7-12-1999

ADA News - 07/12/1999

American Dental Association, Publishing Division

FTC targets quackery on the Net, page six ◆ Licensure update, page 29

AMERICAN DENTAL ASSOCIATION
ADA News®
JULY 12, 1999 www.ada.org VOLUME 30, NO. 13

BRIEFS

Business conference registration open

There's still time to sign up for the popular ADA Dentistry as a Business Conference, "Money, Management, Marketing and Technology."

The two-day event will be held at ADA headquarters July 23-24.

It is sponsored by the ADA Council on Dental Practice and will feature well-known speakers.

Dentists and others interested in attending can receive more information by calling the council on the ADA's toll-free number, Ext. 2895. Registration forms and brochures can be faxed to dentists to expedite the registration process. Online registration, found at "http://www.ada.org" is also acceptable. ■

Volunteers sought for Belize mission

Sumner, Iowa—The Christian Dental Society is seeking volunteers for its one-week dental mission to Belize, Central America, Oct. 23-30.

Housing accommodations will be provided on the island of Ambergris Caye. A charter mission air service will provide transportation about the country.

Ten portable dental units will be furnished, but each participant is required to bring his or her own dental instruments and supplies.

Restorative and preventive dentistry services, as well as some extraction work, will be performed.

For more information contact Dr. J. Franklin Whipps by phone at 1-618-532-1821 or by fax at 1-618-532-1915. ■

INSIDE

Tech Day

Imtiaz Manji to speak. **Story, page 14.**

Pushing patient protection

ADA leaders deliver key points to House members

By Craig Palmer

Washington—The dental profession wants to support patient protection legislation but will not accept legislation "that does not comport with our policy," Association officials told House Speaker Dennis Hastert (R-Ill.) and other congressional leaders June 30.

ADA President S. Timothy Rose, President-elect Richard F. Mascola, Executive Director John S. Zapp and Washington Office Director Dorothy J. Moss met with key House members as the patient protection debate heated up on Capitol Hill.

■ **AMA OKs union; What's it mean for dentistry? Page 18**

Three committees in the U.S.

See PATIENT, page 30

Cuba's future: Children eagerly greet a dentist visiting from America, Dr. Benjamin Mandel. He brought some 80 pounds of dental supplies with him to the Caribbean country. Story, page 28.

Dues increase proposed

Revenue would offset $1.45 million projected deficit

By Judy Jakush

By the close of its June meeting, the ADA Board of Trustees knew it had to propose a $14 dues increase for next year or tap into reserves.

It chose the first option, but as the budget stands now, the proposed $14 would set dues at $357 next year, $25 less than the 1999 level of $382.

Confused?

The reason a proposed dues increase could result in a lower dues rate is that the 1998 House of Delegates directed the Board to use $343 (multiplied by the equivalent of 107,000 full dues-paying members) as a base figure for calculating dues for the year 2000.

The proposed 2000 budget anticipates $65.8 million in expenses against $64.4 million in projected revenue. The $14 dues increase is expected to make up a deficit of about $1.45 million and set dues for 2000 at $357.

Last year's House arrived at the $343 base dues figure by starting with the 1999 dues of $382 and subtracting $14 for programs of a one-time nature that would occur this year and also by subtracting $25 for the national marketing campaign for direct reimbursement.

The 1999 dues year was the final installment of a three-year $7.5 mil-

See BUDGET, page 17

CDT-3 ready to roll

Dentists urged to make it their only one

By Laura McKee

After five years of work, with input from all participants of the revision process, the newly revised "Current Dental Terminology, Third Edition," is poised for release.

Notes Dr. Michael Vaclav, chair of the Council on Dental Benefit Programs, "CDT-3 is a very comprehensive and useful reference manual that every dental office should have to assist dentists and staff with submitting dental claims.

■ **Management column looks at S&P 500, page 25**

"The newly revised manual includes clarified descriptors and more specific codes designed to increase accurate reporting. This accuracy increases claims turnaround time and reimbursement for you and your patients," he says.

CDT-3 will allow dentists to report dental procedures that were previously unavailable and to clarify the appropriate use with more explicit descriptors and nomenclature.

The manual contains a revised Code on Dental Procedures and Nomenclature and a sampling of SNODENT, the "Systematized Nomenclature of Dentistry."

The revised ADA claim form is also shown in the new manual.

Specifically, CDT-3 includes 74

See CDT-3, page 24

Include conferences in summer planning

Don't stop making your summer travel plans after reserving that campsite in Yosemite. You're not done planning your summer until you've signed up for an ADA conference or two.

The ADA will be hosting "Professional Challenges and Obligations," the Eighth National Institute on Dentist Well-Being Aug. 19-21 at ADA headquarters.

The conference, sponsored by the Council on Dental Practice, will feature speakers whose expertise is in addictions, mental health and advocacy for affected professionals. It is designed for dentists interested in these areas and for those professionals who treat dentists facing problems.

Dr. Vincent Rogers, associate administrator for health professions at the Bureau of Health Professions in Rockville, Md., will be keynote speaker. Dentists' spouses are also invited. The Alliance of the ADA is organizing dinner and a cruise from Navy Pier the first night of the conference.

At the same time, the ADA will also host "HIV and Dentistry: The Calm after the Storm." Co-sponsored by the CDP and the Council on Scientific Affairs, this one-day event will be held Aug. 19.

Presenters will include Drs. Michael Glick, Sol Silverman and Cathy Flaitz along with Mardge Cohen, M.D.; Mark Rubin, associate general counsel for the ADA Legal Division; and Kathy Eklund, a dental hygienist.

Keynote speaker for this conference will be Dr. Rogers.

Participants may attend either conference or portions of both.

Cost for the Well-Being Institute is $200 for ADA members and $300 for nonmembers; the HIV conference registration fee is $100 for ADA members and $150 for nonmembers. Hotel reservations at Chicago's Ritz-Carlton must be received by the ADA no later than July 19 to ensure the conference rate of $171 per night. Availability is not guaranteed for registrations received after the deadline. Attendees can qualify for up to a 10 percent discount on airline reservations.

For more information, contact Linda Kittelson at Ext. 2662. ■

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ONLINE EXTRA

When the icon at left appears with an ADA News article, turn to our counterpart on the World Wide Web—the ADA News Daily—for related news and information via ADA ONLINE.

AtPressTime

Big DMSO just got even bigger

American Dental Partners, Inc., a Massachusetts-based dental management service organization, has affiliated with the Hill Dental Group, a Columbia, Md., group practice.

ADPI has acquired certain non-clinical assets and entered a 40-year service agreement with the practice, the company said in a news release. Hill Dental generated revenues of $1 million in 1998.

With this transaction, ADPI is now affiliated with 16 dental group practices and operates 124 dental facilities with more than 1,000 operatories in 10 states.

A calcium supplement that's easy to swallow

Sounds too good to be true, but a popular brand of chocolate-flavored chew may actually offer a health benefit for women.

Viactiv, a soft chocolate chew that also comes in a mochaccino flavor, has been selling off the shelves in supermarkets and drug stores across the country. That's because the product is actually a calcium supplement that can help women fight osteoporosis and other ailments linked to calcium deficiency.

The Chicago Sun-Times reported July 7 that Viactiv was developed at Mead Johnson by a team of women looking for an innovative, more palatable way to offer women calcium supplements.

No mention of whether the chews are fattening or bad for teeth, however. And what exactly is mochaccino?

Pre-existing condition linked to Alzheimer's

A new study in rats conducted at the Ohio State University in Columbus suggests that aging by itself may not affect brain systems that control learning, memory and susceptibility to Alzheimer's disease.

Researchers found, however, that the combination of old age and pre-existing brain pathology led to serious problems in a brain system crucial for normal cognitive abilities.

"We believe that people who develop Alzheimer's disease have something wrong with their brain long before the symptoms appear," said Martin Starter, Ph.D., a psychology professor at OSU." It is the aging process that then makes the disease appear."

Funny bone may not aid healing

Laughter may not be the best medicine after all, the Chicago Tribune reported July 7.

Rod Martin, Ph.D., a killjoy psychologist at the University of Western Ontario, has challenged the common wisdom that a sense of humor can help speed healing and fight disease, the Tribune reported.

Addressing an international conference on humor studies, Dr. Martin noted that a handful of studies have shown humor may improve health by strengthening the immune system. But he's not convinced the link between humor and health is for real, having completed a comprehensive review of the literature.

"I don't want to be totally pessimistic," Dr. Martin told the Tribune. "I think there is good reason to pursue this research. But we certainly can't say that the findings are solidly documented."

Oh, shut up, Dr. Martin.

—Compiled by James Berry

Q&A: Dr. Gary Armitage (above), chair of the Council on Scientific Affairs, fields questions from the audience (right) during CSA's May 12 Open Session.

ViewPoint

Snapshots of American Dentistry

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

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

MyView

Defining the health care vision

William K. Rich, D.M.D.

My introduction to the world of health care financing occurred in the late 1970s when I was asked to represent my community as a board member of a health systems agency. These federally funded and mandated agencies were formed to deal with a growing problem—health care expenditures had grown to 10 percent of our gross national product and the government was paying 60 percent of that bill. It was apparent this could not continue.

Efforts to control costs during this period centered on distribution of facilities, such as hospitals and services. It was apparent that traditional forces of competition had not worked in the health care industry as it existed. The object was to plan and approve, using grassroots input, only necessary services in order to avoid duplication and to ensure accessibility. These efforts were met with strong opposition in most areas. Many people saw this as an attempt to limit health care. Needless to say, the system failed.

Many thought that when health insurance premiums equaled a family's house payment something would have to give.

Since that time, insurance premiums have equaled house payments for many families, and the burden on the federal and state governments is similar. The Clinton health care reform effort and the proposed legislation that has followed are examples of efforts to correct the problem, but a long-term solution still does not exist.

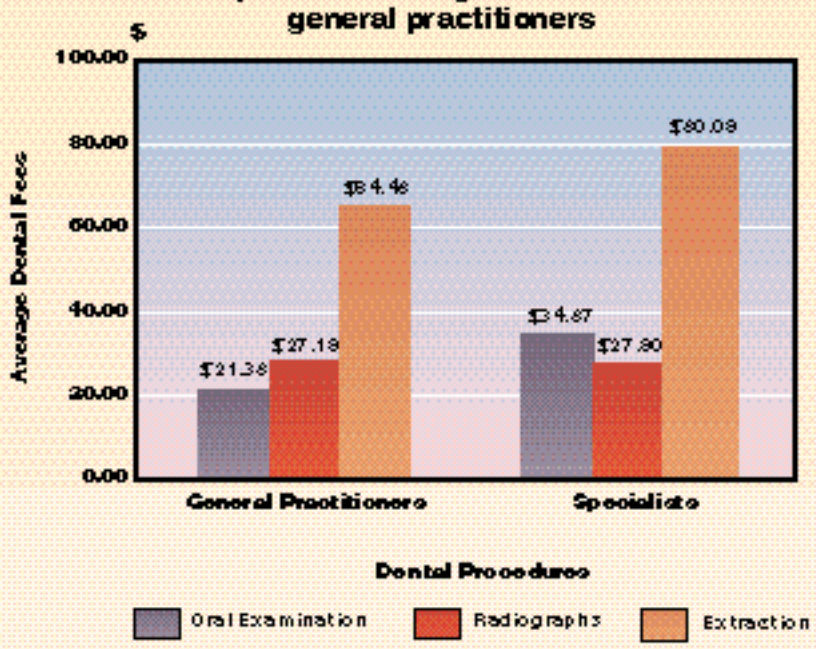
A look at the Medicaid system amply demonstrates many of the problems we see in the industry. In the late 1980s my state realized that it would soon be unable to pay for Medicaid, as its budget was growing faster than any other part of the state budget. The governor—to evaluate and suggest changes that would remedy this problem—formed a task force. We were given the premise that (a) there is a portion of our society that cannot afford health care and (b) those of us who can afford it have an obligation to provide it for them. This premise, whether you agree with it or not, is the basis of all government and public health care plans. Our task force came up with many recommendations that would have positively influenced the problems, but at the time either federal regulation or American Civil Liberties Union lawyers negated most if not all of the plans.

