On the Cusp

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EASTERN DENTISTS INSURANCE COMPANY

By Dentists, For Dentists®

LETTER FROM THE EDIC CHAIRMAN
Across The Board

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

2018 has already brought exciting news for EDIC and its insureds. I am pleased to announce, that as of January 30th, A.M. Best Company upgraded EDIC to an **"A-" (Excellent)** financial strength rating. The most recognized name in the insurance industry, A.M. Best's job is to rate the financial stability of insurance carriers. Not only are we extremely proud of this achievement, we are grateful to all those individuals, both past and present, for the loyalty and dedication they exhibited to facilitate this milestone. I can speak for the whole Board of Directors and for the dedicated staff at EDIC, that we will continue to strive to maintain that same culture of excellence as we grow and move forward as a company.

We also wish to thank you, our policyholders, whose prudent risk management practices contribute to the financial stability of your company. As we all are aware, the careful and ethical practice of dentistry leads to less risk of litigation. That translates to fewer claims, and to cost savings and financial stability for EDIC. When that occurs, we are able to increase our contributions to reserves and surplus, and return a portion of premium dollars back to our policyholders in the form of dividends. That truly is our mission, to provide the best malpractice coverage in the most economical fashion for you, the owners of EDIC.

Thank you all again for your loyalty. Rest assured that the future remains bright for EDIC. We remain committed to serving you.

Richard LoGuercio, DDS

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EDIC Introduces a New Payment Option: Automatic Payment System

At the request of our insured dentists EDIC has added a new feature to our online payment system. An insured can now go online and enroll in automatic payments by registering a credit card or bank account. Premium payments will then be automatically charged to this account until an insured unenrolls.

We feel that this will be a big help to our busy dentists by eliminating late payments and policy cancellations, both of which can result in coverage lapses.

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EDIC CASE STUDY
Oral Cancer and Osteradionecrosis

Barry Regan | Vice President of Claims and Risk Management | bregan@edic.com

The patient was initially referred to our insured periodontist by her general dentist in August 2013 for periodontal evaluation and treatment, with the specific request that Dr. Perio assess the prognosis of tooth #27. The patient's initial visit with Dr. Perio was on August 7, 2013, at which time a health history was obtained, a comprehensive periodontal examination/evaluation was completed, and a 3-D CT scan was taken. Significantly, the patient's medical history included oral cancer which was treated with tumor resection and radiation therapy (6660 cGy total) in 2004.

The patient returned to Dr. Perio's office on September 11, 2013 for consultation and treatment planning presentation. Dr. Perio believed the patient had rampant periodontal disease, and that her entire lower arch was particularly compromised due to advanced periodontal disease and bone loss. Dr. Perio felt that teeth #22 and #26 had a questionable prognosis and that #20-21, #23-25 and #27-28 had a poor prognosis. Dr. Perio recommended extraction of the patient's lower anterior teeth, to be replaced with either a removable partial denture or an implant retained prosthesis. The patient advised Dr. Perio that she preferred the implant retained prosthesis and did not want a removable denture. Accordingly, a treatment plan to extract #20-29 with the imme-diate placement of six implants was prepared and presented to the patient.

Dr. Perio was aware that extraction and implant patients who have undergone radiation treatment for head and neck cancer are at an increased risk of developing osteoradionecrosis of the jaw (ORN) post-operatively. However, he did not discuss that risk with the patient and there is no mention of that risk in the informed consent form that the patient signed.

Dr. Perio recalled learning about hyperbaric oxygen (HBO) therapy in dental school or residency. He testified that he believes HBO can potentially be beneficial in some patients, such as those with chronic non-healing wounds. However, it's his opinion that pre- and post-op HBO was not indicated in this patient's case. Dr. Perio testified that it was and still is his belief that the science behind HBO for patients that had previously undergone oral radiation therapy is unsubstantiated. Accordingly, he had no pre-operative discussions with the patient regarding HBO.

