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HIGHER LIMITS OPTION NOW AVAILABLE

As mentioned in the October 2017 PIE Newsletter, some insured dentists have asked about the availability of higher limits at $2 million per claim, as some federal entities they work for, etc. are starting to require these limits or they do procedures in the hospital and are being pressured to increase their limits. Although our current $1 million limits which have been in place for nearly twenty years are more than adequate for Utah, effective January 1, 2017 we can now offer these higher $2 million limits at renewal time for any of you that need them.

The higher limits have been approved by the Utah Insurance Department and the premium will be $250 more than the existing premium for the $1 million limits. Semiannual and quarterly payments options will also be applicable for the higher limits.

To implement the new limits, you will simply need to mention your desire to your PIE agent, Lisa for those of you with last names from A-L and Maralee for those of you with last names from M-Z.
--RCE

ARE YOU HARBORING ILLEGAL DENTISTRY IN YOUR OFFICE?

Recently Delaware officials suspended Grace Liu, DDS, of The Smile Place in Smyrna, Delaware for at least sixty days, according to Delaware Online.

Could something like this happen in Utah? Occasionally I have had telephone calls from concerned offices where they have observed unusual and/or questionable events happening in adjoining offices, etc. Following are some details from the Delaware article. Are any of these things happening in your office or in your building?

1. Dr. Liu was accused of hiring untrained and unlicensed personnel to perform fillings in children's teeth and to administer nitrous oxide to children.

2. Her license suspension followed previous charges of six counts of endangering the welfare of a child and one count of healthcare fraud. Between March and September, Dr. Liu allowed her untrained staff to administer nitrous oxide to three patients.

3. After the initial charges, Dr. Liu was instructed to remove the untrained staff. However, in November state records found the dentist had still allowed an unlicensed staff member to administer nitrous oxide to an underage patient.

Do you all know the laws in Utah that pertain to who performs dentistry and who can administer nitrous oxide? Let's review a few basics with commentary:

1. The dentist has to establish a baseline on nitrous oxide administration to any patient who receives it in the office for the first time. The flow rate and percentage must be documented in the chart. The dentist must always be in the office while nitrous oxide is being administered and must establish the baseline. The Practice Rules for Utah, R156-69-502 state that "Unprofessional Conduct" includes the following: (1) failing to provide continuous in-operatory observation by a trained dental patient care staff member for any patient under nitrous oxide administration. This means that someone, either the dentist, a hygienist or a trained assistant must stay in the operatory at all times that a patient is under nitrous oxide administration, including the oxygen flush. No exceptions!

2. (2) A dentist with a class II permit: (a) may administer or supervise the administration of nitrous oxide induced conscious sedation in addition to the privileges granted to one holding a Class I permit; and (b) shall ensure that: (i) every patient under nitrous oxide administration is under continuous in-operatory observation by a member of the dental patient care staff; (ii) nitrous oxide and oxygen flow rates and sedation duration and clearing times are appropriately documented in patient records; (iii) reasonable and prudent controls are in place and followed in regard to nitrous oxide to ensure the health

and safety of patients, dental office personnel, and the general public; (iv) the dental facility is equipped with adequate and appropriate equipment, in good working order, to assess vital signs; and (v) equipment used in the administration of nitrous oxide has a scavenging system and that all gas delivery units have an oxygen fail-safe system.

3. Once a baseline is established, dental hygienists can induce nitrous oxide as long as the dentist is on premises, in the office. Although the hygienists can legally see recall patients when the dentist is away, as long as a dentist is available for consultation if necessary, they cannot induce N2O or give local anesthetics unless a dentist is ON SITE in the office, not just next door in another office.

