

QCDS New Member Night

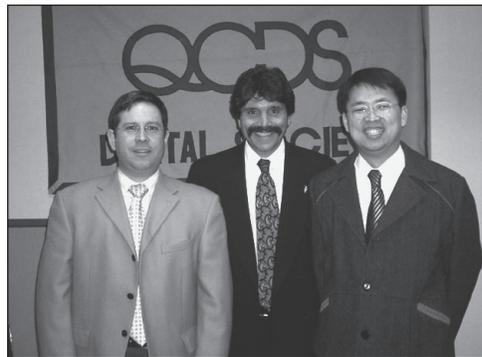
Our annual New Member Night was held on March 13th at QCDS and from the feedback obtained, both the attendees as well as sponsors were quite pleased with the program. Dr. Kiren Gehani, Chairperson of our New Dentist Committee, moderated the meeting which was attended by approximately 60 dentists including 20 residents from various residency programs. She spoke from first hand experience as she attended this meeting one year ago as a resident and is now transitioning into private practice. Dr. Shpuntoff arranged the catering which resulted in a delicious meal for all to enjoy.

Many members of our Board of Trustees and Past Presidents as well as our two NYSDA

Governors and Dr. Rekha Gehani, Past Chairperson of the New York State Board of Dentistry attended the meeting to interact with the new members and residents. Drs. Burt Wasserman, Bernard Shakter and Stephen Quarcoo, Directors of dental programs at New York Medical Center of Queens, Queens Hospital Center, and Flushing Hospital & Medical Center respectively were in attendance as a show of support for this event. We were also honored to have Dr. Steven Gounardes, NYSDA President, attend and he addressed the group stressing the benefits of membership in organized dentistry.

Amy Kulb, a partner in the law firm of

Jacobson, Goldberg and Kulb that specializes in all aspects of professional oversight and regulation spoke to the members detailing many aspects of professional regulation as well as preventive measures dentists can take to avoid difficulties with regulatory agencies and steps to help maintain good patient relations.



ABOVE: NYSDA President Steven Gounardes with Dr. Kiren Gehani at the QCDS Resident Night on March 13

LEFT: NYSDA President Gounardes with Board Members Juan Carlos DeFex and Richard Yang

A record number of sponsors attended including Countrywide Practice Brokerage, Endorsed Administrators Inc., Hayes Handpiece, NuLife Long Island, MLMIC, Sullivan-Schein, Nobel Biocare, Bank of America and Astra Tech and all felt their time was well spent in meeting both the new as well as established members. The sponsors were thanked for their generous support of this event as well as their

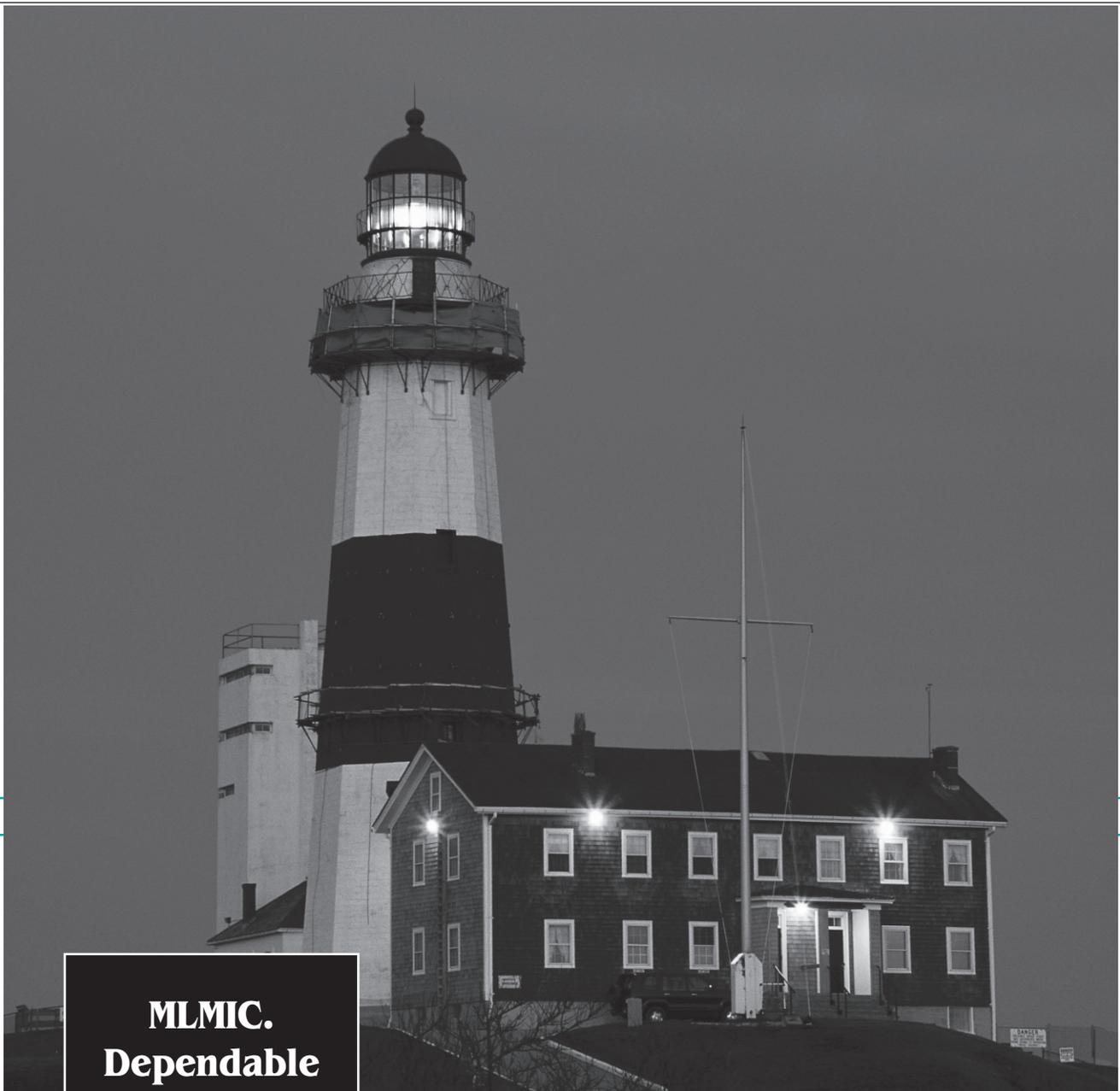
ongoing support of QCDS programs and hopefully our members will reciprocate by supporting those who support us. As the evening concluded, many of the new members were seen speaking with our Trustees as well as the sponsors who provided answers to questions the new members posed. The consensus was that this time well spent!

