CALIFORNIA ACADEMY of GENERAL DENTISTRY

GP NEWS

The Publication Exclusively for the GENERAL PRACTITIONER

Volume 41, Issue Number 3 *September, 2017*

THIS COURSE IS DESIGNED FOR YOU . . . PLAN TO ATTEND

Oral Surgery for the General Practitioner

*The California AGD, in concert with **Delta Dental** of **California**, present courses each Fall for members. Additionally, we are joined again this year by Hiossen Implants, Ultra Light Optics, Kettenbach USA and Garfield Refining in sponsoring this presentation.*

A FOLLOW-UP COURSE WILL BE HELD ON JANUARY 27, 2018 AT THIS SAME LOCATION

The course will be held at

The DUKE Hotel ◆ *Newport Beach, California* ◆ ***Saturday, October 28, 2017***

Our speaker is **DR. KARL KOERNER**

8:00 a.m. till 5:00 p.m.

***COURSE DESCRIPTION**:*

- *Indications and contraindications for surgery*
- *Surgical techniques: surgical extractions, the maxillary sinus and extractions, third molar impactions surgery (various angulations, maxillary and mandibular), socket grafting, related procedures*
- *Avoiding and/or managing surgical complications*
- *Patient age as it relates to surgical difficulty*
- *Patient health and medications*
- *Using the best instruments for maximum proficiency*
- *Regional anatomy and oral surgery*

See page 4 for more details on this course, then see page 16 for information on the hands-on follow-up course to be held on January 27, 2018 (same venue)

Dr. Koerner has presented hundreds of didactic and participation oral surgery courses in the U.S. and around the world. He lectures about twice a month at dental meetings. He is also an Adjunct Professor in Oral Surgery at Roseman University of Health Sciences, College of Dentistry in South Jordan, Utah. His clinical practice consists of only oral surgery procedures which he performs in several offices in Salt Lake City, Utah. He is the author of many articles on various aspects of oral surgery for the general dentist and has authored or co-authored four books on oral surgery. In addition, he has made several DVDs on surgery with Dr. Gordon Christensen. He is past president of the Utah Dental Association and Utah Academy of General Dentistry.

Dr. Koerner received the National AGD's Weclew Award for contributions to dentistry and dental education and also the Utah Dental Association's Distinguished Service Award. He is not an oral surgeon, but received extensive oral surgery training in the U.S. military where he completed a general practice residency in addition to other service.

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G.P. NEWS *A Publication of the* **CALIFORNIA ACADEMY** *of* **GENERAL DENTISTRY**

The GP News is published three times annually by the California Academy of General Dentistry. Inquiries should be made by contacting Terri Wong, Executive Director at 8 River Garden Court, Sacramento, California 95831. *Phone* 877-408-0738 *or fax to* 916-228-4494.

ORAL SURGERY FOR THE G.P. *(continued from the front page)*

More about the course:

- *Registration and breakfast at 7:30 a.m. with the class starting at 8:00 a.m.*
- *Buffet lunch and visit exhibitors at 12:00 noon*
- *Course resumes at 1:00 p.m., ending at 4:00*
- *See page 20 for information on the **hands-on follow-up course** on **January 27, 2018***
  SAME VENUE

Address for the Duke Hotel:

4500 MacArthur Boulevard
Newport Beach, California

Link for Online Registration:

goo.gl/w5ruWx

Tuition: *$**129** for Delta Dental and ADA members; all others pay $**199***

Questions, call Terri at 877-408-0738
or Fax to: 916-228-4494

Credits: *Seven (7) hours "CE"*

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Disneyland and Knott's Berry Farm are only about twenty minutes frrom The Duke Hotel.

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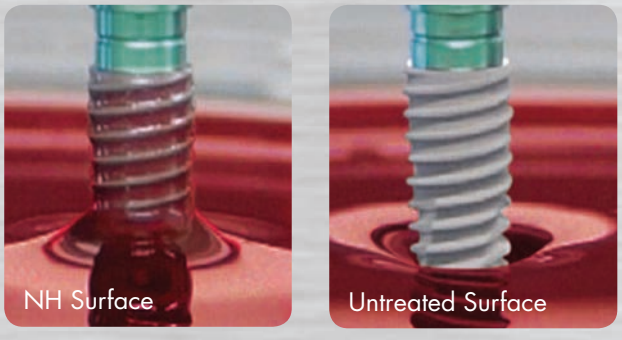

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THE PRESIDENT'S MESSAGE

DR. CHETHAN CHETTY
Eagle Rock

CALIFORNIA ACADEMY of GENERAL DENTISTRY

Your voice for excellence through education and advocacy

Bursting Your "Bubble"

As a private practice dentist, it's hard to see the daylight most days. You know the routine. You get to work a little early to do some paperwork. Then, you end up working through lunch because that 30 minute MO turned into a root canal. Then you finish your day only to endure red lights—L.A. traffic. Get home after dark, skip the gym, spend too few minutes with the family, go the bed. Rinse and repeat. But maybe that's just me, right?

My point is, that is very easy to get stuck in your own "bubble." But at the end of the day, it is easy to feel disconnected from the world around you. And, I think that's a dangerous place to be.

You don't have to look too far outside of your "bubble" to see that the dental world is changing very quickly around us. There are some really great Facebook dental groups that share about these techniques and technology. I've learned a lot from them. True to dental geek form, my newsfeed is full of more x-rays than baby pics. But trying to absorb all of it by yourself can be intimidating and overwhelming. You want to know more, you want to do more. If you're like me, you want to be the best at what you do.

Last month, I had the opportunity to take my family and my team to Las Vegas for the AGD Annual Meeting *(photos below).* Because, I mean, Vegas right? As always, the Annual Meeting was an amazing chance to see old friends and meet new ones. We took some really fun classes on CEREC, Digital Printing, Practice Management, Perio. It was great to learn more about the things that I have been seeing and reading about on social media. In fact, I got to meet many of these amazing doctors that I see online. Without sounding like a fanboy, it was really great to put a face to the profile picture.

I also attended the awards reception. This is where the Fellows, Masters, and LLSRs received their awards. It's an amazing event to watch and be part of. It is inspiring to see so many people dedicate themselves to being the best, so that they can do the best for their patients.

If you ever feel like you are stuck in a "bubble," I encourage you to attend a CE event. Rub elbows with those people who can inspire you to do more. Don't just sit on the sidelines and scroll past the opportunities. ■

Dr. Steve Huang and Dr. Chethan Chetty

Dr. Michael Lew and Dr. Mike Bromberg

Dr. and Mrs. Neil Gajjar, Dr. Manuel Cordero *(AGD Nat'l President Elect),* Dr. Chethan Chetty and Avani Chetty

WatchDog REPORT

DR. GUY ACHESON
Rancho Cordova

This article is an editorial that reflects only the views and opinions of the author and does not represent the views, opinions or positions of the California Academy of General Dentistry.

Dental Board Suspends RDA Practical Exam

For the last couple of years the Dental Board of California (DBC) has been closely watching the pass/fail rates of RDA candidates with concern because the pass rate has been declining. This means fewer RDAs are coming into the workplace.

The practical examination has been under the greatest scrutiny because its pass rate is lower than either the written exam or the California Law & Ethics exam. The RDA practical exam has become the primary rate limiting step for new RDAs entering the workforce.

Many reasons for the declining pass rates are speculated. Are the schools doing a good job of teaching? Are the RDA students less prepared before entering the RDA schools and therefore, struggling to learn the material? Do the exams, written and practical, reflect what is being taught in the schools? Is the fact that the practical exam is given in only a few select locations creating barriers due to the time, travel, and costs involved in just getting to the exam locations? Does the practical exam reflect the actual clinical skills needed by an RDA? The DBC decided to take a deep look at the RDA practical exam. They asked the California Office of Professional Examination Services (OPES) to complete a psychometric evaluation of whether the RDA practical examination accurately tests real world RDA skills, and then present what a fair and accurate practical examination should test. The DBC received the OPES report in a closed session in April. After that meeting the DBC decided to suspend the RDA practical exam until a new examination could be created. This will be a two to three year process. Because the requirement for an RDA practical exam is in statutes, it requires the legislature to pass a bill allowing the DBC to suspend the exam and that is in the works. Once that suspension is allowed, new RDAs will be eligible for a license after completing the written exam and the California Law and Ethics exam. You can read more about this on the DBC website (www.dbc.ca.gov).

