5-7-2001

ADA News - 05/07/2001

American Dental Association, Publishing Division

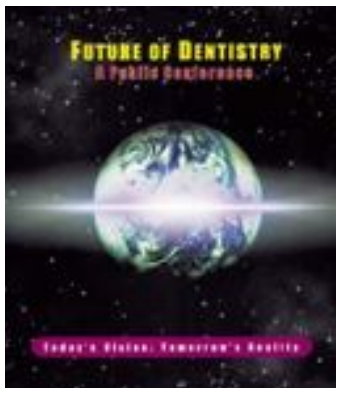
Mercury hearing, page eight ◆ Ergonomics revisited, page 10

AMERICAN DENTAL ASSOCIATION
ADA News®
www.ada.org
MAY 7, 2001 VOLUME 32, NO. 9

BRIEFS

FOD to gather constituent input

Representatives from the constituent dental societies are invited to offer their concerns and concepts about the Association's Future of Dentistry Project on Friday, June 1, 8 a.m. to 4 p.m. at ADA Headquarters.



Project leaders will consider how to incorporate conference input into the final draft of the Future of Dentistry Report.

The document—to map out the road ahead for the dental profession—is slated for presentation to the ADA House of Delegates in October. ■

Montana conferences select speakers

Dillon, Mont.—The Montana Fly Fishing Dental Conferences will convene July 12-14 and again here Sept. 6-8.

Speakers are Dr. William Mihran for the July conference and Dr. Paul Desjardins for the September conference.

To sign up, contact Dr. John B. McCollum by phone at 1-406-683-5125. ■

INSIDE

Post-session

Learn and then take a break on the links. **Story, page 24.**

Dr. James Bramson named ADA's new executive director

Returns to ADA staff after 4 years as state executive

By James Berry

Dr. James B. Bramson, executive director of the Massachusetts Dental Society since 1997 and a veteran of the American Dental Association's senior staff, was appointed ADA executive director April 22 by the Board of Trustees.

■ **A quick look at Dr. Bramson's career, page 19**

A 1979 graduate of the University of Iowa College of Dentistry and a former Hillenbrand Fellow with extensive administrative experience, Dr. Bramson will take up his new duties July 1 as the Association's

See DR. BRAMSON, page 18

He's back: Dr. Bramson will take up his new duties as ADA executive director July 1.

PROFILE

'We're going to build community'

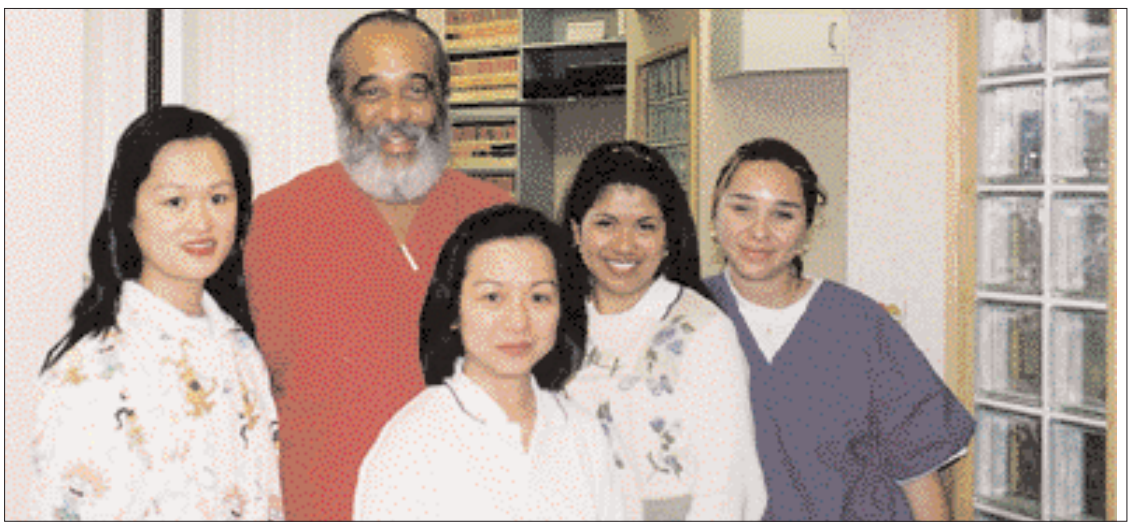
A talk with your new director

By James Berry

He's affable, even gregarious, and seems equally at ease with close associates and strangers. He's also tough-minded, direct, a self-described "prudent risk-taker" who embraces change as a welcome—not simply inevitable—part of life.

See PROFILE, page 18

■ **First in a series**



Dedication: Helping needy children lightens the heavy patient load on Dr. Frederick Coleman and staff (from left) Ly Hoi Hin, Ly My Hin, Samantha Machado and Virginia Corona. But after 19 years, the Oakland pediatric dentist felt financially forced to give up accepting new Medicaid or DentiCal patients.

Eye on access

Association takes action to aid dentists, patients

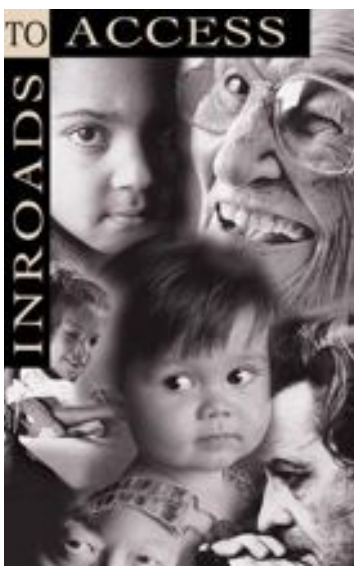
By Mark Berthold

Oakland, Calif.—All 10 children in the Dobashi family can thank Dr. Frederick Coleman for treating their rampant tooth decay, easing their terrible pain and restoring their healthy, happy smiles.

Like the Dobashi children, kids in this neighborhood always wave hello when they see the Harvard-educated pediatric dentist—their multiple caries and abscesses would

■ **National picture, page 20**

■ **Policy, page 23**



See ACCESS, page 22

Education summit

Future faculty shortage feared

By Karen Fox

Dental school faculty shortages, the rising cost of dental education and student debt are forces that threaten to undermine the quality of dental education.

Those concerns spurred ADA President Robert M. Anderton to invite 26 representatives from dental education, the practice community and organized dentistry to Chicago April 11-12 for the first of a two-part Dental Education Summit.

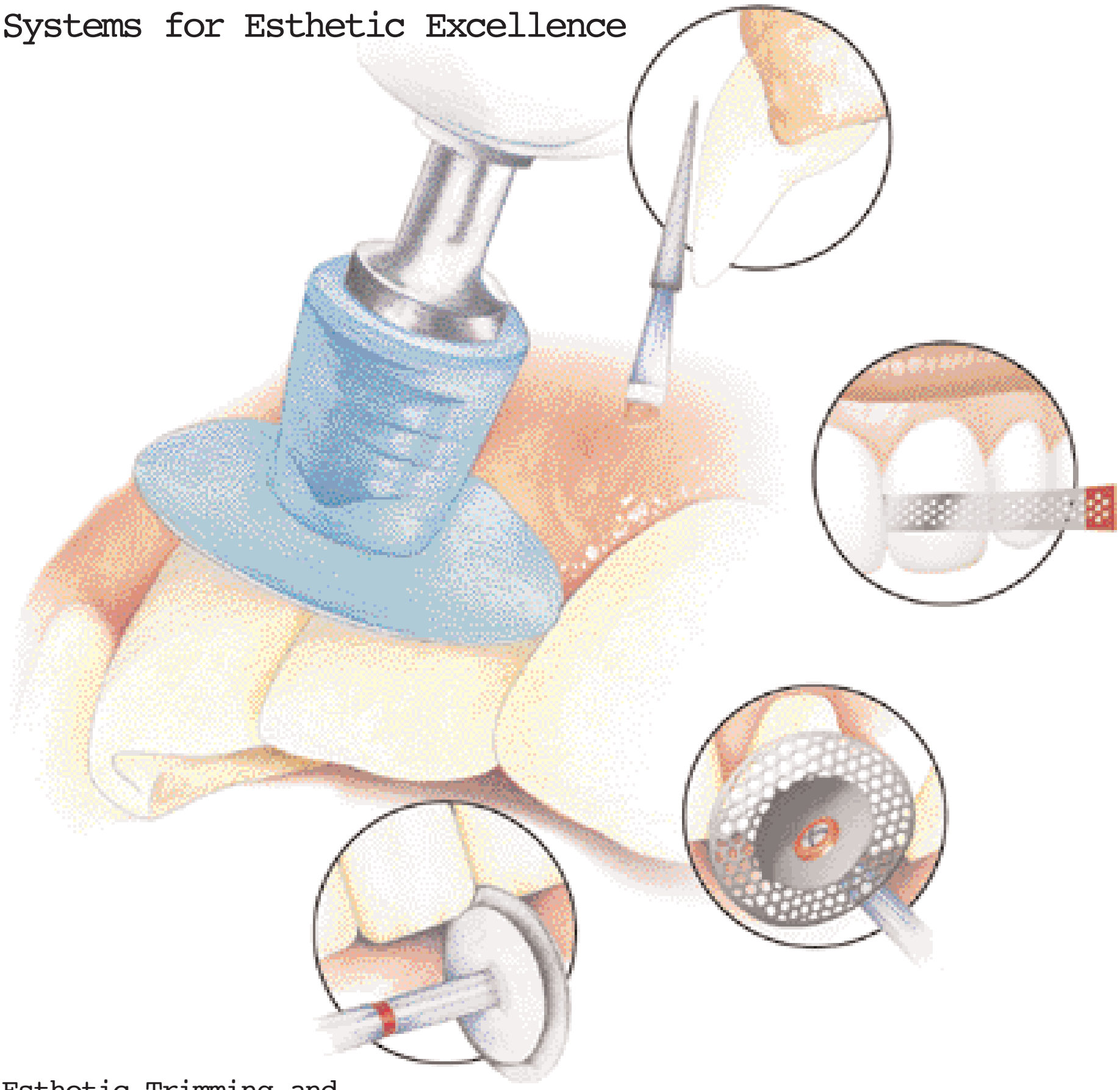
Funding for the Dental Education Summit was approved by the ADA House of Delegates in Res. 108H-2000. The summit's second session takes place July 9-10.

In his opening remarks as chairman, Dr. Anderton stated: "We all agree that no one entity can solve these problems; it will take all of us working together diligently to do so."

A cross-section of the dental

See SUMMIT, page 15

Systems for Esthetic Excellence



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AMERICAN DENTAL ASSOCIATION

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Dr. John L. Bomba, past ADA president, dies at 78

By James Berry

Dr. John L. Bomba, 78, a past ADA president (1984-85) and a dental educator for 30 years, died April 13 in Las Vegas after a long battle with leukemia.

He is survived by his wife of 56 years, Thelma Burket Bomba, seven children and six grandchildren. A native of Philadelphia where he spent his entire professional career, Dr. Bomba received his dental degree from the Temple University School of Dentistry in 1946. After serving in the Air Force, he opened a dental practice in South Philly, on Passyunk Avenue across from the house in which he was born and where his Italian immigrant father ran a tailor shop for 70 years.

In 1957, Dr. Bomba joined Temple's dental faculty, dividing his time between private practice and his duties with the school. At Temple, he served as professor and chairman of the Department of Operative Dentistry from 1965-76, when he was named associate dean. He retired from Temple in 1986, though he continued to serve as professor emeritus.

Dr. Bomba

Throughout his career, Dr. Bomba was active in organized dentistry, helping to found the Southern District Dental Society of Philadelphia and rising through the ranks to become Pennsylvania Dental Association president in 1976-77. On the national level, he represented Pennsylvania as Third District trustee to the ADA Board of Trustees from 1977-83, and served as ADA treasurer from 1982-83.

A funeral Mass for Dr. Bomba was said April 18 in Las Vegas, followed by burial in Boulder City, Nev. Donations can be made in Dr. Bomba's name to St. Elizabeth Ann Seton Roman Catholic Church, 1811 Pueblo Vista Drive, Las Vegas, Nev. 89128, or to the charity of the donor's choice. ■

ViewPoint

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

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

MyView

Harmony vs. discord in dentistry

Wally Brown, D.D.S.

When I awoke in the still moments before dawn, I felt the quiet and peace of the remote village in the central highlands of Nepal. Okhlepani is a village without electricity or roads and is home to about 200 very poor Hindu Nepali villagers. Our group of 25 volunteers had traveled to Okhlepani to provide humanitarian service for these wonderful people.

Our goals were to lay plastic pipe for water supply in a neighboring village, instruct village health care workers and provide much-needed dental treatment. There had never been a dentist in this area of Nepal so there was a formidable accumulation of serious dental problems.

We were housed in the humble homes of the villagers. I was assigned to the Adhikari family home and slept in the small bedroom vacated by the 14-year-old son, Rajendra.

The villagers are lacking in our notions of things of the world but are at peace with their situation and very calm as they go about their daily duties. The children, wearing flip-flops, walk an hour each way to school six days a week. It is a subsistence economy wherein the villagers plant rice in the spring, manage their crops during the monsoon season and harvest in the fall.