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Society members hear about the current controversies regarding bisphosphonates

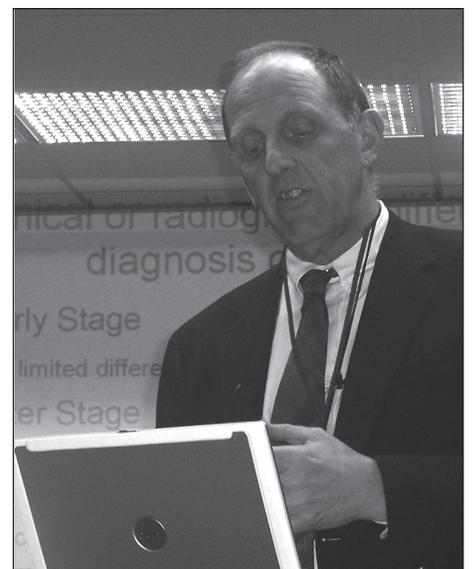
Speakers Discuss Treatment for Osteoporosis and Xerostomia

The March 6th General Membership Meeting featured two outstanding lectures. Our guests were Dr. John Fantasia, Chief of Oral Pathology at Long Island Jewish Medical Center, and Dr. Kathleen Agoglia, Associate Professor of Oral Medicine and Pathology at NYU and Director of the General Practice Residency Program at Brookdale Medical Center.

Dr. Fantasia spoke about the current controversies involving bisphosphonate (ie. Fosa-max) therapy for osteoporosis. Osteonecrosis is a possible side effect of the medication. Dr. Agoglia spoke about the causes, diagnosis and treatment of xerostomia. Her presentation was sponsored by Glaxo-Smith-Kline. Our appreciation is extended to our reps for the company, Miguel Ortega and Peter Schreck. Countrywide Practice Brokerage was also a sponsor for the evening and our thanks go to Marty Mattler for his support.



Dr. Kathleen Agoglia(center) with Miguel Ortega(L) and Peter Schreck (r) of Glaxo-Smith- Kline



RIGHT: Dr. John Fantasia at the March 6 General Membership Meeting



Is There a Doctor in the House?

By Michael S. Burstein

I remember when I was in dental school, upon being presented with a patient with a medically compromised condition, we would joke that this was a case for a R.D., Real Doctor. This self deprecating humor may have been out of place but indicative of the vacuum of education that dental students received in internal medicine. Patients need to be able to view us as “oral health physicians.”

As stated by Dr. Bruce Baum, Chief of Genetics at the National Institute of Dental and Craniofacial Research at NIH, in the January 2007 issue of JADA,

The inadequate training in medicine for dental students presents an impending crisis for dentistry.

“The inadequate training in medicine for dental students presents an impending crisis for dentistry. Dental students need to know enough medicine to treat their patients who have chronic systemic illnesses, a population that continues to increase in size.”