A few years later the Feds decided it made more sense to give the states a "block grant" (a lump sum of money less than what they had been getting) and let the states figure out how to provide the care. This proposal failed when they

See MY VIEW, facing page

Average fees

For three procedures, average fees received from uninsured patients were higher among specialists than general practitioners. When treating uninsured patients, the average fees received by specialists for oral examinations, radiographs and extractions were higher than those received by general practitioners.



Source: ADA Survey Center, 1998 2nd Quarter, Quarterly Survey of Dental Practice

Letters

Hardy fiber

Recently we have seen articles on biodegradability of various materials used around the house and office.

A friend of ours recently had to dig up his septic system after having his sewage back up in his house. The plumber had prepared him for a stopped up drain field but instead found a ball of fibers plugging up the opening into the pipes. What could it be? Careful tweezing found it to be short strings—yes, dental floss!

Folks, it is non-biodegradable! Warn your patients not to throw it into their sewer system!

Happy gums!

John H. Paxton, D.M.D.
Greenville, S.C.

Digital X-rays

I read with interest the excellent article by Stacie Crozier on the current status of dental imaging in the June 21 ADA News.

Two years ago I purchased a system that uses CCD technology involving pixels. In the 42 years I have been in practice (in a small rural town) about the only advances in dentistry I would rank ahead of this are the high-speed handpiece, bonded porcelain crowns and composite restorations.

This system has all the pluses noted in the article, but the most important plus is the enhanced quality of the image for diagnostic purposes: I consider it much better than

film.

Another very significant plus is the advantage of having the image available within a few seconds. And, if it is not what you need, or just want a change in angulation, you can just "pop" on it again. For the busy practitioner the time factor would be significant. I do not see how an endodontist could do without this type of system.

The only minus I would identify is the thickness of the sensor as a problem on some patients who are gaggers or who have a strong tongue thrust. However, there are changes in technique that can be learned to get around this. The sensors are black; white ones could be seen better. As far as cost, the more X-rays you normally take in your office the faster you will pay for the system. I see 90 percent of my patients in two rooms side by side and have it mounted on a cart between them in a recessed door area. The cables are 17 feet long so easily reach in either direction.

For referrals, I can send an image by e-mail to a specialist, and we can sit and talk about the situation over the phone while looking at the same image. The receiving computer does not have to have the digital X-ray system, only a normal e-mail program, the same as receiving photos.

I do business with probably 40 or more dental insurance companies, and I have yet to find one (or the clerk, who probably is the only one who reviews X-rays) who act like they have ever heard of digital X-rays or e-mail transmissions. This has not been a problem so far because they have always accepted a computer printout copy, sometimes even a

See LETTERS, facing page

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".

MyView

Continued from facing page

tried to freeze the funding and increase the services to be provided.

Our state has now decided the best approach is to cut the funding by 15 percent, give the remaining money to the providers in a defined area and let them figure out how to provide the services. The idea is to implement managed care, decrease services and save money. This is part of a "waiver project" in which the federal government is allowing certain states to experiment with ideas which will hopefully bring the budget under control.

In the past year the Feds have implemented the Children's Health Insurance Program or CHIP. This program, in many cases, merely increased the population being treated under an already under-funded plan by adding these children to the Medicaid roll.

On one hand the Medicaid program cannot adequately pay for the services it offers and on the other hand it is mandated to not only pay a reasonable reimbursement rate, but in dentistry's case, to see five times the patients dentists are presently seeing.

Further advancements in technology and pharmacology, the trend toward longer life spans and the shift in the population demographics will continue to stretch Medicaid's financial resources.

Currently, dentistry is involved in an effort to pass patient protection legislation. For today, it is the right thing to do. It should allow equal access to health care for all patients no matter what their insurance plans and it should have no or minimal financial impact, especially on dentistry. However, it will have no effect upon the problem of being able to provide unlimited care with limited resources.

Only a small portion of practicing dentists participates in the Medicaid program. This is understandable considering the problems that exist. Unfortunately this low participation rate and dentistry's diminutive program share (less than 0.5 percent of the budget) does not exclude the profession from the effects of the changes in the health care delivery system brought on by changes in the Medicaid system.

In dentistry, many of our procedures are elective and not covered by an insurance plan. This allows us a certain amount of freedom in the care we deliver. Under the premise that the "haves" must provide for the "have-nots" more and more procedures are being added to the list of covered benefits.

From one perspective, this is good in that it allows new technology to become integrated into the standard of care, but it also puts it on the list of services to be provided and therefore increases total cost to the program.

In the case of Medicaid, the procedure is added but the funding may not be increased, or it is added at a reimbursement rate that is below the doctor's overhead cost and the doctor has to provide even more services at an unreasonable fee. This makes the threat of proposals such as making participation in Medicaid-like programs a condition of licensure or a single payer for health care—that payer being the federal government—a very great concern.

From my perspective, we are walking a fine line. On one hand we must be involved in government and policy-making in order to protect our profession and our ability to deliver care to our patients. We must balance that against being forced into a system that mandates the dentist to provide more and more services with decreasing finances or a system that mandates what services we will provide and what we will be reimbursed. This can only invite more regulation and mandates.

If the other countries of the world are any example, we will eventually have to come to terms with how we will pay for health care and who will get what care. Whatever the outcome, I also believe we need to have a distinct and well-defined vision of where we want dentistry to go. Once that is accomplished we must, I have often been told, be careful what we ask for because we just might get it.

Dr. Rich is past-president of the Kentucky Dental Association. He has a general dental practice in Williamstown, Ky.

Letters

Continued from facing page

faxed copy, either of which are not of diagnostic quality.

From an economic standpoint I will probably retire before the system pays for itself, but after seeing it, this was something I could not do without. This is very uncharacteristic of me, in that I am very conservative and usually am the last one in my area to try something new.

It is obvious I am very high on this digital dental imaging, and particularly on my system. I would be happy to correspond further with anyone interested, through my e-mail address ("loydcmp.@cei.net"). I could transmit a sampling of my digital X-rays; they would be identical to how they come up on my computer.

Marvin D. Loyd, D.D.S.
Lake Village, Ark.

Editor's note: Besides that advantages that Dr. Loyd cites, digital radiography also reduces radiation exposure significantly. Although exposure reductions will vary between units and techniques, a typical reduction is between 50 to 70 percent.

Dosage primer

You printed a letter ("Mercury vs. Amalgam," June 21 ADA News) [from David Hensley, D.D.S., Fife, Wash.] which referred to Dr. Elizabeth's Ward's "Amalgam Wars Revisited" opinion piece in the May 21 ADA News.

One would expect that someone with a scientific education should be familiar with the essential principle of pharmacology: only the dose makes the poison.

Mercury, in the dosage form of methyl mercury, a small amount of which you get in a

See LETTERS, page nine

Government

FTC targets Internet quackery

Agency promotes 'reliable' health care information sites

By Craig Palmer

Washington—The Federal Trade Commission June 24 announced a crackdown on "deceptive and unsubstantiated" health claims on the Internet, directing consumers to selected government Web sites offering "quality" health information.

"Quality, not quackery, is the focus of our new campaign, Operation Cure.All," said Jodie Bernstein, director of the FTC bureau of consumer protection.

One Web site "http://www.healthfinder.gov", recommended at an FTC news conference as "the federal gateway for reliable (health-related) information," offers extensive oral health references including chapter-by-chapter descriptions and a timetable for the first Surgeon General's Report on Oral Health expected early next year.

The "healthfinder" Web site, which appears under a bright shiny red apple, produces referrals to ADA ONLINE among 33 Web resources and 24 organizations in response to an "oral health" search request. "Dental" and "dental health" searches produce other Web resources and organizations.

"It (the 'healthfinder' Web site) provides specific resources to educate people about fraud and quackery and how to find and evaluate information on the Web," said U.S. Surgeon General David Satcher, M.D., whose name will appear on the first Surgeon General's Report on Oral Health.

The Food and Drug Administration Web site at "http://www.fda.gov" was offered as "another valuable source of accurate and unbiased information" on clinical investigations, lasers, latex, temporomandibular joint and other medical/dental devices.

■ Operation Cure.All uses the Internet as a law enforcement tool to deter bogus claims for products and treatments as well as a communication tool to provide consumers with good quality health information, FTC officials said.

The law enforcement side of the dual-purpose Operation Cure.All has focused on Internet products or services purporting to help, cure, treat or prevent heart disease, cancer, HIV/AIDS, diabetes, arthritis and multiple sclerosis.

Operation Cure.All uses the Internet as a law enforcement tool to deter bogus claims for products and treatments as well as a communication tool to provide consumers with good quality health information, FTC officials said.

The FTC said four companies settled charges that the four Web sites made deceptive and unsubstantiated health claims for products advertised on the Internet.

Two "Health Claims Surf Days" conducted by FTC investigators with agencies from several states and 25 countries identified some 800 World Wide Web sites and "numerous" Usenet newsgroups containing questionable promotions, the agency said.

More than 100 sites were alerted by the FTC, by e-mail, that their Web sites could be making

See FTC, page 11

Letters

Continued from page five

can of tuna fish, is highly poisonous. Mercury, in the dosage form found in properly made amalgam, is not.

Marvin J. Schissel, D.D.S.
Woodhaven, N.Y.

Editor's note: Dr. Hensley's name was left off his letter to the editor through a proofreading error.

Try science

As I read through the responses and the continued debate I am struck by the fact that dentists, supposed men and women of science, consistently refer to amalgam restorations by their most volatile and controversial component.

What could possibly be the motivation for this? Wielding the word "mercury" like a club, they consistently point to the fact they wouldn't want "mercury" in their mouths, and are at a loss to understand why any one else would feel differently.

Unless I have missed some important research, there isn't anything that has definitively offered proof that amalgam restorations are unsafe.

The more current claim is that they promote cracking and fracturing of teeth and are subject to recurrent decay.

Is the implication here that if resins, and other bonded restorations were used as widely as amalgam has been up to this point, cracked, fractured teeth and recurrent decay would cease to be? I'll believe this when I see it.

It is my feeling that the main reason for the continued "debate" on this issue is not about each practitioner's freedom to choose and use the materials he or she feels most comfortable with; rather, it is more about the "anti-amalgamists" implication that those who disagree are doing something wrong.

Personally, I couldn't care less what you do in your office. It should have no bearing upon me or my practice.

The present problem is that the pro-active approach adopted by many anti-amalgamists is having an impact on those who feel and practice differently.

