11-21-2005

ADA News - 11/21/2005

American Dental Association, Publishing Division

GlaxoSmithKline gives $1 million, page seven ◆ 2005 resolutions, page 12

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

NOVEMBER 21, 2005 VOLUME 36 NO. 21

Michigan town votes to return fluoridation

BY STACIE CROZIER

Mt. Pleasant, Mich.—By a margin of 63 percent to 37 percent, voters in Mt. Pleasant, Mich., opted Nov. 8 to put fluoride back in their drinking water.

■ **Osteonecrosis warning update, page three**

The 25,000-some citizens of this city in the center of Michigan's lower peninsula had enjoyed the benefits of community water fluoridation since 1957.

See MICHIGAN, page 10

Photo by Karen Fox

First in management: The 35 members of the ADA Executive Management Program for Dentists received their certificates Nov. 8 at the Kellogg School of Management in Chicago. Course dates for next year's "mini-MBA" program for dentists are July 22-26, Sept. 15-19, and Nov. 3-7, 2006. If you'd like more information or to register, go to "www.ADA.org/prof/events/featured/kellogg/index.asp" or call Ext. 3541.

Help shape national boards

ADA seeks clinical cases from dental practice

BY KAREN FOX

Calling all dentists, dental educators, dental hygienists and hygiene education program faculty: the ADA needs you.

More specifically, a variety of well-documented cases and items are being sought for the National Board Dental and Dental Hygiene Examinations.

"What we need are the types of cases that a general dentist would see in private practice, not specialty cases," said Dr. Thomas L. Ziemiecki, a member of Component B of the ADA's Part II Dental Test Construction Committees and associate professor of dentistry in the department of prosthodontics at the University of North Carolina.

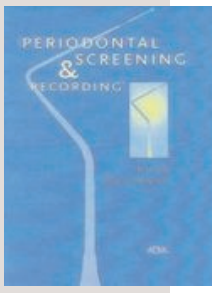
By issuing a call for cases and items, the test construction committees are asking the dental and dental hygiene communities to participate in a process vital to the profession: protecting patient safety by ensuring that future dentists and hygienists are

See EXAM, page 10

BRIEFS

Perio screening:

Update your periodontal screening and recording resources or start a PSR program in your office with the help of a tried and true ADA resource.



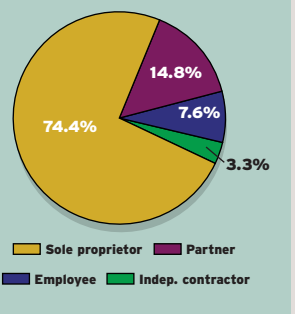
Periodontal Screening and Recording: An Early Detection System, includes instructions, question-and-answer section and color photographs describing the screening process and coding.

The booklet (item J206) and sticker sheets (item J6079) are available by calling 1-800-947-4746 or at "www.adacatalog.org". The member price is $14.95 for the booklet and $12 for the sticker sheets. The nonmember price for the booklet is $22.50 and $18 for the sticker sheets. ■

JUST THE FACTS

Employment

Current employment situation of United States dentists, 2004.



Source: ADA Survey Center "survey@ada.org", Ext. 2568

Track practice efficiency with SurePayroll

ADA MEMBER ADVANTAGE℠

Dentists know the perils of operating a business based on assumptions without knowing the facts.

One way to gain a better understanding of how your business is performing is through an online payroll processing service. ADA Member Advantage endorses SurePayroll, the fastest growing payroll processor nationwide.

SurePayroll specializes in providing a convenient and economical payroll system for dental practices. The company currently processes and remits payroll taxes for hundreds of dental practices across the country.

SurePayroll can help you focus on dental practice metrics, or measurements of business activity. According to ADA Member Advantage, defining and monitoring metrics can benefit you by enhancing vision and decision-making and help you spot threats and opportunities sooner.

For example, if one of your goals is to increase office efficiency, you may want to track key aspects of your business. You can track the volume of patients you serve by the number of hours employees worked—letting you know if your employees are becoming more efficient each month or less.

With SurePayroll, you'll have access to online payroll reports that can quickly pull key payroll metrics such as regular pay hours, overtime hours, 401k payments and benefits. The reports are designed in an easy-to-understand format, and you'll have access to all of your reports at anytime, with vital data regarding your business right at your fingertips.