The patient returned on September 19, 2013, at which time Dr. Perio extracted teeth #19-29. He also placed seven implants in the areas of #19, 20, 22, 24, 26, 28 and 29. Dr. General Dentist came to Dr. Perio's office following the procedures and delivered the patient's temporary removable partial denture. There were no complications noted during the procedures.

The patient returned for her initial post-op visit on September 23, 2013 and was noted to be healing within normal limits. She did have slight swelling, but no bruising. The patient was advised to start taking Doxycycline when her Amoxicillin (which she was started on preoperatively) was finished. The following day, September 24, 2013, the patient called Dr. Perio's office for clarification of her prescription orders. She was supposed to be taking Amoxicillin three times per day, and then begin Doxycycline once the Amoxicillin was completed. She advised the office, however, that she had been taking only one tablet of Amoxicillin per day, as that was what the label on the bottle indicated. The prescription form in Dr. Perio's records states that the patient was to take three Amoxicillin tablets per day.

The patient returned for a second post-op visit on October 1, 2013. At this visit, Dr. Perio found her entire lower arch tissue to be open, with many of the sutures missing. The patient indicated that her lower jaw felt hot and swollen. Dr. Perio's initial thought was that post-op swelling and pressure from the denture on the vestibular tissue may have caused the tissue to open. However, given the report of pain and "hot feeling," infection was a likely contributor. Dr. Perio reflected the buccal and lingual flaps and debrided the area, placing additional BioGuide membrane. The patient was given a guarded prognosis and advised not to wear her partial denture. She was also prescribed prescriptions for pain medications and a steroid.

The patient returned on October 3, 2013, reporting some swelling and increased temperature in the mandibular arch. At this time, Dr. Perio contacted an oral surgeon by telephone and referred the patient to him. That same day, Dr. Oral Surgeon spoke with the patient by phone and made arrangements for her to be seen at an HBO center without evaluating her in person.

The patient returned to Dr. Perio on October 7, 2013. She was scheduled to begin HBO treatments later that week. It was the patient's understanding that she would receive a total of 30 HBO treatments, each lasting two hours twice daily.

The patient's next visit with Dr. Perio was on October 10, 2013. At this time, he prescribed a new antibiotic and noted that the patient was scheduled to begin HBO therapy the following day. Dr. Perio had no further clinical contact with the patient.

The patient was diagnosed with osteoradionecrosis (ORN) of the mandible by Dr. Oral Surgeon and the physicians at the HBO center. She completed her initial HBO therapy in mid-November 2013. By May 2014, Dr. Oral Surgeon felt she was clinically ready to proceed with restoring the implants that Dr. Perio had placed.

A second general dentist restored the implants with a fixed detachable prosthesis in June 2014. However, further complications subsequently developed and in August 2015 Dr. Oral Surgeon removed three of the implants that Dr. Perio had placed. The patient was then referred to the HBO center for another round of HBO therapy, which she completed in October 2015. She has been wearing a removable partial denture since early 2016.

The patient filed a law suit against Dr. Perio in the fall of 2016. She alleged that Dr. Perio should not have placed the implants without pre-surgery HBO treatment. She alleged medical/dental specials totaling approximately $130,000. The HBO center's bills for the two rounds of HBO therapy (even after insurance write-offs) constituted the bulk of this amount.

The oral surgeon acted as the patient's expert witness. He had numerous criticisms of Dr. Perio – pre-operatively, intra-operatively and post-operatively. In a nutshell, it was his opinion that Dr. Perio should have never performed surgery on the patient without first consulting with her radiation

oncologist and having a frank discussion with the patient regarding the risks of ORN as well as the potential benefits of pre- and post-op HBO therapy.

