CALIFORNIA ACADEMY of GENERAL DENTISTRY

# GP NEWS

The Publication Exclusively for the GENERAL PRACTITIONER


**Volume 42, Issue Number 2** **May, 2018**

# Dr. Myron "Mike" Bromberg Appointed AGD's Inaugural Congressional Liaison

Dr. Manuel Cordero, President of AGD national, has apppointed Dr. Mike Bromberg of Reseda as AGD's inaugural Congressional Liaison. Dr. Cordero expressed his appreciation to the Board for supporting the creation of the Congressional Liaison. Dr.Cordero and AGD's lobbyist, Mr. Pat O'connor will accompany Dr. Bromberg on a "Hill" visit within the next month to discuss dental-related appropriations bills that are before Congress.

**DR. MYRON BROMBERG**
*Reseda*

Dr. Bromberg is past chair of AGD's Legislative and Governmental Affairs Council, Dental Practice Council and Division Coordinator for the Advocacy Division. He has served on many task forces including the Future of Dentistry TF and the Corporate Dentistry TF. Dr. Bromberg is AGD's representative on ADPAC. He is a past recipient of the Mark Ritz Advocacy Award for lifetime contributions to advocate for dentistry and the AGD. Dr. Bromberg has held many offices in the California AGD and he is also "Dean" of the AGD House of Delegates.

Dr. Bromberg told the *"GP News"* that never before in the history of our profession has the legislative and regulatory activity had such a profound impact on the manner in which we practice dentistry, now and in the future. We, as general dentists, need to be in Washington, D.C. and in our state capitols. If we aren't there, no one else will be there specifically for us. The AGD has to be the one to carry the banner for general dentists. He further stated that the legislative and regulatory activity regarding dentistry is voluminous with serious implications and ramifications for general dentistry, our profession in general as well as our patients. It is necessary now for us to step up, collaborate and create consistent and interactive contact with our Congressional legislators as well as regulators. One of the activities would be to achieve AGD's legislative priorities by working with our lobbyist in Washington, D.C. as well as creating a cadre of of AGD members who have close personal contact with top federal elected legislators from their respective states.

When *"AGD Impact"* asked Dr. Bromberg what are examples of the legislative and regulatory activity we should be aware of, he replied that the topics are varied and diverse, stating that a good example is the current debate as to whether or not dental benefits should be included in Medicare. It is clear that general dentistry and our patients would be impacted by this more so than any of the specialties. There are many who express great concern regarding this possibility while others are in support of this concept. It is an issue, Bromberg continued, that must be studied in depth due to the serious implications regarding general dentistry. Issues concerning Medicare Part D are being considered as well.

Another significant issue affecting dentistry is the necessary elimination of the anti-trust exemption given to the health

*(continued on page 4...see BROMBERG)*

# YOUR 2018 CALIFORNIA AGD LEADERS

## Trustee, Regional Director, Board Members, Advisors,

**DR. GUY ACHESON**
*Trustee, "WatchDog Report"*
**DDS, MAGD**
*Fair Oaks*

**DR. RICARDO SUAREZ**
*Treasurer*
**DDS**
*West Covina*

**DR. ERIKA KULLBERG**
***San Diego***
*AGD Component President*
**DMD**
*El Cajon*

**DR. CHERYL GOLDASICH**
*Regional Director, CAGD FellowTrack Coordinator*
*(USC, UCLA, LLU, UOP, Western, UCSF)*
**DDS, FAGD**
*Torrance*

**DR. CHIRAG VAID**
*Secretary*
*ALSO SERVING AS*
***Sacramento-Sierra***
*AGD Component President*
**DDS**
*Sacramento*

**DR. CHRIS CHUI**
***Northern California***
*AGD Component President*
**DDS, MAGD**
*Fremont*

**DR. KIRK HOBOCK**
*President*
**DDS, MAGD**
*San Juan Capistrano*

**DR. ROBERT HUBBERT**
*Editor, "GP News"— Editing, Layout, Typesetting*
**DDS, MAGD**
*Santa Ana*

**DR. TRAN HAN**
***Southern California***
*AGD Component President*
**DDS**
*Altadena*

**DR. WILLIAM KUSHNER III**
*President Elect*
**DDS**
*Danville*

**DR. CHETHAN CHETTY**
*Immediate Past President; MasterTrack Course Asst. Director*
**DDS, FAGD**
*Los Angeles*
*AGD Membership Council Member*

**DR. ANITA RATHEE**
*Advisor; Co-Chair, CAGD Dental Practice Committee*
**DDS**
*West Hills*
*AGD Public and Professional Relations; Chair, AGD Policy Review Committee*

**DR. SAMER ALASSAAD**
*Vice President, "GPNewsFlash" Editor*
**DDS, FAGD**
*Davis*
*AGD Examination Committee B*

**DR. RICH RINGROSE**
*MasterTrack Course Director*
**DDS, MAGD**
*Clearlake*

**DR. HOWARD CHI**
*Advisor*
**DMD, MA, MAGD**
*Stockton*
*AGD PACE Council Chair*

# as well as FellowTrack and MasterTrack Coordinators

**DR. MYRON BROMBERG**
*Advisor; Legislative Committee Chair; Co-Chair Dental Practice Committee*
**DDS**
*Reseda*
*AGD Congressional Liaison; Advocacy Division Coordinator; Professional Relations Committee*

**DR. SIREESHA PENUMETCHA**
*Advisor*
**DDS, MAGD**
*Elk Grove*
*AGD Communications Council Member*

**DR. ROBERT GARFIELD**
*Advisor; Assistant Editor, "GP News"*
*Chair, CAGD Awards Committee*
**DDS, FAGD**
*Los Angeles*

**DR. HARRIET SELDIN**
*Advisor; Public Information Officer for CAGD*
**DMD**
*San Diego*

**DR. RALPH HOFFMAN**
*UCSF FellowTrack Coordinator*
**DMD, MAGD**
*San Francisco*

**DR. WILLIAM LANGSTAFF**
*Advisor, CAGD Historian*
**DDS, FAGD**
*Villa Park*

**DR. STEVEN SKUROW**
*Advisor*
**DDS, FAGD**
*West Covina*
*AGD PACE Council Member*

**DR. PHIL BUCHANAN**
*UOP FellowTrack Coordinator*
**DDS, EdD, FAGD**
*San Francisco*

**DR. MARK YAMAMOTO**
*Advisor*
**DDS, MAGD**
*Huntington Beach*
*PACE Approval*

**DR. ERIC WONG**
*Advisor*
**DDS, MAGD**
*Sacramento*
*AGD Continuing Education Division Coordinator*

**DR. JOHN BETTINGER**
*Advisor*
**DDS, FAGD**
*Santa Monica*

**TERRI IWAMOTO-WONG**
*Executive Director*
**BS, MBA**
*Sacramento*

**DR. JOHN DiPONZIANO**
*Advisor*
**DDS, MAGD**
*Pleasanton*


## G.P. NEWS

*A Publication of the* **CALIFORNIA ACADEMY** *of* **GENERAL DENTISTRY**

The GP News or the CAGD will publish signed articles related to all phases of dentistry, but assumes no responsibility for the opinions or results expressed by the contributors. The views expressed are those of the author as an individual, and do not necessarily reflect the positions or endorsement of the CAGD. Acceptance of advertising in no way constitutes professional approval or endorsement. The CAGD does not assume liability for contents of advertisements.

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.

## BROMBERG *(continued from page 1)*

insurance carriers. Congressman Paul Gosar, a dentist from Arizona, has been leading this fight for some time. Student debt, which is causing recent graduates to make career choices they might not make absent the enormity of it, is being looked at in hopes of minimizing it or at least making it more manageable. Mid-level providers, or dental therapists, are essentially a state issue, but have national ramifications as well. Again, these entities affect general dentistry and our patients more than the specialties.

Dr. Bromberg further stated the more dentistry becomes mainstream—the more people go to the dentist—the more regulators feel the need to regulate dentistry. Hence, we must have input into the ever-changing regulations from regulatory agencies such as OSHA, EPA, HIPAA and the myriad of other agencies. We must remain aware and keep abreast of all that affects us.

In conclusion, he stated that this newly-created position is a good example of how the AGD is striving to continue to remain mainstream and current and represent general dentistry in the most effective manner possible utilizing every resource available to it. ◆

---

**STATE AND NAT'L LEGISLATURES:**

*Remember, if we aren't there, no one else will be there specifically for us...!*

***AGD's new policy on the position of Congressional Liaison:***

Resolved that the Board Policy Manual be amended by the addition of a new section, Policy Type II, Section 7, so that it reads:

**Section 7. Congressional Liaison**

*A Congressional Liaison shall be appointed by the President. The Liaison shall be an AGD member in good standing, with the following experience:*

1. Have served on the LGA Council or in some other leadership role within the AGD.
2. Has attended/participated in at least three AGD Hill Days.
3. Has lobbied Congress, state legislatures, or state dental boards at least five times within the past 10 years.
4. A Liaison shall serve for not more than two three year terms equaling six (6) years. Such service may or may not be contiguous. The President shall appoint said liaison.

*The duties of the Congressional Liaison shall be:*

1. Works collaboratively with AGD's contract lobbyist in Washington D.C. on strategies to achieve AGD's legislative priorities.
2. Develops and maintains a cadre of AGD members who have close per sonal contact with top federal elected legislators from their respective states, and relays this information to the Associate Executive Director, Public Affairs (or other appropriate staff) for continued growth of the AGD's advocacy network
3. Represents the AGD at appropriate events in Washington, D.C. and locally in order to further promote and build relationships with legislators.
4. Promotes AGD's position on legislative and regulatory issues directly with top federal elected legislators and senior appointed officials.
5. Serves as a consultant to the Legislative and Governmental Affairs Council without the right to vote.
6. Brings issues of importance to the Executive Committee and the Board in a timely manner via communications done remotely without the need for travel, unless deemed necessary. Travel to present in front of the Executive Committee and the Board to be incorporated into future budgets thereafter as appropriate.
7. Accompanies the AGD President and other AGD officers on Congressional visits when appropriate and feasible.

There shall be a sunset review of this position every two years.

And be it further resolved that $6,000 from the 2018 Contingency Fund be appropriated for this purpose.

**DR. KIRK HOBOCK**
*San Juan Capistrano*

**DR. RICHARD ENGAR**
*Salt Lake City, Utah*

**DR. GUY ACHESON**
*Fair Oaks*

**DR. WILLIAM KUSHNER**
*Danville*

**DR. KEVIN ANDERSON**
*Jamul*

**DR. HARRIET SELDIN**
*San Diego*

**DR. MIKE LEW**
*Novato*

**DR. MUNA SOLTAN**
*Napa*

**DR. BOB GARFIELD**
*Los Angeles*

**ALAN THOMAS, CPA**
*Tustin*

CALIFORNIA ACADEMY of GENERAL DENTISTRY

# In This Issue

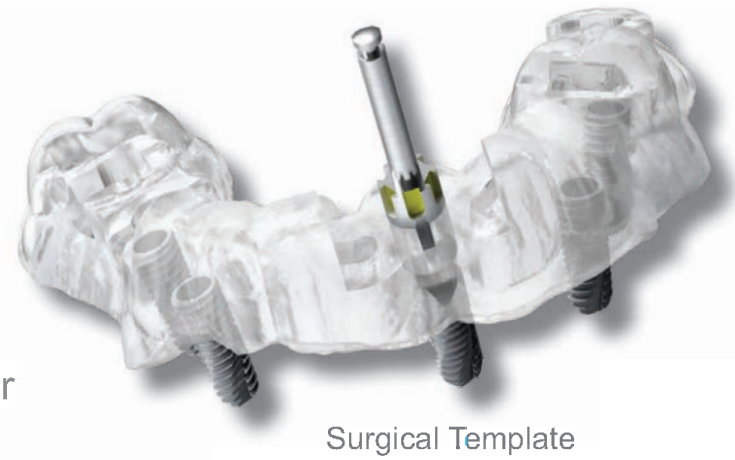
IMPLANTS | PROSTHETICS | INSTRUMENTS | IMPLANTOLOGY COURSES

# One Guide
## Lining this one up is easy.

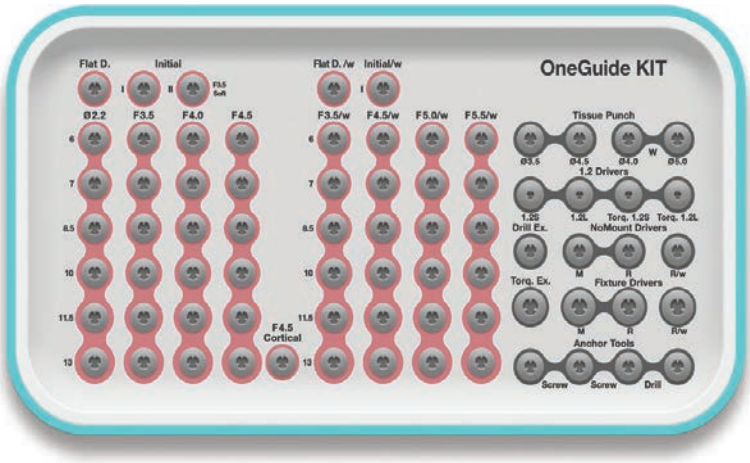
## One Guide Kit

## Precisely Accurate

Guided dental surgery is quickly becoming the new standard in dental implant surgery. The One Guide Kit is a key less guided surgery kit that is designed to be safe and straightforward. Featuring several drilling tools designed for precision, this kit allows for a more accurate, efficient, and safe surgery. Even the playing field, call today for more information.



Surgical Template




(Exclusive drills and components: 68 pcs.)

## Benefits

- Increased safety for patients through improved anatomical visualization and planning.
- Maximized efficiency as doctors can plan and prepare for detailed implant procedures.
- Improved preparation for abutment and supra-structure installations, resulting in improved aesthetics.

