a substantial percentage. Another question posed by a participant regarded nitrous oxide and pregnant operator worker exposure. He cited a study of Russian OR nurses who experienced more fetal malformation as a result of all general anesthetics. Really, we don't know if nitrous is a problem for the pregnant professional, but who wants to find out. In pregnant rats however, we do know that more fetal malformation occurs.

Although local anesthetics are among the safest of all drugs in use today, the fear of pain of the injection still ranks highly in causation for medical emergencies. Syncope is by far the most common easy to treat emergency, happening 15,407 times of a total of 30,608 reported emergencies in one study. His answer to its prevention was simple: Recline the patient for all injections. Many of us learned to inject the inferior alveolar block with the patient sitting up and we should place the patient in a reclined position to avoid syncope associated with dental injections. Dr. Malamed joked that anyone needing to reference the floor and the patient's mandibular plane in order to properly administer the IANB should probably get out of the mouth permanently. In children, he said that fainting associated with the injection is rare because kids usually squirm with pain which keeps the circulation to the brain higher than in the paralyzed adult who is tense but doesn't move due to social inhibition. In fact, 55% of all emergencies happen during or immediately following the local administration. Of the total emergencies in the study, others reported were these: Mild allergy (2583), Angina (2552), postural hypotension (2475), seizure(1595), asthmatic attack(1392), hyperventilation(1326), epi rxn(913), hypoglycemia(890), cardiac arrest(331), anaphylaxis(304), MI(289) and LA overdose(204). Aside from the later four, these are easy to treat, excellent recovery situations that we should feel comfortable in treating.

Dr. Malamed spent much of the time reminding us that all people fall within a Bell curve distribution for all reactions to drugs and treatment. 70% are OK with the usual drug and



usual treatment while 15% of the outliers on both sides will be either hypo or hyper-responsive. If we deal with the fear appropriately, then we can deal with the pain. Dealing with our patient's fears will help us eliminate many of the medical emergencies. This includes setting appointments in the AM, avoiding hot, humid conditions, giving post op analgesics, making a post op phone call, being tolerant of treatment time, and giving effective pain control. We use sedation and iatrosedation to distract the patient. Pharmacologic sedatives depress the CNS in a dose response manner and permit our treatment to occur safely and efficiently while helping us prevent the occurrence of most medical emergencies.

Of the popular sedatives available-- barbiturates, opioids (narcotics), anti-histamines and benzodiazepines-- the benzodiazepines are by far the safest. They act primarily on the CNS and have very little depression of the respiratory or cardiovascular systems. They are readily reversible, come in a variety of effective treatment time options and have few contraindications or severe drug interactions. The AGD and other organizations have published guidelines for the use of sedatives that are worth reviewing. You may find a review of these in the Journal of the AGD September-October 2006 pp 301-4. One of the reasons for the safety of the benzodiazepines as compared to other sedatives lies in the relatively level dose response curve, where titration to various levels of sedation depends more or less acutely on the amount of drug administered.

As we monitor our patient's response to sedation, we should assess blood pressure every 5 minutes and continuously evaluate the heart rate and oxygen saturation through pulse oximetry. Dr. Malamed suggested not disabling the "beep" from the monitor but to learn to consider it a wonderful sound that keeps us tuned to the patient's condition. By the time a patient shows signs of cyanosis, their oxygen saturation is already down to 60. Well down the trail to clinical death. Recall that an oxygen saturation number isn't the percentage of hemoglobin molecules carrying oxygen.

Dr. Malamed gave several suggestions for alternatives to triazolam to try with patients who require a longer procedure

see Sedation pg. 5

Community Dental Health Coordinator



The following e-mail excerpt was sent from National headquarters recently.

Dear AGD member,

The Academy of General Dentistry (AGD) greatly appreciates the effort put forth by the leadership and staff of the American Dental Association (ADA) in fulfilling their role as the recognized voice of the dental profession.

However, as you might be aware, the ADA is promoting a dental entity called the Community Dental Health Coordinator (CDHC). Having studied this entity extensively—and more specifically, noting inconsistencies in the description of what this entity will be, what the CDHC will do, and how the CDHC will operate—the leadership of the AGD has concluded that the CDHC poses an enormous threat to the health of the public and the practice of general dentistry, especially relative to your role as the gatekeeper of oral health. There are several resolutions being debated at the ADA's House of Delegates, October 16 to 21, 2008, but there is one in particular that calls for spending \$5,000,000 on this project!

We are asking you to contact all, or as many as possible, of the ADA delegates and respectfully request that they oppose the CDHC concept. Please let us know about the responses you receive by contacting us at advocacy@agd.org. We are providing you with three talking points and rebuttals to arguments that you might encounter from those in support of the ADA's position:

Pro-CDHC argument: "The CDHC is not a mid-level provider and to describe it as such would be a mistake."