EDIC retained an expert oral surgeon to review the case. He has a very active extraction and implant practice. He describes the use of pre-op and post-op HBO therapy as "old school medicine" which he does not believe is any longer valid. Although HBO therapy may help with soft tissue injuries, he does not believe that it helps with necrotic bone, whether due to radiation treatment or bisphosphonates. He believes that Marx's 1989 study (which the plaintiff's experts relied heavily on) has been effectively repudiated by more current studies. In summary, he was firmly of the opinion that it was not within the standard of care to refer the patient for pre- and post-op HBO treatment. However, he does recognize that patients who receive radiation treatment for head and neck cancer are at an increased risk of developing osteoradionecrosis if they subsequently undergo surgical procedures. Therefore, he would have had a conversation with the patient regarding ORN and reviewed her cancer records to determine the amount of radiation, the location, etc., and would have spoken with her oncologist prior to any surgery.

As EDIC's expert was critical of the informed consent in this case, we obtained Dr. Perio's permission to settle and at a court ordered mediation, we were able to settle the case in the amount of $450,000.

RISK MANAGEMENT COMMENTS

The hardest cases to take to trial involve those with significant damages and a partially supportive expert opinion. The oral surgeon EDIC used in this case was very well credentialed and respected in the dental community where this case occurred. He would have been an excellent witness; however, he also would have had to agree with the patient's expert when it came to the issue of informed consent. While he would have testified that the thinking on HBO treatments to prevent ORN is evolving with time and additional study, he also believes it is something that should be discussed with the patient, even if the surgeon does not recommend the treatment. He also would have had to agree with the patient's expert that a surgeon should have a discussion with the patient's oncologist prior to treatment to determine the type and amount of radiation to appropriately weigh the risk of ORN.

A patient only must hit on one count in a suit to receive a favorable verdict and award. A well-educated jury in this case could have very well rendered a decision that the operative care by Dr. Perio was well within the standard of care, but that the informed consent was not. That is why with Dr. Perio's permission, EDIC agreed to settle the case at mediation.

"My first day of work was less than 24 hours away and my previous provider was unable to accommodate me within eight days of my request. I contacted EDIC about my situation and they had me insured before I saw my first patient the next day. Jessica and her team went above and beyond to provide immediate and efficient customer service. I will gladly recommend any dental professional to join EDIC."

Cindy Kong, DMD
General Dentist, PA
EDIC Insured

WITHIN YOUR CONTROL

Dealing With Difficult Patient Situations

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

A question came from one of our insureds – do I have to treat a patient who came to the office barefoot? The short answer is that unless the patient has a letter from his treating physician stating he was handicapped and can't wear shoes, the dentist was under no obligation to treat the patient. As long as one doesn't run afoul of the discrimination issues of race, creed, sex, personal beliefs/religion, etc., one does not have to accept any patient.

It is the rare dentist who has not had a patient come through the door who raises an uncomfortable feeling, whether you can put your finger on it or not, that things won't go well. The good news is that you don't have to accept this patient. You can tell the patient that you don't feel that he or she will be a good fit for you. If the patient is trying to direct your treatment, or asking for treatment you would not do, the situation becomes even clearer, and easier to deal with.

Before we discuss this issue in more detail, the question of patient dismissals should also be discussed. A friend recently asked me whether she should dismiss a patient who had either cancelled his appointment 20 minutes before the allotted time (leaving a hole in the schedule that couldn't be filled) or didn't show up for the appointment an astonishing 32 times! In addition, the last time he was in, he had been verbally abusive to one of the staff members. Because my friend was in a state university run clinic, her options were not as clear as someone in a private practice.

In your private practice, you have the right to dismiss a patient for a number of reasons; he doesn't follow your instructions, he won't agree to care that is needed, he won't pay his bill. There are other reasons, but these are some of the most common ones. As long as you dismiss the patient in the appropriate manner, you can certainly dismiss them.

First, you can't dismiss a patient in the middle of active treatment. Second, you have to tell the patient you are dismissing him or her. It is best to do this in a letter. It should contain several things: 1) the fact that you are dismissing the patient; 2) give them a 30 day period during which you will be available for emergency treatment; 3) offer to make a copy of their records available to them; and 4) give them a resource to find another dentist (referring them to their insurance panel, or to a county dental society, etc.).

"Should you do what the patient wants, or refuse? Just because a patient asks for some type of treatment, do you have to accede? Where do you draw the line?"

