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American Dental Association, Publishing Division

AMERICAN DENTAL ASSOCIATION
ADA News®
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DARW
Recognition week, page three

BRIEFS

February JADA to feature DMSO supplement

A special report on dental management service organizations will be packaged with the February edition of The Journal of the American Dental Association.

The eight-page supplement authorized by the Board of Trustees includes an introduction that explores the development and potential impact of DMSOs on the dental care marketplace.

Other articles in the supplement review the legal, financial and dental practice issues dentists should understand before affiliating with a DMSO or selling their practice to one.

Prepared by ADA Publishing Co., Inc., the supplement is a project of the ADA Task Force on DMSOs, working in cooperation with the ADA Council on Dental Practice and Division of Legal Affairs. ■

ICD luncheon set for Feb. 18 in Chicago

The International College of Dentists Annual Luncheon and Program is scheduled for Feb. 18 in Room S402A of the McCormick Place convention facility in Chicago. The luncheon is held during the Chicago Mid-Winter Meeting Feb. 18-21.

Dr. Robert Brady, ICD registrar, will speak. Also on the agenda is the presentation of the ICD 8th District Annaul T.V. Weclew Award of Excellence and Distinction to Dr. Calvin C. Akal. ■

INSIDE

Student debt

A look at progress made since the 1997 House of Delegates adopted six directives on student and recent graduate financial issues. **Story, page 28.**

NEWS UPDATE

Court upholds Bragdon finding

Appellate panel rejects argument of 'direct threat' from HIV

By Craig Palmer

Boston—A three-judge U.S. Court of Appeals panel Dec. 29 rejected a Maine dentist's argument of a perceived direct threat to dental office safety from treating an HIV-positive patient.

The court held that there was "competent evidence" and a "scientific foundation" for the conclusion that treating patient Sidney Abbott in his office did not pose a direct threat to others and, therefore, did not fall within the exception to the Americans with Disabilities Act prohibition against discrimination.

■ FEE SURVEY, PAGE 24

In reaching this decision, the court relied in part on guidelines of the Centers for Disease Control and Prevention (CDC) and policy of the American Dental Association on the treatment of HIV-positive individuals.

Federal courts have consistently rejected Dr. Randon Bragdon's argument that universal precautions are insufficient to protect dentists treating patients infected with HIV. The First Circuit Court of Appeals panel, the latest to review this controversial case that divided the U.S. Supreme Court last year, said it tried to give Dr. Bragdon the benefit of the doubt but could still find no basis for accepting his arguments.

The Supreme Court ruled five to four June 25 that HIV-infected patients can be protected by the Americans with Disabilities Act. The Supreme Court returned to the Court

See BRAGDON, page 10

ADA Research Institute launches latex studies

By Daniel McCann

Scientists with the ADA's Research Institute last month began studies on ways to minimize allergic reactions to natural rubber latex gloves.

Initiated by the Council on Scientific Affairs, the investigation focuses on the safety and efficacy of latex gloves with lowered amounts of protein and powder. Scientists will then study whether these changes compromise the gloves' protectiveness.

See LATEX, page 13

NEWS UPDATE

Anesthesia guidelines, patient handout inside

ADA readies for '60 Minutes II'

By David Weissman

Guidelines, a policy statement, patient handout and talking points top the list of Association-related resources for dentists to inform themselves and patients about the use of anesthesia in their offices.

The guidelines—"Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentistry"—are reprinted in their entirety starting on page 15 of this issue.

Also on page 12 of this issue is "Understanding Dental Anesthesia: What Every Patient Should Know." This handout, which dentists are encouraged to remove, duplicate and give to their patients, outlines several pain and anxiety control techniques including local and general anesthesia, conscious and deep sedation, and analgesics.

"The dental profession has established educational, training and practice guidelines for the use of conscious sedation and general anesthesia," said ADA President S. Timothy Rose. "We as a profession need to support these protocols when these

See ANESTHESIA, page 23

U.S. Supreme Court to hear challenge of FTC authority

By Craig Palmer

Washington—The dental profession Jan. 13 will urge the U.S. Supreme Court to limit Federal Trade Commission authority to regulate non-profit associations.

Peter M. Sfikas, ADA general counsel, will represent the California Dental Association before the court, which agreed to review FTC jurisdiction over non-profit dental and other professional associations. The court scheduled oral arguments for Jan. 13.

■ $59 MILLION JUDGMENT, PAGE 20

In taking up the case, the nation's highest court signaled interest in revisiting a 1982 split-court decision that left unresolved the issue of FTC authority over non-profit associations. The court agreed to review two issues raised by the California Dental Association:

- whether the FTC has jurisdiction over non-profit professional associations like the CDA;
- whether a non-profit professional association is in violation of antitrust laws under a cursory analysis used by the FTC in sanctioning the California dental society for its regulation of dentist advertising.

Joining the ADA in the long-standing challenge of FTC regulation of the professions are the American Medical Association, National Soci-

See FTC, page 12

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ONLINE EXTRA

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DARW recognizes team effort

'Together, making a world of difference'

Resolve this year to give your dental assistants the recognition they deserve by participating in this year's Dental Assistant Recognition Week, March 7-13.

This year's slogan, "Together, Making a World of Difference," reflects the importance dental assistants play in the success of a dental practice.

As part of the week, a contest is held to showcase what dentists are doing to recognize and honor their assistants.

"Dental assistants are an invaluable member of the dental team not only for their knowledge and expertise, but also for comforting and guiding patients through their treatment," said Dr. Charles H. Norman III, chairman of the ADA's Council on Dental Practice. "Dental Assistants Recognition Week is a way to honor these individuals and simply say, 'Thanks,' " he said.

DARW, organized each year by the council and the American Dental Assistants Association, provides dentists with the opportunity to improve their relationships with their staff members and give their assistants earned recognition. And for the first time this year, the Canadian Dental Assistants' Association will also serve as a co-sponsor.

Such recognition is especially important in light of concerns over dental assistant shortages, said Dr. Albert Guay, director of the council.

"In focus groups when job satisfaction is dis-

See DARW, page 27

Viewpoint

Laura A. Kosden, *Publisher* Dr. Lawrence H. Meskin, *Editor*

James H. Berry, *Associate Publisher, Editorial* Judy Jakush, *ADA News Editor*

My view

Hippocrates and Maimonides: Where are you?

Editor's note: If you're curious about what Hippocrates, Maimonides and the ADA Pledge say, turn to page eight.

A few years ago, 2,500 years to be reasonably accurate, a fellow by the name of Hippocrates was somewhat upset by the fact that there was no precise code of medical ethics. He took matters in his own hands and came up with what became known as the "Oath of Hippocrates."

A little over one thousand years later, a prominent Jewish physician-philosopher by the name of Moses Maimonides developed his own oath. The two oaths are similar in many respects, although Maimonides seems to be moralistic in his approach to the care of the individual.

In more modern times, there have been a number of additional oaths developed, including the "Oath of the Declaration of Geneva" (1948), the "Oath of Lasagna" (1964), and the Soviet "Oath of Medical Ethics" (1971).

Henry J. Heim, D.D.S.

When one scrutinizes the oaths of Hippocrates and Maimonides, one cannot help but note the emphasis on the caring of the individual, whereas in more recent times, one detects care as it relates to conformity to the state and prevailing societal values.

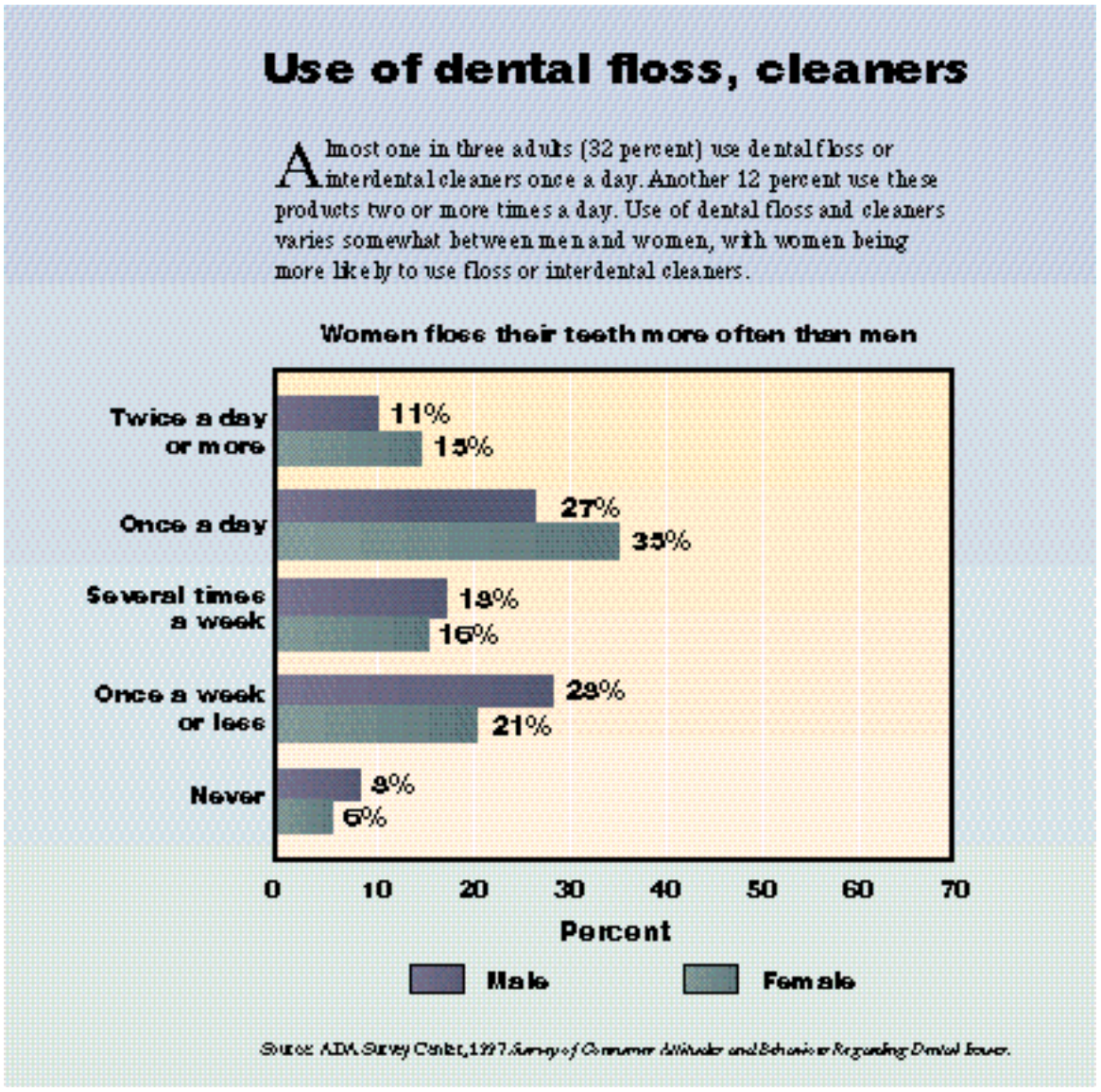
How do we explain this sudden shift away from the principles of Hippocrates and Maimonides? To me, the answer is fairly simple—all we have to do is examine the culture we live in. The ethical standards that for centuries were considered to be the bedrock of civilization have become rubberized—the rules constantly changing, flexible rules adapted to the times we live in.

How does all this impact on us as part of the health professional team? As I see it, we must never forget that we are treating human beings. Certainly, we have to meet our overhead. Certainly, we are entitled to just compensation. But our patients are entitled not only to good technical care, but also to some degree of compassion and understanding. When we lose the personal dimension and forget that we are dealing with individuals made up of hopes and fears, we become the robotlike doctor that symbolizes the tragedy of our society.

Hippocrates and Maimonides, please come home!

Dr. Heim is past president of the District of Columbia Dental Society. This article, reprinted here with permission, originally appeared in the November 1998 issue of the District of Columbia Dental Society Newsletter.

Snapshots of American Dentistry



Letters

Advertising

With the advertising cost of membership taking a back burner nationally, we dentists in Wisconsin are still paying $300 per year for our state advertising campaign.

Why not put the same advertising effort into a freedom-of-choice effort nationally and locally?

Fred E. Zietz, D.D.S.
Middleton, Wis.

Hygienist training

I just read with shock Resolution 31H-1998, from the House of Delegates that was printed in the December 14, 1998, ADA News.

