On the Cusp

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EASTERN DENTISTS INSURANCE COMPANY

*Clinical Risk Management for Today's Dentist*

## EDIC CASE STUDY

# *General Root Canal Leads to Trigeminal Neuralgia*

On September 11, 2012, the plaintiff presented and was seen by the insured general dentist. The plaintiff had a broken filling approaching the nerve at tooth #5. Radiographs were taken and root canal therapy was recommended. The plaintiff was given anesthesia, the decay was excavated and the root canal procedure was completed on tooth #5. The plaintiff was given Vicodin and instructed to return for crown placement.

On September 12, 2012, the plaintiff presented as an emergency was seen by the owner of the practice. It was noted that the plaintiff had swelling on the upper right cheek area, a hematoma, and bruising toward the nasal area and under the eye (black eye). The plaintiff stated she had numbness near her right cheek. The plaintiff was put on Medrol dose pack and instructed to return daily for evaluation and follow-up. The plaintiff was told if the swelling got any worse to go to the emergency room right away.

On September 13, 2012, the plaintiff presented again with a black eye and swelling which was noted to have gone down a little. The plaintiff was seen by the owner and he referred the plaintiff to an oral surgeon for an evaluation and possible incision and drainage. The plaintiff was told by the owner dentist that the swelling may have been caused by sodium hypochlorite extending past the apex of the tooth and causing a reaction.

On September 14, 2012, the plaintiff presented to Dr. Oral Surgeon for an oral surgery consult. It was noted she had a root canal done and had severe swelling and bruising. Dr. Oral Surgeon noted that the plaintiff had a "chemical burn" during the root canal. On examination, she was + V2 numbness and had bruises to her lower lip. Surgeon stated he would refer her to a nerve specialist if the swelling did not resolve.

On September 20, 2012, it was noted in the owner dentist's chart that plaintiff's swelling was significantly down and the bruising was healing well. Symmetry was returning but the plaintiff still had tingling of the nerves and some residual paresthesia. The plaintiff requested a referral to an ENT doctor and was also advised to see a neurologist.

The plaintiff presented to Dr. ENT complaining of numbness and decreased sensation in the right cheek and nasolabial fold. It was noted that the plaintiff underwent a root canal at the 1st right maxillary molar with flushing of the root with syringe and the plaintiff felt it in the eye and cheek. The plaintiff complained of instantaneous swelling in the soft tissue of the right cheek and the intraorbital rim with ecchymosis at the right nasolabial flap. The impression after examination was soft tissue bruising status post dental procedure. The plan was to rule out sinus fistulas with a CT scan. The patient underwent a CT scan of the sinuses without intravenous contrast. The impression was postoperative changes in both maxillary sinuses, marked mucosal thickening and near total opacification of both maxillary sinuses. The findings showed no soft tissue abnormalities.

On October 8, 2012, the plaintiff presented for a neurology evaluation. It was noted that post endodontic therapy the patient sustained facial swelling and numbness. It took about three weeks for the bulk of swelling to go down but the patient was still numb from the tip of the lip down, mostly in a linear fashion and at times spreading to the right cheek. The plaintiff felt sore inside and irritation, and was constantly biting the upper lip. She had twitches in the face and felt a lump in the right upper lip. After examination, the assessment and plan was post-traumatic trigeminal neuralgia. The plaintiff was informed that there are no medications for numbness and was instructed to return if in pain or if persistent twitching occurs.

The patient's attorney filed suit, claiming that the insured forcefully injected a greater volume of sodium hypochlorite than was necessary, that he failed to use a vented syringe and that he failed to act appropriately when the symptoms occurred. They claim that the patient sustained a trigeminal neuralgia and remained symptomatic from her injuries.