HIOSSEN® IMPLANT

Made in the USA

Smiles that last a lifetime

www.hiossen.com
85 Ben Fairless Drive, Fairless Hills, PA 19030
Tel: 888-678-0001

# THE PRESIDENT'S MESSAGE

**DR. KIRK HOBOCK**
*San Juan Capistrano*

CALIFORNIA ACADEMY of GENERAL DENTISTRY

"Thank you for your dedicated service to the California Academy of General Dentistry."

## CAGD Regional Director News

Stephen Lockwood, DMD, MAGD, LLSR has unfortunately stepped down as Regional Director representing our constituency, the California AGD. Dr. Lockwood has long balanced his personal, practice, family, and professional life admirably. But, there is a time where limits are reached. We all hope that his other responsibilities are only temporarily pulling him away from the CAGD.

It is very difficult to outline Dr. Lockwood's accomplishments and paint a decent picture of this multifaceted individual. He has served the CAGD in many positions and is a past-president of the CAGD. He was the "Dentist of the Year" in 2014. He still finds time to volunteer with community organizations such as Veterans' Village and the 1000 Smiles Foundation. Husband, father, and musician, are just a few of the labels that apply to Steve.

Dr. Lockwood has been our Regional Director since 2014, serving with the dedication and passion he has shown throughout his career. Few individuals show this kind of commitment and we are all appreciative of the time and effort you, Steve, have given on our behalf. Thank you for your dedicated service to the California Academy of General Dentistry.

The remaining term for our Regional Director will need to be filled. Doing so requires a special election in order to allow for preparation for the November House of Delegate's Meeting. This special election will take place at the next CAGD Board Meeting on May 19, 2018 in Anaheim. There are important activities taking place between now and the special election. For this reason, an interim Regional Director has been appointed with the CAGD Executive Board's approval.

I have the honor of introducing our interim Regional Director, Dr. Cheryl Goldasich. She has been serving as the CAGD FellowTrack Coordinator, coordinating and overseeing the activities of the students at USC, UCLA, UOP, UCSF, Loma Linda, and Western. She is a past-president of the Southern California AGD and was named "Dentist of the Year" in 2015.

Dr. Goldasich's start in dentistry began in her father's dental office. That turned into a twenty-year career leading to the USC School of Dentistry, where she graduated in 1999. Cheryl is not only a fellow in the AGD, but also has fellowships with the Pierre Fauchard Academy, the American College of Dentists, and the International College of Dentists. She is a part-time faculty member at the USC School of Dentistry and was recognized as the "Part-time Faculty Member of the Year" by a vote of the student body. ◆

Sincerely,

Kirk

# WatchDog REPORT

**DR. GUY ACHESON**

*Rancho Cordova*

First, some very good news. I was just elected as the new AGD Trustee for California. I look forward to making the AGD even better and to hear the concerns of its California members. I thank the CAGD Board for allowing me the privilege of representing California.

Now for the latest regarding the Dental Board of California. There are five empty seats at the table. Three are reserved for dentists. This is a big deal because of the workload. This could be YOUR golden opportunity. If interested, send a letter to the governor.

**EMERGENCY WATER QUALITY STANDARDS** Most of you are aware of a very unusual situation that happened in a pediatric dental office in southern California last year. Many children were infected by bacteria in just this one office when they had a pulpotomy/pulpectomy completed. The infective agent was cultured from the operatory water supply. The response from the legislature was to pass a bill (AB1277) requiring the DBC to develop emergency regulations regarding water quality in dental offices. There is some confusion about what those regulations are. They are, "to require water or other methods used for irrigation to be sterile or contain recognized disinfecting or antibacterial properties when performing dental procedures that expose dental pulp." The DBC is struggling with this because they feel there is a big difference between situations where the planned procedure is intended to expose the pulp, and the real world fact that virtually any restorative procedure on teeth runs the risk of an unplanned exposure of the pulp. There is also the question about what would qualify as "recognized disinfecting or antibacterial properties." I predict that the DBC will not qualify what the alternatives to sterile water can be and will let it be decided by the courts if and when a dentist is charged with violating this rule. I also predict that the dental supply industry will be coming forth with some very interesting ways of delivering sterile water through our dental units. I can foresee some very onerous workloads on dental offices to perform regular water quality testing to confirm that their units are delivering sterile water. Time will tell.

**MID-LEVEL PROVIDERS** A new push for creating Mid-Level Providers has been launched by the Pew and Kellogg foundations in at least fourteen states. These would be non-dentists who would be completing basic restorative procedures and tooth extractions. Every state has a slightly different twist on the proposed provider; direct supervision, indirect supervision, independent practice. California deflected that effort five years ago but the DBC expects another effort in California. We have a Pilot Project for the California version of a mid-level provider that has been running for many years. Our pilot project allows RDHAPs to work at remote sites (schools, residential care facilities) under the indirect supervision of a dentist. Developed by Dr. Paul Glassman, they use telehealth tools (laptop, digital radiographs, digital photography, electronic chart) to complete examinations on people, record all their findings electronic chart, forward the chart to a supervising dentist who makes diagnosis and orders indicated procedures. The RDHAP can then complete a prophylaxis, fluoride varnish, and placement of Interim Therapeutic Restorations (hand excavation of caries and placement of a glass ionomer restoration) when ordered by the supervising dentist. Anything beyond those clinical procedures would require the patient to be referred to a licensed dentist (pulpotomies, composite or amalgam restorations, crowns, extractions).

I was a member of the site visit team on this pilot project. I was favorably impressed because it greatly expanded access to care for many populations and did it under the supervision of a dentist; requiring a dentist to complete all irreversible procedures. It also demonstrated that lack of access to care is NOT DUE TO A LACK OF PROVIDERS. It has to do with poverty, lack of mobility, children in single-parent households where the parent is working multiple jobs, children whose parents are undocumented and don't feel safe driving or filling out forms in a dental office, children who are being raised by grandparents who don't speak English or drive, residents of long term care facilities who have no advocates…the list goes on and on. At the school sites, once a child was identified as needing the care of a dentist, it took an incredible team effort by the hygienist, school nurse, teachers, social workers, school administrators, even school custodians, to obtain consent from the parents, make the dental appointment, and arrange transportation for the child. It was impressive.

**MODERATE SEDATION TRAINING** You are all familiar with my discussion of how moderate sedation training guidelines have been changed by the American Dental Association. The two specific changes that AGD has been resisting are the merging of oral and parenteral moderate sedation training and mandating the use of capnography for moderate sedation. The new guidelines mean that those who only want to deliver oral moderate sedation will have the training time raised from 25 hours to 60 hours as well as raising the number of demonstrted cases from one to twenty. The new guidelines also mandate the use of capnography for all moderate sedation cases instead of having the option to use a precordial stethoscope or just by talking with the patient. For now, these are only changes in training requirements, not licensing regulations. In California, the DBC decides what the training requirements are for sedation permits. However, legislation is in the works to mandate that California permit regulations follow the ADA training guidelines.

*Is this an issue that AGD dentists care about?* I did some research with the help of our CAGD Executive Director. California has issued 3066 oral sedation permits. AGD dentists hold 1499 of those permits. California has issued 570 I.V. sedation permits. AGD dentists hold 196 of those permits. Amazing! Forty-seven percent of all moderate sedation permits are held by AGD dentists. Seventy percent of CAGD members hold a moderate sedation permit. This is a CAGD issue! ◆

As always, this article represents my thoughts and opinions and not that of the CAGD. Any questions, comments, suggestions…contact me at guyacheson@aol.com

*Dr. Harriet Seldin and Senator Toni Atkins*

## ADVOCACY

# HISTORY MADE IN CALIFORNIA SENATE

On March 21st, CAGD's Public Information Officer, Harriet Seldin, DMD, had the privilege of attending the Swearing-in Ceremony for California Senate Pro Tem, Toni Atkins (D), San Diego. Senator Atkins is the first woman to lead the California Senate. The ceremony and celebration took place in the historic Senate Chambers and Rotunda in Sacramento.

The new Senate Pro Tem has a long history of supporting access to care programs and dentistry. She started her career as an executive director of a community clinic, and has been interested in health and homeless issues for many years. In 2011, when the Senator served in the California Assembly, she visited AGD's Outreach event. That Outreach was held as part of the AGD's Annual Meeting, when homeless veterans referred by Veterans' Village of San Diego were treated by volunteer AGD and San Diego County Dental Society dentists in mobile clinics in the San Diego Convention Center. ◆

*The Academy of General Dentistry is your voice for excellance through education and advocacy.*

## DENTAL PHOTOGRAPHY TIP

# Why your fancy SLR camera won't focus sometimes

**Guy Acheson**, **DDS**, **MAGD**, *CAGD Trustee*

The ability to determine a sharp focus with an SLR camera depends on having adequate light on the subject. Whether you are using the automatic focus feature or doing a manual focus, there needs to be enough light to create discernable contrast on the subject. My operatories have large windows that usually provide plenty of light for the camera or my eye to see a sharp focus. However, sometimes we are taking photos in a darker area of the office or as the days get shorter in the winter, we find the camera failing to obtain a focus.

Most dental camera ring-flashes have a special light, typically called a modeling light or auto-focus auxiliary light to overcome this problem. On the Metz flash there is a rectangular button on the upper left area on the back side labeled "AF"—Pushing this button turns on a small light on the front side that illuminates your subject enough to allow the automatic focus feature to work. If you are doing manual focus it allows your eye to determine a sharp focus. The light turns off after every shot so you have to keep turning it on for every shot. *MAGIC . . . !* ◆


## 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? *(Oct., 2017)*
- Lifetime Financial Ratios—Where You Should Be *(Feb., 2018)*
- **Insurance Needs and Practice Overhead**
- Definition of Risk / Investment Alternatives / Leverage
- Optimal Portfolio Withdrawal *("Spend Down")*
- Priority for Tax Efficiency Diversification in Retirement

Now that you are motivated to save and calculated "Your Number" from articles #1 and # 2, and have found "Where You Should Be" along your journey from article #3, we'll now shift our focus to Insurance Needs as well as to an area specific to the operations of a dental business, Practice Overhead.

*Previous articles are available for reference here:*
https://caagd.org/gp-news-archives/

### *Practice Overhead*

When you think about and add up the amount of money that passes through a dental practice over one's career, it is a massive number – in the millions! Fine-tuning one's Practice Overhead will help the practitioner keep more of these funds because, "It isn't what you make, it's what you keep." Many dentists feel both overworked and like they are not getting ahead. Staying laser-focused on specific practice expenditures can yield huge rewards.

***Being aware of a specific overhead category that is out of line with an easily attainable goal will help give one purpose and lead to greater profitability for the dentist. This could lead to an earlier retirement due to a higher savings rate and even a higher practice sales price because of a higher net profit!***

You might already be in the 60-65% range for your practice overhead and you are to be commended. However, it might be time for you to strive to reach the next level by managing your overhead even better.

We're not talking about having your wife/husband and kids work for free, doing your own hygiene and lab work, or having to increase production. We are drilling down on the essential element that make a practice run efficiently yet highly profitable.

A practice overhead of 55% is that next level and would have the following breakdown:

| *Overhead Category* | *Target Percent of Revenue* |
|---|---|
| Dental Supplies | 5% |
| Office Supplies | 2% |
| Rent | 5% |
| Laboratory Fees | 10% |
| Payroll, taxes & benefits | 23% |
| Miscellaneous — Dues, Insurances, CPA, Phone, Marketing | 10% |
| Total | 55% |

**Rent (5%): Needs v. Wants**—You can a practice in an excellent facility and achieve a 5% cost of collections including rent (or mortgage) and utilities. You might have to check your ego at the door and not have such a large private office or staff lunch area. Don't sign your name and future profits away until you are earning twenty times (20x) the amount of monthly revenue to justify the expense. If you've already signed and are committed, and if it is too late to downsize your space or renegotiate your lease, then an increase in revenue can be obtained by personally expanding office hours and/or adding an associate or renting space to a colleague. Better to plan on the front end with your office space as these later mentioned options come with their own set of issues.

**Laboratory Fees (10%):** This figure is based on the dental profession standard of having between 30 to 40% of production coming from crowns, bridges, implants, dentures, etc. If your lab expenses are less than 10-12%, then your production maybe isn't where it could be and you might not be diagnosing comprehensive patient care or addressing barriers preventing patients from pursuing it. If lab expenses are over 10%, the issue might be one of a lack of collections for costly procedures.

**Miscellaneous—Dues, Insurances, CPA, Phone, Marketing (10%):** While many of the items that make up the category like phone, dues, and malpractice insurance don't have much room for negotiation, others like CE and marketing might have more frugal yet just as effective alternatives.

Keep a close watch on this category as it can easily get out of control and run in excess of 15% of revenue!

**Payroll, payroll taxes and benefits (23%):** If you exceed this amount and your profits are not what they should be, you could have an inefficient staff. Many $1m+ offices are what could be labeled 'staff-owned and controlled' where the dentist(s) has lost ownership in the decision-making control of the office, just shows up and does what staff tells him/her. In effect, the dentist has become another employee. Many dentists are pressured into hiring too many staff members thinking that things will be easier, production will increase and, in reality, all they have done is create a more inefficient operation. Clarity in job descriptions with well-trained individuals who take ownership and are accountable is the name of the game. The owner-dentist must be the enforcer of *The Two Success Rules for Dentistry.* Rule #1 is if production is hiring too many staff members thinking that things will be easier going down and overhead is going up, then payroll cannot be increased. Rule #2 is to never forget Rule #1. Practice management consultants can often be worth their fee to help you. Establish a compensation policy based on performance measurements to determine raises. It has been said that employees create the most stress for a dentist and that the problem grows exponentially with the addition of each employee!

**Dental Supplies (5%) + Office Supplies (2%):** If your dental supply costs run greater than 5% of revenues, make sure you are budgeting these expenses and providing clear direction on how much should be allocated to the individual ordering them. Take steps to keep your office well-stocked, but not over-supplied. If you have unused items collecting dust in the cabinet, consider donating them to a children's dental clinic, a dental/hygiene school or others and get a nice tax deduction. If your front office has gadgets and thingamabobs in cabinets and drawers that aren't used, you could take a few steps to control your inventory.