"RES. 31H: Notes ADA support for the alternate pathway model of Dental Hygiene Education as used in Alabama." In this day of so-called managed care, it has been the insurance companies that have stopped calling us doctor, instead referring to us as "providers." In medicine, insurance companies continually attempt to delegate procedures to lower cost providers.

Now I read that my own ADA wants to lower the standards of education in our profession. The Alabama hygiene issue has already surfaced in Florida, and I am proud to say failed. Just the idea that hygienists could get trained on the job scares me. The assisting students that intern at my office tell me the level of interaction at some other offices. It ranges from good to none. There will be no standardization, no consistency and overall we are devaluing hygienists and all periodontal procedures. Patients see little value in hygiene to begin with; they "just want their teeth cleaned." Let me speak openly and honestly.

In my view, this entire proposal is based on the idea that we should increase the supply of hygienists, so we can pay them less, and profit more. This is emerging from the same dentists that seem to have trouble keeping competent hygienists. In our local paper, the same dentists are always looking for hygienists, while other dentists have hygienists stop by and leave resumés.

The problem is not the hygienist, it is the dentist. I have been told by many hygienists that they do not want to work in offices where the dentist does not examine the patient, where patients start in hygiene without a diagnosis, and when they discuss periodontal therapy needs with the dentist, they are not supported but told; "You should be able to clean them in one visit (when they have active disease, or are overdue for care)."

They do not enjoy working in an office where soft tissue management does not exist, where no policies exist for ongoing periodontal evaluation, diagnosis and treatment planning, that patients are not referred for care when they should be and where they are providing continuing supervised neglect (everyone just gets prophies). If all these scenarios are not enough, the most serious reason that we should not lower the standards for hygiene education is the potential threat of this phenomenon spreading to other disciplines.

Some on-the-job lab techs will want to be certified as lab technicians, and maybe some assistants will say, "I have watched the dentist for 10 years, I could do that, I want a dental license."

See LETTERS, page six

Letters policy

ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is (312) 440-3538; email to "ADANews@ada.org".

Letters

Continued from page four

The states will start to ask, why so much training to only be a dentist? The lab techs that make the dentures could probably take some impressions. What harm could that do? Who needs college to take X-rays? The standards will drop for everyone if the ADA is the leader by lowering the hygiene standard.

Sound far fetched? Look into the level of training that qualifies as a dental hygienist in Alabama. If the only thing keeping your mom from having surgery or losing teeth was thorough root planning by an on-the-job trained hygienist vs. a dental school-trained hygienist or dentist, which would you choose? Would we create two titles, Hygiene I and Hygiene II, to signify the difference in training? Would you be honest with your patients if you had hygienists I and II and let them know the difference and choose or would you be embarrassed? Would you pay them the same? If you don't think they would provide the same or better care, then why are we considering this?

Rather than lower the bar, let me make a few suggestions. The ADA should seek to allow licensed hygienists to anesthetize patients by prescription of the diagnosing dentist (like medicine). This could be a certified procedure learned in a continuing education course. Dentists did it after only one year of school, and practiced on each other. In my view, the ADA should pursue changes in the state laws to allow hygienists to perform diagnostic procedures related to hygiene and treatment plan periodontal therapy rather than giving them a degree and then telling them that only the dentist can make hygiene decisions.

We educate them, then stifle them. My hygienist, by the letter of the law, is not allowed to say, "You have gingivitis or periodontitis." That would be diagnosing, which is delegated to the dentist only! This is a dumb turf war to say the least.

Let the ADA standard of care require that all patients start in an office with a complete examination by the dentist before they see a hygienist, and that this examination should include full mouth, recorded periodontal measurements. Care should then be by prescription to the hygienist.

I continue to be shocked when I do a periodontal examination at how many adult patients have never had this done. They think I am overtreating because some past licensed dentist failed to provide the minimum level of diagnosis. The ADA should be the leader of dentistry, defining and raising the standards of our profession, if it is to remain one. Let the insurance companies keep trying to lower the standards. There are no medical doctors left, only providers. I am proud to be a dentist, and I want my hygienist to be able to say the same.

Stephen G. Blank, D.D.S.
Port St. Lucie, Fla.

Editor's note: While Res. 31H-98 refers specfically to the Alabama program, another resolution before the 1998 House of Delegates also addressed the issue of dental staff training. The House chose to amend the ADA's Comprehensive Policy Statement on Dental Auxiliary Personnel through Res. 80H-98 to add the phrase "approved by the respective state's board of dental examiners."

The amended paragraph follows here:

"Dental hygiene education programs are designed to prepare a dental hygienist to provide preventive dental services under the direction and supervision of a dentist. Two academic years of study or its equivalent in an education program accredited by the Commission on Dental Accreditation typically prepares the dental hygienist to perform clinical hygiene services. However, other programs, CDA accredited or approved by the respective state's board of dental examiners, which utilize such methods as institutionally based didactic course work, in-office clinical training or electronic distance education can be an acceptable means to train dental hygienists. Boards of dentistry are urged to review such innovative programs for acceptance."

Air, water, antibiotics

The Dec. 14, 1998, ADA News contained a number of intertwined articles and topics of utmost importance to the future of dentistry. A short look at those topics, the past and the current scientific literature may show how important and how interrelated the topics really are to the future.

Dr. Stephen H. Halem ("My View") expressed quite clearly his concerns regarding air and water quality in the dental office. Daniel McCann reported on the continued debate on prescribing antibiotics to patients at risk of bacterial endocarditis ("Experts Stand by Antibiotic Recommendation"). Dr. Philip M. Hudson reported on the cost/benefit of air abrasion and laser technology. And Craig Palmer reported that patients must pay nearly half the $50 billion annual cost of dental care with the private sector burden far greater than any other health service supply or product ("Dental Spending Exceeds $50 Billion").

Air and water quality in the dental office can surely be improved by reasonable use of newer technology. Reasonable efforts should be tested to avoid regulatory overkill since patients are so often exposed to air and water outside the dental office.

I am reminded of the cardiologist two decades ago who promoted antibiotic premedication prior to dental prophylaxis even though his own cited studies showed similar bacteremia levels from routine brushing. The question I raised 20 years ago is the same today, "If bacteremia still occurs at home two to three times per day, why expose the patient to antibiotics they may need more importantly later?" Furthermore, why propagate more superbugs?

I am also reminded of recent medical literature reporting how some countries have dramatically reduced the use of antibiotics in such situations as ear infections, the number one reason for pediatric visits, because they don't see the benefits for the risk.

What if, in the future, dental treatment could further decrease the need for antibiotic use, as well as other medications? Well, that will be the case. The scientific literature already reports a certain type of dental treatment is 70 percent to 100 percent efficacious in decreasing or stopping chronic bedwetting (nocturnal enuresis) in one to three months (Kurol J, Modin H, Bjerkhoel A. Orthodontic maxillary expansion and its effect on nocturnal enuresis. Angle Orthod 1998;68(3):225). It will also be found to impact ear infections, allergies, asthma and other orofacial related illnesses.

As for the future of air, airway is the key. We need air. We worry about height, weight, diet, liquids, exercise and medications but a real chasm in dental medicine exists. Monitoring growth and development of the orofacial complex, the area surrounding the gateway to our airway, will become the dental medical treatment of the future. Only recently has medicine recognized the importance of nasal breathing, nitric oxide effects, adequate airway growth and development, hormone levels and obstructive apnea effects on blood vessels and the heart.

Although technology will be an adjunct to dental survival and prosperity in the 21st century, the key for dentistry is to understand the correlation between saving teeth and function to overall general human health.

Reportedly, many years ago, Dr. Charles Mayo observed, "With proper dental hygiene and complete dentistry human life can be extended by 10 years." Dentistry must understand what he saw.

Already recorded in the scientific literature is that "deterioration in dental state and dental functional impairment … was [is] significantly associated with a lower capacity in cognition, visual ability, hearing ability, lung volume, heart volume, muscle strength and bone mineral content as well as a lower self-assessment of health." Also recorded is that "dental health was [is] significantly worse in patients with acute myocardialinfarction than in controls."

Yes, dentistry is really medical treatment. It is now, and always has been. As such, third-party payers have no business continuing to propagate separate, thoroughly confusing, treatment-limiting double standards of practice and/or reimbursement. Patients deserve better and so do the dentists that do their best under exceptional, although often thankless, circumstances.

David C. Page, D.D.S.
Baltimore

Discouraged

I read with discouragement Dr. Halem's "My View" regarding air and water contamination. It's bad enough when the sensationalist media go looking for someone to blame for the ills of the world and the spotlight falls on dentistry,

Continued on page eight

My view

For your reference: ethical statements for all healers

Editor's note: These three statements are printed here to provide a reference to Dr. Henry J. Heim's "My View" on page four of this ADA News.

Hippocratic Oath

I swear by Apollo the physician and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner, I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be

See REFERENCE, page nine

Letters

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but it's especially discouraging when that spotlight is aimed by one of our own. In his search to eliminate any form of risk associated with dental care, Dr. Halem has decided that our next phantoms to be eradicated, sans evidence, are the air and water that we use to do our jobs. Does he lie awake nights thinking of new things to worry about?

I know that there were practitioners who, when faced with the prospect of having to adopt universal precautions, remarked, "Gloves? I'm not wearing gloves. I've never worn gloves before and nobody ever got sick at my office." And those of us who are tired of being portrayed as either evil doctors out to poison our patients or well-intentioned, ill-informed saps unwittingly infecting the masses are considered by these "researchers" in the same light.

I love my profession and will for several more years. I have a successful practice, and my patients appreciate the quality of work we do for them. However, I'm glad that none of my children has expressed any interest in the profession and await with anticipation the day when I can hand over the reigns to a younger colleague whose entire dental career has been molded during these times of regulation and suspicion.

Dr. Charles H. Smith, ADA past vice president, dies Dec. 25

Marietta, Ga.—Dr. Charles H. Smith, a past ADA vice president and long-time delegate to the ADA House, died Christmas day. The Marietta, Ga., resident had marked his 75th birthday just the day before his death.

A past president of the Georgia Dental Association, Dr. Smith served as ADA first vice president in 1988-89 and was a Georgia delegate to the ADA House from 1972 through 1989.

An orthodontist, Dr. Smith attended Atlanta's Oglethorpe University and received his dental degree in 1945 from the Emory University School of Dentistry, also in Atlanta.

He served in the U.S. Navy on active duty from June 1945 until June 1947 and remained in the Naval Reserves until 1963, attaining the rank of lieutenant commander.

He received his orthodontic training at the University of Montreal but returned to Atlanta after his residency to open his orthodontic practice. He remained in active practice for more than 50 years.

In 1948, Dr. Smith joined the orthodontic faculty at Emory where he taught for the next 20 years. After a leave of absence, he returned to Emory in 1983 as a part-time faculty member. From 1985-92, he was program chairman of Emory's orthodontic training program.

In addition to his posts with the Georgia Dental Association and the ADA, Dr. Smith was president of the Fifth District Dental Society in 1961, general chairman of the Thomas P. Hinman Dental Meeting in 1963, president of the Georgia Orthodontic Study Group in 1964 and president of the Southern Society of Orthodontists in 1975.

Dr. Smith

He was a diplomate of the American Board of Orthodontics, an honorable fellow of the GDA, a fellow of the American College of Dentists, a fellow of the International College of Dentists and a life member of the American Association of Orthodontists. His fraternal memberships included Psi Omega and Omicron Kappa Upsilon.

Dr. Smith was a life member of Optimist International and past president of the North Fulton Optimist Club of Georgia. He was also a member of Atlanta's Chamber of Commerce and a charter member of the Wieuca Road Baptist Church.

An avid golfer, Dr. Smith was a past president of Atlanta's Druid Hills Country Club, a charter member of the Atlanta Country Club and a member of the Atlanta Classic Foundation.

Funeral services for Dr. Smith were held Dec. 28 followed by interment in Arlington Memorial Park. He is survived by his wife, Mary Kathryn, two sons, two daughters, a sister, six grandchildren and five great-grandchildren. ■

Reference

Continued from page eight

granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

Oath of Maimonides

The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all times; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.

May I never see in the patient anything but a fellow creature in pain.

Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.

Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today. Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling.

Dentists' Pledge

The ADA adopted the Dentists' Pledge, in 1991:

I, (dentist's name), as a member of the dental profession, shall keep this pledge and these stipulations.

I understand and accept that my primary responsibility is to my patients, and I shall dedicate myself to render, to the best of my ability, the highest standard of oral health care and to maintain a relationship of respect and confidence. Therefore, let all come to me safe in the knowledge that their total health and well-being are my first considerations.