If a patient has done something egregious, such as verbally abusing you or a staff member, or physically assaulting someone, you need not give them the 30 day leeway, but you should still send them the letter with the other items.

Returning to the issue of patients trying to direct treatment, it is one that can raise ethical questions. Some examples would include the

patient who wants you to pull seven remaining healthy teeth because he is tired of them and wants dentures, or a patient you've referred for endodontic treatment of a tooth with a tortuous canal who begs you to do the procedure. These types of situations go against your better judgment. Should you do what the patient wants, or refuse? Just because a patient asks for some type of treatment, do you have to accede? Where do you draw the line?

Dentists have professional autonomy, which means having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base, and they use it every day. They examine patients, make diagnoses, and treat patients based on those diagnoses.

Unfortunately, patients question a dentist's professional autonomy regularly. The examples listed above are common, but by no means the only ones. Should you comply with a patient's request even though you think it imprudent? Whether it is a patient who begs you to remove healthy teeth, or do a procedure beyond your training and experience because you are the only one they trust, should you comply?

In these situations, it can be dangerous to let the patient "play dentist" by performing treatment they suggest but you feel is imprudent. No matter the situation, if it goes against your better judgment, acceding to the patient's wishes may not be in your best interest.

In cases where this has happened and a claim was filed after a complication or injury occurred, the questioning went along the following lines:

"Did you think this was a good idea?"
"No."
"Then why did you do it?"

Your judgment will be called into question in a very unflattering way that is hard, if impossible to defend. This is clearly a no-win situation.

As the above examples show, patients may question your professional autonomy in many ways. They are entitled to do so, and you are entitled to maintain your proper and ethical manner of practice. This can sometimes lead to difficult situations. But if you "stick to your guns" and choose to practice in a safe and ethical manner, you will always be on the upside of the situation.

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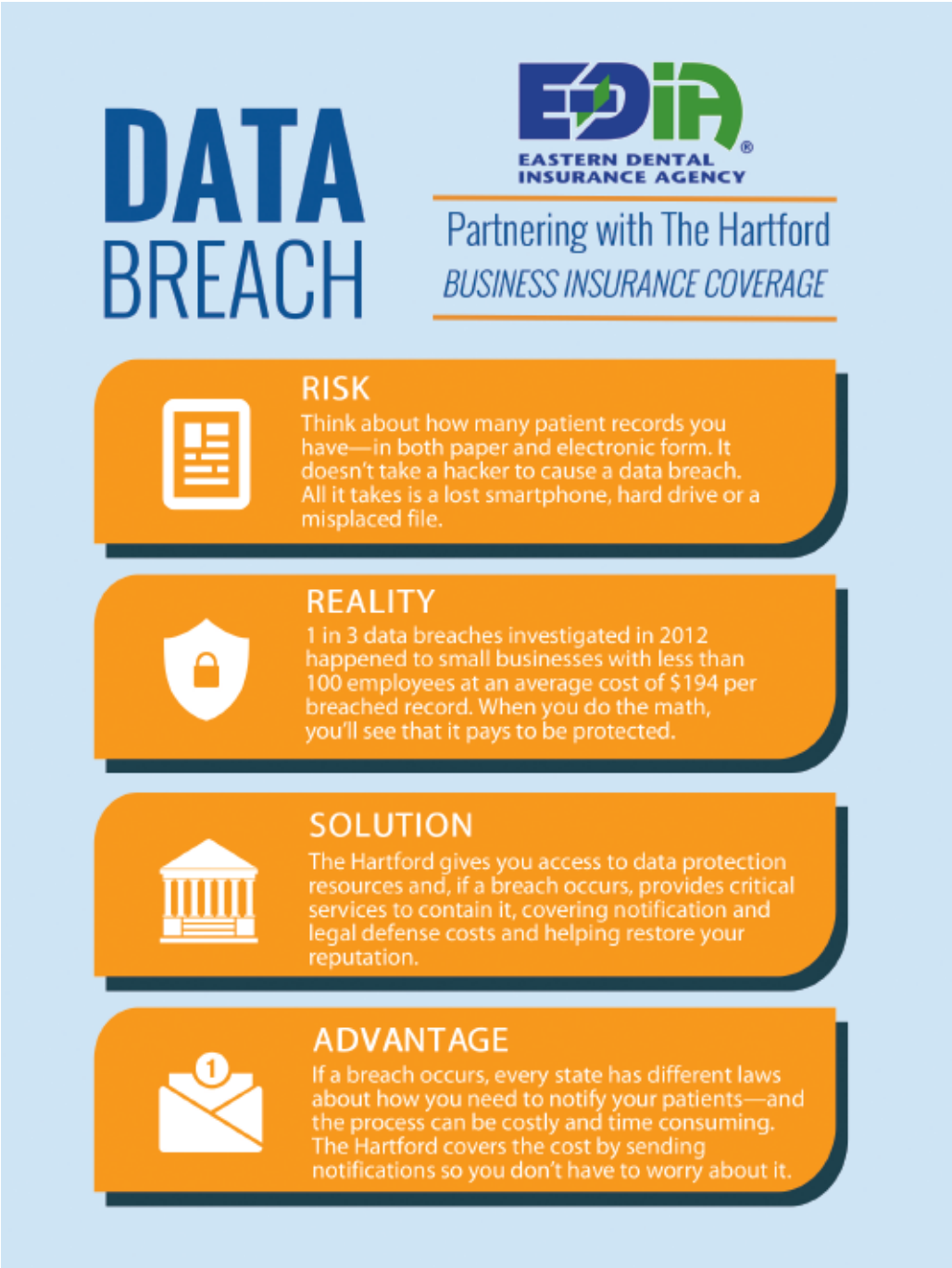
These types of data breaches can result in damage to your reputation, lost customers, potential liability to those whose data was breached and expenses to comply with state notification laws.