The general dentist maintained that this was a routine root canal procedure and the plaintiff did not have a reaction that was out of the ordinary during the root canal procedure. He stated he did use a vented syringe to administer the solution. However, this is contradicted by the plaintiff's testimony that she felt a burning sensation as soon as the general dentist started flushing out the tooth with a syringe and instantly jumped forward in her chair. At the deposition of the dental assistant during this

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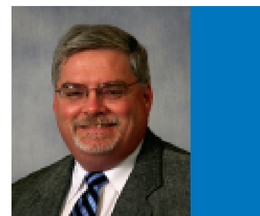

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# 2017 FALL WEBINAR SERIES

ADA CERP® Continuing Education Recognition Program

**Nov 14, 2017 | 7PM EST**

### Dental Ethics in the Workplace

*Presented by Eric Weinstock, DMD*

**Description:**
Dentists face moral dilemmas on a daily basis.
What is the legal obligation versus the moral obligation when it comes to issues like patient requests for refunds, discharging of patients, formulating patient treatment plans, and the use of social media?

**Learning Objectives:**
At the conclusion of this seminar, attendees will have learned how practicing with a sound ethical basis can lead to a more satisfying practice as well as limiting your involvement in the judicial process. Attendees will also gain a better understanding of how to better incorporate the five ADA Ethical Principles into their practice.

**Nov 29, 2017 | 7PM EST**

### Medical Emergencies in the Dental Office

*Presented by Alan Fielding, DDS*

**Description:**
While medical emergencies are not common in the dental office, all staff and doctors need to have the perception of possibilities, be prepared, and practice regular drills. While the doctor is the captain of the ship and the first responder, it is necessary for the entire staff to be involved. Prior delegation is essential. This includes the assignment of responsibilities especially pre-emergency such as knowing the location of the equipment and how to use it, the drugs as to what they are and how they are used, as well as knowledge of their expiration date. The discussion will include the latest medications according to Pennsylvania requirements as to those that are necessary. Other medications will be included and their role in dental emergencies. The following emergencies will be covered: Syncope, Seizure, Hyperventilation, Hypoglycemia, Asthma Attack, Allergy, Drug Overdose, Angina, MI and Cardiac Arrest.

**Learning Objectives:**
- How to recognize and treat life threatening emergencies
- How to train your staff to respond in an emergency situation
- What drugs and equipment should be contained in your emergency kit

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*Case Study... page 1*

procedure, the assistant recalled that once the general dentist began to irrigate with sodium hypochlorite, the plaintiff complained about burning in right cheek and started to get up out of the chair.

EDIC had the case reviewed by an expert endodontist. He opined that although there is no deviation if sodium hypochlorite leaked into the apex; there is a deviation of the standard of care for not irrigating the area with saline when the leakage occurred. EDIC also had the case reviewed by an expert neurologist. He opined that the sodium hypochlorite escape could have caused the plaintiff's trigeminal neuralgia. The expert explained that the distal part of the trigeminal nerve is located in the sinuses and that the sodium hypochlorite could have travelled to the nerve and irritated the nerve, resulting in the plaintiff's onset of trigeminal neuralgia. He further explained that the sodium hypochlorite could have irritated the maxillary sinuses causing persistent numbness. Finally, the expert believed that it could not be a coincidence that the plaintiff would develop trigeminal neuralgia right after this incident occurred; rather, it was the escape of the sodium hypochlorite which brought on the trigeminal neuralgia.

> ***"The patient's attorney filed suit, claiming that the insured forcefully injected a greater volume of sodium hypochlorite than was necessary, that he failed to use a vented syringe and that he failed to act appropriately when the symptoms occurred."***

Based on the negative expert opinions, EDIC recommended to the insured general dentist that we attempt to settle the case, and he agreed. The patient's initial demand to settle was $550,000. At a court ordered mediation, EDIC offered $45,000. The judge came back to us with cell phone photos he had taken of the plaintiff showing what the judge said was an obvious (to him) mouth deformity of the upper right lip, where in the mouth does not close. The judge suggested that this case had a settlement value of greater than $300,000 and our evaluation was low. After several further rounds of negotiation, we settled the case for $300,000.

## LETTER FROM THE EDIC CHAIRMAN
### *Across The Board*

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

For many of our policyholders, 2017 is another year of dental practice. For many of us who have been practicing dentistry for 25+ years, we can celebrate the 25th anniversary of EDIC for many reasons.

