On the Cusp

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EASTERN DENTISTS INSURANCE COMPANY

Clinical Risk Management for Today's Dentist

EDIC CASE STUDY

No Informed Consent = A Fast Track To A Lawsuit

The patient, a 57-year-old male, was first seen by our insured general dentist on December 3, 2003. He presented with pain in tooth #19. In his medical history, the patient indicated that he had been treated for tonsil cancer and he had received chemotherapy and massive doses of radiation treatment in or around 2000-2002. The patient also had visible scarring and deformity from surgical intervention to his neck. It was also noted in the chart that the patient had radiation induced xerostomia. The insured had previously treated radiation patients, and he generally discussed the proposed treatment of a root canal on #19 with the patient as the least invasive procedure. However, the insured did not utilize written informed consent forms, and he did not specifically discuss the potential risk of osteoradionecrosis (ORN) with the patient for this treatment. The root canal on #19 was completed and a crown was placed. Thereafter, the patient became a regular patient for routine hygiene visits, fillings, and several crowns. The insured tried to minimize radiographs, which were only taken when deemed necessary. Recommendations for Biotene and ACT fluoride rinse were also noted in the chart. On December 11, 2008, the patient presented with #25 broken off at the gum line. The coronal portion of the crown had completely separated from the root. Due to the severity of the break, the insured informed the patient about the need for extraction, and advised the patient to speak with his primary care doctor about the situation. In the interim, the patient had a routine hygiene visit on January 6, 2009. There was no notation in the chart, but the insured reported that the patient subsequently spoke to his physician and advised the insured that the extraction could go forward. The insured pre-medicated the patient with Amoxicillin, and #25 was extracted on March 30, 2009 without incident. Once again, no written informed consent was obtained, and the insured acknowledged that he did not discuss the specific risk of ORN with the patient prior to this extraction.

On May 28, 2009, the patient presented for an emergency visit for #30 which was broken off at the gum line. Although not noted in the chart, the insured reported that he discussed the situation with the patient and it was decided to build up the tooth and place a crown. Again, this was the least invasive treatment. The crown was cemented on July 1, 2009. Thereafter, the patient had uneventful prophy visits on July 20, 2009 and January 26, 2010; fillings for #11 and #13 on February 26, 2010; and a prophy visit on August 12, 2010.

On December 29, 2010, the patient presented with an emergency condition of extreme pain and very apparent swelling around #30 and #31. The insured took a periapical x-ray, which he was subsequently unable to locate in his records. The insured recalled that the patient was in excruciating pain and was so swollen that he could neither open nor close his mouth completely. The insured diagnosed an abscess, and it was very apparent to him that the patient was in the midst of a very serious infection, - possibly developing cellulitis. Moreover, the insured was aware that the patient had a greater risk of escalating infection due to his compromised blood flow in this area from the prior radiation treatments. Accordingly, the insured considered this a potential life-threatening situation. He prescribed Keflex because he believed this was the first line of defense against cellulitis. The insured apprised the patient of the severity of the problem. The patient was told to speak to his primary care physician about the situation and to report to an emergency room if the swelling worsened, particularly if he began to experience any difficulty breathing. The patient returned on an emergency basis again on January 6, 2011. The insured reported that the patient said he had spoken to his primary care physician and the chart notes: "Says primary care doctor would like us to prescribe if we feel it necessary (reference to Vicodin?)". There is no other specific notation in the chart as to recommendations from the primary care doctor. The patient was still reporting unbearable pain and the swelling persisted. The insured spoke to the patient about the severity of the unresolving infection and suggested that the extraction of #31 would be the most appropriate and expedient way to address the issue. The insured also determined that, given the patient's extreme pain and unresolved infection, waiting for an oral surgeon referral was unnecessary and potentially dangerous. The patient agreed to proceed with the extraction, but there was no written informed consent given, nor was there any specific discussion about potential ORN risks. The insured believed that the overriding problem was the potentially life threatening infection. In his judgment, whether the patient had ORN, or was at risk for ORN, was irrelevant and impossible to determine at that moment.

