Abstract

Dental care in a hospital or a surgical center operating room (OR) is often the only effective means by which many anxious, autistic, intellectually disabled, medically compromised patients, or people with special needs can receive needed comprehensive dental care. Some patients are too uncooperative or too high risk for routine dental care in an office or alternative setting. The OR provides a safe, effective and efficient environment for needed dentistry to be successfully performed (Figure 1).

The author describes: 1) Why there is a need to use the OR for dental treatment, 2) Which patient populations benefit the most from treatment in the OR, 3) The significant financial benefits to the dental practice when expanding services into the OR, and 4) The steps required to provide such care. Specific pre-op, intra-op and post-op considerations are described, as well as the medical records that must be kept. Ways to minimize the risk of lawsuits are discussed as well as tips found to be useful to the dentist in the OR, the office, and in alternate practice settings.

Introduction

Dentists are very skilled and comfortable performing technical procedures on cooperative patients in their private offices. However, when patients are uncooperative (Figure 2), dentists and hygienists cannot perform their best work, or may not be able to complete the procedures.

Referrals are then difficult, if not impossible, for this patient population with special needs. To be successful, dentists might consider performing these procedures in the operating room, in either a hospital or surgical center. Specific protocols and adaptations are required to provide services in the OR setting. Patients benefit by receiving optimal dentistry in a comfortable and safe environment. Moreover, dentists benefit by expanding their practices, increasing their incomes, and providing care to an underserved population, thus expanding their referral network.

I - HOSPITAL & SURGICENTER GENERAL DENTISTRY: Access to Care

Is there a need for dental care in the OR?

It is the responsibility of the profession of dentistry to identify and break down the existing barriers to patient care. People are living longer due to medical advances. Dental advances now allow teeth to be maintained for a lifetime. Even though the traditional model of dental health care delivery does not include out-of-office care on a part-time basis, the dental profession ethically and economically must adapt to society’s needs, meeting them appropriately and with competence. Additionally, if we don’t do this ourselves, as a profession, it may be mandated upon us by unsympathetic politicians and bureaucrats.

The dentist may be called upon to provide care outside of their private practice for a patient who is homebound, or has been admitted to an institution, assisted living, nursing home, hospice or hospital (Figure 3).

The oral health status of many homebound individuals has been found to be poor, with over 80% of the subjects requiring dental care. Older patients of record within the private practice may be diagnosed with Alzheimer’s disease, profoundly handicapping syndromes, or other medically challenging conditions which make private practice care very difficult, disruptive, problematic, and potentially unsafe for all involved.

Medically compromised patients with life-threatening septicemias or bacteremias of odontogenic origin are most appropriately managed in an OR as there will be no delay in professional emergency care. This also holds true for severely hypertensive, cardiac, or renal failure patients who require dental care with close medical monitoring. Mentally challenged, intellectually disabled or autistic patients may be too combative to be treated safely in an office setting (Figure 4).
Infants and young children may require sedation approaching dangerous levels in order to relax them sufficiently. Perfectly healthy but apprehensive people deny themselves elective dental care due to situational anxiety or other phobias. The operating room may well be the only way to provide these “special needs” groups with excellent complete dental care under safe, controlled circumstances.

Some dental staff members work well in the routine practice, but may not be comfortable with the special needs patient in that same office setting (Figure 5). In the OR, the conditions can better be controlled and are delivered in a professional and comfortable manner for all. Issues often arise in treating the mentally or medically challenged that make the delivery of care in the private office both unsafe and inappropriate, necessitating use of an OR. The goal for dental treatment in the OR is the delivery of controlled, safe, and high quality dental care. Cooperation may be accomplished by utilizing IV sedation or general anesthesia.

Providing OR dental care for the special-needs patient, the uncooperative pediatric, or the high risk geriatric patient population places the dentist’s business into a unique position which distinguishes it from the traditional or typical dental practice.