Eight years prior to the existence of EDIC, all malpractice insurance in the Commonwealth of Massachusetts was purchased through the Joint Underwriting Association (JUA), a state created insurance company conceived to underwrite malpractice insurance policies for all health professionals in the state. It was formed to fill a void because of the absence of commercial companies writing malpractice policies in the state. At that time, my premium as a general dentist was over $5000.00 a year. That represented a cost of almost double of what the average premium is today.

When the malpractice insurance marketplace began to improve in the early nineties, commercial companies re-entered Massachusetts. The leadership of The Massachusetts Dental Society (MDS) was made aware the JUA was going to morph into a private company, controlled mostly by the physicians who were running it. The MDS leadership discovered if that happened, a significant amount of dentist paid excess premium included in their surplus would be lost. Legislation was filed by the MDS to release that excess premium to the individual dentist policyholders as a dividend. Next, the MDS leadership asked each dentist to lend a portion of that dividend to fund a new malpractice insurance company, EDIC, and thus in 1992, the "By Dentists, For Dentists"® company was formed for the exclusive benefit of our member policyholders.

EDIC has grown substantially in twenty-five years to write policies in 11 states with close to 6,000 policyholders. I am proud to say the basic principles on which EDIC was founded had not changed. Our Board of Directors is comprised of dentists and dentist educators and we pride ourselves as a company that provides the best customer service in the industry. Help us celebrate this wonderful achievement as we look forward to another 25 years in stability and growth as the only "By Dentists, For Dentists"® malpractice insurance company.

Richard LoGuercio, DDS

## EDIC BOARD NEWS
### *Robert Leland, DMD*

EDIC is happy to announce the addition of Dr. Robert Leland to the EDIC Board of Directors. Dr. Leland is a general dentist in Hanover, MA. In 2008, he purchased his practice from Dr. Barry Brodil, whom is also an EDIC Board member.

Dr. Leland currently works with a full-time associate dentist, Dr. Matt May, and a support team of twelve. Leland is a 2001 graduate of Tufts University School of Dental Medicine. His accomplishments in organized dentistry include: current member of the Board of Trustees of the Massachusetts Dental Society, former Chair of the Council of Membership for the MDS, former Chair of the South Shore District Dental Society and he was selected as one of the "10 under 10" in Massachusetts. Dr. Leland is a 2007 recipient of the ADA Golden Apple Award for New Dentist Leadership and later served as the chair of the ADA New Dentist Committee in 2011.

## MEMBER SERVICES
### *The 411 On Coverage Denials: Affiliated Entities*

A number of times this past year the EDIC Claims Department has had to deny coverage on a claim or suit. One circumstance that gives rise to this action is the failure of an insured to properly identify and inform EDIC of entities that are affiliated with their practice. These entities include:

1. Multi-member corporations
2. Partnerships
3. Solo corporations
4. DBAs

**Insured's Responsibility to Review**

An insured is only covered by EDIC for what is listed on their declarations page. It is your responsibility to review your insurance documents carefully. Failure to do so may result in you having to hire and pay your own defense counsel. Moreover, should a payment need to be made to settle a claim or should a judgement need to be paid against an entity which is not on your declarations page, you will be personally liable for these payments. Don't put your personal assets at risk for the sake of the few minutes that it takes to do a careful review. EDIC is here to cover claims, but we can only cover what is specifically listed on your policy.

**Risk Management Tips to Prevent Coverage Denials**

1. Carefully review the declarations page(s) sent to you by EDIC to be certain that all affiliated entities are covered.

2. Call your EDIC Account Manager immediately if there are any omissions or if you have any question so that you will not be without coverage should a claim occur.


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WITHIN YOUR CONTROL

# *X-Rays In The Dental Office*

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

Radiographic imaging is a necessary part of a dental examination that has been used for decades. Then why is it so hard to get people to agree to have films taken? Perhaps it's due to the cost. Perhaps, because of negative information about radiation, people are afraid of "getting too much of it." What do you do to get people to change their minds and allow you to take films? What do you do when people still refuse?

