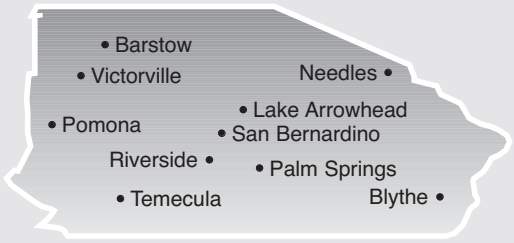
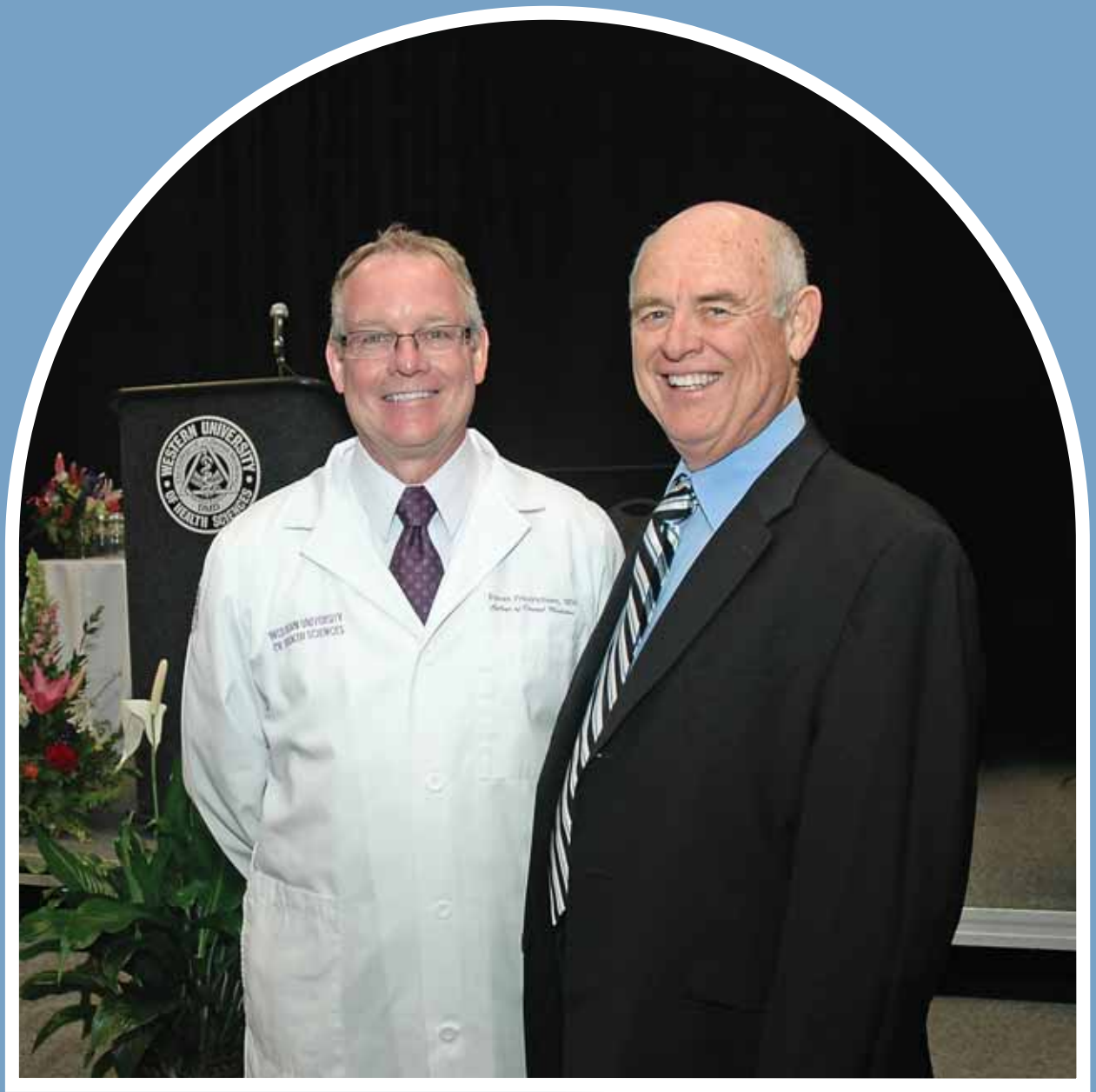


Tri-County Dental Society

BULLETIN

Representing the Dentists of the Inland Empire

SEP/OCT 2011 Volume 58 No 5



TCDS congratulates Western U's new Dean

TCDS Membership Status Report

Active/Recent	1,403
Life Active	77
Life Retired	143
Retired	35
Post Grad	44
Faculty	54
Disabled	13
Military/Public Health	6
Provisional	91
Hardship	12
Pending Applications	18
TOTAL	1,896

Toll-Free Numbers

ADA .....(800) 621-8099
CDA .....(800) 736-8702
Practice Support Center (866) 232-6362
Resource Center. . . . (800) CDA-SMILE *(232-7645)*
TDIC .....(800) 733-0634
TDIC Ins. Solutions ....(800) 733-0633
TCDS .....(800) 287-8237
Denti-Cal Referral. . . . . .(800) 322-6384

HMO Consumer Complaint
Hotline (800) 400-0815
State Dept. of Corporations
Consumer Services Division

In this Issue...

Mission Statement:

It is the mission of the TCDS to be the recognized source for serving the needs and issues of its members and the dental community.

Featured TCDS City

Colton

The banner photo features a last look at the Tri-County Dental Society office in Colton. On November 1, the Dental Society will relocate to 3993 Jurupa Avenue, Riverside.

Featured Cover Photo

Dr. Steven Friedrichsen (left in photo) was named dean of Western University of Health Sciences, College of Dental Medicine. He is pictured with TCDS President Dr. Dan Jenkins prior to the White Coat Ceremony for the incoming dental students at WesternU. For more about Dr. Friedrichsen, go to page ____.

Presidential Message...

Daniel N. Jenkins, DDS, FICD
AADE Certified Dental Editor

Summer

Summer can be a busy time for many of us with vacations, meetings, and just having fun in the sun. While TCDS does not usually hold meetings during the summer, there are many things going on that require attention.

The California Dental Association has held thirteen "Access to Care" meetings throughout the state this summer. Five Tri-County members attended the meeting in Orange County to hear what "access to care" will involve. The CDA Access to Care Report basically proposes a preventive dentistry program along with the education of the children in the schools to reduce tooth decay for the future generations. There are plans to increase the number of general practice residencies in California to provide more clinics for dental work for the lower income population. There is much more to this than I have mentioned here and I encourage each member to check it out at www.cda.org and become versed in it for your own edification.

On another note, the Tri-County Dental Society lease will expire the end of October and the office will be moving to Riverside in November of this year. Thus, there is a lot of planning going on for the new facility in design and cabinetry. It is hoped the new office will last us for many more years. A more modern and efficient board room to hold small CE meetings in with new technology is planned. The new facility will be in a more desirable location and will be housed with the Riverside County Medical Association, the San Bernardino County Medical Society and the California Hospital Association. An open house will be held once things have settled down after the move.