When anesthesia in the office is not enough: Modalities of anesthesia

Rarely is there only one way of doing something. When operating on a patient, there are a number of safe anesthesia modalities which can be used alone or in combination. The options include: oral pills or tablets, oral liquids or elixirs, oral medicated lollipops, liquids through a g-tube, rectal suppositories, regional local anesthesia, intravenous (IV) sedation, intramuscular (IM) sedation, gas inhalation, monitored anesthesia care (MAC), nasal intubation general anesthesia, oral intubation general anesthesia, tracheal tube general anesthesia, acupuncture, and hypnosis.

Each of these modalities has its own unique onset, duration, indications, and contraindications. In a hospital setting, a combination of modalities is most typical. It is common for a patient to have Ativan, Halcion, Valium, or Atarax at home, to begin the pre-operative sedation and cooperation process. Oftentimes, in the pre-operative holding area, liquid Versed or IM Ketamine and/or nitrous oxide gas is employed prior to starting an IV, before intubation general anesthesia is initiated. Not every patient allows an IV to be started without a fuss, and therefore some medicinal coaxing is often necessary.

In the private dental office, the most often-used modality is local anesthesia, then preoperative p.o. sedatives, nitrous oxide, followed by IM or IV sedative or analgesic agents. Differing levels of training, skill, and monitoring are required for each of these modalities. New rules and restrictions have been developed and implemented to regulate the use of these substances in dental offices. Licensing, tests and permits are now required. In most states, anything more than simple anxiolysis requires a permit, obtained only after passing an ACLS course, completing a 24 hour course that includes 20 Power Point patient interactions (such as the courses offered by ADSA, ASDA, DOCS, other organizations and dental schools), plus a site visit. The permit is NOT required in a hospital or surgicenter operating room, where the anesthesiologist or anesthetist, not the dentist, is responsible for monitoring the patient’s vital signs.

It is essential that the proper skills, manpower, and equipment be available for each modality. The minimum skill level for light or mild sedation or simple anxiolysis would be current CPR certification with an emergency medical kit and oxygen. Moderate oral sedation would require at least the protocol indicated in the previous paragraph. Deep oral sedation or general anesthesia in the office would require even more training and certification.

Annual review of office medical emergency protocol is performed in the more cautious and responsive offices. This includes training with the clinical and clerical staff on “who does what and when” for emergencies. Remember that the chain of response is only as strong as its weakest link: someone has to be assigned to call 911!

If local anesthesia, oral sedatives or nitrous oxide are insufficient, be prepared for the inherent risks of placing medicine into someone’s muscles (IM) or veins (IV). If you do not have the additional permits, certification, level of training, equipment, supplies and insurance required to deal with these more dangerous modalities of anesthesia in your office, it is best to operate in a setting that can attend to any emergency. ORs in approved surgicenters or hospitals are the most suitable environment in which to handle these cases. In this setting, the treatment is sequestered and the dentist is not responsible for the anesthesia, nor is the dentist required to certify for moderate/deep sedation or general anesthesia permits, as would be required in a private dental office.

Who are the patients?

Examples of patients who may be candidates for IV sedation would include those with acute hypertension, pulmonary problems, multiple organ and pharmaceutical complications, or the Alzheimer’s patient who requires minimal dental care, yet requires the safe and well-prepared OR setting.

The choice to utilize the OR is appropriate because the hospital medical staff is available to closely monitor and assist in the event of any complication or emergency. The patient who is a candidate for general anesthesia may range from the frightened pediatric patient (Figure 6), to the combative intellectually disabled adult, to the elderly patient with dementia, Parkinson disease, or stroke, the dental phobic, or the patient with severe spreading dental infections requiring IV antibiotics.

These patients may be unable to cooperate while awake or alert, but are medically capable of withstanding extended dental treatment with deep sedation or general anesthesia.

Treatment planning considerations regarding the level of care to be provided to patients must include whether the dentist provides minimum palliative care or comprehensive definitive care.
For example, the healthy but apprehensive 22-year-old with caries and impacted wisdom teeth would be managed very differently from the 92-year-old with Alzheimer’s, advanced periodontal disease, and multiple abscessed teeth. This author feels that everyone has the right to be pain-free and infection-free. This is the minimum baseline for quality of life. Moribund nursing home patients, seemingly oblivious to the draining infections in their mouths, are still entitled to be free of pain and infection. This dental care is designed to improve one’s quality of life, if not the longevity.