Let's look at these issues. First, radiographic films are necessary to properly diagnose oral diseases and conditions or a lack thereof. Dentists sometimes ask how often films should be taken. Though there are no set guidelines, in 2012 the American Dental Association's Council on Scientific Affairs, along with the Food and Drug Administration disseminated a paper titled, "Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure."

They specifically stated that the guidelines were not substitutes for clinical examinations and health histories. The paper further states, "The dentist is advised to conduct a clinical examination, consider the patient's signs, symptoms and oral and medical histories, as well as consider the patient's vulnerability to environmental factors that may affect oral health. This diagnostic and evaluative information may determine the type of imaging to be used or the frequency of its use. Dentists should only order radiographs when they expect that the additional diagnostic information will affect patient care."

The paper includes a chart that describes the need and continuing needs for radiographic imaging. However, while suggestions are given, the statement, "Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships" seems to be the over-riding maxim. Clearly judgement will dictate the time intervals needed for different types of patients. One who has no disease and good oral care would have different requirements than one with poor oral care and a history of dental conditions.

In short, there are no hard and fast rules governing how frequently radiographic imaging is required. In the opinion of an attorney who defends dentists, imaging should be in line with the Standard of Care, which is not derived from a textbook or law statute. It is what the average clinician would reasonably be expected to do in the same circumstances. Other issues, such as film and diagnosis quality are defined. But the time frames are not. They are left to dentists to use their education from dental school and their judgment as to the needs of each patient. It should be mentioned that EDIC recommends a full mouth series of radiographs should be taken every five years. The FDA describes a full mouth series as a set of intraoral radiographs consisting of 14 to 22 periapical and posterior bite wing films intended to display the crown and roots of all teeth, periapical areas and alveolar bone crest. Remember that a panoramic radiograph is not considered a substitute for a full mouth series.

### Dental X-Ray Radiation Comparison

| Ionizing Radiation Source | An adult's approximate effective radiation dose is: | Comparable to natural background radiation for: |
|---|---|---|
| **CT Scan** | 10 mSv | 3 years |
| **Mammogram** | 0.4 mSv | 7 weeks |
| **Chest X-ray** | 0.1 mSv | 10 days |
| **Intraoral X-ray** | 0.005 mSv | 1 day |

This information may have an impact on some patients, but not others. Another example from http://www.xrayrisk.com/faq.php may be more relatable. It shows that daily exposure to nature (otherwise known as being outside) exposes a patient to an effective radiation dose of 3.1 mSv. This may bring home the fact that the "danger" of being exposed to radiation from a digital x-ray is very small, indeed, compared to merely walking around outside.

**Patients Who Refuse X-rays**

Despite your best efforts to explain to patients why radiographic imaging is necessary to properly diagnose and treat them, some will still refuse. This can be particularly frustrating, and leaves the dentist in the unfortunate position of practicing dentistry that may fall below the standard of care. For such patients, additional information may be the only thing that one can use to get their approval.

Much has been written about the dangers of radiographic images, and it may have led to a misunderstanding about how much radiation a patient actually may absorb from dental x-rays. Perhaps an explanation of the relative levels may help. There are several sources that lay out information that may help a patient understand the very low levels of radiation emitted by digital radiographs. As one can see from the chart above (from https:// www.radiologyinfo.org /en/info.cfm?pg=safety-xray), the radiation exposure from a dental x-ray is significantly less than other radiologic procedures.

**Dealing With Patients Who Refuse X-rays**

Patients who still refuse x-rays after all your explanations present a challenge. These patients are, in essence, asking you to practice substandard dentistry. For these patients, your ability to diagnose oral conditions not evident to the naked eye is substantially curtailed. Continuing to treat such patients may put you in the position of treating with benign neglect. If something is brewing that you can't see while performing normal prophylaxes, you are caring for a patient while failing to diagnose a problem. This situation can be very difficult to defend. You would have to admit that you continued to treat a patient in a substandard fashion and failed to diagnose a problem.