Sedation in Dentistry

The Legislature's evaluation of the safety of sedation in dentistry is in its wild adolescence. The alarm bell was rung with the death of Caleb Sears in an oral surgeon's office in 2013. Caleb's parents became instrumental in the passage of Caleb's Law (AB224) which required the DBC to complete a study of the safety of sedation in dentistry and submit a report to the Legislature. The study was completed and submitted. The Legislature has had its public hearings. Now there are three separate bills working through the legislature, each with a different spin on what should be done. The common theme of all these bills is to stratify the sedation permit system into three levels based on the intended depth of sedation; minimal, moderate, and deep/general. Each depth of sedation permit could be further stratified based upon the age of the patient; children under age 7, children age 7 to 13, and everyone over the age of 13. The younger the patient the more complex the requirements for monitoring, the greater number of personnel required to be with the patient during treatment, the more specific the training requirements of all people involved in treating the patient, and for the youngest patients, eliminating the operator/anesthetist practice model, where the dentist providing the dental treatment is also delivering and monitoring the sedation.

Caleb's Law was passed due to a perception that children are dying while under sedation for dental treatment in dental offices because the model for delivering sedation in dental offices is inherently dangerous. That same opinion holds that all sedation should be delivered as it is done in the medical community; using a dedicated sedation provider. I find this to be a fascinating process because in this day and age where our decisions are supposed to be made upon objective evidence (evidence based) the study done by the DBC does not support the opinions that sedation in dentistry is a dangerous activity. Also, the proposed changes in permits and regulation do not address any demonstrated problems. The DBC study found that from January 2010 through December 2015 there were nine deaths involved with dental care and only one occurred in a dental office where the dentist was both providing dental care and general anesthesia. Four of the deaths occurred in the exact situation being fought for; in a hospital with a dedicated anesthesia provider. So much for rational decision making based upon evidence based data.

It gets more complicated. Who is not fully sympathetic to the loss that Caleb's parents experienced. But, does that situation represent the totality of sedation in dentistry? The medical anesthesia lobby is connected and is leveraging our emotional connection to Caleb's parents. Did you see Sunday Night with Megyn Kelly on July 9, 2017?

I am a dentist who does hospital dentistry. I also do conscious sedation (moderate sedation) in my office. About 50% of my practice is moderate sedation / intravenous sedation in my office. The number one reason patients .

(continued on the adjacent page)

New Fellows–*Congratulations!*

ACHIEVING FELLOWSHIP STATUS Candidates for Fellowship in the Academy of General Dentistry must have been members for at least three years prior to becoming a Fellow. They have completed a minimum of 500 hours of continuing education. After that, they must pass a comprehensive 400-question written exam.

That exam is administered by the AGD each year at their annual meeting. Study courses are available at every annual meeting to any AGD members desiring to avail themselves of this. ■

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WATCHDOG *(continued from the previous page)*

are seeking sedation is to overcome the fear of dentistry they have developed from their experiences at the dentist as a child. Pain. Restraint. Papoose boards. Assistants lying on their bodies to hold them in place while the dentist works. Them experiencing pain while the dentist is telling them to be quiet and hold still because they "are numb." The stories go on and on and on. The result of hearing these stories for over 40 years is that I believe general anesthesia is a much needed tool to provide dental care to children who cannot cooperate for dental treatment. The use of restraint, no matter how humanely and lovingly it is provided, is not acceptable to me. These experiences are life long scars to patients. The problem is that general anesthesia is expensive. Denti-Cal's compensation for general anesthesia for dental treatment is an insult. The current requirement of many dental insurance companies to demonstrate the failure of at least two attempts at sedation in an office situation before even considering a benefit for general anesthesia is cruel and unusual punishment to innocent children. It is an insult to the clinical judgment of dental practitioners who have a very good sense of what type of sedation is appropriate for a patient based upon their history, needs, and presentation in the office. Clinical experience and judgment have value. The arbitrary requirement to subject children to forms of sedation that are highly probable to fail is just another form of abuse.

It all comes down to money. It is very easy for Caleb's parents to call for hospital-based delivery of all general anesthesia for dental care. I don't know the financial situation with Caleb's parents, but it is a good guess that money is not a rate-limiting step. The reality is that most of the children with advanced tooth decay are from low income families who depend on insurance and Denti-Cal to pay for dental services. If the political reality is that children all need to have general anesthesia provided in a hospital type setting with a dedicated anesthesia provider, then there needs to be a commitment to providing realistic funding for those services so that hospitals, surgery centers, and anesthesia providers aren't compelled to deny admission for all dental cases because the majority of the cases will be undercompensated. It is time to stop abusing children by requiring top of the line treatment requirements and providing only "dollar store" compensation.

The Status of Oral Health in California

Finally, for those interested in the dental health of our population and what our new State Dental Director is doing, a report has been published by the California Department of Public Health. The Status of Oral Health in California: Oral Disease Burden and Prevention 2017. It says that not much has changed since the Surgeon General's report of 2000. The report points to The Virtual Dental Home as having the most potential to reach out to populations with the greatest dental needs and make a difference. You recall that The Virtual Dental Home is where independent hygienists go to schools and residential care facilities to complete examinations using digital tools and send this information to a supervising dentist for review. The remote dentist can then order preventive services to be completed by the hygienist or refer the patient to a dentist for restorative treatment. The limiting factor with this plan is . . . *money.*

If you would like to discuss any of this with me,
I can be reached at: **drguyacheson@gmail.com**

Biology of Bone Healing and Regeneration

Muna Soltan, DDS, DICOI, FAGD

DR. MUNA SOLTAN
Napa

Bone is a unique organ that has the ability to regenerate and repair itself. The initial response to bone-graft surgery is similar to the healing process that occurs naturally after an injury. Along with the peripheral blood and the adjacent bone, the periosteum is important in this healing process as a source of mesenchymal stem cells that can be transformed into osteoblasts. The fibroblasts from the outer layer of the periosteum and the osteoblasts from the inner layer provide a collagen matrix. They secrete growth factors that stimulate endothelial progenitor cells to proliferate and differentiate into endothelial cells to vascularize the site, bringing nutrients, cells and cytokines that are needed for bone regeneration. Mesenchymal stem cells are normally quiescent. They can be activated by injury to the bone or periosteum, local infection, hypoxia and surgical trauma, including the manipulation involved in releasing the periosteum. During osseous surgical procedures, the manipulation or cutting of the periosteum is responsible for most of the post-operative pain and swelling. Conversely, surgical trauma triggers the body's natural healing response to release mast and other granulation cells. This interaction stimulates stem cells to proliferate, differentiate, and secrete cytokines that activate other cells to migrate to the site of injury.

The reparative potential of the cells released from the periosteum and the cancellous bone depends on a number of factors, including:

1. The patient's age: The adult periosteum contains multipotent mesenchymal stem cells (MSC) that have the ability to repair and regenerate bone. With increasing age, the number of MSCs decrease.

2. Surgical technique: Gentle handling of the periosteum during the dissection can aid in maintaining the vitality of the cells, blood supply to the graft site, and the healing potential of the membrane.

3. Thickness of the graft and the blood supply available: The thicker the graft, the longer it takes to vascularize the site. Also, the thicker the cancellous bone adjacent to the graft, the more the blood supply, and the more predictable the healing and bone regeneration. Drilling holes in the cortical bone adjacent to the graft helps access the blood supply and speed up the healing. This enhances the reparative potential of the bone.