Rebuttal: In a March 27, 2007, written Statement of the American Dental Association to the Subcommittee on Health, Committee on Energy and Commerce of the U.S. House of Representatives' "Insuring Bright Futures: Improving Access To Dental Care and Providing a Healthy Start For Children," then-ADA President, Kathleen Roth, DDS, wrote: "The CDHC will be a new mid-level allied dental provider who will enable the existing dental workforce to expand its reach deep into underserved communities and can be employed by Health Centers, the Indian Health Service, public health clinics, or private practices."

In the 2007 Call for Letters by the ADA, the CDHC was directly called "the new mid-level allied dental personnel." Also, in Congress, in the ADA-supported legislation H.R. 2472, the "Essential Oral Health Care Act of 2007," the CDHC was described as "a new mid-level allied dental professional who will work in underserved communities where residents have no, or limited, access to oral health care."

This demonstrates that communication from the ADA has not been consistent to the leadership and membership regarding the specific designation of the CDHC. The definition changes to suit the need of those supporting the plan.

Pro-CDHC argument: "The CDHC would be under the supervision of a dentist."

Rebuttal: If the problem is that there are not enough dentists in underserved areas, how is it possible that the proposed entity (CDHC) who will be traveling to the underserved area and performing irreversible dental procedures will have a dentist's supervision (general or remote, if existent at all)?

Pro-CDHC argument: "The ADA Workforce Task Force already has carefully evaluated the proposal and has found it acceptable."

Rebuttal: The 2006 Workforce Report never defined what constituted a "mid-level provider" in dentistry. It did not consider differences between dental and medical delivery systems as related to utilization of mid-level providers. Also, it was developed without an acknowledged definition of "access to care"—the very problem that the 2006 Workforce Task Force was supposed to be solving!

Paula S. Jones, DDS, FAGD, President

Editor's comments

I contacted Utah ADA Delegates Drs. Mark Blaisdell and AJ Smith regarding their comments on this matter. They had each received several phone calls from our UAGD membership and offered a few thoughts that need to be reported.

- 1- The Utah ADA delegation is solidly against the formation of a mid-level provider.
- 2- The ADA has published several papers and explanations regarding the CDHC which can be accessed at ada.org. The majority of the callers weren't familiar with the ADA's publications. Drs. Blaisdell and Smith are reading the material and trying to understand this issue thoroughly. They stand with the AGD in being concerned about a mid-level provider threat. In their review of the papers published they said "the CDHC seems to be a dental assistant who comes from the ethnic background of the population served who will facilitate visits to a dental office for treatment. They can do a rubber cup prophylaxis and place IRM, just like any dental assistant, but can't remove caries. They won't be doing extractions or doing any irreversible procedure, but can give oral hygiene instruction, facilitate transportation to a dentist's office, and coordinate payment and benefits."
- 3- The recent creation of the Alaskan DHAT threatens the preservation of dentistry as a profession, endangers the public, and will result in significant complications to those served simply by not providing enough training to manage the outcomes that inevitably result in providing dental care.
- 4- The ADA and AGD seem to be in universal agreement about the need to protect against mid-level providers but nothing to date has solved the access to care problem that exists.
- 5- If organized dentistry doesn't do something to solve access to care issues, our non-dental politicians will mandate solutions that will certainly include a mid-level provider. This will be the worst possible scenario.
- 6- To avoid this horrifying outcome, the ADA is spending much time and money to evaluate its proposal.

Summary: The public wants and deserves dental care provided by trained dental professionals able to manage surgical complications and with a deep understanding of oral and systemic health and pathology. Government officials, the ADA and the AGD and their members want the same thing. So far, no proposal has led to greater access to care for the significant underserved populations that exist.

So we must ask ourselves "How will I as an individual and as a member of a professional society fix this issue?" Will I be willing to travel and practice in an underserved area a certain percentage of the time? Should we mandate that new graduates practice in one of these areas for a time? Should taxes be increased to raise reimbursement to a level that will entice practitioners to serve there? Should a lower cost mid-level provider be trained to give care?

We are all part of the problem and we will all be a part of the solution. The choice in how to proceed is ours for now. But it must be made or it will be made for us.



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Continuing Education Calendar

The UAGD Board continually strives to furnish the best possible CE courses at a reasonable price. There are at least four traditional CE courses offered per year. Two day hands on courses are given on the second or third weekend in March and the first or second weekend of November and follow the rotating schedule shown below. Attendees are often working on Mastership requirements that demand certain hours in each of several areas, but anyone is welcome to attend. Space is limited so register early. Lecture CE courses are usually offered in May and in conjunction with the UAGD Business Meeting in September. Suggestions for future course topics or speakers are welcome.