We are also working on a new website and by the time you read this it should be up and running. We have been having some "difficulties" with the current web master and the new site is promising to be more intuitive for our members and more informational for both our members and the public. This will give a better impression of TCDS to the public as well as a better impression of our profession of dentistry.

I asked TCDS President-Elect Ken Harrison to write an editorial for this issue to provide some information about his end-of-year TCDS party and installation of officers event. This should give you a chance to get more acquainted with Ken by reading his piece. I hope you do read it, but I hope even more so that you will come to the TCDS party on Thursday, December 1.

I also ask that if any of you feel that TCDS can do something for you, your practice, your profession or your life, feel free to contact any of the TCDS' staff or officers. These are difficult and stressful times. I know I speak for the staff and officers in stating that we are here to help all members in any way we can.

Now…with summer over…it is time for board meetings, House of Delegates, committee meetings, budgets, annual reports, and – oh yeah…the end of year party!

I wish you all success, prosperity, patience, patients, and peace!

Congratulations!

We have a winner! Dr. Paulette Newman, Rialto, responded to a survey request from ADA Insurance Plans and was lucky to win an Apple iPad2! She said she had forgotten about the random drawing. When she received a congratulatory e-mail, she thought it was a joke. But, days later the iPad 2 arrived. Congratulations!!

Kenneth T. Harrison, DDS

I'm just talking...

Tri-County Dental Society's (TCDS) esteemed President, Dan Jenkins, has directed me to write a guest editorial since, while wearing both hats of editor and president, Dan is probably feeling slightly over-exposed/overworked in the Bulletin. So, why ask me? Dan is giving me an opportunity to introduce myself to the members of TCDS. I have spent the first nine months of this year serving as TCDS President-Elect. In 2012, it will be my honor to serve for one year as your president. How in the world did that happen? Here's my story and I'm sticking to it.

While I have been a member of TCDS since 1975, I have only gotten off the couch to do TCDS volunteer work since 2004. Until then, I was perfectly content, as many of you are, to let others do the work and fight the battles on my behalf. My first position with Tri-County was as a delegate to the CDA House of Delegates (HOD). My interest in the HOD was actually born on the golf course in 2002 and 2003, listening to narratives of past HOD from my buddy, Butch Ehrler.

Hearing the history and drama from previous HOD debates helped ease the pain of my helplessly poor golf game. I quickly realized that I had no idea what was going on in Sacramento at the California Dental Association (CDA). Also, I had little or no knowledge of what our local dental society had been doing for me during the last 29 years, so I began to feel a combination of both guilt and being terribly out of touch. My complete lack of knowledge continued to gnaw at me until Butch began to tutor me regarding the political structure and everyday workings of both CDA and TCDS. He then set the famous Ehrler hook, "would you be willing to serve as a delegate for TCDS?" Since I knew that Butch had won several world championships in persuasive arm twisting, my answer was a quick "sure."

So, my adventures with TCDS began at the 2004 CDA HOD in San Diego. Bottom line regarding that first house, it was fast paced, full of spirited debate, highly entertaining and slightly overwhelming. But, I loved every minute of it! I was blessed to have been mentored throughout the 2004 and 2005 HOD by Butch, who taught me what was happening during the sessions. Then, between the sessions he introduced me to so many of California's dental volunteers, my head was spinning.

You will notice that whenever a dental volunteer is asked why they continue to volunteer and serve, the answer always seems to be," because of the great people that I get to work with." That answer might seem corny and over the top, but once you've "been there and done that," it does make sense. Organized dentistry does have some amazingly genuine and hard working people who volunteer at both the local and the state levels.

My TCDS path of held positions has now ambled along since 2004 from Delegate to Director to Vice-President to President- Elect and now next year TCDS President. In 2009, I was encouraged (pushed) by Penny Gage and Butch Ehrler to apply for a CDA position. I was fortunate to have been selected to serve on CDA's Judicial Council (JC) and am now completing my third year with the JC. I have applied to serve a second three-year term to begin next year. TCDS is the only CDA component of the 32 components that has 3 of our members on the Judicial Council. I am proud to be the TCDS junior member to Dr. Bob Kiger (now Chair of the Council) and Dr. Jeff Lloyd (TCDS Vice-President). Both Bob and Jeff were very helpful to me when I started my first term in 2009. My experience on the Judicial Council has included two years of serving on the MARS (Membership Application Review

Continued on the next page

Contact Your Dental Society Staff

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Give Kids A Smile/Community Health
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New Professionals Services
Dental Student Services
Website Assistance
Extension 22 – Shehara@tcds.org

I'm just talking.... (continued)

Subcommittee) and currently this year serving on the IP (Investigative Panel) Subcommittee.

Serving at the state level in Sacramento is extremely rewarding. If you have not had the experience of visiting the CDA building located at 1201 K Street in downtown Sacramento, you must put it on your calendar the next time you are in Northern California. You will be completely impressed and blown away with the building, the professionalism of the CDA volunteers and the warmth and helpfulness of CDA's entire staff.

The main point of this narrative is that even a dentist like me, with no experience, limited skills, who for 29 years let everyone else do the work at both the local and state levels, can still get involved just by being willing to donate some time, pay attention to what's going on around you, do some homework and ask a few questions. Personally, I would have never taken the time to call up and volunteer on my own, but fortunately I was asked to help out. TCDS needs you too! The next time you hear from me in this Bulletin (January 2012), I will be outlining several areas where you too can volunteer. But, if you're all fired up now and ready to get started, call TCDS and speak with Penny, Shehara or Monica and they will help you with additional information. Or, stay tuned until the January Bulletin.....because we have a job for you.

TCDS by-laws state that the President-Elect has the responsibility of chairing the Membership Committee. Dan has asked me to give you an update on the activities and vision of our 2011 membership committee. Shehara Gunasekera, Jeff Lloyd and I were privileged to attend the 2011 ADA Annual Conference on Membership, Recruitment and Retention in Chicago, March 31-April 2, 2011. The ADA holds this conference annually to assist all state societies and local components with their membership issues and to try and keep all three legs of our tripartite (ADA, CDA and TCDS) on the same page and working together toward a common goal.

The ADA has indentified three target groups that they believe require some special attention. 1) The ADA is concerned about the advancing age of a large proportion of its members. The concern is that when this group retires that the total market share of ADA membership will drop significantly. So, identifying and meeting the needs of young dentists is a priority. 2) The growing population of female dentists presents a new and unique set of needs. The ADA is attempting to understand and better adapt to the specific challenges that female dentists have in combining professional and family lifestyles. 3) There is a significant drop in membership market share of minority dentists. ADA membership percentages for market share for ADA Members December 31, 2010: All Dentists: 68.2% Women Dentists: 61.8% All Minorities: 53.6%

Here are some closer to home TCDS numbers as of December 31, 2010:

Age of Members	# of Members	% of TCDS Members
20-29	127	6.95
30-39	449	24.58
40-49	425	23.26
50-59	391	21.4
60-69	233	12.75
70+	175	9.58
Unknown age	27	1.48

Stages of Practice	# of Members	% of TCDS Members
Stage 1	365	19.98
Stage 2	291	15.93
Stage 3	585	32.02
Stage 4	586	32.07

Gender	# of Members	% of TCDS Members
Female	520	28.46
Male	1292	70.72
Unknown	15	0.82

Your 2011 TCDS Membership Committee is now attempting to: 1) Organize a Female Dentists' Sub-committee of membership. 2) Market to young dentists in cooperation with The New Dentists Committee's social activities. 3) Continue to study and appreciate the tremendous diversity and needs of TCDS' multi-cultural dentists. 4) And finally, in response to requests from several members, TCDS will bring back some social activities for our members.

