

LECOM, Florida's newest Dental School

by *Brian P. Rask, DMD, FAGD*

If you have not heard yet, Florida has a new, private School of Dental Medicine that will be admitting its first class of 100 DMD students in July of 2012. The name of the school is Lake Erie College of Osteopathic Medicine, or LECOM for short, and their Florida Campus is located in the master-planned Lakewood Ranch community of Bradenton. In addition to having a dental school, LECOM also offers osteopathic medicine and pharmacy programs and has two other campuses in Pennsylvania. Professors for their Problem Based Learning basic science curriculum will be both locally and nationally recruited and shared between all three professional disciplines offered.



LECOM is constructing a 109,000 square foot, state-of-the-art facility in Manatee County, costing \$52 million

dollars. The school will employ about 200 individuals, which includes faculty, staff, and administration. All of this will help to stimulate the economy at both the state and local levels. The direct impact to the Bradenton economy is projected to be around \$14 million and almost \$35 million throughout the state. It is not known how the school will affect private and group dental practitioners locally or statewide. The dental clinic will be able to treat up to 600 patients a day, but only those whose treatment regimen meets the educational requirements of the dental school will be accepted. There is no faculty practice yet but one is planned. LECOM School of Dental Medicine does not offer any foreign trained or specialty program degrees nor is it associated with any teaching hospitals or clinics.

LECOM's School of Dental Medicine's Dean, Robert Hirsch, DDS states, "The College, observing the decline in the number of dentists in the State of Florida is responding to the needs of the Bradenton community with the establishment of this school." In four years the school will have 400 students, who will treat patients in underserved and low income areas where the population's health is at risk due to a decrease in practicing dentists, according to Dr. Hirsch. Michael Polin, Director of Communications and Marketing, says that the costs of dental treatment for patients through the school will be about 1/3rd of what the fees are in private practice. They expect to serve patients without insurance (fixed or low income and Medicaid) in the Bradenton/Sarasota area, and they are open to the idea of drawing patients from the surrounding areas of Tampa and St. Pete as well.

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President's Message



Membership in the AGD . . . A Good Deal!

*By Dr. Tony Menendez
FLAGD President*

As another year comes to a close and we ponder what was and what will be, I ask you to realize the benefits, seen and unseen, of what membership in the Academy of General Dentistry means to you. As most of us experience the hardships of this recession, it is often easier to rationalize and ignore the requests for renewal of your membership. I encourage you to take the time to visit our website and visit member benefits, to update your AGD supported webpage and take advantage of the numerous CE opportunities available. Now is the time to review, refresh and learn about some aspect of dentistry that we were "too busy" to learn about in years past. Very often, idle time is wasted on those things that we are unable to change. We succumb to the loss of control that affects so many of our practices in these tough economic times. As dentists, our success is determined by both our professional and leadership skills. Take back control and set your sights on what you expect your future to be. Determine and solidify your position in the marketplace by strengthening your commitment to lifelong learning. Our profession is changing in ways that, up until a couple of years ago, seemed unimaginable. There is and always will be a place for the general dentist in private practice. Become proactive in establishing your niche, expanding your scope, not narrowing your field, and you will find success.

Currently, the AGD's mentor/mentee program is up and running. There are many compassionate learned members who are more than willing to share their expertise with you. The

mentor/mentee relationship can be as involved as the participants would like, running the gamut from an occasional phone call to a scheduled face to face interaction. As a mentor, there has never been a time where I did not gain from such a relationship. The opportunity to interact and share ideas is a benefit to doctors and patient alike. Should you find in yourself that strong desire to learn, set goals and reach out for the Academy's fellowship designation.

Did you know that the Academy of General Dentistry is the only organization that advocates solely for the general dentist? The Academy makes every effort to advocate on your behalf and has written many position and white papers to insure your ability to continue to be the gatekeeper for your patient's optimal care. The Academy is currently involved in matters such as barriers to care and mid-level providers. In the near future, the Florida Academy of General Dentistry will be surveying its members to determine issues related to barriers to care. We hope to gather information regarding general dentist involvement in providing pro bono or low cost care. I believe that many of you take great pride in delivering care to the underserved and we hope that with your support and cooperation, we can pass this information to the powers that be. Florida Academy members, as well as general dentists throughout the state of Florida, are not being recognized for the service and care they provide to the community. Many members have voiced enthusiasm to be more involved in this care but are unaware as to how they might begin. Help us promote our volunteerism. Take the time to fill out our survey and provide us with the support we, The Florida Academy of General Dentistry, need to insure your ability to provide optimal patient care.

In closing, get involved, stay current and lay the foundation for your future. Renew your membership in the Academy of General Dentistry. Speak out and let your voice be heard. Enlist your colleagues and invite them to join us in an organization dedicated to excellence through lifelong learning and advocacy.

Wishing you happiness and prosperity in the New Year!

FLORIDA FOCUS

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Editor's Message



Standard of Care? Can anyone define it?

by Dr. Chris Wujick
Editor, *Florida Focus*

I used to think standard of care was a bare minimum level of treatment for a geographical area, but I'm not so sure anymore. I seem to hear it used ever more increasingly at CE courses and from product reps about new products or technology. It's an often used concept which I don't think has a clear consensus definition. Where does one find the bylaws for standardization? Perhaps Will Ferrell in *Blades of Glory* had it right: "No one knows what it means. But, it's provocative and it gets the people going!"