With SurePayroll, ADA members are entitled to free set-up and enrollment, free W-2s for the first year, and a six-month money-back guarantee. For information about SurePayroll or to receive a price quote, call 1-866-535-3592. ■

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Health&Science

Alert on cancer patients issued

Research links bisphosphonate drugs, osteonecrosis of the jaw

BY JENNIFER GARVIN

The ADA Division of Science continues to receive questions from members about the link between bisphosphonate drugs and osteonecrosis of the jaw in cancer patients.

Last May, Novartis Pharmaceuticals Corp. sent a letter to dentists informing them that cancer patients being treated with Aredia or Zometa were at risk for developing ONJ.

The company recommends that cancer patients using these drugs avoid invasive dental procedures because dental surgery may exacerbate ONJ in some patients. In the letter Novartis said, "clinical judgment by the treating physician should guide the management plan of each patient based on individual benefit/risk assessment."

Intravenous bisphosphonates (Aredia and Zometa) are drugs that are used to treat cancer patients to help prevent or control bone destruction due to metastatic bone disease. Dentists should ask patients about any ongoing or recent medical treatments. Patients may not remember to tell their dentist that they are receiving these drugs, because they are administered in the oncology chemotherapy unit.

According to a Novartis white paper developed by a team of eight medical professionals, including five dentists, the recommended treatment for patients receiving intravenous bisphosphonate therapy is to:

- Maintain excellent oral hygiene to reduce the risk of dental and periodontal infections.
- Check and adjust removable dentures and perform routine dental cleanings (being sure to avoid soft-tissue injury, especially in tissue overlying bone.)
- Aggressively manage dental infections nonsurgically. Endodontic therapy is preferable to extractions when possible. It may be necessary to carry out coronal amputation with subsequent root canal therapy on retained roots to avoid the need for extractions and the potential development of osteonecrosis.
- If surgery is required in patients with established osteonecrosis, stopping or temporarily stopping bisphosphonate therapy may be considered.

Additionally, osseointegrated dental implants may result in further osteonecrosis and are contraindicated.

Novartis recommends that cancer patients receive a dental examination prior to initiating therapy with Aredia or Zometa, and avoid invasive dental procedures while receiving these drugs. The company has added precautionary information on ONJ to the package insert for both products.

Novartis urges any dentist who observes serious adverse events related to Aredia or Zometa to call 1-800-882-6577, or to call the Food and Drug Administration's MedWatch Adverse Event Reporting program at 1-800-FDA-1088. The FDA's Web site, "www.fda.gov/medwatch" is another online resource. (Go to OnlineXtra for more links related to this story.)

For more information, contact Novartis Oncology Medical Services at 1-888-669-6682.

Also, for more information, go to ADA.org or contact the Division of Science via the ADA toll-free number at Ext. 2553 or e-mail "science@ada.org".

The December issue of The Journal of the American Dental Association contains three articles on bisphosphonate-associated osteonecrosis, including a position paper from the American Academy of Oral Medicine, a review of current knowledge and strategies for prevention and early recognition as well as case reports. ■

OnlineXtra
www. ada.org/goto/newsextra
For more information related to this story, visit the ADA's Web site, using the Web address above.

ViewPoint

MyView

"Transitions": Another word for retirement

Wayne S. Maris, D.D.S.

Those of us entering geezer status must make career decisions. The words from the transitions guru still ring in my head. "Doctors, one day you will leave your practice."

Transition is another way of saying "retirement," or bringing in an associate, or many other changes in a practice. A basic principle in dentistry provides the answer: Do what is best for the patient.

Patients have provided us with a good living over the years and need to receive top consideration. Perpetuation of quality dentistry is in their best interest. In rural areas this may prove difficult. One practice here in rural Georgia is on its third-generation dentist. The first dentist graduated from dental school in 1915. It can happen. Some practices are not so fortunate. Some are forced to simply close. Many graduates are not rural oriented or willing to give up city life.

When studying my situation after considering that one day I will leave my practice, I came across some figures that jolted me. A transitions guru related that the average graduating dentist had educational debt of upwards of $125,000. When my casualty insurance for my office came due, I asked a dental supply company to give me a ballpark figure on replacement cost of my modest four operatories of equipment, computers and so on. The figure was $175,000. Then there is the building. Real estate here in rural Georgia is not as dear as urban areas. Land and my 1,800 square feet of office may be had for $250,000 or so in a similar location. Add that up for a new grad with no patient base.