Although the villagers know each other very well, having been neighbors all their lives, they unfailingly greet each other with hands pressed together in an attitude of prayer and the greeting, "namaste" (na˘ ma˘s ta¯y´).

Namaste is a greeting with significantly more meaning than our trite "hello." It implies a wish for peace, love, Godspeed and good health.

When one arrives at or leaves a home or village, a "tika," the familiar red spot seen among the Hindus, is placed on the forehead as a recognition and blessing.

Perhaps the interrelationships of the Hindu and Buddhist cultures over the past millennia have produced a culture where peace and striving for good are the raison d'etre.

As I lie on Rajendra's rather rough bed and reflect on the peace of the village, I conclude that this environment has taught me some important principles of life. All too soon we leave the village for the hurly-burly of Kathmandu and subsequently the strident busy-ness of home.

My wife, Pat, and I recently attended a concert presented by the Utah Symphony. The guest artist was a young violinist who performed what to us was a discordant and unsettling concerto. She was obviously very talented and had

See MY VIEW, page five

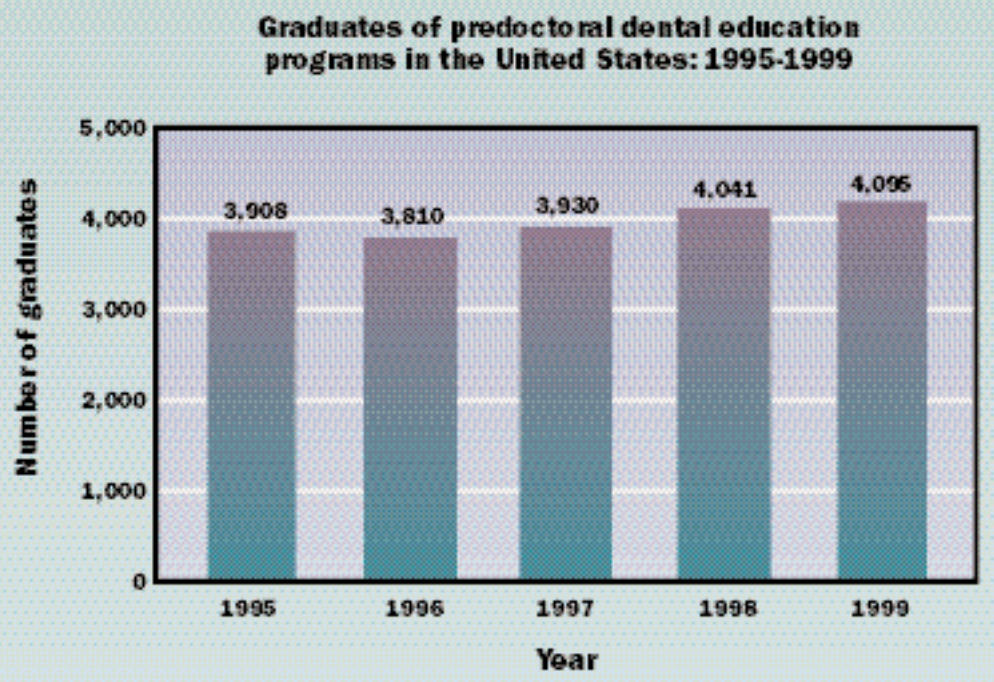
Letters Policy

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 1-312-440-3538; e-mail to "ADANews@ada.org".

Snapshots of American Dentistry

Dental education

Since a slight dip in 1996, the number of graduates of predoctoral dental education programs has risen each year.



Source: American Dental Association, Survey Center, *Survey of Predoctoral Dental Education*

Letters

Prejudice?

In response to Dr. Jean R. Williams' letter in the April 16 ADA News: what are you saying?

Your statement that "subtle and overt prejudice does still exist, and we have to recognize that it exists as a problem before we can change it." Exactly what kind of prejudice does exist in subtle and overt dimensions?

I assume that because you are female and you feel you have been the victim of such discrimination, you are at least referring to gender discrimination.

It seems that you were elected to be president of the Indiana Dental Association by a large majority of males.

I have practiced and taught dentistry for 30 years and have seen much change in the practice and delivery of dentistry. I have also seen some "cream and chaff" in dentistry. However, I have never noticed these rampant prejudices from the members of our profession (male or female, white or non-white, American or other nationality).

Yes, some individuals may not be as kind, generous or accommodating as others. However, in this era of "create a problem and promote rules and regulations to solve it," you have got to be infinitely more specific in your ethereal charges.

The main "prejudice" that I have noticed over the years is recognizing poor, unethical or otherwise slipshod dentistry without regard to race, gender or ethnicity. Please don't help create another victim class within our

profession without the courtesy to explain yourself concisely and completely.

Richard A. De Mark, D.D.S.
Prescott, Ariz.

Tax cut

In regard to Dr. Mark Waltzer's letter in the April 2 ADA News, (" 'No' To Tax Cut"), the reply to Dr. Waltzer is not consistent with his stated concern.

The Editor's Note cited the premise that a tax cut would provide "more discretionary income to the public to spend on goods and services, including necessary and appropriate dental care."

While this premise might be conceptionally true, there are those of us who feel that reduction of the national debt would in the long run assure greater health of our country and our profession.

Since there is a difference of opinion amongst our membership on this issue, which on closer inspection then reveals itself to be a potentially contentious matter, there are those of us who continue to support Dr. Waltzer's position that the ADA should not purport to represent member dentists on purely political issues.

Gary W. Coatoam, D.D.S.
Altamonte Springs, Fla.

Repeal welcomed

The recent repeal of the ergonomics regulations was a huge victory for the American Dental Association.

Many members will never know the details of this terribly intrusive

See LETTERS, page five

MyView

Continued from page four

memorized this technically demanding concerto perfectly. But we couldn't enjoy it.

Fortunately, the next number performed by the orchestra was the marvelous Beethoven Symphony No. 3, Eroica. The lovely second movement was harmonious and fluent. We were able to relax and enjoy the concert. I reflected on the contrast of the discordant and the harmonious, and decided that the music that brought peace to my soul was better for me.

How do these musings relate to my practice of dentistry?

Occasionally I am asked to serve as an expert witness in dental malpractice court cases. These are never a highlight in my day, but they are a necessary service in our system. As these cases unfold during discovery and deposition, it becomes obvious that the dentist involved is suffering because of acts alleged or committed which have now come to this difficult stage.

As we serve our patients we can generally avoid such problems coming to trial by careful recordkeeping, good communication and overwhelming kindness. We have a wonderful profession and a serious obligation to treat our patients with care and consideration. We must be familiar with, and observant of, the standard of care for every case we treat.

It is unfortunate when, on occasion, we are accused of failing to meet that standard and it causes unrest in our lives. I have recently been accused of such a failure and learned firsthand the stress that it can introduce into one's life. The matter has been cleared by peer review, and it has been concluded that my records and treatment were well within the standard of care.

As I reflect on these experiences, I conclude that peace is better than stress, so I will continue to serve my patients in every way to maximize harmony in my practice. It seems to be a better way.

Dr. Brown is the editor of UDA Action, the official publication of the Utah Dental Association. His comments, reprinted here with permission, originally appeared in the March/April issue of that publication.

Letters

Continued from page four

imposition on our practices. OSHA's latest attempt to infiltrate our offices was yet another ill-thought attempt to burden dentists with costly rule making backed with unscientific rationale.

To most dentists, MSDs (musculoskeletal disorders) sounded like the same type of nonsensical jargon instituted several years ago when it was mandated we track and file the dreaded MSD sheets. MSDs would have been far more devastating to our livelihood. Employers would have been forced to compensate employees who had such disorders and assign them to different roles in the workplace. A hang-gliding hygienist who was found to have an MSD would have to be re-assigned to another position in your office.

In one of the options, we would be responsible for "placing limitations on their work activities" or "temporary transfer to another job." At the same time, the employer would have to "continue to pay 100 percent of the earnings and full benefits to the affected employee." This responsibility would have continued until the employee could "resume former work activities or return to the former job" or "the employee can never resume former work activities or the former job," or "90 days were past."

This, coupled with the documentation and the compliance manuals, would have made this task cost prohibitive, time consuming and further burdened our practices with unnecessary paperwork.

Kudos to the grassroots dentists, the ADA's Washington, D.C. office and our lobbyists, and our consortium of like-minded allies.

The reversal using the seldom-used Congressional Review Act was an act of brilliance.

We must stay prepared and poised for any re-introduction of similar rules and regulations that may affect our existence.

Alan V. Dilsaver, D.D.S.
Easton, Pa.

Foreign-trained dentists

I strongly disagree with some parts of Dr. Ed de la Vega's letter published in the March 19 ADA News.

In fairness to the ADA Council on Membership, its definition already covers "individual characteristics and demographics, including but not limited to, race, religion, ethnicity, gender, disability, sexual orientation, socioeconomic status and professional choices." If definition alone is the magic word that spells success, then nothing more could be added to it.

The respect that Dr. de la Vega asks for those foreign-trained dentists who have been loyal members of the ADA and have been in leadership positions in component societies is already there.

Without the recognition that those individuals are asking for, they could not otherwise have attained the leadership positions in local component societies.

Foreign graduates have in the past fought and suffered a lot from issues that attempted to put their status below that of graduates of accredited schools in the United States. One example was when the original Resolution 10 on licensure by credentials was proposed by the ADA Council on Dental Education and Licensure in 1998, graduates of foreign schools licensed in the states were excluded from the provisions for reasons that "all candidates for licensure by credentials be applicable only to graduates from dental schools accredited by the Commission on Dental Accreditation."

See LETTERS, page six

Letters

Continued from page five

Association of Filipino Dentists in America, the Hispanic Dental Association of New York, the Hispanic members of the Dental Society of the State of New York (now New York State Dental Association) and a few other minority groups resulted in the amendments to this resolution.

Nevertheless, some members of the ADA Board of Trustees, including some from California, voted against the amendments to include foreign graduates. Change in "individual characteristics" has to start from the top; that is from the ADA, to its components and societies, including California.

The majority of foreign graduates in California still remember the alleged reasons why the Board Restorative Examination for foreign graduates will be cut off in the year 2003. Testimonies in the halls of the California legislature branded the training of foreign graduates as "inadequate and deficient" in order to justify the closing of the board examination for foreign graduates in California.

Yet the fact still remains that a lot of licensed foreign-graduate dentists in California hold positions of respect in this community and are useful assets to our profession.

Those are not the examples that the ADA should follow as called for in Dr. de la Vega's letter.

A lot of sincere and friendly persuasions still have to be done by good and trusted officers of the American Dental Association and its component societies in order to achieve a semblance of unity in diversity.

Diversity will not succeed with the few loyal foreign-trained dentists, it has to involve the majority. Under such circumstances, the sensible ones will be reluctant to give over a thousand dollars of their hard-earned money regardless of what advertised benefits they are promised.

The ADA and its components have to accept the fact that foreign-graduate dentists here could and will be good, fair and competent in the field of practice. In a free society where equality of all is supposed to prevail, fair competition is always the way of life.

Ramon Z. Nacilla, D.M.D.
Past President, National Association of Filipino Dentists in America
Incoming Executive Director, N.A.F.D.A.
Los Angeles

Not forgotten

When I met Dr. Roger Scholle in 1958, we were freshman dental students at Northwestern University.

We were lab partners and friends for those four years and beyond. Roger was very bright, very organized and very meticulous, but moreover a very funny person.

He had a dry, subtle wit that kept us loose through those trying days of dental school. When one reads his editorials, that subtle humor is often present.

It's asked, "How do you say goodbye to a friend?" The answer is: you don't. You keep his memory. Dr. Roger Scholle provided us with so many memories.

Richard Schmidt, D.D.S.
San Diego

On dental income

Dental student Kimberly Sheppard ("Give Us A Break," March 5 ADA News) suggested that her school debt may detour her from practicing in rural Iowa because the patients there can't afford to pay her enough.

It sounds to me like Mrs. Sheppard was planning for a Cadillac dental practice but is coming to realize there are mainly Fords out there today.

Ms. Sheppard should take some time and check out her northern neighbor, Minnesota. Here, dentists' net incomes are embarrassingly low everywhere.

The further assumption that lawmakers feel sorry for dentists with loan obligations ("Debt Relief," March 5 ADA News) is like assuming these same lawmakers also feel sorry for Bill Gates.

Yes, 30 years ago dentists made very good incomes and, unfortunately, we all continue to be thought of as "rich" today.

In reality, thanks to our friends in managed care, this is most certainly not a truism.

Based on these two articles, the ADA appears to have stooped to beg Congress to help dentists maintain their past rich status. I personally do not think this strategy is going to work very well.

Lloyd Wallin, D.D.S.
Burnsville, Minn.