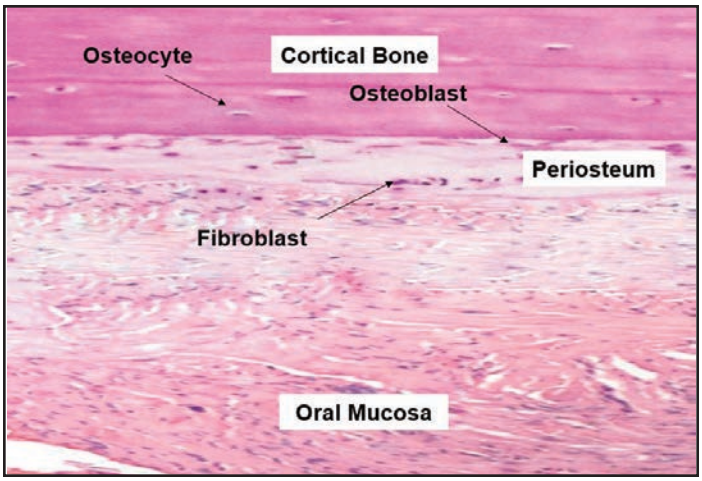
4. Quality of the periosteum or native available bone: A very thin periosteum or one composed of dense fibrous tissue may lack the blood supply necessary to support regeneration, as well as the mesenchymal stem cells needed to proliferate and differentiate into osteoblasts. Also, thin atrophied native bone has less cancellous bone and more cortical bone and therefore has a limited blood supply. The vascular cancellous bone brings blood to the graft; transporting cells, cytokines, oxygen and nourishment needed for regeneration and remodeling.

5. Systemic health: The presence of systemic disease such as diabetes, HIV, or certain metabolic disorders can hinder the process of healing and bone regeneration. The initial immune reaction of inflammation is critical in providing the cascade reactions for bringing and recruiting cells that organize and form blood vessels. This happens in the first three weeks of healing. Once the area is vascularized, the stem cells from the adjacent bone can specialize to form osteoblasts. Osteoblasts are the bone forming cells that require increased amounts of nutrients to build the initial bone matrix, called osteoid. The osteoblast mineralizes that matrix, and gets trapped in lacunae to become osteocytes. These cells are responsible in maintaining the bony matrix.

Chronic infection, on the other hand, is not desirable because it activates osteoclastic activity that resorbs bone.

6. Medications: Medications such as steroids, immunosuppressant drugs, or bisphosphonates, can decrease the ability of the cells to form and/or remodel bone. Anti-inflammatory medication for example, inhibit the acute inflammatory reaction such as monocytes that are needed to recruit the stem cells to form blood vessels and recruit osteoblasts to form bone.

7. Patient habits: Smoking or the use of drugs, such as cocaine, decreases the body's ability to heal and resist infections and can compromise the vascular supply.



Oral mucosa attached to the periosteum and the periosteum is attached to cortical bone. The Osteoblasts are present in the layer between the periosteum and bone where they get activated by certain cytokines and growth factors that signal them to go the surgical site to secrete bone matrix. The osteoblasts are the mature cells present in a lacuna found in the cancellous and cortical bone. In the cancellous bone, they are less mature and are less organized than in the cortical bone. ■

References:

1. Mathew RA, Janet MH, David BB. Periosteum: biology, regulation, and response to osteoporosis therapy. Bone. 1004;35:1003-1012.
2. Donahue HJ, Siedlecki CA, Vogler E. Osteoblastic and osteocytic biology and bone tissue engineering. Bone Tissue Engineering. edited by Hollinger JO, Einhorn TA, Doll BA. Sfeir C. Boca Raton, Florida CRC Press 2005:44-54.

New Masters—Congratulations!

ACHIEVING MASTERSHIP STATUS

The three practitioners pictured immediately below qualified for and received the Academy of General Dentistry's prestigious Mastership award in La Vegas at the AGD's Annual Meeting. They successfully completed a rigorous curriculum outlined by the national Academy of General Dentistry.

Mastership is the highest award available in the AGD. It is one of the most respected and recognizable designations in the dental profession. Less than one percent of the general practitioner population in the United States have achieved this lofty goal. California has 184 actively practicing Masters out of a population of over 21,600 general dentists.

To achieve Mastership a dentist must complete a minimum of 1,100 hours of approved continuing dental education. Most who have reached this level of continuing education have many, many more hours than the minimum number. At least 400 hours must be accrued in participation, hands-on courses in sixteen different subjects.

Students are involved in the demonstration of a particular skill or technique under the direct supervision of highly skilled experts. ■

DR. THIEN H. VU
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DR. GENE R. HERRERA
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CALIFORNIA ACADEMY
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GENERAL DENTISTRY

Oral Health Literacy High on AGD List of Priorities

CAGD's Dr. Myron (Mike) Bromberg moderates a panel discussion of Oral Health Literacy at AGD's Scientific Session in Las Vegas.

Moderating a panel discussion which included Dr. Ralph Cooley, a general dentist from Texas and Dr. Rocky Napier, a pediatric dentist from South Carolina, Dr. Bromberg stated the overwhelming need for Oral Health Literacy. The promotion of Oral Health Literacy is a priority for the AGD, targeting amongst others, the populations that don't understand even the most basic concepts of oral health and dental disease prevention. As an example, he spoke of the parents who still fill the baby's bottle with apple juice at bedtime. Citing studies that show in certain populations, the child's first dental visit is to the hospital emergency room, *in pain,* he stated: *"This is **not** okay. It is inappropriate and dangerous to wait that long. We need to change that mindset and the only way we can do it is with education."*

To achieve its goals of educating vast numbers of people regarding oral health in general, the AGD is working with public policy makers, legislators, regulators, other dental organizations and the public.

Another panel on this subject will be held at the AGD House of Delegates meeting In November of this year in Chicago. ■

A PATHWAY IN PREPARATION FOR A

Financially Independent "Retirement"

DR. KEVIN ANDERSON
Jamul

AN EXCLUSIVE SEVEN-PART SERIES OF ARTICLES FOR "GP NEWS" RECIPIENTS DESIGNED TO ASSIST IN MANAGING THE PROCESS

- Savings – It's Never Too Early To Save! *(May, 2017)*
- **Finding Your Number—How Much Do You Need?** *(October, 2017)*
- Lifetime Financial Ratios—Where You Should Be
- Insurance Needs and Practice Overhead
- Definition of Risk / Investment Alternatives / Leverage
- Optimal Portfolio Withdrawal *("Spend Down")*
- Priority for Tax Efficiency Diversification in Retirement

A quick review of our first article, #1 Savings – It's Never Too Early To Save!, is in order as each successive article builds on the steps required to ascend the financial independence staircase. We discussed the dedication and focus required to save and how small differences in one's savings rates or savings start age make huge differences in terminal portfolio values. We looked at how these both relate to delayed gratification and then how the Rule of 72 works to compound these savings over a lifetime. Finally, we addressed the importance of an Emergency Cash Reserve Fund, personal and retirement account buckets. With this foundation in place, let's move on to the next step #2: *Finding Your Number – How Much Do You Need?*

What's Your Number?

One of my lifetime mentors, Charlie Munger, is a firm believer in utilizing the reverse engineering approach to solving many of life's problems. While he will take the concept to crazy extremes with quotes like, "All I want to know is where I'm going to die so I'll never go there," in this article we will reverse engineer with math to help us determine the answer to our question, "What's Your Number?" How much is retirement freedom of choice worth to you? While the answer is different for everybody, it is well worth your time to find the answer that works best for you! It's important for one to utilize a little time taking pencil to paper or using free financial software to avoid the two diametrically opposed but both potentially sad endings – working far too long because you reached your number and didn't know it (you didn't calculate it!) or not working long enough to reach your number and running short of money. Research shows that goals are best met when written down, shared confidentially with another and visited regularly.

Less than half of all dentists have computed how much they will need to retire. This is an important step – why leave you and your family's future up to chance when you can sit down and with some elementary math skills and diligence improve your odds in life? This can be a daunting task for our profession that prides itself on near perfection with every procedure. In this step, however, knowing the rules of thumb and understanding the built-in assumptions are far more important than carrying out your number to the third digit past the decimal point. Additionally, the importance of building in a large Margin of Safety in your calculations will serve you well. This can be compared to a driver of a 10,000 lb truck preparing to cross a 10,000 lb limit bridge. *Don't go there!* Don't cut it close as this might not be your lucky day. Drive on down the road and take the 30,000 lb limit bridge!

Spending is the major element that drives most of the decisions in the financial game of life – from influencing savings rates while working to impacting lifestyle spending down in retirement – spending also forms the basis for one of the methods used in calculating your number. And while the question, "What's Your Number?" is simple, the answer has many moving parts. Some additionally important elements besides spending in calculating an answer include Savings Rate, Portfolio Returns, Portfolio Withdrawal Rates, Inflation, Legacy Desires and Longevity. Several of these we can control, but since we cannot be absolutely certain with unknowns, it is important to build in a Margin of Safety to anticipate any unlikely events.