Our first big social event will be an expansion of the traditional year-end party and installation of officers. This 'Cowboy Themed Party' will be held from 6-10 p.m. on Thursday, December 1, 2011, at Mill Creek Cattle Company in Mentone, CA. A new unbelievably low price of only $35.00 per person will get you a hearty cowboy buffet dinner, a souvenir photo of your party in their best cowboy duds, plus the live music of Audio Illusion for your listening and dancing pleasure. So, knock the dust off your boots, grab your cowboy hat and sign up early for this "sure to be sold out" event. My wife Jules and I are looking forward to meeting new faces at the party and I'll talk with y'all again in January.

Chicago… My kind of town. ADA… My kind of organization!

Joseph D. Jordan DDS

So, there I was – carefully navigating the corridors of Chicago O'Hare International Airport. It was the 15th of June, just minutes to midnight, I was alone, and I was exhilarated! I had never been to Chicago before and here I was—on a mission.

Soon I would be meeting up with Dr. Al Ochoa, and together we would be representing the new dentists from Tri-County. The mission was to spend the next three days engaged in networking, social events, and continuing education. Yes, we would be attending the 2011 ADA sponsored 25th New Dentist Conference in Chicago.

But, first things first. I needed to figure out the most prudent way to get to my hotel room located in downtown Chicago. Fortunately, with some guidance via mobile telephone, I found the public transportation system and for approximately $2.50, I spent the next 45 minutes zooming along the iron rails towards my final destination.

This was not only my first trip to The Windy City, but it was also my first New Dentist Conference. I had attended other dental conferences but none that focused exclusively on the new dentist (those who have been practicing their profession for 10 years or less). So, as I prepared for the first morning session, I wasn't sure what to expect.

Beginning at the sign-in table, I quickly realized I had stepped into an atmosphere devoted to creating a more personal experience – this despite the fact that apparently there would be around 325 new dentists in attendance. Regardless of the exact count, I simply did not feel like I was just another number walking around with my generic name tag that said, "Hello, my name is JOE THE DENTIST." No, I felt acknowledged and appreciated.

As the sessions went by, I was able to reconnect with some familiar faces and it was refreshing to be able to visit face to face (as opposed to internet assistance). Inevitably, these friendships were strengthened and new friendships commenced as we highlighted our recent joys and struggles.

As I hinted earlier, my impression was that the conference had been engineered from the perspective of strengthening our intrapersonal relationships. The value of social structure and its emphasis was evident and proved to reinforce the many discussions in which our own local new dentist committee has often engaged. Over and over again, similar ideas, thoughts, and impressions were expressed from all over the United States as new dentists everywhere echoed the same frustrations and excitement with respect to engaging the new dentist.

The emphasis on networking and social opportunities appears to clearly be the matrix for the further development of the new dentist. It is from a strong social and networking structure that the springboard to success for the new dentist resides. I do not believe there is a more effective substitute. And while it could be argued that this is nothing new, I would respectfully disagree. Taking into consideration a few variables such as the role of corporate dentistry, the never-ending and exponential advancement in technology, and the natural evolution of the younger generation(s) of dentists, I believe this is quite "new." The social magnitude and the social methods to gain and sustain connection have evolved dramatically and there is no indication of slowing down.

Having attended and survived the conference, I have a new and much improved understanding and appreciation for the role of organized dentistry. This was realized directly through the exposure at the New Dentist Conference in Chicago. With such current topics as the role of midlevel providers, corporate dentistry, and the influx of new dental schools, I believe organized dentistry to be vital to the continued blessings our shared occupation has historically enjoyed. Strength is in unity and numbers.

TCDS, thank you so much for the amazing opportunity to travel and represent. It will not be quickly forgotten. I am inspired and proud to be connected and I plan on staying connected to the organized dental community.

I am anxious to repeat the journey next year when the trek will be made to Washington D.C., and I can only hope and loudly encourage every new dentist to very seriously consider attending. Hope to see you there!

Western University appoints new College of Dental Medicine Dean

Western University of Health Sciences has named TCDS member, Steven W. Friedrichsen, DDS, the new Dean of the College of Dental Medicine.

"In his academic and professional qualifications, and in the way he interacts with students and staff, Steve Friedrichsen represents everything that makes Western University of Health Sciences the special place it is," said Ben Cohen, DO, provost and chief operating officer of WesternU. "I am extremely pleased to appoint him as Dean for the College of Dental Medicine, and am confident that the College's reputation and stature will only grow under his watch."

Dr. Friedrichsen joined WesternU as the Associate Dean of Patient Care and Clinical Curriculum in January 2010. He has served as interim dean since Feb. 1, 2011, after Founding Dean James Koelbl accepted a position with the University of New England.

"I am honored to continue my service to Western University of Health Sciences and the College of Dental Medicine," Dr. Friedrichsen said. "Western U is a unique academic environment, and the College of Dental Medicine plays a pivotal role in the University's vision for the future of health care education."

Prior to joining the College of Dental Medicine, Dr. Friedrichsen was Dean of Creighton University Medical Center School of Dentistry and Special Assistant to the University President for Healthcare Strategies. He also served for more than 20 years as Chairman, Department of Dental Sciences, and Director, Idaho Dental Education Program at Idaho State University. During that time, he concurrently held the position of Director, Idaho Advanced General Dentistry Residency Program for five years.

Students recite the Dentist's Pledge during the White Coat Ceremony for Western University of Health Sciences, College of Dental Medicine.

Dr. Friedrichsen has taught at Northwestern University Dental School, Idaho State University and Creighton University School of Dentistry on such topics as dental anatomy, occlusion, expanded function dental hygiene, dental literature review and preclinical and clinical restorative dentistry. He has published on a wide array of topics including Balancing Leadership and Management, Rural Behavioral Dental Health Care, Periodontal-Restorative Interactions, and a Socio-Economic Comparison of Prosthetic Patients in a Two-Tier Delivery System. He has also made numerous presentations to local, state and national conferences.

Dr. Friedrichsen maintained his own private practice in general dentistry for more than 25 years in both urban and rural settings.

"The Dean plays a vital role in moving the college forward and challenging students and faculty to excel," said WesternU President Philip Pumerantz, PhD. "We are proud of all of our Deans, and we know Dr. Friedrichsen will continue this tradition of excellence."

Tri-County Dental Society is proud to, again, have one of its esteemed members become the Dean of the Western University's College of Dental Medicine and wishes Dr. Friedrichsen continued success in his new position.

In Memoriam - *Lloyd Baum, DMD • 1923 - 2011*

When Lloyd Baum, DMD, died on July 25, 2011, he left an indelible impression on the Loma Linda University School of Dentistry community, where he spent a major portion of his professional career. His pioneering, innovative impact on the dental profession world-wide, however, was also unmistakable.

Born in Ashton, Idaho, on May 11, 1923, Dr. Baum pursued pre-dental studies at Walla Walla College, Washington, while enrolled in the Army Reserve. After completing dentistry at the University of Oregon in 1946 as one of its youngest alumni, Dr. Baum practiced briefly before serving on a flag ship in the South Pacific.