CE courses have also been offered at other UAGD sponsored activities such as the golf outing, cruise or special events.

- 2008
 - November 14-15 Oral Mucosal Conditions Hands on course by Scott Benjamin
- 2009
 - March 13-14 Steve Christensen OSHA and Blow Yur Socks Off
 - Photography
 - May 8 Dr. John Corollo, DMD Anterior Esthetics for Implants and Natural Teeth @Joseph Smith Memorial Bldg, SLC
 - September 11 Barry Bartee, DDS, MD Esthetic Ridge Preservation for Implant and Pontic Site Development @ Joseph Smith Memorial Bldg, SLC
 - November MPD/Occlusion hands on
- 2010
 - March Operative hands on
 - May TBA
 - September Business meeting
 - November Fixed Prosthodontics hands on
- 2011
 - March Removable Prosthodontics hands on
 - May TBA
 - September Business meeting
 - November Periodontics hands on
- 2012
 - March Endodontics hands on
 - May TBA
 - September Business meeting
 - November Oral Surgery hands on



President's message continued from pg 1

As I was listening to the various political speeches, John McCain said toward the end of his speech that we need to be involved in serving a cause greater than ourselves. I echo that thought. If any of you would like to help in the UT AGD please email me at flyingboston@gmail.com and let me know. We will find a way that you can help give back to general dentistry. If you do not want to do it within the AGD, then help mentor a dental student, help a colleague that needs help, donate time to the Donated Dental Services, or help the UDA. Whatever you do, I can promise that you will receive much more out of it than you put into it. I look at all the opportunities that the AGD has given me to expand my view of dentistry. I have been able to meet some wonderful dentists that I consider as mentors, yet not all of them would be big name speakers. I have been able to increase my ability to serve my patients by getting my Fellow and Master. I have made long term friendships with colleagues that share the same concerns and frustrations of being a dentist. I have been blessed beyond what I have given to the organization. To all of you I will do my best this following year to represent all of general dentists in the state of Utah. I only ask that you join in the journey and together we can make dentistry better of all of our patients.
--Dr. Dan Boston, UAGD President

Sedation continued from pg. 2

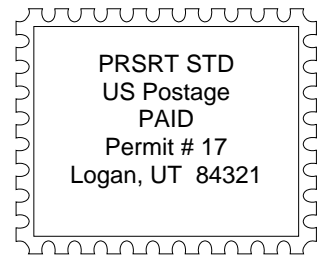
or who don't respond favorably to our "normal regimen". He was adamant about titration being the key to safety and efficacy and emphasized that single appointment titration is not an option for oral medications, but is really only available for IV procedures. He reminded the group that duration of action and half life are in no way related and that a medication is generally considered to be gone from the blood stream by 6 half lives.

Overall, participants left armed with a desire to conduct sedations correctly and preserve the safety for this useful adjunct to our practices. He encouraged a visit to his website at www.drmlamed.com for free downloads, helpful journal articles and a bibliography of his publications.

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Answers to the public with questions on mid-level providers

As a dental professional you may know of the recent trend to graduate mid-level providers to offer dental services in low access areas. These providers do not have a professional dental degree but are licensed to perform many dental services. Of course, the lines between simple and complex treatments are easily blurred which will inevitably lead to confusion on the part of the public and profession alike. We should understand the issues and be prepared with answers for those who may ask us questions about these mid-level providers. Perhaps we feel that our turf is threatened, or perhaps we will respond with genuine concern for the public's safety. In any case, these high school graduates are now in the United States doing what you do and making a living at it.

The AGD published a white paper recently reflecting some of the views of our society. A brief summary follows, but the full text was published in the September 2008 AGD Impact and can also be found by visiting <http://www.agd.org/support/articles/?ArtID=3790>

"...(P)resent efforts to institute independent mid-level providers—lesser educated providers who are not dentists—to provide unsupervised care to underserved patients are not only economically unfeasible but also work against the prevention model. Because underserved patients often exhibit a greater degree of complication and other systemic health conditions, the use of lesser-educated providers risks jeopardizing the patients' health and safety. This approach will provide lesser quality care to the poor."

"Instead, solving the access to and utilization of care issues, thereby bridging the gap between the 'haves' and the 'have-nots,' requires collaboration among professional organizations, local, state, and federal governments, community organizations, and other private entities. This collaboration must strive toward a multi-faceted approach that focuses on oral health literacy, incentives to promote dentistry and dental teams in underserved areas (including through increased Medicaid and Title VII funding), provision of volunteer services through programs, such as Donated Dental Services (DDS), and bridging the divide between patients' access and utilization through the use of community services like transportation to indigent populations."