But, what people does it get going and for what reason? Is its origin from the Hippocratic Oath ensuring that we "do no harm?" Or, is it from the dental companies who try to inspire us to "do no other product?" The standard of care is legally defined as the degree of care that a reasonable and prudent dentist would exercise under the same or similar circumstances. (Historically, the standard has been expressed in terms of a dentist "in the community with similar education and experience.") Conduct failing to conform to the standard of care constitutes a breach of duty to the patient – an element of negligence. I worry that marketing, rather than dentists and their patients, is attempting to dictate care.

Of course, we need to do what's in the best interest of the patient considering all of the pros and cons of a given procedure. But, we need to keep in mind that not all patients are the same. And especially when considering this economy, not all patients can afford the same treatments. If we consider something to be a "standard of care" we need to use it with consideration to all patients. Because, if there is a standard, then that means that there is a sub-standard as well.

If a treatment was performed without using a proclaimed "standard of care" method or technology, and the treatment was performed safely and effectively as it had been done for many years in the past, and the patient was happy, then

why should such treatment be considered sub-standard simply because it did not use a new method or technology?

I often like to use the "mom method" of treatment assessment. What would you do for your mom in this situation? But, for a standard of care, shouldn't you consider this from two perspectives? As a professional we have disposable income to consider the best for mom within our means. But, also we have to consider what we would do for mom if we were still in college and had to support mom on a ramen noodle budget. Because, that is what a lot of patients are going through right now and we cannot forget about them when we set standards. This is especially true when considering the serious public concern of access to care. Unnecessarily limiting the general dentist's ability to provide care or forcing care to be more expensive will only greater limit access to care.

Don't get me wrong, it is fun to practice in such a high tech era. These advancements allow us to deliver better care and allow us to better avoid complications. Certain situations will warrant newer and more expensive options, or at least will warrant their presentation as an option where greater risk is likely when utilizing more traditional protocols. But, to suggest a requirement of a more expensive modality, when a more traditional method is consistently safe and effective can present a disservice to our patients.

Ultimately, we all individually decide how and by what method we treat our patients. I would hate to see this decision perversely influenced by marketing. It's fine for corporations to market, but let's all avoid referring to the newest technologies and methods as the "standard of care" as soon as they are released.



New FLAGD President, Dr. Tony Menendez (r), presents plaque to outgoing President, Dr. Don Thomas



Cone Beam Radiography and Standard of Care

Comments on the Editor's Message
by Laurence A. Grayhills, DMD, MAGD

Our practice life is evolving daily with the advent of a variety of new technologies. I venture to say that I'm performing most procedures differently than I was taught in dental school twenty years ago! With each new era of dentistry comes an evolution of procedures and techniques ultimately intended to improve efficacy, clinical results and satisfaction for both the patient and doctor. This is not to say that these technologies were consistently met with open arms. At their inception, implants were considered an experimental procedure, certainly beyond the scope of the general practitioner. This treatment modality is now considered "standard of care" for the replacement of missing teeth and is well considered within the scope of care offered by the general practitioner.



This brings us to the definition of "standard of care". If we've been performing a given procedure for years with good clinical results, and a new technique is discovered which can improve the results of the older technique, is it still acceptable to perform the older technique? If the clinical results are deemed a success by both techniques, then the standard-of-care would be met. Good luck to the practitioner who performs a given procedure by the "tried-and-true" methods he has employed for the past twenty years and meets with a clinical failure. If it is adjudicated in a court of law that the outcome might have been better had the practitioner adopted the newer methodology, the "standard of care" would not have been met. In certain professions (such as dentistry), the standard of care is determined by the standard that would be exercised by the reasonably prudent professional in that line of work. The "Bolam Test" is used to determine whether a doctor or dentist is liable for malpractice (Bolam Test states: "If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent"¹). This standard of care is not relevant in many cases and is only there to help the defendant in a malpractice action.

I recently made the decision to incorporate cone-beam-computed tomography (CBCT) in our general practice. The decision was not made lightly, not least of all due to the price. I've been placing implants for approximately 19 years without the use of CBCT. This is not to say that I didn't have a great deal of trepidation every time I placed an implant in the posterior mandible or in proximity to a

pneumatized sinus. I recently attended a class on periodontal plastic surgery, block bone grafts and sinus augmentation in preparation for implant placement, given by Dr. Mike Pikos. In his course, he stressed the mandatory necessity for CBCT in preparation and treatment planning these cases. In the limited experience that I've had with my new equipment, I couldn't agree more. However, in discussing the matter with many of my colleagues since then, I've found a diverse range of pro and con opinions regarding the use of CBCT in general dentistry.

The major issues seem to revolve around whether or not CBCT should be considered the new standard of care in the diagnosis and treatment of numerous dental therapies from root canals to implant placement. Needless to say, the advent of CBCT has made it possible to visualize the dentition, the maxillofacial skeleton and the relationship of anatomic structures in three dimensions,² and in more than half the cases studied has revealed additional radiographic information to that which was targeted when compared to conventional radiographs.³

Common areas of concern in the incorporation of CBCT technology in the any office revolve around safety to patients and staff, size of the field of view (FOV), interpretation of the product, dose considerations, patient selection criteria and adequate patient consent.⁴

To each of these points, limited volume CBCT is preferred over large-volume. The size of the exposure should be no more than is necessary for the task. Additionally, the patient's situation must justify the use of CBCT and present a demonstrable need over potential risks, especially in regard to the treatment of children. As the quantity and quality of information gathered by the technique may be outside of a practitioner's expertise image data and interpretation should be referred to a specialist for interpretations. When CBCT is to be used, the practitioner should exercise careful consideration to whether the enhanced information will actually lead to an improved outcome. Of equal importance is the exclusion of pathology when selecting the appropriate treatment.