Dr. Baum points out that “a short substantive training experience in general internal medicine for dental students would be extremely beneficial and accomplish several goals:

- Allow dentists to better manage the care of medically compromised patients
- Help dentists generally to recognize and address the

needs and problems of the whole patient.

- Demonstrate to dental students the relevance of biological sciences in the study of cardiology, pulmonary and renal physiology.
- Help educate physicians and medical students about relevant oral health concerns.
- Enhance dentistry's role as a key partner in health care.”

New advances in dentistry have only reinforced the connection between oral health and internal medicine. The associations of periodontal disease and cardiovascular problems as well as the relationship with diabetes have been well documented. New rationales in the study of caries have taken a more immunological approach and implants require a good appreciation of histology and immunology. Genetic testing from oral fluids or stem cell research from tooth buds will offer new avenues for dentists to interact with medicine. Many systemic diseases first manifest themselves as oral lesions.

Efforts are being made to bridge this gap. The passage here in New York of the PGY-1 program, requiring completion of a general or specialty practice residency for licensure, has ultimately added a year to the already overcrowded four year dental school curriculum. Hospital programs require residents to cycle through clinical rotations in family medicine, anesthesiology and attend grand rounds. New York has set an example for the rest of the country on this and we should be applauded. NYU has recently merged its Nursing School in with its dental program. This was designed to reinforce the

medical-dental connection.

We at QCDS have made every effort to fulfill its members need for medical education. We have recently offered courses in sleep apnea and breathing disorders, colon and prostate cancer, bisphosphonates and osteoporosis, neonatal development, smoking cessation and we are working with the NYS Dental Foundation for a program on diabetes. We have also started what we hope to be a most rewarding affiliation with the Queens County Medical Society.

According to past JADA Editor and Dean at University of Pennsylvania, Dr. Marjorie Jeffcoat, “if dentistry fails to

New advances in dentistry have only reinforced the connection between oral health and internal medicine.

provide the training that enables most general dentists to offer dental care to patients with complex medical conditions, it will lose its current status as a valued health care profession and become marginalized.”

We certainly need to promote the undergraduate and postgraduate education programs in internal medicine so that we may maintain the stature as doctors that we deserve.

Program with Chinese Dental Association Highlights Korean Entrepreneur

As part of a joint program in conjunction with the Chinese American Dental Association, QCDS sponsored a terrific dinner and lecture on March 29th held at the Sheraton Hotel in Flushing. Our speaker was Dr. Kwangbum Park of Daegu, Korea, presenting “Practical Steps for Implant Dentistry.”

The meeting was cordial and enriching with about 60 members of the Chinese Association joining about an equal number of QCDS members. Everyone reported having a good time.

Dr. Park has a phenomenal background. By starting with a small dental office with his wife his business expanded to currently 17 “dental hospitals” throughout Korea. Each is about ten stories high with facilities for all facets of dentistry, technology, lab, and continuing education. Thousands of employees are all briefed and trained in procedures, technology, and practice management.

The focus of the practice is dental implants. Over one million implants have been placed. The demand prompted Dr. Park to design his own implant line and establish his own manufacturing division, Magagen, Korea. He has elected to take a one year hiatus from practice and operations in Korea to establish his line here in the U.S. The implant assortment includes fixtures for fixed or removable cases, a wide variety of implant length and widths, “rescue” implants to replace failing implants and mini implants for temporary use or tight areas.

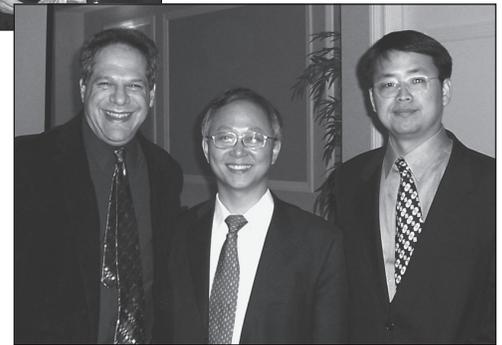
We look forward to having many more joint programs with the Chinese and other ethnic societies. We extend our appreciation to committee chairs Richard Yang and Jay Ledner for planning and arrangements for the event and to the people at Megagen who sponsored the evening.



ABOVE: Program co-chair Richard Yang with QCDS's own Barbara McCormick



ABOVE: Program co-chair Jay Ledner and board member Dr. Doron Kalman



QCDS President Michael Burstein, Dr. Kwangbum Park, and Chinese American Dental Association President Richard Yang



Candid photos of some of those attending the Chinese American Dental Association dinner and lecture.





Peer Review By William Bayer

As a member of organized dentistry, you should be aware one of the major benefits available to you is access to the PEER REVIEW process as a means of resolving patient dissatisfaction with the outcome of a dental procedure. Although many practitioners initially are upset when contacted by their component and advised of a patient complaint, this process provides an alternative to the even more unpleasant prospect of a malpractice action or referral to the Office of Professional Discipline. The following overview of the process should provide an understanding of both the process and your role as a member of organized dentistry.