A short article like this can only skim the surface. If you are in need of help, seek it from professionals that you trust. Another area that we haven't addressed, but that is very important is the need to continually adjust your practice fees. After establishing your fees, considering the quality of dentistry and the experience you provide, do adjust fees upward as inflation and cost factors increase. While this doesn't go unnoticed by patients, it will not cause a mass exodus of patients leaving your practice!

## ***Insurance Perspectives***

Insurance should be a diligent purchase decision to transfer large risks that you cannot afford to take. While we cannot live life without risk, the laying out of a relatively small fee can insure against an enormous financial strain on you or your family. There is a proper balance between having enough insurance and being over-insured or buying insurance riders you are unlikely to need. The insurance needs of a dentist change over one's career. In you're journey to achieve financial independence and to transition from being a Laborer to a Capitalist (see the last article, Feb., 2018), you can drop or reduce some types of insurance as you build capital. An emergency cash fund of three to six months of income will cover insurance deductibles and wait periods until claims are paid. The number of insurances to have can be daunting -– car, health, disability, home, office over head, professional liability, life, long-term care and umbrella policies. Insuring against a potential (and more probable) huge loss is critical to your financial independence. Therefore, especially early in your career when your savings are just starting, long-term disability insurance is the most important one to have. ***You spent large amounts of time and money getting educated and trained to be a dentist and should insure your expected future income stream against a possible disability.***

**Disability Insurance:** Get it when you are young, healthy and insurable. Benefits are quoted in monthly benefit amounts (e.g. $5,000/month) and are limited to 60% of your monthly pay. Increase your benefit as your income grows. Pay up to have a true Guaranteed Renewable, Non-cancellable, Own Occupation Policy with Future Increase Option and a Cost-of-Living-Adjustment (COLA) riders from a reputable "A" rated company as opposed to a cheaper group policy from associations. These much less expensive association group policies have many holes and drawbacks which can be more restrictive in the definition of disability, more limited in time and deductions from social security. Review your coverage with your agent annually to make sure it is keeping up with your income stream. Opt for the longest wait period available to reduce premiums and consider an IRA penalty-free withdrawal for a disability if needed to cover expenses during a longer wait period before benefits are received. Make sure to have an expert on your side if the need to file a claim arises. Consider cutting back on your coverage once your Capital-to-Income ratio is 8x. As disability benefits end at age 65, you don't want to overpay for a continually reducing benefit pay out. Once you reach a Capital-to-Income ratio of 12x, strongly consider dropping your disability insurance.

| *Age* | *Disability to Income Ratio* |
|---|---|
| 25-55 | .60 |
| 60 | .40 |
| 65 | 0 |

**Life Insurance:** While a disability is far more likely (1:8 over a career), life insurance should strongly be considered for those that have families and debt. Because of the odds of dying (1:100 at age 55), the relative cost of life insurance is much less. Obviously, this insurance is not for you but for your dependents financial security. Four groups of people that do not need life insurance: Single with no dependents, non-working spouses with no dependents, children, retirees living off investments.

While insurance companies and their agents love to sell the more highly commissioned whole-life and universal policies, buy term insurance. You don't want to overpay on the premium, get a dividend or have a savings vehicle through an insurance company! The amount of coverage to have is the direct inverse of your Capital-to-Income Ratio over your lifetime. For example *(and from the chart that follows on page 31),* if you are making $200,000 at age 35 with $280,000 saved, you will want to protect your family with a $2.12m term life-insurance policy. Your family will then have 12x your income (1.4x from savings + 10.6x from the policy payout) to live from and this should be enough considering lifestyles at the time. Choose the life insurance company rated "A" or above with the lowest premiums.

*(continued on page 25 . . . RETIREMENT)*

# Twenty Years Since Dentist Barbie and Looking Back at the History of Women in Dentistry

**DR. HARRIET SELDIN**
*San Diego*

Twenty years ago I asked a question, "as women become a larger proportion of the dental population, is the profession and the public's view of it likely to change?" This was written in an editorial for CDA Update titled "Barbie is a DDS, but what of her future?" where I discussed Mattel's Barbie Dentist doll as an allegory to women entering our profession.

In January of last year, the CDA Journal published a historical article about women in dentistry that I co-wrote with Brian Shue, DDS. It included information from the book "Critical Mass," which talked about how various institutions in our society change when the numbers of women reach a critical mass. We wrote thousands of words to understand our history, partially in an attempt to answer that question. And I don't have the answer.

What we have are correlations, not necessarily causation. More dentists practice in corporate practices, community health centers and other non-tradtional settings. While Dentist Barbie is still in a solo private practice in her display case, there are fewer dentists in their own solo private practices and more employee dentists. But is that because there are more women? Or just a trend due to other historical forces? Women dentists continue to make less money than male dentists, but there are more women in leadership of organized dentistry. Many women have recently served as President of the San Diego County Dental Society and our current CDA Trustees are both women.

The overall public impression of dentistry, as measured in the annual surveys of the most trusted professions, has dentistry now and then, ranked as fifth most trusted. A greater percentage of women hasn't made a difference in public trust, positive or negative.

Would the State law preventing registered sex offenders from practicing dentistry have passed had I or another woman not served on the Dental Board of California at the time?

Would our local efforts promoting diversity and international collaboration be continuing to grow without our member Lilia Larin, DDS, who is a founder of the bi-national San Diego/Baja chapter of the Hispanic Dental Association?

Looking to the future, I see our member Malieka Johnson, DDS, an alumna of the ADA Institute for Diversity in Leadership, who serves as an officer of the San Diego Leadership Alliance. She is looking to have an impact on the community as a whole in developing future leaders in government and non-profits.

While it is unclear what changes in dentistry are the result of more women in the profession or other factors, there certainly are individual women dentists leading the way. They are leaders in protecting patients and in collaborative decision-making in our professional organizations and the larger community.

I'd be remiss if I didn't mention that none of this is meant to disparage men in any way, but rather to highlight the accomplishments of women. And while many women support each other in furthering their careers and ambitions, not all do. Some of the best mentors and supporters for women dentists are men.◆


***Reprinted with permission from Facets, the newsletter of the San Diego County Dental Society. Editorial from the December, 2017 issue. Women in Dentistry graphic is the cover of the January, 2018 issue. To read more about the history of women in dentistry in California, send a request for articles to drhfseldin@aol.com***

**DR. MUNA SOLTAN**
*Napa*

# Bone Loss Around Dental Implants

**Muna Soltan, DDS, DICOI, FAGD**, *Napa*

Bone loss around dental implants is the most common complication that may lead to implant failure. It is a multifactorial phenomenon that has biological, mechanical, and iatrogenic components. Bone loss may result in compromised esthetics, weakening the functionality of the implant, and jeopardizing the longevity of the final restoration.

Dental implants are biocompatible analogs that are surrounded by biologically dynamic tissue entities such as bone and soft tissue.

***Points unique to implants that require special considerations:***

1. Implants only replicate natural teeth
2. Implant-mucosa-bone interface only approximates the natural periosteum
3. There is no cementum or periodontal ligament
4. There is less vasculature and fibroblasts
5. Parallel orientation of supracrestal connective tissue

All these factors make implants more prone to bone loss and failure as opposed to natural dentition. The bone surrounding dental implants is a dynamic tissue that responds to various forces in the mouth. If excessive forces are constant, volumes of bone is lost and that can be detrimental to the health and longevity of the implant. Maintaining that bone when the implant is placed in function, is the ultimate goal of good outcome of dental implant therapy. A good way to determine the success of implant therapy is to follow the bone around the implants. The complexities of various causes are presented with clinical suggestions to avoid such problems.

***Causes of early bone loss:***

1. The quality and quantity of bone supporting the initial stability of the implant is crucial. Also paucity of blood supply diminishes bone healing. In general, the thicker the cancellous bone with ample of blood supply, the better the outcome.

2. As the bone is healing, early occlusal loading or overloading during temporization from prosthesis can be detrimental. If the prosthesis is irritating the surgical site by rubbing on the implant from functional or parafunctional activities, that implant will not integrate.

3. Excessive surgical trauma can increase the failure rate of the surgical outcome.

4. Violation of biologic width with improper positioning of the implant will affect the health of the bone. Implants need to be positioned one to one and a half millimeters away from the buccal bone to maintain the health of the crestal bone. The surgeon can do that by choosing the proper diameter and angulation of the implant.

5. Excessive smoking, uncontrolled diabetes, certain medications such as steroids should be monitored and considered prior to surgery. They can interfere with healing.

6. Following the final restoration, there is an initial bone loss up to 1 mm. This takes place due to the the homeostatic balance of the final restoration in function.

***Causes of late bone loss is the continuation of the gradual loss of marginal bone that goes beyond the initial biologic adjustment. Many factors contribute:***

1. Peri-implantitis caused by poor oral hygiene, or surgical and prosthetic iatrogenic causes such as: overhang restorations, excess cement left behind causing soft tissue irritation, or improper fit of the abutment and/or the crown creating a microgap between the implant and the restoration. The microgap provides space for the micro-organisms to flourish.

2. Occlusal overloading where the occlusal forces are more than what the bone and implants can maintain healthy environment of modeling and remodeling of bone. This can cause failure of the bone and the restoration. Placing sufficient number and size of implants as well as proper angulations of the implant to support a functional prosthesis is crucial.

3. Smoking and/or diabetes can reduce the immune reaction of the body to repair itself. Patients are more prone to peri-implantitis and excessive bone loss.

4. Failure to adequately treatment plan. The functional and parafunctional over load forces should be considered. Implant failure can be related to the type of prosthesis and its location in the arch. The number and size of the implants used. Are they individual or splinted. Are they functioning against natural teeth, a denture, or other implants? Single restorations on implants are the most predictable restoration. In the maxilla, the failure rate is nine times greater than the mandible. Implants are more likely to fail in the posterior maxilla with full sinus augmentation, using a single crown restoration, than if the restoration is splinted together. In the maxilla, individual unconnected implants supporting a removable prosthesis have a higher failure rate than those incorporated in an over -denture bar. In the maxilla a bar over-denture supported by 6-8 implants has a higher success rate than cases using just 4 or fewer implants. This is especially true in grafted bone.

5. Implant placed close to a root apex can cause bone loss and implant failure. This can happen without perforation of the apical cortical plate. Avoiding proximity to adjacent roots by using template and intraoperative radiographs can minimize devitalization of a natural tooth. Implant failure associated with asymptomatic root canal treatment is evident. This is caused by a developing apical lesion on an adjacent tooth or reactivation of a prior apical lesion. Implant failure associated with close proximity to a periodontally involved tooth. Bacteria from the adjacent periodontal tooth can infect the implant site.

6. Margin of implant-abutment connection below the bone where the biologic width is compromised as well as making hygiene maintenance difficult. ◆

---

*Dr. Soltan retired from clinical dentistry in January of 2018. She is currently a consultant on dental implantology. If any questions, she can be reached at* ***muna.soltan@aol.com***

*References:*

Jensen OT, Cockrell R, Kuhlke L , et al. Anterior maxillary alveolar distraction osteogenesis: A prospective 5 – year clinical study. Int J Oral Maxillofac Implants.2002;17:507-516.

Hutton JE, Health Mr, Chai JY, et al. Factors related to success and failure rate at 3year follow up in a multicenter study of overdentures supported by Branemark implants. Int J Oral Maxillofac Impl. 1995;10:33-42.

Misch CE, Goodacre CJ, Finely JM, et al. Consensus conference panel report: Crown-height space guidelines for implant Dentistry-part 1. Implant dent.2005;14:312-318.

Moheng P, Feryn JM. Implant Dent. 2005;14(3):281-288.

Isidor F. Loss of osseointegration caused by occlusal load of oral implants. A clinical and radiographic study monkeys. Clin Oral Implants Res. 1996;7:143-152.

Miyata T, Kobayashi Y, Araki H, et al. The influence of controlled occlusal overload on peri-implant tissue. Part 3: A histologic study in mondys. Int J Oral Maxillofac Implants.200;15:425-431

# Tools for Leading Yourself, Leading Your Family and Leading in Your Workplace

"We are what we repeatedly do. Excellence, then, is not an act, but a habit."

**DR. MIKE LEW**
*AGD Nat'l Secretary*
*Novato*

*Thoughts shared with me by Dr. Renata Pleshchuk, Senior Psychologist at CSP-SAC.*

In his outstanding book, *"The Slight Edge,"* on the cumulative effect of habits, Jeff Olson uses the powerful illustration of the water hyacinth, perhaps the fastest growing plant on earth. You might be asking yourself, what could this flower possibly have to do with self-leadership? In the early stages of its growth, it is hardly perceptible. But since it nearly doubles in size every day, people eventually wake up one morning and it seems to have exploded overnight!

Our habits are like that. They may not seem to make much of a difference at first, but over time they pick up momentum, grow deep roots in our brains, and make us who we are. Like the Aristotle quote above, to no small degree—we are what we repeatedly do. No discussion of self-leadership would be complete without talking about habits.

Dave Ramsey recommends we adopt the following mindset—*"An overnight success is fifteen years in the making."* I love that.

He goes on to say, *"In order to win at nearly anything, you have to have focused intensity over time."* It's a good reminder that anything worth doing takes time, and our habits are the vehicle that will take us closer to, or further away from, our goals.

In a 2005 study by Duke university, researchers found that up to 45% of our behaviors are done out of semiconscious repetition every day! Depending on your habits, this could be good news or bad news! While I was in graduate school studying behavior chains, we had a name for these tiny, daily habits—seemingly insignificant decisions. But these seemingly insignificant decisions will eventually add up to become your life and your legacy.

When you think about your vision for your life, daily habits are the essential building blocks of your goals. Just reflect on these for a moment.

## What would be the cumulative effect of:

- Scheduling a non-negotiable date with your spouse every week?
- Scheduling a memory-making family vacation twice a year?
- Investing in a 401k plan every month for twenty years?
- Performing your highest-impact work tasks every single week?
- Exercising just thirty minutes a day, three times a week?