Lastly, if those so deathly afraid of "mercury" will take a moment to read over the material safety data sheets packaged with each product they use in their office, they will find most contain some component that would be a danger to life and limb if a patient was exposed to a high dosage.

Does this mean we should abandon all materials that have a "dangerous" component? If so we will be left to do our dentistry with very few choices of available materials.

Anthony E. Badalamenti, D.D.S.
West Islip, N.Y.

Sargenti debate

Sadly, I noted the passing of an old acquaintance, Dr. Angelo Sargenti, in Switzerland recently. He developed the "Sargenti endodontic technique."

For all of the controversy surrounding "N2," some benign, some downright nasty, Dr. Sargenti made a major contribution in getting the dental profession to think "save teeth" instead of "extract teeth."

His technique made endodontic treatment plausible for the average dentist.

When the technique was practiced precisely as Dr. Sargenti had taught, it worked very well.

The biggest problem arose when thousands of American dentists took a one day course, now having considered it a "miracle" treatment, and applied it with every degree of skill, including the lowest.

The debate between the board-certified endodontists and those practicing "N2" was a black eye for American dentistry.

Both parties, through discussion, negotiation and reconciliation, could have developed something great—for that point in our dental history.

Victor J. Nitti, D.M.D.
Washington Township, N.J.

Ergonomics issue headed for showdown

By Craig Palmer

Washington—Congress and the White House moved toward confrontation June 23 over federal ergonomics regulations aimed at reducing workplace repetitive stress injury.

The Occupational Safety and Health Administration announced plans earlier this year to issue a new standard that could reach dental offices and many other workplaces in the year 2000. The standard would not cover agricultural, construction or maritime industries.

The business community, which opposes ergonomics regulations, won a key vote in Congress June 23.

The House Education and the Workforce Committee cleared a bill sponsored by Rep. Roy Blunt (R-Mo.), HR 987, to bar OSHA from promulgating new ergonomic standards in the workplace until the National Academy of Sciences has completed a second study of the issue.

The 23-18 committee vote followed party lines. Only one Republican joined Democrats opposing the legislation, which is certain to face a White House veto if it clears Congress. Sen. Kit Bond (R-Mo.) has offered a companion measure, S 1070.

■ Battle lines are forming along political party lines, Republicans arguing that science does not warrant sufficiently new government regulations and Democrats contending such regulations are long overdue.

Labor Secretary Alexis M. Herman said she would recommend a veto if the legislation succeeds. "If Congress passes this bill, I will urge the president to veto it. The scientific and medical experts agree. Biomechanical stress at work causes injury. Even more important, we know how to reduce these stresses and cut the risk of injury. We cannot afford to delay any longer."

Government

Organized labor and other proponents of ergonomics regulations are urging OSHA, a Labor Department agency, to act immediately to reduce occupational repetitive-stress injuries rather than awaiting an NAS literature review expected in 2001. OSHA released a draft version of proposed rules earlier this year, estimating a $3.5 billion implementation cost with a $4 benefit for each dollar invested in regulations and enforcement.

A regulatory review panel, based on testimony from small business representatives including a Michigan dentist, urged OSHA May 3 to evaluate the impact of ergonomics rules on dental practices and other small businesses before issuing a final rule. Dr. Connie Verhagen, a Muskegon, Mich., dentist and member of the ADA Council on Scientific Affairs, said employers would incur substantial costs "simply to understand the standard."

Battle lines are forming along political party lines, Republicans arguing that science does not warrant sufficiently new government regulations and Democrats contending such regulations are long overdue. ■

Sen. Bond: Offered companion bill in Senate.

FTC

Continued from page six

questionable claims subsequently made changes—removing the claims or taking down the Web site—that "cleaned up their act," said FTC's consumer protection chief. She said the FTC would continue to monitor the Web for fraud and deception and bring law enforcement cases as appropriate.

Five products involved in the FTC complaints claim to cure, prevent or treat 30 diseases and health conditions or symptoms associated with them:

Arthritis, autoimmune illness, bedsores, benign prostrate hyperplasia, bursitis, cancer, cardiac arrhythmia, carpal tunnel syndrome, circulatory disease, chronic back pain, chronic bronchitis, diabetic neuropathy, diarrhea, degenerative joint conditions, dysentery, emphysema, gallbladder stones, heart disease, HIV/AIDS, hypertension, hypotension, kidney stones, lupus, multiple sclerosis, neurodegenerative disease, osteoarthritis, rheumatoid arthritis, sciatica, silicone breast disease and urinary ulcers. ■

Law

Supreme Court rules on job-bias case

By James Berry

In a case involving a former ADA employee, the U.S. Supreme Court ruled June 22 that workers who claim job discrimination cannot collect extra damages to punish employers if the employers can show they've made a good-faith effort to comply with federal civil rights laws.

In a 5-4 vote on Kolstad vs. the American Dental Association, the justices said employers could not be forced to pay the extra damages for the misconduct of managers if the employer has acted in good faith to comply with the law.

"This means that very few employers will be forced to pay punitive damages because most will have a written anti-discrimination policy in place," said Peter M. Sfikas, ADA general counsel.

"If you have such a written policy, it's not likely that you will be held liable for a manager's sexual misconduct or discrimination," he said. "Employers who don't have such policies will be encouraged to establish them."

In a separate 7-2 decision on the same case, the Supreme Court set aside a lower court ruling that required employees to prove their employers were guilty of "egregious" violations of the law to collect punitive damages.

The decision returns the case to the lower court, the U.S. District Court for the District of Columbia, which will be asked to reconsider whether plaintiff Carole Kolstad is entitled to extra damages.

Ms. Kolstad, an attorney, joined the Association's Washington Office staff in 1988 after six years with the Department of Defense.

In late 1992, retirement created a staff vacancy for the dual post of director, Legislation and Legislative Policy, and director, Council on Governmental Affairs and Federal Dental Services (since renamed the Council on Government Affairs).

Ms. Kolstad and a male colleague, also a lawyer, applied for the job, which would qualify as a promotion for either candidate.

The male employee got the job, prompting Ms. Kolstad to allege that he had been "preselected" for the post by two male supervisors who are no longer with the Association.

Ms. Kolstad sued the ADA in 1994 claiming she had been passed over for the promotion on the basis of sex discrimination. A jury in the trial court found in her favor and awarded her $52,718 in back pay.

But the trial court judge barred the jurors from considering punitive damages against the ADA, spurring Ms. Kolstad's appeal.

A divided three-judge panel of the U.S. District Court of Appeals for the District of Columbia found that the trial judge had erred when he refused to let the jury consider punitive damages.

The Association appealed that decision, causing the full appeals court to rehear the case. The full court ruled 6-5 that Ms. Kolstad had failed to present sufficient evidence to support an award of punitive damages.

The appeals court said such damages are allowed in job-bias cases only when "egregious conduct" is proved—a requirement the Supreme Court has now lifted. The court now requires an intent to violate federal law in order for the issue of punitive damages to go to a jury.

Mr. Sfikas said the high court's decision that employers who have acted in good faith should not pay extra damages for an employee's misconduct was consistent with the common law on punitive damages.

"Under the common law," he said, "you have to show that the company or organization itself was involved in discrimination, not just an employee of the company."

Under a 1991 amendment to the Civil Rights Act of 1964, combined awards for compensatory and punitive damages are capped at $50,000 to $300,000, depending on an organization's size. ■

Correction

On page 17 of the June 21 ADA News, Dr. Kimberly McFarland is shown seated at the head of the table at a meeting of the National Fluoridation Advisory Committee. She was misidentified in the original caption.

Annual Session

Get ready to synthesize

‘Dream or reality’? Find out at Tech Day

Honolulu—Imtiaz Manji compares the aethestic value of dentistry to the value of art. It’s intangible.

But if the value of dentistry can be made known to your chairside patients, he says, like the favorable effect of a painting upon an observer, what can result is a “new patient experience” that can benefit your practice and, most importantly, your patients.

Learn more about Mr. Manji’s approach and other fascinating ways to harness the power of technology when you attend this year’s annual session’s “Tech Day II: Taking Another Byte Out of Technology,” Oct. 8 from 8 a.m.-4:30 p.m.

Tech Day ’98: Mr. Manji addresses a standing-room-only crowd in San Francisco.

Developed by the ADA’s Dental Information Technology Committee and Council on ADA Sessions and International Programs, the program features more than 20 presentations, small group discussions, question-and-answer sessions, hands-on demonstrations and technology exhibits.

Practice consultant Mr. Manji’s “Dream or Reality,” which closes the day-long program, will synthesize the day’s preceding presentations and show how to integrate them into your practice. He says his presentation is designed to “put all the presentations together in the right context.”

Dental technology has changed dramatically in the last decade; cameras have replaced mirrors; digital imaging has replaced film; ultrasound has replaced scalers; and Web sites are replacing brochures, says Mr. Manji, reciting some of dentistry’s recent technological advances.

Mr. Manji says it’s important that attendees at Tech Day II come away from the program with a technology plan that can be applied to their own practices.

“I want attendees to be empowered by technology,” says Mr. Manji. “I want them to have, like their patients, a new experience.”

To register online or for more information, visit ADA ONLINE, the Association’s Web page, at “http://www.ada.org/session” or pick-up a copy of the April 19 ADA News or the July JADA.

Tickets cost is $245 for dentists (RC1) and $150 for staff (RC1A).

Attendance is limited, so plan your schedule early. ■

Alliance readies special event

Honolulu—The Alliance to the American Dental Association is offering “Breakfast at Neiman Marcus,” a before-store hours fashion show at Neiman Marcus department store Oct. 9 from 9:30-10:30 a.m.

The fashion show will feature “the best of Neiman Marcus,” informal modeling of easy-dressing, island chic apparel from the store’s most important designers of the season.

Store and event location is the Ala Moana Shopping Center.

Ticket cost is $25. Because of limited seating, only the first 150 reservations can be accommodated.

To make reservations, call the Alliance Central Office at the ADA’s toll-free number, Ext. 2865. ■

Annual Session

Health screening to include HCV test

For the first time since 1992 dentists can receive a screening for antibodies to the hepatitis C virus at the ADA annual session in Hawaii.

The ADA Health Foundation's Health Screening Program also will offer a variety of other screenings such as electrocardiagram; blood pressure and weight; head, neck and oral examination; hepatitis B markers; latex hypersensitivity screening; urinary mercury analysis; carpal tunnel screening; and blood chemistry including total cholesterol and high- and low-density lipoproteins.

The screenings will be administered free of charge.

ADA Executive Director John S. Zapp says the HSP is a "cost-efficient, accessible and user-friendly way for dentists to check their personal health and serve the profession by augmenting its database on critical issues in dentistry, such as HCV."

He also adds that "individual dentists have been well served by the HSP through early detection of oral cancers, cardiac disease and latex allergies."

The ADA Health Foundation's data base was broadened to include the entire dental team. Latex hypersensitivity, confidential hepatitis B and C screens will be available to dental assistants and dental hygienists who attend this year's meeting.

The HIV screening, previously offered at concurrent annual sessions, will be offered every three years beginning in 2002.

According to Dr. Dan Meyer, associate executive director, ADA Division of Science, HSP has screened more than 18,000 dentists for HIV antibodies since 1987. Since that time only two have tested positive for antibodies to the virus.

He says that HSP data indicates that HIV infection rates in the profession remain exceedingly low because of the low infectivity of the virus and the effectiveness of infection control procedures in further reducing the transmission risk.