While only the largest or most egregious data breaches make the evening news, companies with fewer than 1,000 employees are the most frequent victims of data breach because they typically lack comprehensive data security protocols or tools.

Consider these findings from the 2012 Verizon Data Breach Investigations* report:

- 79% of victims were targets of opportunity
- 98% of data breaches stemmed from external agents
- 81% involved some form of hacking
- 85% of breaches took two weeks or more to discover
- 97% of breaches were avoidable through simple or intermediate controls

Contact EDIC or your EDIC customer service representation to learn more about our Cyber Liability coverage through The Hartford, a leading provider of specialty insurance with extensive experience providing coverage to dental and medical practices throughout the country.



For more information on the Cyber and Data Breach Liability Benefit as an EDIC insured, please contact EDIC at 800-898-3342 or contact your exclusive EDIC customer service representative.

* Verizon Risk Team, U.S. Secret Service and Dutch High Tech Team, 2012

EDIC ROOT OF THE MATTER BLOG SPOTLIGHT

Michael Mayr, DMD: Slimming Down in the New Year

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

It's a new year and with that comes new resolutions. Some may elect to do something to improve the quality of their personal life. And some of us may elect to do something that improves our work life. If you're like me and came from dental school with the goal of working as many days as possible to maximize your income, you may be asking yourself, when can I cut down my hours and still maintain my income.

As a new graduate, it is not uncommon to be working at multiple offices. Unless you've signed on with a corporate practice that can hire full-time associates, small private practices often do not have the ability to hire a new graduate for full-time work. However, working at multiple practices as a new graduate has so many great benefits. You get to diversify your experiences, learn different approaches to treatment and experience different patient populations. However, most young dentists I've talked to aspire to narrow it down to one or two practices or buy their own practice.