Typically, a patient who is unhappy with the treatment you provided, will contact QCDS to lodge their complaint although either you or a third-party may initiate the process. Such complaint is eligible for Peer Review only if the dentist is a member, the treatment in question was completed less than 30 months ago, is not the subject of collection, litigation or being investigated by OPD, and has not been altered so

as to make clinical evaluation impossible. Non-NYSDA dentists who are employed by a NYSDA member are eligible for Peer Review under certain circumstances. The issue must involve appropriateness of treatment or quality of care. The patient is required to sign the peer review agreement which waives their right to initiation of any future malpractice action or collection efforts. As a member of organized dentistry, you MUST submit to this process and failure to do so constitutes an ethics violation. All fees paid to the dentist or owed to the dentist for the procedure(s) in question must be placed in escrow with QCDS. After all records and paperwork have been received, a mediator who is a member of the Peer Review Committee, contacts you in an effort to settle the case without a formal hearing before the Committee. At this stage, if you realize that the outcome may not have been as expected or you simply would like to resolve the issue as a matter of expediency, a compromise settlement offer can be made for hopeful acceptance by the patient. A partial fee refund for a specific procedure in question is possible only at this mediation level. If mediation is unsuccessful, the matter proceeds to a hearing where the outcome to both patient and dentist is all or nothing, meaning if the dentistry in question is found to be clinically unacceptable, then the full fee for that procedure(s) will be refunded to the patient with the possibility the dentist will be required to complete C.E. in the deficient area where the dentist has repeatedly appeared before Peer Review. Similarly, if the dentistry is found to be clinically acceptable, the patient receives nothing. The mediation level allows a compromise to be agreed upon for a refund of a partial fee for a specific procedure mutually agreed to which many times offers each party a degree of satisfaction with the outcome. However if mediation fails, the only result of a hearing is either full refund for the clinically unacceptable procedure(s) or a finding of clinical acceptability resulting in no award to the patient. Although many times a patient alleges multiple procedures are deficient, only the procedure(s) found by the committee to be unacceptable will result in a refund. For example, a patient alleges three crowns at \$800 each are deficient and claims a refund of \$2400 is due but the committee finds 2 acceptable and one unacceptable. This would result in a patient award of \$800 although the patient requested \$2400. Partial refunds for specific procedures are not possible at the Hearing level: therefore, each unacceptable crown results in the full \$800 refund award. If the dentist firmly believes the dentistry performed is acceptable, mediation is usually not a viable option.

If the complaint proceeds to hearing, both parties will appear before a committee of three dentists and a hearing committee chairperson (Dr. Adam Lighter is currently the chairman of the QCDS Peer Review Committee) at a mutually agreed upon date/time which is a weekday evening. If the dentistry was performed by a specialist who was practicing within the scope of the specialty, the panel will be comprised of specialists, not general practitioners. Both parties appear together at the hearing which is held in our conference room and both will present their cases verbally to the committee members who have already reviewed the prior documents and records that had been submitted. The committee may question each party; however, the parties themselves should

see **Peer Review** page 13

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TIME: Pre-registered check-in 8:30 a.m. Seminar runs 9 a.m. – 4 p.m.
Includes continental breakfast and buffet lunch
COST: ADA members \$275; non-ADA \$450; Auxiliaries \$75.

Conventional endodontic treatment has undergone dramatic change in the last decade. Shaping procedures which used to take years of training and hours of clinical time to accomplish can now routinely be done by novices in less than five minutes with remarkably consistent results. Three-dimensional warm gutta percha obturation techniques, previously considered to be difficult, are now easier and can be done in less time than lateral condensation.

The excitement in dentistry over these amazing technical advances is palpable, yet belies the greater importance of basic procedural factors in achieving predictable endodontic success. Cutting safe, effective access cavities, negotiating root canals to their terminal points, and accurate determination of canal length must be accomplished at a high level or the shaping and filling outcomes are irrelevant to the success of the case.

This lecture will describe the concepts and techniques necessary for clinicians to experience their delivery of conventional endodontic treatment as an enjoyable and profitable part of their dental practices. Critical technique fundamentals will be explained and shown, as well as state-of-the-art advancements in instruments, materials and technique nuance that can propel effective clinicians through several levels of higher performance.