Water Fluoridation Discontinued in Pinellas County

by Dr. Chris Wujick, FLAGD Editor

Our state's progress in protecting the population's teeth with water fluoridation took a step backwards on October 4th. The Pinellas County Commission voted 4-3 to halt fluoridation to its approximately 700,000 customers.

Pinellas County began adding fluoride to its water in 2004 when it was the largest water supplier in the eastern United States without water fluoridation. Now, the county reverses course with its vote following three hours of contentious discussion in front of the commissioners.

The discussions illuminated a large disparity in the attitudes towards the naturally occurring mineral amongst the community. It is largely understood among the dental community of the dental health benefits that fluoride provides, especially to the lower socioeconomic segment of the population, where proper oral hygiene is most likely deficient. However, there is a very vocal portion of the community which disagrees with fluoridation of the water supply.

These critics disagree for several reasons, ranging from the desire for less government involvement and trying to save the county about \$205,000 a year to backlash against recent nation-wide governmental spread into healthcare. Some speakers present for the debate were concerned of the systemic side-effects of fluoride intake such as contribution towards cancer and deteriorating bones. And others compared the governmental usage of fluoride to Soviet and Nazi practices, in which this toxic substance is part of greater agenda to suppress the intellect of its citizens in order to expand its control.

To the dental profession these statements seem scientifically unsupported at minor doses of fluoride. Pinellas County had been fluoridating its water to 0.8 milligrams per liter. Many of the claims from the critics are constructed by opinions instead of based on facts supported by peer-reviewed scientific articles. However, the important message from the event comes from the perspective of the tie-breaking vote, Commissioner John Morroni. In a classic case of the squeaky wheel getting the grease, the opposition to fluoride was just more intense.

Since the adoption of water fluoridation in the county, complaints were voiced. These objections grew louder as time lapsed and eventually swayed Morroni, even though he

initially sided in favor of fluoridation almost a decade earlier. Morroni hence joined three other newer commissioners Norm Roche, Neil Brickfield and Nancy Bostock who were more firmly against the intrusion of government into the water supply. Morroni states "the dental community is ignoring both health concerns, including a correlation between fluoride and thyroid problems, as well as the rights of the many residents that cannot use the county water and must purchase other sources of water because of the fluoridation content." His new position was due to this greater understanding of the mineral and its risks as well as an apparent outcry from the public for its disapproval.

The irony of the situation is that the demographic that would most benefit from the inclusion of fluoride, the less-privileged children, are voiceless in the debate. Their parents are either too busy with their daily struggle or uneducated on the issues to realize the disservice to their children. It is true that proper brushing, flossing and diet can prevent dental disease, however these practices are often not enforced by parents in lower socio-economic families. And while money might be saved initially by with-holding fluoride, the costs associated with treating the potential oral disease might be far greater and may affect the children at a much younger age.

Hope does still remain for the residents of the county who want water fluoridation. Several of the municipalities, including the largest city of St. Petersburg will probably maintain fluoridation at the municipality level at the city's expense. And there is a movement to put this issue on the election ballot in November of 2012 to allow the community to decide its use. Morroni supports "a referendum on this personal health care issue because of the intense emotional feelings from both sides."

This situation in which one vote can have such a large impact highlights the importance of the dental communities need for activism. Dental health is often misunderstood by the public and if not for the strong voice of those who are best informed, the community might be vulnerable to unfavorable policies. And remember, not only can we educate our community in a political forum, but also in our offices one patient at a time.



Legislative and Governmental Affairs Report

Dentist Day on the Hill 2012:

Mark your calendars, this years Dentist Day on the Hill will be held on Wednesday, February 1, 2012. The FDA will conduct a briefing for dentists on Tuesday, January 31. The Florida Dental Association (FDA) encourages all dentists to come out and show our unity to the Legislature. Year after year, legislators are impressed by the turn out and message from dentistry. Get involved with dentistry. Make a commitment to go to Dentist Day on the Hill, even if you have never been before. If you have strong opinions, get involved with the FLAGD Board, it's committees, and the FDA. There are so many threats to our profession and your timely voice is important. Especially during this economy, your voice is needed the most.



Dr. Rod Shaw, Chair
Legislative & Governmental
Affairs Committee

Legislature 2012:

This year's Legislature will be tasked with the process of redistricting. This process occurs every 10 years and this is the year. Much of the legislative energy will be consumed by this process leaving little room for landmark legislation. Having said that, there are several issues worth consideration by this session.

Non-Covered Services Bill: Numerous states throughout the country have adopted this type of insurance reform. With this plan, insurance plans could no longer dictate a fee for dentists to charge when the insurance company provides no benefit. For example, insurance companies could not dictate that a dentist would place implants for \$500 when the insurance reimbursement is \$0.