At annual session in 1992, the hepatitis C screening was offered to only some of the attendees, he explains, because the assessment was a preliminary investigation to assess the risk of dentists occupationally acquiring the disease.

According to a national survey, Dr. Meyer says, "the prevalence of HCV infection in the general population is about 1.8 percent, corresponding to an estimated 3.9 million Americans infected with HCV and resulting in a large reservoir of chronically infected persons who are potentially infectious to others."

Chet Siew, Ph.D., director of the ADA's Department of Toxicology, Division of Science, says that HCV is a bloodborne pathogen that was first identified in the late 1980s.

The pilot study conducted in the early 1990s indicated that HCV rates among general dentists were comparable to those of the general population.

"Dentists appear to show no increased risk of HCV infection through the practice of dentistry providing appropriate infection control procedures are followed," he states.

The HCV screening, offered by ADA Health Foundation scientists in conjunction with the ADA Research Institute and Division of the Science staff, requires that participants allow a blood sample to be taken and complete an occupational and personal behavior risk assessment questionnaire.

Information obtained from this year's and subsequent Health Screening Program testing will help investigators to confirm earlier pilot study results and to develop prevention strategies to further lower the risk of exposure to HCV infection among dental practitioners ■

HSP marks 35th year of service

By Clayton Luz

The ADA Health Foundation Health Screening Program celebrates a Jade Anniversary this year.

For the 35th year at annual session, the program will offer registered attendees more than eight major types of screenings designed to monitor their oral and systemic health.

Dr. John S. Zapp, ADA executive director, says that "The ADAHF Health Screening Program continues to provide great value for America's dentists and the public."

As it has in the past, the ADAHF Health Screening Program received invaluable corporate support. Twenty-three corporations this year helped the foundation to defray costs associated with equipment, materials, supplies, promotion and program rental space.

Dr. Dan Meyer, associate executive director, ADA Division of Science, says the health screening program was started because dentists, generally, are self-employed or practice independently and "do not necessarily take time away from their busy schedules to properly assess their own health needs."

The Health Screening Program is administered by the ADA Health Foundation, which addresses the national need for accelerated dental research, education and patient-care project support to enhance clinical dentistry for the benefit of the public.

The following supporters contributed financially to the HSP: American Dental Supply, Inc.; Block Drug Company, Inc.; Brassler USA, Inc.; Church & Dwight Company, Inc.; Colgate-Palmolive Company; Equitable Life Assurance Society; Heraeus Kulzer, Inc.; Hu-Friedy Manufacturing Company; John O. Butler; KaVo America Corporation; Macan Engineering & Manufacturing; Optiva Corporation; Patterson Dental Supply; Personal Products Company; Procter & Gamble Company; Porter Instrument Company, Inc.; Smart Practice; SmithKline Beecham; Sullivan–Schein Dental; Teledyne Water Pik; Unilever Home & Personal Care USA; Warner-Lambert Company; Warner-Lambert Foundation; Zila, Inc.

The following supporters contributed products and materials to the HSP: American Dental Association, Division of Science; Becton-Dickinson; Cheng & Associates Inc.; Colin Medical; Orlando Fla. Department of Veterans Affairs; Johnson & Johnson Personal Care; Johnson & Johnson Medical Inc.; Kendall Healthcare Products Company; Patterson Dental Company; SmartPractice; Tillotson Healthcare Corp.; and Welch Allyn

Budget

Continued from page one

lion expenditure for DR.

ADA President-elect Richard F. Mascola said the Board carefully scrutinized programs. "There were things we needed to eliminate to balance the budget, and the dues increase is directly linked to programs we thought the membership should have. We felt it was inappropriate to take money from reserves that should be used for other purposes," he said.

Dr. Mascola said the Board expected that a resolution to continue the DR program will go to the House this year, which if adopted could mean retention of the $25 dues increase originally adopted for the DR campaign in 1997.

Any other programs with a cost attached to them would also add to the dues total for 2000.

"Until we increase the revenue from our for-profit companies and begin to generate more outside income, we will rely on dues to fund programs for the membership," Dr. Mascola said. "My goal would be to generate enough income from our for-profits to equal the money we take in dues. If we could do that, we would eliminate or reduce significantly dues increases."

Dr. John S. Zapp, ADA executive director, noted that the for-profit entities of the Association actually increased their profitability last year.

"Indications are that this trend will continue," said Dr. Zapp. "However, as the overall budget grows, all sources of revenue must grow just to keep pace. The annual increased cost of operating our Association is more than $1.5 million—and that's just to operate at the same level as the previous year."

ADA Holding Co. oversees the Association's for-profit subsidiaries: ADA Financial Services Co., ADA Electronic Commerce Co., ADA Publishing Co.

The 2000 budget proposal covers some 2,000 pages and includes 400 requests for funding. Explained Dr. Rene Rosas, ADA treasurer, "The budget is a long, arduous complicated process. It starts in January with middle and upper management developing their budgets in preparation for administrative review in March. The administrative review committee was presented with a $5.3 million deficit at its first meeting."

Dr. Mascola: Effort made to bring more people into the budget process.

The Administrative Review Committee, which traditionally consisted of the president-elect, treasurer and executive director, was expanded this year to include the four ADA trustees who make up the Board's Finance Committee.

"We made the change because the budget has always been an enigma for everybody who works on it," said Dr. Mascola, who promoted the committees' merging. "The trustees on the finance committee will eventually serve a four-year term on the committee and will become expert in the budget."

Having more eyes on the budget process from the start allowed for more in-depth analysis of the budget by the Board, said Dr. Rosas. "The Board in June reviewed the budget as presented by the expanded Administrative Review Committee and the Board restored what it considered vital and important programs for the membership," he said. "That gave us the $1.4 million deficit and resulted in the vote to present the House with a proposal to increase dues by $14."

While it's not included in this year's budget proposal, Dr. Rosas said a major issue dangling for next year is the proposal to renovate Association-occupied space in the Chicago headquarters building.

Last year, the House deferred until the year 2000 action on a proposal to renovate the space, calling for further study. "I think one of our top priorities should be to keep the Chicago building marketable and current so that we can develop increased revenues through leasing of office space."

When the House convenes Oct. 9-13 in Hawaii, delegates will not only consider the Board's budget proposal with its $14 dues increase, but any number of resolutions from the states that could have financial implications. ■

Marketplace

Unionization

A look at the AMA's vote and its implications for dentistry

By James Berry

The American Medical Association's decision to form a national collective bargaining unit (read: union) raises a number of questions for dentistry, some of them bound to make their way to the ADA's House of Delegates this fall.

- Would development of a labor organization have any value for dentistry?
- What's the ADA's policy on unions?
- Could dentistry get caught up in something that started in medicine and spread to the other health professions?
- What motivated the AMA's House of Delegates to support formation of a national labor organization?
- Without the right to strike, how effectively can any labor union negotiate?
- And why is the ADA, like the AMA, supporting a bill in Congress that would relax antitrust regulations and allow self-employed professionals to engage in collective bargaining?

Illustration by Ted Wright

A dental benefit?

The June 23 vote of the AMA House acknowledged that increasing numbers of physicians are employees—part of the nation's labor force—rather than independent practitioners. Under existing antitrust laws, only those who qualify as nonsupervisory employees can unionize for collective bargaining.

Of the roughly 620,000 "patient care physicians" in the United States in 1998, 26.6 percent, or about 135,000, qualified as "institutional employees," says the AMA, adding that a lesser number, about 108,000 or 17 percent, could be served by a union.

"This is not for all physicians," notes AMA President-elect Randolph D. Smoak Jr., M.D. "This will not be a traditional labor union."

For dentistry, most agree a labor organization would have far less impact because so few dentists qualify as true employees under current law. The ADA Survey Center reports that less than 6 percent of all U.S. dentists, about 8,000 practitioners, are employees.

But even those figures may be inflated in terms of who would qualify for union representation, says ADA General Counsel Peter M. Sfikas. He adds, "You may be technically an employee, a dental practice associate, for example. But suppose you supervise a dental assistant or hygienist. That could make you a supervisor—management—under the law, and disqualify you as a beneficiary of labor negotiation."

In a statement to constituent dental societies, the ADA noted that "unlike physicians, very few dentists would qualify under current law to negotiate collectively, because the overwhelming majority of dentists are independent practitioners, not employees."

"Unlike physicians, very few dentists would qualify under current law to negotiate collectively, because the overwhelming majority of dentists are independent practitioners, not employees."

Current policies

The 1973 ADA House of Delegates adopted a policy that essentially opposes unions on professional and legal grounds, while acknowledging that the ADA and affiliated organizations "must work harder than ever before to be sensitive to the legitimate self-interest of dentists and to represent that view accurately in public forums."

Much has changed in the dental marketplace since 1973, when managed care was distant thunder. Resolutions adopted by the ADA House since the mid-'70s have aimed squarely at relaxing antitrust laws and regulations—without touching directly on the topic of unionization.

These House-adopted measures call for antitrust reforms that would, among other changes, allow networks of dentists to negotiate with health care purchasers; tighten regulation of insurance companies; limit Federal Trade Commission jurisdiction over professional associations; and repeal the McCarran-Ferguson Act, which bestows a degree of antitrust immunity on insurance carriers.

Such policies reflect dentistry's growing frustration with a system that appears to favor coverage providers over care providers. ADA

President-elect Richard F. Mascola gave voice to that frustration last year in a stunning statement to the ADA House.

"I believe in managed care," Dr. Mascola told the delegates, "that is, dental care that is managed by the dentist in consultation with the patient and without intrusion from government, insurance companies or any entity that would intrude on the sanctity of the doctor-patient relationship."

More recently, in the Queens County (New York) Dental Society Bulletin, Dr. Mascola renewed his pledge to "devote as much energy as possible in working to preserve the autonomy of the dental profession."

In related action, the Association has been pushing for both administrative and legislative reforms to the Employee Retirement Income Security Act.

The act gives the Department of Labor federal jurisdiction over self-funded employer health plans. To allow multistate companies to offer uniform benefits, the law preempts state regulation of self-insured plans.

Since ERISA was adopted in 1974, employer-provided health plans have expanded dramatically, boosting their impact on the health care marketplace. For a variety of reasons, employers have been moving to self-funded plans rather than purchasing insurance policies.

Today, about 40 percent of workers—some 50 million Americans—with employer-provided benefits are under self-funded plans, beyond the protections of state standards.

The ADA has been urging "vigorous enforcement" of ERISA regulations to give ERISA enrollees the same protections afforded subscribers of state-regulated insurance plans.

ADA President S. Timothy Rose told the Department of Labor Feb. 19 that dentistry favors ERISA administrative reforms that would give patients more information on how dental claims are handled and faster responses to claims denied.

The Association also supports legislative reforms that would protect both patients and providers under ERISA-regulated plans. Such reforms would ensure the rights of patients to choose their own doctor, make the plans more accountable for their funding decisions and provide an appeals process when claims are denied.

Snagged in a medical model?

Since the AMA vote on unionization, some in dentistry have expressed concerns that the dental profession could get caught up in a medicine-centered movement.

Shortly after the AMA vote, the Washington State Dental Association issued a news release with a headline insisting: "Dentists not affected by AMA union vote."