They are choices that are easy to do, or not to do, but the effects over time are enormous. A very brief search for the best leadership books will reveal that successful people attribute much of their success to daily disciplines like sleep, diet, exercise, clear personal priorities, or meditation/prayer.

They are *"Slight Edge"* habits. *How can you take action this week?* Tape this to your office wall, then look at it every day for thirty days. Identify the one daily new habit in 2018 that would have the biggest overall effect on all the other areas of your life, then set to work changing it. ◆

---

*Read one of these suggested resources:*

**The Slight Edge**—*Jeff Olson*
**The Compound Effect**—*Darren Hardy*
**The Power of Habit**—*Charles Duhigg*

Seemingly insignificant decisions will eventually add up to become your life and your legacy.

# INFORMED Consent and INFORMED Refusal

**DR. BOB GARFIELD**
*Los Angeles*

Informed consent is a process, not a single event; not a signature; not a nod of okay. It is logical; it is natural, and it will result in greater case acceptance and an improved professional image.

Proper informed consent will help prevent patient management problems from occurring, and was written into California law in 1998. This means that the patient's chart must indicate that the informed consent process was performed by the doctor

## Some Elements of an INFORMED CONSENT

***The elements of informed consent that must be in the patient's chart consist of:***

**RBA** & **SOAP** accompanied by the patient's signature. The general office questionnaire and its signature of consent-to-treat is not enough any longer. Complex, comprehensive cases such as with advanced restorative dentistry may require a special and dedicated informed consent that covers everything in the entire treatment plan.

Avoid alarming the patient by asking him/her to sign all of this. Instead, encourage the patient to listen and ask (and write down) questions about the treatment. Log it all in the record. Explain that you will be asking them at a later appointment to sign a paper saying that they understood all that you have told them, and that other doctors that you send them to will also ask them to sign a similar paper. Patients will accept this process and you will look like a very good practitioner. Patients do not decline treatment because of the risks. They just want to know what those risks are and will be better patients for knowing this.

Generally, it is the restorative doctor who is the captain of the implant/restorative dental team. This restorative doctor makes diagnostic casts and occlusal records. He/she orders the radiographs and CT scans, and takes responsibility for the overall management of the case. This doctor discusses and records all of the team's activity with surgeons and laboratory technicians and explains everything to the patient. This way there will be NO SURPRISES when the patient finally meets the surgeon who will place the implants and do the bone grafting, if necessary. This means that the restorative doctor must know a little bit about radiographic and scan interpretation. The restorative dentist DIRECTS THE TREATMENT. Therefore, there is much to learn, and belonging to implant study groups and attending programs will certainly help you to learn if you need help.

With the surgeon's input, issues such as the need for bone grafting, and the number of implants necessary to adequately support the restoration and reduce the risk of failures should be done by the restorative dentist and are part of the informed consent process.

The issue of implant failures should be discussed ("rosebush story: some die"), and why biomechanical deficiencies present in the mouth should be corrected before loading of the implants is undertaken. The four main biomechanical factors to check are: Occlusal plane orientation, anterior guidance, vertical relation and CO-CR discrepancies.

## Some Elements of an INFORMED REFUSAL

Patients who are about to lose teeth should clearly understand these issues, the documentation of which is vital.

***The extraction of a single tooth and the placement of a fixed partial denture can result in the following:***

1. Alveolar collapse and bone resorption in the area of the extraction socket.
2. The loss of the interdental papillae.
3. The preparation (grinding away) of otherwise sound, healthy adjacent teeth.
4. Sensitive abutment teeth.
5. Esthetic displeasure due to three crowns and a pontic to replace just one tooth.
6. Oral hygiene difficulties primarily with the use of dental floss.
7. Recurrent caries on the abutment teeth.
8. Endodontic involvement requiring access cutting through abutment crowns.
9. The loss of an abutment tooth requiring a remake and extension of the prosthesis.
10. An unhappy patient with expectations that have not been met.

***The extraction of multiple teeth and the placement of a removable partial denture can result in the following:***

1. Damage and caries to clasped abutment teeth.
2. Continual loss of bone underlying the denture bases.
3. The supereruption and shifting of opposing teeth due to wear on the prosthesis and/or the patient's lack of compliance in wearing it often enough.
4. The development of parafunctional habits that can be harmful to the teeth.
5. Orthodontic shifting of adjacent teeth in the mouth.
6. Irritation to periodontal tissues around abutment teeth.

*The informed consent/refusal requirement can be a windfall to your practice if done in a sequential and logical manner and delivered confidently with knowledge.* ◆

# Dental Malpractice Claims

**EDITOR'S NOTE:** ***We are pleased that Richard Engar, DDS and Chief Executive Officer of Professional Insurance Exchange Mutual, Inc., has agreed to contribute to the "GP News." Dr. Engar's articles will draw upon over twenty-five years of experience covering dentists for malpractice. His column will cover pertinent topics involving the daily practice of dentistry that will be of special interest to general practitioners. When appropriate, he will cite examples from actual cases.***

**DR. RICHARD ENGAR**
*Salt Lake City*

I appreciate this opportunity that the California AGD has given me to contribute articles to the *GP News.* Since California AGD members have access to the quarterly columns I write for *AGD Impact,* I do not intend to rehash the cases covered there but plan to present different approaches to malpractice issues to hopefully help your membership save themselves trouble and heartburn. For this first column, I thought it would be worthwhile to look at the factors that must generally be present for a case to go beyond the preliminary stage of mere threats and ultimately end up as a lawsuit which could end up in court.

When a dentist becomes aware of a problem that could escalate into a claim or lawsuit, most have been instructed to contact their malpractice insurance carrier, whether it be TDIC, Dentist's Advantage or any other national carrier. Each insurance carrier has different parameters or criteria that must be met before they will open a claim. When a dentist reports an incident where a patient is upset or demands a refund, the simple act of reporting a potential problem often does not generate that company opening a claim file. However, I am aware of some companies that do indeed open a claim file to go on your record simply from your contacting them about something as simple as a patient swallowing a small dental bur during a procedure. Therefore, it might not be a bad idea for you to check with your own carrier to see what conditions must be in place for them to open a file. For example, does a simple demand letter from a patient or a lawyer cause your carrier to open a claim file? Or, does it take a more formal letter such as an official Notice of Intent to take Action from a lawyer, which states a former patient's intent to sue, in accordance with the judicial rules governing malpractice claims in a particular state. In California, such a Notice must be sent or delivered ninety days before a Complaint can be filed in court.

Once a claim file is opened by the insurance carrier, the dentist must report that claim from then on to any entities that ask about any claims history. Therefore, it is in a dentist's best interest to not have any claims on their record, which is why, ideally, a malpractice carrier should refrain as long as possible from actually opening a claim file. This is why it would be worth your time to check with your own malpractice carrier to verify their criteria for opening a reportable claim so you have a better grasp of your options and any possible consequences of reporting anything to your carrier.

Now, when a lawyer meets with a patient and potential client to discuss the possible claim, it is in the lawyer's best interest to learn as soon as possible the facts that would come into play should the case go to court.

The wise lawyer will probe to see if the following parameters are in place which may make the case worth their time to pursue:

1. ***Did the dentist meet his or her duty as far as treatment rendered?*** If the duty is shirked, and the procedure is not done according to known protocols, then there is negligence. For example, dentists are taught to stay within the confines of a root canal when placing a post and are taught to use x-rays or other safeguards to ensure proper preparation and placement. If a dentist ignores these safeguards and deviates laterally in his/her preparation such that the drill penetrates several mm outside the confines of the root canal and determines that there is copious bleeding, yet still attempts to cement a post without confirming what has already happened, etc. then this dentist has breached his/her duty and is negligent. Other examples include following the necessary steps to complete a procedure, such as G.V. Black's principles of cavity preparation for us old-timers and steps taken to remove a tooth such as tissue reflection, elevation and forceps removal as necessary. These steps are relatively straightforward and it is relatively easy to see if they were followed.

2. ***Did the dentist meet the Standard of Care?*** The concept of "Standard of Care" can be more vague or amorphous than that of duty since this standard may vary from community to community. For example, if none of the ten dentists in a particular area use a rubber dam for isolation during endodontic procedures, then it is hard to argue that one of them violated the standard of care if a patient swallowed a root canal file where no rubber dam was in place to perhaps serve as a shield and prevent such a mishap. Yet, the consensus is that there is a general or national standard that must be adhered to, and, if breached, puts the dentist below this national standard. Going back to the example of post perforation, most dentists would argue that although post perforations can happen to anyone who does enough of these procedures, it is still below the standard of care to perforate laterally out of the root canal channel because such a procedural mishap generally spells doom for the tooth in question and is not a desirable outcome.

3. ***What damages can the patient claim?*** When a root is perforated by post preparation, it often means that the tooth has to be extracted and replaced with an implant or other procedure. The damages can be defined as the amount the subsequent dentist must charge to remediate the problem. Therefore a money figure is attached and the settlement value is quantified.

Once the lawyer obtains the "facts" from the patient, he/she will then usually request copies of the dental records and then refer to textbooks or the internet to obtain information about the

*(continued on the next page)*

dentist's duty or how the procedure should have been done. Once this is established, the next step for the lawyer will be to consult with an expert witness to determine whether or not there was a breach in the Standard of Care. The importance of obtaining an expert witness early in the process is twofold. First of all, the lawyer now has motivation and back-up to pursue the claim. Second, in most jurisdictions, for a malpractice case to go before a jury, the plaintiff has to line up an expert witness willing to testify under oath that the defendant dentist breached the standard of care in some way. These alleged breaches may range from relatively adjunct issues such as incomplete or scanty record keeping to generally unacceptable results such as the lateral perforation with a post we have covered. The expert witness may have never set foot in California, yet he/she can still make general statements as to the standard of care in your own community because of the amorphous nature of the legal theory of community standards. Most readers of *GP News* could opine on whether or not they believe the standard of care was met in a particular case if we published x-rays and asked you to look at open margins, endo overfills or obvious perforations.

If I presented you with an x-ray showing a short fill or missed canal, would your opinion be different as far as the standard of care if you learned that the x-ray represents a procedure performed by an endodontic specialist? *It should not be.* The converse is also true in that general dentists are held to the same legal standard of treatment as a specialist. In other words, in the eyes of the law, you had better be as capable of achieving the same result in instrumenting and filling a four-canal upper first molar as an endodontic specialist. If all specialists in your community use surgical microscopes to complete treatment, you might be at a disadvantage if you have a problem with a case and do not have such a microscope in your armamentarium.

How are damages determined? In our perforation case the damages could include the fees for removing the tooth, doing a bone graft, placing an implant and abutment, and placing a crown. The attorney would get an estimate from the subsequent dentist to determine the amount. The patient may also claim lost wages and the attorney can quantify this amount by obtaining employment records.

Once damages are established, the patient and attorney will decide what they can obtain in general damages which is where "pain and suffering" come in. There are various formulas that are used to determine this amount but an initial figure, usually on the high side, is presented to the insurance carrier and the defense lawyer to gauge the initial reaction. If the carrier considers the initial demand to be too high, which is usually the case, the demand is denied and the next step will be to file the case in court in line with regulations governed by the California Judicial Code. The hope the lawyer and plaintiff have at this point is that a jury will agree that the damages are substantial enough overall to justify the amount demanded.

One other aspect of damages known as "punitive damages" must also be discussed. These damages are more onerous as they are generally not covered by malpractice insurance carriers. The idea here is that the acts performed by the dentist were so callous and heinous that the patient's welfare was entirely disregarded and, as a result, the dentist must be punished. It is up to the jury to determine what financial amount should be rewarded to the patient as punishment for the horrible acts the dentist foisted on their poor victim! We have never had a Utah case I am familiar with where such damages were awarded to a plaintiff/patient, but I am obligated to inform the dentist involved that punitive damages are part of a claim and they are advised to obtain their own legal counsel, at their expense, to deal with this portion of the claim. The standard reply from the dentist's attorney is then for us to try to settle the case such that the punitive damages do not become an issue that could have an adverse effect on the dentist's personal assets. Now, in California, in any action for damages arising out of the professional negligence of a health care provider, no claim for punitive damages shall be included in a complaint or other pleading unless the court enters an order allowing an amended pleading that includes a claim for punitive damages to be filed. The court may allow the filing of an amended pleading claiming punitive damages on a motion by the party seeking the amended pleading and on the basis of the supporting and opposing affidavits presented that the plaintiff has established that there is a substantial probability that the plaintiff will prevail on the claim pursuant to Section 3294 of the California Civil Code.

So, there you have it as far as what attorneys look for if they wish to prosecute a successful case against you. In future editions of this column I will cover ways to avoid getting yourself in situations where these conditions can be used against you! ◆

---

MORE ABOUT DR. ENGAR:

Dr. Richard C. Engar was graduated with a B.A. from the University of Utah in 1976 and attended the University of Washington School of Dentistry until graduation in 1980. From there he completed a GPR at Sinai Hospital of Detroit, Michigan and entered private practice in Salt Lake City from 1981 to 1991 as a general dentist. In August 1991 he became CEO of Professional Insurance Exchange Mutual, Inc., a company which provides malpractice insurance to Utah dentists which is his current position and occupation. He also maintains a faculty position with the University of Utah General Practice Residency Program, now part of the University of Utah School of Dentistry, which he has held since 1988.

Dr. Engar has served as Treasurer of the Salt Lake District Dental Society, Editor of UDA Action and Speaker of the House for the Utah Dental Association. He was a Trustee and Regional Director for the Academy of General Dentistry on a national basis and held all the local offices for the Utah AGD. He has served for several years as Utah Section Co-Chair for the Pierre Fauchard Academy. He holds fellowships in the AGD, Pierre Fauchard Academy, Academy of Dentistry International, International College of Dentists and American College of Dentists. He has been designated "Dentist of the Year" by the Utah AGD in 1997 and received recognition as a "Distinguished Dentist" by the Pierre Fauchard Academy in 2006. He received a lifetime service award from the Utah Chapter of the International College of Dentists in 2015 and received the Distinguished Service Award from the Utah Dental Association in 2017. He has written articles for several publications for the Arizona Dental Association, Utah Dental Association, Academy of General Dentistry and the International Plastic Modelers Society.