Retiring early (say, before the age of 60) can be very challenging due to the high savings requirements, long life expectancy causing a long portfolio withdrawal timeframe and lack of receiving social security benefits prior to being eligible. Comfortably retiring later (say, past the age of 70) is very possible for dentists even with a poor savings history because of higher social security benefits and a shorter life expectancy. Because Social Security benefits continue to increase until age 70, the longer one works, the easier it is to afford a comfortable retirement. Because of the math, an increasing number of dentists are spending their golden years at chairside. Let's now take a look at three methodologies for calculating your number along with some rules of thumb for "Your Number."

The Income Method: This method is the easiest to calculate. Simply take your income (use line 43 of your recent tax return) and multiply it by a factor to determine Your Number. ***Exactly how much you should multiply your income by is a matter of debate.*** Fidelity recommends that you have at least **eight** times your income. According to this method, Fidelity's recommendation for Dr. Average Joe non-owner dentist salary of $132k (as per 2015 ADA stats), a savings of just over a million dollars is required ($132k x 8). Others, like respected financial author Charles Farrell, recommend savings of at least **twelve** times your income depending on how much of your income you want to replace. This takes our Dr. Joe's recommended savings to $1.58M ($132k x 12). Before you get too excited, note that both of these recommendations factor in that Dr. Average Joe will be spending only a certain percentage (60-80%) of his pre-retirement income in retirement. *Also note that both of these recommendations assume that Joe will also be receiving Social Security benefits in addition to his income from his savings.* Using your percentage of income you will require in retirement and subtracting your annual Social Security benefit (remember it increases if you

(continued on the adjacent page)

RETIREMENT *(continued from the adjacent page)*

wait until age 70), you can determine your number by multiplying by twenty-five (assuming a 4% Portfolio Withdrawal Rate – a topic we will discuss in Part #6 of this series). Using our Dr. Average Joe example, if Dr. Joe requires 70% of his annual pre-retirement income or $92k ($132k x .7) and will receive $25k in Social Security benefits, Joe will need to replace $67,400 of his income which will require a recommended nest egg of $1.7M ($67.4k x 25). This Joe example also assumes no lump sums coming from either a practice sale and/or any inheritances – factors which can help Joe to decrease his required number.

An entirely different set of higher numbers must apply if Joe wants to retire early because Social Security benefits won't factor in and the portfolio must survive longer (increased portfolio withdrawal period). If we assume Average Joe wants to retire early at the same 70% of his pre-retirement income level or $92k ($132k x .7), Joe's number would need to be on the order of $2.3M ($92k x 25).

The Income Method give us an easy calculation, however, Your Number can vary dramatically depending on desires and circumstances. In this case, our Dr. Average Joe's number varied from $1M to $2.3M. There is one drawback to this method. What you need in retirement is to cover your expenses, not a proportion of your pre-retirement income. While most will spend 60-80% of their pre-retirement income in retirement, certainly many will not.

The Expense Method: The goal of this method is to define your retirement number based on your expenses in retirement. This is best accomplished by keeping a detailed budget and tracking expenses so that you will have a reasonable understanding of what your costs will be during retirement. Adjustments to a pre-retirement budget must be made in consideration of the following: no more retirement contributions, possibly no more mortgage or a move to a less expensive part of the country, etc. Once your likely retirement expenses are known, determining your number with a simple calculation is easy. Again, always allow for a large Margin of Safety! One would first subtract Social Security benefits from expected expenses to determine how much must be met from your savings. Multiply the remainder by 25 to arrive at Your Number. If Dr. Joe has adjusted his pre-retirement expenses to an annual number of $60k (expected in retirement), then his number is $1.5M ($60k x 25).

The Savings Method: This method is in some ways a hybrid of the other two and was used successfully by me. The Savings Method doesn't directly attempt to estimate expenditures in retirement but, instead, the focus is on saving a set percentage of one's gross income. Under this approach, the minimum savings rate is 10% of gross pay although many recommend at least 20%. As you save a greater percentage of your income, two interesting things begin to happen.

First, the more you save, the larger and faster your nest egg grows. Second, as you save more, you learn to live on less. The result is an ever-increasing retirement portfolio with lower expense needs in retirement. When taken to an extreme with a savings rates of say 33% (as in my case), one can have the freedom to retire at a younger age.

The savings rate does raise the additional question of how much income a portfolio will generate. You can always use the 4% withdrawal rule to get an estimate. Let's say Dr. Average Joe saves 25% of his gross income of $132k or $33k annually. If he earns an average stock market return of 9%, Dr. Joe will have accumulated $1.7M after just twenty years in his portfolio. Based on that amount, he could pull $68k from the portfolio per year for the rest of his life with little risk of ever running out. If Dr. Average Joe were able to maintain a savings rate of 33%, saving $44k per year, he could be in this same early retirement position in a only seventeen years!

A Bonus Method: If you would really like to have some fun in calculating your number and playing with different retirement dates and spending amounts, the use of a $29 Texas Instruments BA2 Plus handheld calculator (Amazon Prime) is very useful. One can find their number by determining how much they spend (or dream to spend) in retirement, put in varying years, inflate it by 3.7%, take it from present value to future value and back out any fixed returns. What you will realize is that depending on life choices, every person is truly capable of having lotto-type money – but it's achieved (and appreciated more) over the long-term!

What About Dr. Ludicrous Tesla Who Forgot To Save?

Filtering through many dentist retirement scenarios, I discovered that the bell curve of probable dentists retirement age is heavily weighted between 63 to 69 years old. Even a hypothetical Dr. Ludicrous Tesla with no savings at age 62 and a net practice income of $200k has the potential for a decent retirement at age 76 receiving income of $140k. You wonder how this is even possible. If Dr. Tesla delays receiving his and his spouse's social security benefits until age 70 (Tesla's $40k plus $20k spousal benefit per year) and then doesn't touch, but saves it from age 70-76, he will have at least $360k saved not including any growth. An additional $300k from his practice sale plus a possible $200k from inheritance (the average expected for Boomers) will leave Ludicrous with a portfolio of $860k. At age 76, longevity is muted tremendously compared to one in his mid-sixties. A withdrawal rate of 10% is acceptable which provides $86k. This plus the $60k of Social Security will provide upwards of $140K annually in income. The irony here is that Dr. Tesla's annual retirement income is about the cost of a fully loaded Ludicrous Tesla S!

In conclusion, hopefully this discussion of Your Number has helped you to consider something that you never even gave any thought. And if you have already thought about it, hopefully it has helped refine the process. Your Number is one of those issues in life that can certainly be reversed engineered with reasonable certainty utilizing a large Margin of Safety.

If you should have any questions or comments, I would love to hear from you. Please do not hesitate to contact me! ■

My next "GP News" topic will be:

Lifetime Financial Ratios –
Where You Should Be Financially at Various Age Points!