4. Can dental assistants induce nitrous oxide? Utah rules are vague but to be on the safe side the dentist should induce the N2O and then an assistant can stay with the patient until they are ready for local anesthesia or other procedure. If the dentist is not in the office for the first morning appointment, for example, and the patient is seated in the operatory and tempts the assistants to start the nitrous oxide, they should inform the patient that such action is illegal and they will have to wait. It gets interesting if the patient exclaims that in their old office the assistants did that all the time without the dentist being there! Tell the patients that you practice to a higher and safer standard, and if this practice happens in your office, cease and desist!

5. I hear stories about dentists allowing dental assistants to give local anesthetics, place composite resin fillings, even do root canals on relatives on Saturday when no one is in the office (and the dentist is unaware of what is going on). I hear stories of persons who were dentists in foreign countries but never certified or licensed in the U.S. who give patients the impression that they are bona-fide U.S. dentists and do more than they should. Again, if I am talking about something going on in your own office, cease and desist. If a complaint goes to DOPL we cannot help you and you will have a hard time justifying the events you are allowing to transpire in your office whether under your watch or not!
--RCE

COMMENTARY FROM A DENTAL ANESTHESIOLOGIST

Recently Dr. Mitch Duckworth of Summit Anesthesia volunteered to furnish an article about the state of training for dental anesthesiologist and safety concerns. Where DOPL is contemplating modifications in the Rules that cover sedation, this article is very timely. We appreciate Dr. Duckworth for sharing his expertise and contributing this article.

A dentist anesthesiologist (DA) provides advanced anesthesia and pain management services for dental and oral maxillofacial surgical procedures. Some dentist anesthesiologists also attend medical surgeries. Post-doctoral specialty programs that train dentist anesthesiologists are rooted in medical anesthesia residencies, with DA residents closely and in some instances identically following the medical anesthesia residency training as their physician cohorts.

Similar to other dental specialties trained in advanced anesthesia, a dental anesthesiology 3-year residency consists of Commission on Dental Accreditation (CODA) standards that outline an advanced anesthesia education program to ensure proficiency in anesthesia delivery, including intravenous deep sedation and general anesthesia. Unlike other dental specialties, dental anesthesiology focuses exclusively on anesthesia delivery.

The dental anesthesia residency curriculum consists of emergency rescue, advanced airway management, internal medicine, emergency medicine, cardiology, and intensive care rotations. DA residents participate alongside their physician colleagues in general, ENT, complex oral, cosmetic and body contouring, orthopedic, and organ transplant surgeries, as well as satellite anesthesia delivery in nuclear medicine, radiology, cardiac catheterization, and other hospital areas where pediatric or adult sedation is needed.

Some DA residency programs offer rotations in obstetric anesthesia, including spinal and epidural anesthesia, regional anesthesia, 3 to 4 months of dedicated pediatric anesthesia, and office-based anesthesia in the dental setting. DA residencies devote time to anesthesia research projects, medical academic conferences, medical grand rounds, problem-based case learning, and journal club anesthesia-based presentations.

The practice of dental anesthesiology is recognized by the ADA and has recently gained specialty status in select states, with other states sure to follow. After residency, dentist anesthesiologists work within the profession as mobile anesthesia providers in dental and medical settings, hospital anesthesiologists for medical and dental cases, anesthesiologists in ambulatory surgical centers, and anesthesia faculty in medical and dental academic institutions.

Dentist anesthesiologists collaborate with other dentists and dental specialists to expand the field of dental medicine and help maintain a high level of behavior management and anesthetic safety during dental procedures. Many DAs hold faculty positions in academic learning centers. And in carrying on with the tradition that Horace Wells, a dentist and acknowledged “Father of Modern Anesthesia,” started nearly 200 years ago, these specialists enjoy passing on their anesthesia knowledge and experience to future generations of dental, medical, and nursing professional colleagues. Most patients served by dentist anesthesiologists are patients with special needs, fearful children, patients with complex treatments, patients with post-traumatic stress disorder, or dental-phobics.