The transition gurus seem to be on the same page with this problem. Make it an opportunity for a new grad with a win-win associate and buy-in situation. So at age 59 with no plans to retire, it seems the best thing to do. Many in my general age group think the same.

At a recent unrelated seminar, during a break I spoke with an aging dentist from urban Florida who had a different view. We were talking shop about equipment. I had just installed digital radiography. He said he was not spending any more money than he had to on his office since he would be gone in 10 years. Ouch!

I just ordered two new rooms of equipment with computers in each operatory. Flat screen monitors will face the patients for viewing of patient education videos and digital radiographs. This upgrade is my interpretation of what is best for the patient. The equipment seems best for my ergonomics and infection control. My left hand has developed an occasional twitch. Old equipment has many nooks and crannies and is more difficult to clean.

This is a gamble. There is the possibility of having to walk away from the investment. In the meantime, patients are positively influenced by an up-to-date office. This also conveys the treatment is up-to-date.

Most of my rural colleagues have the same philosophy of staying up-to-date. Practicing close to a peanut field need not influence the quality of practice. The best

See MY VIEW, page five

LettersPolicy

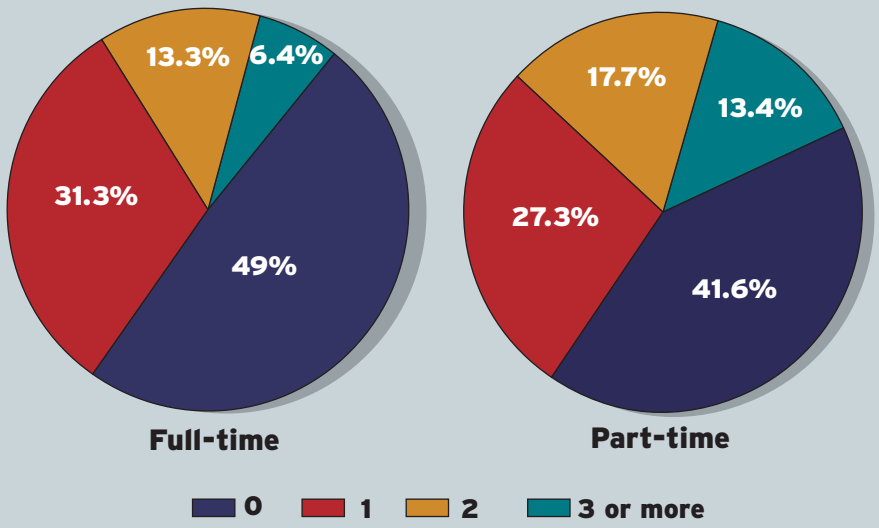
ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views on topics of interest in dentistry. Brevity is appreciated. For those wishing to fax their letters, the number is 1-312-440-3538; e-mail to "ADANews@ada.org".

SNAPSHOTS OF AMERICAN DENTISTRY

Dental workforce

More than half of dentists report employing one or more full-time dental hygienist. Some 58.4 percent of dentists report employing one or more part-time dental hygienist.

Number of full- and part-time dental hygienists currently employed by dentists



Source: American Dental Association, Survey Center, *2004 Workforce Needs Assessment Survey.*

Letters

Thanks, Dr. Sklar

Below is a copy of a letter I am sending to Dr. Andrew M. Sklar of Alexandria, Va., to thank him for his hospitality after I fled from my Katrina-devastated home.

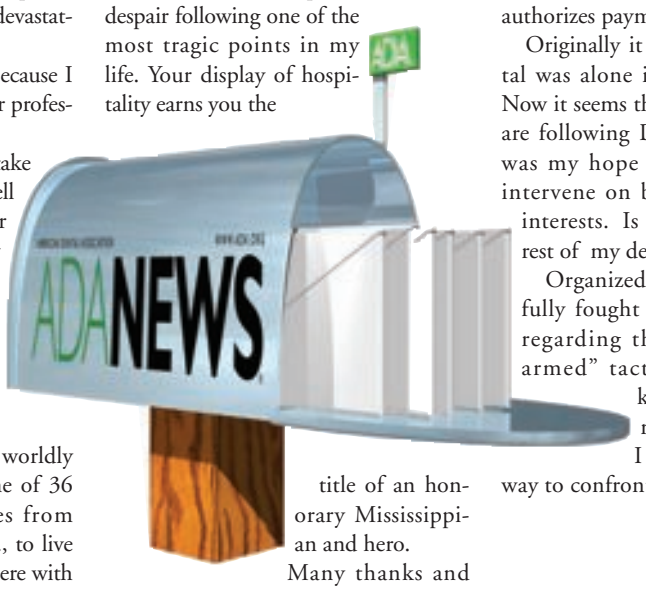
I wanted to share with you because I believe he embodies all that your profession holds as core values.