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Case Study... page 1

The insured recalled that #31 was easily extracted (non-surgical), and he adamantly denied that he could have injured or fractured the patient's jaw during this procedure. The patient continued the same antibiotic and was reminded of the potential severity of the infection, and emergency protocol.

The patient returned four days later on January 10, 2011 for an unscheduled visit. He reported continuing pain. Upon examination, the insured noted that the extraction socket was not healing as expected. He switched the patient's antibiotic to Amoxicillin and referred him to an oral surgeon for evaluation.

This insured notified EDIC by letter on 8/26/13 stating that he had received notice of a lawsuit. The suit alleged that the insured should have had the patient on a regimen of fluoride. The suit further alleged that a CT scan showed a fracture through the extraction site of #31 and a diagnosis of ORN was made by the oral surgeon. They claimed a failure to consult with the PCP, failure to utilize less invasive treatment, failure to inform the patient of alternatives and risks, and failure to treat the patient properly for his complications. His most significant injuries were to his speech and ability to swallow secondary to jaw resection surgery. The hospital swallow therapy records confirmed that the muscle and nerve damage post mandible resection caused the patient to swallow food into his windpipe. He needed to put his head down and force liquids into his throat properly. His condition was such that he was sensorally unaware that he was swallowing into his lungs. This condition was permanent and not treatable. He claimed he could not eat any solid foods and had lost over 30 pounds since the 2011 mandible surgery. He reached such a level that his physicians had to insert a feeding tube for nourishment. The patient remained exposed to aspiration and in fact had a severe incident of aspiration pneumonia. The family feared that he would not pull through that incident. The patient alleged over $100,000 in medical bills because of the insured's negligence.

The plaintiff identified a well credentialed oral surgeon as his expert. The expert opined that the failure of the insured in safeguarding the dentition of a radiated patient, failure to refer to an oral surgeon, and failure to utilize hyperbaric oxygen prior to the extraction were all below the standard of care expected and caused the patient's injuries.

"...the insured did not utilize written informed consent forms, and he did not specifically discuss the potential risk of osteoradionecrosis (ORN) with the patient for this treatment."

EDIC hired an oral surgery expert as well, and this expert was critical of the insured in several areas of this case. The expert stated that having no informed consent for the extraction, having no person to person contact between the dentist and the Oncologist/MD to know exactly where the area of radiation was exposed in the treatment of tonsil cancer, and the choice of Keflex as first antibiotic were all below the standard of care. The fact that the initial x-ray was lost was also impossible to defend. However, the oral surgeon also explained that research indicated an approximate 20% risk of a radiated patient developing post-surgical ORN without hyperbaric oxygen pretreatment. But even with hyperbaric pretreatment, the risk is not eliminated, but merely reduced to approximately 5%. Our oral surgeon also disagreed with the plaintiff's expert that hyperbaric pretreatment was the standard of care. The expert stated that those treatments require more than 20 ½ hour to 1 hour sessions, prior to surgery. This patient had an active and non-responsive infection and pain, which would not accommodate this lengthy pretreatment protocol. He also pointed out that the patient did not have hyperbaric oxygen pretreatment before undergoing his post-extraction mandible resection surgery at the hospital following the dental treatment in question.

Our expert further opined that the "pathologic fracture" to the patient's jaw was not caused by the trauma of the extraction, rather it was due to the ORN taking effect. If the fracture had occurred at the time of the extraction, the patient would have experienced pain immediately, but the patient reported he was comfortable for more than 2 days post-surgery. Our oral surgeon believed that the patient likely had ORN at the time of the infection. Conversely, an infection can cause ORN progressing to a pathologic fracture. The expert stated that ORN would not have been detectible from the missing 12/27/10 PA x-ray. There is no "test" for ORN that could have been performed; a dentist cannot "diagnose" ORN without a biopsy to confirm dead bone.

While EDIC believed we had a solid causation defense to present at trial, the patient's overall presentation was sad enough that we had a real concern a jury could ignore a robust and substantively solid defense at trial. The patient's facial deformation was obvious. His speech impediment was severe, and emphasized by the genuine effort and struggle he had with certain words. If a jury found in favor of the patient, a verdict would have certainly exceeded the insured's $1 million policy limit. With the insured's permission to attempt settlement, EDIC and the patient's attorney agreed to go to mediation of the case. The patient's initial demand was for the insured's $1 million limit. After several mediation sessions, the case was settled for $600,000.