Hygiene Anesthesia: There is discussion of the FDA and FDHA proposing a legislative change which would permit dental hygienists to administer local anesthesia. Further training would be required to obtain such a permit. The FDA may propose this legislation if the opportunity permits.

Medicaid: The FLAGD and FDA will be monitoring all Medicaid proposals and their impact on dentistry.

Board of Dentistry:

The Board of Dentistry elected Wade Winker, DDS, a General Dentist from Eustis, as the new chair for the BOD. Also, Joe Thomas, DDS, a General Dentist from Vero Beach was reappointed to the Board by Governor Rick Scott for another three year term.

The Board of Dentistry is interested in adopting rules which would establish curriculum guidelines for assistants and hygienists to place restorations in Florida. No language has been

adopted or agreed upon at this time.

From the Capital Report, Vol 18, No. 2, September 30, 2011:

"At the May 2011 BOD meeting, Chairperson Dr. Thad Morgan asked for a group to be established with representation from the FDA, Florida Dental Hygiene Association, Florida Dental Assistants Association, Nova Southeastern University and the University of Florida to make recommendations to the BOD about restorative functions dental auxiliaries. He asked for a report to be completed in time to be reviewed at this BOD meeting.

The FDA Board of Trustees created a task group with the above mentioned representation that worked on a draft proposal for BOD review. It was clearly stated that this is not official FDA policy, as it has to go before the FDA House of Delegates prior to becoming policy. The FDA draft includes suggestions that, under the direct supervision of a dentist, both hygienists and assistants will be able to place and finish amalgam and composite restorations with proper training and education.

The FDA's restorative functions dental auxiliaries proposal was referred back to the BOD Council on Hygiene and Assisting for input. Dr. Morgan applauded the FDA report for its thoroughness and thanked the FDA for the quick turnaround time.

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Florida Board of Governors (formerly the Florida Board of Regents for old guys like me) which administers the University System for Florida has under consideration additional Dental Schools for Florida. Proposals are for new Dental Schools at UCF in Orlando and FAMU in Tallahassee. The University of Florida has proposed enlargement of the size of the dental school class to 92 students per class. A copy of the full proposal can be found at:

http://www.dental.ufl.edu/About_the_College/message_from_dean.php



Region 20 Report



Practiceology Conference - A Success!

*by Dr. Richard Kanter
Region 20 Trustee*

Take the Lead! Become a Volunteer Leader

The Academy of General Dentistry (AGD) is searching for members with great ideas, enthusiasm, and expertise to volunteer now for both local and national leadership positions. The success of the AGD is due largely in part to the commitment, energy, and expertise of our volunteer leaders. Responding to the AGD's Call for Volunteer Leaders is a great way to get involved and truly realize the potential of your AGD membership. The volunteer deadline for 2012–2013 national-level AGD leadership positions is January 13, 2012. Learn more about the the AGD's Call for Volunteers and fill out a Call for Volunteers Application by calling Rosie Small, our Executive Director, at 305-613-2742.

AGD's First Practice Management Conference Was A Big Success!

AGD 2011 Practiceology Conference
Nov. 10 – 12, 2011

The AGD's first conference offering for practice management proved to be a huge success! Nearly 160 dentists, dental team members, speakers, and sponsors converged upon Las Vegas' Cosmopolitan Hotel from Nov. 10-12, 2011, to learn practical insights on running a dental practice from some of the top speakers in the industry while sharing perspectives with other attendees from across the country.

Meeting Highlights:

Thursday, Nov. 10, 2011:

Dr. Howard Gamble, AGD president, got the meeting off to a great start by sharing many of the great successes that the AGD has had throughout 2011. After his presentation,

Linda Miles, CSP, CMC, talked to the attendees about "Learning, Living and Loving Dentistry!" Later, meeting attendees got to try their hand at a multitude of casino games while enjoying the opportunity to talk with speakers, sponsors and other attendees.

Friday, Nov. 11, 2011:

Rhonda Savage, DDS, kicked off a day of high energy learning with her presentation "How to be a Leader in Your Business." Following her presentation, attendees had the opportunity to learn from some of the best speakers in the business, including Lois Banta, Linda Miles, CSP, CMC, and Sandy Pardue!

Later, attendees had a chance to ask the experts all of the questions that they didn't get to ask during the sessions during Friday night's Happy Hour event.

Saturday, Nov. 12, 2011:

Saturday was another jam-packed day of learning, beginning with Timothy Twigg's presentation "Employment Compliance for Dentists: What You Don't Know Could Hurt You." Attendees then had the opportunity to listen in on other programs that focused on HR, leadership, efficiency and productivity.

At the end of another education-filled day, Lois Banta closed out a great meeting, talking to attendees about lessons learned in her presentation "Leadership 101."

Don't miss the opportunity to catch the Practiceology Conference next year. As soon as the 2012 dates and location have been set, members will be notified.

The Florida AGD Needs YOU!!!

Are you adept at Facebook and other social media?

Do you have a few minutes each week to update and maintain the FLAGD's Facebook page?

Please call FLAGD Exective Director,
Rosie Small, at 866-620-0773
to volunteer.



Call for Submissions for 2012 FLAGD Membership Awards

by Harvey P. Gordon, DDS, MAGD

It's time to consider names to submit to the FLAGD for the annual Membership Awards. The awards, beautiful etched crystal vases or similar, are presented at the FLAGD General Assembly luncheon, which is held on the Friday of the Florida Dental Association's annual meeting, the FNDC, at the Gaylord Palms Resort in Orlando. This year, the General Assembly will be held on Friday, June 15, 2012, and also again this year, the luncheon will be free to FLAGD members.