Dear Dr. Sklar: I wanted to take some time and thank you as well as ensure others know of your passionate selflessness. To say my life was turned upside down within the course of 12 hours as Hurricane Katrina devastated the Mississippi and Louisiana Gulf Coasts is an understatement.

Six days after losing all my worldly possessions including my home of 36 years, I traveled 1,000 miles from Biloxi, Miss., to Alexandria, Va., to live with my son who is stationed there with the U.S. Air Force.

I traveled with only the clothes on my back and the few clothes I purchased prior to my travel. Although all my possessions are gone, I thank God everyday that my family survived without injury.

While visiting the American Red Cross, a nurse interviewed me and gave your name and number as a dental professional providing pro-bono assistance to Katrina victims. From the time I initially called your office to the time I left your office after receiving your services, I was impressed with you and your office's professionalism and care. You were a beacon of hope in a storm of despair following one of the most tragic points in my life. Your display of hospitality earns you the



title of an honorary Mississippian and hero.

Many thanks and God Bless.

Brenda M. Tillman
Biloxi, Miss.

EOBs

I would like to express an opinion regarding what I consider an abuse by dental insurance companies. I am not a "preferred provider" to any company's plan. Delta started sending my payments to the subscriber. At first they sent the usual explanation of benefits stating that the payment was sent to the patient. Now they have begun sending the payment without sending an EOB. The patient claim form authorizes payment to the provider.

Originally it seems that Delta Dental was alone in doing this practice. Now it seems that the other companies are following Delta's bad example. It was my hope that the ADA would intervene on behalf of the dentists' interests. Is this happening to the rest of my dental colleagues?

Organized dentistry has successfully fought back on several issues regarding these types of "strong armed" tactics. I would like to know if the ADA is ready for another fight. I do not know any other way to confront this issue.

Scott A. Terry, D.D.S.
North Vernon, Ind.

Editor's note: The Council on Dental Benefit Programs recognizes that this practice is of concern to noncontracted dentists. There is no question that payers promote direct payments to the treating dentist as an advantage to participation and a disadvantage to nonparticipation in network-based plans. The Council has found that enforcement of the insured's authorization to pay deci-

See LETTERS, page five

GKAS '06 product request deadline: Dec. 1

Give Kids A Smile, the national children's dental health access day, is Feb. 3, 2006.

You can register your GKAS program right up until the day of the event, however the product request deadline is less than two weeks away. To request products, register online by Dec. 1 ("www.ada.org/goto/gkas"). Requests are processed after Dec. 1 and product recipients will be notified by mid-January.

More than 40,000 dental team members registered in 2005—providing 485,700 children with oral health care valued at $32,561,073.

Earlier this year, Crest Healthy Smiles and the ADA presented the winners of the 2005 GKAS scholarship awards to the winning programs. Top honors in the constituent society category went to the District of Columbia Dental Society; in the component society category, the Central Arizona Dental Society took home the prize.

One of the founding corporate sponsors of

Give Kids A Smile, Crest Healthy Smiles sponsors the scholarship awards for outstanding GKAS programs.

"Dental society support for Give Kids A Smile enabled tens of thousands of underprivileged kids to receive care this year, and we really appreciate your ongoing participation," said Mike Sudzina, Procter & Gamble's director of professional and scientific relations (oral care).

The winning societies each took home a $5,000 dental school student scholarship to award to a recipient of their choosing. ■

Winners: The DC Dental Society and Central Arizona Dental Society receive scholarship awards for GKAS excellence. Pictured from left are Mr. Sudzina; C. Jay Brown, DC Dental Society executive director; Dr. Angela Noguera, 2004-05 DC Dental Society president; Rick Murray, Arizona Dental Association executive director; and Dr. Richard Haught, 2004-05 ADA president.

MyView

Continued from page four

approach for us geezers is to employ professional transitions people. With good fortune it will work out.