Some dentists may choose to defer x-rays for a period of time. Others may choose not to treat a patient who refuses x-rays. If that is the choice, one should dismiss the patient in the correct manner. Patients who are currently undergoing treatment should not be dismissed until the treatment is completed so as to avoid a complaint of abandonment. You should be available to the patient on an emergency basis for a period of time, usually 30 days. The patient should be given information to help locate a subsequent dentist (referral to an insurance panel or a country dental society). The dismissal should be confirmed by letter.

Overall, such situations can be difficult. If a patient can be convinced of the safety and minimal radiation exposure of digital dental x-rays so that he or she agrees to have them taken, so much the better. If there is no agreement, you may choose to dismiss the patient. No matter the circumstance, it is important to not let a patient's refusal to have x-rays result in practicing substandard care. Don't let anyone, including patients, talk you into practicing substandard care. It goes against everything you've been taught and have practiced.

# Unlicensed Practices

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***William S. Spiegel and Marc R. Leffler, DDS, Esq. are both lead trial attorneys at the law firm of Spiegel Leffler in New York City. Spiegel is a former assistant corporation counsel to the City of New York — Medical Malpractice Division. Leffler received his dental degree from Columbia University, completed a residency in oral and maxillofacial surgery at New York University, and is a diplomate of the American Board of Oral and Maxillofacial Surgery.***

**Facts**

A 44-year-old man had been a dental patient of the practice for some 20 years. Initially he was under the care of the sole dentist in the practice. A few years later, the dentist's son graduated from dental school and joined his father's practice of general dentistry; the patient treated with both father and son, based upon their availability, and he was happy to do so. Unfortunately, several years before the subject treatment, the father had been involved with inappropriate billing practices, and he ultimately lost his license to practice dentistry.

The dental treatment at issue was quite uncomplicated: as a younger man, the patient suffered an incident of blunt trauma to his upper anterior teeth; although the teeth were vital and asymptomatic at the time, he had been advised by the father that they might sometime later require root canal therapy (RCT) on some or all of them, and that he might even lose one or more. They remained asymptomatic until shortly before his presentation, when the 2 upper incisors, teeth 8 and 9, were becoming increasingly painful. He came to the office, was told that he needed RCT on both teeth due to the latent effects of the prior trauma, he agreed to have it done, and both teeth were treated endodontically that day without complication. Post-treatment periapical x-rays showed dense gutta-percha fills to the radiographic apex, and he was discharged with instructions, including that he should return for posts and crowns on those teeth.

The pain persisted on the teeth, so he called the office to complain. The receptionist took the information over the phone, and got back to the patient with the advice that he should see an oral surgeon, whose contact information she provided to the patient. The patient went to the oral surgeon who explained that he required apicoectomies on both teeth; they were subsequently performed and there were apparently no complications, but the oral surgeon emphasized that the prognosis of both teeth was guarded, due to the trauma history.

**Legal Stance**

The patient retained an attorney who filed a malpractice action on behalf of the now-plaintiff. The substance of the claim was improper RCTs so as to cause the need for apicoectomies and creating a questionable prognosis going forward. The defendants named in the suit were the father, the son, and the practice entity. It was the father who had performed the RCTs.

When we received the case from the insurer, we learned about the father's prior license revocation and the fact that he had no insurance coverage; however, because the son and the entity had coverage, a defense was to be provided to all defendants, as it would have been virtually impossible to separate them out from a legal standpoint, and there was a properly stated claim of dental malpractice.

**Legal Actions in Defense**

As we always do, we contacted and met with the defendants to discuss the case and all of its ramifications. As a result of the meeting and a review of the dental records and x-rays, in consultation with an endodontics expert, we viewed the issue of defending the dentistry to be as straightforward as a dental malpractice defense can be: the patient had a history of trauma which created potential problems of the type actually experienced, and he had been advised in that regard early in the treatment period with the father; the RCTs were done well, both by description and by radiographic appearance; apicoectomies are sometimes required following RCTs, even when all was done properly; and the apicoectomies were done well, with nothing more than the potential for early tooth loss (which, again, was told to the patient many years before).