- Upon completion of this presentation, the attending clinician will have a greater understanding of the following:
- Access outline forms needed for safe rotary shaping and new instruments which help accomplish those preparations
 - Negotiating strategies which maximize the possibility of getting to the ends of root canals and avoiding blockage
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Dr. L. Stephen Buchanan completed the Endodontic Graduate program at Temple University in 1980. In 1983 he established Dental Education Laboratories and built a state-of-the-art teaching lab devoted to hands-on endodontic instruction, where he continues to teach today. In 1986 he became the first person in dentistry to use micro CT technology to show the intricacies of root structure. In addition to his activities as an educator and practicing clinician, he holds a number of patents for dental instruments and techniques. He is a diplomate of the American Board of Endodontics and also serves as an assistant clinical professor at USC Dept. of Graduate Endodontics. He maintains a private practice limited to endodontics in Santa Barbara, CA.

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Your Contributions are Welcome

We cordially invite anyone to submit articles about any interesting members. We welcome stories about their background, experiences, hobbies or travels. If writing is not your thing, call us with the information and we will do it for you. Thank you.

Your Assistance Please

One of our priorities for 2007 is to increase our efforts both at membership retention as well as recruitment. If you have any new graduates or non-members working as associates in your office, it would be extremely helpful if you could provide us with their contact information so that our Membership Committee can reach out to them and discuss the benefits of membership in organized dentistry. Aside from the graduated dues reduction program which affords them an excellent opportunity to experience membership at a greatly reduced rate, many other benefits are available to them such as reduced cost or free CE, networking/mentoring opportunities, malpractice insurance discounts, access to Peer Review and many others that we would be more than happy to discuss with any prospective member. You have made a wise decision to participate in organized dentistry and this is an opportunity for you to share this experience with a colleague.

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Timing It Right

By Risë and Martin Mattler
Countrywide Practice Brokerage

Deciding on the best time to sell an established practice is a significant lifestyle and financial decision. We get lots of timing questions so we compiled the most frequently asked ones and our responses. While only you can make this decision, we think the following advice will be of help.

Question: Is there really a best time to sell my practice?

Answer:

The best strategy is to strive to time the sale of your practice to achieve the maximum financial gain possible. Ideally, your practice should show steadily increasing gross income over a three-year period prior to putting it on the market. It should also be netting 40 percent or more on an annual basis.

While this is the best timing scenario, the reality is that we find few doctors who actually sell a practice at its peak. Many practices we list are either on a slight decline or gross income has been flat for a few years. That's because most doctors sell at the tail end of their career once they have already cut back work days or are less productive during the hours they are working.

When making the decision to sell, we advise doing it when you can afford to financially and when you're valuing your personal time more than the next dollar you can earn.

Question: What characteristics are important to the market value of my practice?

Answer:

It is simplistic to arbitrarily appraise a practice at a set percentage of gross income, just as you wouldn't appraise a home strictly on square footage. While all practices sell for a percentage of their gross income, the transferable profit is the most important component to valuing it. Other key factors in pricing it include: patient base, fee structure, remaining staff, attractiveness of facility and location. You should understand how the key characteristics of your practice are perceived in the marketplace and then seek to attract a doctor who appreciates what your practice has to offer.

Question: How do I know when I can afford to retire?

Answer:

The best advice we can give is to make sure that you can provide for your financial needs once you no longer earn income

from your practice. If you already have a financial planner, this professional should be implementing an investment strategy to help you prepare for retirement. If you don't have a planner, we recommend hiring one.

While the proceeds from the sale of your practice should supplement retirement income, generally these monies alone are insufficient to be the major source for your retirement years.



Risë and Martin Mattler

Question: How much time is needed to sell my practice?

Answer: Our general rule of thumb is that it takes four to nine months to successfully market a practice to a qualified purchaser. If you have a practice in the outer boundaries of the New York metropolitan area, it may take a bit longer. That is because these areas are somewhat less popular with prospective buyers than those closer to New York City

Question: Can I expect to continue working part time in my practice after selling it?

Answer:

Working part-time after normal retirement age is a popular idea among some dentists. The ability to do this depends largely on these factors: how much your practice is grossing, how many patients you have, the physical space and the willingness of the purchaser to keep you on staff.

Generally, if you have a full-time practice grossing over \$700k a year, there may be sufficient physical space and patient load to support the purchaser working full time and you continuing part-time. Alternatively, if your practice is currently part-time and you wish to continue working, you may be able to merge your practice into another doctor's office nearby. In this scenario, the purchaser would pay for the equity in your practice and hire you to work a reduced schedule.

In conclusion, you have more than one option for transitioning your practice. The more thought and planning you put into it, the greater the chances that you will be able to leave your practice knowing that it will be just as valuable to a new owner as it has been for you through the years.

Martin and Risë Mattler are principals of Countrywide Practice Brokerage, the endorsed practice broker of Queens County Dental Society. They can be reached at 800-222-7848 or visit their website: www.ddsbrokers.com

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Peer Review *from page 7*

not direct questions to each other. Either party may have attorney representation. After this exchange, all parties will go downstairs to our dental exam area (so that's why we have that dental chair) where the committee will exam the patient and dentistry in question. After the exam, all return to the conference room for any other comment or questions from the committee and upon completion, the hearing concludes. Both parties receive written notification of the decision which is also filed with NYSDA. This decision is subject to APPEAL by either party within 30 days on the limited grounds of significant "new" evidence or major irregularities on the part of the committee with the appeal reviewed by NYSDA's Council on Peer Review and Quality Assurance.