Editor's note: The ADA Council on Dental Education and Licensure says that according to the background information in the report to the 1998 House of Delegates, the intent of Resolution 10-1998 (Trans.1998:722) was twofold:

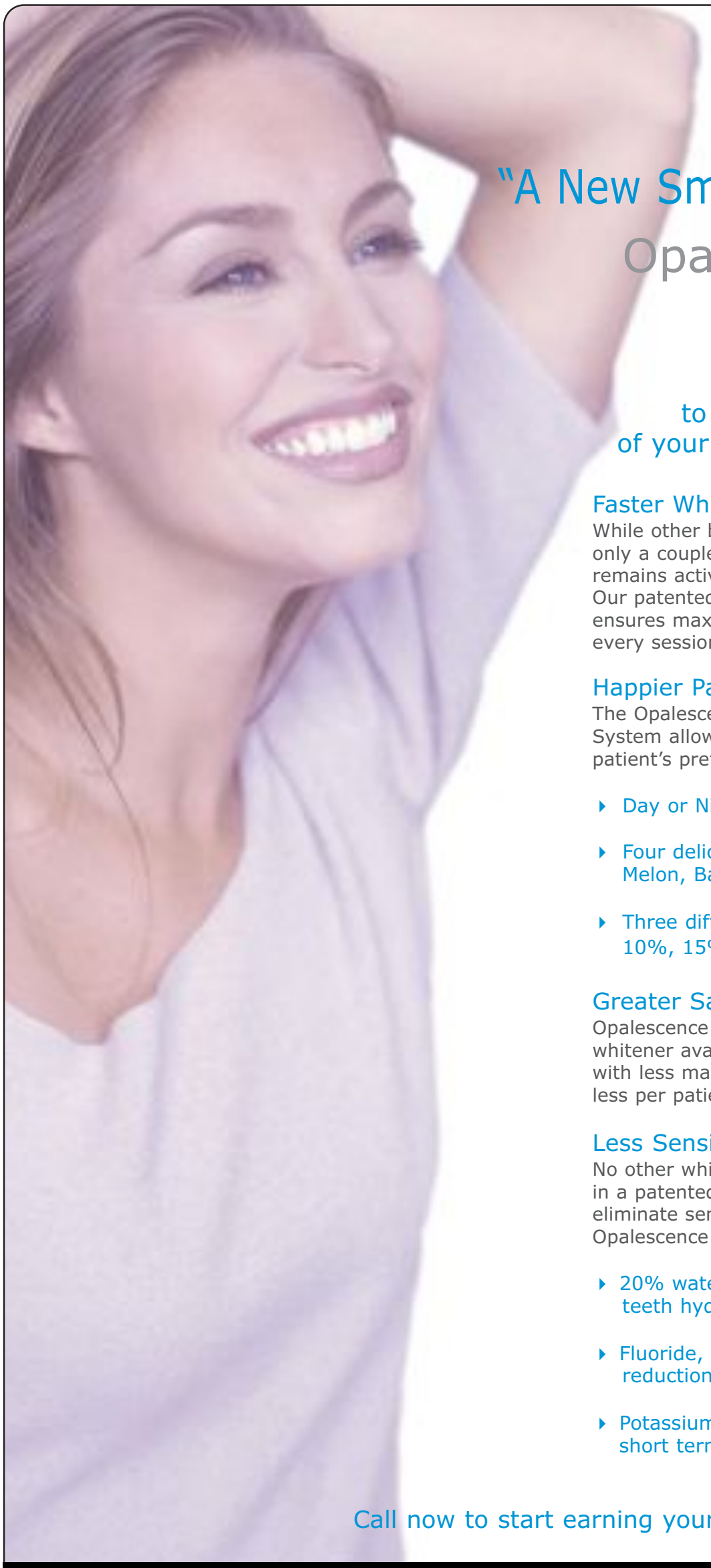
(1) To clarify that the same educational standards should apply for both initial licensure and licensure by credentials;

(2) To parallel the language in the 1984 Policy on Licensure of Graduates of Nonaccredited Dental Schools.

Resolution 10-1998 was not adopted but rather referred for further study to the Council on Dental Education and Licensure.

Upon further consideration, the council submitted, and the House adopted, Resolution 11H-1999 (Trans.1999:630), which recommends that, in addition to graduates of accredited programs, licensure by credentials be available to candidates who have obtained supplemental education in an accredited program, been certified by the dean of an accredited dental school as having achieved the same level of didactic and clinical competence as expected of a graduate of the school, or has completed an educational experience that is recognized by the respective state board as equivalent to the above.

As stated in the background information to the House of Delegates, the intent of Res. 11H-1999 was to support accredited dental education, while at the same time give sufficient latitude to the state boards to potentially accept graduates of foreign programs.



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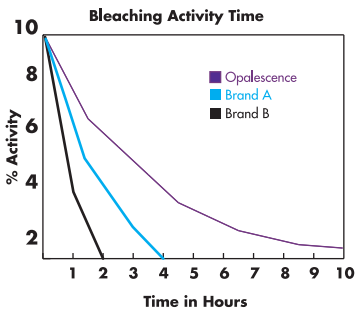

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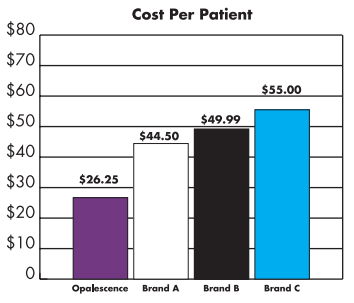

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House panel probes mercury use

Hearings coincide with reports of anti-amalgam lawsuits

By Craig Palmer

Washington—Rep. Dan Burton (R-Ind.) said April 25 he would ask the National Institutes of Health to study the safety of low-level medical and dental uses of mercury, including amalgam.

The chair of the House Committee on Government Reform called for such studies at an emotional hearing on the safety of childhood vaccines and in response to a request from a committee witness.

Meanwhile, the Americans Against Mercury coalition announced a "first round" of legal actions against individual dentists, dental and vaccine manufacturers and a dental service corporation alleging various misrepresentations and product defects in the use and manufacture of dental amalgams and childhood vaccines.

The ADA was reportedly named as a defendant in a lawsuit brought by an individual against her dentist for alleged malpractice. As of this writing, the Association had not been served with a copy of the complaint.

The legal actions were announced at a sparsely attended media conference April 24 at the National Press Club. The coalition said "virtually no one using or disposing of mercury will be unaffected by the first round of class action lawsuits and other actions" seeking "the outright and immediate ban of the use of mercury in the U.S." The committee hearing record will be open until May 11.

"There has been a paucity of NIH funds spent to study the potential neuro-toxicity of mercury routinely placed in human contact by medicine and dentistry," Boyd Haley of the University of Kentucky said in testimony on autism and neurological diseases. "I would like to encourage the members of this committee to support extended research into the potential causal and/or exacerbation relationship of mercury to these neurological diseases and to support studies to improve the therapeutic treatment of autism and related disorders.

The legal actions were announced at a sparsely attended media conference April 24. The coalition said "virtually no one using or disposing of mercury will be unaffected."

"If you go to the NIH and screen their grants, they fund no grants to look at the effects of low-level mercury on the health of Americans," he said. "I would urge you to put some pressure on the NIH to look at these medical and dental uses of mercury." He said he has "been in a fight with pro-amalgam people for many years who say there's not enough mercury there (in dental amalgam) to do any damage."

"You can rest assured, Mr. Haley, that we are going to put as much information—you can call it pressure—as we can on them to look at this," Rep. Burton said. The hearing, however, focused on use and risk of childhood vaccines using mercury-based preservatives and any possible link to what Rep. Burton said is "an epidemic" of autism devastating to families including his own.

"Show me the science," he said in opening two days of hearings on increased rates of autism.

An April 23 National Academy of Sciences Institute of Medicine report found no direct link between a measles-mumps-rubella vaccine and the developmental disorder autism and said no change in immunization procedures is warranted based on current scientific evidence.

See MERCURY, page 12

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Dr. Mark Goodman
New Milford, NJ

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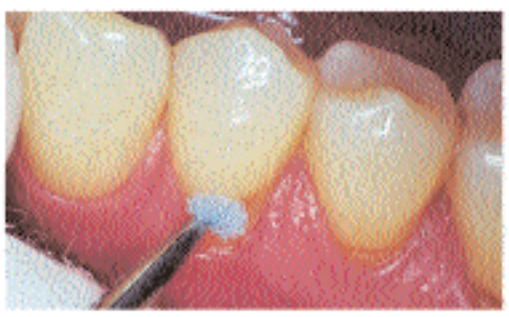

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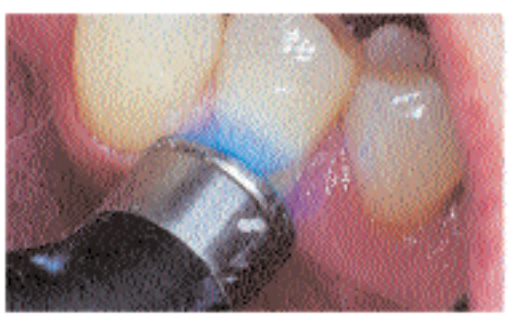

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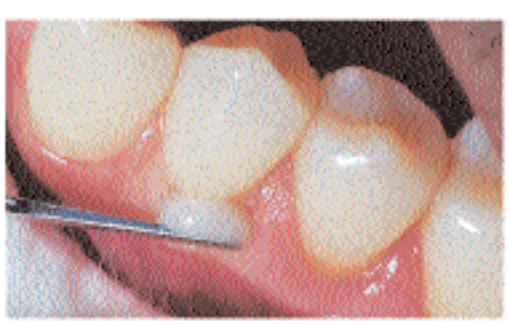

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Ergonomics standard dead

Official notice of 'removal' published April 23 in Federal Register

By Craig Palmer

Washington—They gave the ergonomics rules a bureaucratic burial April 23 with a notice in the Federal Register, "Final rule, removal."

That invalidated finally, officially and forever, a government regulation defeated by Congress and penned to an early demise by President Bush barely two months after taking effect.

The American Dental Association fought the regulation throughout the rule-making process as "too intrusive, too costly" for dental practices and other small businesses.

Government

The Association publicly congratulated the profession's grassroots activists for taking the case against ergonomics rules to the U.S. Congress. Dentists in turn went to Capitol Hill during the March 25-27 Washington Leadership Conference to thank House and Senate members who voted for the resolution of disapproval signed into law March 20 by President Bush.

"This is one of the best things we have done," ADA President Robert M. Anderton told state dental society and grassroots action team leaders at the early-spring meeting. "I think we all owe ourselves a pat on the back for that."

The Occupational Safety and Health Administration issued the "ergonomics program standard" Nov. 14, 2000, to take effect in stages starting Jan. 16, 2001. Dentists were uncertain how employee work-related musculoskeletal disorders covered by the standard would affect the practice and, if necessary, the rotation of licensed clinicians.

The Federal Register notice removes that uncertainty. "Because Public Law 107-5 invalidates the standard, OSHA is hereby removing it from the Code of Federal Regulations," said the notice in the official government record of regulatory activity.

The law prohibits the Department of Labor from issuing rules in "substantially the same form" though it does not preclude other regulatory or legislative measures to address on-the-job repetitive-stress injury. OSHA is a Labor Department agency. ■

Administration proposes direction for revisiting ergonomics

By Craig Palmer

Washington—The Bush administration April 26 unveiled principles for a new regulatory plan to reduce work-related repetitive stress injury just days after invalidating ergonomics rules issued by the Clinton administration.

"Ergonomics injuries are real," Labor Secretary Elaine Chao told a Senate appropriations panel taking testimony on the administration's budget requests. "And defining the best, comprehensive approach for ergonomic injuries is not a simple process."

She urged Congress to give the administration time to develop its own plan and proposed "a new approach based on cooperation and prevention, rather than the antiquated adversarial approach of the past."

The new regulatory effort will be based on seven principles, said the administration's top labor official:

- preventing injuries before they occur;
- the best available science and research;
- cooperation between the Occupational Safety and Health Administration and employers;
- avoiding a one-size-fits-all approach;
- recognition of the regulatory costs for small business;
- short, simple and common-sense instructions.

"Guiding principles will provide a vital starting point for common understanding, a point from which consensus can be attained," Secretary Chao testified.

She urged lawmakers not to set an artificial deadline for new regulations, indicating this was one of the contributing factors to the demise of the previous ergonomics standard.

OSHA, a Labor Department agency, issued regulations Jan. 16 that would have taken effect this fall for dentists and other covered employers.