CASE STUDY
Risk Management Comments

This would have been a very difficult case to bring to a jury. Movie buffs may recall the old Hitchcock plot device called the McGuffin. Hitchcock would lead his viewers down a path of misdirection so as not to spoil the surprise ending. In this case, our defense counsel would have been forced to spend so much time jockeying with the plaintiff and his experts over the poor record keeping and lack of informed consent, that the jury might had been distracted from the real fact in this matter, that our insured did nothing wrong clinically which caused the ORN. Again, it became another instance of poor record keeping and lack of informed consent rather than clinical practice that did not meet the standard of care that could have led to a jury verdict. A patient's attorney will throw many theories at a jury: below standard treatment, lack of informed consent, poor record keeping, missing radiographs, and poor follow up care. If a professional baseball player hit 1 for 5, he wouldn't last long in the major leagues. However, a patient's attorney must hit only on one of these theories of negligence to win an award. This patient would have made a tremendously sympathetic appearance to a jury, having survived throat cancer, but now unable to eat, losing weight, and facing several almost fatal bouts of aspiration pneumonia. If EDIC had tried the case and lost, the jury verdict would have almost certainly been more than the $1 million policy limit.

2017 SPRING WEBINAR SERIES

ADA C·E·R·P® | Continuing Education Recognition Program

May 9, 2017 | 7PM EST

Practical Periodontics: A Review of Core Periodontal Concepts

Presented by Ancy Verdier, DMD

Topics Covered:
Socket Preservation
(Bone grafting methods and reasoning)
A review of various patterns of bone loss: Vertical vs. Horizontal. Gain a better perspective on various bone grafting procedures and a review of materials utilized in grafts.

Osseous Surgery/ Crown Lengthening
A review in bone types 1-4, as well as bone morphology and histology. Participants will also receive a review on equipment utilized with different osseous surgeries from implants and extraction to pocket reduction. Basic review on flap design and suture techniques utilized for maximal esthetic consideration.

Periodontal Disease Classification
(Reviews current periodontal classification from AAP)
A review of basic and current classification of periodontal disease and prior treatment modalities as well as current trends in care.

Soft Tissue; CT Graft
A review of different types of connective tissue and basic histology and cellular components.

June 7, 2017 | 7PM EST

Picture Perfect

Presented by Ronni A. Schnell, DMD

Description: Digital photography is an integral component of your practice armamentarium. It is as important in patient intake as well as during the course of treatment. It can facilitate treatment planning, become part of the patient permanent record and showcase your before and afters. Digital photography is also an excellent communication tool with laboratories, specialists and in online marketing. Like any technical skill, it takes practice to master, but having the right tools, both in equipment and knowledge, will put you on the right path to get started.

Learning Objectives:
- Types of equipment available
- Mirror and retractor use
- Patient positioning
- Camera, lens and patient positioning
- Storing and transferring images

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EDIC is an ADA-CERP recognized provider, and dentists may earn two CEU credits per session and be eligible for risk management insurance discounts.

LETTER FROM THE EDIC CHAIRMAN

Across The Board

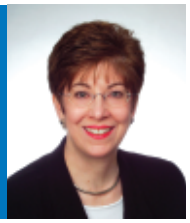
Richard LoGuercio, DDS | Chairman of the Board | rloguercio@edic.com

As Chairman of EDIC, my primary role is to continue to protect, preserve, and advance the mission of the company with the assistance of the Board Directors and our dedicated and knowledgeable staff. That mission is to provide the best possible malpractice insurance coverage that protects you, our policyholders, at the least possible premium, while maintaining a financially sound company. With EDIC's continued growth into eleven states; we have diversified our risk of policyholders and mitigated our risks. As owners and policyholders of the company, you can help our company's risk management efforts by practicing dentistry in a manner that mitigates your risk of being sued.