I shall accept the responsibility that, as a professional, my competence rests on continuing the attainment of knowledge and skill in the arts and science of dentistry.

I acknowledge my obligation to support and sustain the honor and integrity of the profession and to conduct myself in all endeavors such that I shall merit the respect of patients, colleagues and my community. I further commit myself to the betterment of my community for the benefit of all of society.

I shall faithfully observe the Principles of Ethics and Code of Professional Conduct set forth by the profession.

All this I pledge with pride in my commitment to the profession and the public it serves. ■

LEGAL AFFAIRS

Judges ask questions on 'direct threat' arguments at hearing

By Craig Palmer

Boston—The U.S. government, in a strong endorsement of ADA policy, told a federal Court of Appeals Dec. 9, "it is safe to treat [HIV-positive] patients in a dental setting so long as universal precautions are used."

A three-judge appellate panel, acting at U.S. Supreme Court direction, heard arguments—from attorneys for a dentist, a patient and the government—on the extent of risk to dentists in treating patients with infectious disease such as HIV and the effectiveness of universal precautions, which require use of infection control procedures under which every patient is treated as if infectious.

"This is a case with obvious significance, legal and social, and it's easy to understand the positions of both [sides]," Judge Bruce Selya said in concluding the 45-minute hearing.

"The issues are not easy. The briefs were very helpful. Hopefully this case will be as well decided as it was argued."

The Supreme Court ruled June 25 that HIV-infected patients can be protected by the Americans with Disabilities Act and asked the Court of Appeals to determine whether Dr. Randon Bragdon, a Maine dentist, could refuse to treat an asymptomatic HIV-positive patient in his office on the basis of a perceived threat of HIV transmission.

Both the Court of Appeals and a U.S. District Court had previously ruled there was no direct threat to Dr. Bragdon in treating an HIV-positive patient in his office.

The Supreme Court also called for further review of the science and public health guidelines including ADA policy and Centers for Disease Control and Prevention guidelines, which encourage dentists and other health professionals to use universal precautions with all patients.

"Although the Supreme Court expressed concern over the reliance given to the 1993 CDC Guidelines and the 1991 American Dental Association policy, upon a full examination of the record, this concern is unfounded," the Justice Department told the Court of Appeals for the First Circuit.

"In short, the Association's policy statement reflects the considered view of the nation's leading dental association, representing over 140,000 active licensed dentists," the government argued. The Association filed a brief with the Court of Appeals setting forth the scientific basis of its policies.

Dr. Bragdon sat with family members during the Dec. 9 proceedings at the Boston Harbor courthouse and at one point stepped toward the bench as if to speak. After the hearing, the ADA News asked why he stood as if to address the court and what he intended to say.

Dr. Bragdon said he was "outraged" at what he saw as attempts by attorneys arguing the case "to say what I think" and to try to minimize the risk to dentists in treating HIV-positive patients. Had he spoken, Dr. Bragdon said, "I would have told them it was obvious from the very beginning that HIV was very serious in the health setting."

The First Circuit Court of Appeals ruled that Dr. Bragdon violated the disabilities act in declining to treat the patient, Sidney Abbott, in his office. Attorneys for Dr. Bragdon and Ms. Abbott presented arguments Dec. 9 on whether there is a direct threat to dentists and the dental staff in treating HIV-positive patients.

The weight of the arguments and questions by the judges gave little indication of support for Dr. Bragdon's position.

"There is no direct threat in circumstances such as there are in this case," the Justice Department told the court. Justice Department attorney Ms. Jessica D. Silver said public health experts agree "that by using universal precautions it is safe to treat HIV-positive patients in a dental setting."

"Dr. Bragdon's policy [of refusing to treat patients with HIV disease in his private office] does not make it safer for dentists," said the patient's attorney, Bennett H. Klein. "Risk, though remote, is unavoidable and dentists should use universal precautions for all patients."

Judge Norman H. Stahl asked Mr. Klein, "So what you are saying is the risk is not significant and there is no reason to disturb our prior finding [of no direct threat]?"

"That is correct," Mr. Klein replied.

Dr. Bragdon's attorney, John W. McCarthy, told the court that needlestick injuries increase the risk of disease transmission, an argument Judge Selya found wanting.

"For percutaneous injury," Mr. McCarthy said, "it's incontrovertible that universal precautions are not effective."

"To me, it is incontrovertible that they are effective," Judge Selya replied. He said the arguments Mr. McCarthy presented indicate that "Dr. Bragdon seems to be more prone to percutaneous injuries than the average dentist. Aren't we dealing with what a reasonable, objective dentist would see under the circumstances?"

He questioned the relevance of Mr. McCarthy's argument about needlesticks to the issue before the court and questioned Dr. Bragdon's assertion that the patient could be better treated in a hospital. "I don't understand how filling a cavity in the hospital reduces the possibility of a needlestick injury," Judge Selya said.

"It doesn't," Mr. McCarthy replied. "It's going to be more comfortable, a setting where he [Dr. Bragdon] is much less likely to be interrupted."

"I don't know of any physician who is more comfortable in a hospital setting than in his own office," Judge Selya responded.

"I would disagree with you on the facts but I don't want to get sidetracked on that," Mr. McCarthy continued. "It's more comfortable to be in a hospital but it isn't necessary." ■

Fielding questions: Dr. Bragdon is shown hereon March 30, 1998, talking to reporters on the steps of the Supreme Court building.

Association's HIV statement offered

Association policy, based on current scientific information, says: "Current scientific and epidemiological evidence indicates that there is little risk of transmission of infectious disease through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed."

The ADA views as unethical a decision not to provide treatment to an individual because the individual is HIV seropositive or has AIDS, based solely on that fact. ■

DOJ cites ADA policy before appellate court

The U.S. government, in a legal brief supporting Association policy, said the Association has made clear that its policy represents "longstanding" and "cornerstone" views that:

- there is little risk of transmission of HIV through dental treatment if recommended infection control procedures are routinely followed;
- patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed;
- such infection control procedures provide protection for both patients and dental personnel.

"In short, the Association's policy statement reflects the considered view of the nation's leading dental association, representing over 140,000 active licensed dentists."

The Justice Department said that "the Association's view on the risk of disease transmission during routine dental care" would support a Court of Appeals decision that there is no direct threat to Dr. Bragdon in treating an HIV-positive patient in his office. ■

Bragdon

Continued from page one

of Appeals the sole question of whether Dr. Bragdon could refuse to treat an asymptomatic HIV-positive patient in his office on the basis of a perceived threat of HIV transmission. Dr. Bragdon declined to fill the cavity of patient Sidney Abbott in his office, offering instead to treat her at a hospital, citing the perceived direct threat to others as a justification.

"In our reexamination, we apply conventional summary judgment jurisprudence, drawing all reasonable factual inferences in favor of Dr. Bragdon," the Court of Appeals said. "Despite the leniency of this approach, we do not indulge 'conclusory allegations, improbable inferences, and unsupported speculation'."

More persuasive to the court, the judges wrote, were the CDC guidelines and Association policy that were questioned by the Supreme Court in last year's ruling (ADA News July 13, 1998). The Supreme Court said it was "unable to determine" the effectiveness of universal precautions based on the limited record before the court and questioned the appropriate scientific weight to give Association Policy on AIDS, HIV Infection and the Practice of Dentistry.

The Court of Appeals reexamined both the CDC guidelines and Association policy and stated in the Dec. 29 ruling:

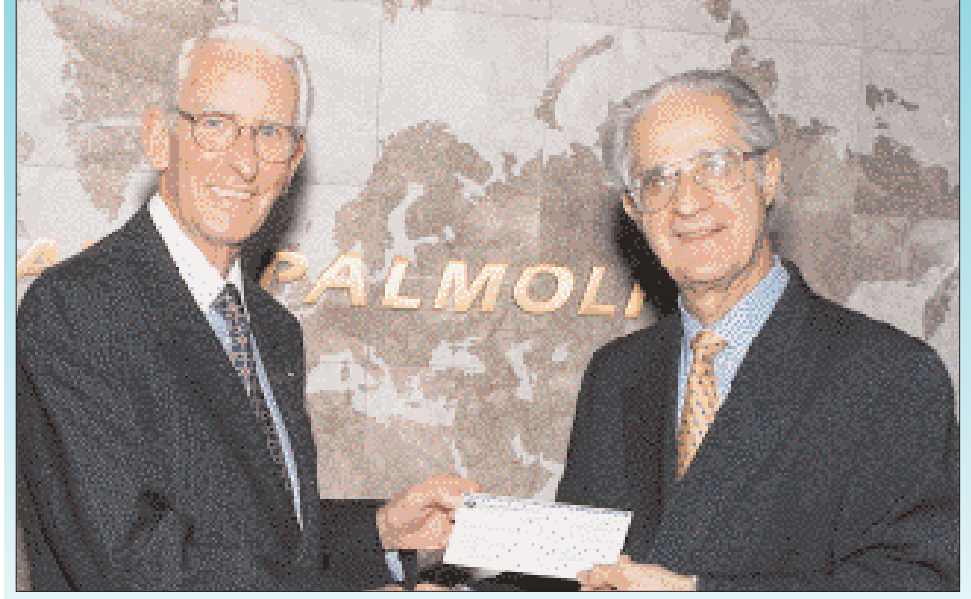
We have again determined that the guidelines are competent evidence that public health authorities considered treatment of the kind that Ms. Abbott required to be safe, if undertaken using universal precautions.

The Association formulates scientific and ethical policies by separate procedures, drawing on different member groups and different staff complements. … Although the Association's House of Delegates must approve policies drafted by (two) council(s), we think that the origins of the Policy satisfy any doubts regarding its scientific foundation.

"For these reasons, we are confident that we appropriately relied on the guidelines and the Policy," the court said.

"Our assessment of Dr. Bragdon's, and his amici's [supporting legal briefs] other reprised arguments similarly remains unchanged. Each piece of evidence to which they direct us is still 'too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact' ".

The court said its ruling relates to this specific case and cautioned the judicial system to consider whether other cases in the future—on the basis of scientific advances, more complete research or special circumstances might warrant "a different decision." ■



Something to smile about: ADA Executive Director John S. Zapp accepts a donation of $14,800 on behalf of the ADA Health Foundation from Dr. Tony Volpe of Colgate-Palmolive Co.

University of Colorado to name Dr. Landesman dean of dental school

Denver—Dr. Howard M. Landesman will be named dean of the University of Colorado School of Dentistry July 1.

Dr. Landesman

Dr. Landesman, dean of the University of Southern California School of Dentistry for the past eight years, was appointed by CU Health Sciences Center Chancellor James H. Shore.

A diplomate and past president of the American Board of Prosthodontics, he is also a fellow of the American and International College of Dentists, the American and International College of Prosthodontists, the Academy of Prosthodontics, the Academy of Restorative Dentistry and the Pacific Coast Society of Prosthodontists. Dr. Landesman is a former captain in the U.S. Air Force Dental Corps.

He received his dental degree and an advanced specialty certificate in prosthodontics from the USC School of Dentistry. Dr. Landesman also received a master's degree in education from USC. ■

Temple, Penn launch joint NIH grant venture

Philadelphia—Temple University and the University of Pennsylvania dental schools, have launched a joint venture that will enable pre-doctoral dental students considering a career in research or teaching to share in a National Institutes of Health research grant.

The National Institute of Dental and Craniofacial Research will administer the grant and directly fund students over a three-year period so that they may pursue their research interests during the summer.

The award represents the first time the two schools have applied jointly for a grant, and it enables students to conduct research at either institution.

Students may attend special research training seminars and receive a month of full-time, hands-on experience in clinical or laboratory research at either Temple or Penn. ■

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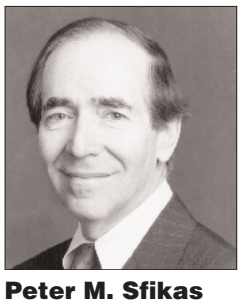

Peter M. Sfikas

ety of Professional Engineers, American Society of Association Executives and other professional groups who filed a joint legal brief with the Supreme Court.

Twenty-eight states, led by the Illinois attorney general's office, filed a brief supporting the FTC.

The American College for Advancement in Medicine, in another brief, called on the court to clarify the issue for the FTC and the profes-

Science

Continued from page one

"There are about 256 proteins in these gloves," said Chakwan Siew, Ph.D., director of Toxicology Research. "Researchers will attempt to identify the proteins or groups of proteins responsible for sensitization."