The big problem was the treatment by an unlicensed dentist, with the clear – at least tacit – approval of the son and the practice entity. Not only is unlicensed practice a crime, but so is the abetting of it. Moreover, while the insurer was obligated to and did provide a legal defense, they placed all of the defendants on notice – with a letter known as a Reservation of Rights – that they might not provide indemnification (payment) in the event that there would be a settlement or a judgment stemming from a jury verdict.

Although the plaintiff had not been previously aware of the father's license status, he and his attorney quickly learned about it, and let us know that they were so aware. To the credit of plaintiff's counsel, he did not overtly use that issue to try to seek a resolution, but he certainly knew that we – and, consequently, our clients – were aware of the situation and all of its implications. He did, however, amend his Complaint to add a claim for punitive damages, which is not covered by insurance and which allows a jury to punish (with essentially boundless monetary limits) defendants whom the jury believes acted with deceit or gross disregard.

**Case Resolution**

The plaintiff's attorney approached us, earlier than usual in the course of the litigation, with a settlement demand. His monetary demand was based upon the amount of money that would be involved with extracting the teeth, placing implants in their sites, and restoring them (even though the teeth were certainly not imminently in need of extraction), as well as a component of pain and suffering involving the pain of the teeth after the RCTs and the need to undergo apical surgery. Our clients became very familiar with their potential risks, in the litigation, criminal, and administrative realms, so they decided to pay the demanded settlement amount out of their own pockets. As with almost all settlements, the plaintiff signed an agreement to keep the settlement and the facts involved with the case confidential; however, such an agreement cannot require any person to refrain from contacting municipal authorities.

**Administrative Action**

Not unpredictably, the son and the practice shortly thereafter received notice from the State authorities that a complaint had been filed regarding the events of the underlying lawsuit. (Note that, because the father was no longer a licensed professional, he was not personally subject to the State's administrative agency which became involved here, but the son and the practice entity were.)

Because of the nature of the events which followed, we feel constrained to withhold the details about how this aspect of the situation came to conclusion.

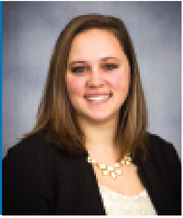
**Practice Tips**

We have, unfortunately, seen a number of circumstances involving dental practice by those not licensed to perform it. Some have involved dentists from other countries who have come to the United States and not obtained licenses yet or at all, some have involved a dentist continuing to practice while in a period of suspension and claiming lack of awareness as to the significance of that suspension, and some have been similar to the case we discuss here.

Whatever the specific conditions may be, it should go without saying that no person who is not duly licensed to practice dentistry should treat dental patients, and no person should assist any unlicensed person in practicing without a valid license.

When it occurs, it carries with it the real risks of criminal jeopardy, administrative peril, and liability insurance disclaimers which will leave the insured as if there were no insurance in place at all.

*Disclaimer: Nothing contained in this column is intended as legal advice. Our practice is focused in the state of New York, and there are variations in rules of practice, evidence, and procedure among the states. This column scratches the surface on many legal issues that could call for a chapter unto themselves. Some of the facts and other case information have been changed to protect the privacy of actual parties.*



# EDIC STUDENT BLOG SPOTLIGHT

## *Dave Lane, DMD: Serving His Country Through Dental Corps*

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

*Many new dental school graduates know exactly what their career path will be upon graduating dental school. Sometimes their path takes a different direction without expecting it. In this recent Root of The Matter EDIC Blog written by Dave Lane, DMD, he outlines the arduous process of applying for the Army Reserves. Dr. Lane's candor explains patience and perseverance that one needs not only in this process but in anything you do in your dental career. EDIC is happy to share Dr. Lane's blog posting on his experience with this journey.*

Since October 2016, I've gone through the process of applying for the Army Reserves and commissioning as a captain, O-3 to a unit based near me in Atlanta. A great benefit of this opportunity is loan repayment options, but I want to make it abundantly clear that you should not apply to the military for the sole reason of loan repayment. Not only is it a duty that should be carefully considered for personal reasons, but it is also an extremely arduous application process that may become aggravating if you are in it for the wrong reasons ie: money. In this post, I will go over the process I went through to get into the Army Reserves, then will summarize what I "get" in return.