Secretary Chao said OSHA was asked to complete the rejected standard in an unreasonable period of time. ■

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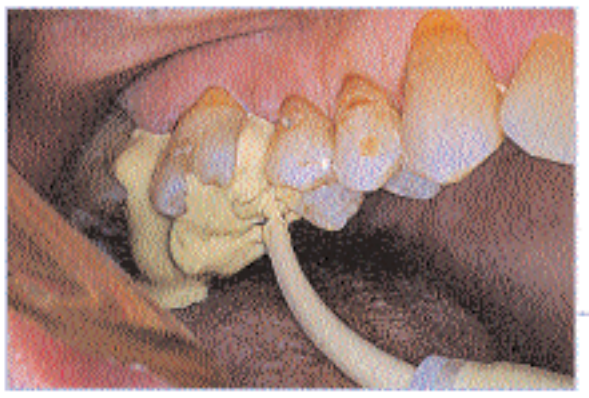

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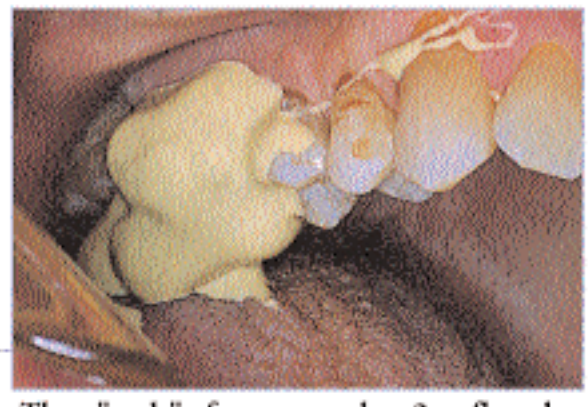

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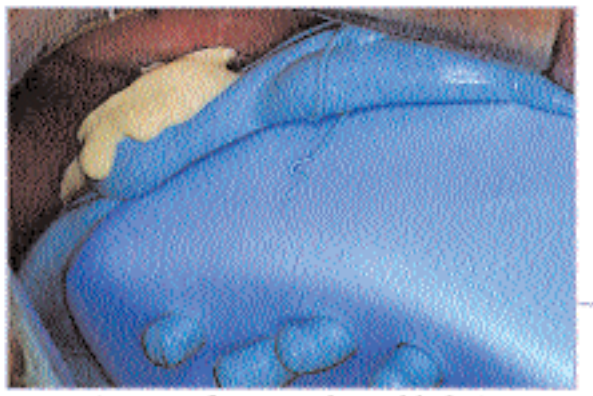

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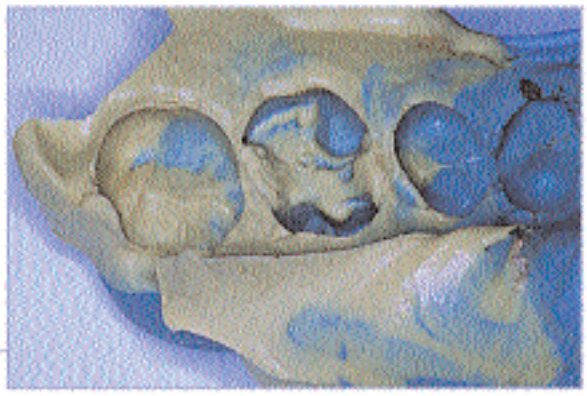

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Association statement on dental amalgam

Editor's note: The following statement was distributed at April 25-26 congressional hearings on the safety of childhood vaccines, which included discussion on mercury in amalgam.

● Dental amalgam (silver filling) is considered a safe, affordable and durable material that has been used to restore the teeth of more than 100 million Americans. It contains a mixture of metals such as silver, copper and tin, in addition to mercury, which chemically binds these components into a hard, stable and safe substance. Dental amalgam has been used for more than 150 years and, during that time, has established an extensively reviewed record of safety and effectiveness.

● Issued in late 1997, the FDI World Dental Federation and the World Health Organization consensus statement on dental amalgam stated, "No controlled studies have been published demonstrating systemic adverse effects from amalgam restorations." The document also states that, aside from rare instances of local side effects of allergic reactions, "the small amount of mercury released from amalgam restorations, especially during placement and removal, has not been shown to cause any … adverse health effects."

● The ADA's Council on Scientific Affairs' 1998 report on its review of the recent scientific literature on amalgam states: "The Council concludes that, based on available scientific information, amalgam continues to be a safe and effective restorative material." The Council's report also states, "There currently appears to be no justification for discontinuing the use of dental amalgam."

● In an article published in the February 1999 issue of The Journal of the American Dental Association, researchers report finding "no significant association of Alzheimer's Disease with the number, surface area or history of having dental amalgam restorations" and "no statistically significant differences in brain mercury levels between subjects with Alzheimer's Disease and control subjects."

● The U.S. Public Health Service issued a report in 1993 stating there is no health reason not to use amalgam, except in the extremely rare case of the patient who is allergic to a component of amalgam. This supports the findings of the Food and Drug Administration, the National Institutes of Health Technology Assessment Conference and the National Institute of Dental and Craniofacial Research, that dental amalgam is a safe and effective restorative material. In addition, in 1991, Consumer Reports noted, "Given their solid track record … amalgam fillings are still your best bet."

● In 1991, the U.S. Food and Drug Administration's Dental Products Panel found no valid data to demonstrate clinical harm to patients from amalgams or that having them removed would prevent adverse health effects or reverse the course of existing diseases. The U.S. Public Health Service found in 1993 "no persuasive reason to believe that avoiding amalgams or having them removed will have a beneficial effect on health." In fact, it is inadvisable to have amalgams removed unnecessarily because it can cause structural damage to healthy teeth.

● The ADA supports ongoing research in the development of new materials that it hopes will someday prove to be as safe and effective as dental amalgam. However, the ADA continues to believe that amalgam is a valuable, viable and safe choice for dental patients and concurs with the findings of the U.S. Public Health Service that amalgam has "continuing value in maintaining oral health."

For more information about this and other oral health topics, please visit ADA.org and select "Patients and Consumers." ■

Mercury

Continued from page eight

Dental amalgam or silver filling is considered a safe, affordable and durable material used to restore the teeth of more than 100 million Americans, the American Dental Association said in a statement distributed to reporters. (See statement, this page.) It has been used for more than 150 years and, during that time, has established an extensively reviewed record of safety and effectiveness, the Association said.

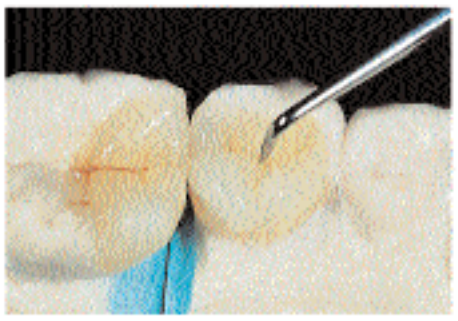
The National Institute of Dental and Craniofacial Research supports two "very large" clinical trials on the health effects of dental amalgam, said Norman S. Braveman, Ph.D., associate director for clinical, behavioral and health promotion research. Studies underway in Portugal and the United States involve direct neurophysiological measures and behavioral and cognitive functional assessments.

"In addition, the trials are monitoring the impact of amalgam on immune function, antibiotic resistance and renal function," Dr. Braveman said. "Our position all along is we want to make sure this is not an unsafe material." The research is necessary "and we are doing it."

Rep. Henry Waxman (Calif.), the reform committee's ranking Democrat, said during hearings the chairman's focus on an undemonstrated link between childhood vaccines and autism represents "a disservice" to families with autistic children. "Where are we going to put the money to fight autism?" he said. "Should we continue to pursue a theory that isn't very persuasive?"

Reps. Burton, Christopher Smith (R-N.J.) and Mike Doyle (D-Pa.) announced formation of a bipartisan 114-member congressional caucus pushing for increased research funding on childhood disease, illness and treatment and full implementation of the Children's Health Act of 2000, which includes provisions to increase access to oral health care services for children.

At press time, the Wall Street Journal was planning a story on mercury and interviewed ADA spokesperson Dr. J. Rodway Mackert Jr. of the Medical College of Georgia. ■



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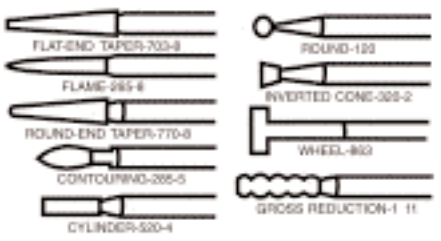

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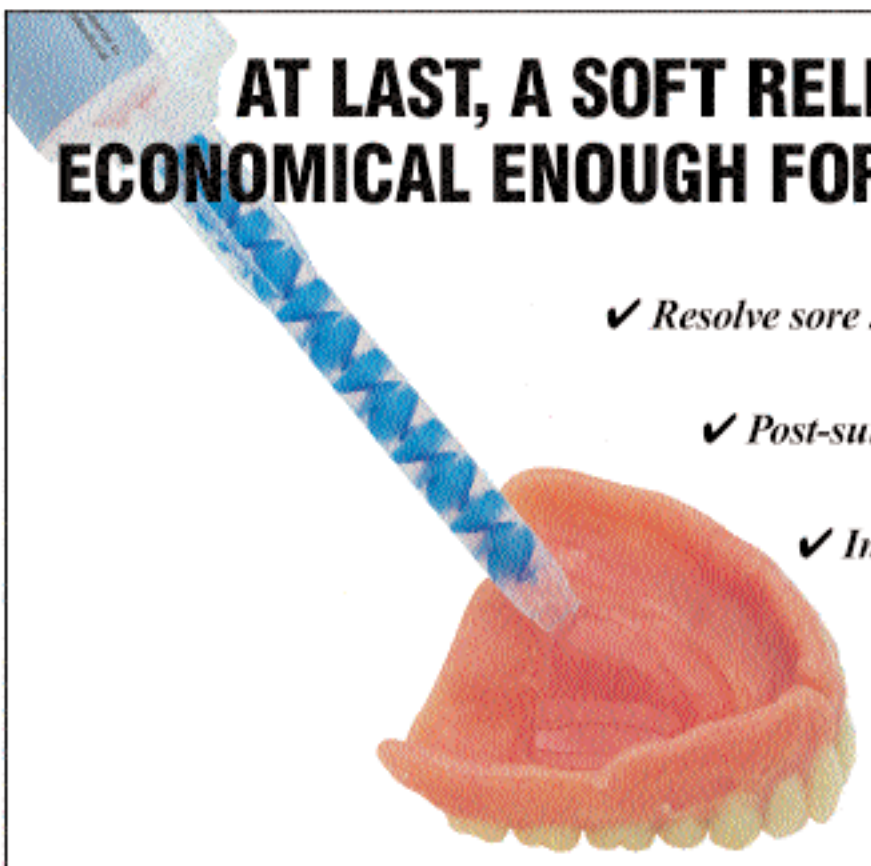

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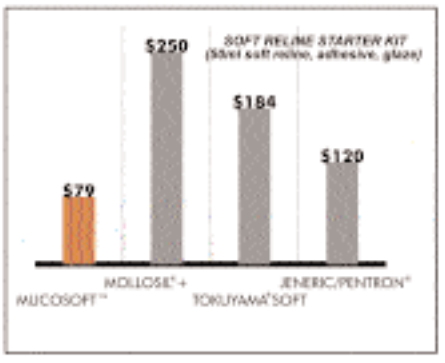

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Education

Faculty shortages persist

Trend poses threat to 'foundation for new knowledge'

By Karen Fox

Last year, Dr. Eric Hovland experienced firsthand an unwelcome and growing trend in dental education.

The dean of the Louisiana State University School of Dentistry lost four faculty members in a span of just one year. Three faculty members left academia for private practice and one accepted a position at another dental school.

Unfortunately, Dr. Hovland's experience is not unique. Many believe there is a crisis in dental education—as with other health professions—with far too many dental schools struggling to recruit and retain quality faculty members.

There are about 3,500 full-time clinical faculty positions in U.S. dental schools. A September 2000 report from the American Dental Education Association indicates the number of vacant, budgeted faculty positions in dental education now approaches 400.

The issue of faculty shortages was a priority item on the agenda at last month's Dental Education Summit. (See story, page one.)

Dr. Hovland said the following factors contribute to the faculty shortages:

- the income differential between academic dentists and private practitioners, whether general dentists or specialists;
- student indebtedness that reduces the number of graduates who pursue teaching;
- the high expectations of parent institutions related to research, community service and teaching loads;
- the time it takes to prepare for a teaching career.

"Certainly one of the most critical factors is the increasing differential between base salaries of faculty compared to private practice income," said Dr. Hovland, adding that an assistant professor's salary approximates about one-half of a private practitioner's income.

Future retirement further threatens to increase the number of vacancies. ADEA reports that in dental schools, the average age of a full professor in 1999 was 60.4 years.

N. Karl Haden, Ph.D., associate executive director and director of ADEA's Center for Educational Policy and Research, has studied dental school workforce issues for the past three years.

As a member of ADEA's Task Force on Future Dental School Faculty, Dr. Haden and his colleagues developed several recommendations that address the shortages. One strategy that he believes may become more prominent is recruiting into dental schools those people who have an interest in academic careers.

"It seems to me that the type of person we're currently recruiting into dentistry are people whose primary goal is private practice," said Dr. Haden, who was one of several ADEA representatives at the Dental Education Summit.