Dr. Engar's wife, Ann, is a full Professor at the University of Utah and he has three grown children including an attorney, medical resident in anesthesia and schoolteacher.

His hobbies include photography, painting, golf and scale model building. He competes at various levels with his scale models and is a National Champion.

ALAN THOMAS RICHARD BENNER

# 2018 Tax Cuts and Jobs Act (TCJA)

*EDITOR'S NOTE: We are pleased that Thomas & Fees, a long-standing accountancy firm in California, has agreed to contribute to the "GP News." Their articles will draw upon over forty years of experience as Certified Public Accountants providing service almost exclusively to the dental profession. Their column will cover pertinent topics involving the accounting aspects of operating a dental practice. For new dentists, an article about purchasing a practice. For dentists close to retirement, an article providing transition guidance in the sale of a practice.*

The TCJA law is a sweeping overhaul of the tax code. Most of the changes that affect businesses are permanent, while most of the provisions for individuals are temporary and "sunset" after 2025. What follows is a brief summary of some of the important individual tax changes.

The article is divided into two parts: Part 1 is a limited discussion of the TCJA changes that took place January 1, 2018, with an emphasis on the tax changes most likely to impact your income tax situation. Part 2 is a discussion of eight strategies you can use to reduce your tax bill.

## Part 1 – TCJA Changes for 2018

***Tax Rates***–The new law lowers tax rates approximately 3% for individuals and adjusts bracket amounts. For 2018 through 2025, the tax rates are 10%, 12%, 22%, 24%, 32% 35% and 37%, respectively.

***Standard Deduction***–The standard deduction is increased to $12,000 for single and $24,000 for married filers, almost double the amount in previous years.

***Personal Exemptions*** – The approximately $4,000 personal exemption for all taxpayers and qualified dependents has been repealed – a significant loss for taxpayers with large families.

***State Income Taxes and Property Taxes*** – The law now limits this deduction to $10,000 annually. This is a "big hit" for taxpayers living in states with high state income taxes and property taxes, such as California.

***Mortgage Interest*** *(personal residence)* – The deductible interest on a personal residence acquired in 2018 is limited to the first $750,000 of debt. In other words, if you buy a house with a $1,000,000 loan in 2018, only 75% of the interest will be deductible. Interest on secondary homes is no longer deductible. Interest on home equity loans (HELOCs) is no longer deductible, unless those loans are used to buy, build, or substantially improve the taxpayer's home. A HELOC is a loan in which the lender agrees to lend a maximum amount for a certain time period using the borrower's equity as collateral (similar to a second mortgage). Interest-deductible HELOCs should still be available to homeowners provided that they use the proceeds to make "substantial improvements" to their homes, and that the combined total of their first mortgage balance and their HELOC does not exceed the new $750,000 limit on mortgage amounts qualified for interest deductions. For home loans made prior to 2018, you can still deduct interest on loans up to $1.1 million.

***Casualty and Theft Losses*** – Itemized deductions for casualty and theft losses have been repealed. Now, only losses incurred in federal disaster areas are deductible.

***Alimony Payments*** – In past years, alimony payments were deductible by the payor and taxable to the payee. That is no longer the case. Any divorce or separation agreement dated after December 31, 2018, will no longer permit the deduction and taxation arrangements. We anticipate that divorce settlements in the future will be adjusted due to the changes in alimony deductibility.

***Moving Expenses*** – Moving expenses will no longer be deductible.

***Additional Miscellaneous Itemized Deductions*** – For 1040 filers, the following itemized deductions have been eliminated: professional fees (tax preparation, investment advisory fees, etc.) and unreimbursed employee business expenses (education expenses, professional dues, etc.).

***Estate Tax*** – In 2018 the federal Estate Tax Exemption is $11.2 million for an individual or $22.4 million for a married couple, and will be effective for the estate of decedents who passed away after December 31, 2017.

***Pass-through Entities: S Corporations, Partnerships, and Sole Proprietorships*** – A pass-through entity is a special business structure that is used to reduce the effects of double taxation. Pass-through entities don't pay income taxes. Instead, pass-through income is allocated among the owners, and income taxes are only levied at the individual owners' level. These business structures only report 80% of their qualified business income, as long as they pass a taxable income threshold test ($157,500 for single taxpayers and $315,000 for married taxpayers). This is only for professional services. Qualified business income (QBI) is income from pass-through *(continued on the next page)*

# and Strategies to Reduce Your Tax Bill

Alan Thomas, CPA
Richard Benner, CPA

entities. QBI is net income from your business without regard to amounts paid as reasonable compensation by S corporations, or guaranteed payments by partnerships.

***Health Savings Accounts*** *(HSA)* – Generally, you can only take medical expenses as itemized deductions, and then only if they exceed 7½% of your adjusted gross income. The HSA allows you to avoid tax not only on your initial contribution but also on the earnings. The contribution could be as much as $6,900 per year for a family or $3,450 for an individual. If not used, the balance is carried forward and can be invested similar to other retirement plans. You can pay up to $13,000 in medical costs from your HSA account annually and it comes out free of tax.

***529 Plans and Educational Savings Plans*** – There is a big change in this area of the tax law. You can now pay for elementary and secondary school costs as well as college. You don't get a deduction for the contributions into the savings plans, but the earnings and distributions are not taxable if used for education.

***Home Office Expenses*** – If you use part of your home regularly and exclusively for business, you may deduct the costs of your home office.

***Retirement Plans*** – If you don't have one, work with your CPA and institute a retirement plan that meets your needs. Some plans don't require you to include your employees (IRA). Others require employee contributions as little as 3% of their salaries, and the employer could put up to $54,000 into the plan for themselves.

***Required Minimum Withdrawals from Individual Retirement Accounts*** – Taxpayers over the age of 70½ are required to take minimum withdrawals from their IRAs. Failure to do so subjects them to a 50% penalty on the required amount.

## Part 2–Eight Strategies To Reduce Your Tax Bill

1. This may sound obvious, but the best way to save money on your 2018 income tax bill is to *plan ahead!* That's right. You should start planning to save money as soon as your accountant has filed your 2017 return. If you don't plan now to reduce your taxes, you will miss opportunities.

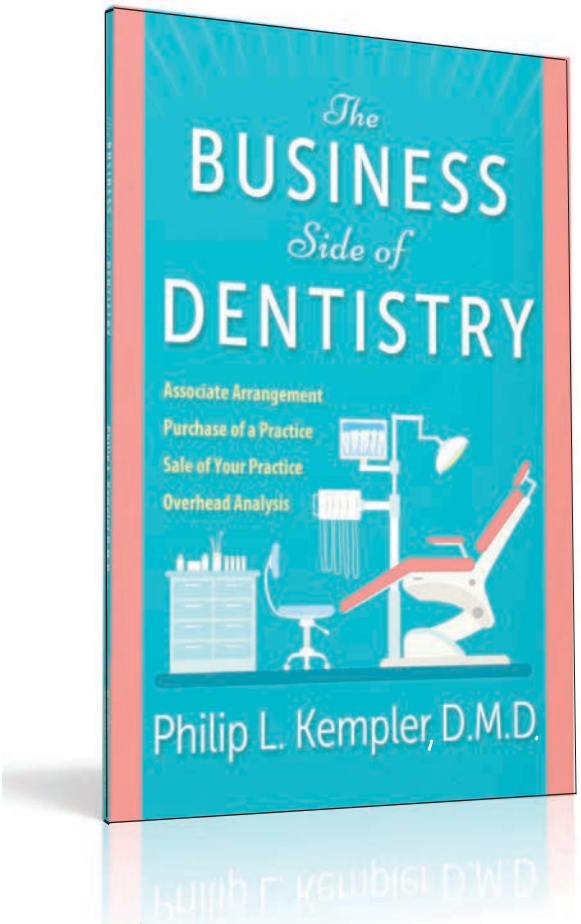
2. Start a retirement plan as soon as you can. It's an excellent tool for saving money for your future and a way to reduce taxes as well. The type you choose will depend on your income tax situation, and, if you have employees, your employee census. Retirement plans should be explored with your personal advisors.

3. We hear it all the time: "I don't take a home-office deduction because my accountant says it's a red flag with the IRS." *Not true.* We know dentists, and we know that most have every right and should take legitimate deductions for the home office. If you're like most, you make calls in the evening from your den, analyze your overhead, pay bills, work on patient charts, contact and consult with your peers about difficult cases, and follow-up with patients you are concerned about. If you create a designated place in your home to conduct such activities (it must be exclusively used for that purpose), you may deduct a percentage of your home's square footage, utilities, and other expenses, which typically amount to about $4,200.

4. Keep Records. The days of throwing your receipts in a box under the bed are over. With computer programs that keep track of everything in your life from appoint ments to anniversaries, there is no excuse for poor record keeping. You take extensive notes and x-rays on patients so you won't miss anything. That's the purpose of good recordkeeping. Also, good recordkeeping doesn't just affect the current tax year. For example, expensive home improvements such as room additions, roofing, air conditioning, gutters, furnaces, or that "dream kitchen" you've always wanted — increase a home's value and can be used to off-set capital gains when you sell the property. Good records of your expenditures will keep you from missing legitimate deductions that could reduce taxes in 2018, and in future years as well.

5. Solar panels anyone? If you haven't already done so, this year might be the perfect time to install energy-saving solar panels. As you may know, the IRS offers tax credits for solar-powered systems. In addition to reducing use of fossil fuels, solar power reduces your individual carbon footprint. However, it is much more expensive than electricity from natural gas and other sources. That's why tax credits for solar-powered systems are being offered. The tax credit is available for improvements you make to your primary or secondary home and allows you to take the

*(continued on page 25...see STRATEGIES)*




"The info about due diligence when buying a practice on pg. 33, prevented me from making a monumental error that would have cost me hundreds of thousands!"

—Dr. Claire Bishop

"The chapter on overhead control completely changed the way I operate and my overhead has dropped from 70% down to 50% while simplifying my life."

—Gregory Jones, DDS

"I've been practicing for decades and wish this book had come out sooner. Dr. Kempler addresses so many aspects of dentistry that directly impact profitability . . . lessons I learned the hard way during my career. This book is a must read!"

—Dr. Dean Patterson

"One chapter just saved me 1000s of dollars in taxes for 2017! Thank you Phil!"

—Dr. B. Barrymore

# "The best book I ever read on dental prosperity!"

## —Los Angeles Dentist, Dr. L. Chen

Dentistry is a business and this book is the business side of dentistry. Whether you are just out of dental school, buying your first practice, or selling your dental practice and heading into retirement . . . this book will be beneficial:

- Associate arrangement—What to expect on your first job
- When and where to buy a practice
- How to value a dental practice
- Due diligence—What are you really buying? Look deeper!
- Overhead Analysis—Poor overhead control reduces your take home pay!
- Tax consequences of buying or selling a practice. "Asset allocation" two words that can make or break the deal.
- Practice brokers . . . the good, the bad and the ugly!
- Includes overhead analysis templates and retirement income planners.

## Complimentary Copy

### *Free* to CAGD dentists

Email us your contact and credit card information and pay only $5 for shipping.