**EDIC Dental School Programs**

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I've always been interested in serving my country after dental school. I applied for the HPSP (Health Professions Scholarship Program) prior to school but was too late applying for consideration. Throughout dental school, at Boston University School of Dental Medicine, I would speak to military booths at ASDA conferences, continuing education events, and even went to recruiting offices in my junior year. In July 2016, after graduation, I started working with my Atlanta, Georgia recruiter for the Army, explaining to him that I had a dental associate job in the private sector but was interested in the Reserves.

### The Application Process

The first step is to fill out a large packet of paperwork that needs to have the right signatures and initials all in the correct places and documents for just about everything. This part doesn't take much brainpower but it takes a lot of time because you have to gather information about your family members, gain letters of recommendation, and document every address you've lived at for the past 10 years. It's very time-consuming. Once I completed these documents, I was taken to a day-long physical at MEPS (Military Entrance Processing Station) to verify my document packet and make sure I was medically qualified. Your recruiter will submit your packet to a board.

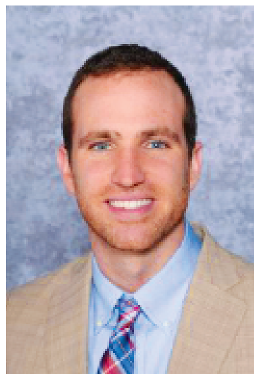
The board reviews your packet and either selects you or not. Your recruiter can't give you too much information on this because the board will be faced with the budget, the current slot availability, and other things that determine how many selects they can review. Do not be fooled into thinking there's a guarantee that you get in. Also, don't get discouraged if it takes a long time to hear back from the board. In November 2016, four months after my application process, I heard I had been selected.

I received a phone call in March 2017 that everything from the board had been signed by the Department of Defense and I was ready for commissioning. I had a nice ceremony at my house with my family where I signed a contract and swore an oath of office. It was a very exciting time and seemed like everything was done and in motion.

In April 2017, after being selected, I took a fitness test, the OPAT (Occupational Physical Assessment Test) to be assigned to my unit for final clearance. I was then cleared to go get my military ID and get my uniform. This was done with my recruiter to escort me around the base. I met my unit administrators, the full time team that runs the show when the unit is not drilling on the weekend.

Finally, in May 2017, I was contacted by my unit administrator and was told I needed to start my online training. It wasn't glamorous but taking webinars on phishing scams and web hacking was my first report to duty.

After almost a year from the application process, I'm officially on a normal schedule with my unit to report for drill weekends. If you're interested in signing up, know that this process took almost a year of "hurry up and wait". If you are interested in the military, look up medical recruiters not



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your local enlisted recruiter, which is the best way to get the most recent information, details, and timelines.

**Expectations**

Okay, so what is expected of me for my service? I can only speak to the Army Reserves as of my application from 2016-17 but here's my personal highlighted list for both Giving and Getting from my newly acquired position in the military:

**What I Give**

• I owe at least 8 years of service, but not all have to be active. Staying in longer can lead to promotion and can lead to retirement after 20 years (can combine with any previous active duty time towards retirement, as well).

• I report for drills 1 weekend a month. This is usually 2 days, but can be 3 days if need be.

• There is a month each year that has 2 week AT (annual training). This can be a wide range of things and I can't speak on this too much yet.

• Basic Officer Leader Course (BOLC) is a 6 week mini-bootcamp for officers. Dentists are known to be babied in the military, but this is an opportunity to learn the ins and outs of the Army while getting a light taste of boot camp in San Antonio: 3 weeks are classroom based, which can be done online from home, and 3 weeks are field training onsite.