In my forty-four years of general practice, here is my professional philosophy on how to treat patients:

- Treat every patient as a member of your own family with empathy and kindness.
- Your motivation and rationale for treatment should always have the best interests of the patient.
- Patients don't always care about how much you know, but they always care about how much you care.
- Always inform before you perform, give patients choices, be transparent about the risks involved regarding your treatment plan and what patient expectations are for the final result.
- Don't attempt any procedure on a patient that you can't anticipate the same result that a specialist would get if they did the same procedure.
- Always document what transpires at a treatment visit. A complete record always aids in defending your treatment if an unfortunate incident should occur with a patient.
- Make sure your staff exhibits that same philosophy in their patient interactions.

EDIC continues to build its extensive risk management program for you, our colleagues, because we want you to be better clinicians. As we celebrate EDIC's 25th anniversary, it gives me great pride to be at the helm of the only "By Dentists, For Dentists"® company and we support our colleagues 100%. Thank you for your continued loyalty.



WITHIN YOUR CONTROL

HIPAA Security – How Does it Relate to Personal Devices?

Debra K. Udey | Risk Manager | dudey@edic.com

As everyone knows, HIPAA, the Health Insurance Portability and Accountability Act, was passed in 1996. The major piece of the Act allowed people to keep their health insurance when they changed employers. Another piece of the Act involved the confidentiality of personal health information (PHI).

HIPAA History and Compliance Requirements

In order to be compliant with the HIPAA Act, covered entities (dental offices) needed to create a plan that would keep their PHI confidential by:

a. Performing an assessment to ensure their practices and protocols met with the confidentiality requirements,

b. Establishing a HIPAA plan for the office to maintain confidentiality of all PHI,

c. Training their staff to abide by the requirements,

d. Putting agreements in place with Business Associates (BA) who had access to confidential information (billing, accounting, answering service, transcription services, etc.) to ensure any information they accessed was kept confidential,

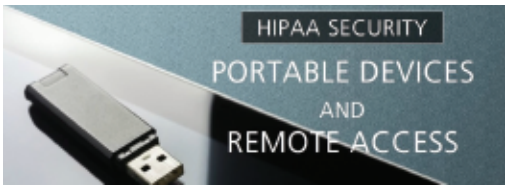
e. Generating a HIPAA document for patients to acknowledge their approval for the office to use their PHI in the office's normal course of business.

Though this was initially viewed as overwhelming, most offices were able to reasonably accommodate the requirements. The law was initially fairly benign, and unless a situation occurred such as someone dumping many years' worth of records into an open dumpster where they could fly around, fines were relatively rare.

In 2009, the HIPAA HITECH Act went into effect. It was attached to the Affordable Care Act, and dealt with the electronic version of PHI. Additional requirements were put into place to ensure that PHI kept electronically (through any electronic device) was kept safe.

Then, on September 23, 2013, the Omnibus Rule was passed that mandated that the Health and Human Services (HHS) Office of Civil Rights (OCR) begin to audit covered entities and Business Associates. The Rule primarily enforced the regulations already in place, and added a burden to BAs requiring them to adhere to the privacy and security rules themselves.

The Rule called for Federal auditing of covered



entities and increased funding for the audits. Prior to this time, investigations were carried out largely due to complaints by patients.

Ominous stories began to surface about fines being assessed such as one for $1 million to an Ophthalmology practice that lost an unencrypted laptop containing patient information (though the information was not accessed).

The rule also held that wrongful disclosure of PHI was now a criminal tort (legal wrongdoing) that could land the covered entity in jail for wrongful disclosure on his or her part as well as for acts of an improperly trained staff. While this is enough to keep people awake at night, the fact of the matter is that there have not been any such actions.

New Technology and Security Requirements

Technology keeps advancing that makes lives easier for dentists. With those advances comes the necessity to ensure that the information shared through various technologies (websites, email, texting) meets the security requirements. The question whether the HIPAA Privacy Rule permit health care providers to use e-mail to discuss health issues and treatment with their patients has been answered by HHS – the Privacy Rule allows covered health care providers to communicate electronically with their patients, provided they apply reasonable safeguards when doing so. Encryption is not required for such email transmission, but other safeguards should be used, such as:

- Checking email addresses for accuracy before sending
- Sending an e-mail alert to the patient for address confirmation prior to sending the message

When sending information to other care providers via email:

- Limit the amount or type of information disclosed through unencrypted e-mail (as patients have the right to request copies of all information)
- Limit identifiable patient information

Texting is also allowed given the same parameters. In general, items such as appointment reminders and prescription refills do not need to be encrypted, but other clinical information should be.