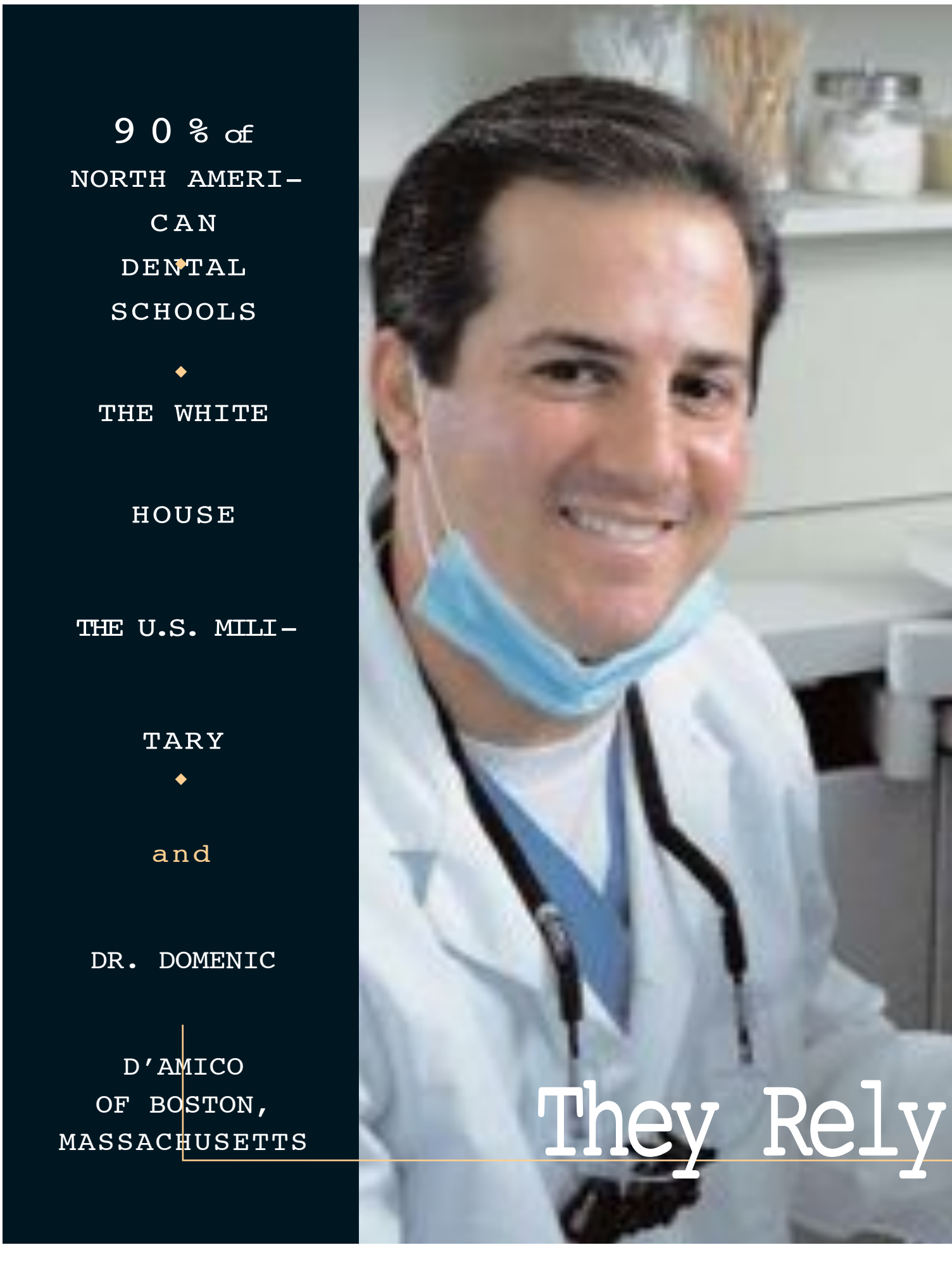
The American Association of Endodontists has already taken a step in this direction.

Last year, the AAE Foundation dedicated funds for the tuition and stipends for five endodontic residents who will commit to a full-time academic career in endodontics for a minimum of five years ("www.aae.org/fdnaward.html").

The dental specialties engaged their own task force to study faculty shortages and make recommendations—the Dental Specialty Task Force on Faculty Recruitment and Retention.

The specialties are on the forefront of this discussion for a good reason.

"If a school can't recruit specialists to teach, dental schools must rely on those outside the specialty to teach in those areas, merge or eliminate those programs," said Dr. Haden. "If more and more of these programs have to close, there certainly will be a scarcity of specialists in a

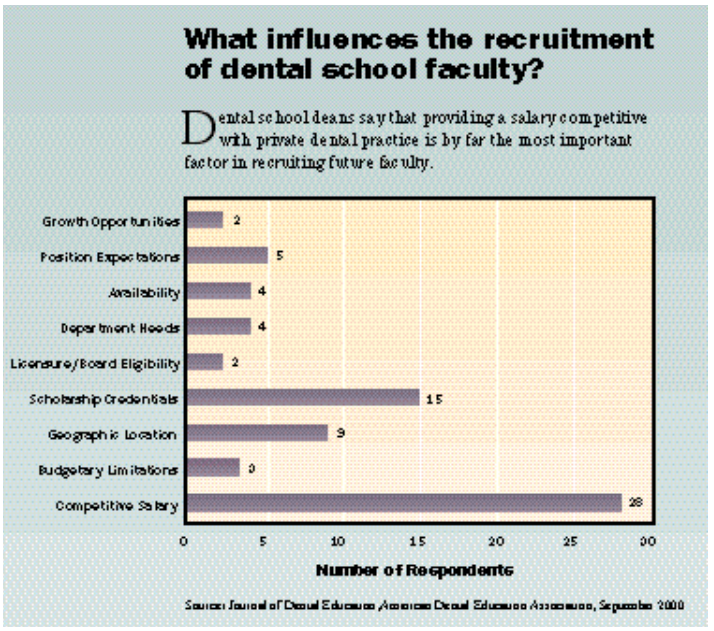


given area, but it's even feasible that the specialty could be subsumed by another specialty, or just disappear because there's no one here to carry it on in the academic setting."

Drs. Haden and Hovland agree that the salary differential with private practice is one of the most notable reasons for the faculty shortages, but they are quick to add it's not just a matter of income.

"Academic careers attract those who are interested in working with other faculty members, mentors and people they respect. They also want time and the opportunity to pursue the intellectual activities they are interested in, so you need to provide an environment that allows the faculty to develop and allows them time to follow their pursuits and scholarly activities," said Dr. Hovland.

What faculty are finding, however, is that the



added pressure to fill the gap caused by vacancies contributes to a significant decline in enthusiasm.

What will happen if the current decline in faculty continues?

Already the shortage impacts the goals reflected in the U.S. Surgeon General's Report related to oral health disparities and access to care.

Dr. Haden sees additional consequences.

"The foundation for new knowledge is in jeopardy if we don't have faculty to do the research and the teaching," he stated.

"Also, it is clear that the number of students we're graduating is not going to replace the number of dentists who are going to retire in the next decade, and we don't have the option of increasing class sizes. If we increase class sizes, who is going to teach the students?"

He continued: "If dental schools don't graduate an adequate number of dentists because they don't have qualified faculty, and consequently there are fewer dentists out there, then someone else is going to have to step in and address oral health care needs. That might be medicine or it might be allied dental professionals. Ultimately, this could endanger the profession as it exists today." ■

Education

Summit

Continued from page one

profession comprised the summit's participants. They included representation from the ADA Board of Trustees; ADA members-at-large; the Future of Dentistry Oversight Committee; ADA councils on Access, Prevention and Interprofessional Relations; Dental Education and Licensure; Government Affairs; the Committee on the New Dentist; the Commission on Dental Accreditation; the National Institute for Dental and Craniofacial Research; the American Dental Education Association; the American Student Dental Association; the American Academy of Pediatric Dentistry; and the Dental Specialty Task Force on Faculty Recruitment and Retention.

"The ultimate goal of the summit," said Dr. Anderton, "is to generate specific action plans that will be presented to the ADA Board of Trustees in August, then to the 2001 House of Delegates in October."

He praised the participants for their preparation and open discussion during last month's session. "I was very pleased with the progress we made at this first session. There was an air of mutual concern that contributed to that," he said.

The summit's structure enabled participants to define the problems related to the cost of dental education, student debt and faculty/researcher shortages, and determine the impact those issues have on dental practice, education, students, new dentists, research, the public and the ADA.

At the meeting's conclusion, those attending were directed to distribute the reports to their individual communities of interest for review and comment. Developing action plans and strategies is the goal of the July session.

Three dental educators delivered presentations on the summit's main topics:

- Student debt—Dr. William Kotowicz, dean of the University of Michigan School of Dentistry;
- Cost of dental education—Dr. Howard L. Bailit, professor at the University of Connecticut Health Center and director of its Health Policy and Primary Care Research Center;
- Dental school faculty shortages—Dr. Eric J. Hovland, dean of the Louisiana State University School of Dentistry.

The speakers outlined the grim realities in dental education today.

Dr. Kotowicz stated that the level of student

See SUMMIT, page 16

Summit

Continued from page 15

indebtedness and the number of students with debt have reached serious proportions. In 1980, the average debt of a dental graduate was $20,000. By 2000, debt increased to nearly $100,000.

Student debt impacts career decisions, where students will practice or whether they seek advanced training. Eventually, high rates of debt could negatively affect enrollment trends in dental schools as well—students could choose a profession where the cost of education results in less debt.

Dr. Bailit examined the rising cost of dental education.

Noting the seven dental school closures in the past 15 years, the decline in full-time faculty members, the number of vacant clinical faculty positions and the aging infrastructure of many dental schools, Dr. Bailit stated that dental schools are finding it difficult to generate adequate resources to meet their needs. Public support for dental education is on the decline and there exists a remarkable gap between actual and needed spending.

Dr. Bailit and his workgroup agreed that if not addressed, the educational infrastructure will continue to deteriorate and the problems associated with the cost of dental education will reach crisis proportions in the next five to eight years.

Dr. Hovland, who also chairs the ADA Commission on Dental Accreditation, spoke on the issue of dental school faculty/researcher shortages. (See story, page 14.)

He reported that there are currently about 3,500 full-time clinical faculty in U.S. dental schools, while at the same time the number of vacant faculty positions is nearing 400. Additionally, almost half of the dental school faculty members are over age 50. Dr. Hovland warned that sufficient numbers of new faculty members are not being recruited to fill the vacant positions.

Participants: From left, Drs. Lawrence Meskin and Howard Landesman, the University of Colorado; Jennifer McConathy, representing ASDA; and Dr. Deron Ohtani, Council on Dental Education and Licensure chair.

Dr. Anderton: 'Dentistry is a profession because it has education.'

He attributed many factors to the difficulty in recruiting and retaining faculty members, including the income differential between academic dentists and private practitioners, whether general dentists or specialists. Further, the dental specialties will not be able to sustain themselves without faculty to educate and train the next generation of specialists.

The summit's final presentations included updates on the ADA's Future of Dentistry Project and the Global Congress in Dental Education held in Prague in March.

Participants noted that some of the topics discussed at the summit overlapped with the "Dental Education Panel" of the Association's two-year-old Future of Dentistry Project. Dr. Kenneth L. Kalkwarf, dean of the University of Texas Health Sciences Center at San Antonio Dental School, presented an update on the FOD's report developed by the Dental Education Panel. Dr. Kalkwarf is a member of the FOD Oversight Committee and the Commission on Dental Accreditation.

Dr. Laura Neumann, ADA group associate executive director, Professional Services and Education, was one in a group of ADA representatives—including Dr. Anderton—who attended the March 2001 "Global Congress in Dental Education" in Prague.

Dr. Neumann said the group's interactions with members of the international dental education community indicates that factors influencing dental education in the United States are also shared by other countries.

Added Dr. Anderton: "Our international colleagues are aware that we have initiated this process, and they are very interested in the outcome." ■

Summer conferences

There is still time to register for two upcoming symposiums at ADA Headquarters in Chicago.

- The ADA councils on Dental Practice; Scientific Affairs and Access, Prevention and Interprofessional Relations will present "Forensic Dentistry 2001: A Symposium with Workshops," July 19-21.

During the three-day conference, forensic experts will present lectures and hands-on workshops on topics including a mass disaster exercise and computer-assisted identification of fatalities.

- "Taking Oral Health to Heart: Exploring the Interrelationship Between Oral and Cardiovascular Disease," will convene July 26-27.

Leading oral health experts in this field will discuss epidemiologic studies that examine an oral-cardiovascular association as well as provide information on the basis, significance and clinical implications of a possible link.

For more information on either symposium go to ADA.org. Contact the Council on Dental Practice at 1-312-440-2895 about the Forensic conference or dentists can call the Council on Scientific Affairs at Ext. 2522 about "Taking Oral Health to Heart." ■

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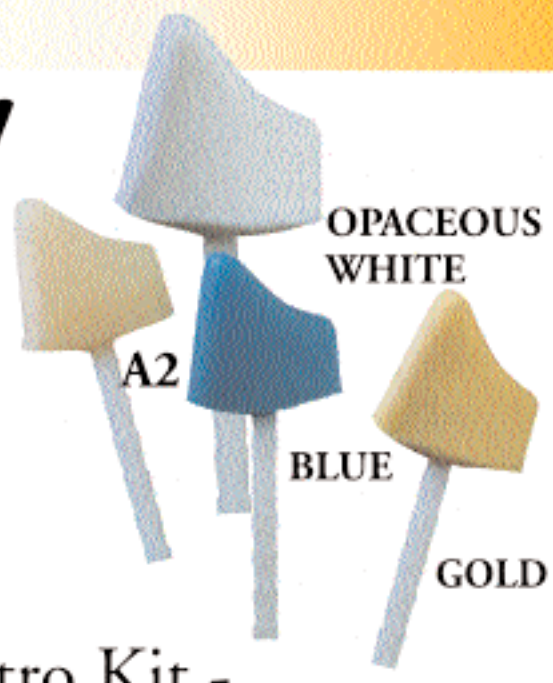

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Profile

Continued from page one

Dr. James B. Bramson, who assumes his new duties as the ADA's ninth executive director July 1, comes to the post with impressive credentials and an unambiguous understanding of what really counts: It's all about membership service.