Email: bizsideofdentistry@gmail.com

*Buy on Amazon by searching:*

***The Business Side of Dentistry***

*by* **Philip L. Kempler, D.M.D.**

*or email:* bizsideofdentistry@gmail.com

# California AGD Welcomes Our New Members

*December 11, 2017 thru March 26, 2018*

*(all Californians except where noted otherwise)*

***Dr. Mariam Samir Abadir**, San Francisco*
***Dr. Tigon Huong Abalos**, Fresno*
***Dr. Edward Araz Adourian**, Carlsbad*
***Dr. Atul Kumar Agrawal**, San Francisco*
***Dr. Ashley Ahuja**, Woodland Hills*
***Dr. Lana Alawwad Haddad**, Los Angeles*
***Dr. Heba Almalfouh**, San Jose*
***Dr. Sophie Ballard**, San Francisco*
***Dr. Nayantara Bhatt**, San Francisco*
***Dr. Varo Boyer**, Van Nuys*
***Dr. Andrea Chang**, Los Angeles*
***Dr. Alexander V. Chang**, San Gabriel*
***Dr. Leticia Adriana Chavez**, San Francisco*
***Dr. Serafine Chen**, Santa Clara*
***Dr. Priyanka Chitkul**, San Francisco*
***Dr. Kimberly Chyu**, Los Angeles*
***Dr. Mina Davar**, Tarzana*
***Dr. Regina DelaCruz**, Lake Worth, Florida*
***Dr. Francis Earvin Delos Reyes**, Daly City*
***Dr. Krishna Desai**, Los Angeles*
***Dr. Megan Elizabeth Dietz**, Encinitas*
***Dr. Jeanett Escareno**, Bell Gardents*
***Dr. Jesse S. Felema**, Loma Linda*
***Dr. Rene Gacives Vega**, Los Angeles*
***Dr. Steven J. Gigli**, Manteca*
***Dr. Sukhjit Gill**, Delhi*
***Dr. Jesica Gonzalez**, San Francisco*
***Dr. Georgia Haddad**, Oxnard*
***Dr. Joseph Hanna**, Woodland Hills*
***Dr. Christofer Hatzis**, San Francisco*
***Dr. Kevin Hildebrandt**, San Francisco*
***Dr. K-Lynn Hogh**, San Francisco*
***Dr. Julian Q. Huynh**, San Francisco*
***Dr. Eric Joo**, Riverside*
***Dr. Taewon Timothy Jung**, San Francisco*
***Dr. Arshia Kalantar**, Mission Viejo*
***Dr. Jyoti Ranjan Kansara**, Los Angeles*
***Dr. Pranav Kataria**, Los Angeles*
***Dr. Fariya Khan**, Centrevill, Virginia*
***Dr. Sahar Khooshab**, Carlsbad*
***Dr. Rodney K. Kihara**, Auburn*
***Dr. Hui Jong Kim**, Monterey*
***Dr. Maryna Kozyryev**, San Francisco*
***Dr. Mini Krishnakumar**, San Jose*
***Dr. Ann Lee**, Santa Barbara*
***Dr. Katherine Leung**, Pleasanton*
***Dr. Ken Lim**, Chino*
***Dr. Young Sik Lim**, Loma Linda*
***Dr. Jenny Ma**, Los Angeles*
***Dr. Nipun Mahajan**, San Francisco*
***Dr. Nicole Mahdavi**, Upland*
***Dr. Kasia Marelich**, Santa Rosa*
***Dr. Armine Ani Martirosian**, Anaheim*
***Dr. Eric Mastanduono**, Los Angeles*
***Dr. Ashkan Shawn Milani**, Arcadia*
***Dr. Shinam Mittal**, Los Angeles*
***Dr. Varun Mittal**, San Francisco*
***Dr. Kamyab Mohager**, Beverly Hills*
***Dr. Karen Lynne Nakagawa**, Santa Monica*
***Dr. Nidhi Nangia**, San Francisco*
***Dr. Ajay Kumar, Nathani**, Los Angeles*
***Dr. Kelly Elizabeth Nelson**, Chino Hills*
***Dr. Albert Ngo**, San Francisco*
***Dr. Thomas Nguyen**, Alhambra*
***Dr. Helen Nguyen**, San Francisco*
***Dr. Catherine N. Nguyen**, Monterey Park*
***Dr. Trang Nguyen**, Bakersfield*
***Dr. Farida Bhanu Noorbash**, Wilmington*
***Dr. Akshay Parmar**, San Francisco*
***Dr. Margi Patel***
***Dr. Aldo Peralta**, Chula Vista*
***Dr. Marites M. Perez**, Temecula*
***Dr. Roza Poghosyan**, San Francisco*
***Dr. Tabasom Rafi**, San Francisco*
***Dr. Archnaa Rajasekaran**, Dublin*
***Dr. Deepika Ramachandran**, San Francisco*
***Dr. Alan Remi**, Pomona*
***Dr. Kelly Ren**, San Francisco*
***Dr. Laura Constanza Rey**, San Francisco*
***Dr. Elizabeth Rodriguez**, San Diego*
***Dr. Christopher Keas Roebken**, Rohnert Park*
***Dr. Jaspreet K. Saini**, El Sobrante*
***Dr. Delaram Salamati**, Irvine*
***Dr. Christian Yuzon Santa Maria**, Daly City*
***Dr. Lusine Sargsyan**, Panorama City*
***Dr. Vladimir Sarkisov**, San Francisco*
***Dr. Semyon Segal**, Pacifica*
***Dr. Nalorn N. Sengamphan**, Apple Valley*
***Dr. Karishma Shah**, San Francisco*
***Dr. Nadia Shaheen**, Stockton*
***Dr. Mayank Sharma**, San Francisco*
***Dr. Adam Shinkawa**, Fresno*
***Dr. Caleb Tam**, Cupertino*
***Dr. Sarah Tam**, Sacramento*
***Dr. Danna M. Tamayo**, Carson*
***Dr. Lin Thu**, Los Angeles*
***Dr. Randy Tran**, Santa Ana*
***Dr. Dan Van Truong**, San Jose*
***Dr. Harry Tseng**, San Jose*
***Dr. Jaime A. Valencia**, Fremont*
***Dr. Chirag Vora**, Fontana*
***Dr. Safina Waljee**, Redlands*
***Dr. Hiyab Woldeselasie**, San Rafael*
***Dr. Ju Quan Wu**, Los Angeles*
***Dr. Hyung Rok You**, San Francisco*
***Dr. Ivana N. Younan**, Canyon Country*
***Dr. Jaclyn Young**, Walnut Creek*
***Dr. Helen Yuan**, Los Angeles*
***Dr. Ehsan Zahedi**, San Francisco*
***Dr. Beinan Zhao**, San Francisco* ◆

**DR. CHIRAG VAID**
*President*
*Sacramento*

*Dear SSAGD Members,*

*We have hit the ground running in Sacramento with two CE events under our belts, 2018 is shaping up to be a productive and exciting year. As we look to expand our membership, we invite you all to reach out to colleagues who may be a good fit for our group and invite them to our next event. I hope you have a wonderful summer and we look forward to seeing you in September (see ad to the right).* ◆

*Sincerely,*

*Chirag Vaid*

## End of Summer Continuing Education Event

***Thursday, September 6*** *(6:30 p.m. - 8:30 p.m.)*

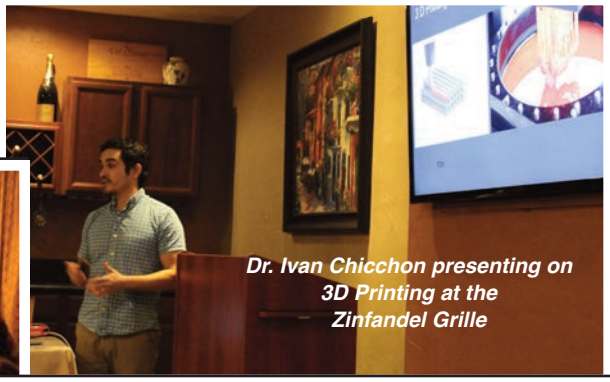
### *Digital Dentistry and Implant Dentistry*

*Location:* **Zinfandel Grille**
*2384 Fair Oaks Blvd., Sacramento*

*Speaker:* **Dr. Quincy Gibbs**

*Cost:* AGD Members: $40;
Non-AGD Members: $50 *(dinner included)*

***Attendees at our January CE event at the Zinfandel Grille***



***Dr. Ivan Chicchon presenting on 3D Printing at the Zinfandel Grille***


***Digital Scanner Course in Sacramento. Hands Training with Trios, Cerec and Itero.***

***Lecture regarding 3D Printing with MoonRay Printer by Dr. Arthur Kwan***

*Stay updated with event details at:* **www.ssagd.org**

*Register for courses at:* **terri@cagd.com**

**DR. ERIKA KULLBERG**
*President, El Cajon*

Our Second Annual SDAGD Membership Social was held at Duke's La Jolla. Dr. Thanh Tran was awarded the Vernetti Award, presented by the San Diego AGD to someone who consistently promotes the practice of general dentistry and serves the SDAGD in an extraordinary fashion. Thanh is highly involved in providing membership benefits, such as coordinating local CE courses. Furthermore, he stepped back into the role of treasurer, even after serving as the SDAGD president.

The SDAGD implemented a Short Course Series, offering four evening courses to members. The first event featured Ali Oromchian, JD, LLM on *"Human Resources Made Easy for Dentists."* We will have an oral surgery course with Dr. Paul Koshgerian on July 11th. Additional courses on September 26th and December 5th *(details TBD).* We are expanding our connections with the San Diego County Dental Society by offering a joint CE course on June 8th with Dr. James Kohner on "Crown Lengthening." Mark your calendar. ◆

*For more details, contact:*
**zeynep.barakat@gmail.com**

*Dr. Erika Kullberg*

*Vernetti Awardee Dr. Than Tranh*

*Dr. Kullberg welcomes attendees at the social event*


*Dr. Omar Bissar*

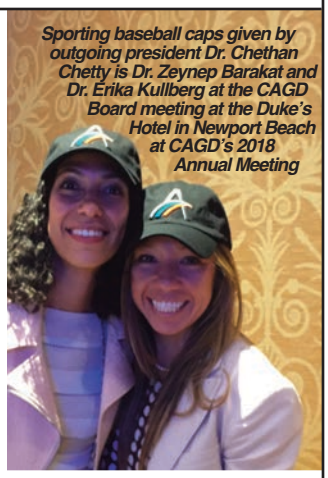
*Dr. Eric Lewis*

*Dr. Kevin Le*

*Dr. Jestina Benson*

*Dr. Larry Pawl*

*Dr. Jenna Lau*



*Sporting baseball caps given by outgoing president Dr. Chethan Chetty is Dr. Zeynep Barakat and Dr. Erika Kullberg at the CAGD Board meeting at the Duke's Hotel in Newport Beach at CAGD's 2018 Annual Meeting*

SDAGD's first meeting of our Board for 2018. The venue was Gordon Biersch Restaurant in Mission Valley. Attendees were *(left to right):* Jestina Benson, Dan Gibson, Larry Pawl, Erika Kullberg, Harriet Seldin, Alicia *(pre-dental student),* Zeynep Barakat, Stephen Lockwood, Mark Martin, Frank Ceja, Jenna Lau, Jay Thompson, Eric Lewis and Kevin Anderson.

DR. TRAN HAN
*President*
*Altadena*

# MODERN DIGITAL ENDODONTICS ✳ *Making Dentistry Easier*

***A lecture and hands-on workshop on endodontics. Learn about the significant technological advances in the last decade enhancing the precision and predictability of endodontic treatment. The course will cover practical everyday endodontics. You will spend time practicing with the latest rotary files, learn about 3D-guided endodontic treatment, learn how to read CBCT scans for endodontic purposes and more.***

*Speaker:* **DAVID KELLINY, DDS**

*When:* ***Sunday, August 26, 2018***

*Where:* *Neo Dental Laboratory*
*13073 166th Street, Cerritos, California*

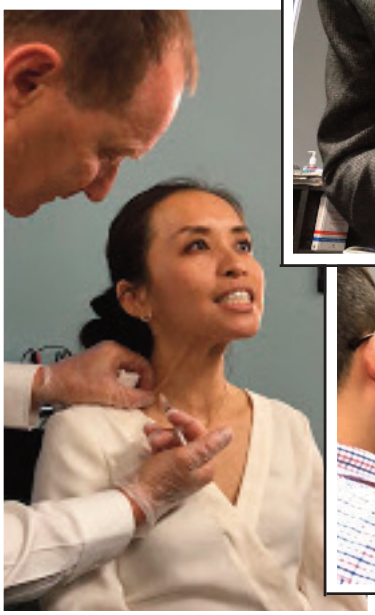
*About the Speaker: Dr. Kelliny earned his Certificate in Endodontics from USC in 2001. He is currently a Clinical Assistant Professor at the USC School of Dentistry it the post-graduate Endodontics program. He has been teaching residents at USC on various aspects of endodontics with a specific emphasis on Surgical Endodontics, 3D Endodontics, and dental implants.*

*Course flyer coming soon.*

*Registration, go to:* **scagd.com**

*Snapshots from previous events:*

## BOTOX COURSE

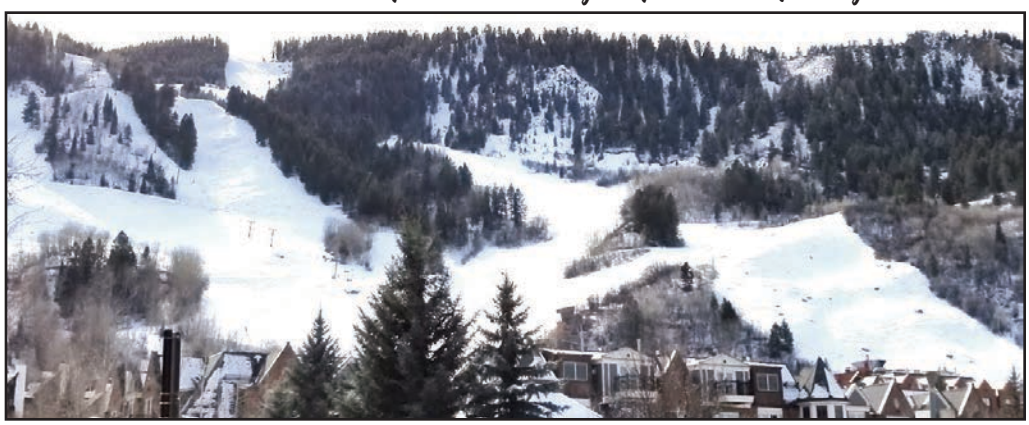


## SKI & LEARN SEMINAR

*If you missed our 2018 Annual Ski and Learn Seminar you missed a good one! Plan to attend next year. The dates are February 2-9, 2019.*

*Photos on page 31 capture some of the seminar at Snowmass this year.*

*More about our* ***2019 Ski & Learn Seminar*** *at* ***Vail*** *in the next issue.*



# STRATEGIES *(continued from page 19)*

amount directly off your tax payment (30% of your total equipment cost). The credit is available through the end of 2019, after which, the percentage steps down annually and stops at the end of 2021. Just remember, the equipment must be used to generate power or heat water in your primary or secondary home, not for solar equipment purchased for a hot tub or swimming pool.