A dentist anesthesiologist typically is asked to assist the general dental or dental specialist surgeon with cases that need higher levels of anesthetic administration or increased airway management skills for improved patient cooperation. Reasons for lack of patient cooperation in the dental setting may be age, previous dental trauma, a history of post-traumatic stress disorder, inadequate comprehension of procedure, the patient's inability to control movements, or a lengthy involved surgical procedure.

Bringing a dentist anesthesiologist into the dental team aids the operating dentist or specialist in maximizing patient safety, comfort, and procedure timeliness, while minimizing negative, disruptive behaviors.

There are societies within dental medicine that offer resources to learn more about dentist anesthesiologists and associated specialty residencies, such as the American Society of Dentist Anesthesiologists, American Dental Society of Anesthesiology, National Dental Board of Anesthesiology, and American Board of Dental Specialties.

--Contributed by Mitchell Duckworth, DDS
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DEMOGRAPHICS SURVEY RESULTS

Several months ago we sent out a survey with the Annual Meeting information to better understand the volume of patients seen by general dentists for specific types of treatment pertaining to endodontics, oral surgery and implants. We have finally been able to compile the data and the results are summarized in this article. 451 general dentists returned the surveys to us which represents 39% of our insured general dentists. Of course specialists were not asked to return the forms as we were interested in the habits of general dentists.

1. How many vital molar endo cases do you complete per week?

Zero:	162	36%	7-9	2
1-3	249	55%	10+	5
4-6	23	5%	No ans.	10

2. Do you currently refer out more than half of your vital molar endo cases to specialists?
Yes: 206 No: 201 No ans. 44

3. On average, how many molar endo retreatment cases do you complete per week?

Zero:	369	82%	7-9	0
1-3	65	14%	10+	2
4-6	3		No ans.	12

4. Do you currently refer more than half of your endo retreatment cases to specialists?
Yes: 373 No: 46 No ans. 32

5. How many simple (non-impacted third molar extraction cases do you do per week?

Zero:	195	43%	7-9	2
1-3	218	48%	10+	7
4-6	11	2%	No ans.	6

Fewer than 10/yr: 12

6. Do you currently refer more than half your complicated third molar extraction cases to specialists?
Yes: 239 No: 191 No ans. 21

7. How many complicated third molar extraction cases do you complete per week?

Zero:	320	71%	7-9	1
1-3	104	23%	10+	7
4-6	4		No ans.	7

Fewer than 4/mo: 8

8. Do you currently refer more than half your complicated third molar extractions to specialists?
Yes: 350 No: 78 No ans. 23

9. On average, how many implants do you place per week?

Zero:	278	62%	7-9	2
1-3	139	31%	10+	1
4-6	9		No ans.	7

1-3/Mo: 12 1-4/Yr: 3

10. Do you perform sinus lift procedures yourself, where indicated for posterior maxillary implants?
Yes: 66 No: 373 No ans. 12

11. Do you perform bone grafting procedures yourself, where indicated for posterior maxillary implants?
Yes: 74 No: 363 No ans. 14

12. Do you currently refer more than half of your implant placement cases to specialists?
Yes: 294 No: 129 No ans. 37

13. If you refer more than half of your implant cases to specialists, indicate the percentage of cases you refer to either periodontists or oral surgeons.

	Oral surgeons	Periodontists
1-10%	55	63
11-20%	19	30
21-30%	22	26
31-40%	6	6
41-50%	38	29
51-60%	9	7
61-70%	9	7
71-80%	31	24
81-90%	40	21
91-100%	97	54
TOTAL	326	267

So, what do these number tell us? As far as endodontics, most general dentists are leaving the majority of vital molar endo cases to the endodontists as 91% of the

dentists that completed the survey do none or very few of these cases per week. 96% of the dentists who completed the survey do none or few molar endo retreatments.

43% of the respondents do not perform simple third molar extraction cases and 71% do not do any complicated third molar extraction cases. 78% of the dentists surveyed refer more than half of possible third molar extraction cases to oral surgeons.