In addition, he continued, scientists will try to determine whether a lower level of proteins might also lessen the risk of reactions.

Defining such a threshold, say researchers, would provide a benchmark for glove manufacturers who advertise their products as having reduced protein. Though that claim is often taken to mean reduced risk, so far there's been no science to support such an interpretation.

In addition to lowering protein levels, Institute scientists will study how reducing glove powder might also lessen occupational exposure to proteins.

The powder (or, more precisely, a modified cornstarch) is added to the gloves during the manufacturing process to make them easier to slip on.

When the cornstarch mixes with natural rubber latex proteins, it acts as a vehicle to carry the proteins into the air.

As susceptible people come into contact with the proteins, either by touching them or inhaling them, they may suffer allergic reactions.

"So," said Dr. Siew, "if you lower protein concentration in the gloves and, in turn, reduce protein exposure in the air, it would seem logical that you would also lower, though not eliminate, the risk."

Finally, the investigation also calls for studying what effect, if any, lowered protein and powder levels might have on the gloves' integrity, making them either more prone to tear or more difficult to use.

In addition to the the Research Institute study, CSA Senior director Dr. Kenneth Burrell noted that "the council recently completed a report to the profession titled 'The Dental Team and Latex Hypersensitivity,' which will published in the February issue of the Journal of the American Dental Association."

The council's paper, he continued, will include the latest scientific information on the symptoms of latex protein allergies, diagnosis of the condition and how to reduce occupational exposure to allergens in the dental office.

Both the reduced protein study and the CSA paper, said Dr. Burrell, represent the council's long-standing concern about natural rubber latex proteins and the potential problems they can present for the dental team and those they treat.

Ever since the onset of universal precautions, in the 1980s, protective gloves made of latex and alternatives such as vinyl have been central to ensuring the safety of patients and health care workers.

Many dentists say they prefer latex gloves because of their greater tactile senstivity. But over the years, concerns have grown about the incidence of latex hypersensitivity.

Researchers have identified two types of allergic reactions associated with frequent glove use:

- type IV hypersensitivity usually appears 48-72 hours after exposure and it's characterized by dry or cracked skin caused by chemicals added during the collection and manufacturing of latex gloves;
- Type I hypersensitivity occurs minutes after a person's skin or mucus membrane has been in contact with protein allergens. Reactions can range from the appearance of hives to sneezing and itchy eyes and, rarely, anaphylaxis.

An estimated 0.12 percent to 6 percent of the general population suffers from natural latex hypersensitivity. At the ADA's 1994 and 1995 annual sessions, a total of 1,701 dentists, dental hygienists and dental assistants underwent skin-prick tests for latex allergy as part of the ADA Health Foundation's Health Screening Program.

Of these, 105 dental professionals, or 6.2 percent, tested positive for Type I hypersensitivity. ■

Minimizing risk of latex exposure

Members of the Council on Scientific Affairs have drafted a number of practical recommendations as general guidance for avoiding exposure to natural rubber latex in the dental office.

These include:

- Use low-protein, powder latex gloves;
- frequently change ventilation filters and vacuum bags used in latex-contaminated areas;
- check ventilation systems to ensure that they provide adequate fresh or recirculating air;
- Frequently clean work areas contaminated with latex dust;
- Educate dental staff on the signs and symptoms of latex allergies.

The council further recommends that dental workers "definitively diagnosed" with natural rubber latex protein hypersensitivity use only non-latex (synthetic) gloves.

"Remaining staff members," CSA continues, "should wear either synthetic or powder-free latex gloves. [And] only synthetic or powder-free latex rubber dams should be used."

Also, dry rubber products such as bite blocks and prophy cups probably do not need to be replaced unless the protein-allergic dental worker is receiving dental care. ■

ADA Seal Products

Below is a partial list of products that earned the ADA Seal of Acceptance in September and October 1998.

American Sales Inc.
Finast Angled & Elite Angle Toothbrush
Stop & Shop Bi-Level Gem Head Toothbrush
Stop & Shop Dental Floss
Stop & Shop Dental Tape
Stop & Shop Gem Head Toothbrush
Stop & Shop Hi-Tech Dental Floss
Stop & Shop Toothbrush

Certified Grocers of California Ltd.
Springfield Hi-Tech Floss

Crosstex International
Ultra Plus Latex Exam Gloves
Ultra Plus Powderless Latex Exam Gloves

Cub Foods
Cub Foods Dental Floss
Cub Foods Gem Head Toothbrush
Cub Foods Hi-Tech Dental Floss
Cub Foods Toothbrush

CVS
CVS Antiseptic Mouth Rinse
CVS Blue Mint Antiseptic Mouth Rinse
CVS Green Mint Antiseptic Mouth Rinse
CVS Super Toothbrush
CVS Toothbrush

Discount Drug Mart Inc.
Discount Drug Mart Bi-Level Toothbrush

Eckerd Drug Co.
Eckerd Hi-Tech Floss

Federated Group Inc.
Hy-Top Icy Mint Antiseptic Mouth Rinse
Hy-Top Original Antiseptic Mouth Rinse
Parade Icy Mint Antiseptic Mouth Rinse
Parade Original Antiseptic Mouth Rinse

Fleming Companies Inc.
Marquee Blue Mint Antiseptic Mouth Rinse

Genovese Drug Stores Inc.
Genovese Antiseptic Mouth Rinse
Genovese Blue Mint Antiseptic Mouth Rinse
Genovese Spring Mint Antiseptic Mouth Rinse

Henry Schein Inc.
Henry Schein Self-Seal Sterilization Pouch
Henry Schein Stratosphere, Fast Set
Henry Schein Stratosphere, Regular Set

Ingles Markets
Laura Lynn Dental Floss
Laura Lynn Super Angle Toothbrush
Laura Lynn Supra Toothbrush

Ivoclar North America Inc.
Will-Ceram Litecast/Will-Ceram V Series
Will-Ceram Protocol/Will-Ceram V Series
Will-Ceram W-1/Will-Ceram V Series

JF Jelenko and Co.
Sturdicast Casting Alloy

McKesson Drug Co.
Health Mart Pharmacies Hi-Tech Floss
Valu-Rite Hi-Tech Floss

Nash Finch Co.
Our Family Angled Toothbrush
Our Family Gem Head Toothbrush
Our Family Hi-Tech Dental Floss
Our Family Perfect Straight Handled Toothbrush
Our Family Tartar Control Fluoride Toothpaste
Our Family Tartar Control Fresh Mint Gel Toothpaste
Our Family Toothbrush

Nobel Biocare USA Inc.
Steri-Oss Titanium Screw Type Dental Implant

Plak Smacker Inc.
Perfect Saver Powdered Latex Exam Gloves
Perfect Saver Powder-Free Latex Exam Gloves
Plak Smacker Diamond Head Toothbrush

Premier Dental Products Co.
Periowise Periodontal Probe

Prophy Perfect Inc.
Prophy Perfect Toothbrush

RHH Inc.
Neons Color Toothbrush

Shopko Stores Inc.
ShopKo Dental Floss
ShopKo Gem Head Toothbrush
ShopKo Hi-Tech Dental Floss
ShopKo Perfect Angled Handle Toothbrush

Southern Dental Industries Inc.
Patterson Dental Admix Alloy, Fast Set
Patterson Dental Admix Alloy, Regular Set
Patterson Dental Spherical Alloy, Fast Set
Patterson Dental Spherical Alloy, Regular Set

Team Technologies Inc.
Team Diamond Head Toothbrush
Team Toothbrush

Topco Associates Inc.
Dominick's Dental Floss

Weis Markets Inc.
Weis Quality Gem Head Toothbrush
Weis Quality Hi-Tech Floss

Zila Pharmaceuticals Inc.
Peridex Oral Rinse

AMERICAN DENTAL ASSOCIATION POLICY STATEMENT:

*THE USE OF CONSCIOUS SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA IN DENTISTRY**

INTRODUCTION

Dentists have had both a historic and specific continuing expertise in providing anesthetic, sedative and other anxiety and pain control procedures for their patients. The effective control of anxiety and pain has been an integral part of dental practice since the early development of the profession. Use of a wide variety of anxiety and pain control techniques has enabled the profession to extend oral health care to millions of individuals who would otherwise remain untreated. Without effective anxiety and pain control, numerous dental procedures are virtually impossible and many patients do not seek needed dental treatment. In addition, both anxiety and pain control techniques are often essential for the management of special patients, young children and the mentally and physically challenged. The use of anxiolytic sedative and anesthetic techniques by appropriately trained dentists in the dental office and other settings continues to have a remarkable record of safety.

Anxiety and pain can be modified by both psychological and pharmacological techniques. In some instances, psychological approaches are sufficient. However, in many instances, pharmacological approaches are required.

Local anesthetics are used to control regional pain. Sedative drugs and techniques may control fear and anxiety, but do not by themselves fully control pain and, thus, are commonly used in conjunction with local anesthetics. General anesthesia provides complete relief from both anxiety and pain.

This policy statement addresses the use of conscious sedation, deep sedation and general anesthesia, as defined in the Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. These terms refer to the effects upon the central nervous system and should not be confused with any route of drug administration.

The use of conscious sedation, deep sedation and general anesthesia in dentistry is safe and effective when properly administered by trained individuals. The American Dental Association strongly supports the right of appropriately trained dentists to use these modalities for the management of dental patients and is committed to ensuring their safe and effective use.

*Adopted by the American Dental Association House of Delegates, October 1998.

EDUCATION

Dentists who have received appropriate formal education in conscious sedation, deep sedation and general anesthesia are qualified to use these modalities in practice. Training to competency in conscious sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious sedation are expected to successfully complete formal training which is structured in accordance with the Association's educational Guidelines, "Part One: Teaching the Comprehensive Control of Pain and Anxiety to the Dental Student" and/or "Part Three: Teaching the Comprehensive Control of Pain and Anxiety in a Continuing Education Program."

The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of predoctoral and continuing education. Only dentists who have completed an advanced education program structured in accordance with "Part Two: Teaching the Comprehensive Control of Pain and Anxiety at the Advanced Education Level" of the Guidelines or equivalent advanced education are considered educationally qualified to use deep sedation and general anesthesia in practice.

The dental profession's continued ability to control anxiety and pain effectively is dependent on maintaining a strong educational foundation in the discipline. While many practicing dentists may elect not to use conscious sedation, deep sedation or general anesthesia, it is critical that those who wish to do so have access to adequate training. The Association supports efforts to expand the availability of courses and programs at the predoctoral, advanced and continuing educational levels which are structured in accordance with its educational Guidelines in anxiety and pain control. It urges dental schools to expand opportunities for predoctoral students to receive training and clinical experience in conscious sedation techniques. It urges continuing education sponsors to offer comprehensive courses in accordance with the Guidelines in conscious sedation techniques which include sufficient opportunity for supervised clinical experience to enable participants to achieve competency in these techniques. Finally, it urges sponsors of advanced dental education to develop programs at the postgraduate level which are designed to train individuals in conscious sedation, deep sedation and general anesthesia.

The objective of educating dentists to utilize conscious sedation, deep sedation and general anesthesia is to enhance their ability to provide oral health care.

RISK MANAGEMENT

Appropriate educational preparation, while necessary, is not by itself sufficient to ensure safe and effective use of conscious sedation, deep sedation and general anesthesia. There is some degree of risk associated with the use of any drug, even when administered by trained individuals. Dentists who are qualified to utilize conscious sedation, deep sedation and/or general anesthesia have a responsibility to minimize risk to patients undergoing dental treatment by:

- Using only those drugs and techniques with which they are thoroughly familiar, i.e., understand the indications, contraindications, adverse reactions and their management, drug interactions and proper dosage for the desired effect;
- Limiting use of these modalities to patients who require them due to such factors as the extent and type of the operative procedure, psychological need or medical status;
- Conducting comprehensive preoperative evaluation of each patient to include a comprehensive medical history, assessment of current physical and psychological status, age and preference for and past experience with sedation and anesthesia;
- Conducting physiologic and visual monitoring of the patient as needed from onset of anesthesia/sedation through recovery;
- Having available appropriate emergency drugs, equipment and facilities and maintaining competency in their use;
- Maintaining fully documented records of drugs used, dosage, vital signs monitored, adverse reactions, recovery from the anesthetic, and, if applicable, emergency procedures employed;
- Utilizing sufficient support personnel who are properly trained for the functions they are assigned to perform;
- Treating high risk patients in a setting equipped to provide for their care.