6. Health Savings Account (HSA). As explained earlier, an HSA can reduce taxes by allowing you to deduct contributions to the plan up to $6,900 per family. Also, withdrawals for qualifying medical expenses come out free of tax. You can therefore avoid tax not only on your initial contribution but also on any earnings that your savings generate while they're inside the HSA. *Here's a tip for keeping track of medical expenses:* Designate one credit card and use it only for medical costs. Obviously, choose a card that offers benefits like cash back or air miles. When it comes tax time, you will have your qualifying expenses in one place, on your credit card statements. But do keep the actual receipts as well, in case the IRS wants proof of purchase.
7. For new dentists, don't forget your hand instruments and the dental library that you purchased for dental school. As an independent contractor you may be able to get a tax deduction for these items.
8. As stated above, if you are a W2 employee and you don't own a practice, you can no longer deduct your professional expenses (continuing education, professional dues, licenses, and other professional costs). Since your professional expenses are no longer deductible, have your employer pay for your professional expenses and reduce your wages by a like amount. This saves the employer and the employee payroll taxes, and the employee, income taxes. ◆

*An additional comment about this article:*

*The sweeping overhaul of our tax system was so massive that it made an in-depth review impossible. Our emphasis in this article was on the tax changes that would most likely affect our reading audience and eight ways to save taxes.*

*For questions regarding your specific income tax situation, we encourage you to contact your CPA or advisor.*

---

ABOUT THE AUTHOR-CONTRIBUTORS:

*Thomas & Fees Accountancy Corporation is a Tustin, California CPA firm that has been working almost exclusively with dentists for forty-plus years. President and co-founder, Alan B. Thomas, C.P.A., is a graduate of California State University at Long Beach and holds a BS and an MBA.*

*Richard C. Benner, CPA, Partner, joined Thomas & Fees Accountancy after a career with the public accounting firm of PricewaterhouseCoopers (PwC) in the Real Estate and Consumer Products Assurance Practices. Assisting in financial statement assurance, some of his past clients include Mattel, Inc., Disney, Herbalife, Memorial Healthcare, Pacific Coast Capital Partners, LLC and USC. Richard holds a BAcc degree from University of San Diego.*

*The title of our next article is*

**"Dental Office Profitability"**

*We will discuss overhead analysis and how to keep your expenses under control.*

*—Thomas & Fees Accountancy, Tustin*

# RETIREMENT *(continued from page 11)*

| *Age* | *Capital to Income Ratio* | *Life Insurance to Income Ratio* |
|---|---|---|
| 25 | 0.1 | 12 |
| 30 | 0.6 | 11.4 |
| 35 | 1.4 | 10.6 |
| 40 | 2.4 | 9.6 |
| 45 | 3.7 | 8.3 |
| 50 | 5.2 | 6.8 |
| 55 | 7.1 | 4.9 |
| 60 | 9.4 | 2.6 |
| 65 | 12 | 0 |

**Tips on Saving Thousands and Insurance Ripoffs:** The optimal insurance is self-insurance which requires having the wealth to cover your contingencies or potential risks so that you do not need to rely on a claim funded by overpaid insurance premiums. When insurance is necessary, buy it without emotion or deceptive sales pitches but instead with knowledge. Think of insurance as a financial alternative and not a potential windfall. You can only protect against a major financial loss. As your wealth goes up, take higher and higher deductibles on health, automobile and homeowner's insurance and longer waiting periods and reduced benefits on disability insurance. Self-insure for the first $500 to $1,000 damage to your car. Drop your comprehensive and collision insurance when the value of your vehicle drops below $8,000. Never buy extended warranties or auto service contracts. Cancel your extended warranties and get a refund. If you have a high net-worth, insure millions of dollars of personal liability with a relatively inexpensive umbrella policy available through your automobile insurance carrier. *Keep smiling!* ◆

---

ABOUT THE AUTHOR:

*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*

*My next "GP News" topic will be:*

**"Definition of Risk, Investment Alternatives and Leverage"**

*—Dr. Kevin Anderson, Founder, AIF, Jamul*

## AN UNRECOGNIZED SPECIALTY

# Dental Care in the Prison System

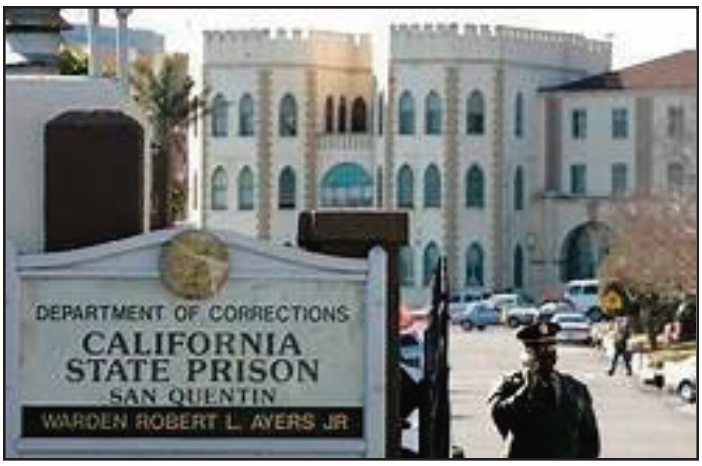
**William Kushner III, DDS**, *CAGD President Elect, Danville*

*"You are hereby sentenced to a term no less than the remainder of your natural life at a facility to be determined by the California Department of Corrections and Rehabilitation."*

People are always fascinated by the notoriety of inmates such as Charlie Manson, Charles Eng, Richard "The Night Stalker" Ramirez or even Scott Peterson. Is it Scary? Are the guards nearby? What is it like? These are just some of the questions I am asked. I have spent approximately thirteen years working at various California State prisons including serving as Chief Dentist at San Quentin State Prison.

Although I have met and even treated some of the most notorious California inmates, including many of those on Death Row, my focus has always been on improving the professional image of Dentistry in Prison.

Learning to be patient while waiting for the yard to be "cleared" so a condemned inmate wearing belly chains and leg irons can be walked across the institution to the dental clinic. Knowing when to draw the line with a career manipulating serial rapist who is trying to "make eyes" at a young female dental assistant. Always being on guard to be protective of your staff can certainly be exhausting. Understanding the legalities of working under a federal lawsuit, reporting to court experts, conducting self-audits, working within budgetary constraints during a state government fiscal crisis. Can't I just do dentistry? This job is not as easy as I thought it would be when I first applied. Not to mention the complexity of patient medical conditions. Providing care to patients with "Meth Mouth," schizophrenia, organ transplants, or even gunshot wounds to the face are a daily challenge.




***Front entrance to San Quenton State Prison***

You must be a special breed of dentist to look past the façade of the Grey Bar Hotel and into the mouth of a serial killer.

But what kind of treatment do they get, you ask? Well, kind of a glorified dentical level of care. We provide comprehensive exams every year (or every other year) depending on age and chronic care conditions. The ideal is to develop a dental treatment plan consisting of their dental needs that can be sequenced in an organized fashion based on their treatment priorities.

Non-surgical periodontal therapy consisting of nearly limitless scaling and root planning until it is determined that they are not responding to care or they have no signs of active disease. Once stabilized, they will be placed on a periodontal maintenance schedule as determined by the treating dentist.

Amalgam posterior fillings are required while anterior composites are permitted. Anterior acrylic crowns can be fabricated if the decay is not too extensive. However, posterior stainless steel crowns are the last restorative resort as precious metals or ceramics are not allowed.

Removeable prosthetics (acrylic or cast partials or full dentures) are often an ultimate end result. But it doesn't end there. Let's rewind a bit.

Inmates come into the prison system generally with addictions or other poorly treated systemic diseases. As a private practicing dentist for over 23 years, I can honestly say that it is not until now that I considered myself a primary care provider. Prison dentistry has definitely refined my skills in understanding general pathology and systemic disease.

For example, anticoagulant therapy is a common place in prison health care. Many patients that have a history of stimulant abuse or intravenous drug use have problems with atrial fibrillation (A Fib) or Deep Vein Thrombosis (DVT) requiring anticoagulants. Generally, coumadin is still the drug of choice and monitoring the patients International Normalized Ratio (INR) is paramount to bleeding control. This may require the ordering of a blood draw to update the INR 48 hours before an invasive surgery.

Monitoring the HbA1c for diabetics is the standard of care. The A1c test measures the amount of glucose (blood sugar) bound to hemoglobulin (blood protein) in your red blood cells. As glucose builds up *(continued on the adjacent page)*

# California Is Well-Represented at the AGD National Level

**Howard H. Chi, DMD, MA, MAGD, DICOI**, *Stockton*

## Do you know how involved California is in representing General Practitioners?

***Below** (IN ALPHABETICAL ORDER) **is a list of CAGD members who hold a national AGD council or committee position:***

**Dr. Guy Acheson** (Sacramento-Sierra AGD) — *Trustee*

**Dr. Samer Alassaad** (Sacramento-Sierra AGD) — *Examination Committee B*

**Dr. Mike Bromberg** (Southern California AGD) — *AGD Congressional Liaison*

**Dr. Howard Chi** (Sacramento-Sierra AGD) — *PACE Council Chair*

**Dr. Chethan Chetty** (Southern California AGD) — *Membership Council Member*

**Dr. Cheryl Goldasich** (Southern California AGD) — *Regional Director*

**Dr. Dinu Gray** (Northern California AGD) — *Membership Council Consultant*

**Dr. Michael Lew** (Northern California AGD) — *AGD Secretary*

**Dr. Sireesha Penumetcha** (Sacramento-Sierra AGD) — *Communications Council Member*

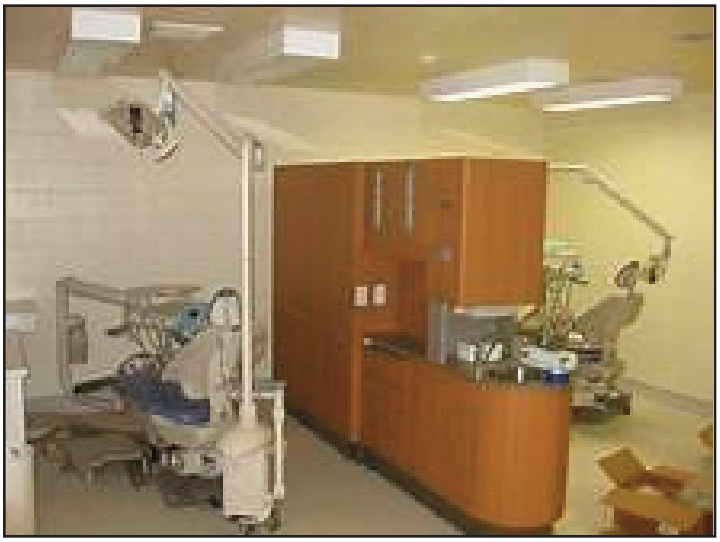
**Dr. Anita Rathee** (Southern California AGD) — *Public and Professional Relations Division Coordinator, Policy Review Chair*

**Dr. Steve Skurow** (Southern California AGD) — *PACE Council Member*

**Dr. Eric Wong** (Sacramento-Sierra AGD) — *Continuing Education Division Coordinator*

## PRISON DENTAL CARE *(continued from the previous page)*

in your blood it binds to hemoglobulin thus increasing this marker in your blood. Understanding the A1c may provide the dentist a good basis to predict how well a patient may heal based on their ability to control their blood sugar. Often, I may use this to contact the primary care provider to ensure the patient is compliant with his insulin or if a modification of his dose is needed. A pre-op blood sugar test is recommended for invasive or long procedures.



***A snapshot into a prison dental clinic: Rebuild of California State Prison Solano Annex Clinic.***

Providing input to the PCP regarding polypharmacy and understanding how a simple prescription for analgesics can complicate the patients care plan. I have never felt more comfortable working with physicians and pharmacists.

At California Medical Facility, where I am currently assigned, the patient's healthcare needs are even more complicated. Many patients are treated with bisphosphonates for metastatic cancer to their bones. We all know the osteonecrosis risk this drug class presents. Many patients have been organ transplant recipients, have HIV, or other immunodeficiencies. Some patients end up in the specialized Hospice unit.

Working in a correctional facility is certainly a challenging profession. It is no wonder that a staggering 34% of staff working in prison suffer from Post-Traumatic Stress Disorder (PTSD). Acts of violence occur daily in the prison environment. It is not uncommon to witness such events as a prison gang fight, stabbing with an inmate-manufactured weapon, or even a simple assault. Ultimately, we treat those patients for lacerations or facial fractures. Dealing with this on a daily basis certainly has its effects on your wellness.

The dedication of dentists working in this public health setting is certainly a specialized arena. Not many dentists that go to work every day have to worry about whether you will make it home or not. Correctional Dentists are certainly in a league of their own. ◆

# University of Southern California

Ostrow School of Dentistry

**Rebecca Yamane**, *Co-President '18, AGD FellowTrack Student Chapter at USC*

**REBECCA YAMANE**
*Arcadia*

The mission of our group is to deepen the knowledge and understanding of the critical problems faced in dentistry and to educate tomorrow's leaders who will address them. At the USC FellowTrack Chapter we are very proud of our past year's accomplishments and are using the momentum to continue growing as a chapter.

Dennis Sourvanos, the Past President as well as current Board Chairman, took our organization to new heights in going from one Lunch 'n' Learn per trimester to one Lunch 'n' Learn per month. In being recognized as a student organization on the USC campus, we are able to fund all our Lunch 'n' Learns to provide our students and speakers with lunch, snacks, coffee, and desserts. Our turnout grew immensely during this time, as the word spread that we were having seminars on oral pathologies, forensic dentistry, peri-implantitis, and dental photography (to name a few) by world renown faculty.

Dennis also set into place opportunities to bring hands-on workshops to the students. In partnering with the Patterson, he opened the doors to have a hands-on workshop on the newest CAD/CAM technology. Due to the overwhelming number of students who had interest in this workshop, we were forced to invite only the most committed members to come due to limited spacing. Our chapter was flourishing with people wanting to join and be given opportunities that one could only dream of as a dental student.

This was the status of the AGD FellowTrack Chapter at USC when Tim, my Co-President, and I inherited it and so, we took the baton and continued running with it. Once a month, we continued to have prestigious Lunch 'n' Learns, hosting only the best faculty with the most interesting topics. We continued to set up hands-on workshops; we are hosting a hands-on CAD/CAM based reconstruction course. Additionally, we continued to publish the Future Fellow Magazine which allows our students to hear from existing AGD members, fellows, and masters to hear about how and why they love the AGD. And yet, we had our own goals that we wished to reach by the end of the year.

I worked to expand our social media base. We were able to bring our followers on Facebook and Instagram up to over half of the school. Our partners are also able to follow us and see what we are up to. Students are more informed about our events and are able to communicate with us directly through a method that is relevant to them.

Through social media, we have also been able to connect with AGD national leaders, such as Dr. Maria Smith and Dr. Manuel Cordero, in efforts to bridge the gap between what is happening with the AGD in the real world and the AGD at our school.

Tim has been working tirelessly to bring USC to Washington, DC. One of his goals was to encourage students to be advocates for general dentistry during AGD's Annual Hill Day. This past year he was able to take a team to stand up for our profession. These students were able to personally meet the leaders of the AGD as well as representatives of their states and hear about the most relevant problems that we face in dentistry.

In the future, we look forward to seeing what initiatives the new board will bring in. As board chair(wo)man next year, I would like to continue to see Lunch 'n' Learns, hands-on workshops, the Future Fellow magazine, social media outlets, and national advocacy thrive and will make sure they do so.