Learning in 1951 that plans for a dental school were underway at Loma Linda University, Dr. Baum agreed to pursue postgraduate education in restorative dentistry at the University of Michigan, to prepare for a faculty appointment. He spent a year on the faculty of the USC School of Dentistry before joining Loma Linda University's fledgling institution, becoming one of its earliest clinical faculty. For the next 20 years Dr. Baum was a key teaching clinician in the School, where he earned a reputation as a superb role model of clinical resourcefulness and clinical precision in restorative dentistry and fixed prosthodontics. In addition to Dr. Baum's full load of teaching responsibilities he also served at various times as a department chair, the director of clinics, and an assistant dean. Teaching was a natural fit for him. "I guess I kind of like to tell people what to do," he observed recently with a smile.

Many times during his LLUSD appointment Dr. Baum arrived at the clinic ready to try out an innovation developed in the early morning hours at his basement machine shop. He developed a gold mallet with Dr. William Outhwaite (SD'65). Later he would involve Dr. Outhwaite in making Goldent, a powdered gold, to be marketed as E-Z Gold. In 1958 he created a tungsten carbide drill driven by a single slot-car motor. Seeking to involve colleagues and students in his creative efforts, he developed along with a student, Virgil Lau (SD'60), what became known as the Loma Linda parallelometer to facilitate drill alignment. Clelan Ehrler (SD'68) and Lawrence Seifert (SD'68) shared in development of a slot-car motor-driven slow speed hand press. And the "Baum Carver" (interproximal carver) became the second most popular hand instrument used in dentistry.

An indefatigable researcher and academician, Dr. Baum authored six dental textbooks, which have been translated into several languages, and more than 100 articles in refereed scientific journals. In addition, he was a popular invited lecturer in more than 300 professional settings in the United States and other countries.

Becoming professor of restorative dentistry at The State University of New York at Stony Brooke in 1972, Dr. Baum played a key role for six years, organizing the restorative dentistry and fixed prosthodontics curriculum in the newly formed dental school on that campus. Before returning to Loma Linda, Dr. Baum spent a year as professor of restorative dentistry at the University Connecticut School of Dental Medicine.

Returning to the Loma Linda campus, Dr. Baum initiated the International Dentist Program, which accepted its first three students in 1985. Dr. Baum's leadership and influence enriched this program until he retired from full-time service in 1993. The program now has more than 400 alumni who have benefited from his foresight and capable direction.

Yet another emerging dental school received Dr. Baum's support when the University of Montemorelos in Mexico sought his consultation and supervision in developing a school of dentistry. The Dr. Lloyd Baum School of Dentistry opened at the University of Montemorelos in 2004. At the 2009 graduation of its first 20 dentists, Dr. Hector Navaro, dean of the Dr. Lloyd Baum School of Dentistry, pointed with appreciation to the bust of Dr. Baum at the entrance of the school's clinic. "Everyone on this campus knows about Dr. Baum's unrelenting efforts to see this school established," he noted. It is no surprise that students at the school have been introduced to a service learning component similar to that practiced at LLUSD, working in mobile and stationary clinics as well as in remote areas to provide treatment to the underserved.

Another chapter in his life sketch would describe Dr. Baum's participation in organizing and bringing to full operation the dental service at Sir Run Run Shaw Hospital in Hangzhou, China. Still another chapter would include his remarkable family, which also enjoyed the support and inspiration of their father and husband: Alma, his wife of 58 years, and Marti, a Loma Linda pediatrician; Brad, a Corona orthopedic surgeon; and seven grandchildren, all of whom have gathered joyfully and regularly for Friday night family interaction at the Baums' home in Loma Linda. "The walls would bulge with laughter," says Alma.

In recognition of his creativity, distinguished scholarship, and multiple achievements which have advanced the mission of Loma Linda University, The School of Dentistry honored Dr. Lloyd Baum, professor emeritus for his nearly six decades of illustrious service that has resonated through his profession. The school's Distinguished Research Award was announced at the conferring of degrees for the School of Dentistry in 2010.

A memorial service honoring Dr. Baum was held on August 7th in the Loma Linda University Church.

(Article courtesy of Loma Linda University, School of Dentistry.)

Policyholder Expectiation: Professional Liability v. Workers' Compensation

Taiba Solaiman • TDIC Risk Management Analyst

Professional Liability policyholders should expect excellent claims service from their carrier. For example, once a TDIC policyholder opens a claim under a professional liability line of coverage, an assigned claim representative acts as the policyholder's advocate by keeping him or her informed and engaged throughout the claim process.

On the other hand, Workers' Compensation insurance provides protection for injured employees. The carrier designates a claims examiner to investigate the claim made by the injured worker. The examiner must remain impartial throughout the investigation to determine the extent of the injury and provide benefits to the injured employee in accordance with state regulations.

"Workers' compensation laws provide money and medical benefits to an employee who has an injury as a result of an accident, injury or occupational disease on-the-job. Workers' compensation is designed to protect workers and their dependents against the hardships from injury or death arising out of the work environment. It is intended to benefit the employee and employer alike. The employee receives money (usually on a weekly or biweekly basis) and medical benefits in exchange for forfeiting the common law right to sue the employer. The employer benefits by receiving immunity from court actions against them by the employee in exchange for accepting liability that is limited and determined."

---www.workerscompensation.com

All states require employers to promptly report work related injuries. It is not at the discretion of the employer to determine whether or not an employee should receive a medical evaluation following an incident. Failure to report an injury is a violation of the workers' compensation regulations and can result in substantial penalties to the employer.

Most dental office workplace injuries result in medical treatment only and do not result in the employee taking time off from work. If the injury does require the employee to remain off the job, the workers' compensation claims examiner will request a copy of the employee's payroll information to calculate disability payments that may be due. The examiner also coordinates the employees' return to work. Be prepared to give the claims examiner a copy of the injured employee's job description. The treating physician advises the examiner about which regular job tasks the employee can perform and which tasks need modification. Check with your workers' compensation carrier for state-specific information.

While the professional liability policyholder participates in the decision making process on how a claim is handled, workers' compensation gives employers (policyholders) limited rights. They can obtain general information regarding the status of a claim such as the employee's anticipated return to work date and any necessary job modifications. Privacy laws do not allow specific medical information about the employee to be disclosed to the employer.

For more information or advice on workplace injuries, please call TDIC Insurance Solutions at 800.733.0633 option 1.

Financial Success in Hard Times

Lee J. Harris, DDS

In these trying economic times, many dentists are struggling to grow their practices. Dentists, like all other small business owners, face many challenges that they have either not experienced before or may be beyond their scope of expertise. Aside from the time and effort required to stay abreast of advances in clinical practice and technology, much time and effort is needed to gain the business skills needed to successfully manage and grow a profitable dental practice that fulfills the personal desires and aspirations of the practice owner. For new graduates as well as established practices, developing and maintaining an organizational structure that allows the dentist to maintain control of his or her future success is essential to productive and profitable practice growth. In the established dental practice, this can be particularly challenging.

The practice structure, internal controls, and other operating systems should be organized so as to reach the vision and goals of the owner. Additionally, managing human resources, the practice's greatest expense, requires leadership skills, team building and clear communications. One of the most critical components is effective communication to patients.