It is noteworthy that an adverse finding against the dentist is not reportable to the National Practitioner Data Bank which is not the case where any type of settlement has been made by an insurance carrier in a malpractice action. (NOTE: If the dentist elects to have his/her liability carrier make payment, then the carrier must make a National Practitioner Data Bank report so most dentists do not involve their malpractice carrier). The peer review process and decision is confidential and the outcome of the hearing or mediation is essentially known only to those who participated. Unlike a malpractice action where a dentist has virtually unlimited financial liability, the peer review process established the maximum potential award to the patient as a full refund of the fee paid for the service at issue. No award can be made for "pain/suffering" or punitive damages.

In the interests of providing an overview of this process, I have omitted many other facts relative to Peer Review. NYSDA publishes a booklet (GUIDE TO PEER REVIEW) available to those members who would like to explore this issue in more detail. Although the vast majority of you may never be involved in the

Peer Review process, this is a valuable benefit available to you in the event that all your efforts to satisfy a particular patient are unsuccessful.

Peer Review provides a valuable mechanism to address dissatisfied patients who have very limited alternatives in that dental malpractice actions usually are not of interest to attorneys and the OPD process may result in a punitive action relative to a dental license but cannot provide any financial or remedial relief. The dental profession has the opportunity to "police" itself and demonstrate that we are concerned that patients receive appropriate dental care- one of the few "win/win" situations for both patient and dentist!

Thanks to Dr. Lighter for his help in preparing this article.

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Study Clubs

Wednesday
May 2, 2007
7:00-10:00 PM

- **Importance of Proper Record Keeping**
Speaker Ms Toni Reale, Esq
Registration 516 775 7080
Glen Head Study Club

Tuesday
May 8, 2007
7:00-9:00PM

- **Dentures and Overdentures: The Sleeping Giant**
Speaker Dr. Steven Weisglass
Mr. Lenny Marotta
Registration 718 544 8787
Assn for Advanced Dental Studies Meeting

Wednesday
May 9, 2007
7:00-9:00 PM

- **Orofacial Pain & Dysfunction-Differential Diagnosis & Management**
Speaker Dr James Uyanik
Registration 718 299 3838
Fialkoff Study Club

Friday & Saturday
May 18 & 19, 2007
9:30-3:30 pm Friday
10:00-2:00pm Sat.

- **The Innovative Approach to Implant Surgery for the General Practitioner**
Speaker Dr. Michael Katzap
Rego Park Dental Study Club

Wednesday
May 23, 2007
6:30-9:00PM

- **Implant Borne vs. Tissue Borne Overdentures**
Speaker Dr Glen Applebaum
Registration 718 268 7400
Implant Study Club

Wednesday
June 13, 2007
7:00-9:00 PM

- **Immediate Implant Teeth - Current State of the Art**
Speaker Dr. Keith Progebin
Registration 718 299 3838
Fialkoff Study Group

Tuesday
June 19, 2007
6:30-9:00 PM

- **Laser Dentistry for the GP**
Speaker David J. Poiman, DDS, FAGD
Registration 718 634 2123
Steinway Dental Study Group

Wednesday
June 20, 2007
7:00-9:00 PM

- **Laser Dentistry for the GP**
Speaker David J. Poiman, DDS, FAGD
Registration 718 634 2123
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CE Courses

Pre registration is required for all continuing education

Friday, May 4, 2007

9:00-11:00 AM 2 CE

VIDEO STUDY CLUB

Inexpensive, Strong Splinting Of Teeth

Splinting with crowns is effective, but radical and expensive. This presentation shows simple, strong technique for splinting periodontally weakened teeth with resin and various reinforcement materials, including wire and Kevlar. Techniques are fast, easy and economically acceptable. It allows improvements in esthetics while splinting teeth.

MODERATOR: DR. A. AL GULUM

A member benefit course
Non ADA Members \$250.00
Light breakfast served

Friday, June 15, 2007

9:00-11:00 AM 2 CE

VIDEO STUDY CLUB

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new tape

Splinting Teeth With Reinforcement Fibers

(New Concepts Video Series)

Simple esthetic splinting of periodontally or orthodontically traumatized and weakened teeth with reinforcement fibers. This technique is fast, effective and greatly appreciated by your patients!

MODERATOR: DR. A. AL GULUM

A member benefit course
Non ADA members \$250.00
light breakfast served

Friday, May 11, 2007

9:00 AM- 4:00 PM 5 CE

CPR - Certification & Re certification

Basic Cardiac Life Support

Certification & Re Certification will cover 1 & 2 rescuer CPR, Heimlich maneuver, child CPR and AED.