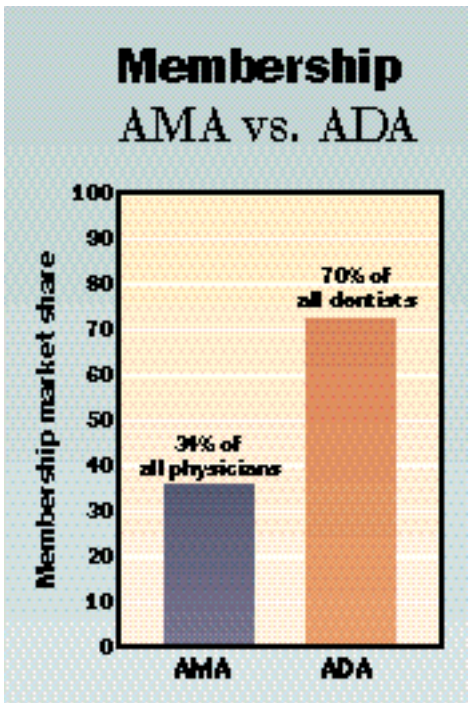
The release notes that WSDA's 3,000 member dentists are "overwhelmingly independent practicing professionals" who are "dedicated to providing the best patient care at the most personal level."

The words suggest that collective bargaining would threaten the independence, professionalism and personal touches associated with dentistry and dental care delivery.

"We did not want the public or the news media to believe that dentists can't be far behind" on unionization, said WSDA Executive Director Stephen Hardymon, when asked what prompted the news release.

He added, "ADA has done a good job in Washington separating the dental profession from the medical profession through [the campaign with the slogan] 'Dentistry: Health Care That Works.'"

But he and some others are much less enthusiastic about the Association's support of a bill now before Congress that would relax the antitrust laws and allow self-employed health professionals to negotiate contracts collectively with health plans.



The Campbell bill

Introduced by Rep. Tom Campbell, a California Republican, the proposed Quality Health Care Coalition Act (HR 1304) is part of a widening campaign to level the playing field between health professionals on one side and health plans, including managed care organizations, on the other.

WSDA's Mr. Hardymon says the ADA's support of the bill is misplaced. "Managed care is not a reality in dentistry—certainly not out here," he insists, arguing that medical doctors are "giving up professionalism, their right to be professionals" through their support of unionization and the Campbell bill.

Liz Snow, legislative specialist with the California Dental Association, says CDA officially supports the ADA's position on HR 1304, though she's heard rumblings of concern about the measure.

"Yes, there are some concerns, but there has been no change in our position," she says.

In a news release issued in March, shortly after the Campbell bill was introduced, ADA President Rose explained the Association's support of the measure.

"The century-old antitrust laws were written to protect consumers from powerful corporate monopolies," he said. "But the prevailing interpretation of these laws has the unintended effect of placing dentists and other health care providers in an unfair disadvantage when negotiating contracts with health plans."

Under current federal and state antitrust laws, noted Dr. Rose, dentists exchanging information about their fees, "even to help them negotiate

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Marketplace

Unionization

Continued from page 19

with powerful health care corporations," risk prosecution, fines and even imprisonment.

The Campbell bill would "promote fair competition by allowing dentists and other health professionals to collectively negotiate fees and other contract provisions with health plans," said the ADA president, adding that the bill has nothing to do with unions, strikes or boycotts.

"This is about the ability of doctors to present a unified front and negotiate from greater strength on behalf of our patients," he said. "Lifting the threat of antitrust violations will allow these doctors to advocate better health plans that promote patient-doctor communication, appropriate treatment protocols, decision-making by appropriately trained personnel, prompt and fair reimbursement for patients and doctors, and fair and timely adjudication processes when disputes arise over whether plans will cover patient care."

ADA officials also note that support of the Campbell bill is consistent with antitrust reform measures adopted by the House since the mid-'70s.

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ADA Executive Director John S. Zapp described the Campbell bill as "the epitome for a professional organization."

He added, "With passage, the bill would grant us parity with those who are paying for the services that we provide for our patients."

In what may be a harbinger of things to come, Texas Gov. George W. Bush June 22 signed the first state law granting health professionals the right to jointly negotiate fees and terms of health plan contracts.

Backed by the ADA and the Texas Dental Association, this state-level facsimile of the Campbell bill will take effect Sept. 1 at the earliest.

AMA's motivation

In voting to establish a collective bargaining unit, the AMA's stated goal was to unite physicians as a countervailing force against powerful managed care organizations, hospital networks and others.

"Our objective here," says AMA President-elect Smoak, "is to give America's physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits."

The 152-year-old, Chicago-based AMA represents about 34 percent of all U.S. physicians (291,000 doctors), down from 45 percent a decade ago. In contrast, the ADA represents about 70 percent of U.S. dentists.

The AMA's membership retention has been harmed by recent events, including the ill-fated Sunbeam product endorsement deal in 1997 and January's very public firing of George D. Lundberg, M.D., after 17 years as editor of The Journal of the American Medical Association.

In its support of collective bargaining, was the AMA House at least partly motivated by a desire to truncate the bleeding in the physician group's membership rolls?

No, insists Dr. Smoak. "This decision was not based on membership issues, though certainly we hope that the people who participate will see fit to be members of the American Medical Association," he says.

Where's the leverage?

Dr. Smoak said a "common thread" linking AMA delegates on both sides of the debate over a labor organization was their shared opposition to strikes and boycotts as bargaining chips.

Without the right to strike, then, what leverage would the AMA's collective bargaining unit have in negotiating with employers?

"We will have meaningful clout in any market by virtue of our sheer numbers," says Dr. Smoak, a general surgeon from Orangeburg, S.C. He says, too, that patients will be educated and enlisted as an "added voice" in negotiations with managed care groups, insurance carriers, hospitals and others.

What's more, he says, the AMA's labor organization will encourage certain "harassment techniques"—delaying the submission of records, for example—that will "slow down the process without interfering with patient care."

ADA House

It's too soon to tell how these developments in medicine will affect deliberations in the ADA House when it convenes in October.

It's not unfathomable that the House could see a resolution or two calling for the ADA to investigate the merits of a labor organization for dentistry.

On the other hand, there could be measures asking the Association to renounce any connection with the medical profession's fledgling union movement.

Again, it's too soon to tell. More about this later. ■

Going beyond introductions

FINCO offers low-rate credit card, other benefits

By Karen Fox

A new lower credit card rate that competes with the lowest rates in the marketplace is just the first of many benefits resulting from the new ADA Financial Services Co. partnership with Citigroup. FINCO officials say there's plenty more to come.

In April, Citigroup purchased the credit card and unsecured credit line portfolios fromMellon Bank Corp., which was the ADA 1 PLAN's financial products provider since 1995. FINCO will now manage all ADA 1 PLAN products with multiple providers, and FINCO officials say the early effects of this new product management strategy are indications of a prosperous future.

"Now we have more choice in the products we can offer our members," says Susan Moseley, FINCO's new chief operating officer. "We can now go out to a broad marketplace and determine which product is best for our members, which benefits members because it allows us to be more competitive in obtaining the best product at the best price."

"There is a management challenge for FINCO, moving away from managing a single provider of multiple products to managing multiple providers," she says. "There are some inherent changes in the way that we will now have to manage the business."

Under the new multiple provider arrangement, FINCO secured a contract with Citigroup to manage its credit card products and entered into negotiations with two other product providers: The Matsco Companies, an Emeryville, Calif.-based company that specializes in practice financing for dentists and takes a consultative approach in working with clients; and Paymentech Merchant Services, headquartered in Dallas, the nation's third largest credit card processing provider.

"While it's a period of transition, it should be a seamless one for ADA 1 PLAN members," says Dr. John S. Zapp, ADA executive director and chairman of the FINCO board of directors. "The changes affecting customers will be positive, such as new credit card features."

Maintaining continuity for ADA 1 PLAN members will not be difficult, according to Ms. Moseley. For instance, FINCO will continue to market financial services and products under the ADA 1 PLAN brand name that was originally developed by Mellon Bank; ADA 1 PLAN members' TravelReturns points are not affected; and the toll-free customer service line for ADA 1 PLAN members will remain the same.

Another example is the enhanced working relationships with Matsco and Paymentech. Matsco's products include practice acquisition and new practice financing, equipment leasing, and commercial real estate and business loan consolidation. Paymentech provides a low discount rate of 1.89 percent for electronic card swipe transactions and a wide selection of processing equipment.

■ "We can now go out to a broad marketplace and determine which product is best for our members, which benefits members because it allows us to be more competitive in obtaining the best product at the best price."

Now Matsco and Paymentech are able to work directly with the ADA to share ideas about assisting dentists who are establishing practices, making practice changes or seeking improved business tools to assist patients and staff.

"What is important about us working directly with Matsco and Paymentech now is that we're able to bring a real practice-focused product to ADA members," says Ms. Moseley.

Spurred by the new direct relationship with the ADA, Matsco is developing a young dental advocate program to assist ADA 1 PLAN members who are interested in purchasing dental practices. The idea is based on the role of brokers who assist professionals in practice sales. However brokers represent sellers, which often leaves the buyer without protective financial advocacy.

"Matsco's program will assist buyers who lack adequate representation by connecting them with brokers who can show them all the pitfalls ahead," explains Ms. Moseley.

"Matsco offers services dentists need for their professional lives, and what they need to find

financing for their practice," she says. "And we endorse that.

"What's changed is that we are modifying our product," says Ms. Moseley. "There will be other marketing programs that are new, but there is no impact on customer service."

The Citigroup credit card offers new account holders an introductory annual percentage rate of 3.9 percent and a fixed rate of 9.9 percent

"As everyone can tell by opening their mailbox, the credit card arena is very competitive," she says. "We believe the card endorsed by the ADA adds value and relevance to our members because it offers a great rate.

"If earning free or discounted air travel is more important to you, the TravelReturns program is very competitive," says Ms. Moseley.

"Our feeling is that it surpasses most airline programs because you can fly on any airline, there are no blackout dates and no cap on the number of points you can earn. And these products are available to all members regardless of their state-endorsed credit card program."

Citigroup's sophisticated Internet presence with online banking services is one of the ADA 1 PLAN's enhancements. Citigroup and FINCO are currently developing a Web site specifically for ADA 1 PLAN members.

FINCO expects to launch the new Citigroup credit card by October. Ms. Moseley describes this process as a "soft" launch, meaning FINCO will not reissue new credit cards to all members immediately. Rather as cards are due for reissue, members will receive an ADA/Citigroup card, and new customers who apply (when the new card is launched) will

CITIGROUP FACTS

- Citigroup is considered the world's premier financial services company, offering consumer and private banking, investments, insurance and asset management.
- $850 billion in assets;
- 100 million customers in 100 countries;
- Citigroup is the No. 1 credit card issuer in the world;
- Citigroup's niche as a credit card issuer is managing smaller affinity programs like the American Dental Association's ADA 1 PLAN. Other affinity groups currently managed by Citigroup include: American Bar Association, Salomon Smith Barney, the Humane Society of the United States and Quicken. ■

Oral health messages promoted

London—"Core Messages in Oral Health Education" is the theme of the FDI 2nd World Conference on Oral Health Promotion scheduled Aug. 27-29 at the Royal College of Physicians here.

World-renowned experts will gather to discuss scientifically valid research on fluoride, diet, saliva and oral hygiene. The goal is to develop professional—and eventually public—consensus statements on achieving and maintaining optimal oral health throughout life.