Kevin Anderson, DDS, MAGD, is the Founder & General Partner of The Anderson Investment Fund. The Fund is limited to high net-worth individuals, companies and retirement plans and utilizes a value-based investing approach. Kevin achieved financial independence and the freedom to retire early from dentistry at age 43. Dr. Anderson is available to speak to dental groups on financial topics like Successful Investing for Retirement, Practice Overhead and Financial Ratios and can be reached at (619) 248-7379, sdkevindds@aol.com or you can visit his funds web site www.AndersonInvestmentFundLP.com

California Leaders at the AGD NATIONAL CONVENTION in Las Vegas in July

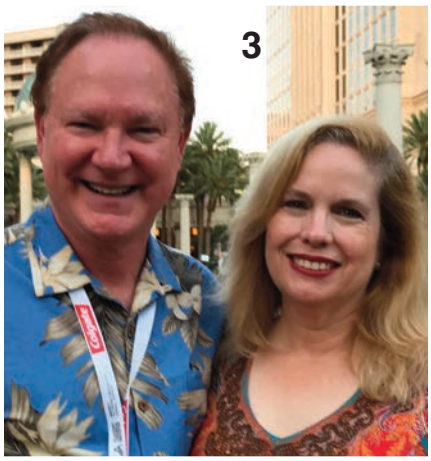

PHOTO LEGEND:

1. AGD Nat'l President, **Dr. Maria Smith** and **Dr. Howard Chi**
2. **Dr. Mike Bromberg** speaking at the Oral Health Literacy Symposium
3. **Dr.** and **Mrs. Stephen Lockwood**
4. **Dr. Chethan Chetty**, **Dr. Austin Griffith**, **Dr. Heather Anderson**, **Dr. Karly Suhut Neppl**, **Dr. Ratna Indah**, **Dr. John Tong**, **Dr. Michael Lew**, **Dr. Mike Bromberg**, **Dr. Kayee Siu**, **Dr. Steve Huang** and **Dr. Gisella Angatita** at the Convocation Celebration
5. **Dr. Mike Lew** carrying the AGD flag followed by AGD President is **Dr. Maria Smith** and **Dr. Manuel Cordero**, AGD President Elect
6. **Dr. Chethan Chetty**, **Dr. Maria Smith** and **Dr. Mike Bromberg** at the Convocation Celebration
7. **Dr. Gisella Angarita and Dr. Ratna Indah,** FAGD awardees
8. **Dr. Austin Griffith** and **Dr. Heather Anderson,** husband and wife FAGD awardees

CALIFORNIA ACADEMY of GENERAL DENTISTRY

9. **Dr. Efrem Trpkov, Dr. Manuel Cordero, Dr. Chethan Chetty, Dr. Neil Gajjar**
10. **Steve Huang followed by Dr. Austin Griffith and Dr. Heather Griffith (all received their FAGD and are currently in MasterTrack 4**
11. **Dr. David Yoshimaru and son**
12. **Drs. Jungman (father and son)**
13. **AGD's new logo displayed in cupcakes (delicious)**

ORAL SURGERY FOR THE GENERAL PRACTITIONER

Hands-on for all attendees

DR. KOERNER

Instructor: DR. KARL KOERNER

About Dr. Koerner: He has presented hundreds of didactic and participation oral surgery courses in the U.S. and around the world. He lectures about twice a month at dental meetings. He is also an Adjunct Professor in Oral Surgery at Roseman University of Health Sciences, College of Dentistry in South Jordan, Utah. His clinical practice consists of only oral surgery procedures which he performs in several offices in Salt Lake City, Utah. He is the author of many articles on various aspects of oral surgery for the general dentist and has authored or co-authored four books on oral surgery.

In addition, Dr. Koerner has made several DVDs on surgery with Dr. Gordon Christensen. He is past president of the Utah Dental Association and Utah Academy of General Dentistry. He received the National AGD's Weclew Award for contributions to dentistry and dental education and also the Utah Dental Association's Distinguished Service Award. He is not an oral surgeon, but received extensive oral surgery training in the U.S. military where he completed a general practice residency in addition to other service.

Course Outline:

- Hands-on incisions and flaps
- Hands-on suturing
- Root removal *(at bone level)*
- Need for oral sedation
- Hands-on lower molar sectioning and socket grafting
- Hands-on upper molar sectioning and root into sinus
- Hands-on lower and upper third molar removal
- Hands-on multiple extractions, alveoplasty, continuous-lock sutures

Location:

Tuition:

*$**450** for ADA and AGD members; all others pay $**650***

Registration:

Register on our website at:

www.cagd.org

*Questions, call Terri at **877-408-0738***

In and around Newport Beach:

With nine miles of sandy beaches, the opportunities are nearly endless for beach lovers in California's most picturesque playground. But the fun doesn't stop on the sand! Newport Beach and the surrounding areas are also home to many museums, world-class shopping, fine dining, challenging golf courses, renowned atrractions, performing art venues and spas. Special events and festivals are another way to experience the unique character of Newport Beach. A year 'round schedule of events, food and wine tastings, film and music festivals, boat parades and more ensures your stay is full of new ways to play.

Also, Disneyland and Knott's Berry Farm are only about twenty minutes from The Duke Hotel.

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6/01/16 to 5/31/2022

Candidate for Secretary **MICHAEL W. LEW**, DMD, MAGD

Michael W. Lew, DMD, MAGD, currently serves as trustee representing the California AGD. He received his Bachelor of Arts degree from the University of California Berkeley in 1979 and his Doctor of Dental Medicine degree from the University of Pennsylvania in 1983. While studying at the University of Pennsylvania, he was recognized as an outstanding student in both endodontics and dental radiology.

Dr. Lew joined the AGD immediately after graduating from dental school, receiving his Fellowship in 1993 and his Mastership in 2007. He also has fellowships with the Academy of Cosmetic and Adhesive Dentistry and International Congress of Oral Implantologists.

Dr. Lew has served on the Northern California AGD Board (San Francisco) and the California AGD Board since 2003 in multiple leadership capacities. He has led or supported membership drives, student events, socials for new dentists, task forces, and educational courses at the local and state levels. He has been a delegate to the AGD House of Delegates since 2003. Nationally, Lew served AGD on its Strategic Planning Committee and Membership Council. He was regional director from 2009 to 2014, including leading as chair and overseeing the Leadership Conference. As trustee, he currently participates as board liaison to the Membership Council, associate member of the Investment Committee, and member of the Budget and Finance Committee. In 2013, Lew was awarded "Dentist of the Year" by the California AGD.

"The AGD is a great organization representing general dentists and their educational achievements. We have unlimited potential for our future. I want our AGD to be at the forefront of that process."

Dr. Lew has also been active with the American Dental Association (ADA). He led local study clubs for his dental society for years. He was trustee to the California Dental Association (CDA) and a member of the Dentists Insurance Company Board of Directors, CDA Legislative Affairs Council and CDA Strategic Planning Group. In addition, he was alternate delegate to ADA.

In 2005, he joined the Dental Board of California, where he would chair the Continuing Education Committee and participate on the Examination Committee. At the Dental Board, Lew successfully advocated for cultural diversity in dental education and acceptance of AGD's PACE as dental board-approved courses in California. He was a consistent voice for the general dentist throughout many deliberations.

Lew was in private practice for twenty-five years before joining the state of California as a correctional health dentist. Dr. Lew is married to Vivian, a professional photographer. They have three children. His interests outside of dentistry include history, finance, hiking and music.

Personal Statement

"The AGD is a great organization representing general dentists and their educational achievements. We have unlimited potential for our future. I want our AGD to be at the forefront of that process. I am asking you to make me part of that leadership team. I believe in servant leadership and in serving AGD for the benefit of the organization and its members. I support AGD's continuing process of strategic planning and growth, and if elected, I will work to further AGD's goals as decided by the House of Delegates.

"Like you, I struggled with intrusive government regulations, diminished insurance reimbursements, staff challenges and other changes in our profession. This motivated me to get involved with organized dentistry to help solve the problems of the everyday general dentist, including licensure for new graduates, increasing the numbers of dental hygienists, increasing the number of eligible dental courses allowable for licensure, advocating for the general dentists to perform Invisalign® procedures and fighting the promotion of the midlevel provider. Shortly after I began, dentistry changed with the advent of cosmetic dentistry, posterior composites, dental implants and rotary endodontics. With my AGD friends, I organized courses in these areas to educate our members. My leadership at the local, state and national levels has always focused on how to help other leaders succeed.

"Let me work with you to help our members succeed in the face of challenge through advocacy and education. Together, let us build a stronger AGD with more members and programs that are second-to-none. With your help and support, I will serve you, the members of AGD, as your secretary. Please vote for me to become your next secretary of AGD." ■

DR. ERIKA KULLBERG
President Elect
El Cajon

Dr. Larry Pawl hosted the SDAGD Practice Management Study Club in April 2017, featuring a lecture on "How To Steal from a Dentist." David Harris, CEO and founder of Prosperident, talked about potential embezzlement within your practice and methods for prevention. The course was well-received by numerous attendees.

SDAGD has one remaining meeting in our last and final year of the Practice Management Study Club. Twelve courses total will have been put on over three years.

In June of 2017, SDAGD held it's most recent board meeting at Empire House in Hillcrest. Upcoming events, such as the joint SDAGD/SDCDS CE course in 2018 were discussed.