Personal Devices

Personal devices are considered the highest risk for breach potential. Each office should have a policy in place to cover personal devices. When an audit is performed on all electronic devices used in the office to ensure that proper precautions have been taken to protect the information on them, personal devices should be included.

All devices, personal or other, that contain PHI should be encrypted. Breaches of PHI on any device used by the office are reportable to the HHS OCR, except for encrypted devices. Hence, the importance of encrypting the devices. As the most common cause of a breach is stolen devices, encryption of them is even more important.

General Tips to Prevent Disclosure of Data

Dental and physician offices have unfortunately become targets of hackers, given the amount of information (medical, financial, etc.) kept in them. Some clinical offices have been the target of hackers, some of whom encrypt your data and demand a ransom to unencrypt it. Here are some general tips to help protect yourself.

- Use encryption for all devices in the office (e.g., Bitlocker is an easy encryption application)
- Chrome and Firefox are harder to break into than Internet Explorer
- USB memory sticks can be used to insert malware into your computers. Beware of memory sticks found out in the open – hackers may place them to be "found" by innocent people who then "use" them in their computers to disastrous results.
- Train staff not only on HIPAA requirements, but also about phishing emails
- There are free text encryption applications that can be used to encrypt texts

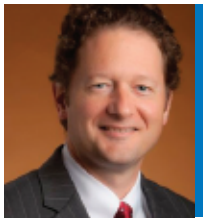
Summary

Electronic devices have made many of the tasks necessary in the dental office easier to accomplish. With the ease comes requirements to keep PHI safe. Take the time necessary to complete an audit of your data and electronic information to ensure you keep it, and you, safe.

ATTORNEY'S VAULT

Prenatal Dental Treatment

Robert C. Shindell | Barton Gilman, LLP | rshindell@bartongilman.com



Robert C. Shindell is a partner at Barton Gilman, LLP (bartongilman.com), with offices in Boston and Providence. Bob has defended dentists and other professionals in the courts of Massachusetts and Rhode Island for over twenty years.

In a recent article published in JADA, Dr. Thomas Raimann reviewed ethical issues that can arise in the context of treating (or declining to treat) a patient during pregnancy. (Raimann, The Ethics of Dental Treatment During Pregnancy. JADA. 2016; 147(8): 688-689.) The article was premised upon a question raised by a practitioner involved in a program to promote dental care during pregnancy, who noted a "problem with some dentists refusing to see pregnant women until after they give birth."

Dr. Raimann addressed this question from the standpoint of pertinent sections of the ADA Principles of Ethics and Code of Professional Conduct. In brief, he wrote that where a patient seeks emergency, preventative or restorative treatment and the practitioner refuses treatment "solely because the patient is pregnant," the "dentist is misinformed about the guidelines for treatment of pregnant women and may be placing concerns about liability above the needs of the patient." He premised this conclusion in part on a study that concluded that prenatal dental treatment is "not associated with an increased risk of experiencing serious adverse medical events, preterm . . . deliveries, spontaneous abortions or stillbirths, or fetal anomalies" (citing and quoting Michalowicz BS, DiAngelis AJ, Novak MJ, et al. Examining the safety of dental treatment in pregnant women. JADA. 2008; 139 (6): 685-695). Dr. Raimann also cited a consensus statement from the Oral Care During Pregnancy Expert Workgroup in 2012 that "dental treatment during pregnancy is not only safe but also a key to overall health and wellbeing," (*Oral Health Care During Pregnancy: A National Consensus Statement.* Washington, DC: National Maternal and Child Health Resource Center; 2012) as well as a JADA article from 2015 finding that use of local anesthetic during pregnancy is safe (Hagai A, Diav-Citron O, Schechtman S, Ornoy A. Pregnancy outcome after in utero exposure to local anesthetics as part of dental treatment: a prospective comparative cohort study. JADA 2015; 146(8): 572-580 [published correction appears at JADA. 2015; 146(12): 874]).