The Association expects that patient safety will be the foremost consideration of dentists who use conscious sedation, deep sedation and/or general anesthesia. Dentists who use these modalities should take all necessary measures to minimize risk to patients.

STATE REGULATION

State dental boards have a responsibility to ensure that only dentists who are properly trained, experienced, and currently competent are permitted to use conscious sedation, deep sedation and general anesthesia within their jurisdictions. For this reason, the Association strongly urges state dental boards to regulate dentists' use of these modalities. In addition to identifying educational requirements which are consistent with the Association's Guidelines, state dental boards should evaluate and certify dentists who apply to administer conscious sedation, deep sedation and/or general anesthesia to ensure that the protocol, procedures, facilities, drugs, equipment and personnel utilization meet acceptable standards for safe and appropriate delivery of anesthesia care.

The Association recognizes the existence of office-based ambulatory anesthesia as an integral part of the management of anxiety and pain control for dental patients. It is important that state dental boards be aware that ambulatory anesthesia services, will be increasingly available from well qualified dentists. It is in the best interest of the public and the profession that access to this cost-effective service be widely available.

States introducing regulation of conscious sedation, deep sedation and/or general anesthesia may elect to identify a period of time during which practitioners without the specified educational qualifications may apply and be evaluated for the use of these modalities. These practitioners should have demonstrated competence in the use of the regulated modalities over an extended period of time as determined by the state dental board.

RESEARCH

The use of conscious sedation, deep sedation and general anesthesia in dentistry will be significantly affected by research findings and advances in these areas. The Association strongly supports the expansion of both basic and clinical research in anxiety and pain control. It urges institutions and agencies that fund and sponsor research to place a high priority on this type of research, which should include: 1) epidemiological studies which provide data on the number of these procedures performed and on morbidity and mortality rates, 2) clinical studies of drug safety and efficacy, 3) basic research on the development of safer and more effective drugs and techniques, 4) studies on improving patient monitoring, and 5) research on behavioral and other non-pharmacological approaches to anxiety and pain control. ■

AMERICAN DENTAL ASSOCIATION GUIDELINES FOR THE USE OF CONSCIOUS SEDATION, DEEP SEDATION AND GENERAL ANESTHESIA FOR DENTISTS*

I. INTRODUCTION

A. ADA Policy Statement on Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry

B. Purpose

The purpose of these guidelines is to allow dentists to provide their patients with the benefits of anxiety and pain control in a safe and efficacious manner. These guidelines are not intended to include the use of nitrous oxide/oxygen when used alone and/or with local anesthesia.

II. DEFINITIONS

Methods of Anxiety and Pain Control

Analgesia–the diminution or elimination of pain.

Anxiolysis–the diminution or elimination of anxiety.

Local anesthesia–the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Conscious sedation[1]–a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

Combination inhalation–enteral conscious sedation (combined conscious sedation)–conscious sedation using inhalation and enteral agents except when the only intent is anxiolysis.

Nitrous oxide/oxygen when used in combination with sedative agents may produce conscious or deep sedation or general anesthesia.

Deep sedation–an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation **or** verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

General anesthesia–an induced state of unconsciousness accompanied by partial or complete loss of protective reflexes, including the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

Routes of Administration

Enteral–any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

Parenteral–a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraocular (IO)].

Transdermal/transmucosal–a technique of administration in which the drug is administered by patch or iontophoresis.

Inhalation–a technique of administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

Terms

Must/shall–indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Should–indicates the recommended manner to obtain the standard; highly desirable.

May–indicates freedom or liberty to follow a reasonable alternative.

Continual–repeated regularly and frequently in a steady succession.

Continuous–prolonged without any interruption at any time.

Time-oriented anesthesia record - documentation at appropriate intervals of drugs, doses and physiologic data obtained during patient monitoring.

Immediately available–on site in the facility and available for immediate use.

Levels of Knowledge

Familiarity–a simplified knowledge for the purpose of orientation and recognition of general principles.

In-depth–a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Levels of Skill

Exposed–the level of skill attained by observation of or participation in a particular activity.

Competent–displaying special skill or knowledge derived from training and experience.

Proficient–the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time (highest level of skill).

III. PATIENT PHYSICAL STATUS CLASSIFICATION

ASA I–A normal healthy patient. (ASA = American Society of Anesthesiologists)

ASA II–A patient with mild systemic disease.

ASA III–A patient with severe systemic disease.

ASA IV–A patient with severe systemic disease that is a constant threat to life.

ASA V–A moribund patient who is not expected to survive without the operation.

ASA VI–A declared brain-dead patient whose organs are being removed for donor purposes.

E–Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

IV. EDUCATIONAL REQUIREMENTS

A. Combination Inhalation-Enteral Conscious Sedation (combined conscious sedation)

1. To administer combined conscious sedation, the dentist must satisfy one of the following criteria:

a. Must have completed training to the level of competency in combined conscious sedation consistent with that prescribed in Part I and Part III of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry.[2]

b. Completion of an ADA accredited post-doctoral training program which affords comprehensive and appropriate training necessary to administer and manage combined conscious sedation.

c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of combined conscious sedation in the dental office.

a. Administration of combined conscious sedation by another duly qualified dentist or physician requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, administration of combined conscious sedation by a CRNA shall require the operating dentist to have completed training in combined conscious sedation, commensurate with these guidelines.

c. A dentist administering combined conscious sedation must document current successful completion of a Basic Life Support (BLS) course.

B. Parenteral Conscious Sedation

1. To administer parenteral conscious sedation, the dentist must satisfy one of the following criteria:

a. Completion of a comprehensive training program in parenteral conscious sedation that satisfies the requirements described in Part III of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry at the time training was commenced.[3]

b. Completion of an ADA accredited post-doctoral training program (e.g., general practice residency) which affords comprehensive and appropriate training necessary to administer and manage parenteral conscious sedation.

c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of parenteral conscious sedation in the dental office:

a. Administration of parenteral conscious sedation by another duly qualified dentist or physician

*Adopted by the American Dental Association House of Delegates, October 1998.

[1] Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.

[2] The ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry will be updated to incorporate content related to combined conscious sedation.

[3] Prior to July 1, 1993, the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry required only 40 hours of a comprehensive course in parenteral conscious sedation. Since July 1, 1993, the requirement has been increased to 60 hours in addition to laboratory experience and supervised management of 20 patients.

requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, administration of parenteral conscious sedation by a CRNA shall require the operating dentist to have completed training in parenteral conscious sedation, commensurate with these guidelines.

c. A dentist administering parenteral conscious sedation must document current, successful completion of a Basic Life Support (BLS) course. Advanced Cardiac Life Support (ACLS) or an appropriate equivalent is encouraged.

C. Deep Sedation/General Anesthesia

1. To administer deep sedation/general anesthesia, the dentist must satisfy one of the following criteria:

a. Completion of an advanced training program in anesthesia and related subjects beyond the undergraduate dental curriculum that satisfies the requirements described in Part II of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry at the time training was commenced.[4]

b. Completion of an ADA accredited post-doctoral training program (e.g., oral and maxillofacial surgery) which affords comprehensive and appropriate training necessary to administer and manage deep sedation/general anesthesia, commensurate with these guidelines.

c. This should not exclude individuals who would be grandfathered by individual state laws.

2. The following guidelines shall apply to the administration of deep sedation/general anesthesia in the dental office:

a. Administration of deep sedation/general anesthesia by another duly qualified dentist or physician requires the operating dentist and his/her clinical staff to maintain current expertise in Basic Life Support (BLS).

b. When a Certified Registered Nurse Anesthetist (CRNA) is permitted to function under the supervision of a dentist, administration of deep sedation/general anesthesia by a CRNA shall require the operating dentist to have completed training in deep sedation/general anesthesia, commensurate with these guidelines.

c. A dentist administering deep sedation/general anesthesia must document current, successful completion of an Advanced Cardiac Life Support (ACLS) course (or an appropriate equivalent).

V. CLINICAL GUIDELINES

A. Combined Inhalation-Enteral Conscious Sedation (combined conscious sedation)

1. Patient Evaluation

Patients subjected to combined conscious sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist regarding potential procedure risk may be desirable.

2. Pre-Operative Preparation

Informed Consent:

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of any sedative agents and the appropriate informed consent should be obtained.
- Inhalation equipment used in conjunction with combined conscious sedation, must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs should be obtained unless the patient's behavior prohibits such determination.
- Pretreatment physical evaluation must be performed as deemed appropriate.
- Specific dietary instructions must be delineated based on the technique used and patient's physical status.
- Appropriate verbal or written instructions must be given to the patient and/or guardian.

3. Personnel and Equipment Requirements

Personnel:

- During administration of combined conscious sedation, at least one additional person should be present, in addition to the dentist. This may be the chairside dental assistant.

Equipment:

- Must have a fail-safe system that is appropriately checked and calibrated.
- If nitrous oxide and oxygen delivery equipment capable of delivering less than 25% oxygen is used, an in-line oxygen analyzer must be used.
- The equipment must have an appropriate scavenging system.

4. Monitoring and Documentation

Monitoring:

- Direct clinical observation of patient during administration must occur.

Oxygenation:

- Color of mucosa, skin or blood should be continually evaluated.
- Oxygen saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Must observe chest excursions and/or auscultation of breath sounds.

Circulation:

- Should continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate such monitoring).

Documentation:

- Appropriate time-oriented anesthetic record must be maintained.
- Should document individuals present during the administration of combined conscious sedation.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available in the recovery area and/or operatory.
- Continual monitoring of oxygenation, ventilation and circulation when the anesthetic is no longer being administered; patient must have continuous supervision until oxygenation, ventilation and circulation are stable and the patient is appropriately responsive for discharge from the facility.
- Must determine and document that oxygenation, ventilation and circulation are stable prior to discharge.
- Must provide explanation and documentation of postoperative instructions to the patient and/or a responsible adult at the time of discharge.
- The dentist must determine that the patient has met discharge criteria prior to leaving the office.

6. Emergency Management

- The anesthesia permit holder/provider is responsible for the anesthetic management, adequacy of the facility, and treatment of emergencies associated with the administration of combined conscious sedation, including immediate access to pharmacologic antagonists, if any, and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

B. Parenteral Conscious Sedation

1. Patient Evaluation

Patients subjected to parenteral conscious sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist regarding potential procedure risk or special monitoring requirements may be desirable.

2. Pre-operative Preparation

Informed Consent:

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of any sedative agents and the appropriate informed consent should be obtained.
- If inhalation equipment is used in conjunction with parenteral conscious sedation, the equipment must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs should be obtained unless the patient's behavior prohibits such determination.
- Pretreatment physical evaluation must be performed as deemed appropriate.
- Specific dietary restrictions must be delineated based on the technique used and patient's physical status.
- Appropriate verbal or written instructions must be given to the patient and/or guardian.
- An intravenous line which is secured throughout the sedation procedure must be established (see exceptions: special situations).

3. Personnel Requirements and Equipment

Personnel:

- During administration of parenteral conscious sedation, the dentist and at least one other individual who is currently competent in Basic Life Support (BLS), or its equivalent, must be present.

Equipment (if appropriate for procedure):

- Must have a fail-safe system that is appropriately checked and calibrated.
- If nitrous oxide and oxygen delivery equipment capable of delivering less than 25% oxygen is used, an in-line oxygen analyzer must be used.
- The equipment must have an appropriate scavenging system.
- Regardless of procedure, a positive pressure oxygen system suitable for patients being treated must be available.

4. Monitoring and Documentation

Monitoring:

- Direct clinical observation of patient during administration must occur.

Oxygenation:

- Color of mucosa, skin or blood should be continually evaluated.
- Oxygen saturation must be evaluated continuously by pulse oximetry.

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[4] Prior to July 1, 1993, the prescribed length of training described in the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry was of one year's duration. As of July 1, 1993, the prescribed length was extended to two years.

Ventilation:

- Must observe chest excursions and/or auscultation of breath sounds.

Circulation:

- Should continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate).
- Continuous EKG monitoring of patients with significant cardiovascular disease must be accomplished.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained.
- Should document individuals present during the administration of parenteral conscious sedation.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available in the recovery area and/or operatory.
- Continual monitoring of oxygenation, ventilation and circulation when the anesthetic is no longer being administered; patient must have continuous supervision until oxygenation, ventilation and circulation are stable and the patient is appropriately responsive for discharge from the facility.
- Must determine and document that oxygenation, ventilation and circulation are stable prior to discharge.
- Must provide explanation and documentation of postoperative instructions to the patient and/or a responsible adult at the time of discharge.
- The dentist must determine that the patient has met discharge criteria prior to leaving the office.