Similar statistics are found with implants. 93% of the general dentists returning surveys do not place or place only 1-3 implants per week. 15% perform sinus lifts and a similar percentage performs bone grafting procedures in the maxillary posterior area with implants. 65% of those returning their surveys refer more than half of their implant placement cases to specialists.

We asked those general dentists who refer more than half of their implant cases to specialists and 55% of the cases go to oral surgeons and 45% of the cases go to periodontists so the distribution is close.

Finally, it is interesting to note that the numbers of cases completed per week for molar endo, molar endo retreatments, difficult third molar extractions and implant placement are comparably low, being below 10% in all cases. Fortunately we see a concomitant number of claims currently being reported in these three areas, with implant related claims currently leading the way. We get more calls about endo complications with molars but the vast majority of those cases are handled with refunds and releases such that most do not become cases that result in claim files being opened.

--RCE

WHO IS AN AVERAGE DENTIST?

This article is an excerpt of a longer article written by ADA Executive Director Kathleen T O'Loughlin.

How do you describe the average dentist in America?

A paper written in the 1940s that was co-authored by Dr. Harold Hillenbrand, a former executive director of the American Dental Association, made an attempt:

The average dentist in the United States is a white male who is engaged in private practice. He is married, has 2.4 children, a fairly well-worn Chevrolet and a home about which the bank still has something to say…. His feet, very often, hurt him except after thirty-six holes of golf when they feel fine because of the exercise….

All in all, the average dentist and private practitioner is a pretty good American in a casual sort of way. He is a pretty good fisherman, shoots a respectable game of golf, likes a nip or two on occasion, and smokes more cigarettes than are good for him. He's going to quit smoking and drinking 'pretty soon,' but never does.

It is this very human bundle of contradictions, superstitions, likes, dislikes, failings and virtues that we call the average American dentist in private practice.

This colorful, if incomplete, description of the average dentist may have been accurate in the 1940s, and likely for many decades after that, but no part of this assessment of old rings true today, except perhaps the last line of it. While I enjoy thirty-six holes of "exercise" as much as the next dentist, it's about time to let go of the idea that there is such a thing as an "average" dentist in America.

And that's OK.

Different is good. Diverse perspectives make us stronger, and that's one of the reasons we should strive to embrace and promote diversity and inclusion at all levels of our Association. Best practice leadership standards across a variety of industries suggest that an organization's leadership and governance composition should reflect the varied constituents it serves. There is an abundance of well-done business research that strongly suggests that increasing diversity enhances team performance in very measureable ways.

Many dentists and dental students understand this. We need our associations as a whole to understand this, too. We have to first acknowledge—all of us—that we have the ongoing need to build and sustain a truly diverse and inclusive environment.

I speak from firsthand experience.

INFORMED CONSENT WHEN MINORS ARE INVOLVED

Occasionally we get questions from dentists about informed consent involving minors. The most recent question went as follows:

I have a 16 year old patient with a 2 year old baby that needs dental work. Who can sign the informed consent for the 2 year old? And, can the 16 year old sign for herself since she is apparently estranged from her parents?

The short answers are as follows:

1. If the mother is single, she can provide consent for the 2 year old.
2. If the mother is married, either her or the father can provide informed consent.
3. If the 16 year old mother needs dentistry herself and is emancipated as in this example, the patient can provide consent for herself. Emancipation is a legal mechanism by which a minor is freed from control by their parents or guardians, and the parents or guardians are freed from any and all responsibility toward the child.
4. If a 16 year old mother happens to be living with her parents, the parents provide consent for her.

Now, I wish to expand on the answer to #1. If the mother has an unmarried live-in who brings the child in for treatment, you should obtain verification of paternity if there is any doubt as to the live-in's legal authority to provide consent for the child. If you are not sure about the situation, you can either insist that the person claiming to be the father provides a copy of a Voluntary Declaration of Paternity or obtain, with the alleged father's consent, confirmation from the Office of Vital Records that such a declaration has been filed and accepted.