There have been very few dental malpractice lawsuits reported in which prenatal dental treatment is central to the case. One such matter was Robinson v. Wilkinson, filed in Louisiana. The patient claimed that an anesthetic used by her dentist somehow caused or contributed to her miscarriage. Although the background information about the case is scant, it appears that there was no jury award at trial. However, there may have been a confidential settlement to resolve the case.

In a case filed in Michigan, Mitchell v. Scesny, the patient alleged failure to diagnose and treat periodontal disease. She claimed that her dentist did not take radiographs because she was pregnant, and that the dentist's failure to take radiographs and perform pocket depth probing delayed her diagnosis of periodontal disease. In contrast, the dentist contended that the patient declined radiographs due to cost, and that she was herself negligent for missing appointments. The defense also put on expert testimony that the delay in diagnosis did not affect the patient's outcome. The jury in the case found a breach of the standard of care by the dentist, but no proximate cause between the breach of the standard of care and harm to the patient. The net effect of this finding was a defense verdict.

The patient in Grimaldo v. Palancar, which was filed in Florida, underwent surgical extraction of a third molar while pregnant. She developed a dry socket and subsequent osteomyelitis of the mandible and soft tissue cellulitis. The patient contended that the dentist breached the standard of care by not taking radiographs before the extraction. (In contrast, the dentist asserted that the patient had declined radiographs because she was pregnant.) Further, the patient claimed that she should have been prescribed post-operative antibiotics. The jury returned a verdict for $125,000, which was reduced to $93,750 because the patient was found to be 25% at fault. It is possible, though unclear, that the jury made this reduction because it gave credence to the defense's contention that the patient had refused radiographs.

The patient in Mendivil v. Ratner brought suit in Orange County, California. She was being treated for TMJ dysfunction, and contended that the surgery to remove fixation wires was improper while she was pregnant, and that the removal was also premature. The patient claimed that the removal of the fixation wires caused her to suffer a relapse that led to the need for further surgery. Aside from denying liability on the merits, the dentist also raised a statute of limitations defense. The jury in the case returned a defense verdict.

While it is difficult to draw overarching conclusions from the limited number of reported cases in which prenatal dental care is at issue, it is important to bear in mind that the standard of care does not in any way hinge upon a practitioner's concern that treatment may potentially bring about legal liability. As noted by Dr. Raimann in his recent JADA article, "[a] dentist with a pregnant patient must discuss all of the risks and benefits with the patient and allow her to make an informed choice. If the dentist feels that her care is beyond his or her scope, then he or she should refer her to another dentist who can provide her with the care that she needs."

MALPRACTICE INSURANCE FOR U

Issues for New To Practice Dentists

Debra K. Udey | Risk Manager | dudey@edic.com

Going out into practice is very exciting. You finally get to put all your training into action on your own, and it can be a heady experience. Hopefully you have set up your practice environment carefully. Some situations can impose requirements which, if not worked out carefully, may potentially give rise to circumstances that may not serve you well. There are two in particular.

Performing procedures beyond training

Large dental groups can sometimes impose quotas on dentists who work there. Sometimes those quotas include procedures that may be beyond the training and experience of the dentist. In one particular claim, a patient was scheduled for one surface composite restoration. The treatment plan was originally to refer to an OMS for the extraction of #17, but the dentist was "pressured" by the employer to extract the tooth on the day the patient presented for treatment. It was a difficult procedure, and a paresthesia resulted. The dentist was sued, and the lawsuit alleged the dentist performed a procedure beyond his training as well as a lack of communication – the patient thought she was only going to have a restoration.

This case highlights the potential problems that can occur when the limits of practice and training are not fully discussed and set forth with the employer. It is important to understand this as well as how quota requirements will impact the care you render.

Dealing with Patient's Demands for Unreasonable Care

Another issue that can arise is patients who demand care that is unreasonable, or that asks you to render substandard care. A common, but difficult example is a patient who refuses x-rays but asks you to continue to deliver prophylactic care. This patient is essentially asking you to render substandard care since you can't properly diagnose potential problems. You can warn the patient about your inability to properly treat him or her without obtaining x-rays. It is permissible to perform the prophy once, or even twice. Beyond that, you are leaving yourself open to a potential claim of treating in a substandard method, or even benign neglect.