"We're going to build community for them," he says of the members. "We're going to make sure that they feel comfortable, that they feel welcome. They're going to know that this community of dentists is out there working for them, out there protecting them, out there creating that professional glue that we all need."

An 11-year veteran of the ADA staff and director of the Massachusetts Dental Society for the past four years, Jim Bramson is plainly not the caretaker type.

His appointment to the ADA's top staff position sends a message that the Board of Trustees endorses substantive change—not change for its own sake, but change meant to improve the stature and responsiveness of the organization.

Under Dr. Bramson's leadership and considering his experience, look for the ADA to place greater emphasis on dental practice concerns such as helping dentists successfully navigate a changing dental marketplace.

Look also for stepped-up efforts to boost the membership roles, to improve communications and understanding throughout the profession and to shore up the tripartite relationship—the familial ties that bind organized dentistry's local, state and national organizations.

"We will do some of it through the membership, and I've been there," notes Dr. Bramson. "We will do some of it through the staff, and I've been there. And we will do some of it through the states, and I've been there, too."

Paging through his curriculum vitae, you might conclude that Jim Bramson was predestined for his new job. From his earliest days, the 47-year-old general practitioner seemed to do all the right things. He got the right education, gained the right experience, met the right people, took the right advice.

On paper, his life has the look of a calculated series of strategic moves. To be sure, much of it has been carefully planned. But as in any life, some of it has been pure serendipity, a chance taken, an opportunity seized.

After dental school at the University of Iowa (class of '79), Dr. Bramson started a general practice from scratch in tiny Parkersburg, northeast of Des Moines. A couple of years later, he expanded the practice through acquisition and appeared on his way to a comfortable life of rewarding work, community involvement, Rotary Club luncheons and summer afternoons on the golf course.

Then in 1986, with a wife and two small children, he chucked it all, packed up the family and moved to Chicago to accept a one-year Hillenbrand Fellowship.

It was a foot in the door at the ADA, but it came with no guarantees for the future. Until the big move, Dr. Bramson's wife, Joanne, had been working as an assistant vice president for a local savings and loan.

"We both thought there was something else out there for us, and we had to try," recalls Dr. Bramson. "Earlier Hillenbrand Fellows had landed in leadership positions with other organizations, with dental schools or dental service corporations and the like. Looking back on it, I like to think of that move as prudent risk taking."

His work that year won him a staff appointment as associate director of the Council on Dental Practice. He was named council director in 1990. Staff who worked with him in those days remember him as a hands-on facilitator who always wanted to know how what they were doing applied to the practicing dentist.

"His focus was always on making things better for dentists in the field," says one staffer.

Taking the helm: Just hours after being named executive director by the Board of Trustees, Dr. Bramson tries out the desk in his new office at ADA headquarters.

Adds another, "His style was to give people who worked for him the freedom to really fly, to pursue new ideas and projects. He was hands-on, but he let you do your job. If he thought you were going in the wrong direction, he'd steer you back on line."

Dr. Bramson prizes his early years on the ADA staff as an invaluable learning experience.

"The ADA impressed me back then as an organization with incredible resources and the ability to affect change in a way that no other organization can because of it stature and size," he says. "The ADA can do a lot of things that no other organization can."

In 1997, Jim Bramson got an offer he couldn't refuse. He was named executive director of the 4,500-member Massachusetts Dental Society, an organization he describes as "a microcosm" of the ADA.

"The state has both urban and rural problems," he notes. "It has three dental schools and enough practitioners that you're going to have a very broad range of activities and enough resources that you can get things done. There's a very active public-health sector. There are policy issues and legislative activities and one of the finest dental meetings in the country [the annual Yankee Dental Congress]."

Working with the MDS leadership and staff, Dr. Bramson introduced a new budgeting system that held a tighter rein on costs. He restructured the organization, developing the society's first-ever mission statement and strategic plan.

He pushed legislation that boosted Medicaid reimbursements for dentists by 35 percent—the first increase of its kind in 13 years.

"The improved reimbursement has stopped the flow of dentists out of the program," he notes. "It also caused the state to put some incentive money into its budget to encourage dentists to work with community health centers to bring care to the needy that way."

■ "His style was to give people who worked for him the freedom to really fly, to pursue new ideas and projects. He was hands-on, but he let you do your job. If he thought you were going in the wrong direction, he'd steer you back on line."

Also at MDS, Dr. Bramson started a grassroots network of dentists to communicate with legislators, and he formed a number of coalitions targeting specific issues or needs.

Prime example: the Massachusetts Coalition for Oral Health, which mainly promotes community water fluoridation. In addition to the MDS, this broad-based coalition includes Delta Dental, the state's three dental schools (Harvard, Tufts and the University of Boston), the Massachusetts Public Health Department, the Boston Public Health Department, the Massachusetts Dental Assistants Association and the Massachusetts Dental Hygienists' Association.

Under Dr. Bramson's leadership, the MDS built a new headquarters building and negotiated a unique agreement that made the society a copartner in a limited liability corporation.

See PROFILE, page 19

ADA Reports

Dr. Bramson

Continued from page one

ninth executive director.

"Overwhelmed," the ADA's new chief executive said when asked for his reaction to the Board's decision. "The Board and I spent a lot of time together discussing our shared vision for the organization and how to make the best use of our extensive resources."

At the heart of that "shared vision," he said, was a mutual desire "to add value to membership," a theme Dr. Bramson has stressed during his tenure in Massachusetts.

The new executive director's appointment culminates a five-month search begun shortly after Dr. John S. Zapp announced that he would retire as the ADA's chief executive at the end of March.

Dr. D. Gregory Chadwick, ADA president-elect, headed a six-member Board search committee that started work in November. Resumes were reviewed initially by the ADA's Human Resources Department. If the candidate met minimum job requirements, the resume was sent to a screening committee that included a past ADA president, a past trustee, one constituent society executive director, three members of the ADA House of Delegates and the entire search committee.

Ultimately, the full Board of Trustees made the choice.

Dr. Chadwick described the process as "thorough and exhaustive." He added, "Because of the quality of all the candidates, the Board faced a tough decision. We had candidates of exceptional quality and diversity of background."

He said Dr. Bramson "brings a great deal of experience and expertise" to his new post. "We look forward to his leadership as we join with him and move forward," said the president-elect.

Dr. Bramson's resume runs the gamut of professional experience. Beyond his administrative work, the 47-year-old general dentist has been a private practitioner and a clinical instructor.

He's a published author who has written and lectured extensively on a broad range of topics: the changing dental marketplace, risk management, recordkeeping, dental office ergonomics, infection control and liability, dental practice sales, taxation, team management and many clinical topics.

After dental school, Dr. Bramson started a solo dental practice in Parkersburg, Iowa, later purchasing a satellite facility in a neighboring town.

In 1986, he was awarded the ADA's prestigious Hillenbrand Fellowship in Dental Administration, a year-long program that brought him on board with the ADA to gain practical administrative experience.

His year as a Hillenbrand Fellow led to a staff appointment in 1987, when he was named associate director, Council on Dental Practice. Among other duties, Dr. Bramson developed and presented practice management seminars for dental students.

In 1990, he was appointed director of the Council on Dental Practice, serving concurrently as director of the Commission on Relief Fund Activities, secretary/treasurer of the ADA Endowment and Assistance Fund Inc. and secretary/treasurer of the ADA Emergency Fund Inc.

In 1997, he left the ADA for the top job at the 4,500-member Massachusetts Dental Society.

Dr. Bramson and his wife, Joanne, have three school-aged children, Adam, Matt and Lauren. ■

Dr. Bramson: Career at a glance

By James Berry

Dr. James Bramson was born in Moville, Iowa (population: 1,500), where his mother still resides. His late father, Robert, had been editor and publisher of the community newspaper, the Moville Record. His older brother Steve is in the printing business in Las Vegas.

Inspired by the town's only dentist ("He was the nicest guy and a pillar of the community"), Jim Bramson started telling people that he was going to be a dentist when he was 8 years old.

"You tell people that long enough, eventually you have to do it," he says now.

Dr. Bramson and his wife, Joanne, have two sons and a daughter: Adam, 20; Matt, 17; and Lauren, 9.

Some highlights from the new executive director's career:

1979—Receives his dental degree from the University of Iowa College of Dentistry; starts a solo general dental practice in Parkersburg, Iowa.

1982—Purchases a dental practice in nearby Ackley, Iowa, and opens a satellite office.

1986—Is awarded the Hillenbrand Fellowship in Dental Administration, a year of study and practical experience that brings him to Chicago and the ADA; main areas of interest: risk management, professional liability and the use of informed consent in dentistry.

1987—Appointed associate director, ADA Council on Dental Practice.

1990—Promoted to director, ADA Council on Dental Practice; through much of this period, concurrently holds several other titles: director, Commission on Relief Fund Activities; secretary/treasurer, ADA Endowment and Assistance Fund Inc.; secretary/treasurer, ADA Emergency Fund Inc.

1997—Named executive director, Massachusetts Dental Society; also serves as corporate secretary for MDS Insurance Services Inc. and MDS Foundation Inc.

2001—Returns to the ADA staff as chief executive officer, the Association's ninth executive director. ■

On the job: Dr. Bramson sports a mustache during his early years with ADA staff.

Profile

Continued from page 18

"The way it worked out, we're a tenant, a landlord and a partner all at the same time," he says. "We built it for about $5 million; it's probably worth about $7 million now."

MDS also got into the health insurance business when the carrier providing coverage for its members threatened to cut the intermediaries—including the state society—out of the small-group market.

As a countermeasure and with help from the Florida Dental Association, the MDS chartered a for-profit subsidiary to serve as a brokerage agency for health insurance.

"We partnered with Florida to kick this off," says Dr. Bramson. "They helped administer it for us while we were getting on our feet. After a year and a half, we were able to move the operation [to MDS]. If you can say something nice about the Florida Dental Association, that would be great."

Done.

The subsidiary brokers health insurance provided by about 10 different carriers. It turned its first profit after about 18 months of operation.

■ MDS also got into the health insurance business when the carrier providing coverage for its members threatened to cut the intermediaries—including the state society—out of the small-group market.

Now, at the tender age of two years, it has emerged as the largest single broker of small group plans in the Commonwealth of Massachusetts.

When Dr. Bramson accepted the directorship at MDS, he thought of it as the pinnacle of his career and expected to stay on there for many years. When asked if he ever imagined he'd be returning to the ADA as its chief executive officer, he effectively dodged the question.

"I came here committed to work for the Massachusetts Dental Society," he said. "I came here because I saw what I thought were wonderful opportunities. We've been fortunate that the resources here have allowed us to do some good things, working with a fabulous staff of very creative people."

Your new executive director knows how to work the crowd. ■

Access

Continued from page one

probably have gone untreated if not for his open door.

"We've been with Dr. Coleman a long, long time—since I was six and my brother, Antonio, was seven," says local resident Angel Carter. "We're still friends to this day and he's like a parent and a dentist with my own children."

But those days appear to be over.

After 19 years of treating thousands of low-income children, Dr. Coleman has given up accepting any new Medicaid and DentiCal patients.

"It was a really hard decision not to take any new DentiCal patients," says Dr. Coleman. "But with office overhead being 65 to 75 percent, it's just impossible for me to donate so much care for lower reimbursement.

"For every $100,000 that DentiCal reimburses, I essentially donate $150,000 to $200,000 in uncompensated dental care—and I haven't even raised my fees in a very long time," he continues. Furthermore, "the low reimbursement is making it more difficult to find quality dental assistants and hygienists, especially at 30 cents on the dollar."

Dr. Coleman's exit from the Medicaid system leaves Oakland's poor children with a precarious future. "The number of pediatric dentists who are accepting new DentiCal patients is down to one," he estimates. "There may be others, but I know of no other. That's a reason why I kept accepting new patients for so long."

"Not being able to go to Dr. Coleman will be a great loss to many children in the area," says Ms. Carter. "I understand Dr. Coleman's reason for [exiting the system], but the children and the parents will suffer."

Disabled and willing: Dr. Coleman with patients Antonio 'Tony' Johnson (left), who has cerebral palsy, and his sister Angel Carter.

Though poor families can still obtain dental care at a health center, most will not be treated by a dentist, let alone a pediatric dentist, without Dr. Coleman's involvement. In the past, kids who visited a health center often were referred to Dr. Coleman anyway "because they're too young, have too much tooth decay, or are physically or mentally disabled," he says.