There are two types of Awards given, the Achievement Awards and the Continuing Education Awards. There will be two CE Awards presented this year – one for the total CE hours earned in 2011 and one for the most participation CE hours earned in 2011. Members may nominate themselves for either or both of the Continuing Education Awards. Each application must be confirmed by the submission of a copy of the nominee's AGD Transcript and must be accompanied by all associated documentation of course attendance. Hours earned in a formal program, i.e. graduate school or a MasterTrack program, will not be counted toward the Continuing Education Award. **The 2011 winner of the total CE Award was Dr. Keith Friefeld, with over 300 verifiable CE hours.** If you think you may qualify for these awards, contact the AGD for a copy of your transcript and mail it to the Florida AGD office at 2372 NW 8th St., Delray Beach, 33445, or fax it to us at 707-220-2861.

The other awards that will be presented at the General Assembly are our three Achievement Awards:

The J. Frank Collins Lifetime Achievement Award:

This award will recognize individuals who have demonstrated innovation and leadership, dedication to the advancement of dentistry, tenacity in pursuing idealistic goals, and who have made positive changes for the benefit of the dental profession and the dental health of the public. In 2010, this award was presented posthumously to former FLAGD and AGD President, **Dr. J. Frank Collins**, following which the FLAGD Board of Directors named the

award in Dr. Collins' honor. **Dr. Larry Scheitler** was the 2011 winner of this prestigious award.

The Distinguished Service Award:

This award will be presented to a Council, Committee or Task Force Member who has served the Florida AGD in an outstanding manner. The recipient will have gone beyond the call of duty in assuring continuity and integrity in the operations of this organization, as in the development of new programs, and has served the changing needs of the membership. In 2010, the first recipient of this award was **Dr. Mel Kessler**, Chairman of the FLAGD Program (Continuing Education) Committee. I am humbled to report that I was the recipient of this award last year, for my long-time work as FLAGD Treasurer and manager of the FLAGD reserve accounts.

The Humanitarian Award:

The Humanitarian Award was established to recognize an individual who volunteers his or her service in conjunction with a consistent commitment to enhance the image of general dentistry through the continuous delivery of quality dental care and through consistent leadership in areas of civic involvement. The volunteer service does not need to be done in conjunction with the Florida AGD, nor does it need to be performed in the United States. The inaugural recipient of this award in 2010 was **Dr. John Ohlsson** for his mission work, and the 2011 winner was **Dr. Raul Molina** from Miami for his volunteer work in Florida as well as his many missions overseas.

The deadline for submission of nominations is Friday, March 16, 2012 at 5:00 p.m. Please use the nomination form on the next page, or download a form from the FLAGD web site (www.flagd.org). You may mail, fax or email the form to the FLAGD office. Reminder - no form is necessary to self-nominate for the CE Award, just send a letter with your accompanying AGD transcript for 2011.

2012 FLAGD AWARD NOMINATION FORM

Please consider this candidate for the following Membership Award:

- Lifetime Achievement Award
- Distinguished Service Award
- Humanitarian Award

Please consider me for The Most CE Hours Award and/or The Most Participation CE hours Award.
(A copy of my AGD CE transcript is attached to this form)

Personal

Nominee; _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Office #: _____
Email address: _____

Description of Candidate's Qualifications

Briefly describe the works for which the individual is being nominated, and for which award.

Use additional sheets if necessary

List of Nominees other honors and awards

Nomination submitted by:

Name: _____ AGD #: _____
Phone: _____ Fax: _____
Email : _____

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INCORPORATING ORAL SEDATION TECHNIQUES INTO THE FLORIDA DENTAL PRACTICE SETTING

A Clinical Article in Two Parts

By K. David Stillwell, DDS, MAGD, FAAHD ^{a b}

Associate Professor and Assistant Director, University Hospital General Practice Residency,
University of Alabama at Birmingham

PREAMBLE

Phobic, elderly, physically disabled, or emotionally challenged patients present unique challenges in the dental operating environment. Reducing stress during the dental appointment allows for improved cooperation, safety and clinical efficiency. There is an increased need for dentists who are able to confidently and competently render care to these patients. Adult oral conscious sedation at the minimal level is a valuable way to more effectively manage the specific dental needs of this growing population. In this two-part series, information and procedures will be outlined to assist the dentist with incorporation of sedation techniques into daily practice.

PART ONE: Background, Patient Evaluation, Risk Assessment, Preoperative and Intraoperative Responsibilities

INTRODUCTION

In Part One of this series, I will provide a detailed outline of information and procedures for a systematic sedation protocol as currently employed in a hospital-based general practice residency program. We describe our protocol as Adult Minimal Oral Sedation (AMOS) which we define as a minimally depressed level of consciousness produced by a pharmacologic method in which ventilatory and cardiovascular functions are unaffected while yielding a patient that can respond normally to tactile stimulation and verbal commands. 1 The Part One outline will detail the various in-office processes employed in our AMOS methodology, including: 1) proper patient selection for minimal sedation, including use of an appropriate preoperative physical status assessment tool like the American Society of Anesthesiologists (ASA) classification method, 2) effective preoperative physical evaluation procedures, 3) medical risk assessment and informed consent, and 4) practice logistics, information flow, and instrumentation. This protocol has been observed to be a valuable and reliable adjunct to our clinic patients which could be reproduced in other practice environments.