Aging colleagues, get busy. It is later than you think! In the meantime, according to the ADA Best Management Practices, I must give up mulling amalgam in my hand and thumbing it in. Times do change.

Dr. Maris is a columnist for GDA Action, the monthly journal of the Georgia Dental Association. His comments, reprinted here with permission, originally appeared in the January issue of that publication.

Editor's note: The ADA Council on Dental Practice adds: "Positioning your practice for transition is an important aspect of retirement planning. As Dr. Maris has observed, capital improvements made by a mature practitioner can lead to an easier transition from practice. Every dentist should assess the costs and possible benefits of this decision.

"The Council on Dental Practice has developed resources to help members with practice transitions. These resources are available online or by calling the toll-free number, Ext. 2895."

Letters

Continued from page four

sion, normally executed through the standard claim form, is tied to state law. Consequently, several constituent dental societies promote state insurance regulations that require payers to honor a patient's authorization to pay the provider directly. This is consistent with policy adopted by the House of Delegates in 1994 (Trans.1994:665).

Materials&Technology

DICOM promotes digital X-ray standards

BY ARLENE FURLONG

Does your digital radiographic system and practice management software speak the same language?

Chances are they don't.

To get the entire message across, digital images have to be sent and received in the same language. There's only one that's international. It's ADA endorsed as the standard means for exchange of all digital dental images. Its name? DICOM.

Digital Imaging and Communications in Medicine creates the interoperability necessary for dentists to communicate digital radiographs to any third party, such as other dentists and specialists, and between practice management systems and software systems from different vendors.

Some dentists are under the mistaken impression that any receiver can interpret digital images and display them on a computer monitor, explains Dr. Allan Farman, co-chair of the ADA Standards Committee on Dental Informatics working group for Digital Interoperability/DICOM in dentistry.

Dr. Farman

"I can still listen to 'I Can't Get No Satisfaction' at 45 RPMs if I have a turntable, but I can't play the same record on a CD or DVD player," he said. "There are too many physical issues that prevent that from happening. The same concept also applies to transporting digital diagnostic images." No software standard will guarantee against hardware obsolescence. Interoperability through DICOM is based on the "tune" not the "player."

Now available from the ADA's electronic catalog at "www.adacatalog.org", ADA SCDI Technical Report No. 1023 for Implementation Requirements for DICOM removes the barriers to interoperability between different vendors' digital X-ray system image files. This report provides a template for vendors from which to implement DICOM in a way that is compatible with systems of other vendors who do the same. This report also provides an explanation of DICOM for dental practice.

The ability to export and read DICOM conformant image files is essential to protecting a dental practice's investment in digital imaging equipment down the road, according to Dr. Farman. In the future, communication of dental digital diagnostic images will be as easy as sending a fax and it will be difficult for vendors of digital dental systems to resist becoming DICOM conformant if they wish to compete in the market, he says.

"It would be unlikely that manufacturers of fax machines would have much success selling their products if their machines only accepted transmissions from faxes manufactured by their own company," said Dr. Farman. "And I wouldn't consider purchasing a digital radiographic system from a manufacturer who was not on the list of those who had their digital images validated for DICOM conformance."

Right now, 14 dental practice management software and digital radiographic system manufacturers have successfully participated in the ADA SCDI Work Group 12.1 interoperability demonstration projects that validate DICOM conformance. These companies, and others that are still striving toward reaching the standard, are active in the ADA Standards Committee on Dental Informatics and promote DICOM in dentistry.

"Just as the proof of the pudding is in the eating, the proof of interoperability is in demonstration," comments Dr. Farman, adding that dentists shouldn't rely on testing for DICOM conformance by the companies who sell them the products, but from a neutral entity.

The ADA has conducted demonstrations at the past four consecutive ADA annual sessions—starting with a demonstration at an ADA Technology Day seminar in 2002 and continuing in

See DICOM, page nine

Older adult access program gets boost

GlaxoSmithKline contributes $1 million to ADA Foundation

BY STACIE CROZIER

Philadelphia—Building on the success of the ADA Access to Oral Health Care for Older Adults Initiative, GlaxoSmithKline Consumer Healthcare announced Oct. 8 that it will increase its support for this initiative with a $1 million contribution to the ADA Foundation.