"[My brother] Tony has cerebral palsy," Ms. Carter explains, "and Dr. Coleman was one of very few pediatric dentists who accepted DentiCal and stood by Tony—no matter what treatment he needed.

"Tony was not a difficult patient," she continues, "but my mother was especially happy that she didn't have to hold his hand during treatment because Dr. Coleman worked particularly well one-on-one with him, [disability] and all."

And up until now, Dr. Coleman agreed to treat these kids to "give back to the community," he says. "Despite the low reimbursement, the massive work needed, language barriers and cultural differences, missed appointments, parents bringing in more kids than we planned to treat, we treated them anyway."

The American Dental Association commends dentists who accept Medicaid and Children's Health Initiative Program patients into their private practices—but the Association is also concerned that thousands of Dr. Colemans across the United States are not getting enough support to continue offering dental services to people in need.

"Providing Medicaid services is a major issue in almost every ADA constituent society," says Dr. Robert M. Anderton, ADA president. "My concerns were intensified with the Surgeon General's Report, which overall praised dentistry for its accomplishments in improving oral health care, but also pointed out that 80 percent of dental caries in children is suffered by only 25 percent of the population—mostly the underserved.

"These factors," adds Dr. Anderton, "prompted me to begin inquiries to discover exactly what our problems are, what barriers to care may exist and where we might make improvements in our delivery systems."

The overall issue of access to dental services in the United States—especially for the underserved, indigent and special-needs children and adults—has been a long-standing concern of the American Dental Association.

"The ADA Council on Access, Prevention and Interprofessional Relations has long promoted organized dentistry's role in delivering care to those most in need like persons with disabilities and low-income senior citizens," says Dr. Kimberly McFarland, council chair. "In 1979, CAPIR sent to the House of Delegates the first formal, broadly stated, Association-wide dental access report."

Today, ADA council members, consultants

See ACCESS, page 23

Access resolution from 2000 House of Delegates in full

Here follows the text of ADA Res. 45H-2000: Access to Dental Services for the Underserved:

Resolved, that the appropriate agencies of the Association support the development of state legislative models to be used by constituent societies to resolve issues related to access to dental care for the underserved, indigent and special needs children and adults, and be it further

Resolved, that the Association monitor, respond and, if necessary, pursue federal legislation to improve access to dental care of this same population using the following guidance:

A. Collection of Data and Development of Definitions: Terms, such as "need and demand for services" and "dental shortage areas" will be defined and data regarding the prevalence of dental disease among underserved children shall be collected and reported.

B. Reimbursement for Dental Health Care Providers: Grants shall be made to participating states that agree to make the application, claims processing and reimbursement systems more like the marketplace. This would include, for example, higher reimbursement levels and use of the ADA claim form and code.

C. Education: Grants to develop and/or enhance educational programs to educate pediatric and general dentists to serve children will be provided and federal loan repayment options for dentists who serve in faculty positions and/or who conduct research shall be made available.

D. Availability of Providers: Educational loan reductions for dentists in underserved areas and grants for mobile dental facilities that provide comprehensive care.

E. Federally Qualified Health Centers: Require FQHCs to make it a priority to provide care to the indigent and to provide reports regarding their funding.

F. Oral Health Awareness and Social Training: Materials will be developed to increase oral health care awareness and to promote better oral health care.

G. Community Water Fluoridation: Appropriate federal agencies shall increase research and public awareness efforts regarding the benefits of community fluoridation and grants will be provided to communities for water supply fluoridation.

H. Scope of Dental Practice Laws Protected: No provision of this guidance shall be interpreted to expand the scope of dental practice to allow untrained and/or unqualified personnel to perform any dental service. ■

Access

Continued from page 22

and staff continue to address the issue on a number of fronts:

- House of Delegates Res. 45H: a two-part resolution that calls for the Association to support state legislative models that constituent societies can use to resolve access issues, and to monitor, respond to and if necessary pursue federal legislation on access to dental care;
- Dental Education Summit Meeting: including discussion on quality of education, "particularly with regard to access to care" (see story, page one);
- Board of Trustees resolution: urges constituent societies to push Medicaid reforms, lobby their state governments and encourage members to respond favorably to reimbursement increases;
- Task Force on Access: composed of members of the Board and various ADA councils, and stems from the Board's recognition that Association sponsorship or support of legislation on access to oral health care is a significant activity;
- The Future of Dentistry Project's panel on Financing of and Access to Dental Services.

Says Dr. Anderton, "This F.O.D. report should address areas of our dental health care delivery system that can be improved and/or implemented, provide solutions for immediate problems and offer measures that will prevent their recurrence."

- ADA Principles of Ethics and Code of Professional Conduct.

Says Dr. Anderton, "In addition to our pursuit of federal legislation, I would like to add a major area of concern internal to the profession, and that is possible additions or revisions of our Code of Ethics. These would involve increasing awareness of our moral and ethical obligations, not only to the public we serve, but also to each other as professionals."

Dr. Anderton has also drafted a proposal of possible legislation to increase the number of private-sector dentists involved in providing services to the underserved, especially children.

During the following months, ADA News will explore Medicaid reform, specific groups within the United States who are in critical need of better care, dentists' pro-bono work, workforce issues, the experimental project in Michigan to privatize Medicaid and other such efforts to meet the sizable challenge of overcoming barriers toward better access to dental services.

"We need more dentists trained, equipped and willing to treat small children, and we need improvements in the Medicaid systems in almost every state," says Dr. Anderton. "Our goal has been to address reimbursement issues at the federal level with the intention that states will have more of an incentive to address these issues locally. We have already begun to see results of this work." ■

Annual Session

Historic Westport

Where past, present mix in Kansas City

Editor's note: This is the third installment of a continuing series of personal impressions by ADA News Senior Editor Clayton Luz that will explore Kansas City, Mo., site of the 142nd Annual Session of the American Dental Association.

Kansas City's Westport District's proximity to the Missouri River made it a popular jumping-off point in the 1800s for settlers traveling westward on the Santa Fe, California and Oregon trails.

So my tour guide, Brandon Billings, public relations assistant with the Convention and Visitors Bureau of Greater Kansas City, and I jumped off here (actually, he waited in the car while I nosed around).

In Westport, Kansas City's sophistication converges with 19th-century charm and frontier history. Westport Square, for example, offers a variety of boutiques housed in a historic building once used as a horse stable for a nearby icehouse.

History buffs may wish to take a walking tour of the community, which begins at the crossroads of Main and Westport Road. Historical and architectural highlights include the Allen Library, which opened in 1898 and became the first branch library of Kansas City's public library system; the Harris-Kearney House, an antebellum building listed on the National Register of Historical Places; and 444 Westport Road, the address of John Calvin McCoy's Store.

Originally built in 1833 as a two-story log cabin, the store eventually became the district's trade center and later the Harris House Hotel.

This address also marks the site of the Battle of Westport, the Civil War's final battle west of the Mississippi in 1864. Union Major General Samuel Ryan Curtis had his field command post on top of McCoy's store in order to view the battle down along nearby Brush Creek.

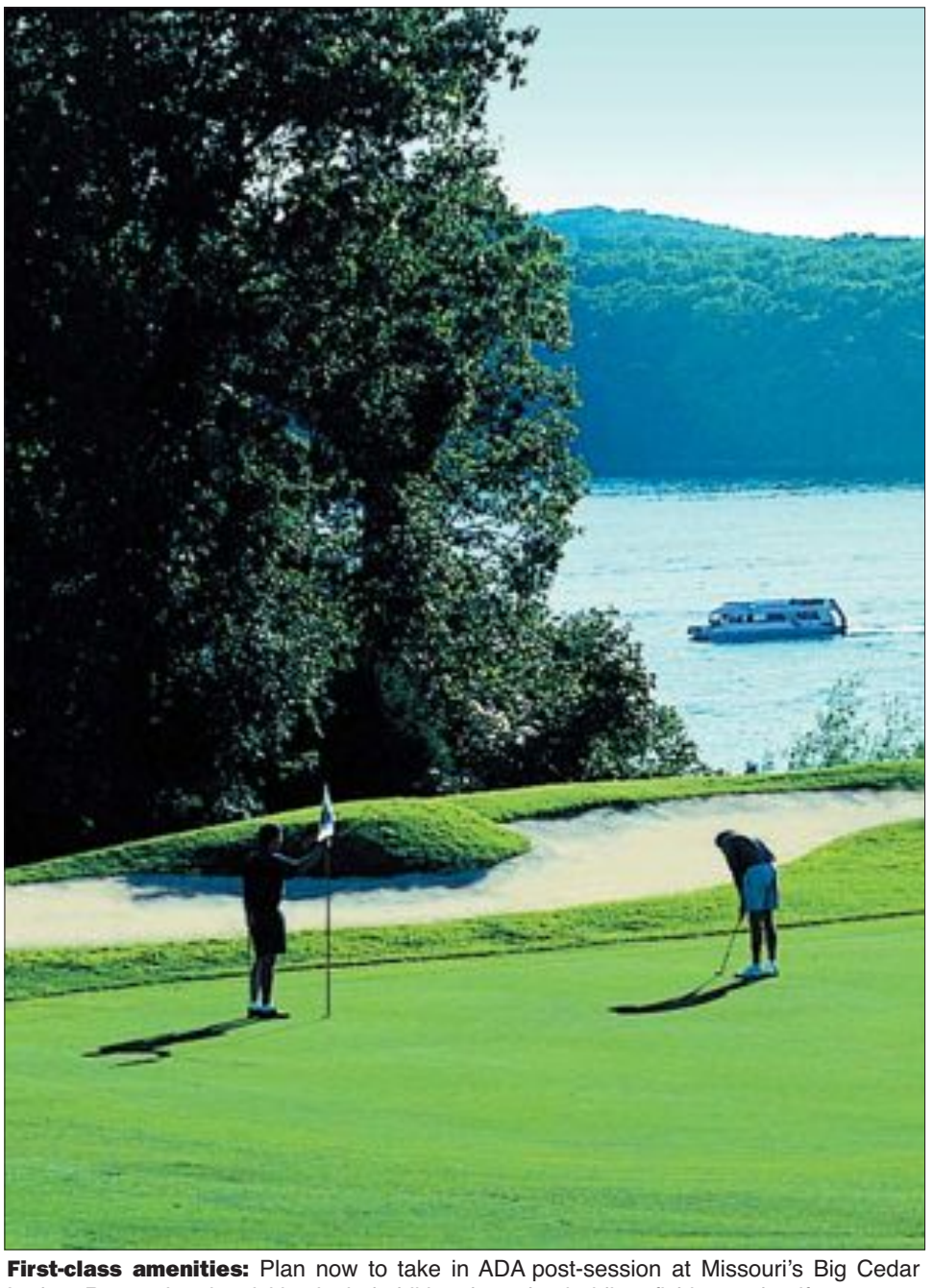
Thankfully, things have calmed down in Westport since then. Today the village offers visitors a grand selection of sidewalk cafes, blues and jazz venues, open-air dining establishments, retail and specialty shops, galleries, boutiques, even a comedy club and a microbrewery.

Kansas City's Westport District is a delightful mix of the past and present.

Stay tuned for my next installment, when I visit the Nelson-Atkins Museum of Art, Kemper Museum and Kansas City's River Market.

Plan now to attend the ADA annual session—Oct. 13-17, with pre-sessions starting Oct. 12. ■

Old-time charm: Visitors to Kansas City's Westport District will enjoy sidewalk cafes, open-air dining, shopping, music and more.



First-class amenities: Plan now to take in ADA post-session at Missouri's Big Cedar Lodge. Recreational activities include hiking, horseback riding, fishing and golf.

Fishing, golf and CE: You'll find it all at ADA post-session Oct. 18-19

BY CLAYTON LUZ

Ridgedale, Mo.—Six words describe 10,000 acres and two information-packed programs at the ADA 2001 post-session seminar.

Relax. Rejuvenate. Learn.

Hills. Woods. Waters.

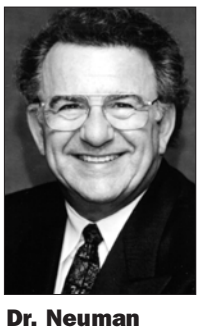
Enjoy the breathtaking beauty of the Ozark Mountains while advancing your professional and educational development at the ADA post-session program.

The program is scheduled Oct. 18-19 at Big Cedar Lodge, Missouri's premier country resort. The lodge is conveniently close, only a one-hour commuter flight followed by a one-hour scenic drive from Kansas City, Mo., site of the ADA annual session. Big Cedar Lodge, owned by Bass Pro Shops, offers first-class amenities such as a fitness center, day spa, hot tub and sauna. Recreational activities include hiking, horseback riding, and golfing on the first Jack Nicklaus Signature Par 3 course ever built. For young and old, there's world-class fishing and water sports on Table Rock Lake. If you choose to drive to Big Cedar Lodge from Kansas City, allow 3-4 hours traveling time.

So while you're relaxing, rejuvenating and learning, your family can hike the hills, explore the woods and swim the waters.