Oral health messages geared to the general public stem from a variety of sources, such as dental and medical professionals, associations and the food, beverage and pharmaceutical industries.

The FDI believes that, in principle, all messages should be based on and express current scientific and empirical evidence and knowledge.

The conference is meant to focus on consensus statements in relation to dental caries and periodontal disease, although comments may be made in relation to other oral diseases. Consensus statements should express FDI's and its national member associations' current positions and will be sent to the FDI general assembly for approval.

Officials say the conference is relevant to dental associations and their publications, organizations and individuals involved in oral health education, dentists and oral health professionals and related industry representatives.

For more information about the 2nd World Conference on Oral Health Promotion, call 011 44 171 935 7852 or contact the FDI via e-mail at "congress@fdi.org.uk". ■

Survey questions practitioners

The 1999 Survey of Dental Practice, the most complete source of information on the private practice of dentistry in the United States, has been mailed to a 5 percent sample of active private practitioners nationwide.

The survey is conducted annually by the ADA Survey Center. Dentists receiving surveys are urged to respond.

Data from the survey are used to assess the current status of, and trends in, practice activity, auxiliary employment, income and other characteristics of the dental profession. The Survey Center has conducted the Survey of Dental Practice for more than 40 years. Past survey results are available through the Survey Center, 1-312-440-2568.

The 1999 survey will provide the Association with detailed information on dental specialties. It also contains questions on Dental Management Service Organizations, which will attempt to determine the extent of participation in these organizations. ■

CDT-3

Continued from page one

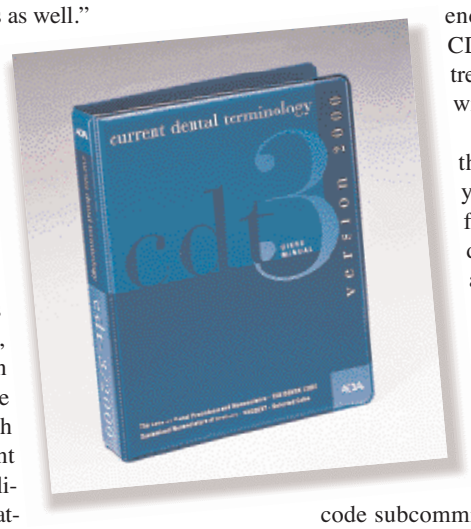
new codes, 20 revised nomenclatures and 51 revised descriptors with a total of 501 procedure codes.

Seven codes were deleted from CDT-2 and obsolete procedures were removed in response to changes that have occurred in dentistry. The changes will allow dentists to more accurately report the procedures they perform. The codes will go into effect for use Jan. 1, 2000.

Dr. Vaclav says the council strongly urges dentists and staff to use CDT-3 codes only.

"It's really critical that dentists note all changes and understand their appropriate use," he says. "And because several descriptors for existing codes have been revised, it is also important that dentists note those changes as well."

Codes marked with a ● symbol indicate a changed descriptor. "If you learn these changes you'll ensure that the codes are being used correctly. That could mean improved reimbursement," says Dr. Vaclav.



With the revised codes a dentist will, for example, be able to convey to an insurance company that he or she was unable to finish an endodontic treatment due to unexpected complications. Before this, treatment would have been coded as an "unspecified endodontic procedure." CDT-3 will allow this treatment to be reported with a specific code.

"The project has been the culmination of five years' work with input from many dentists, dental organizations and third-party payers. There are several new codes which will allow dentists to precisely report procedures to third-party payers," says Dr. Francesca DeRose, chair of the code subcommittee.

As another example, a dentist using CDT-3 will be able to specify that he used a stronger laboratory-made provisional crown when the patient is undergoing additional dental treatment over a period of time.

A new category for implant-supported prosthetics was also developed. This section will include 23 new codes covering prefabricated and custom abutments, abutment-supported crowns and implant-supported crowns made from various materials.

This section will also include codes for implant-supported retainers and implant/abutement-supported fixed dentures for completely and partially edentulous cases.

In addition to code changes, the council has greatly revised the claim form. Available this summer, the form won't become effective until Jan. 1.

The ADA introduced the first version of the Current Dental Terminology in 1991 after four years of development. In 1995, CDT-2 was published and contained changes to the Dental Code and claim form. CDT-2 is the current version of the code.

The manual will be sold in an easy-to-use, small three-ring binder with color-coded sections and tabs. Dentists may also choose to purchase CDT-3 on a compact disc.

To order copies of CDT-3, which includes the Dental Codes with descriptors, new claim form and the Dental Benefits Glossary, contact the Department of Salable Materials at 1-800-947-4746. ■

Take a quick peek at CDT-3

The following are examples of codes that appear in CDT-3.

Diagnostic

- Problem-focused re-evaluation on an established patient. This code should be used when assessing the status of a previously existing condition. It is useful when patients require several visits for the same condition.
- 7-8 vertical bitewing X-rays. A full series of vertical bitewings is more beneficial in diagnosing periodontal disease because vertical bitewings expose more bone depth. Also, it is beneficial to have the 3-4 anterior films to detect interproximal decay.

Restorative

- Resin-based composite crowns on permanent anterior teeth. Previously, there was only a resin-based composite crown for anterior primary teeth.
- Resin-based composite for four or more surfaces on a posterior permanent tooth.
- Provisional crown utilized as an interim restoration for at least six months during restorative treatment.

Endodontic

- Non-surgical access to treat root canal obstructions, an incomplete endodontic therapy code for inoperable or fractured teeth and an internal root repair of perforation defects.

Fixed Prosthodontics

- Fixed partial denture category for porcelain/ceramic pontics, inlays/onlays and retainers. New fixed partial denture retainer 3/4 crowns for the various materials used.

Orthodontics

- Orthodontic repair. This includes repair on functional appliances and palatal expanders, but does not include brackets and standard fixed orthodontics appliances.

Anesthesia

- Anxiolysis, intravenous sedation and non-intravenous conscious sedation. ■

The Standard & Poor's 500 Index

Size, diversity make it a reliable benchmark

Most market watchers are familiar with the popular Dow Jones Industrial Average as a measure of stock market performance.

While the Dow may be the oldest and best known of the major stock indexes, some analysts point to the Standard & Poor's 500 as the more reliable and accurate of the two leading stock indexes. Why? And what are the differences between them?

Standard & Poor's is a leading financial information and services corporation and a division of The McGraw-Hill Companies since 1966.

The Standard & Poor's 500 Composite Stock Price Index, as it is formally known, was introduced in 1923 as a series of indexes that originally included 233 companies and covered 26 industries.

By Jon Spisiak

Today's index was created in 1957 and currently encompasses 500 companies that span 90 different industry groups.

The companies range in size from small industry-specific leaders to some of the largest corporations in the world. Of the companies currently listed, 91 percent are listed on the New York Stock Exchange, with the remaining 9 percent on the NASDAQ or the American Stock Exchange.

How are Companies Chosen for the S&P 500?

The S&P Index Committee is responsible for establishing index policy. Companies may also be removed from the index because of mergers, bankruptcies, restructuring or other events that the committee deems significant. Companies are chosen based on market size, liquidity and industry group representation. The index is made up of four major industry sectors: industrials, utilities, financial and transportation. The industrial group is the largest, with 76 percent of the companies drawn from that sector.

A More Accurate Benchmark

Because of its diversity and size, many analysts consider the S&P 500 to be a more accurate benchmark for measuring the performance of the U.S. stock market than the Dow. The Dow is composed of just 30 large-capitalization blue chip stocks that measure a very small sector of the overall U.S. stock market.

In contrast, the S&P 500 includes a larger number of companies with a wider range of market size. Thus, the S&P 500 is able to take a more precise snapshot of the overall market's ebb and flow.

In addition, all of the companies currently listed on the Dow are included in the S&P 500.

MANAGEMENT

How Does the Index Move Up and Down?

The S&P 500 is market value–weighted. This means that each company's stock price is multiplied by its shares outstanding, with each company's influence on the index's performance directly proportional to its market value.

As a result, a larger company has more influence on the S&P 500 than a smaller one does. But because there are 500 companies, not just 30, the overall effect of a single company's price fluctuation is limited, giving the investor a more accurate picture of the market's activity.

If you are a market watcher who wants a more precise evaluation of market fluctuations, you will no doubt want to keep a close watch on the S&P 500 Index. ■

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

ADA Reports

ADA ONLINE celebrates 4th birthday

Internet service now nears 5,000 visits each day

As it nears 5,000 visits a day, ADA ONLINE turned 4 years old June 30, drawing more than twice as many hits as it did two years ago.

In May, the ADA ONLINE home page racked up an average of nearly 2,500 hits per day, according to the WebTrends analysis software used to track traffic throughout the site. Just two years ago, that number hovered around 1,100 hits a day.

What's more, the number of visits to the Web site climbed to more than 4,600, the WebTrends report shows. A visit, by the way, is defined as a session of activity for one user and may include any number of hits throughout a Web site. A visit, also known as a user session, ends when a user is inactive on the Web site for more than 30 minutes.

While there were about 145,000 visits to ADA ONLINE in May, the number of hits throughout the site reached nearly 2.5 million. That's an average of 78,753 hits per day.

Meanwhile, the popularity of the Association's Web site among member dentists appears to be growing rapidly.

As of June 30, more than 13,000 ADA member dentists had registered for members-only content within ADA ONLINE. That represents a growth rate of about 1,000 members a month since May of this year. (Though more members likely visit ADA ONLINE, the Association can only count those who sign up for members-only content.)

Online annual session registration, another sign of the site's growing popularity, accounts for about 20 percent of all those who have registered for the annual meeting in Hawaii. Online annual session registration has been available through ADA ONLINE since April.

Other high-traffic areas of the site include the searchable membership directory, the education section and the ADA Discussion Forum ■

Popular pages within ADA ONLINE eyed at a glance

Consumer and patient information pages are among the most popular in ADA ONLINE at the Association's Web site "http://www.ada.org".

Among the 150 most popular ADA ONLINE pages as measured during May were:

- ADA Member Directory;
- Patients & Consumers;
- Research & Clinical Issues;
- Gum Disease consumer brochure;
- Root Canal (Endodontic) Treatment consumer brochure;
- Cleaning Your Teeth and Gums consumer brochure;
- Topical Index: Tooth Decay & Dental Caries;
- Frequently Asked Questions: Patients & Consumers—Gum Disease;
- Frequently Asked Questions: Patients & Consumers—Diseases and Disorders.

Rankings change from month to month. ■

Standards approves proposed document

The Accredited Standards Committee MD156 has approved for circulation and comment the new Proposed ANSI/ADA Specification No. 78 for Endodontic Obturating Cones.

The Council on Scientific Affairs uses this document and other specifications in its evaluation of ADA Seal of Acceptance products.

Free copies of the specification are available by calling the ADA toll-free number, Ext. 2506 or 2533. ■

A good year for Dr. Meskin

JADA editor earns honors from students, university

By James Berry

JADA Editor Larry Meskin is not one to toot his own horn. So we'll just have to do it for him.

In the summer edition of its journal, Dentistry99, the American Student Dental Association saluted Dr. Meskin as one of the profession's "25 dental visionaries."