6. Special Situations (to include multiple/combination techniques and types of special patients)

In selected circumstances, parenteral conscious sedation may be utilized without establishing an indwelling intravenous line. These circumstances include sedation for very brief procedures; young children managed entirely by non-intravenous techniques; or the establishment of intravenous access after sedation has been induced due to poor patient cooperation.

7. Emergency Management

- The anesthesia permit holder/provider is responsible for the anesthetic management, adequacy of the facility, and treatment of emergencies associated with the administration of parenteral conscious sedation, including immediate access to pharmacologic antagonists, if any, and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

C. Deep Sedation/General Anesthesia

1. Patient Evaluation

Patients subjected to deep sedation/general anesthesia must be suitably evaluated prior to the start of any sedative/anesthetic procedure. In healthy or medically stable individuals (ASA I, II) this may be simply a review of their current medical history and medication use. However, with individuals who may not be medically stable or who have a significant health disability (ASA III, IV) consultation with their primary care physician or consulting medical specialist regarding potential procedure risk should be considered.

2. Pre-procedure Preparation, including Informed Consent

- The patient and/or guardian must be advised regarding the procedure associated with the delivery of any sedative agents and the appropriate informed consent should be obtained.
- If inhalation equipment is used in conjunction with deep sedation/general anesthesia, the equipment must be evaluated for proper operation and delivery of inhalation agents prior to use on each patient.
- Determination of adequate oxygen supply must be completed prior to use with each patient.
- Baseline vital signs should be obtained unless the patient's behavior prohibits such determination.
- Pretreatment physical evaluation must be performed as deemed appropriate.
- Specific dietary restrictions must be delineated based on the technique used and patient's physical status.
- Appropriate verbal or written instructions must be given to the patient and/or guardian.
- An intravenous line which is secured throughout the procedure must be established (see exceptions: special situations).

3. Personnel and Equipment Requirement

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified, in accordance with Part IV, Section C of this document, to administer the deep sedation/general anesthesia, shall be designated to be in charge of the administration of the anesthesia care.
- Two individuals who are currently competent in Basic Life Support (BLS) or its equivalent, one of whom is trained in patient monitoring.
- When the same individual administering the deep sedation/general anesthesia is performing the dental procedure, there must be a second individual trained in patient monitoring and who is currently competent in Basic Life Support (BLS) or its equivalent.

Equipment:

- Equipment suitable to provide advanced airway management and advanced life support should be on premises and available for use.
- With intubated patients, in-line oxygen analyzers should be used.

4. Monitoring and Documentation

Monitoring:

- Direct clinical observation of patient during administration must occur.

Oxygenation:

- Color of mucosa, skin or blood should be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: Monitor end-tidal CO_2.
- Non-intubated patient: Must auscultate breath sounds and/or monitor end-tidal CO_2.

Circulation:

- Continuous EKG monitoring of all patients throughout the procedure with electrocardioscopy must occur.
- Must take and record blood pressure and pulse continually at least every five (5) minutes.

Temperature:

- A device capable of measuring body temperature should be readily available, if needed, during the administration of deep sedation/general anesthesia.
- When agents implicated in precipitating malignant hyperthermia are utilized, continual monitoring of body temperature must be performed.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained.
- Should document individuals present during the administration of deep sedation/general anesthesia.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available in the recovery area and/or operatory.
- Continual monitoring of oxygenation, ventilation, circulation and temperature, as indicated, when the anesthetic is no longer being administered; patient must have continuous supervision until oxygenation, ventilation, circulation and temperature, as indicated, are stable and the patient is appropriately responsive for discharge from the facility.
- Must determine and document that oxygenation, ventilation, circulation and temperature, as indicated, are stable prior to discharge.
- Must provide explanation and documentation of postoperative instructions to the patient and/or a responsible adult at the time of discharge.
- The dentist must determine that the patient has met discharge criteria prior to leaving the office.

6. Special Situations (to include multiple/combination techniques and types of special patients).

In selected circumstances, deep sedation/general anesthesia may be utilized without first establishing an indwelling intravenous line. These circumstances include deep sedation/general anesthesia for very brief procedures; or brief periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation/general anesthesia has been induced due to poor patient cooperation.

Due to the fact that many dental patients undergoing deep sedation/general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation/general anesthesia should document the reasons preventing the recommended preoperative management.

7. Emergency Management

- The anesthesia permit holder/provider is responsible for the anesthetic management, adequacy of the facility, and treatment of emergencies associated with the administration of deep sedation and general anesthesia, including immediate access to pharmacologic antagonists and appropriately sized equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.
- Advanced airway equipment, resuscitation medications and a defibrillator must also be immediately available.
- Appropriate pharmacologic agents must be immediately available if known triggering agents of malignant hyperthermia are part of the anesthesia plan. ■

Jury awards dentist nearly $59 million in disability judgment

By Daniel McCann

Phoenix—Dr. Ronald Diamond wasn't about to miss any part of his trial before a superior court jury here last fall.

He took time off from his regular job as a biomedical technician, vacation time, to ensure that he'd be on hand to hear every piece of testimony.

He saw how his lawyer, Charles Surrano, methodically led the jury through the story behind his lawsuit against General American Life Insurance Co.

He listened while Mr. Surrano took jurors back to 1990, when, the attorney claimed, the insurer's disability line was an open wound.

The company's mounting losses, Mr. Surrano pointed out, ranged from $40 million to $60 million—the consequence, he contended, of poorly managed underwriting policies.

So, continued Mr. Surrano, General American officials hatched a plan to stanch the draining funds. They compiled a list of 61 claimants whose policies entitled them to $100,000 or more. Then they embarked on an aggressive campaign to buy-out those policies with lowball offers or otherwise find ways to cut or reduce the benefits.

In the case of Dr. Diamond, that campaign took the form of a 1991 letter informing the dentist that he was no longer considered disabled with carpal tunnel syndrome—the condition that forced him to sell his practice three years earlier and find another line of work.

But Dr. Diamond contested the decision, and the payments continued. Two months later, though, General American sent another letter informing the dentist that his Own Occupation Rider disability policy had simply run its course. And with that, the disability payments stopped permanently. (In fact, in a summary judgment before the jury trial, Superior Court Judge Steven Sheldon ruled that Dr. Diamond's policy had not run out, and found that the insurer had breached the contract.)

Through it all, Mr. Surrano backed his account with General American documents and memos, among them a note suggesting that the company's aggressive plan be kept "informal" with "nothing in writing or in a memo" that could be used in the event of litigation.

In a statement released after the trial, the company said that Mr. Surrano "mischaracterized as a 'secret hit list'" the paper containing the names of policyholders with reserves of $100,000 or more.

That "document," said the insurer, "was in fact a list of disability claim reserves, a list the company routinely generated on a quarterly basis as a necessary part of managing a block of business."

Furthermore, the company said, "there was no evidence of any plan to act against any of those policyholders, nor was there any evidence of wrongdoing by General American relating to any of its policyholders."

Dr. Diamond

While the insurer conceded that its disability line was losing money in 1990, its solution to the problem had been "to stop selling disability policies, to post the necessary reserves to meet existing obligation, and to continue to administer its disability claims administration."

At no time during the month-long trial, could Dr. Diamond detect which way the jury was leaning. "They were expressionless," he recalls, "extremely difficult to read." But on Nov. 13, jurors took just over a couple of hours to decide that they sided with Mr. Surrano's version of events—and they sealed their assent with a verdict calling for nearly $1 million in compensatory damages and $58 million in punitive damages.

Afterward, Mr. Surrano speculated on why the jury set such a high award. "I think what bothered them was that we were able to show that it wasn't just Dr. Diamond [who was affected]. It was much more pervasive than that. For example, the day before Dr. Diamond got his letter telling him his benefits were cut off because he didn't have any objective symptoms, another doctor in the community, an osteopath suffering from heart problems, received a similar letter. And his policy didn't say you had to have objective symptomology either."

In its statement, General American said that its "decisions relating to Dr. Diamond's claim were responsible and reasonable. The verdict, on the other hand, was irresponsible and unreasonable. Accordingly, General American will seek a reversal." ■

Does a free Hawaii trip sound enticing?

ADA 1 PLAN kicks off the new year with a credit card sweepstakes

By David Weissman

The ADA Financial Services Co. kicked off 1999 by rolling out two new products and a credit card sweepstakes with grand prizes of two all-expense Hawaii vacations, 10 round-trip airline tickets to Hawaii, more than $20,000 in cash prizes and other ADA 1 PLAN discounts and bonuses.

The new products, commercial real estate mortgages and equipment leasing, are available through an alliance between the ADA 1 PLAN and the Matsco Companies, which specializes in these types of practice financing.

Members who apply through the ADA 1 PLAN will receive preferred rates and a three-month free subscription to Video Staff Meetings, a practice management service.

"Equipment leasing allows dentists 100 percent financing, flexible repayment terms and tax advantages such as writing off the monthly payment," explains Allison Farey, senior vice president at Matsco.

"Lease payments are very low in comparison to loans," she adds, "and are very often below the prime lending rate."

ADA members can also apply for a commercial real estate mortgage when they apply for a practice acquisition or expansion loan.

The "Win Hawaii" sweepstakes, which begin this month, feature two all-expenses paid trips for two to Hawaii, including round-trip airfare, six nights' accommodations in Hawaii, a rental car, inter-island flights and $1,000 in spending money.

Ten round-trip tickets to Hawaii also will be awarded.

ADA 1 PLAN card holders are automatically entered in the sweepstakes drawings each time they use their credit card.

The drawings will be held on Aug. 16. Winners may use their Hawaii trips to coincide with the ADA annual session in Hawaii Oct. 9-13, if they so choose.

Cash prizes also will be awarded through "Win Hawaii" instant scratch-and-win game cards.

The cards offer instant prizes of $5, $25, $100 and $1,000. The cards also feature several bonus prizes, including:

- interest rate discounts on unsecured lines of credit;
- a special interest rate for home equity loans;
- 1,000 free travel points through the Travel-Returns program;
- no annual fee for one year for the Travel-Returns program;
- free terminals for new accounts set up for credit card processing.

All ADA 1 PLAN credit card holders will receive a game card with their statement each month until April 30. Members approved for a new ADA 1 PLAN credit card from now until July 31 also will receive game cards.

In addition, game cards also will be distributed at 40 dental meetings including the Yankee Dental Congress (Jan. 21-24), Chicago Midwinter (Feb. 18-21) and the Hinman Dental Meeting (March 18-21).

No purchase or transaction is necessary. Entrants must be at least 18 years old. The odds of winning depend on the number of entries received.

For the official rules, more information about the Win Hawaii Sweepstakes or other financial services, call the ADA 1 PLAN at 1-800-767-7526. ■

Ford Foundation offers competition

Washington—The 1999 Ford Foundation Dissertation Fellowships for Minorities will make some 29 awards for study in research-based doctoral programs (Ph.D or Sc.D) in the behavioral and social sciences, humanities, engineering, mathematics, physical sciences and life sciences, or for interdisciplinary programs composed of two or more eligibile disciplines.

The nationwide competition is sponsored by the Ford Foundation and administered by the National Research Council.

Applicants must have completed all course work, examinations, language requirements and all other departmental and institutional requirements for the Ph.D. or Sc.D (except for the writing and defense of the dissertation) by Feb. 14. Applications may be downloaded from the NRC's Website or completed on-line.

Application deadline is November 14, 1999. For more information contact the National Research Council Fellowship Office by phone at 1-202-334-2872; by e-mail at infofell@nas.edu or via the Web at "http://www.fellowships.nas.edu". ■

Inside the Beltway

Great debate

Major players in the great patient protection debate are regrouping for a new Congress. Senate Democrats say they will begin pushing a bill as early as January, when the 106th Congress convenes.

Rep. Charlie Norwood (R-Ga.), one of four dentists in the House of Representatives, says he is preparing a comprehensive patient protection bill and a stand-alone measure that would open the doors to malpractice suits against ERISA-shielded health plans, including managed care plans. At least one rising Republican star, Rep. Lindsay Graham (R-S.C.), has gone on record as favoring substantive health reforms.

The opposition isn't sitting on its hands, however. Insurers, health plans and business lobbies continue to oppose restraints on managed care.

An industry umbrella group, the American Association of Health Plans, has launched a multimillion dollar public image campaign to improve public perceptions of health maintenance organizations.