Michael Mayr, DMD
General Dentist, MA
BUSDM, 2016
Graduate
EDIC Insured

Timing is tough when it comes to your time. Over the past couple of years, I've begun to get a good feel for my abilities and my limits as a practitioner. Of the multiple practices I'm in, I've now been able to gauge what I should be expecting when it comes to my monthly income and the value of my time in each practice. At the point when you decide to start making changes, it can be very intimidating. If you're like me, the greatest fear is being able to consolidate my time into fewer practice locations while still maintaining and hope-fully increasing my earning potential. It's kind of like being on the game show "Wipe Out" where contestants try to make their way through a daunting obstacle course. You come to the moving platform that you have to jump onto, but you're not sure of the right time to jump and how far to jump.

The good news is, we're not the only ones. These struggles have been faced by almost every dentist you talk to. You hear a lot of success stories and you hear even more unsuccessful stories. A few things I'm doing to prepare for the big jump include knowing my daily production potential at each practice, looking at the previous year of my schedule to see trends in my production amounts, and most importantly, doing a self evaluation to determine where I am most happy and where I see the most potential for growth.

When it comes time to slim down and optimize how and where you practice, it is key to keep lines of communication open with your practices, owners and managers. Don't be afraid to ask for help and advice. And don't be scared to take the leap. You may not make a clean landing, but ultimately we continue our advance towards the finish line.

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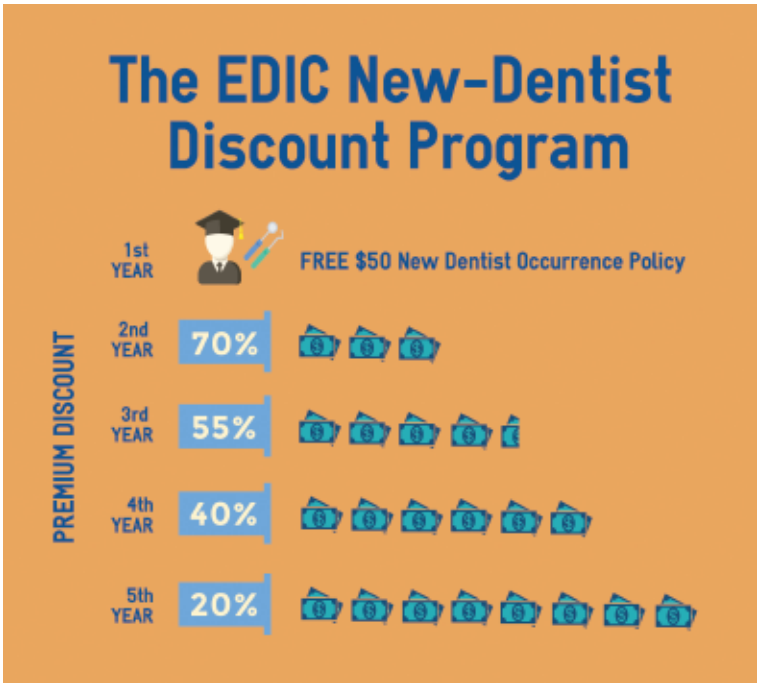

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Unlicensed Practices

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In Pennsylvania, we have a unique doctrine regarding informed consent. Unlike most States, which use a negligence standard to govern whether a doctor should convey certain risks to a patient, Pennsylvania is a battery doctrine State. In that regard, if a physician fails to obtain a patient's full and informed consent, it is akin to a doctor physically committing a battery upon a patient. In essence, the failure to obtain consent constitutes "offensive touching" without the patient's full and informed consent and therefore, as a matter of law, the doctor is liable for all complications that came to fruition even if the doctor's care and treatment met the standard of care. Under our law, to obtain consent, a doctor must:

1. Counsel the patient about the nature of the surgery;
2. Advise the patient about the material, important risks involved in the proposed surgery;
3. Discuss alternative procedures and options to the proposed operation; and
4. Let the patient know what significant risks are involved in each potential alternative.

Festa v. Greenberg, 511 A.2d 1371 (Pa. Super. 1986).