BACKGROUND AND EVOLUTION OF AMOS

As the adult segment of the U.S. population continues to grow and age, there is an increased need for dentists who are able to safely and routinely render sedative dental procedures to these



patients. Standards of care continue to evolve as new evidence on sedative agents and technique is reported. This has recently prompted most state dental boards to revise their regulation of the enteral (oral, sublingual, rectal) administration of sedatives to be consistent with the American Dental Association's 2007 Guidelines for the Use of Sedation and General Anesthesia by Dentists. 2

Rules governing the administration of anesthesia in the state of Florida are contained in the Florida Administrative Code, Chapter 64B5-14. Florida dentists considering the use of in-office sedative techniques should carefully review FAC rules related to additional training and education, issuance of permits, and requirements for administration of oral conscious sedation. Florida's rules and regulations have not been standardized to the 2007 ADA Guidelines, so each dentist should review and understand the differences in terminology that currently exist.

Expanding the capabilities of a practitioner to safely implement and provide outpatient sedation hinges upon the individual's willingness to seek out appropriate and frequent continuing education courses and to dedicate sufficient time, resources, and training within the office environment. In general, minimal sedation training should include updates in patient evaluation, informed consent, monitoring, discharge criteria, documentation, facilities, equipment and personnel. The treatment environment must be properly equipped with redundant suction devices, physiologic monitoring equipment, a positive pressure oxygen delivery system, and emergency drugs including the benzodiazepine reversal agent, flumazenil.

In-office protocols for the delivery of dentistry under sedation must be developed to include assessment of recovery for home readiness and activation of emergency management services (EMS). Training programs for staff should be held at frequent intervals and documented in order to maintain compliance with regulatory agencies. 3 AMOS can be safely rendered by more practitioners once these training programs are completed, additional equipment is obtained, and office procedures are modified to incorporate all of the defined regulatory requirements.

PATIENT EVALUATION AND RISK ASSESSMENT

Advances in medical care have resulted in dental outpatients who are both medically and pharmacologically complex. Many adult



patients require sedation in order to complete a thorough oral examination and subsequent care because of behavioral, communicative, or complex medical problems. For those with compromised medical status, lack of a physiologic reserve capacity coupled with the stress and anxiety of a dental procedure can precipitate a medical emergency or urgency outside the scope of a dentist's management expertise. AMOS can be considered as an important adjunct in the treatment of such patients to minimize stress and the resultant autonomic response. 6, 14

Prudent risk management indicates that dentists should limit the use of sedation to those patients who require the modality after careful screening and physical assessment; the practitioner should only administer sedation when adequate training has been completed, monitoring equipment is in place, and emergency preparedness scenarios are established. 3

The physical evaluation consists of a current medical history, which includes a written review of systems, medication review, and a basic physical inspection. The pharmacologic history should include prescription medications, over-the-counter medications, and dietary supplements (herbals, alternative medicines, etc) as well as a complete list of all allergies and major side effects. 6 It is also helpful to discuss with the patient their history with sedative procedures including general anesthesia. Baseline vital signs should be noted during the preliminary evaluation. Often, with the elderly and medically complex, a consult with the physician is needed for more specific information.

The American Society of Anesthesiologists has formulated the most commonly used system to assess physical status or risk (ASA I-VI).4, 5 The ASA status of each potential sedation patient should be classified and recorded. With the significant physical findings from the examination captured, eligibility for receiving sedative therapies in our clinic will bear a close dependence on the ASA status of the candidate patient. Minimal sedation may be used routinely for patients that are classified as ASA I or II. Patients who are classified as ASA III or IV should only be considered for minimal sedation after written medical clearance from their primary care physician and/or relevant specialist. Modifications are often necessary for patients in ASA III and IV classifications (Table One: Evaluation of Preoperative Health Status Prior to AMOS can be found on the Florida AGD Website, www.flagd.org).

PREOPERATIVE AND INTRAOPERATIVE RESPONSIBILITIES

A preoperative office visit is employed in order to obtain informed consent for the sedation procedure and to verbally review our written pre- and postoperative instructions with each patient. Each patient must identify a responsible adult companion. That companion is informed that their cooperation is required to deliver the patient to the clinic, to remain in the clinic and be available for the full duration of the appointment, and to transport the patient home and remain with that patient for an extended period of observation. The guardian should be given copies of the specific written patient care instructions and should

agree to provide that care.

All patients are required to remain NPO after midnight (nulla per os or nothing by mouth) for morning appointments. For patients receiving AMOS in the afternoon hours, we encourage the intake of small amounts of clear fluid with dry toast or crackers to avoid dehydration and to absorb gastric secretions. Patients who regularly take prescribed medications in the morning should do so with a small sip of water. Insulin-dependent diabetics should not postpone their morning dose prior to a sedative procedure. For the diabetic patient, we encourage them to utilize morning dental appointments for AMOS. Upon arrival in the clinic, we administer small amounts of apple juice to stabilize blood glucose levels and we keep a concentrated glucose source nearby (cake icing).