From the first call or contact with your practice, management of patient communications is essential to your success. Patients must feel that they are valued, that you are listening to their needs and concerns, and that you are trustworthy. Without the effective management of these elements, your case acceptance rates and productivity may be less than optimal. The case presentation process is particularly important. Every aspect of this process must be managed including: the space where this process happens, the person communicating with the patient, the visual tools available to your staff, and especially the process of gaining the patient's trust in you, your staff, your facilities, and the services you provide.

Dr. Lee Harris has a BA in Biology and a DDS from Temple University in Philadelphia. After sixteen years managing multi-location group practices in Pennsylvania, Dr. Harris worked in the dental benefits industry for fourteen years including eight years as Chief Dental Officer for PacifiCare. He is past President of the California Association of Dental Plans and Board Member of the National Association of Dental Plans. More recently, Dr. Harris was Executive Director for Wilshire Park Dental Group, an 18 chair multi-specialty group practice in Los Angeles for seven years. Currently, Dr. Harris serves as Dental Director at Sun Life Financial, practice management consultant to dental practices and as a dental expert witness.

(Dr. Harris' presentations are part of the TCDS Dental Deals in conjunction with the Warschaw Learning Institute. Check for Dental Deals in Tri-County's monthly e-newsletter, or call 888.822.0917, or go to www.WarschawLearningInstitute.com for more information. – Ed)

Unclassifieds

Be sure to visit Classified Ads on your personal web page at www.tcds.org.

Orthodontic Suite for Rent or Purchase. 1600 to 1950 sq. ft. Oceanside, Carlsbad area. Rent or Purchase. Contact Tom Aspel at taspel@cox.net or (760) 639-3842.

Going on Vacation and Need a Dentist Temporarily? Need a dentist to monitor your office while you are away? I am a 67 year-old retired Periodontist who practiced in Orange County. I can take care of emergencies and monitor the office, including the hygienists so they can function as usual. If interested, please contact me at (760) 565-1459 or cell: (714) 801-6880.

Coachella Valley Dental Office For Sale. Frontage road on Hwy 111. 4 ops, 3 equipped. General/endo. $65K. (760) 341-8441.

Board Certified Anesthesiologist…providing mobile anesthesia services for all dental procedures from general anesthesia to IV sedation. BLS, ACLS, PALS certified. Please call (206) 948-2468 or email 40winksanes@gmail.com for more information.

Office space available in Redlands on beautiful Brookside Avenue. 300(4 rooms)-2000((11 rooms) Sq/feet @ $2/ft includes utilities. Perfect for specialty dentist (orthodontist, oral surgeon) or dental lab looking to expand into the Inland Empire. Separate reception area, restrooms. Close to downtown, shopping, restaurants, bus, movie theaters. Contact Dr. James Patrick Caley at 909-798-5117 or nsczolgist@aol.com.

Periodontist Wanted. Position available in a beautiful group dental office in Las Vegas, NV and Dallas, TX. We are looking for a motivated and experienced periodontist to join our busy group general practice that has a strong emphasis on specialties. 1-2 days a month, state of the art offices, excellent compensation, flexible days. Would prefer more than one year of experience. For more information, please send resume to periodontal-providers@hotmail.com or call (818) 389-7288.

Dentists Wanted. Indio Surgery Center located at 46-900 Monroe St., Suite B-201, in Indio, CA, is available to dentists who are interested in treating their own patients under general anesthesia. Call Larry Church,DDS, or Diana Jesson, RN, at 760-396-5733 or e-mail d.jesson@indiosurgerycenter.com

CDA Holds Access Forums throughout California

Alvaro Ochoa, DDS, Chair
Council on Legislation

The California Dental Association held several forums this past month for its members to present the CDA Access to Care Report. A report that outlines a 2 year long effort to research and evaluate the access to dental care issue we face in our state and also nationwide. In the report, the recommendation is made for a 3 phase approach to improve access in the state of California.

The 3 phase approach includes the following recommendations:

Phase 1 – Establish state oral health leadership and optimize existing resources.

Phase 2 – Focus on prevention and early intervention for children

Phase 3 – Innovate the dental delivery system to expand capacity

Some key features of this report include the following recommendations:

- Developing and supporting expanded function dental assistants to work in dental public health settings
- Promoting the expansion of dental care in public health clinics to utilize and contract with private dental providers
- Continue promotion of Community Water Fluoridation
- Advocate for a scientifically rigorous study to answer questions regarding the safety, quality and cost effectiveness of having a mid-level provider added to the workforce.
- Support a one year post graduate residency requirement for California dental licensure.
- Support the augmentation of rates for both commercial benefit plans and also Medicaid rates.

Many other recommendations are included in the full report. To view the report, visit www.cda.org and click on "Access Report and Recommendations" or enter http://cda.org/advocacy_&_the_law/access_to_care/forums/access_report into your web browser (your member name and password is required).

Dental Board Amends Code of Regulations

The Dental Board of California, Department of Consumer Affairs has recently amended the Code of Regulations (Title 16, Division 10, Section 1005, Article 1) with numerous changes one of which includes the new requirement that facemasks be changed in between each patient regardless of soil or contamination. Section (4) under "Personal Protective Equipment" reads "After each patient treatment, masks shall be changed and disposed".

The previous regulation stated "After each patient and during patient treatment if applicable, masks shall be changed if moist or contaminated."

Also included in the amendment is a new requirement that "Puncture Resistant Utility Gloves" be worn when handling hazardous chemicals.

To view the specific changes made in the new amendment visit http://www.dbc.ca.gov/formspubs/1005plang.pdf

CDA Compass Tip

Download The Treatment Coordinator - Who, What, When, Where, Why and How? and The Treatment Coordinator Flow Sheet and Scripts Checklist at www.compass.com for sample responses to assist the treatment coordinator with common patient questions.

Checkout CDA Compass resources to help your office fine-tune the new patient process.

- The New Patient Process, Part One
- The New Patient Process Checklist
- Case Acceptance Tracking and Follow-up


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Short Abstracts

At the 2011 CDA House of Delegates, a proposed list of guidelines for dentists to be involved in treating sleep disorders (Dental Sleep Medicine) will be proposed to the delegates. It would be a good idea for all TCDS dentists to become more educated concerning sleep disorders. Check out these statistics!

Sleep Study Survey

SLEEP 2011: Associated Professional Sleep Societies 25th Annual Meeting: Abstract 0975. Presented June 15, 2011, Jon-Erik Holty, MD

National Health and Nutrition Examination Survey (NHANES) is a nationally representative, cross-sectional survey of health and nutrition conducted annually and including approximately 5000 English- and Spanish-speaking adults and children.

The primary purpose of NHANES is to estimate the prevalence and risk factors of major disease within the United States, he explained. Beginning in 2005, 25 questions related to sleep habits, complaints, and disorders and 10 questions on healthcare utilization were added. The researchers analyzed responses from 2183 non-institutionalized adult respondents (mean age, 46 years; 51% female) with a mean body mass index of 28. Most reported their health as "excellent," "very good," or "good."