A more complete answer as to whether or not a minor parent may consent to health care services provided to the minor's child is found under Utah law. The highlights are as follows:
The following persons are authorized and empowered to consent to any health care not prohibited by law:

1. Any parent, whether an adult or minor, for the parent's minor child.
2. Any married person for a spouse.
3. Any person temporarily standing in loco parentis meaning acting as a legally authorized temporary parent, whether formally serving or not, for the minor under that person's care and any guardian for the guardian's ward.
4. Any person 18 or over for that person's parent who is unable by reason of age, physical or mental condition, to provide such consent.
5. Any patient 18 years of age or older.
6. Any female regardless of age or marital status, when given in connection with pregnancy or childbirth.
7. In the absence of a parent, any adult for the adult's minor brother or sister.
8. In the absence of a parent, any grandparent for the grandparent's minor grandchild.
9. An emancipated minor.
10. A minor who has contracted a lawful marriage.
11. An unaccompanied homeless minor.

We often deal with questions about minor patients and so we hope this article will help to clarify actions you should take when faced with these situations.

One other factor to consider, however, is financial obligations. If the parents are the ones paying for dental procedures and an adult sibling or grandparents bring a minor in for procedures and the treatment plan changes, such as a tooth with deep caries that you determines needs a root canal, what should you do? The wise protocol is to call one of the parents and notify them of the situation and make sure they agree to cover the fee. Otherwise a palliative procedure should be considered until the financial arrangements can be worked out.
--RCE

SOME THOUGHTS FOR THE NEW YEAR

I receive e-mails from a number of sources and one is Scott Manning, a practice management consultant. Recently he had some thoughts that may be good to consider as you contemplate the new year and how your practices are going to go. Following are some ideas Scott suggest that are in your patient's heads that you may want to be ready to answer:

"As you prepare for the New Year, I'll remind you of a short list of various things your patients think about before, during and after they visit you. Your ability and willingness to manage, offset, counteract, be transparent with and help your patients through these thoughts will, in and of themselves, ensure that you are different and you will make your patients more comfortable with you.

"What is the dentist going to find?"
"They always find something."
"It's going to be expensive."
"Do I really need that?"
"DID I really need that?"
"This place smells funny."
"I really hate that buzzing sound."
"I dread my appointment because…"
"It's going to hurt… they say it won't but it always does."
"I wonder if they are telling me the truth."
"I hope I don't have any cavities."
"They always run late."
"I don't care what I look like."
"It doesn't look that bad."
"That's really not important to me."
"It can wait"
"I'm not going to spend that on myself."
"Is it really worth it? It's not really worth it…besides I was saving for a new…"

You can't imagine all the ways the patient's mind is working against you. I could go on but that's enough for now. You can run down the list and double check yourself as to what you are doing to reshape the way patients see and experience you. Make note of the ones that you feel you are being negligent with."

GUEST COMMENTARY

- **GARY B. WIEST, DMD**
- **MEMBER, PIE BOARD OF DIRECTORS**

"Many people across the U.S. have developed dangerous reactions and drug habits after being prescribed opioids, most of the time resulting in overdose and death. If you or a loved one were prescribed opioids, and suffered from addiction or death, you may be entitled to compensation. Contact the "WHOEVER" LAW GROUP today for a free and confidential care evaluation by filling out our online form or calling us toll free at 1(888) SUE YOU!."

This is not a real law group or phone number, but a real online Ad that is one of many reaching out to individuals harmed by opioid pain medications. Since President Trump declared the opioid epidemic a national public health emergency last fall, the public and attorneys are alerted to this medical conundrum. For the attorneys, it is an opportunity to sue big drug companies and possibly providers.