Earlier in the year, Dr. Meskin received the 1998 Thomas Jefferson Award for faculty from the University of Colorado, where he is director of continuing education in the dental school.

The award is bestowed each year in three categories—faculty, student and staff—to recipients who have "broad interests in literature, arts and sciences, and public affairs." Other required qualities: "a strong concern for the advancement of higher education; a deeply seated sense of individual civic responsibility; a profound commitment to the welfare and rights of the individual."

Judging from their tribute, it was many of those same qualities that earned the JADA editor a spot on ASDA's roster of 25 dental visionaries.

Dr. Meskin

"The first thing many readers consult when diving into each new issue [of JADA] is Dr. Meskin's latest report from the profession's forefront," noted ASDA in a biographical tribute penned by Dr. Matt Dunn, a recent graduate of Chicago's Northwestern University dental school and, like Dr. Meskin, a Coloradan. Though they're both from Denver, the two have never met. At least not yet.

Wrote Dr. Dunn, "Incisive, opinionated and amusing, Dr. Meskin has set the standard for column writing in the profession—with the kind of power you might expect from an individual with such a daunting truckload of professional degrees but with little trace of the academician in his prose. When Dr. Meskin offers an opinion, you know where he stands."

Dr. Meskin received the University of Colorado's Jefferson Award at an April 29 banquet hosted by university President John Buechner, Ph.D. Dr. Douglas Berkey, who chairs the dental school's Department of Applied Dentistry, nominated Dr. Meskin for the honor. Dr. Berkey is a former student of Dr. Meskin's.

"He is the teacher of teachers, the mentor of mentors, a distinguished scholar, a caring advocate and truly a godsend to me and many other fortunate individuals," Dr. Berkey said of his colleague. ■

Those whom youth admires

ASDA's 25 'dental visionaries'

Mas'ood Cajee has at least 25 influential friends he can count on in a pinch, possibly for the rest of his life.

Mr. Cajee, a third-year student at the University of Oklahoma's College of Dentistry, is the editor-in-chief of Dentistry99, the quarterly journal of the American Student Dental Association.

He and the publication's editorial board spent the better part of a year sorting through the endless possibilities to compile a list of "25 dental visionaries." The 25 are saluted and profiled in the current, summer edition of Dentistry99.

First the process.

"We generated a lengthy list of possible visionaries in brainstorming sessions, which we supplemented with nominations from our readers through the magazine and surveys we conducted at our regional meetings in Miami, Minneapolis and New York," recalled Mr. Cajee.

To make the cut, he said, candidates had to be "actively shaping the future of American dentistry through their leadership and vision."

He continued, "We tried to achieve a diversity of visionaries that represented all facets of the profession: education, practice, research, politics, etc."

The future dentist understood that such an undertaking had its pitfalls—beyond the 25 pleased to have made the list, umpteen others could be dismayed at having been … uh … passed over.

"Picking 25 out of the possibilities was tough," he acknowledged. "There is a lot of subjectivity and weighing of choices in a process like this. We certainly did not intend to slight people not on the list."

He added, "To think that dentistry had only 25 visionaries would be presumptuous and preposterous. The 25 we did pick seemed to be excellent and appropriate career role models for our readership—America's dental students."

JADA Editor Lawrence H. Meskin was one who made the list (see related story). But that, of course, is not the only reason we did this story. Of course not.

We also wanted to name the other 24. And here they are:

Dr. Arthur A. Dugoni, dean of University of the Pacific School of Dentistry and a past president of both the ADA and the American Association of Dental Schools.

Dr. Burton I. Edelstein, director, Children's Dental Health Project; president, Children's

See Vision, page31

People

Cuba: Many dentists, few supplies

California dentist gets a firsthand look at country's oral health

By Daniel McCann

Dr. Benjamin Mandel felt the jet slide into its descent. It was shortly after 10 p.m., Jan. 8, and Dr. Mandel's flight was scheduled to arrive at Cuba's Havana airport at 10:30 p.m.

As the jet began its approach, Dr. Mandel drew to the window. Save for the parallel lines of runway lights, he could see nothing.

"I was looking for buildings and homes," he recalls, "but I couldn't see anything. It was pitch black. I thought we were in the middle of a field or something."

As part of a humanitarian effort called the Cuba-America Jewish Mission, Dr. Mandel had with him an estimated 80 pounds of dental supplies—amalgam capsules, rubber gloves, toothbrushes, gauze and more—to distribute to the dentists and people of Cuba. He knew all about the vast shortages across the island.

But he wasn't prepared for the blackened scene outside his jet window that night—though it would prove a fitting introduction to a country trying to find its way in a new world.

"Once I landed, I realized why it was so dark," says Dr. Mandel. "Along with other shortages, there's a tremendous need for lighting in Cuba. Nothing is well-lit. They might have a lampost every two or three blocks."

For more than 90 years, the Pan American Health Organization, based in Washington, D.C., has worked to improve the public health of residents throughout the countries of Latin America and the Caribbean.

A PAHO report describes Cuba as being in the grip of "a profound economic crisis." This, the PAHO says, can be attributed to the long-standing U.S. embargo of the island and the dismantling of the Soviet Union. Socialist bloc countries and the Soviet Union had accounted for 85 percent of Cuba's foreign trade. From 1989 to 1993, Cuba's gross domestic product declined by 35 percent and its exports dropped by 75 percent.

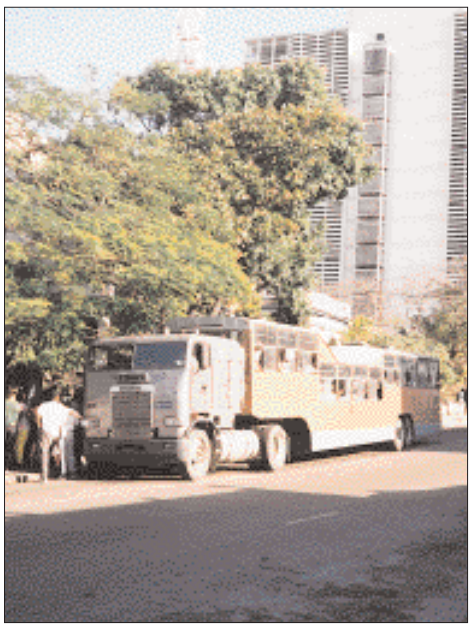
Its stability and future at stake, the Cuban government has been forced to venture in new directions. Among other measures, the country is encouraging foreign investment and economic collaboration, trying to find new agricultural and industrial markets, allowing more private enterprise and welcoming humanitarian aid.

For two weeks, Dr. Mandel traveled across Cuba, dropping supplies off at dental schools, providing impromptu oral health classes among the residents.

"The people are very friendly, very happy," says Dr. Mandel. "Everywhere I went, their first questions were about sports: 'Tell us about [baseball star] Sammy Sosa, Michael Jordan.'"

At no time, though, was Dr. Mandel allowed to treat people. "They are very proud of their dentists, and they have enough to go around. But their supplies are few, and they welcomed what I brought."

The lack of basic dental materials has placed tight limits on what treatments Cuban dentists can provide. Dr. Mandel: "The people would tell me that while there are many dentists, they don't have any amalgam to fill the teeth. So they wait until their teeth decay. And then when the teeth start hurting, they have them pulled."



Bus stop: Semitrailer trucks and pickup trucks are prime sources of public transportation in Cuba.

In the city of Guantanamo, Dr. Mandel screened some of the residents and then provided a workshop of sorts on maintaining oral health.

"We had to go up to the rooftop of a house because there was only one light in the home, and it was much too dark," said Dr. Mandel. During his talk, he distributed toothbrushes, explained their use and the importance of plaque removal.

"Many adults had lost most of their teeth," said Dr. Mandel, "so they were especially interested in maintaining their children's oral health."

Aside from the paucity of dental supplies, the pervasiveness of sugar—a staple of the Cuban diet—presents dentists there with a major challenge.

"Sugar is plentiful and cheap, and they eat a lot of it," said Dr. Mandel. "Everybody is always drinking coffee and sugar. So I told the children that even if they don't happen to have a toothbrush with them, they should try to swish their mouth with water."

Whenever he talked with people about dentistry, Dr. Mandel made it a point to proceed slowly and respectfully. "You cannot just say, 'You have problems, and here's how you fix them,'" he says. "The people have a lot of pride. So you listen to them, and then you say something like, 'There might be another way to solve this problem.'"

After two weeks among the people, Dr. Mandel would acknowledge that there's no quick or easy fix for all of the people's oral health problems. He might have made some inroads, but he also sees that there's much more to be done.

So he plans to return. "Now that I know how they live, and I've been into their homes, and they treated me as a friend, I can't turn back. I'm taking another trip down there next May. And I'm spreading the word among my dentist friends that this time I want to take down there donated composites, fiber optic lights, cavitrons, anesthetics, curettes, scalers, amalgam and acrylic material for prosthetic teeth."

Donations of dental supplies can be sent to: Dr. Benjamin Mandel, 74 Harold Ave., San Jose, Calif. 95117-1080. ■

Among the people: Dr. Mandel screens a boy for caries.

At the shops: Havana residents buy produce at one of the city's free markets.

Making the rounds: Dr. Mandel (third from left) visits faculty at the Santiago de Cuba dental school.

Education

Broadening dentists' possibilities

State-level initiatives transforming licensure requirements

By karen fox

If you're a dentist frustrated with practice restrictions due to licensure requirements, you're not alone.

But what you may not know is there have been significant changes, including new policies and initiatives that are beginning to widen dentists' practice possibilities.

Individual states develop licensure requirements, not the ADA, and it's the states that are beginning to consider alternatives to current requirements.

The ADA's bi-annual licensure conferences have brought together practice, education, student and testing agency representatives in order to review processes that hinder mobility. So far six invitational licensure conferences have been held—March 2, 1999 the most recent—and officials believe the objectives set forth in the Agenda for Change are coming to fruition.

The Agenda for Change ("http://www.ada.org/prac/careers/agenda.html)—a 12-objective document developed in 1997 by clinical testing agencies, licensing jurisdictions and other participating organizations including the ADA—called for improvements in the clinical licensure process.

There has been progress, says Dr. Donald E. Demkee, chair, Council on Dental Education and Licensure, however success is dependent on individual states' involvement as many key obstacles are beyond the ADA's and CDEL's control.

"How does one agency know that another is grading the same way? If they're not grading the same, you can't equate the results and award licensure by credentials."

"Through actions of the House of Delegates and as a result of activities under CDEL's purview, the ADA has committed both its time and resources to facilitating changes in the licensure process," says Dr. Demkee.

"Now we have all the testing agencies, regional testing boards and states sitting at the same table and talking about accepting licensure by credentials, accepting each other's testing systems and discussing ways to eliminate barriers to freedom of movement."

Many of the agenda's goals are already becoming reality. For example:

- 35 of the 53 ADA jurisdictions now grant licensure by credentials;
- a number of states accept exam results from multiple testing agencies, and several others are considering it;
- only 10 states continue to administer their own clinical examinations (Alabama, California, Delaware, Florida, Hawaii, Indiana, Louisiana, Mississippi, Nevada and North Carolina); the rest are included in one of the four regional testing agencies;
- the majority of clinical testing agencies have dropped additional written exam requirements and accept the National Board Part II as their written requirement.