The ability to recognize the signals of a heart attack and provide stabilization of the victim at the scene of a cardiac arrest is a priceless commodity. Life over death may some day become a reality to someone you know or care for. Be prepared to help save a life.

If your CPR certification is 2 years old or less and you want to re-certify, you must submit a copy of your BLS card with your registration. If you do not have a current BLS card, you will need to take the complete certification course again.

Instructors: Mr. Paul Jacobs, BLS Instructor, NYU College of Dentistry and Bellevue Hospital Center and Staff

Tuition: ADA Member \$95
ADA Member's Staff \$95
Non ADA Member \$250

Light Lunch Served
Please register early with a copy of your BLS card
registration is limited

Tuesday, 5/1/07

General Membership Meeting

SCIENTIFIC SESSION.....8:00 PM 1 CE

Providing Dental Care To Patients with Developmental Disabilities An Introduction For The Private Practitioner

Currently, the number of dentists engaged in institutional or public health dentistry is a minority, perhaps only 10% of the total in the state. It is to the vast pool of private practitioners to whom we look for assistance in meeting the monumental challenge of providing care for the developmentally disabled.

During the past 20 to 25 years, in New York State, most individual with developmental disabilities who had previously been housed in large institutions have been mainstreamed into community-based residences. This shift has created a need for dental services in the community. This lecture will provide information and tips to assist the general practitioner with integrating these patients into a private practice setting.

SPEAKER: DR. RODERICK MAC RAE

Adjunct Assistant Professor, Columbia University, Division of Community Health, past Chairman, NYS OMRDD Task Force on Special Care Dentistry, Co-founder, NYS Office of the Mentally Retarded & Developmentally Disabled Task Force on Special Care Dentistry.

Restrictive Covenants In Dental Employment .1 CE

A restrictive covenant is a contract provision that specifies a limitation of a specified time, scope and geographic area on the ability of the newly hired dentist to practice dentistry if he or she departs the practice, in exchange for the physician being employed by or obtaining a equity interest in a practice.

Obviously, the validity of the restrictive covenant is of paramount concern to both the existing practice & the newly hired practitioner. As to the latter, given the possibility of failure inherent in all employment relationships, he or she is understandably concerned about whether or not the restrictive covenant will unduly interfere with the ability to practice dentistry should the relationship terminate.

This lecture will address the legal principles involved in enforcing - or avoiding the enforcement of - restrictive covenants

Speaker: Mr Andrew Zwerling Esq
Garfunkel, Wild & Travis

THE CHILDREN'S DENTAL HEALTH MONTH CONTEST WINNERS FOR QUEENS WILL BE PRESENTED THEIR AWARDS DURING THIS EVENING. AT 6:30 PM PLEASE JOIN US FOR A FESTIVE PARTY TO CONGRATULATE THE CONTESTANTS AND OFFER OUR ENCOURAGEMENT AND SUPPORT.

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A Look at Dental Forensics

Identification of Resins Aid in Body Recognition

When an explosion, accidental cremation or a fire set deliberately to cover a crime destroys a body, precious little may remain to link it to a life once lived.

Yet even among the ashes, a team of forensic dental researchers at the University at Buffalo has shown that evidence exists that can help identify human remains when all else -- flesh, bones, teeth, DNA -- is lost.

The evidence can be hard to recognize, but it is distinctive.

In a series of experiments reported in the May 2006 issue the *Journal of Forensic Science* and in an upcoming article in the same journal, the researchers show for the first time that inorganic resins that make up the central matrix of tooth-colored dental fillings can withstand temperatures of 1,800 degrees Fahrenheit, be recovered and named by brand or brand group.

Even when only fragments of resin could be found, the researchers were able to classify the composition of elements in the filling. Comparing those elements and their proportions to the composition of the known filling brands recorded in a deceased's dental chart could, under the best circumstances, help identify the remains unequivocally.

At the very least, the analysis could determine if the filling material was or was not consistent with a person's dental records.

Mary A. Bush, D.D.S., said this new type of evidence could have a major impact on forensic dentistry.

"To date, no one has recognized that many modern restorative resins have unique characteristics that can be distinguished and used for forensic identification," said Bush, assistant professor of restorative dentistry in the School of Dental Medicine at the University at Buffalo and lead author on the studies.

"Nobody has applied the standard analytical methods that we have at UB to survey these materials and determine these properties."

Peter Bush, director of the instrument center where much of the research analysis was conducted, was a major contributor to the research, along with Raymond Miller, D.D.S., UB clinical assistant professor of oral diagnostic sciences and a forensic den-

tal expert, and Jennifer Prutsman-Pfeiffer, anthropologist and UB doctoral student.