• I can be deployed at any moment the Army needs me. Deployment for Reserve dentists has to be conducive to maintaining a private practice, so the deployments are left at 90 days.

• Physical fitness is a given for the military. I'm not expected to be an Olympian, but I'm a fool to not keep in shape and watch what I eat a little more than if I didn't have physical standards.

**What I Get**

• $40k a year in loan repayment or $25K cash bonus a year. The loan repayment caps out at $250k at 7 years. Um… sign me up.

• Position of Captain, O-3 (Army and Air Force, Navy is Lieutenant because Captain is O-6) upon commissioning. This is taking a major leap into the ranks, so this is quite an honor.

• Pay for each drill weekend and AT (and the one-time BOLC) based on Captain (or Navy Lieutenant) salary, including housing allowances for the AT if not on base near you.

• Education opportunities too numerous to list with the Army. For example, I'm interested in Airborne School once I get settled in.

• Affordable life insurance. It's never fun to plan for unforeseen tragedy, but this helps make it an affordable option.

• And, not to be cliché, but the opportunity to serve your country. If this isn't the main appeal on this list, I would highly recommend reconsidering applying. There is a lot of work that goes into this commitment and it is an honorable position, so it may not be the simplest means to loan repayment (NOT discounting how much it helps!!).

**Debt Management in The Military**

I think I've talked enough about how debt management is not the primary reason to apply to the military. I can now briefly discuss how this new position in the Army Reserves is going to affect my student loans.

Upon graduation, most financial advisors suggested I sign up for the PAYE or REPAYE income repayment plans. I won't go into the details of those in this post, but I was never going to pay off my loans on those plans. The plan was to have remaining balances forgiven at the end and pay tax on the forgiven amount. I'm going to be honest; I hated the idea of this. It seemed like cheating and that it would only add burden to taxpayers because I was working a system. With the loan repayment help I'm getting for my service, this is no longer the case. I WILL pay off my debt. I can't tell you how long it will take me, but it's a huge relief to know that the plan is not to pass my debt along to Uncle Sam/everyone else. There are several programs that have loan repayment, but the military is a forerunner in this arena and have some of the most enticing options.

If you DO sign up, loan repayment will be very structured and I can't tell you every detail until my taxes come around in 2018. The way it works is that you get your loan repayment in one lump sum at the end of the year of service. A year of service starts at commissioning and depends on getting enough credits going to drill, AT, BOLC, events, etc. to qualify. This IS taxable money! So it's not $40k taken off your loans.

Also, your loans must be federal loans to qualify for repayment and it only repays principle (will not pay interest with repayment funds). That's huge… make sure you don't refinance any loan principle that you plan on getting help with via repayment funding. Financial planning is key with all of this. When we're talking hundreds of thousands of dollars in income/debt/ repayment, do not feel bad to ask for help.

If you're seriously considering signing up for Army Reserves, please feel free to reach out to me with any questions your recruiting office can't answer. There's a lot of information and one can only help if they have experienced the process themselves. Luckily, I had a great and committed recruiter that had experience as well. I'd be happy to answer questions about Army life, applying, what to expect, or how it helps with loans.

**For more information about the Army Dental Corps, go to: https://www.goarmy.com/amedd/dentist/dental-corps.html**

***"I want to make it abundantly clear that you should not apply to the military for the sole reason of loan repayment."***

**All inquires for Student Spotlight, Blogs, 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

Dear Insureds,

2017 marks EDIC's 25th anniversary. We have achieved this milestone through the dedication of our Board of Directors, the hard work of our staff, the loyalty of our dentist insureds and, most significantly, through our corporate culture of customer service that permeates throughout the entire organization. Our trademark, "By Dentists, for Dentists"®, philosophy has endured and rings as true today as it did in 1992.

So, as we commemorate these 25 years, we take pride in our accomplishments. We could not have delivered on our mission without the support of our insureds and we look forward to your continued partnership to help your company grow and thrive.

With heartfelt thanks,

Sheila A. Anzuoni, Esq.

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