Patients may also demand care for whatever reason (inability to pay for appropriate treatment, etc.) that again puts you in a position of rendering substandard care. In one claim, a patient appeared with tooth that had been previously bonded several times. The dentist recommended orthognathic surgery to address the occlusion, but she was put off by the patient. The insured placed cosmetic crowns that broke off. She had offered a build up and post, but the patient was lost to follow up. The patient ultimately brought a claim for the loss of the tooth and subsequent care.

If you give in to the patient's demand for substandard care and a claim is brought, you may be asked if you thought the care you rendered met the standard of care. You may have to answer that it did not, only to be asked why you rendered substandard care. If a patient is asking for care that is substandard, think carefully about whether you will render it. If you are uncomfortable giving the care that is requested, it is probably a good idea not to. Explain as politely and carefully as you can to the patient why you will not agree to what he or she wants. The patient may leave your care, but the loss of one patient may be insignificant compared to the loss you may sustain if that patient brings a claim for damages resulting from your care.

In summary, plan carefully for your practice, and put yourself in the best position possible to deliver care in the careful and complete fashion you learned in dental school. That way you can begin your long and successful career on a positive note.

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MALPRACTICE INSURANCE FOR The EDIC Dental Student Program

EDIC STUDENT SPOTLIGHT

Missions of Success - Spring 2017

Jessica Chaffee | Dental School Coordinator | jchaffee@edic.com

LaJoi Wiggins

Class of 2017 | DMD
ECU School of Dental Medicine

If you had asked me five years ago how my life would be today, I would have looked at you like you were crazy. I had the vision in place, I wanted to be a dentist but didn't know how I was going to get there. Stemming from humble beginnings, from a military family living in low-income housing to being within weeks of calling myself a licensed dentist, is something that is so surreal especially for my family. My parents didn't have the opportunity to attend college. They made it their life efforts to ensure that their children would acquire the resources they needed to accomplish their dreams. They sacrificed; a concurrent theme throughout my upbringing that is a huge part of who I am today. My parents educated me on how important it is to sacrifice and serve others who are less fortunate than I. I can recall our family waking up at 2 am on Black Friday, not to go shopping or to be the first in line for a door buster, but to cook breakfast for the Raleigh Rescue Mission. Year after year it became less of a chore and more of an honor that confirmed my desire that whatever I decided to become in life, I was to use my gifts to advance my community further. I decided to give back to my community through the art of dentistry. Having the opportunity to pursue my dream of becoming a dentist has afforded me to do that and has opened more doors than just one.

It was at ECU SoDM where I found my love for organized dentistry. I was over-involved during my undergrad career and told myself once I got into dental school I was done with extracurricular activities. The more I focused on school and myself, the more I felt as if I didn't have any purpose. I wasn't making an impact on my community or the people around me at all. I decided to get involved with ASDA. I started off as our class Lunch and Learn Coordinator, which was a role that I was very familiar with. From there I went from second to the first delegate of my local chapter, Student Trustee for the North Carolina Dental Society and then as District 4 Trustee. Talk about a change in plans from not wanting to be overly involved again. But honestly, I loved it. I enjoyed interacting with students across the country and inspiring them to chase after their dreams and their health. In the process of helping others, I forgot to help myself. I dedicated so much time to flying across to conferences, speaking in front of legislators, and countless hours planning meetings and events that I realized I didn't devote much time to my own future plans. This past year, life finally forced me to sit down and ask myself important questions about my life plan. There was a moment during my experience as a national leader that I considered postponing a few of my goals or maybe not even completing a post-graduate program because I truly wanted a break. With the down time, life gave me, I decided to apply for a GPR program. I was fortunate to find the GPR that was the best match for me, Oklahoma's Children's GPR Program. I knew that I loved children but wanted more experience in other aspects of dentistry. My acceptance into this program has brought me an overwhelming amount of joy. To begin this venture, moving to Oklahoma will be the furthest and the most extended period of time away from my family. I am sure at times it will be scary. I will be challenged and I am certain I will make mistakes. But most importantly, I will grow. And that is what life is all about, growth. If I have any advice for dental students, it would be to never stop looking for opportunities to grow despite how difficult the path may be. My life experience has taught me that regardless of the obstacles that come across your path, don't stop doing what you love. It is in those moments that when you want to give up, you find out what you are made of.