A conflict arose with the date for San Diego AGD's Annual Meeting. A new date will be announced soon. Dr. Doug Lambert will be presenting on "Restorative Options Overload." He will discuss the current trends, materials and indications for different restorative materials. The course will be held at the Patterson Dental Center and will start at 8:30 a.m. and conclude at 3 p.m. Six CE credits will be earned. More information on this course is located on page 29 herein.

SDAGD also plans to collaborate again with the SDCDS this fall to sponsor another continuing education program in 2018. The proposed speaker, Dr. James Kohner, will present on "Crown Lengthening and Soft Tissue Management." ■

The San Diego AGD Annual Meeting date has met with a conflict. Stay tuned. A new date will be announced soon.

The SDAGD Board of Directors *(from left to right):* **Dr. Larry Pawl, Dr. Jay Thompson, Dr. Erika Kullberg, Dr. Zeynep Barakat, Dr. Steve Lockwood, Dr. Harriet Seldin, Dr. Frank Ceja and Dr. Thanh Tran.**

CALIFORNIA ACADEMY of GENERAL DENTISTRY

Southern California COMPONENT

Implants and Socket Grafting

AN INTRODUCTORY MINI HANDS-ON WORKSHOP

IMPLANTS *Predictable Implant dentistry has been done by dentists for over 35 years. Yet, many general practitioners still strangely believe that these treatments should be done by specialists. Implant dentistry is a restorative discipline with a surgical component and thus the domain of no specialty.*

GRAFTING & AUGMENTATION *Bone grafting and augmentation have become quite predictable and necessary since the early days of implant dentistry. Today, the principles for successful results are better understood and are within the capabilities of general practitioners.*

October 6, 2017

Benco Dental
3590 Harbor Gateway North, Costa Mesa

Two Sessions: *Registration and continental breakfast provided (8:30-9:00 a.m.)*
9-12 p.m. ***Socket Grafting*** *(3 CE); 12-1 p.m. lunch (provided);*
1-4 p.m. ***Introduction to Implants*** *(3 CE)*

Kevin Frawley, DDS, *Instructor, is a UCLA graduate practicing implant dentistry in Beverly Hills for 35 years. Dr. Frawley is involved in the manufacture of regenerative surgical materials for implant dentistry.*

Tuition *for AGD members is $100 for each session or $150 for both; non-members at $200 per session or $350 for both.*

Registration *Go to* ***www.scagd.com*** *OR Contact Avani at* ***310-471-4916***

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Congratulations—LLSR Achievers

Lifelong Learning and Service Recognition (LLSR) acknowledges the continued achievements of AGD Mastership recipients who recognize the need for continuous learning and to stay active both in organized dentistry and their communities.

To be eligible for LLSR, you must have completed the following requirements:

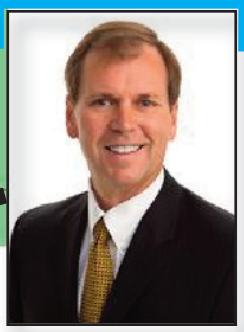
- Current AGD membership in good standing
- A Mastership Award
- A course of study in 17 dental disciplines, totaling more than 1,600 hours of continuing education
- 100 service points in any combination of dental-related community volunteer service and/or service to organized dentistry
  (only those services performed since the date Mastership was received or since a previous LLSR was received are eligible). ■

DR. HOWARD CHI
Stockton

DR. JOHN K. TONG
Cupertino

The San Diego Academy of General Dentistry presents Dr. Doug Lambert

Restorative Options Overload?



Patterson Dental Center

4030 Sorrento Valley Boulevard
San Diego, California 92121

A revised date will be announced soon
8:30 a.m. till 3:00 p.m.

SIX CONTINUING EDUCATION HOURS

LIMITED SEATING AVAILABLE.
RESERVE YOUR SEAT TODAY.

- ***Current trends and materials for direct and indirect restorative dentistry***
- ***Discuss the differences between translucent zirconia and lithium disilicates***
- ***Review indications for different restorative materials***
- ***Compare cementing versus bonding***
- ***Developments in direct restorative dentistry***

Sign up now at: **SDAGD.ORG** *(Continuing Education)*

*Tuition**	BEFORE 9/20	AFTER 9/20
AGD Member	$99	$129
Non-Member	$129	$149
Staff/Military	$49	$59

**Breakfast, lunch and parking included*

ivoclar vivadent

Questions:
SanDiegoAGD@gmail.com

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How Did This Happen?

—**DR. ERIC WONG,** *Sacramento*

The Dental Board of California held a special meeting to discuss the findings of the review of the Registered Dental Assistant (RDA) practical examination conducted by the Office of Professional Examination Services (OPES) of the Department of Consumer Affairs (DCA). After reviewing the findings of the report, the Board voted to suspend the administration of the RDA practical examination effective immediately and until July 1, 2017. Pursuant to Business and Professions Code Section 1752.1, the suspension of the practical examination can only remain in effect until July 1, 2017. After this date, the exam is reinstated as a requirement for RDA licensure. The Board sought an author to carry urgency legislation that will continue the suspension from July 1, 2017 until January 1, 2020, at which date the practical examination or an alternative means of measuring competency would be implemented. Assembly Bill (AB) 1707 will be the vehicle that will carry the provisions to extend the suspension date so that the Board may continue licensing qualified RDA applicants until an exam or an alternative is identified and implemented. If the bill is signed as urgency legislation, it will become effective immediately. The last day for the Governor to sign legislation is October 15, 2017. If the bill is not designated as urgency legislation and the Governor signs it, the law would become effective on January 1, 2018. The necessary legislation to extend the suspension of the practical examination will not be effective by July 1, 2017. This means that the board cannot legally issue RDA licenses until the legislation is enacted into law and becomes effective. The legislative calendar provides the various deadlines for bills to pass out of the legislature and to be signed by the Governor, however the legislative process is complex and subject to variation. The Board is doing everything within its power to facilitate this legislation but is unable to provide a date certain by which we will again be able to issue RDA licenses. The Board encourages applicants for RDA licensure to continue to submit their applications to the Board. Applicants who submit complete applications will be issued eligibility to take the RDA Written Examination and the RDA Law & Ethics Examination. Once the effective date of the practical examination suspension is extended, the Board will resume issuing RDA licenses to applicants who have not taken the practical examination, so long as that applicant meets all other requirements for licensure. The Board will continue to do all it can to expedite AB 1707 through the legislative process and on to the Governor.

The Office of Professional Examination Services (OPES) sent a representative to observe one of the RDA practical examinations, and internal reports were generated to formulate a conclusive report about the validity of the RDA practical. It appears that the RDA practical licensure examinations were deemed to be "outside of the psychometric norms." Candidates must successfully pass the written and practical portions of the examination given by the Dental Board of California to attain their RDA licensure. I was the former Chief Examiner SME (Subject Matter Expert) contracted by the Dental Board to calibrate and supervise the Examiners of the RDA practical. The practical was administered by Dental Board staff, proctors, and the examiner team. The Dental Board met in closed session on April 6, 2017 and voted to suspend the administration of the RDA practical examination. The practical examination consisted of fabricating an acrylic provisional restoration on #8, cementation, and the placement of an IRM provisional on #19-D—all as a typodont exercise. As a standard, each case was graded independently, and if there was a disagreement about the scoring with regard to passing or failing, the possibility of additional independent graders would determine the final grade. All this work was conducted with anonymity between candidates and the examiners.

Prior to my appointment as Chief Examiner to the RDA practical exam, RDA examiners were comprised entirely of RDA's. After observing a few examinations, it became evident to me that the grading rubrics were not being adhered to. At the time, the pass rates were very high, which would be expected when criteria and standards were not being enforced. During my tenure, I gave testimony at a Dental Board meeting on November 6, 2014. Minutes of this meeting can be viewed at:

http://www.dbc.ca.gov/about_us/minutes/20141106jntmin.pdf

I interpreted the grading standards that were in place prior to my appointment. The subsequent pass rates began to drop, and the RDA practical became more difficult for candidates to pass. The Dental Board presented Town Hall meetings to explain these standards that were now being enforced. Standard principles of dentistry included occlusion, margins, and contacts were being evaluated. The grading rubrics for each procedure made sense to me. The Town Hall meetings were attended by many and are archived on the Dental Board website. RDA program educators participated and viewed the webcast and began making changes to their programs to adapt to the RDA practical. Unfortunately, not enough time has elapsed for the educators to calibrate their students to adhere to these newly enforced standards. The timing of the OPES report and the low pass rates has doomed the RDA practical examination.