Help with loans

New dentists with educational loan debt have an opportunity through Jan. 31 to consolidate loans and reduce monthly payments thanks to legislation supported by the dental profession, approved by the 105th Congress and signed into law by President Clinton last fall.

Borrowers must act by Jan. 31 to qualify for savings, however. Contact the Department of Education or your private lender for information/applications. The education agency advises direct loan borrowers to call the direct loan origination center at 1-800-557-7392 and request an application by mail or download an application form from "http://www.ed.gov/DirectLoan". Student borrowers are ineligible for the early loan consolidation. However, students may find loans less expensive, thanks to joint lobbying efforts of the Association and the American Student Dental Association. (See Nov. 16 ADA News page 8 for more detail.)

Report due

Expected early this year from the U.S. Public Health Service: the very first Surgeon General's Report on Oral Health.

The profession is monitoring development of what could be a landmark report and, to the extent possible, contributing to its planning. The Association views the report as an opportunity to refocus the nation's attention on oral health and appropriately recognize the contributions and service of private practice dentists in meeting the oral health care needs of patients.

Claude E. Fox, M.D., Health Resources and Services Administration chief, told the Association at a Dec. 7 meeting with Executive Director John S. Zapp and Washington Office staff that he sees the report as "an opportunity to pull us together, not drive us apart." HRSA is among the several Public Health Service agencies preparing this report. The newly named National Institute of Dental and Craniofacial Research (the former NIDR) has the lead role in developing this important report. We'll keep you posted.

Plan opposed

ADA President S. Timothy Rose told the National Bipartisan Commission on the Future of Medicare that the Association opposes a proposal to finance graduate medical education payments through the annual appropriations process, a "very unpredictable" process that could jeopardize physician/dentist training funds.

"Training programs by their very nature need stability to be effective," Dr. Rose said in a Nov. 23 letter to Rep. William M. Thomas (R-Calif.), the commission's administrative chair. "In our view the benefits of GME training can only be realized if a reliable and predictable source of funding is guaranteed. The appropriations process simply does not provide that guarantee." ■

—Craig Palmer

Dr. Gilmore named professor, dean emeritus at Indiana University

Indianapolis—Dr. H. William Gilmore, former professor and dean at Indiana University School of Dentistry, has been named professor of dentistry emeritus and dean emeritus.

Dr. Gilmore

Dr. Gilmore received the honor in October.

Dr. Gilmore, longtime professor of operative dentistry, former chair of the school's operative dentistry department and dean of dentistry from 1985 to 1996, retired from the IU faculty in September 1997.

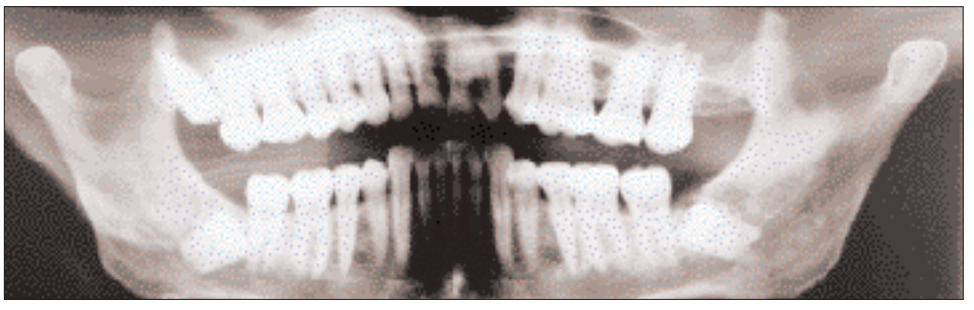
From 1974 to 1990, he served as editor-in-chief of the Journal of the Indiana Dental Association.

Dr. Gilmore graduated from the Indiana University School of Dentistry in 1958 and its operative dentistry graduate program in 1961.

He maintained a private practice for 27 years. ■

Sheriff looks to dentist to solve 1997 murder

Victim received cosmetic fillings



Radiograph: Shows the victim's teeth were in good condition due to dental care.

Bunnell, Fla.—Identification of a murder victim will help Florida law officials close the book on a year-old unsolved homicide.

You may be able to help.

According to Rich Brendel, a detective with the Flagler County Sheriff's Department, the body of a Caucasian male was found in the Intracoastal Waterway on Sept. 10, 1997. The victim, estimated to be in his 40s, stood 5′8″ and weighed between 160-175 pounds.

During the body's autopsy, a dentist reported the victim's teeth were in good condition, likely from having received adequate dental care that included cosmetic fillings.

The dental examination also noted the following: No. 10—slightly distally rotated; No. 8—slight buccal protrusion to upper right central; No. 16—missing; No. 18—fractured enamel on facial lower left second molar; Nos. 22-27—2-3 mm super eruption of lower anteriors.

Forensic evidence also revealed the victim suffered a broken nose that had healed to the left.

Det. Brendel reported the victim had no scars, tattoos and, particularly noteworthy, no body or facial hair.

The victim: Was a 5′8″ male, probably in his 40s.

If you know the victim or have information about this homicide, contact Det. Brendel at 1-904-437-4116, ext. 217. You may also contact Special Agent Dexter Brown, Florida Department of Law Enforcement, at 1-800-738-4635. ■

Anesthesia

Continued from page one

procedures are used to treat patients."

The information should prove timely as the profession braces for what is likely to be a fear-inducing story on dental anesthesia.

The story, which could air as soon as Jan. 13 as part of the debut of "60 Minutes II" (CBS-TV, 9 p.m. Eastern Standard Time), is expected to focus on three young boys who died after being sedated or anesthetized in three separate dental offices.

In anticipation of the story, the ADA this month also mailed a series of "talking points" to leaders of state and local dental societies. The talking points are designed to help societies, their spokespeople and individual dentists respond to any additional local media coverage generated by the "60 Minutes II" story.

"Patient safety is the most important aspect of health care, and the best key to safety is information," says Dr. William Tonne, chair of the ADA Council on Communications. "Information is equally important for patients to understand the benefits and risks of these services. Dentists will find ADA materials on anesthesia very helpful in communicating with their patients."

THE COMPLETE TEXT OF BOTH ADA GUIDELINES AND THE POLICY STATEMENT ALSO IS AVAILABLE IN THE "EDUCATION" SECTION OF ADA ONLINE.

Other Association resources:

- "The Use of Conscious Sedation, Deep Sedation and General Anesthesia in Dentistry." The policy statement, revised and adopted by the 1998 House of Delegates, addresses the issue in four areas: education, risk management, state regulation and research;
- "Dental Anesthesia: Providing a More Comfortable Dental Visit," a patient education brochure that will be available through the ADA Department of Salable Materials later this month.
- "Guidelines for Teaching the Control of Pain and Anxiety in Dentistry." The guidelines, which will be revised and sent to the 1999 House of Delegates for approval, detail student requirements, prerequisites, the didactic curricular content and the sequence of instruction for three levels.

The complete text of both ADA guidelines and the policy statement also is available in the "Education" section of ADA ONLINE ("http://www.ada.org"). ■

Free publication focuses on closing dental practice

The ADA's Council on Dental Practice has just published its publication, "Closing a Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse."

The publication is free to all ADA members.

The publication is designed for people wanting to close, not sell, dental practices. It provides advice on what to do with records, who to notify and more.

"We get many calls from spouses whose dentist-spouses have just died and they want help from the ADA on how to go about closing the practice," said Dr. Donald Collins, manager, Council on Dental Practice.

"The same thing happens with some of our older dentists. They just want to know how to properly close their practice."

"The council is proud of this publication because it aims to help surviving spouses and elderly dentists," Dr. Collins said.

The 37-page publication takes dentists or spouses through all aspects of closing a practice, including how to find competent professional advice, announcing the closing, evaluating patient records, issuing professional notifications and revising your insurance portfolio.

Six appendices include sample letters, a list of publications suggested by the council, a list of constituent dental societies and tips at retirement that could change a practice closing into a successful sale.

The publication is available to all ADA members free of charge.

To receive your copy, contact the Council on Dental Practice by calling the toll-free number, Ext. 7473. ■

Yearbook reports on sports safety

Boston—The Yearbook of Youth Sports Safety '97, featuring reports by national medical and sports organizations on issues of youth sports safety, is available.

Published by the National Youth Sports Safety Foundation, the Yearbook also includes a bibliography of related journal articles, the United States Olympic Committee Code of Ethics for coaches and other current information.

Publication copies are available for $25 each plus $6.75 shipping and handling. Write NYSSF, Dept. YB, 333 Longwood Ave., Suite 202, Boston 02115-5711. ■

ADA Survey Center report examines dental fee variations

By Laura McKee

The fees patients pay for the same dental procedures can vary widely depending on geographic area and supply and demand.

The ADA Survey Center's newest report, 1997 Survey of Dental Fees, offers a detailed list of fees charged for 167 dental procedures provided by general practitioners, oral and maxillofacial surgeons, endodontists, orthodontists and dentofacial orthopedists, pediatric dentists, periodontists and prosthodontists across the country. This report updates the 1995 edition.

Individual specialists' fees are only provided on a national level because the number of specialists who responded was too low to allow reliable results for each region.

However, the report lists fees charged by general practitioners both nationally and in nine geographic regions.

These regions include New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont), Middle Atlantic (New Jersey, Pennsylvania, New York), East North Central (Illinois, Indiana, Michigan, Ohio, Wisconsin), West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota), South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia), East South Central (Alabama, Kentucky, Mississippi, Tennessee), West South Central (Arkansas, Louisiana, Oklahoma, Texas), Mountain (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming), and Pacific (Alaska, California, Hawaii, Oregon, Washington).

The report begins with demographics of the respondents, but consists primarily of charts. These provide a list of dental procedures, including CDT-2 codes, followed by the number of dentists responding to the question, average fee charged, standard deviation, standard error, the most frequently reported fee, and fees in the 10th, 25th, 50th, 75th, 90th and 95th percentiles. A list of definitions in the back assists in interpreting the information.

A section on background and methodology at the beginning of the report explains how data was collected. The main emphasis of the report is its lists of fees which appear to vary greatly throughout the country.

The greatest variation in fees dentists across the country charge for their services, in general, occur in more complicated procedures. The report shows that there is typically less variation in fees charged for more routine dental procedures.

The Survey Center first mailed questionnaires for the 1997 Survey of Dental Fees in May 1997. Surveys were sent to a nationwide random sample of 6,828 private practitioners, including both general practitioners and specialists. The center followed up with those who didn't respond to the initial mailing with additional mailings and phone calls and concluded the survey in January 1998.

The popular report can be purchased by contacting the Survey Center via the ADA's toll-free number or by calling 1-312-440-2568 or by accessing the order form on ADA ONLINE under Dental Practice. The report costs $40 for ADA members, $60 for non-member dentists, and $120 for commercial firms. The catalog number is 5F97. ■

Editor's Note: The law requires that dentists establish their own fees based on their individual practice and market considerations.

1997 National general practitioners fees

Description of Service	Average	CDT-2 Code	Description of Service	Average	CDT-2 Code
Periodic oral exam	$23.19	00120	Sealant—per tooth	$26.69	01351
Comprehensive oral exam	$36.05	00150	Amalgam—one surface, permanent	$59.81	02140
Intraoral radiographs—complete series with bitewings	$66.88	00210	Amalgam—three surfaces, permanent	$91.45	02160
Diagnostic casts	$46.98	00470	Resin—one surface, anterior	$72.64	02330
Diagnostic photographs	$28.50	00471	Resin—one surface, posterior-permanent	$79.55	02335
Adult prophylaxis	$48.52	01110	Crown—resin with high noble metal	$556.07	02720
Child prophylaxis with topical application of fluoride	$45.23	01201	Endodontic therapy, anterior—excluding final restoration	$336.15	03310
Complete denture maxillary	$774.07	05110	Gingivectomy or gingivoplasty-per quadrant	$267.74	04210

Source: ADA Survey Center, 1997 Survey of Dental Fees

Chicago visit: U.S. Rep. David Minge (R-Minn.) meets with Executive Director John S. Zapp during a fall visit to ADA headquarters in Chicago. Rep. Minge sits on the agriculture and budget committees.

Hinman dental meeting set for spring

Atlanta—Get ready, get set for the 1999 Thomas P. Hinman dental meeting, scheduled for March 18-21.

Event programs are designed to prepare dentists and their team members for the "explosive professional world in which we practice."

This year's meeting will include four additional hands-on participation programs for dentists, a greater variety of auxiliary programs including two additional participation courses, and a tour of dentists' offices representing different design firms.