Symptomatic teeth need to be extracted, even when necessary periodontal and restorative therapy is not performed. We would not consider full-banded orthodontics on an uncooperative Alzheimer’s patient, but we would remove their infected teeth, in the office or in the OR, under safe conditions.

It is plausible that the term “cooperate” originated from two doctors simultaneously operating on the same patient in the OR. This is a common practice in the OR. Whenever we have a mentally challenged or combative female, we always invite the OB/GYN to come in to perform a Pap and pelvic exam. It takes 10 minutes of OR time, and is a valuable service to the patient. We often invite other doctors—especially ENT, GI, and podiatry specialists—and technicians who need to run various lab tests such as blood draws, x-rays, and EKGs—to co-operate with us, while the patient is asleep (Figure 7).

What are the benefits to the dental practice?

The dentist who assists these patients benefits personally and professionally. Dentists with hospital privileges who treat medically compromised patients are regarded as dental authorities by the hospital medical staff. They are recognized as such and receive patient referrals from the hospital and from the physicians’ private practices. The patients who are treated become ‘missionaries’ for the dental practice because the hospital dentist was there for them when they were in severe need. The community benefits from this provision of service because the special patient population, the pediatric, and the geriatric patients are enabled to maintain their teeth, thereby improving their nutritional status, their quality of life, and prolonging their life expectancy. The community further benefits by having problems attended to by appointment, rather than clogging the emergency rooms with untreated chronic oral infections.

Dentists may consider treating only three or four patients in a day at the hospital to be a low-production use of their time, when they can treat more than twenty patients in their private practices. It may be argued that the total number of patients cared for would diminish, but the opposite is the case because patients not currently receiving dental care would be brought into the health care system. In the OR virtually all the work can be completed in one long uninterrupted visit, rather than in multiple, less productive, shorter office visits, which do not even ensure successful completion.

Private practice dentists who contemplate working in the OR may be concerned that their practice productivity could potentially decline, and that their ability to service debt obligations while generating a livable income may be compromised. This concern is not valid. In fact, working in the hospital OR generates a four-fold increase in productivity per unit time in comparison to private practice, and a quadrupling of OR gross income relative to office gross income. If your office hourly income is $750/hour, generating $3,000/hour in the OR is easily a realistic expectation.

The productivity of the hospital arena is enhanced by the fact that with the patient under general anesthesia, the dentist has total control while the patient is in complete compliance. The patient cannot fight, spit, thrash or get out of the chair. Resistance really is futile. The required time to accomplish procedures is greatly diminished and the number of procedures provided is dramatically increased. This clinical efficiency offsets the time in travel, consultations, hospital report dictation and other tasks, realizing a 400% increase relative to the office hourly income.

There are several professional benefits that the hospital dentist receives from providing OR care. As members of the hospital medical staff, dentists will, by association and affiliation with other professionals, be encouraged intellectually and clinically by their peers. Hospital dentists may be asked to present dental health care issues at medical staff meetings, which create opportunities to promote public dental health awareness as well as promote their own private practices. The hospital emergency room will appreciate being able to call the hospital dentist whenever they have dental emergency patients. Referrals may also originate from medical colleagues, nurses, technicians, clerical and administrative staff at the hospital, the local dental society, as well as from dentists who do not offer hospital dental care.