I have had the opportunity to network with general dentists—*those who are most impacted*—throughout the country. When I share this story with my colleagues, they are genuinely startled, and they often ask me, "How can this happen?" I believe that there are several factors. The Dental Board has gone through no less than four key employment changes with the RDA practical exam administrator during my short tenure. This key person has varied in their ability to coordinate and administer the examinations. Only one of these four key personnel held a clinical licensure certification. To average out my experience with these four individuals, it would be approximately eight months with each. I can understand how it would be difficult for these individuals to become comfortable with their proficiency as the lead representative from the Dental Board administering these exams. Most of the Dental Board staff are state employees with standard state work class designations. *It is, however, essential to hire contracted Subject Matter Experts (SMEs) to interpret and consult about topics germane to* ***dentistry****.* At times, I have found it to be difficult to communicate dentistry as an SME to state board personnel. Certain individuals are determined to control the exam and will not process feedback from advisors. Without the need to administer the practical exam, the dental board staff maintains greater control by only having to process applications —without direct contact with candidates—being isolated within the secure confines within their offices.

In conclusion, I wanted to write this article to share with my peers how this RDA practical may impact us. Without a way of testing competency, the Dental Board will begin issuing RDA licenses without a challenging practical examination. One must only pass a written examination. This will effectively require dentists to pay a higher salary to an employee who may not have the basic skill set to benefit his or her practice. I have heard the argument that you can train this individual yourself to bring them up to speed. I believe that on-the-job training is great, but most personnel can benefit from a structured curriculum administered by an educational program to provide the basics. The dental profession has evolved to provide accessible healthcare with countless beneficial outpatient surgeries provided every single day. *I am asking you to join me to preserve this practical examination.* Modifying this exam to an acceptable contemporary model would be more logical than eliminating it. It would be a disservice to our profession and to our patients not to continue with the practical examinations. I do not believe that OPES will ever validate any form of procedure practical-based exams. The healing arts, such as dentistry, encompasses art and science. OPES studies only can account for the science portion of dentistry; therefore, findings will not be able to validate the art of providing dental procedures. Simply, to allow the elimination of this RDA practical exam would not be in alignment with the primary directive of the California Dental Board to protect the public. More importantly, *I urge you to contact your legislators and leaders in organized dentistry. Voice your opinions on this matter before it is too late.* I thank you for allowing me to share my experiences and sincerely hope that I was able to provide information about this very important issue.

The RDAEF examination, which allows auxiliaries to place definitive restorations, continues without change currently.

The Dental Board *(as this issue goes to press on August 3)* has this on their agenda for August 10, 2017. *More later.* I welcome any comments from all who have any opinions about the RDA practical examination. ■

The opinions of the author are those of his own. He does not represent the views of the SDDS or the Dental Board of California.

Eric Wong, DDS, MAGD (Master Academy of General Dentistry) currently works for the State of California, Dept. of Corrections and Rehabilitation, after twenty years of private practice experience in the Sacramento region. He is the current National PACE Council Chair for the Academy of General Dentistry.

For the Spring Quarter, AGD chapter at UCLA held three educational events in addition to holding weekly "AGD Shadowing Day" sessions at the participating faculties' private practices. Here are the summaries of the events:

AEGD Panel

Four residents from two different AEGD programs, Venice and Westwood, held a panel regarding AEGD programs. They discussed the application process, advantages/disadvantages, and the type of treatments done at their respective programs. Also, the difference between GPR and AEGD programs were discussed as well. One year postdoctoral training program was highly recommended by the residents to enhance clinical experience and knowledge. This was a great session for students who needed clarifications on AEGD and GPR programs.

Hands-on CAD/CAM Workshop *by Dr. Greg Campbell*

Our second educational event of the quarter was held by nationally and internationally recognized Dr. Greg Campbell at Patterson Technology Center in El Segundo. While Dr. Campbell concentrated on the latest CAD/CAM technologies available by Cerec and Sirona, he also gave very useful advice to dental students regarding how to run their future practice. Dr. Campbell's advice on bringing anything into the practice should make one more productive, increase the quality of care to the patient, and not disrupt the inner Ergonomic Principles. After talking about the technical problems that negatively impact conventional impression technique such as moisture control and air bubbles, Dr. Campbell mentioned that digital impression does not have as many negative points. However, the proper tissue management remains the challenge for both conventional and digital impressions. Furthermore, Dr. Campbell talked about the newest version of CAD/CAM machines having shade match built-in which will allow the restorations to be darker. He also went into detail about how the flow charts in the machine advise on the type of material to mill and also, allow adjustment of translucency. Overall, the attendees were very happy with the knowledge gained from Dr. Campbell and were satisfied with the hands-on lecture.

Clinical Occlusion Insights *by Dr. Richard G. Stevenson III*

Dr. Stevenson started his presentation by sharing several cases of patients with occlusion problems and the type of questions he usually asks to get to the root of the problem. Then he went over the five possible functional diagnosis for occlusion, which are: acceptable, dysfunction, constricted chewing patter, parafunction, and neuromuscular disorders. Some of the key points learned from all the possible diagnosis are as follows:

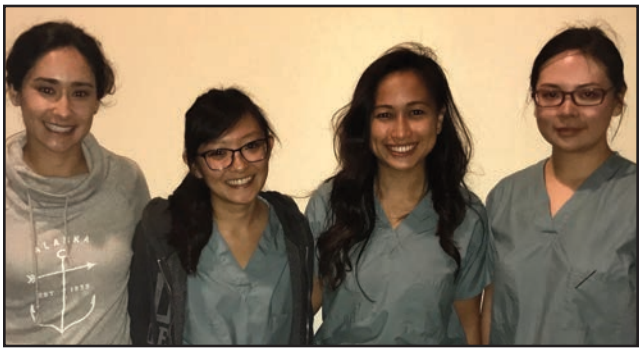
- Acceptable Function – wear may exist, but patient has adapted
- Dysfunction – could be treated with equilibration, restorative work, orthodontics or surgery
- Constricted Chewing Pattern – could be treated with restorative work, orthodontics or surgery
- Parafunction – could be treated with a referral to a sleep medicine specialist, night guard
- Neuromuscular Disorders – should be referred to an orofacial pain specialist for diagnosis and treatment

Afterwards, Dr. Stevenson went over the Leaf Gauge technique for a Centric Relation (CR) check and the steps to take for proper occlusal adjustments.

With the greatest turnout for our last educational lecture event, the attendees expressed their satisfaction with our educational events and their will to continue being a member of our chapter. With this being said, it was my pleasure to serve for our AGD members during the past academic year. I am excited for the new cabinet taking on their roles and cannot wait to attend the upcoming events they have in store for us all. ■

— Valentina Babuchyan, *Immediate Past President, Los Angeles*

AGD cabinet members with Dr. Stevenson. Tanya Kavoussi, Kearny Chang, Dr. Richard G. Stevenson III, Valentina Babuchyan.



Dr. J. Gunther, Dr. A. Ozaki, Dr. S. Sarno, Dr. Y. Luo. Participating residents of the AEGD Panel.

Dr. Greg Campbell presenting on CAD-CAM . . . a hands-on workshop.

AGD Vice Presidents, Mark Materum (left) **and Kearny Chang** (right) **with Dr. Greg Campbell.**

USING CHECKLISTS TO MANAGE MEDICALLY COMPLEX PATIENTS REQUIRING ROUTINE DENTAL CARE

Corey D. Stein, MS; Michael Benichou, BCom; Bertha Alarcon, DDS;Effuah Harris, DDS; Paul Simeteys, DDS; Jeffrey A. Elo, DDS, MS, FACS

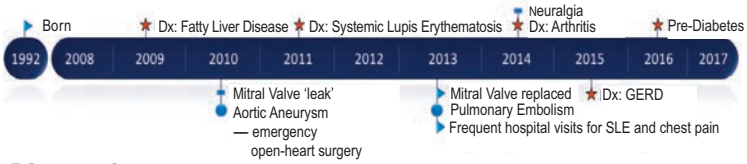
Introduction

Many patients with comorbid medical complexities are unable to receive routine dental care because their conditions make general dentists uncomfortable to treat. Individuals suffering from multiple systemic medical conditions compounded with extensive pharmaceutical regimens can be treated in outpatient dental settings if clinicians are aware of potential disease implications and complications at each appointment. Although some very serious and/or unstable medical conditions may certainly disqualify individuals from outpatient dental care, incorporating precautionary checklists for patient encounters can increase safety and predictability for adverse clinical scenarios.