Licensure: Dr. Demkee, shown chairing the CDEL meeting this year, says many state dental boards are considering changes in their licensure processes. Pictured left to right are Diane Boehm, manager, dental education; Dr. Arnold Baker; Dr. Richard Buchanan; Dr. Demkee; and Judith Nix, director, CDEL.

Frustration over policies that keep dentists from relocating to certain states or regions and concerns from students and new dentists over the entire examination process are the reasons licensure conferences have been convened. Licensure by credentials, standardization of examinations, accepting results from multiple clinical testing agencies for initial licensure and other issues included as part of the Agenda for Change have been studied by conference participants, who include representatives from the four regional testing agencies and 12 of the jurisdictions that adminster their own clinical exams.

"This is vital to the group's direction," says Dr. Demkee. "The Agenda for Change is the one document that is generally supported by all conference participants."

The conferences—funded by the ADA and hosted by the ADA president—include the president-elect, representatives from the American Association of Dental Examiners, American Association of Dental Schools, American Student Dental Association and representatives of the Committee on the New Dentist and CDEL.

"Basic differences with some testing agencies still exist, and we're working to resolve that," says Dr. Demkee. "It's a tremendous achievement just to have come this far.

"Our next step is to sit down and figure out how we can all get on the same page with scoring and grading," says Dr. Demkee.

Providing similar guidelines for exam scoring criteria and exam administration has become one of CDEL's top priorities. Two steps toward achieving standardization were accomplished in 1998: an ADA/AADE joint committee drafted the "Guidelines for Examiner Standardization," which was later endorsed by the 1998 ADA House of Delegates and approved by the AADE general assembly.

"Our goal is getting the right data, and being able to equate one exam to the other in a reliable manner," says Dr. Demkee. "What we're looking for is assurance of clinical competency—the ability for the dentist to demonstrate that they have the ability to take the information and didactic understanding and transfer it to clinical skills where they can perform the task competently."

He says right now it's very difficult to compare candidate performance on exams, and if the results can't be equated, there are obstacles to moving from one state to another without taking another clinical examination.

"Regional testing agencies and state boards currently give exams to qualify candidates for licensure," says Dr. Demkee. "How does one agency know that another is grading the same way? If they're not grading the same, you can't equate the results and award licensure by credentials.

"We're currently collecting data on licensure by credentials, but also we need to sit down with psychometricians (mathematicians who calibrate examinations) to establish guidelines for scoring exams in a uniform manner."

The CDEL has proposed a task force be appointed by the ADA president to develop

See STATES, page 30

States

Continued from page 29

guidelines for scoring criteria and exam administration. Pending approval for funding, a "best practices in scoring" document will be drafted for preliminary review at a year 2000 invitational licensure conference.

Slow progress is better than no progress, but licensure restrictions still challenge the patience of many dentists.

"People don't think we're doing anything, but these are extremely complicated issues where the ADA can have substantial influence," says Dr. Demkee, indicating that neither the ADA or CDEL has the authority to force state dental boards to accept licensure by credentials or eliminate clinical examinations as a requirement for initial licensure.

"No matter what we do, or what resolutions the ADA House of Delegates passes, the final outcome is dependent on what various state dental boards do. The state boards are the ones who make the decisions about how things are done in their states."

Dr. Demkee says that convincing states to implement all objectives in the Agenda for Change requires patience.

"Unfortunately, that process is very slow."

Simpler items on the Agenda for Change have been successfully addressed. What remains now are the difficult issues that will take more time.

Even when dental boards agree to adopt new policies, their options may be limited until state lawmaking bodies act.

"A lot of things that happen on the state level, such as licensure by credentials, are bound by state statutes that do not permit these activities," says Dr. Demkee.

Even so, CDEL maintains a vital role in developing agreement and compromise within the licensure community.

"The licensure community is trying to come up with the same terms, the same thoughts and the same understandings," he says.

Dr. Demkee says some dental media coverage of licensure limitations is unfair, and he hopes constituent and component societies and state legislatures continue to work closely with their dental boards to make changes.

"All state dental boards have relationships with state dental associations, but they are different entities. They usually have ongoing liaison. State associations need to be aware of what ADA is doing, ask questions and make sure the facts are presented to their membership, not just accept information that has been passed on based on anecdotal comments."

He says CDEL will evaluate and maintain current data useful for lobbying state dental boards and legislatures, such as the 1998 Survey on Licensure by Credentials. The survey was mailed in December 1998 to 54 executive directors and administrators of the state dental boards, resulting in a 72 percent response rate.

The final report and data on the 1998 survey will be available through the ADA Survey Center in the late summer or early fall of 1999. The CDEL will comprehensively review this data at its November 1999 meeting.

Policy statements and licensure-related documents such as Facts on Dental Licensure and Dentistry in the United States: Information on Education and Licensure are available to ADA-member dentists, state dental boards and constituent and component societies.

Dr. Demkee encourages dentist members to become familiar with all ADA licensure-related policies.

For information on these documents, visit "http://www.ada.org/tc-prac.html#licensure" or contact the Committee on Licensure at Ext. 2694. ■

Trends in the clinical licensure process

- 35 of the 53 ADA jurisdictions now grant licensure by credentials;
- there are a number of states that accept exam results from multiple testing agencies, and several others are considering it;
- only 10 states continue to administer their own clinical examinations (Alabama, California, Delaware, Florida, Hawaii, Indiana, Louisiana, Mississippi, Nevada and North Carolina); the rest are included in one of the four regional testing agencies;
- the majority of clinical testing agencies have dropped additional written exam requirements and accept the National Board Part II as their written requirement. ■

Patient

Continued from page one

House of Representatives are working on patient protection legislation. Senate leaders agreed to allow a full debate of the issues in that chamber July 12-15.

"I think he heard us," Dr. Rose said after meeting with the Speaker of the House, who revealed a passion for collecting old cars and ushered his guests to an expansive balcony view of the mall stretching toward the Washington Monument and White House. "I think he appreciates where organized dentistry and the dental profession fit into health reform."

"Patient protection legislation is back on the front burner," Dr. Mascola said after the meetings with Speaker Hastert and dentist/Rep. Charlie Norwood (R-Ga.). "The Speaker listened to us but made no commitments. Charlie really believes there will be movement and that accountability and point-of-service will be part of the package."

The Association called for comprehensive legislation that fully applies to dentistry, covers dental plans and offers health plan subscribers freedom to choose their own doctors at the point of service, with an effective plan accountability process that would not preclude the opportunity for litigation, said Dr. Zapp.

"We told the Speaker that our House of Delegates supports these basic principles and will not accept our involvement in supporting legislation that does not comport with our policy," he said.

Rep. Hastert, who managed patient protection legislation for House leaders in the last Congress before his recent accession to House Speaker, was described by the Association representatives as hopeful the House will produce a bill by Congress' August recess. The Speaker is the presiding officer of the House of Representatives and leader of its majority party. ■

Vision

Continued from page 27

Dental Associates of New London County; associate clinical professor, Department of Oral Health Policy and Epidemiology, Harvard School of Dental Medicine.

- Dr. Fredrick C. Eichmiller, director, Paffenbarger Research Center, ADA Health Foundation.
- Dr. Ellen Eisenberg, professor and division head, Oral and Maxillofacial Pathology, Department of Oral Diagnosis, University of Connecticut School of Dental Medicine.
- Dr. Dan Fischer, founder, president and chief executive officer, Ultradent Products, Inc.
- Dr. Samuel D. Harris, retired practitioner and renowned philanthropist; founded American Society of Dentistry for Children; helped establish Academy and College of Pediatric Dentistry.
- Dr. Herold Heymann, professor and chair, Department of Operative Dentistry, University of North Carolina, Chapel Hill.
- Dr. Ronald Jackson, director, Posterior Esthetics Program, Las Vegas Institute for Advanced Dental Studies.
- Dr. Lee Jameson, dean, Northwestern University dental school; president, Odontographic Society of Chicago; supreme president-elect, Xi Psi Phi Dental Fraternity.
- Dr. Lynn Johnson, assistant professor and coordinator, Instructional, Technology and Research Program, University of Iowa.
- Dr. David Nash, professor of Dental Education, University of Kentucky College of Dentistry.
- Dr. Charlie Norwood, Republican U.S. congressman from Georgia.
- Dr. Jeffrey Okeson, professor and director, Orofacial Pain Center, University of Kentucky College of Dentistry.
- Dr. Deborah Studen Pavolovich, associate professor, director, Predoctoral Pediatric Dentistry, University of Pittsburgh School of Dental Medicine.
- Dr. William Proffit, Kenan professor, chair, Department of Orthodontics, University of North Carolina, Chapel Hill.
- Dr. Malvin Ring, retired dental historian.
- Dr. John Rutkauskas, newly appointed executive director, American Academy of Pediatric Dentistry.
- Dr. Titus Schleyer, associate professor and chair, Department of Dental Informatics, Temple University School of Dentistry.
- Dr. Harold Slavkin, director, National Institute of Dental and Craniofacial Research.
- Dr. Stephen Sonis, department head, Harvard School of Dental Medicine; division chief, Brigham and Women's Hospital; senior fellow, Harvard Medical School; associate physician in Surgical Oncology, Dana Farber Cancer Institute.
- Dr. Van Thompson, associate dean, Research, Industrial Relations and Program Development, University of Medicine and Dentistry, New Jersey dental school.
- Dr. Sharon Turner, dean, School of Dentistry, Oregon Health Sciences Center.
- Dr. Frank J. Wiebelt, chair, Department of Removable Prosthodontics, University of Oklahoma College of Dentistry.
- Dr. David Wong, chief, Laboratory of Molecular Pathology and head, Division of

July JADA focuses on preventing oral cancer

Resolving oral leukoplakia—and thus preventing oral cancer—may be as simple as abstaining from tobacco use for six weeks.

So say the authors of the cover story in the July issue of The Journal of the American Dental Association. Dr. Gary Chad Martin, a lieutenant colonel in the U.S. Air Force Dental Corps, and research colleagues studied the oral leukoplakia status of USAF basic military trainees who were, as a part of basic training, deprived of tobacco products for six weeks.

Of the more than 3,000 trainees examined in the study, about 300 were users of smokeless tobacco before entering training, and about 40 percent of those had oral leukoplakia.

By the end of the six-week training period, 97.5 percent of the leukoplakic lesions had achieved clinical resolution.

"Our important new finding is that if a young healthy man will stop using all tobacco products for six weeks, most leukoplakic lesions will resolve clinically and a biopsy will not be required," the researchers write.

Some of the other reports in July JADA:

- case studies of the use of mineral trioxide aggregate, a new material developed for endodontics that allows for the overgrowth of cementum and may facilitate regeneration of the periodontal ligament;
- an evaluation of the pain-relieving properties of the analgesic tramadol vs. those of the more traditionally used codeine combinations;
- new mercury hygiene recommendations from the ADA Council on Scientific Affairs. ■

AAOMS to feature "Challenges"

Boston—"Challenges Facing the Oral and Maxillofacial Surgeon" will be in the spotlight at the American Association of Oral and Maxillofacial Surgeons' 81st Annual Meeting here Sept. 29-Oct. 2.

Offering more than a dozen major symposia, exhibits and special presentations, this year's meeting will be held at the Boston Marriott Copley Place hotel and adjacent Hynes Convention Center.

The advance registration deadline is Aug. 13. For information, contact AAOMS at 1-847-678-6200, Ext. 378 or "inquiries@aaoms.org".