How to go about providing OR dental care

The dentist needs to become comfortable with the idea of providing special needs patient care outside their office. The practitioner may choose to gradually incorporate OR care into their practice. This may begin with an occasional case, perhaps on a day off, and progress to a regular schedule of periodic OR block time, depending upon caseload. In some hospitals or surgicenters, dentists may be able to schedule cases as their first patient of the day at 7 or 7:30 am, or the last patient at 4 pm, or even on Saturdays.
Surgicenters are less expensive for the patient, less labor intensive for the dentist and provide a quieter environment than hospitals. Surgicenters do not support an expensive ER and there is also a lower staff payroll and bureaucracy to fund. They spend proportionally less money on equipment and supplies, which helps keep expenses and overhead down. For the doctor, surgicenters are often easier to schedule since there may be less competition with other doctors for OR time. There is less paperwork involved and the turnover time between cases is less than that in a hospital setting. The doctor is free of obligations to attend time-consuming staff or department meetings or join committees. Surgicenters are smaller and generally more efficient than hospitals. They provide a quieter and more private pre-operative and post-operative area. This often suits the autist child who shuns bright lights and abhors a noisy environment, the busy person who desires efficiency of time, or the private person who prefers not be seen in a public medical setting. This setting is ideal for the American Society of Anesthesiologists (ASA) type 1 or 2 patients. The ASA physical status classification system is a system for assessing the fitness of patients before surgery which has a six-category classification system. These are:

1. A normal healthy patient.
2. A patient with mild systemic disease.
3. A patient with severe systemic disease, which limits function, but is not incapacitating.
4. A patient with severe systemic disease that is a constant threat to life.
5. A moribund patient who is not expected to survive without the operation.
6. A declared brain-dead patient whose organs are being removed for donor purposes.

Hospitals, on the other hand, have many advantages that make them the first choice and sometimes the only choice for many cases (Figure 8). While surgicenters are confined to ASA 1-2 type elective cases (occasionally an ASA type 3), hospitals can accommodate ASA 1-5 cases for dental care. Hospitals offer overnight admissions before and/or after the surgery, which may be required for cases involving anticoagulation disorders, trauma, respiratory complications, behavior-compliance issues, and a host of other reasons requiring skilled medical nursing, laboratory support, and monitoring.

At times, an unexpected medical problem during the elective general anesthesia mandates an overnight stay for treatment or monitoring. If any medical problem should arise, physicians and nurses will respond immediately. By providing care in the hospital OR there is no need to transport the patient to a hospital ER for potential emergency care or evaluation. Some procedures are only covered by the insurance carrier if performed in a hospital that participates in that policy or program. Hospitals are known to participate in insurance plans and programs for which surgicenters may have chosen not to participate. Hospitals have a large staff, which offers more opportunities for networking and thus for new patient referrals. The nurses, doctors, clerical and other staff may themselves become patients, in addition to the patients who they refer to your office. However time-consuming, department and staff meetings, and tumor boards allow the dentist to consult with medical colleagues to discuss cases, enjoy sponsored meals, meet old friends, make new acquaintances, take advantage of educational opportunities, and access library resources.

In choosing a hospital or surgicenter, you may wish to consider the location and proximity to your office as well as your home, the hours of OR availability, the type and condition of dental equipment available for use, and the attitude or helpfulness of the OR staff. You should locate a facility which offers OR times that complement your lifestyle, rather than complicate it.

The hospital or surgicenter will require you to complete an application for OR privileges. Some facilities utilize a universal application to facilitate the process. The universal application may be completed once and used for many facilities. Other facilities require a specific application that includes confirmation of background and training, CPR, liability insurance, and other details. You will apply for privileges to perform specific procedures and your scope of practice will be limited to those procedures for which privileges are granted by the facility’s credentials committee.

Most often, outpatient dental surgical patients are dismissed 60-90 minutes after surgery. Sometimes there is a medical or dental complication, and a patient may need to be observed for several more hours. The hospital dentist may need to apply for admitting privileges in order to permit the patient to stay at the hospital for post-op care and observation overnight. Otherwise, a staff physician or hospitalist may be asked to admit and care for the in-house patient. Hospitals and surgicenters may differ in their application processes for privileges. Admissions privileges also vary from state to state.

If you decide to offer OR services, you might wish to start your marketing efforts by informing your own patients that these services are available. Your current patients and staff provide your best testimonials and are your best “word of mouth” advertising. Just let it be known, and don’t be shy about promoting what you are offering. You can also use newsletters, articles, ads, lectures, fliers in your waiting room, and many creative other ways to inform your potential referral base of the services you offer and perform.
II - IN THE OR

Pre-Op Procedures #1: Consult and Consent

Following the patient’s agreement to go to the OR with an approved treatment plan, the dentist and patient, or the dentist and the legal guardian or responsible party must meet to review the informed consent for care in the OR (Figure 9).