Almost everyone (99%) reported at least 1 sleep complaint, with a mean of 4.2 complaints per respondent. Specifically, 56% reported feeling unrested despite adequate hours of sleep, 54% reported not getting enough sleep, 45% reported snoring, 45% reported excessive daytime sleepiness, 37% reported trouble falling asleep, and 12% reported nocturnal gasping or witnessed apnea.

Although 1% had clinically diagnosed insomnia, 37% had possible insomnia. Similarly, although 4.6% had clinically diagnosed sleep apnea, 33% had possible sleep apnea. Only 24% of respondents had reported their sleep complaints to their physician or healthcare provider, yet these sleep complaints were directly linked to an increased rate of healthcare visits in the last year.

Compared with good sleepers, people who have trouble sleeping were more likely to have had a healthcare visit within the past year (85% vs 59%), more likely to have been hospitalized (16% vs 8%), more likely to have had one or more mental healthcare visits (20% vs 5%), and more likely to have missed 6 or more days of work (14% vs 7%), Dr. Holty announced.

After adjusting for known risk factors for sleep problems, multivariate analysis showed that people who have trouble with sleep had an odds ratios (OR) of 3.1 for having more than 1 annual healthcare visit, an OR of 2.8 for hospitalization, an OR of 4.9 for a mental health visit, and an OR of 2.4 for missing 6 or more days of work.

The mean number of hours of sleep reported by respondents was 6.9 per night, with 5% reporting less than 5 hours per night. In addition, 15% reported the use of sleeping pills 2 or more times per month.

Respondents with less than 5 or more than 9 hours of sleep per night had the highest rates of healthcare utilization.

Those reporting trouble sleeping were also more likely to have cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, or hypertension.

Hot Shorts

Are you an orthodontist? You could be a part of an office-based intervention designed to increase physical activity, reduce sedentary practices and promote healthy diets, or to reduce tobacco initiation and exposure among preteens. **"Healthy Smiles: An Orthodontist Program"** is a scientific study funded by the National Institutes of Health testing some simple ways health care providers can expand the range of health protective services they provide their pre-teen and teen patients. This San Diego State University study is currently in 15 San Diego offices. The program is now looking to expand into Riverside and Orange Counties. Click here or contact the program at 858-505-4770, ext. 151, to learn more.

Fourth Annual CDA Dental Motorcycle Ride, June 7-10, 2012. Plan now to explore the San Jacinto and San Bernardino Mountains. The weekend will combine riding through some beautiful and interesting scenery, fellowship with your fellow dentists, great food and top-notch CE provided by Dr. Lane Thompson. Accommodations will be at the Highland Springs Resort in Cherry Valley. For more information go to https://sites.google.com/site/dentistrides/ or call Tri-County Dental Society, (909) 370-2112, for to receive an informational flyer/registration form.

Case Acceptance is a Team "Sport"

Debra Quarles
Innovative Practice Solutions

Not an Individual "Event"

This is Part 4 of a series of six articles designed to get your practice working efficiently and effectively in 2011. The following tips will help you maximize every patient encounter.

Case acceptance starts the moment a patient enters your practice. It is your job to make them feel comfortable. Many of you might think this is about bottles of water, coffee or cushy seats, but really, the best way to make your patient comfortable is by assessing their communication style and using it to give them the information they truly need to make a decision.

There are basically four different communication styles. In determining their style, first ask yourself how do they speak? Then determine whether they are asking questions or just listening. Once you have this information you are ready.

People who:
Speak: Loud and Fast & Ask Questions

They want to know:
Time, Money & End Result

You should be:
Direct

People who:
Speak: Loud and Fast & Listen

They want to know:
How will it look?

You should be:
Enthusiastic

People who:
Speak Soft and Slow & Ask a lot of Questions

They want to know:
Will the treatment affect function?

You should be:
Thorough

People who:
Speak Soft and Slow & Listen

They want to know:
Will the treatment hurt?

You should be:
Comforting

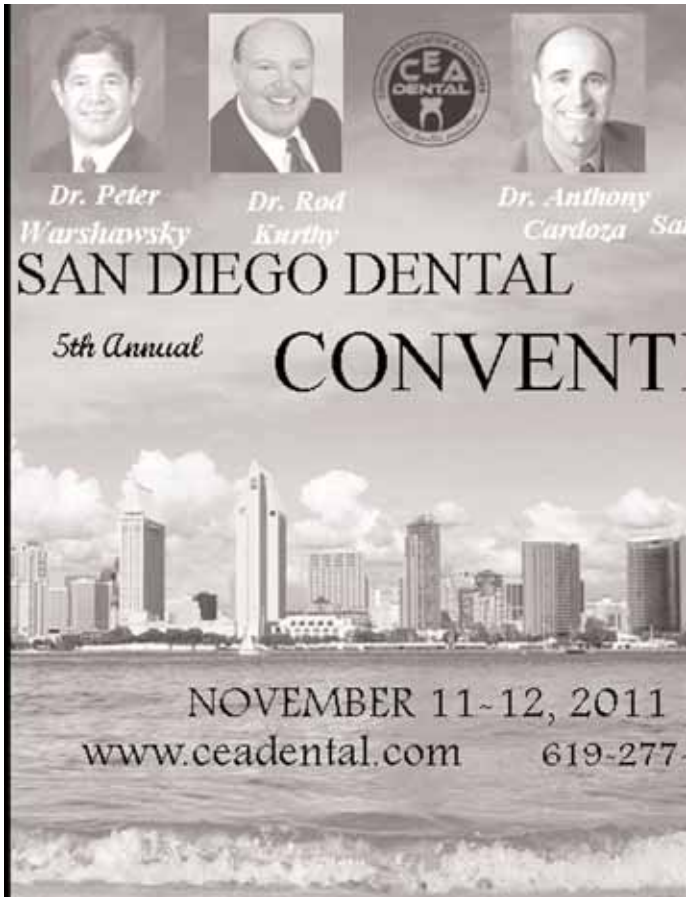
Understanding a patient's communication style and mirroring it while providing the information most desired, creates an atmosphere of trust and a feeling of being understood. It is a great place to start, but there's more that can be done.

Each member of your team has a specific role when it comes to case acceptance.

Hygienists and assistants should provide comfort, warmth, and give information. While they cannot diagnose, they certainly can educate. Providing them with standard questions that can be asked of every patient will help them find topics they can discuss prior to the doctor's exam. For example, "Are you experiencing any sensitivity anywhere in your mouth when you eat something hard or crunchy like nuts or steak?" Or, "What about the color, shape or alignment of your teeth would you like to change?" These questions can lead to conversations about what might be recommended or what types of treatment the practice offers. All of which can then be tailored to a patient's communication style.

Instead of having a private conversation where the doctor and assistant or hygienist discuss what the patient has said, have the conversation in front of the patient involving them in the process. "Mr. Gonzales, you were telling me you are having pain when you chew on the right side. We discussed how sometimes that can mean a tooth may be fracturing. We also discussed that doctor

Continued on the next page



might recommend a filling or it might need a covering of some sort, like a crown." Speak to the patient and allow the doctor to overhear. This transfers the information, and if the assistant misses something important the patient will know and supply the additional information.

You may have noticed in my example above, that urgency words were used. Words such as fracturing, decaying, cracking and breaking. Keep in mind: Hoover Dam is cracked and leaks. It sounds as though the process is mostly complete. Or, you could say Hoover Dam is cracking and leaking. Doesn't it sound like someone should do something quick?