Participants can visit the technical exhibits March 19-21. More than 800 booths, located in one hall, will showcase the latest equipment, materials and services.

For more information, contact the Hinman Dental Society of Atlanta at 1-404-231-1663, or download a registration form online at "www.hinman.org". ■

Note winning ideas from 1998's top contestants

Those dental offices setting their sites on placing in this year's DARW competition would do well to take note of what winners in the 1998 contest have done.

First place in the Dental Assisting Associations category went to the Peninsular Dental Assistants Society, Virginia. The group collected clothing for dental missions and shelters and sponsored a blood drive.

Second place in the same category went to the Philadelphia Dental Assistants Society, Pennsylvania. They held a membership drive for the ADAA in conjunction with the city's annual dental meeting.

First place in the Dental Assisting Schools category went to the Median School of Allied Health Careers, Pittsburgh, where students collected toothbrushes from more than 1,500 dental offices and distributed them to homeless shelters.

Second place went to the Northeast Wisconsin Technical College in Green Bay, Wis., where students volunteered for American Cancer Society fundraising activities and gave oral health instructions to children.

First place in the Dental Office, one to 10 assistants category, went to Dr. C. Edwin Wentz, Lubbock, Texas, who kicked off DARW celebrations by honoring an assistant who had recently earned her certification from the Dental Assisting National Board. Plans were also made for a staff appreciation retreat to Cancun, Mexico.

Second place in the same category went to Dr. Oscar and Herlinda Quintana, Albuquerque, N.M., who gave food baskets to their dental assistants and DARW information to local radio stations. They also provided oral health presentations at area schools.

First place in the Dental Office, 11 or more assistants category, went to the dental assistant staff at the Eifel Community Dental Clinic, Spangdahlem Air Base in Germany. They recognized DARW by issuing a proclamation from the 52nd Fighter Wing Commander and submitting a feature news story for each day of DARW on the Armed Forces Network TV.

Second place went to the 90th Dental Squadron of the Francis E. Warren Air Force Base in Wyoming. They held a luncheon honoring the squadron's dental assistants and created a professional photographic collage. ■

DARW

Continued from page three

cussed, it is apparent that employee recognition was more highly valued than other motivating factors such as salary or benefits," he said. "Of paramount importance to the dental assistants was recognition and appreciation for their contribution to the success of their particular dental practice."

To enter the contest, dentists or their staff members should describe in 100 words or less how they celebrated the week of DARW. DARW activities can be scheduled from March 1-22.

First place, second place and honorable mention winners will be selected in the spring for the following categories:

- dental assisting associations:
- dental assisting schools:
- dental offices with six or more assistants:
- dental offices with fewer than six assistants.

In previous years, dental office classifications included those with 10 or fewer assistants and those with 11 or more. The council recommended reducing the number of assistants in each category to encourage participation among smaller dental offices, said Joan Block, manager of the council's practice management projects.

Contest participants are asked, but not required, to send a photo of their dental team with their entry.

All entries must be mailed by April 1.

To receive an entry form, call the ADA on the toll-free number and ask for Ext. 2895. To order special DARW recognition gifts, call 1-800-947-4746. ■

STARTING OUT

New Dentist Committee, ADA councils respond to six-part resolution on financing, student debt

By David Weissman

Never has the issue of student debt been more firmly addressed by the ADA House of Delegates than it was in the fall of 1997.

That was the year the House passed Res. 52H-1997, six directives designed to address issues of student debt and education financing for dental students and recent graduates.

The resolution was referred to the ADA Committee on the New Dentist to coordinate implementation with participation from the Council on Dental Education and Licensure, Council on Dental Practice, Survey Center, American Association of Dental Schools and the American Student Dental Association.

"The Committee takes these issues very seriously," says Dr. Raymond Cohlmia, who was installed as CND chair during annual session in October. "Smart financial choices start the day a student enters dental school, and poor choices can impact future dentists for the rest of their career. We want to do all we can to help."

The CND sent a report to last year's House in San Francisco to provide an update on Association activities. Here are the results.

The first directive urged the American Student Dental Association to incorporate a column on financial management issues in its quarterly newspaper, ASDA News. After receiving the request, the ASDA News editorial board decided the information would be better suited to the ASDA Handbook, which is distributed to every new ASDA member in their first year of dental school.

As a result, the 1998 handbook now includes 16 pages of information on managing student loans, as well as information on scholarships and grants.

The second directive asked that the American Association of Dental Schools include a new session, "The Effect of Student Indebtedness on the New Dentist," at its annual conference for financial aid officers. AADS agreed; CND chair Dr. Raymond Cohlmia will present this session at the Jan. 15 AADS conference in San Diego.

Directive three called for a revision of "Financial Planning Issues for Dental Students" that would include a personal planning worksheet.

The directive also called for the information to be distributed to predental advisors and incoming freshmen, and that it be posted on ADA ONLINE.

The ADA office of Student Affairs in July 1998 revised and distributed the publication as directed. The publication is also posted in the "New Dentist" and "Education" areas of ADA ONLINE.

Directive four called for the development of a financial management seminar to be piloted at five dental schools. The seminar would be modeled after the Council on Dental Practice's popular SUCCESS program, a series of hands-on practice management seminars for practicing dentists. The CDP currently is developing the content for this program and anticipates its debut in 1999.

The fifth directive called for intensified advocacy efforts to expand public service loan forgiveness programs—programs that offered financial incentives for participation in the National Health Services Corps and the Indian Health Service.

Other advocacy efforts outlined in the directive included expanding the tax deductibility of student loan interest.

Last year the Association successfully lobbied to pass a provision in the Tax Relief Act that allows a phased-in deduction of up to $2,500 for interest payments on qualified educational loans.

The phase-in schedule allowed a $1,000 deduction last year, and permits deductions of $1,500 this year, $2,000 in the year 2000 and $2,500 in 2001 and beyond.

Also last year, then-ADA President David A. Whiston testified before the House Appropriations Subcommittee on Labor, the Department of Health and Human Services, Education and Related Agencies requesting support for the National Health Service Corps Scholarship and Loan Forgiveness Programs.

Dr. Whiston also asked the subcommittee to broaden the group of students eligible for the federal HEAL loan program, and for continued support of the Health Profession's Student Loan Program.

The sixth and final directive called for the development of a "Handbook for Mentors." The handbook would contain guidelines and goals such as financial counseling to reduce student borrowing, and would urge constituent societies to develop student mentorship or counseling committees.

The CND developed the handbook as directed and will distribute it to constituents and components this month.

"The Committee on the New Dentist will continue to look at the issues associated with student debt and look for more opportunities to help," says Dr. Cohlmia. "It's the number one concern for all our colleagues, and we're pleased with the efforts made by all the agencies involved to provide education and assistance." ■

THE CND SENT A REPORT TO LAST YEAR'S HOUSE IN SAN FRANCISCO TO PROVIDE AN UPDATE ON ASSOCIATION ACTIVITIES. HERE ARE THE RESULTS.

Star of North meeting set

St. Paul, Minn.—The Star of the North meeting will be held at RiverCentre in St. Paul, Minn., April 24-26.

This will be the 116th scientific session sponsored by the Minnesota Dental Association.

Attendance is expected to reach 9,000 and will feature more than 250 exhibits.

For more information, call the Minnesota Dental Association at 1-651-646-7454. ■

CORRECTION

The ADA News incorrectly reported that the California Dental Association's current executive director, Timothy Comstock, is its first nondentist leader. (CDA picks executive director, Sept. 7). In fact, Ernest T. Guy was the CDA's first non-dentist executive director. Henry L. Ernstthal, also a non-dentist, followed him as director from 1974-78. The ADA News regrets the error. ■

MANAGEMENT

QTIP trusts protect your children's inheritance

Important advice available to parents who have been remarried

In today's world, remarriage is often part of life and, as such, can impact an estate plan and the status of children's future inheritance. For example, if you have children from a previous marriage and your current spouse survives you, he or she could be the one who decides who will next inherit your assets.

A Will May Not be a Solution

If you leave your estate directly to your spouse, your will cannot control the choices your spouse makes in the future.

Even if your spouse's current will names your natural children as heirs, nothing prevents a future change. Once a spouse inherits your estate, he or she will have an unlimited legal right to choose other heirs.

By Jon Spisiak

Look to a QTIP to Provide for Both Children and Spouse

You can protect your children's inheritance as well as provide for your spouse by setting up a Qualified Terminable Interest Property. A QTIP trust will provide your spouse a lifetime income after your death.

After the death of your spouse, your children then inherit the trust's assets. The trust will also qualify for estate tax deferral via the unlimited marital deduction, if your spouse is a U.S. citizen.

How the QTIP Trust Works

With a QTIP trust, assets are transferred to a trust either during your lifetime or at your death.

The trustee administering the trust has a legal responsibility to invest the assets pay lifetime income to your spouse from the trust's investment earnings.

Upon your spouse's death, the trust is transferred to the beneficiaries—your children—thus assuring your spouse a lifetime income but paying the principal to your children. For tax purposes, the trust is usually considered a transfer to your spouse, if your spouse is a U.S. citizen, and taxes are deferred under the unlimited marital deduction. (With this deduction, QTIP assets will be included in your spouse's gross estate for tax purposes.)

Beyond providing for your spouse and your children, a QTIP trust can provide another benefit—experienced investment management for your assets.

This is especially true if you choose a trustee who is also an investment professional.

Because of the impact that estate taxes can have, a QTIP requires careful planning with your tax and legal advisors. Be sure to consult both if you are considering this type of trust. ■

Mr. Spisiak is senior vice president of investment for Morgan Stanley Dean Witter, 2825 N. University Dr., Ste. 400, Coral Springs, Fla., 33065 and can be reached at 1-954-757-2707 or 1-800-854-1039. *Information supplied here is not to be deemed a solicitation for Dean Witter. The views expressed in this column are those of the author and may not reflect the opinion of the ADA or its subsidiaries. Before acting on the information offered here, dentists should consult their own attorneys, accountants or financial advisors.*

Council gathering: Chairs from ADA councils came to ADA headquarters last month for a discussion of several key issues to be addressed in the coming year.

ADA ONLINE features JADA cover story on adverse drug interactions in dentistry

This month's cover story in The Journal of the American Dental Association examines the myths surrounding adverse drug interactions in dentistry.

And ADA members can access the complete article on the Internet at ADA ONLINE, the Association's Web site.

Just visit "www.ada.org" and click on the ADA Publishing Co., Inc. button. Then click on the JADA cover icon.

The cover story is the first in a five-part JADA series based on a 1998 International Association for Dental Research symposium, "Adverse Drug Interactions in Dentistry: Separating the Myths From the Facts."

"The goal of the series is to identify specific adverse drug interactions that are relevant to the therapeutic agents commonly used in general dental practice: analgesics, antibiotics, sedatives, local anesthetics and vasoconstrictors," notes the article's abstract.

The cover story and abstracts of other articles in this month's issue of JADA are available online. Abstracts are open to the general public.

Other recent additions to the Web site include:

- Full text of the January "Editor's Note" column from the ADA Legal Adviser, a monthly newsletter produced jointly by the ADA Division of Legal Affairs and the ADA Publishing Co., Inc.

The January column asks the question: "Can an employer be held liable for negligent hiring?" The answer could be yes "if an employee's harmful workplace conduct could have been foreseen before he or she was hired," observes the monthly column by Peter M. Sfikas, ADA general counsel and editor of the Adviser.

To visit the Adviser online, go to the ADA Publishing Co. section of the Association's Web site and click on the Adviser's icon.

- The January-June 1999 Continuing Education Course Listing, compiled twice a year to provide assistance to dental professionals seeking information on continuing education programs.

The listing, provided online to ADA members only, is offered by subject category and separated by regions within each category. Just visit the ADA ONLINE homepage at www.ada.org and click on the "CE Course Listing" link.

- A page looking at the Y2K problem, which may reveal itself Jan. 1, 2000, in older computers unable to differentiate between the years 1900 and 2000.

The Web page discusses how the Y2K bug may affect dentistry. Just visit the ADA ONLINE homepage at www.ada.org and click on the "Y2K & Dentistry" link. Again, this is available online to ADA members only. ■

CSDA schedules May 18-20 annual meeting

Hartford, Conn.—The Connecticut State Dental Association will convene its annual meeting here May 18-20, 1999, at the Foxwoods Resort and Casino.

For more information, contact the CSDA by phone at 1-860-278-5550 or by mail at 62 Russ St., Hartford, Conn. 06106. ■