Figure 9. Mother of handicapped child consulting with dental staff prior to OR.

This informed consent must clearly explain to the parties involved the treatment indicated, options for alternative care, anticipated outcome, and potential complications. The option of “no treatment” must be discussed, along with the potential risks to the patient associated with general anesthesia. Through analysis of the risk to benefit considerations for the patient, it might be determined that the risk outweighs the benefit, and thus dental treatment is restricted or withheld. For example, in an elderly patient with pulmonary problems, IV is considered rather than intubation general anesthesia in order to reduce the likelihood of pulmonary complications. The patient and family must be willing to discuss and accept responsibility for the possibility of potentially undesirable outcomes. Prior to rendering treatment, frank and open discussion of potential complications will prevent hostility, if the outcome is not what was anticipated. Extensive details about informed consent are provided below.

Pre-Op Procedures #2: Clinical considerations

Prior to care in the OR, the patient’s dental diagnosis and treatment plan must be relayed to the physician, preferably with privileges at that particular facility. The patient will be given an H&P (“History & Physical Exam”) by that physician. Based on this assessment and the treatment recommended by the dentist, the physician may request lab tests in addition to those required by the hospital. The physician establishes that the patient is a good candidate for care under general anesthesia and for the procedures that are being recommended. In the OR, the patient’s medical history and the doctor’s recommendations will be reviewed by the anesthesiologist.

Lab pre-admission tests (PATs) are essential to determining a patient’s pre-operative medical status and condition. Test results provide valuable and needed information that can be critical to the anesthesiologist who has the primary responsibility to maintain the patient in stable health while you, the dentist, operate on their mouth. These tests are gender- and age-specific, and reduce the chances of any untoward events that may compromise the patient’s health. Knowing a patient’s underlying cardiac and respiratory status can mean the difference between a routine, successful case versus one with life-threatening complications.

Knowing the pregnancy status of a female patient can prevent an inadvertent loss of pregnancy. Blood tests and careful planning are essential for patients with coagulopathies. Monitoring of glucose and insulin levels is essential for patients with diabetes. Monitoring of liver function is necessary with hepatitis patients, and renal tests are necessary with dialysis patients. This list is far from exhaustive, which is why it is necessary to rely on our medical colleagues for consultation and coordination of efforts, to ensure the welfare of our patients.

Tests cover more than blood and other body fluids. Chest x-rays, EKGs, various scans and other diagnostic tools can reveal essential data, useful to all the physicians who will attend to the patient as well as to the physicians who will monitor the patient’s health before and after the operation, and to the anesthesiologist who is responsible for the patient’s health and well-being until the patient is safely discharged from the facility. Some patients may become too combative for any pre-operative testing. Intellectually disabled patients may not allow anyone to draw blood, or may not sit still long enough for an X-ray or other non-invasive tests to be performed.

On these occasions, in consultation with the primary physician and with the approval of the anesthesiologist, intra-operative tests can be performed with a pre-arranged stat test result. Urine can be brought in by the family or caretaker. After the patient has been successfully sedated, blood and other fluid tests can be run along with chest x-ray, EKG, etc.

In the case of routine screening tests, such stat tests need not delay the operation. For the medically compromised patient, such tests pose a higher risk, and the operation may be delayed until the tests have been performed and stat results are reported to the satisfaction of the anesthesiologist.

Pre- and post-operative alteration of medications must be coordinated and discussed with the attending physician. Common medications potentially requiring an alteration of the schedule and/or dosage may include insulin, antibiotics, hypertensive medications, corticosteroids, anticoagulants, seizure medications, and analgesics.

Intra-operative consideration #1: Anesthesia

The treatment of the patient in the OR is similar to treatment in the dental office, except that while under general anesthesia the patient is totally cooperative and compliant. The anesthesiologist is responsible for safely putting the patient to sleep, by whatever technique the anesthesiologist and the dentist have agreed upon. Naso-tracheal intubation is preferred in order to give the dental team the greatest access to the oral cavity (Figure 10).