Cole Staines

Class of 2017 | DMD
UB School of Dental Medicine

UB Dental has a great presence in the community of Buffalo and also does mission work at the national and international level. Much of this outreach is organized by UB Dental's outreach club BOCA (Buffalo Outreach and Community Awareness).

One such mission is the UB Dental Run for Smiles 5K which has been an annual event at the school for the past 5 years. It was started by Dr. Anna Bailey, a 2012 alum. The race is organized entirely by dental students. The goal of the event is to raise community awareness of the importance of oral health. The UB School of Dental Medicine continuously accepts patients and is available as a dental home to those in need. The race is still growing today with nearly 500 registrants! The proceeds benefit the school's BOCA club, and also UB Dental's CARES program, a social work program designed to help patients receive the dental care that they deserve, whether that be through finances, transportation, or other ways.

Cole has been involved with the UB Run for Smiles 5K since his first year as a dental student. Cole served as the 2016 race director and will be director for 2017. With the help of several committees, they provide a "pre-health" fair that incorporates the other professional schools (pharmacy, nursing, medical, etc.) to provide screenings for the runners and participants. All of the proceeds from the race are donated to the school. These proceeds help fund supplies for community, national, and international mission trips. Cole had the opportunity to attend one of these trips to the Dominican Republic last summer which he said was an amazing experience. "To be able to help those who need it most is such an indescribable experience, and I hope to be able to participate in similar trips in the future as a dentist". In the future, Cole is looking forward to attending a national trip to Memphis, Tennessee to participate in a RAM (Remote Area Medical) trip to provide free dental treatment.

UB Dental Run for Smiles 5K - Saturday, April 23rd, 2016
Back row (L-R): Andrew Trooien (Class of 2017), Cole Staines - Race Director (Class of 2017), Marcus Spera (Class of 2017), Kevin Kurtzner, DDS (Class of 2016), Adam Gregor (Class of 2017), Patrick Micaroni (Class of 2017), Drew Ferrell (Class of 2017) Front row (L-R): Brittany Kraft, DDS (Class of 2016), Samantha Kelly (Class of 2017), Cynthia Dowsland (Class of 2017), Clare Maloy, DDS (Class of 2016).

UB Dental students continue to reach out to those who need it most in the community and abroad. If you are in Buffalo in mid-April (date is still TBD), you should check it out their next 5K Run.

All inquires for Student Spotlight, Lunch and Learns, Educational Seminars, and School Events should be directed to Jessica Chaffee at jchaffee@edic.com | 800-898-3342 X231

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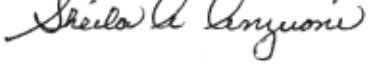
NOTE FROM THE EDITOR

Sheila A. Anzuoni, Esq. | Executive Vice President and COO | sanzuoni@edic.com

The axiom "an ounce of prevention is worth a pound of cure" is as true today as it was when Benjamin Franklin said it.

With respect to getting sued for malpractice, risk management is the "ounce of prevention." To this end, we have refocused the company's newsletter to emphasize risk management information and techniques. We here at EDIC want to do everything we can to prevent you from getting sued in the first place. If you do get sued, we want to be sure that you have taken measures to eliminate your being found liable or, in the worst-case scenario, to minimize any award we pay out on your behalf. Just as importantly, we want to spare you the ordeal of a lawsuit. (Those of you who have been sued know what I mean.)

We hope that you find this new direction valuable. We want to hear your suggestions on which risk management issues and questions you would like us to address in subsequent editions of our newsletter. Our Risk Manager, Debra Udey, can be reached at dudey@edic.com and, as always, I am available to you at sanzuoni@edic.com or please just give me a call at 1-800-898-3342. I love to hear from you.



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