You can learn at these post-session seminars:

- "Technology: Are You Maximizing Your Investment?" (PS1)—Dr. Ken Neuman will show you how to more effectively use your intraoral camera. How? "It's a matter of time commitment," says Dr. Neuman. "Once you've become familiar with using your intraoral camera and imaging system, you'll see how it improves patient communication. Patients develop a tremendous change in the appreciation of what goes into something like a simple restoration. And you'll develop a renewed enthusiasm for your system." Oct. 18-19, 8:30 a.m.-noon. Tickets cost $200 ($250 on-site);



Dr. Neuman

Dr. Steinberg

- "A Team Approach to Treating the Dental Patient with Medical Problems" (PS2)—Dr. Barbara J. Steinberg will discuss a comprehensive approach for evaluating the physical and psychological status of a patient before treatment.

Other topics include how to gain improved understanding of the treatment and processes of common medical problems, an update on various infectious diseases such as hepatitis B and C, as well as updates on new diagnostic methodology, and regimen for osteoporosis prevention and treatment. Oct. 18-19, 1-4:30 p.m. Ticket cost is $200 ($250 onsite).

Space is limited and advance registration is recommended. The special per-night room rate for seminar registrants is $121, plus tax.

For more information contact the Council on ADA Sessions and International Programs, 211 E. Chicago Ave., Suite 200, Chicago 60611-2658; call 1-800-232-1432 or 1-312-440-2388; or e-mail "annualsession@ada. org". ■

Get ready for Tech Day IV

'Results-oriented' CE program geared to dentists, staff members

By Clayton Luz

Kansas City, Mo.—It's the 21st century, dawn of a new millennium.

What are you waiting for?

Bring your dental practice to the cutting edge at Technology Day IV, a pre-session program scheduled Friday, Oct. 12, at the Kansas City Convention Center.

More than 24 technology experts will discuss the latest developments in dental technology and how to integrate that technology into your practice.

Dr. Emmott

The results-oriented technology program will help improve your patient care, increase your bottom line and lower your stress.

Dr. Larry Emmott, a practicing dentist and technology expert, says integrating technology into one's practice "should be a planned effort over a period of time. It's a process that doesn't happen overnight, for it to be successful."

Dr. Freydberg

He says Technology Day IV offers participants a "blueprint" that will show how they can "phase technology into their practice, gradually."

Dr. Miles

Doing so, Dr. Emmott explains, "will help you get the most from your technology purchases without overwhelming your staff. Integrating technology is relatively easy, but you must plan to get value for your investment. Tech Day will show you how to do that."

Dr. Takahashi

Below are some of this year's Technology Day IV programs:

- "High Tech–High Touch"—Dr. Emmott will discuss how technology can increase effectiveness, streamline business procedures, improve treatment acceptance and facilitate communication in your dental practice;
- "Digital Radiology"—Dr. Dale Miles will speak about digital X-ray systems and what participants need to know when selecting a system for the dental practice;
- "Which Comes First … the Chicken or the Egg?"—Technology Consultant Ted Takahashi says "there are plenty of documents that promote technology, and many manufacturers that provide good products, but there's no one there to show participants how to put it all together." Mr. Takahashi's approach, which he calls the "objective integration process," will show participants how to establish a technology plan for their office that will meet the functional requirements of the office while solving the clinical needs of the practice.
- "Interdisciplinary Care—Using the Internet to Your Advantage"—Dr. Barry Freydberg will demonstrate how the Internet can power your practice by showing a live video conference/consultation via the Internet using intraoral camera, computer and digital radiography;
- "What Happens to Technology When Your Doctor Leaves the Treatment Room?"—Dr. Freydberg and dental hygienist Betty Weidenbach will present a program on how assisting staff and hygienists actually use technology in their treatment rooms.

For more information, contact the Council on ADA Sessions and International Programs, 211 E. Chicago Ave., Suite 200, Chicago 60611-2658; call 1-800-232-1432 or 1-312-440-2388; or e-mail "annualsession@ada.org".

Updates on annual session events are posted on ADA.org, the Association's Web page, at "www.ada.org/session". ■

'Special Smiles' volunteers needed

Special Olympics Special Smiles seeks dentist and hygienist volunteers to provide Special Olympics athletes at state-level competitions with oral health care instruction and a non-invasive dental screening.

For information, contact Susan Wilcox at 1-732-632-4695 or e-mail "sfwspecialsmiles@aol.com".

Dates and locations for remaining 2001 SOSS events include:

May 11 Phoenix; **May 12** Pittsburgh; Ft. Jackson, S.C.; **May 18** Billings, Mont.; Omaha, Neb.; **May 19** Hammond, La.; **May 19** Tuscaloosa, Ala.; Latrobe, Pa.; **May 24** Chicago; **May 25** Ames, Iowa; **June 2** Atlanta; New York City; Richmond, Ky.; Albuquerque, N.M.; Durham, N.C.; Kingston, R.I.; Ft. Lewis/Tacoma, Wash.; Raleigh, N.C.; Mt. Pleasant, Mich.; Ft. Collins, Colo.; **June 2-3** Ewing, N.J.; **June 8** Stevens Point, Wis.; **June 9** College Park, Md.; Middlebury, Vt.; New Haven, Conn.; Richmond, Va.; Newark, Del.; Anchorage, Ala.; **June 16** Normal, Ill.; Albany, N.Y.; Long Beach, Calif.; Orono, Maine; Cambridge, Mass.; **June 23** Twin Cities, Minn.; Columbus, Ohio; **July 6-8** Eugene, Ore.; **Sept./Oct. TBD** Philadelphia; Detroit; **Oct. TBD** Jackson, Miss.; **Oct. 6** Boise, Idaho; **Dec. 1** Kaneohe Marine Base, Hawaii; Milwaukee. ■

ADA Reports

ADA finds an easy win in twins

Minority dental school scholarship awarded to brothers

By Arlene Furlong

They grew up together as children, live across the street from each other as adults and think so much alike that they complete each other's sentences.

So it should be no surprise that Carl and Craig Bahr both won a 2000-2001 ADA Minority Dental School Scholarship together; the first time in history a scholarship has been awarded to twins.

"One of the reasons we're so happy is that we've put so much effort into the program," said Carl.

Academically, Carl and Craig are tied for first place in their dental school class at Southern Illinois University. Each of the twins finished their first year with a perfect 4.0 GPA.

"The scholarship is really a pat on the back," said Craig. "And because it goes directly toward reducing the amount of money we will have to borrow, its value is even greater."

Carl and Craig are happy to be where they are today. "Lifestyle issues had a lot to do with our decision," agreed both Craig and Carl. "With dentistry, we envision the perfect balance between a meaningful professional career and maintaining a family life."

The brothers intend to start a joint practice near a dental school so they can alternate between teaching and practicing dentistry. They hope to find a location that would allow them to provide care at a needy American Indian reservation.

"We're going to rotate our time," said Craig. "Right now, we're so bogged down in the work of dental school that we haven't had the chance to figure out all the logistics."

Deuce: From left, Craig and Carl Bahr

"But we know we'll be able to work it out," said Carl. "We both feel the same way—so fortunate. And to he who has been given much …well, you know the rest," he said.

The Association's scholarship programs are jointly administered and funded by the ADA Endowment and Assistance Fund Inc. and the ADA Health Foundation.

Corporate sponsors Colgate Palmolive, Oral-B Laboratories and Procter and Gamble assisted in funding the Minority Dental Student Scholarship Program. This scholarship grant of $2,500 is given to second-year dental students who are underrepresented in dental school enrollment: African-American, Hispanic and American Indian students. For the 2000-2001 academic year, 25 scholarships were funded.

The Dental Student Scholarship Program provided 25 students each with $2,500 awards for the 2000-2001 academic year.

The Allied Dental Health Scholarship Program provided $1,000 grants to 10 dental hygiene students, 10 dental assisting and five dental laboratory technology students. Handler Manufacturing Company Inc. provided additional funding for the dental lab technology scholarship last year.

For more information about the Association's scholarship programs, call the Endowment Fund using the ADA's toll-free number, Ext. 2567. ■

ADA scholarships 2000-2001

Students awarded in dentistry and allied programs

A total of 75 students pursuing dental careers and allied dental health careers received scholarships for the 2000-2001 academic year.

The ADA's scholarship programs are jointly administered and funded by the ADA Endowment and Assistance Fund and the ADA Health Foundation.

The Minority Dental Student Scholarship recipients were:

Araceli Adame, University of Texas, San Antonio; Anthony Alonso, Tufts University; Safuratu Aranmolate, Ohio State University; Lenny Arias, University of Texas, Houston; Carl Bahr, Southern Illinois University; Craig Bahr, Southern Illinois University; Adrian Bell, Medical University of South Carolina; George Betancourt, University of Connecticut; Sherdon Cordova, University of Minnesota; Karsten Craven, Howard University; Gregory Edens, University of Kentucky; Karla Gavaldon, Temple University; Michael Glass, University of Michigan; Roel Gonzalez, University of Pennsylvania; Elizabeth Hevia-Wright, University of Louisville; Rakiya Jones, Loma Linda University; Michael LeBlanc, University of Missouri; Mauricio Martinez, University of Florida; LeKecia McGee, University of North Carolina; Erica McGhee, Meharry Medical College; Tonya Parris-Wilkins, Virginia Commonwealth University; Elizabeth Sandoval, University of Medicine and Dentistry of New Jersey; Rigoberto Ulloa, University of Illinois; Vanessa Vargas, Medical College of Georgia; Valerie Vehemente, Harvard School of Dental Medicine.

■ The ADA Endowment and Assistance Fund, Inc. was established by the 1989 ADA House of Delegates and organized exclusively for charitable and educational purposes to assist dentists and dental or allied dental health students.

The Dental Student Scholarship winners were: Anthony Black, Howard University; Kari Borgen, Oregon Health Sciences; Michelle Chew, Case Western Reserve University; Matthew Clegg, University of Iowa; Jonathon Delf, University of Minnesota; Erin Elliott, Creighton University; Donald Ellis, Virginia Commonwealth University; Michael French, Indiana University; Sonia Giordano, University of Medicine and Dentistry of New Jersey; Ginger Glayzer, University of California, San Francisco; Cynthia Green, Meharry Medical College; Sean Gubler, Loma Linda University; Cang Huynh, Medical College of Georgia; Warren Johnson, Baylor College; Jannie Lee, University of North Carolina; Jennifer Rankinf, Temple University; Dawn Nguyen, Boston University; Micah Pope, University of Missouri; Mark Raymond, University of Kentucky; Daniel Rejman, University of Michigan; Shiva Sheikholeslam, Tufts University; David Swiderski, Indiana University; Michael Thompson, University of Illinois; Vincent To, University of Texas, San Antonio; James Ziuchkovski, University of Colorado.

The Dental Hygiene Recipients were:

Angela Brewer, Midlands Technical College; Karen Calhoun, Wichita State University; Cheryl Engleman, University of Maryland; Kimberly Ferguson, University of New England; Keena Harding, University of New Mexico; Davene Lott, Colorado Northwestern Community College; Jennifer Roe, University of Texas, San Antonio; Katherine Shropshire, University of Mississippi; Rachel Swackhamer, Indiana University; Jennifer Uttenreither, University of Maryland.

The Dental Assisting Recipients were:

Jill Bertram, Ivy Technical State College; Dawn Daniels, Professional Careers Institute; Nikia Davis, Grayson County College; Elizabeth Gonzalez, Santa Fe Community College; Amie Herrmann, Luzerne County Community College; Susan Kapinos, Berdan Institute; Regina Keck, Median School; Donna Lewis, Coastal Carolina Community College; Jennifer Marroney, Pueblo Community College; Leslie Mendoza, Sacramento City College.

Recipients of the Dental Laboratory Technology Scholarship were:

Lisa Berthold, Indian River Community College; Laura Foltz, Southern Illinois University; Gerardo Garcia, University of Texas, San Antonio; Ryan Gottlieb, Durham Technical Community College; Warren Shaeffer, Indian River Community College. ■

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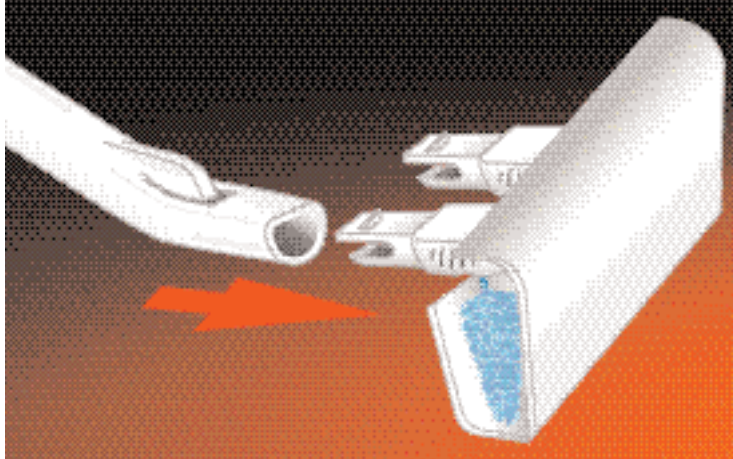

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