At times nasal intubation fails or is impossible. In those instances, oral intubation is utilized. For both types of
intubation the patient’s airway is always protected with a throat pack. This may simply be a roll of moistened gauze packed into the posterior pharynx from side to side. A lubricant is applied to the lips, and a mouth prop is utilized to maintain access to the oral cavity.

In our 1,600 OR cases, the desired nasal tube was not possible 15% of the time. More details about nasal and oral intubation are provided in the “tips” section later.

Intra-operative consideration #2: Procedures

In some cases, intra-operative IV antibiotics and/or steroids are employed to protect the patient and to facilitate post-operative healing. Often a local anesthetic is also administered for hemostasis and post-op pain-control. For nasal intubations, a mouth prop is placed on one side while all non-surgical procedures are performed on the other side.

Following completion of the diagnostic exam and periodontal therapy, then restorative and endodontic procedures, the mouth prop is switched to the other side of the oral cavity. For oral intubations, a ratchet mouth prop is employed on the same side as the tube while treatment is rendered on the opposite side.

The ideal sequencing of restorations allows restorative materials to harden with maximum time prior to the extraction of adjacent teeth. Surgical procedures are usually performed last, in order to prevent blood from interfering with the restorative or endodontic procedures. The application of bio-mechanical principles of exodontia will greatly expedite the removal of teeth, eliminate wrist fatigue, and reduce the number of fractured roots by 75%. This is an entire topic unto itself. For more information via an online course, see www.nova.edu oral surgery by Dr. Harvey Levy.

Upon completion of the dental case, the mouth is thoroughly irrigated and the throat pack is removed. The dentist and auxiliaries stand back as the anesthesiologist extubates and safely wakes up the patient.

Intra-operative consideration #3: Keeping records

Throughout the operation the dentist continually announces the work being performed. Someone in the OR is assigned to record these notations, to enable the dentist to later dictate an accurate operative report. The anesthesiologist also monitors the patient and keeps records pertaining to anesthesia throughout the operation.

Post-operative considerations

The completion of the operation is NOT the end of the case. When your work is done, someone else’s job is just beginning. The OR staff transports the patient to the post anesthesia care unit (PACU), where a new team takes over the care of the patient. The recovery staff is given a verbal narrative by the OR nurse who transported the patient, as well as written orders and instructions by you. The recovery team needs to know the following: what procedures were performed, what is expected of them for the duration in the unit, and what is expected of the patient and his/her family or guardian/caretakers upon discharge. They need to know the criteria for discharge, and what to give the patient in terms of medications, gauze, written instructions, and follow-up after discharge. Though you’ll provide the written criteria for discharge, it will be the PACU nurse’s judgment call just when to discharge. The patient shouldn’t be kept longer than necessary, but should only be allowed to leave when it is reasonably safe to do so. Vital signs, bleeding, nausea, pain and alertness all play a role in the decision.

Medicines

Healing and patient comfort are facilitated by prudent pharmaceutical therapy. Upon completion of the operation, the dentist prescribes post-operative medications, as well as orders for the PACU and for home care. Appropriate analgesics may be administered IV by the anesthesiologist prior to extubation or in the PACU, and continued by prescription at home after release. Such medications often include: analgesics, antibiotics, anti-inflammatories, and antiemetics (to prevent dehydration, swelling and other post-operative complications arising from gastric contamination of oral surgical wounds).

Gauze

The nursing staff in charge of the patient in the PACU will need to know how to care for the oral surgical sites and what to expect. The dentist should provide instructions for hemostasis and compression of the wounds using gauze packing. Instructions to the staff must also address issues such as the use of straws and ice chips. The non-surgical patient can sip liquid through a straw. Straws are discouraged in surgical cases where the vacuum action of the straw may disrupt the blood clot from the fresh extraction site. For patients who have undergone restorative care with amalgams, implants or temporary acrylic crowns, ice chips may be contraindicated. The patient may receive clear liquid by sipping from a cup.