Are we aware of all the risks and not just the benefits of opioid medications? Are we covered if someone we prescribe opioids for has a bad reaction or becomes addicted and dies of an

overdose? A few years ago, I served in the Utah County Drug Taskforce branded as SMART (Substance Misuse and Abuse Reduction Team). On the taskforce were parents and community leaders that had lost loved ones due in part to a Dentist introducing an individual to opioids by a dental procedure, usually third molar extractions. It is sad and tragic that good young people, after using opioids went down the path to destruction from just an innocent opioid prescription.

Approximately 64,000 Americans died from overdoses last year. That is 175 people every day, and seven people every hour dying because of opioid medications. Just recently it was reported that for the first time in more than half a century, Americas' life expectancy declined for the second straight year, a change most probably driven by drug overdose deaths among younger people.

What is also being discovered is the immediate consequences of opioid medication. In some cases, individuals die of respiratory depression the night immediately following receipt of an opioid prescription. A sad case that happened a year ago in Vernal, Utah was just published in the Deseret News on December 17, 2017. A young man had his tonsils removed and he was prescribed the usual opioid narcotics to control the acute pain. He died that night from respiratory depression as an apparent result of taking an opioid pain medication before going to sleep.

Dr. David Hasleton, associate chief officer at Intermountain Healthcare, commented on this recently discovered relationship. "Awareness of the risks of taking opioids, even as prescribed, is quite low among patients. By and large the general public has no idea. If you ask people they say when it comes down to them, they believe if they are prescribed something, that prescription is safe for them. .But the reality is, a prescription does not fit everybody the same way. Specifically, a person who suffers from sleep apnea, (a condition in which a person's breathing is swallow or under goes abnormally long pauses while sleeping) is known to have a greater reaction to even a prescribed dose of painkillers."

Dr. Jonathan Boltax, who works as a clinical pulmonary care instructor with the Department of Pulmonary and Critical Care Medicine at the University of Utah Health Sciences Center, said "The respiratory risks of opioids are considered common knowledge among doctors and researchers. There is absolutely no question that opioids suppress respiratory drive and lead to deaths from respiratory failure."

During the upcoming session of the Legislature, bills will be introduced that will affect our practice of pain control and monitoring opioid medications for our patients. Representative Steve Eliason wants to introduce legislation to form an Opioid Fatality Commission and improve the online Database Dashboard. Senator Kevin Van Tassell will be sponsoring a resolution for further research into Opioid-induced postoperative respiratory depression, and what can be done to avoid deaths resulting from complications associated with opioid use.

I think that we as dentists of Utah need to be more proactive now, and in the future, to slow down and stop the opioid death epidemic. PIE has previously instructed dentists to furnish drug information sheets to patients and it is even more important to give them such a sheet for any opioids which outlines the potential risks. See a sample information sheet for opioids at the end of this online PIE Newsletter. Stay tuned to what will come forth nationally and from the Utah Legislature in the near future concerning our prescribing habits. We as dentists could very well be one of the problems, but have such a great potential to help in the solution.

DRUG INFORMATION SHEET - OPIOID ANALGESICS

The following precautions must be considered for any opioid analgesic prescribed:

1. There may be benefits of trying non-opioid medications, such as combinations of nonsteroidal medications such as ibuprofen in combination with acetaminophen before I take any opioid pain medications. Such combinations may be more effective than opioids, unless contraindicated.

2. When I take any opioid, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, and depressed breathing.

3. When I take opioid medications it is not considered safe for me to drive a vehicle, operate machinery or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk.

4. I will not drink alcohol, take any cough-cold, allergy, or anti-depressive medications while on opioid medications.

5. When I take these opioid medications, even for a short time, I could become physically dependent on them, meaning, that my brain could be altered with changes in the chemistry and grey matter. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep problems.

6. I may become addicted to these opioid medications and would require counseling or anti-dependence treatment if I cannot control how I am using them.

7. It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications. This is so I can be treated safely and effectively.

8. Anyone can develop an addiction or dependence to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I should tell my dentist if I, or if anyone in my family, has had any of these types of problems.