Case Presentation

A 24-year old female presented to the dental clinic at Western University of Health Sciences (WesternU) after years of inconsistent dental treatment. Clinical and radiographic examination revealed the need for direct and indirect restorations, endodontic therapy, surgical extractions, prosthodontics, and orthodontic therapy to stabilize her dentition. Her medical history (Figure 1) was significant for systemic lupus erythematosus, aortic aneurysm, thrombocytopenia, and a prosthetic mitral valve replacement. She was taking seventeen medications (Table 1) and underwent monthly laboratory studies, including International Normalized Ratio (INR), comprehensive metabolic panel, and liver function tests. While such a medical history may intimidate some providers and prevent her care in an outpatient setting, checklists can help inspire greater confidence in dentists while minimizing the inclination to refer.

Figure 1: Medical History



Discussion

Modifications to her dental treatment included appropriate antibiotic prophylaxis (600 mg clindamycin) prior to each dental procedure to minimize the risk of infective endocarditis.[1] Patients with prosthetic valve replacements have an INR goal of 2.5-3.5, and while warfarin dosage tapering is a debatable practice, anti-coagulation therapy holidays are contraindicated.[2] Dentists treating patients with an increased risk of bleeding must also be prepared for advanced hemorrhagic control. Soluble regenerated cellulose products that are fibrous and gauze-like can be condensed or sutured into bleeding sites. In more emergent scenarios, contact-activated microfibrillar collagen can be placed to cause immediate platelet aggregation. Thrombin powder, aminocaproic acid, or tranexamic acid are similarly effective. Her chronic use of Norco® and heightened tolerance required consideration for alternatives for acute post-operative pain control. The strength and frequency of her Norco® dose could both be increased. Additionally, Percocet® 5/325 could replace her Norco® in the immediate post-operative period. NSAIDs were contraindicated due to her heightened risk of bleeding. Throughout any invasive dental procedure in patients with complex medical histories, consideration might be given for monitoring the heart, blood pressure, and respirations, given the central nervous system depressant effects of several of these medications. Long-term corticosteroid treatment, specifically prednisone, diminishes the body's cortisol levels and the ability to balance physiological stress. No evidence suggests routine dental care, including minor oral surgical procedures, will precipitate an adrenal crisis. [3] However, prophylactic and episodic administration of 50-100mg of a corticosteroid (i.e. hydrocortisone), or its equivalent, should be considered for prevention and management of symptoms.

Conclusion

Utilizing precautionary checklists prior to treating patients with multiple systemic medical complexities promotes safer patient encounters and preparedness for optimal treatment outcomes. While this case report highlights its benefit for treat- ing complex medical patients, the practi- cality of a checklist is scalable for the majority of patients presenting to the dental center at WesternU. The adoption of this checklist allows dental students and faculty to gain confidence and preparedness while treating patients with greater medical considerations. In addition, we hope this can also decrease the number of patients referred out of the clinic due to perceived unmanageable medical comorbidities. ■

Table 1: Medications

- Albuterol
- Aspirin
- Baclofen
- Diphenhydramine
- Docusate
- Furosemide
- Gabapentin
- Azathioprine
- Metoprolol
- Norco® 5/325
- Hydroxychloroquine
- Prednisone
- Famotidine
- Warfarin
- Alprazolam

Figure 2: Pre-Procedural Checklist

DENTAL PRECAUTIONS:

- ❑ **Allergies:** Penicillin, Amoxicillin, Cephalosporin (Clindamycin okay)
- ❑ **Contraindicated Medications:** NSAIDs
- ❑ Heightened tolerance to pain medication
- ❑ INR Value: 2.5-3.5

  Monitor risk for:
  - ❑ Increased bleeding
  - ❑ Drowsiness
  - ❑ CNS depression (heart rate, breathing rate)
  - ❑ Adrenal crisis
  - ❑ Rx-induced hepatoxicity

MEDICAL CHECKLIST:

- ❑ Any updates to medical history?_____
- ❑ Have medications been taken as prescribed (warfarin, blood pressure, steroid, etc.)?
- ❑ Has antibiotic prophylaxis been administered 60 minutes prior to tx? [Y] [N]
- ❑ Will oral or conscious sedationtherapy be required? [Y] [N]
- ❑ Most recent values:
  - ❑ INR: _____, taken_____
  - ❑ HbA1c:_____, taken_____
  - ❑ Glucose:_____, taken_____

Are the following items available chairside?

- ❑ Surgical blood pressure monitor
- ❑ Albuterol inhaler
- ❑ 50-100 mg. Hydrocortisone or equivalent
- ❑ Soluble regenerated cellulose hemostatic dressing or equivalent
- ❑ Content-activated platelet aggregation thrombin powder or equivalent

[1] American Heart Association and American Dental Association, February 2017
[2] American Academy of Oral Medicine, June 2016
[3] Malamed, SF. Medical Emergencies in the Dental Office (7th ed.). St. Louis, Missouri: Mosby Elsevier. 2015.

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For more information, contact:

Dr. Robert Garfield, *Seminar Director*
2720 Aqua Verde Circle, Los Angeles, California 90077 ◆ *Phone:* **310.472.2949**
E-mail: **drrobertgarfield@aol.com**

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Ho-Hyun (Brian) Sun at Western University, College of Dental Medicine Honored

Ho-Hyun (Brian) Sun from Western University of Health Sciences, College of Dental Medicine receiving the Outstanding Student Award from the Pierre Fauchard Academy at CDA Presents in Anaheim (May, 2017). Dr. John Taylor, the section chairman for the Southern California PFA, made the presentation.

Brian is the outgoing FellowTrack President from Western and also won second place in the poster presentation at the American Student Dental Assn., District 11 meeting last Fall.

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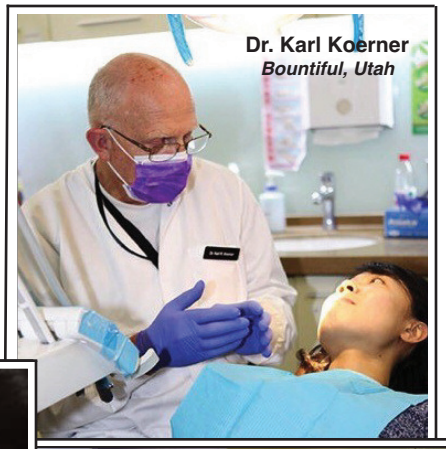
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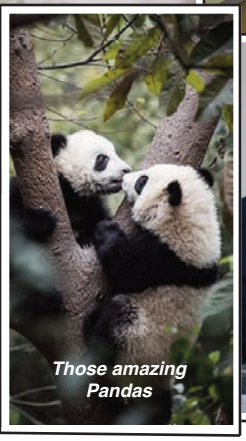
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Dr. Karl Koerner has helped organize many dental humanitarian trips to three different cities in China since 2007. He speaks Mandarin Chinese. Dr. Koerner, a general dentist, is Associate Professor of oral surgery at Roseman University, School of Dental Medicine in South Jordan, Utah. He enjoys helping create professional and cultural exchanges that touch the lives of all who participate in special and lasting ways. karlrkoerner@comcast.net


DR. BOSLER

Dr. Bruce Bosler has been involved with several humanitarian and teaching trips to China. He speaks Mandarin Chinese. He holds a surgical and prosthetic fellowship in the Misch International Implant Institute and a mastership in the Academy of General Dentistry. He is in private practice in Vacaville, California.

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Post-Doctoral Institution | STATE/PROVINCE | Start Date *(month and year)* to End Date *(month and year)*

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