From the outset, the doctrine of informed consent has only been applicable to surgical procedures. In Smith v. Yohe, 194 A.2d 167 (Pa. 1963), the Supreme Court, in discussing the law regarding informed consent in the context of a surgical procedure to insert a pin into a patient's leg, held:

Principles of law applicable in this phase of the litigation are clear. Such principles are:

(a) Where a patient is mentally and physically able to consult about his condition, in the absence of an emergency, the consent of the patient is "a prerequisite to a surgical operation by his physician and an operation without the patient's consent is a technical assault..."

(b) The burden is on the plaintiff to prove "that the operation performed or substantially that operation, was not authorized by him."

Id. 174

Following that decision, courts have repeatedly upheld the applicability of that doctrine to a surgical procedure involving the cutting of bones, removal of organs, etc. See Stover v. Association of Thoracic and Cardiovascular Surgeons, 635 A.2d 1047 (Pa. Super. 1993) (physician must inform patient not only of the risks of open heart surgery but also the different medically recognized alternative prosthetic devices that could be implanted during surgery); Friter v. Iolab Corp., 607 A.2d 1111 (Pa. Super. 1992) (informed con-sent required before implantation of an experimental intraocular lens following cataract surgery); Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966) (question for the jury was whether the operating surgeon obtained proper informed consent prior to an exploratory laminectomy).

The doctrine, however, has not been applied to those procedures which traditionally have not fallen under the guise of a surgical procedure. See Foflygn v. Zemel, 615 A.2d 1345 (Pa. Super. 1992)(the Supreme Court noted that the doctrine of informed consent has been historically limited to surgeons who perform operations based upon a battery theory and therefore the physician who performed the pre-surgery physical examination and the nurse were under no duty to obtain the patient's informed consent to the surgery); Sinclair v. Block, 633 A.2d 1137 (Pa. 1993) (the Supreme Court ruled that the doctrine of informed consent did not apply to the use of forceps to facilitate natural delivery emphasizing that the doctrine is based upon the patient's right to make an informed choice whether to proceed with a "surgical or operative procedure" which was not present in the case, and therefore, the informed consent claim was barred); Shaw v. Kirschbaum, 653 A.2d 12 (Pa. Super. 1994), appeal denied, 664 A.2d 542 (Pa. 1995) (the Superior Court held that the doctrine of informed consent did not apply to the physician who referred the patient for heart surgery concluding that the patient's consent is only required of the surgeon before a surgical operation is commenced); Matukonis v. Trainer, 657 A.2d 1314 (Pa. Super. 1995), appeal denied, 666 A.2d 1057 (Pa. 1995)(Superior Court ruled that the doctrine of informed consent was inapplicable to chiropractic manipulation of the patient's neck); Morgan v. McPhail, 704 A.2d 617 (Pa. 1999)(the Supreme Court noted that the doctrine of informed consent did not apply to the administration of intercostal nerve blocks reasoning that informed consent, based upon a battery standard, requires offensive touching in the context of the surgical procedure and since the patient was not undergoing surgery at the time the doctrine did not apply).

Now, in the context of dental procedures, the law is clear that when a dentist is performing a surgery, informed consent applies. There are well-established court opinions concluding that the doctrine of informed consent applies to situations where a dentist is perform-ing a root canal. See Perkins v. Desipio, 736 A.2d 608 (Pa. Super. 1999). The doctrine of informed consent also applies to situations where a dentist is performing an extraction. Bulman v. Myers, 467 A.2d 1353 (Pa. Super. 1983); Sauro v. Shea, 390 A.2d 259 (Pa. Super. 1978). Although there are no published opinions on the subject to our knowledge, it is reasonable to conclude that informed consent would also apply to gum surgery, biopsies, and to surgical procedures involving the removal of tumors, the placement of dental implants, as well as surgeries to repair fractured jaws, bilateral sagittal split osteotomies, and TMJ arthroscopy or arthroplasty.