From the time the patient is seated in the operatory until officially discharged, the dentist or a basic life support trained staff member must remain with the patient at all times. Physiologic and visual monitoring of the patient should commence as soon as the individual is seated and all procedures have been reviewed. Monitoring must always include oxygenation, ventilation, and circulation and a consistent method of recording must be established. A pulse oximeter with integrated blood pressure cuff is the standard of care to ensure proper oxygenation and circulation. Percentage hemoglobin oxygen saturation (SpO₂) as tracked by the pulse oximeter typically ranges from 93-100%; when SpO₂ falls to 92%, the device is programmed to emit an audible warning. The patient is instructed to take one or two deep breaths, and the lowered oxygen saturation level normally responds by moving back into the upper acceptable range in a matter of a few seconds.

In addition to instrumented monitoring, chest excursions, respirations, and the mucosa color should be continuously observed. Vital signs are recorded pre-operatively, post-operatively and intra-operatively at specific intervals. For our AMOS patients, we record blood pressure at 15 minute intervals and heart rate and oxygen saturation continuously. Proper patient documentation should include a paper printout of the pulse oximeter readings throughout the procedure. It may be appropriate to include a supplemental anesthesia record (Figure One: Example Anesthesia Record, can be found on the Florida AGD Website, www.flagd.org).

With vital signs assessed as stable, with all consents properly executed, and with the adult responsible companion present in the office, the sedative procedure can begin. A sedative agent is selected and administered which best matches the patient's medical profile and coordinates the agent's half-life with the anticipated length of the dental procedure. No additional medication is administered as long as the patient displays signs of sedation and is tolerant of dental treatment. The operatory configuration during dental procedures under oral sedation is only altered by the presence and use of the pulse oximeter unit. We frequently employ the GE Dinamap[®] Model DPC 400N-EN pulse oximeter to monitor patients.

Changes, continued from page 1

Tuition rates for students will be starting at \$48,000 per year, costing them about \$200,000 plus expenses for their dental school education. LECOM is currently working on options for different forms of financial aid and scholarships at this time, as federal loans will not cover the entire tuition amount. The school is not receiving any government funding or grants as of now. No statistical or demographic data has been compiled yet for the initial cohort of applicants since the school is still in the process of selecting their first class. As of the beginning of December, 2,200 students have applied.

The first two years of preclinical education will be by LECOM's Problem-Based Learning (PBL) Pathway, in which "studies are based around patient cases that provide the context for acquiring the knowledge and understanding of basic medical science. This method of learning promotes critical thinking and clinical

reasoning skills, while retention of knowledge is enhanced through its contextual nature. Since the PBL process emphasizes self-directed study with a team approach, it strongly promotes independent learning and interpersonal skills," according to the school's website. LECOM will also offer research in the area of dental education.

The LECOM DMD clinical portion of student education will be a competency based program like Nova Southeastern University, meaning that students will need to pass testing on certain procedures instead of completing a specific quantity of procedures, as in a requirement based program like the University of Florida. According to Dr. Hirsch, students will spend their entire fourth year at an extramural rotation clinic in an underserved area in either Erie, Pennsylvania or in a yet to be determined rural area of Florida. It is part of the school's mission to have

their students stay in Florida to practice dentistry once they graduate. There will be approximately 330 students earning DMD degrees per year from Florida schools, between the three college's graduate and foreign-trained dental programs.

Also, recently announced was the partnering of Springfield College in Massachusetts and LECOM to offer early admission into the Doctor of Dental Medicine program after 3 years of the college's pre-medical education. Students must successfully complete required courses while maintaining an overall GPA of 3.4 and a science GPA of 3.2, and take the DAT. This will be given to a maximum of five Springfield College students per year. There is no plan for a program like this with any Florida schools as of now. LECOM received initial accreditation in February from the Commission on Dental Accreditation.

Radiography, Continued from page 4

All new technologies should be viewed with skepticism until clinical trials are completed. However, once through the vetting process, any procedure that allows the practitioner to produce a better dental product with a more predictable outcome, while reducing practitioner liability should receive serious consideration. In "raising the bar" so too rises the expectations of the medical/dental community and thus the standard of care.

¹ Bolam v. Friern Hospital Management Committee; Wikipedia.org/wiki/Standard of Care.

² American Association of Endodontists; AAE and AAOMR Joint Position Statement

³ Cone Beam Computed Tomography in Oral Radiology; Suomalainen, Anni; Academic Dissertation; University of Helsinki, Institute of Dentistry, Mannerheimintie 172

⁴ American Association of Endodontists; AAE and AAOMR Joint Position Statement



Dr. Don Thomas, outgoing FLAGD President, transfers gavel to new President, Dr. Tony Menendez



There are certain patient factors that may require an increase of dosing or a repeat of dosing during AMOS; these include: 1) extreme anxiety or fear, 2) liver enzyme induction, 3) increased body mass or fat, 4) heavy use of stimulants (such as caffeine or tobacco), and 5) admitted drug tolerance related to past use. Certain patients will be extreme hypo-responder. These individuals are candidates for a deeper level of sedation and need to be recognized early on in the AMOS procedure and referred appropriately. Under no circumstance should a hypo-responder be administered excessive dosages outside of the established in-office sedation protocol. Instead, the dental visit should be terminated, with all routine dismissal procedures followed prior to releasing the patient to the responsible adult companion.