The team's work has yielded unexpected rewards. The FBI has offered to include the information in their database, and the American Society of Forensic Odontology provided a grant to help assemble the data.

"The importance of identifying these properties is, first, to show that it can be done," said Bush, "and second, that it can be done even after extreme events such as mass disasters, plane crashes or explosions," or a murder.

The 1999 trial of Donald Blom, accused of killing Katie Poirier after abducting her from a Minnesota convenience store, demonstrated the usefulness of such forensic evidence. Blom confessed to the crime, but later recanted. The body never was found, but human bone fragments and a single tooth were unearthed in a burn pit on Blom's vacation property. Analysis of the components of the tooth's filling material matched the brand of filling recorded in the victim's dental records. That evidence helped put Blom in prison for life.

Bush and colleagues began their experiments in mid-2005, using UB's specially equipped instrument center, which includes a scanning electron microscopy/energy dispersive X-ray spectroscopy equipment, known as SEM/EDS, and a portable X-ray fluorescence (XRF) unit to conduct material analysis outside the lab.

They had access to cadavers for the second research phase through the UB School of Medicine and Biomedical Sciences' Anatomical Gift Program, to which persons donate their bodies for use in teaching and scientific research.

Initial experiments were carried out with teeth only.

The investigators created disks of 10 different resins used for standard tooth fillings to serve as controls, then filled extracted teeth with the resins and incinerated them in an oven at 900 degrees Centigrade (1,652 degrees Fahrenheit) for 30 minutes.

These conditions were more extreme than in a standard cremation, Bush noted, because teeth normally would be protected by flesh and bone, allowing them to withstand the high temperature for a longer

period of time. With no such protection, the extracted teeth fragmented in half-an-hour.

Dental resins consist of an organic matrix surrounding inorganic filler particles. "At these high temperatures, everything organic is destroyed," said Bush. "It was the inorganic material that was recoverable."

After retrieving the resins fragments, the team analyzed their elemental composition using SEM/EDS. In the May 2006 issue of *Journal of Forensic Science* they reported they were able to identify the concentration and microstructure of the inorganic elements in the fragments and link them to the specific brand or brand group of the material documented in the controls.

"Not only do these materials have various microstructures," said Bush, "they also have unique elemental compositions, which makes it possible to distinguish between brand or brand groups. We showed that the elemental distinction remains even after extreme conditions such as cremation."

To create a true-to-life scenario, the team worked next with cadavers donated to the medical school's Anatomical Gift Program. (Full approval from the university's Human Subject Review Board was obtained for the study.) They removed all existing resin fillings from the teeth of six cadavers and replaced them with a total of 70 fillings representing five different resin brands. The filling brands used were recorded in each cadaver's dental record.

With the new fillings in place, the bodies were put through the standard two-step cremation process: very high heat (1,800 degrees Fahrenheit) for two and a half hours, which destroys all flesh and small bones, then crushed in a grinder and reduced to ashes.

Bush and colleagues were able to find and identify enough of the resins to make a positive identification of each cadaver, using the portable XRF unit to mimic investigations that need to be conducted in the field.

The results of this study will appear in the online version of the *Journal of Forensic Science* in December 2006 and will be published in the January 2007 print issue.

"Even in the ashes, we were able to

see *Dental Forensics* page 19

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Dental Forensics *from page 17*

retrieve small pieces of resin and distinguish between cadavers," said Bush. "To my knowledge, this is the first time this type of analysis has been done. This study provides hope of identification when little hope may be present.

"If an individual isn't burned to this extreme and the teeth are intact, but the dental X-ray comparison is questionable or teeth are fragmented, this type of analysis can give another level of certainty on which to base an identity," she said.

XRF doesn't provide as much information as the lab-based SEM/EDS equipment, Bush noted, but its speed compensates for lack of precision. The device can identify the chemical spectrum of elements in inorganic material in 6-10 seconds, providing quick on-site screening of suspected material.

The ability to distinguish between resins gives investigators a new tool for use in special circumstances, Bush said.

"Retrieving small amounts of resin as we did in this study would not carry as much weight for identification as a dental chart comparison, but the evidence was indisputable and unequivocal. This evidence would serve as an aid in identification when very little other evidence exists or when added scientific corroboration is needed."

Bush and her co-investigators currently are working with the FBI to construct a database of the most common brands of dental restoration materials and their elemental composition for use in criminal investigations.

"There are more than 50 filling materials on the market today," said Bush. "We have analyzed the 30 most popular resins and 23 historical resins dating back to 1971. There are also many other unique dental materials -- posts, cements, crowns, sealers -- that also will be included in our database. Again, no one else has attempted such a comprehensive survey of their properties."

The database does have limitations: It will be useful only if dentists document all dental restorations, including brand names, in their dental records, noted Bush.

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