I am also looking to hold more social events so that we are able to have more networking opportunities, not only with peers and faculty of USC, but also with AGD members with fellowships and masterships. I believe that it is important for our students to understand the purpose and goals of the AGD outside of dental school. I believe that this will open the door for students to ask questions and find out more about what the AGD stands for so that we are continually looking towards our futures beyond dental school. ◆

*Fight On...!*

# University of California, Los Angeles

**KEARNY CHANG**
*Taipei, Taiwan*

In this past winter quarter, our chapter has worked closely with our mentor Dr. Sreenivas Koka to host several Lunch & Learns and a Veneer Workshop for UCLA. Dr. Koka, currently serving as our restorative chair at UCLA, is a well-known international speaker to many dental professionals, students and educators. His knowledge goes beyond academic dentistry to leadership and management of a dental practice. Dr. Koka has presented "Building an Effective Team—Lessons in Leadership" in three parts. His lectures are very thought-triggering to dental students. We were caused to think about potential challenges and issues in managing a dental practice and ethics in dentistry. He encourages students to think outside of the box when dealing with problems and to focus on what is truly important. There are many topics that were interesting. I will list a few takeaways:

"A fish rots from the head down"—bad leadership is the essential cause of business failure. A good practice should strive on having good management strategy and create a positive and open working environment."

"Always do your best"—if you do a really good job, your patient will tell at least one person. If you do a bad job, your patient will tell seven. It takes many good reviews to build up your reputation; just one single bad review can destroy it."

"The #1 thing patients care about in their dentist is confidence—You can do that by trying to showcase them all the successful treatments you have done in the past."

"There are studies that show that having dental offices charge a small late penalty fee can actually worsen the situation. It is because the patient now can pay off their guilt with a small fee. This shows that sometimes patient incentives are incompatible with money."

**Kearny Chang**, *President, AGD FellowTrack Student Chapter*

In April, our chapter has invited Dr. Shashikant Singhal from Ivoclar Vivadent to do a veneer workshop for our AGD members. We learned about different types of cement, when to use them and how they are different from each other. The members had the opportunity to cement their veneer and different types of indirect restorations. It was a very fun experience for everyone. We are planning to have even more workshop experiences for all our members next year.

As a dental student, we are limited to things that are taught in class. However, the AGD provided all of us with opportunity to learn outside of the classroom. From Dr. Koka, we learned about effective communicating and managing a dental practice. And from our veneer workshop, we are able to differentiate between types of cements and know when to use them.

The AGD provided us many invaluable lessons this quarter. We look forward to more. ◆

**VENEER WORKSHOP ARMAMENTARIA**

*Materials provided by Ivoclar Vivadent (various cements)*

**VENEER WORKSHOP ATTENDEES** *Event hosted by the AGD Student Chapter and Ivoclar with Dr. Singhai presenting*

**Joshua Sanchez**, DMD '19, *President, AGD FellowTrack Student Chapter at Western U*
**Jesse Toftely**, DMD '18, *Co-author, Senior at Western U*

**JOSHUA SANCHEZ**
*Hollister*

## INTERESTING CASE

# Cemento-Osseous Dysplasia

A 44-year-old African-American female presented to Western University of Health Sciences Dental Clinic for a comprehensive oral exam with a chief complaint of *"I need a crown in my upper left."* The patient had described health as "Good" and takes the following medications/supplements: Singulair 1xday (seasonal allergies), Vitamin C, Vitamin D, Cumin supplement, and a baby aspirin 1xday. The patient's medical history was only significant for hypertension managed without medications but otherwise uneventful with no known allergies to medications and an ASA Classification of 2. Extraoral and intraoral examination revealed no notable orofacial pathologies and no signs of swelling, trismus, pain or nervous deficits.

A panoramic radiograph *(Image 1)* was taken showing multiple mixed radioopacities in the maxilla and mandible.

A FMX was warranted. Upon examination of the radiographs the mixed radiolucency lesions were seen as cause for concern. Specifically, the lower anterior radiographs *(Image 2)* which shows multiple mixed density lesions spanning from the apices of #22 thru #27 with a radiolucent border of varying width surrounded by a band of sclerotic bone. Other locations: Mesial roots of #30 (not shown) and a band of about 3mm around root apices of #18 and #19 *(Image 3)*.

Endodontic testing was done on the dentition in question showing vitality in all teeth. It was also recommended by our endodontic faculty, Dr. Keith Boyer, to create a test prep by drilling a small hole into the occlusal surface to determine if the patient has a response to this stimuli. If the patient has sensation from the test prep then it would provide more evidence that the suspected tooth truly has cemento-osseous dysplasia (COD) and is not necrotic. Using both clinical evaluation and radiographic evidence it was determined that the patient did have COD which is not of neoplastic origin.

Diagnoses of COD is not entirely novel or rare, however, due to the less vascular nature of the disease, it is important to recognize this lesion and avoid biopsy as intervention may cause secondary infection of the cementum-like radioopacities, which may in turn induce osteomyelitis in these lesions. It is also important to interpret vitality testing correctly to prevent unwanted endodontic treatment.

Periodic follow-ups and maintaining excellent hygiene to avoid periodontal disease is important for this condition and saucerization of the dead bone may speed healing. ◆

References:
Eskandarloo A, Yousefi F. CBCT findings of periapical cemento osseous dysplasia: A case report. Imaging science in dentistry. 2013;43:215-218. DOI: 10.5624/isd.2013.43.3.215.
Chi, Angela, Brad Neville, Douglas Damm, Carl Allen. Oral and Maxillofacial pathology, 4th edition. Saunders, 052015.
Lavasani, S. (Dec, 2015) Intraoral Imaging interpretation

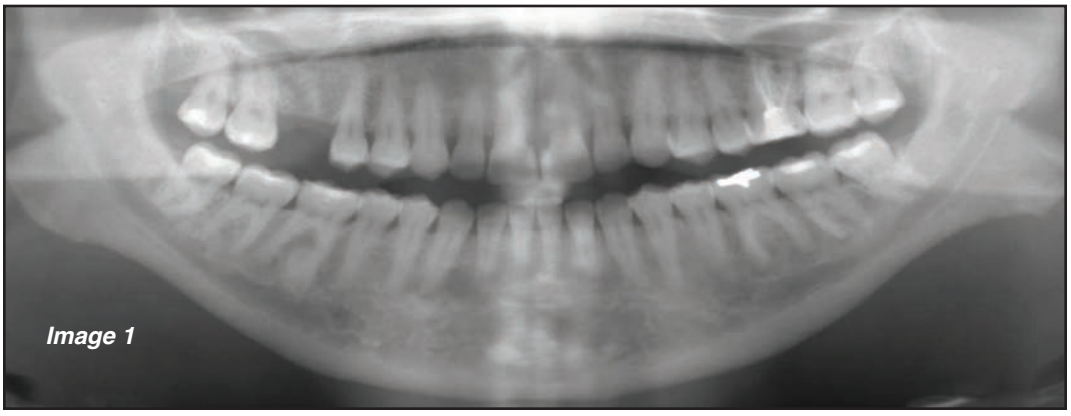


Image 1

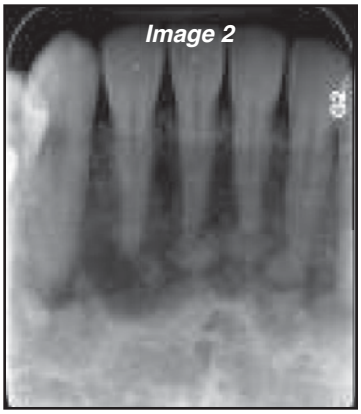


Image 2

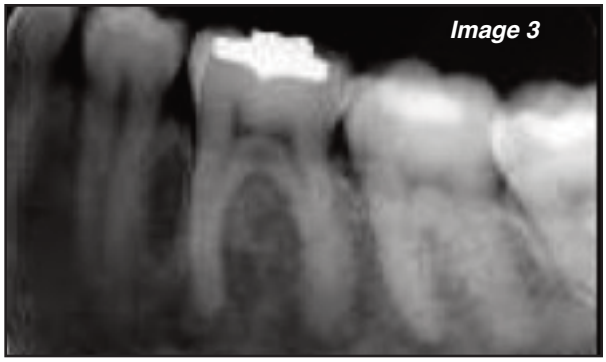


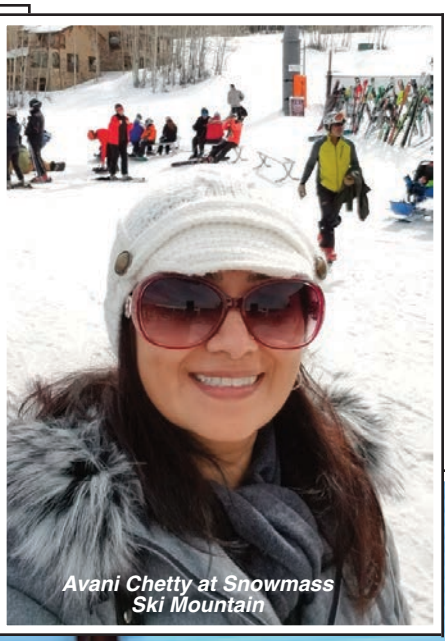
Image 3

ACADEMY of GENERAL DENTISTRY
Western University's FellowTrack Student Chapter

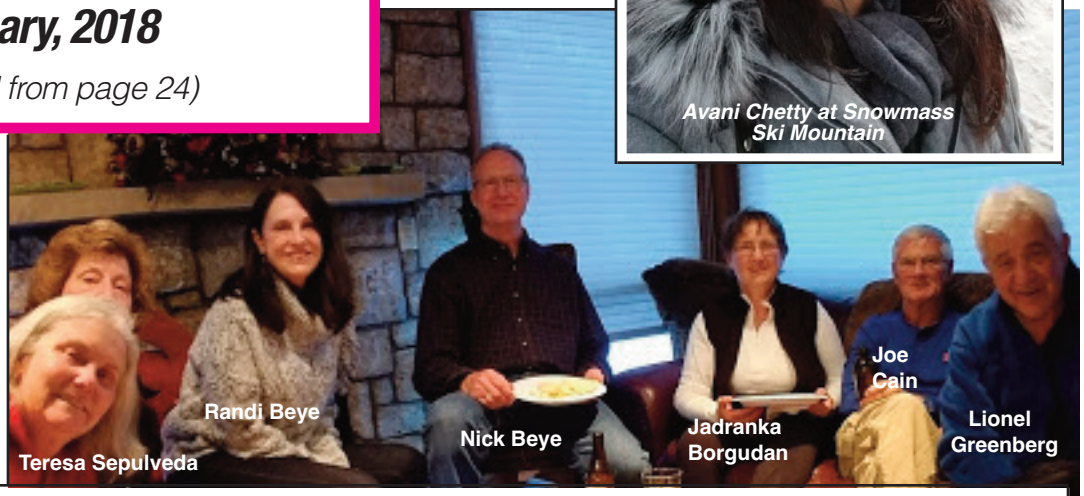

# SNOWMASS, COLORADO

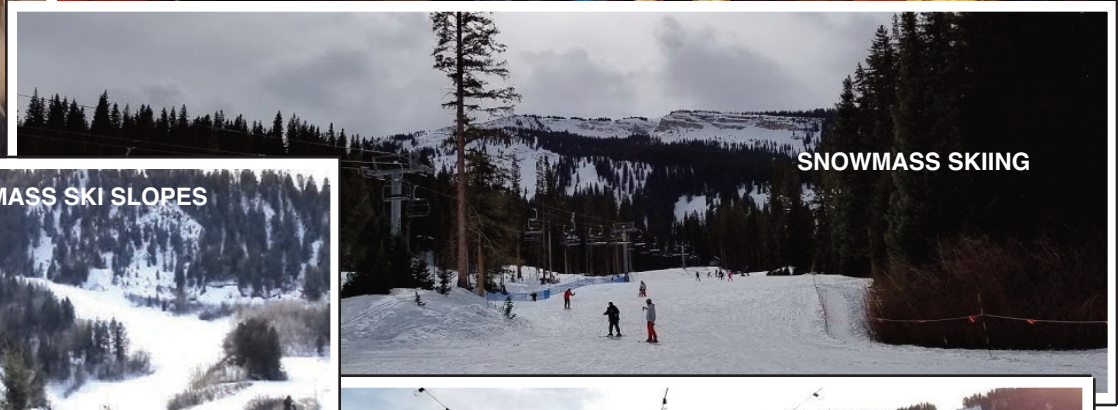
## February, 2018

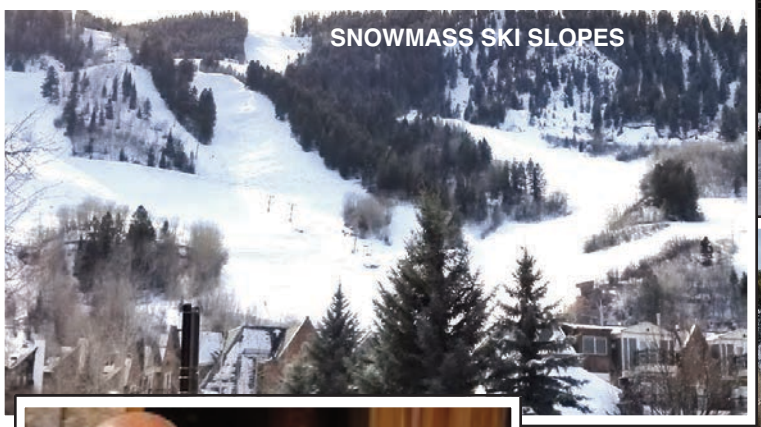
(continued from page 24)










# CALIFORNIA ACADEMY of GENERAL DENTISTRY

Post Office Box 22417, Sacramento, California 95822

Presorted Standard
U.S. POSTAGE
PAID
Fullerton, California
Permit No. 664

The Academy of General Dentistry is the premiere organization for the general practitioner.

For more information on AGD benefits and membership, visit our website at

www.AGD.org

The broader the base of our membership, the more effective is our representation on your behalf.