The opposite situation, when individuals are found to be extreme hyper-responders, carries with it the more important risk for creating an overdosing situation. These patients frequently react to medications in an idiosyncratic or exaggerated fashion. Often, a hyper-responder will provide during physical evaluation a long list of medication allergies. When properly researched, these medication lists are often found to include common manifestations of known side effects instead of true anaphylactic reactions.

Dose reductions for AMOS should be strongly considered in an identified hyper-responder, particularly if the patient is taking other concurrent medications or herbal supplements that are known to decrease metabolic clearance or inhibit hepatic enzyme systems. Well publicized lists of commonly prescribed medications are known to be moderate to potent inhibitors of the cytochrome P450 CYP3A4 hepatic enzyme. Co-administration of sedative agents in an individual suspected to have attenuated function of P450 will significantly increase the potential to over-sedate. This can inadvertently take an individual into a deeper plane of anesthesia. Patients can swiftly move from the minimal level into moderate or deep sedation which may necessitate intensive management of an unintended sedation complication.

Minimal sedation, moderate sedation, deep sedation, and general anesthesia should be viewed as a continuum. It is important to understand that every level in this continuum can be reached regardless of the route of administration or tendency for hyper-response. Individuals can easily progress into a deeper level of sedation, particularly the elderly patient. Reduced dosage (50% less than maximum recommended dose) has been advocated when sedating patients over age 65 primarily due to polypharmacy, drug interaction potential, and reduced metabolic clearance.^{6,7} Acknowledging the potential for an unplanned progression of sedation to a deeper plane was the rationale for the 2007 ADA guidelines to include training in compromised airway management. Support of respiration is an essential skill for those undertaking sedative procedures. Airway repositioning (chin lift procedures), placement of oral airways, and administration of positive pressure ventilation is often all that is required to prevent the development of a life-threatening emergency while the effects of a mild over-sedation wane. However, intraoperative recognition of an inadvertently over-sedated patient is a critical

skill. Training in the use of appropriate sedative reversal agents (like flumazenil) and keeping the agent as part of the in-office emergency drug kit will insure adequate preparedness for any rare occasion that may necessitate an anesthesia rescue procedure (see Part Two: Recovery and Reversal of the AMOS Patient).

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**LETTER SENT ON BEHALF OF DR. TERESA DOLAN
EMAIL TO UFCD STAKEHOLDERS**

It is my pleasure to provide this update about dental school proposals under consideration by the Florida Board of Governors. As you know, the University of Central Florida (UCF) and Florida A&M University (FAMU) presented proposals for new dental schools at the September meeting of the Florida Board of Governors. At that time, I had an opportunity to present a proposal on behalf of the University of Florida to expand our DMD class size, and to request operational and renovation funds to support this expansion. The agenda and meeting materials from the September 14, 2011 BOG meeting can be found at: http://flbog.org/pressroom/meeting_items.php?id=150&agenda=541 . In addition, the presentations can be found on the BOG Meeting Archives at http://www.flbog.org/pressroom/meeting_media.php?id=150 . You can also follow the press coverage of this issue at: <http://www.dental.ufl.edu/Offices/News/college-dentistry-in-news.php> .

At the conclusion of the September BOG meeting, UF, UCF and FAMU were encouraged to work together and develop collaborative proposals that would cost-effectively meet the dentist workforce needs in Florida, taking into consideration the resource challenges facing Florida and the SUS system.

In response, UF and FAMU submitted a collaborative proposal with the following key elements:

- FAMU would establish a Health Sciences Academic Enrichment Program to recruit and prepare 50 disadvantaged students for professional education in medicine and dentistry. FAMU would also implement a Post-Baccalaureate Program for students planning to apply to dental, medical and other health profession programs. UF would collaborate on these efforts as well as expand our Summer of Learning program, with the goal of enhancing the pipeline of underrepresented minority and disadvantaged students into dentistry. FAMU will not pursue a dental school at this time.
- UF would expand its DMD class size to 92 students per year. While these DMD “seats” are not promised to any group or organization, the goal is to expand dental educational opportunities for qualified Floridians. We would actively work with FAMU to enhance access for socially and economically disadvantaged students, and broadening the diversity of students enrolled in the DMD program. Renovation and operating funds are requested to support this class size expansion.

A copy of the full proposal can be found at: http://www.dental.ufl.edu/About_the_College/message_from_dean.php

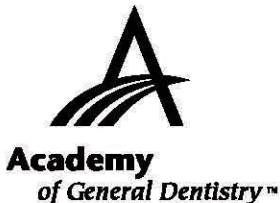
In addition, UF agreed to provide advice and consultation to UCF, should their dental school be approved by the BOG.

Prior to the Board of Governors meeting on November 9th, UCF withdrew its proposal. However, they may resubmit the proposal to the BOG for consideration at a future meeting. The UF/FAMU collaborative proposal was supported “in concept.” However, the BOG requested additional information about the budget request. As always, I will keep you informed about the outcome of future meetings.

I would like to thank the university administration, including President Machen, Provost Glover, and Sr. Vice-President Guzik, for their support and assistance during the previous few months. They have devoted a significant amount of time and attention to this issue and have been very supportive of me and the College in the process. Likewise, I appreciate the support and assistance from Florida Dental Association and the many alumni and friends of the College.

Thank you,

Teresa A. Dolan, DDS, MPH
Professor and Dean
University of Florida College of Dentistry



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