It is interesting that when most dentists do a periodontal exam they start out letting the patient know they will hear some numbers – "1-3 is healthy, but if you hear 4's or higher it means that is an area of concern." By the time the periodontal exam is completed and the patient has heard 4's, 5's or 6's, they are asking you what can be done. So why is the clinical exam handled differently? "Tooth number 3, broken cusp, crown." Diagnosis complete. But what did the patient hear? They heard MONEY!

Patients must own the problem for a while before you suggest a solution. So instead move through the mouth. "Upper first molar, decaying." Or "Number 3 MOD decaying." Then move on. When you've completed the arch, or quadrant, if there is significant decay, sit the patient up. The patient now has had some time to own their problem. "I see you have some things going on in your mouth. May I get your permission to tell you everything I see and to give you my best recommendation?" With their permission, you are able to do a comprehensive exam – one that will be well received by the patient.

Now is when the treatment coordinator enters the picture. First things first, I'm a fan of doctors giving round numbers and ranges only, when asked about cost. "It will be somewhere between 500 and a thousand dollars. The treatment coordinator will let you know the full details." Or, you can just leave it all to be discussed by your financial person.

When the financial coordinator enters the room, the first question should be, "Do you have any questions regarding the treatment that Doctor has recommended?"

If so, the doctor or assistant isn't finished yet. Just like doctors and assistants shouldn't discuss money too much, financial people shouldn't discuss treatment too much, mainly because they were probably not present for the exam. This means they may not know why a particular treatment is being recommended. For great case acceptance, the message the patient needs to hear, must be consistent.

Keep in mind, patients generally want to know the cost of the total treatment, not each individual procedure. So the dialog might go something like this, "Doctor has recommended 2 crowns, 3 fillings and a cleaning. Your total investment is $3,300." There is no real need to tell the patient tooth numbers or areas of the mouth. Discuss the treatment recommendations by grouping and list from most expensive to least expensive. Fine clothing stores use this technique. They show you the most expensive item first and then recommend the lesser priced accessories to go with it, knowing you'll buy more items that way.

What we need to focus on is a total investment of $3300 and how we can help our patient proceed with treatment. If insurance is involved ,a simple statement letting them know "we will maximize your benefits" is enough. Now stop. If they say, "That's a lot of money." Agree. "You're right. It is an investment in your health." Let the patient control the conversation and just ask questions. They ask, "Can I make payments?" We ask, "What kind of payments are you interested in?" Too many times we assume this means monthly payments, but it could just as easily be two payments, one today and the next when treatment is started. When a patient says they can only pay fifty dollars today, it doesn't mean they can't have the full balance to you by the end of the week. Don't assume; ask questions until you know exactly what the patient wants. Once the patient has told you what they want to do and when, repeat it back to them while nodding your head. "So, if we could do something where you could pay $500 today and then make payments each month of $100, that would work for you? Let me get an application for our financial plan and let's see if we can get you approved."

Finally, keep in mind the "rule of four." Patients should ideally hear the recommendation four times before they leave your office. Put all of the advice together and you have the secret to improving your case acceptance and making the most of every encounter.

Look for our next article where we will help you create an unforgettable new patient experience. We will outline skills that will turn your new patients into your best referral sources.

Debbie Quarles is a dental practice consultant with Innovative Practice Solutions. If you wish to contact her about this article or desire more information, you may contact her at info@ipsdentist.com or go to the IPS facebook page at:
https://www.facebook.com/InnovativePracticeSolutions

Mid-level Providers = Low-Level Care …

Guy G. Giacopuzzi, III DDS

… and a little difference in cost

If you haven't noticed the current dental political rage in the last year, you're sticking your head in the sand. It's a new variation of the old "access to care" theme: Mid-level providers. It's the latest variant of an old movement.

In the late seventies and early eighties, the government tried hard to lower the price of dental care by simply increasing the number of dentists. Because of a total misunderstanding of the nature of dentistry and dental care (more on this later), this resulted in a glut of dentists and inadvertently accelerated (or gave birth to, possibly) esthetic dentistry. This was not exactly what the government wanted, as it created even more demand.

Instead of "I have a right to not have dental pain," it became, "I have a right to a nice smile." Dentistry, as a profession had to clean up the mess by decreasing class size, closing some dental schools, and otherwise downsizing the educational machine back to reason. It is curious to observe, however, that increased numbers of dentists did nothing to decrease fee structures or lower the cost of dentistry. The cost of dentistry continued on as normal....and you can read "normal" as expensive.

Soon after this, the call was for "expanded function …" You can fill in the blank. The idea was if we had assistants and hygienists filling teeth, dentists would become more "efficient" and the net would be lower costs to the consumer. This, too, failed on several counts.

Now, we have the latest incarnation from the cost lowering gurus: mid-level providers. Spurred on by supposed successes in New Zealand and Alaska, enter the "dental nurse," "dental therapist," or "mid-level provider" (MLP). Here we have a quasi-dental-"operator" that can take x-ray images, diagnose decay, extract teeth, fill teeth, construct dentures and partials, and again, you can fill in the blank as to whatever the legislator happens to put into the bill.

The history of the MLP is a bit interesting and important to our discussion. Alaska, especially southeast Alaska, has long had a problem of providing dental care to its native population. Since the intrusion of the always-evil-white-man, it seems these natives have had a major problem with dental health, especially decay. State dental staff positions have gone unfilled, and well, the natives just suffered.

Our government to the rescue? Yes, in the form of the "dental therapist." The original few were trained in New Zealand, subsequent practitioners have been trained in programs in Anchorage and Bethel; you only need a high school diploma to get in. (Yes, this really makes me worry–our hygienists are way better trained than these!)

The Kellogg Foundation (Yes, they have an agenda.) did a study, and guess what? The MLPs look like they're doing a great job! (Yes, all five in the study.) Naturally, the ADA and AGD have come out with statements not exactly supportive of this endeavor, from a quality of care standpoint.

It should also be noted that Alaska, per se, is not exactly an ideal model for MLPs, with its remoteness, etc., and any extrapolation to the rest of the country should be highly suspect. In spite of this, Kellogg is funding a number of other MLP projects in the lower 48. But, once again, the originators of the MLP concept are totally blind to the nature of dentistry, and its history. Let's take a moment and look at these.

The most obvious blind spot lies in the very nature of dentistry as a profession. We are, by definition, an outpatient surgical service. And surgery costs more than diagnostics. This is what makes us so different than any model in medicine, and makes comparisons with existing medical models all but impossible. You cannot draw parallels with nurse practitioners, physician assistants and other medical "mid-level" providers because they are not surgically based. Most of what they do is diagnose. Most of what we do is hands on, technically based, surgical treatment. (Remember, cutting tooth structure is surgery.) Big difference. And, this point is easy to prove. And there's a problem associated with this—the problem of cost.

The "independent hygiene" movement didn't work. It didn't work because of costs. Independent hygienists discovered that they needed more than just a set of scalers to provide care. They needed dental chairs, dental lights, compressors, vacuums, autoclaves, etcetera—virtually the same equipment that a dentist needed. And it doesn't cost any less because you have an RDH behind your name instead of a DDS. Not to mention a location with a lease and a monthly rent. And they were doing a procedure that typically commanded less than $100/hour. It didn't pencil out on the bottom line.