Written instructions

Follow-up care for the patient must be prescribed at the time of release, and the patient must be given this recommendation in writing prior to discharge from the hospital. Typically these instructions are reviewed prior to discharge to ensure that the patient or caretaker is capable and willing to follow them. The patient is typically contacted within 24 hours by a phone call and/or a visit. This allows the dentist to respond to any condition resulting from the operation which may require attention. Close and continued follow-up care on a periodic and on an as-needed basis reduces the likelihood of complications or reoccurrence of the dental conditions.

Follow-up after discharge from the PACU

After discharge from the PACU, the patient may either be sent to a room in the hospital for continued follow-up care, or sent directly to their home, nursing home, institution, or other facility. If the patient is going to a room in the hospital, then the floor nurse will comply with your notes and orders. If the patient is going home, you must provide to the patient and/or to the person who is taking them home both written and verbal instructions regarding immediate care, information for the next one to two days, and further follow-up.

Immediate and next-day instructions:

These include how to care for the mouth, important information about general health (vital signs and medical considerations), what can be expected concerning the mouth, any new medications you’ve prescribed, resumption of suspended medications, what to do if something unexpected occurs, and who to contact if assistance is needed after discharge. Having pre-printed instruction sheets for each separate procedure (extraction, root canal, crown/bridge, immediate denture, partial/full removable dentures, implant, space maintainer, periodontal treatment) virtually eliminate patients’ follow-up calls with predictable questions. If you use pre-printed instruction sheets in the office, then bring them to the OR with you. If not, then make them and use them to save time.
and prevent late night calls. If local anesthetics were used for either hemostasis or pain control, then OraVerse (phentolamine mesylate by Septodont) may be injected into that same site to hasten local vasodilation and reversal of the anesthetic effect. This often prevents post-operative biting of one’s tongue, lip or cheek.

**Follow-up appointment information**

This should be included so that the dentist can check any sockets or surgical sites, treat high spots on restorations, deliver or adjust appliances being fabricated including crown/bridge, implants, space maintainers, full or partial dentures, and review with the patient and caretakers what to do regarding long term care in order to reduce the likelihood of repeat operations. Oral hygiene and home care review is essential at this point. The follow-up appointment is also a good time to handle any financial and insurance matters, and to make an appointment for continued dental care.

*This article will be continued in the next issue of the GP, the journal of the NYSAGD.*

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**Congratulations, Paula!**

Please join us in celebrating and thanking our Executive Director, Mrs. Paula Bostick, upon reaching her 10 year anniversary with the New York State Academy of General Dentistry. Paula joined the NYSAGD on January 3, 2006, and initially served as Education Manager. On September 12, 2011, she was appointed Executive Director of the NYSAGD. In 2012, Paula was very instrumental in the relocation of the NYSAGD headquarters from White Plains to Whitestone and the establishment of our Learning Center. Paula continues to serve as our Executive Director and very efficiently carries out the continuing education and the administrative operations of the NYSAGD. We look forward to having Paula Bostick as part of the NYSAGD family for many years to come and thank her for her teamwork and many contributions.

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*Dr. Harvey Levy has been practicing general dentistry in hospital and alternative settings in Frederick, Maryland since 1980. Originally from Brooklyn, NY, he graduated from Tufts Dental in 1974, and completed a 2-year GPR at Eastman in Rochester, NY in 1976. He is a former full time instructor and program coordinator of the Hospital of the University of Pennsylvania General Dentistry Residency Program. Dr. Levy is a recipient of the ADA 2002 Access to Care Award, the AGD 1986 Humanitarian Award, the Maryland Governor’s Doctor of the Year Award, the Morgen State Public Oral Health Award, Maryland State Dental Association first Arthur Fridley Humanitarian Award, and the Special Care Dentistry Saul Kamen Award. He holds eight dental fellowships, five Diplomate certificates, Board Certification in Integrative Medicine in addition to AGD Mastership plus four Lifelong Learning and Service Recognitions in the AGD.*

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