Now, against that backdrop, Pennsylvania law has traditionally been murky on whether the surgeon can delegate the obligation to obtain a patient's full and complete consent to a resident, nurse, or dental assistant. In the landmark case, Shinal v. Toms, 162 A.3d 429 (Pa. 2016), the Supreme Court clarified the law and held that a surgeon has a non-delegable duty to obtain a patient's full and informed consent before proceeding with a surgical procedure. In Shinal, the defendant, Dr. Steven Toms, a neurosurgeon, performed surgery upon the plaintiff, Megan Shinal, to remove her brain tumor. Before the surgery, Ms. Shinal and Dr. Toms had met for preliminary discussions regarding her goals, potential procedures available, and the risks involved in those procedures. At trial, Ms. Shinal claimed that she did not explicitly express to Dr. Toms that she wanted him to remove the entire tumor. Based upon their conversations, however, Dr. Toms assumed she wanted complete surgical removal of the tumor. Importantly, between the preliminary meeting and the eventual surgery, Ms. Shinal and Dr. Toms' physician assistant had also met and further discussed the procedure and its inherent risks. The physician assistant also answered the patient's questions over the phone and reviewed the actual written consent forms with her. During the surgery, where Dr. Toms was going to remove the tumor, he inadvertently perforated the patient's carotid artery causing hemorrhage, stroke, and resultant brain damage with partial blindness. The patient subsequently sued Dr. Toms claiming that he did not obtain her full and informed consent. The jury found in favor of Dr. Toms and the Superior Court affirmed. On appeal, the Supreme Court, in a 4-3 decision, reversed and held that "a physician cannot rely upon a subordinate to disclose the information required to obtain informed consent." The High Court reasoned that surgeon has a non-delegable duty to obtain the patient's full and informed consent and the new rule would strengthen the doctor/patient relationship.

Without question, the Shinal decision has far reaching consequences. Many physicians and dentists use staff to help guide patients through the informed consent process. The Court's ruling has now increased the doctor's responsibilities tenfold. No longer can a surgeon rely upon staff to review a consent form with a patient, and no longer can a surgeon rely upon a resident to explain the risks involved in the procedure. The surgeon must directly obtain the consent from the patient. Based upon the Shinal Court's ruling, here are our "best practice" suggestions:

1.The surgeon must sign off on the consent form, and must review the entire consent form with the patient before signing off;

2. The surgeon should separately record in the patient's chart that the doctor directly and expressly reviewed the nature of the surgery with the patient, alternatives to that recommended surgery, the risks involved in the surgery, and the risks involved in the proposed alterna-tives. The doctor should also note that the patient understood everything that was reviewed;

3. Staff members can still participate in the informed consent process by providing the patient with brochures regarding the proposed surgery, signing off as witnesses to consent forms, and also by being present during discussions regarding the procedure. The surgeon can chart that staff were present, and that will simply provide extra witnesses to confirm that the surgeon had directly obtained consent from the patient.

In conclusion, the Shinal holding clearly shows that the Court is unaware about the modern realities to the practice of surgery. Frequently, surgeons are tied up from one procedure to the next, and have relied rightly so upon staff to assist in the surgical process including the consenting of patients. The Court has now imposed a stricter and burdensome requirement upon surgeons to basically sit down with each and every patient and obtain their full and complete consent before proceeding with surgery. That said, for surgeons in Pennsylvania, the obligation is now non-delegable and the surgeon must directly obtain their patient's consent before operating upon their patient.

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MAY 17, 2018 | 7PM EST


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Presented by Anubha Sacheti, DMD and David Leader, DMD, MPH

Description:
Massachusetts Department of Public Health data demonstrates that women are much less likely to obtain oral healthcare during pregnancy than before pregnancy. The American Congress of Obstetricians and Gynecologists emphasizes that dental treatment is safe and desirable during pregnancy. Dr. David Leader and Dr. Anubha Sacheti will present information on the way that normal and pathologic aspects of pregnancy may affect oral health and oral health care. Specific recommendations for oral healthcare providers include assessment (including all necessary radiography), advice, education, and the provision of all necessary treatment. Pregnancy in itself should not affect the type or quality of oral health care offered to pregnant patients.

MAY 24, 2018 | 7PM EST

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