Another "proof" of the high cost of dentistry is the experience of the typical HMO/discount dental plan practice. As every dentist who participates in one of these knows, if you're not doing "upgrades" or significant cost shifting, you can't begin to make one of these plans profitable. Simply, the cost of providing the service exceeds what you're being paid.

Which brings us to an interesting, yet sobering reality: Dentistry, by its very nature, is expensive. Even if you cut out the dentist and his/her remuneration, it's still

expensive. Got that? It's expensive even if you don't get paid! We, as dentists, are often blind to just how expensive it really is.

The next time you quote a $10,000 treatment plan that a patient "can't possibly afford," just for the fun of it, ask if they can afford $7500—the actual cost of the service, less your profit. You'll probably get the same response. But look at what it takes to do an average resin filling these days—you have a handpiece, now with ceramic bearings and fiberoptics with bulbs that can burn out. You made the diagnosis with a rather pricey CMOS digital sensor, on which you shined x-rays, from an x-ray tube you have to pay a fee to the state for, just to have it in your office. You have a set of hand instruments that go thru an autoclave that's checked every week for its effectiveness, operated by an assistant with CPR training, who you pay payroll taxes on, in addition to her salary. She has hepatitis B antibodies running in her bloodstream because of a vaccine that you paid for, mandated by the state.

The patient sits in a dental chair that's been scrubbed with antimicrobial chemicals to prevent cross contamination...the chemicals deteriorate the vinyl, which you replace every couple of years. And the dental upholstery company actually has the nerve to charge you to recover the chair. I haven't even started to describe the rest of the office, the rest of the equipment, the rent, the government fees for needle disposal, ad infinitum. Dentistry, not necessarily dentists, is expensive.

This makes the whole idea of the mid-level provider a bit of a joke and a fantasy. Creating a provider that works for say, $65,000/year will do nothing if he/she is still having to deal with the same equipment, supplies, support employee costs, etc, that we as dentists have to deal with.

Dentistry has always been expensive. One only has to look at the history of modern dental care to see this. I happen to belong to the American Academy for the History of Dentistry (yes, there really is one, and we even have a journal! See www.histden.org). If we assume that modern dentistry had its birth around 1875 or so—when dental care beyond exodontia was provided on a regular basis—it's easy to see that one had to have some financial means to afford fillings, dentures, and bridges, even long ago. We know what fees were in those days; once you compare the fees with typical incomes of the time, it's easy to see that the cost of dental care, as a percentage of income, isn't any different than today.

So what will be the result if "mid-levels" come into reality? The first thing the politicians might notice is the cost doesn't go down, for the aforementioned reasons. But if they demand lower costs, the only way to lower costs is to lower the quality of care. Doing fewer fillings is certainly cheaper than doing the required number. Performing pulpotomies is cheaper than doing root canal treatments. Having crown lab work done in Asia is always cheaper than domestic.

Dentists are already somewhat guilty of under-diagnosing; giving the job to an auxiliary will probably make the diagnostic depth and numbers even less given that the mid-level will certainly have less training in perio and occlusion. And, as if the state boards didn't have enough to do with illegal practice, think of the policing problems associated with an auxiliary that starts adding "dentist-only" procedures to the list of legal ones. Oh yeah, tell me that won't happen. And, what if we have quality of care issues that have to be re-treated by "real" dentists? Now, do we really want to do this?

The "access to care" flag has been waving in our face for years now. This author has previously written exhaustively about the supposed "right to health care." Justifying such a right is no easier than justifying a right to auto repair or housing. Yet the socialist-progressive cry for such a right drags on with a constant din, hoping to wear us out.

It's interesting that the same government that gives us more and more costly regulations is now trying to lower costs with the introduction of the mid-level concept. You'd think that they would recognize that they've helped create the problem. No, wait, that would take some common sense. Government? Common sense? Now I'm fantasizing.

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[1] I'm using a 25% profit margin, which, as of 9/10, is considered to be a reliable national average.

TROUBLE with ADDICTION?

Alcoholism and drug addiction can touch any of us.

The Well Being Committee is an organization of dental professionals who can give CONFIDENTIAL ASSISTANCE to members of the profession, their spouses and staff members. Information, help and/or support is available at the numbers below.

Southern California Well Being Committee
(818) 437-3204 or (310) 406-6319

Tri-County Dental Society Well Being Committee
(951) 203-0505

What's Happening?

Day/Date	Event Details
Mon. Sept. 5	**Labor Day** TCDS Office Closed
Thurs. Sept. 8	**New Dentist Seminar** TCDS Office Registration, 6:30 p.m. Lecture, 7-9 p.m. "How to Market for Success Online" Lance McCollough, Prosites, Inc.
Mon. Sept. 12	**GKAS Committee Meeting** TCDS Office, 6:30 p.m.
Tues. Sept. 13	**Board of Directors Meeting** TCDS Office, 6:30 p.m.
Thurs. Sept. 15	**Continuing Education Meeting** TCDS Board Room Social Hour: 5:30-6:30 p.m. Lecture: 6:30-8:30 p.m. "What You Need To Know About Dental Trauma" Leif Bakland, DDS "Planning Successful Outcomes for Dental Implant Surgery" Jaime Lozada, DDS
Sept. 22-24	**CDA Presents** San Francisco
Thurs. Oct. 6	**New Dentist Seminar** TCDS Office Registration, 6:30 p.m. Lecture, 7-9 p.m. "How to Assess Associateship Contracts" Robyn Thomason, CDA
Oct. 10-13	**ADA Annual Meeting** Las Vegas
Thurs. Oct. 20	**New Dentist Mixer** Place to be announced
Mon. Nov. 7	**New Dentist Study Club** TCDS Office, 6:30 p.m.
Tues. Nov. 8	**Board of Directors Meeting** TCDS Office, 6:00 p.m.
Tues. Nov. 8	**TCDS Caucus** TCDS Office, 7:00 p.m.
Nov. 11-13	**CDA House of Delegates** Sacramento

Dental Dote

Re-Cycled Floss?

Well, I thought I had heard every excuse in the world of why my patients don't floss. "I don't have any!" "I don't have the time!" "My gums have always bled!" But today was a first.

My patient told me floss was bad for the environment and that they should make reusable floss. I told her there are some things you just don't want to reuse and I was going to give her some examples. Then, I thought about it and she probably does reuse those things and I didn't want to know about it.

So, until they make reusable floss, she said she is not flossing!

Can you say IMPLANTS?

Tri-County Dental Society
BULLETIN
Representing the Dentists of the Inland Empire

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Say What? Members attending the June New Dentist Mixer at Black Angus Restaurant in San Bernardino were asked "What is the wisest advice anyone ever gave you about practicing dentistry?"

Brinda Kansagra, Diamond Bar, "It's more than just the mouth."

Lalisa Yaowarattana, Grand Terrace, "Don't tell them your root canal is pain free."

Michael Murray, Oral & Maxillofacial Surgery Resident, LLU/SD, "Find something that you like and dedicate yourself to that endeavor."

Norma Lantzch, Riverside, "Go to bed at peace knowing you did your best and treated people with dignity, love, and overall, that you cared."

Patrick Hachee, Redlands, "Know my limits."