"Once again we are thrilled to partner with the ADA and its Foundation in helping to address the critical need for older Americans to have access to dental care," said Sydney Rollock, vice president, Oral Care, GSK Consumer Healthcare. "This multi-year grant shows our ongoing commitment to this important issue, and we look forward to working with the Foundation to build on the success of this past year."

GSK officials announced the donation at a reception following the 2005 ADA Aging Conference at annual session in Philadelphia. The all-day conference, presented in cooperation with Special Care Dentistry and the ADA Council on Access, Prevention and Interprofessional Relations, was underwritten by a grant from GlaxoSmithKline.

Dr. David Alexander, director, GSK professional affairs, global, and Dr. Ronald Rupp, GSK senior manager, professional relations, presented a $1 million check to ADA and ADAF officials.

The contribution adds to a $250,000 program now under way that funded six access programs around the country to spur development of programs to help older Americans who face financial or other challenges in accessing dental care.

"GlaxoSmithKline, partnered with the ADA and its Foundation, is taking a leadership role in raising awareness about the oral health concerns among the older adult community," says Dr. Arthur A. Dugoni, ADAF president. "Their generous support lays the foundation for a strong partnership in addressing this important access to care issue."

The new funding has not been designated yet for specific programs but could be used to expand the existing program and engage in other professional and public awareness activities. ■

Photo by Lagniappe Studio

Access for older adults: GSK representatives Dr. David Alexander, second from left, and Dr. Ronald L. Rupp, far right, present a check for $1 million to the ADA Foundation Oct. 8. Accepting the check are, far left, Dr. Arthur A. Dugoni, ADAF president; Dr. James B. Bramson, center, ADA executive director; and Dr. Richard Haught, then-ADA president (2004-2005).

Donation to create study hall at UOP

San Francisco—Orthodontic residents at the University of the Pacific Arthur A. Dugoni School of Dentistry are getting a gift from a generous benefactor.

Dr. Robert N. Pickron donated $250,000 to the school to build the "Dr. Robert Pickron Family Residents Study," which will serve as a study hall with private cubicles for orthodontic residents.

"Our constant commitment to learning is what distinguishes us as orthodontists and allows us to serve our patients with the best care possible," said Dr. Pickron, who manages 23 orthodontic offices in the Atlanta area. "Continuing study is essential in a field where change occurs rapidly."

Dr. Pickron selected Pacific for the donation after touring the campus and dental school.

"I felt like the teachers had a humanistic approach to treatment, both for students and patients," he said. "Teachers listen to students; in turn students listen to and focus on patients' needs. It is only through listening that we learn." ■

Singapore awaits dentists

BY STACIE CROZIER

Singapore—The 4th International Dental Exhibition and Meeting will be held April 7-9, 2006, in Singapore.

Koelnmesse, the Singapore Dental Association and the FDI World Dental Federation have joined forces to organize the scientific program and exhibition for the meeting.

IDEM Singapore will feature a variety of continuing education opportunities for attending dentists and dental team members, including courses in restorative dentistry, endodontics, implants, infection control, cosmetic dentistry and orthodontics. Participants can also enroll in hands-on workshops in veneers and endodontics. IDEM Singapore also features the largest dental exhibition in Southeast Asia.

The meeting offers a variety of tour options to help international visitors enjoy the wonders of Singapore—a melting pot city where eastern and western cultures meet and blend. Historic sites and architecture, the arts, fine dining, health spas, shopping and lush gardens and parks are just a few of Singapore's wondrous attractions.

For more information or to register, visit IDEM Singapore's Web site: "www.idem-singapore.com". To learn more about Singapore browse "www.visitsingapore.com". ■

Photo courtesy of Singapore Tourism Board

International sparkle: The glittering city skyline of Singapore's Central Business District awaits those who attend IDEM-Singapore April 7-9, 2006. The dental meeting will feature a scientific program and dental exhibition and is the largest in southeast Asia.

Support oral health worldwide

BY STACIE CROZIER

Ferney-Voltaire, France—You can support oral health projects in developing and underserved areas worldwide and keep informed about the latest developments in international dentistry by joining the Friends of the FDI.

The FDI World Dental Federation offers the Friends of the FDI membership to dentists, dental team members, dental trade and industry representatives or anyone else interested in the activities of the FDI.

For a monthly membership fee of €20 (about $24 dollars at current exchange rates), Friends of the FDI members receive six issues of the International Dental Journal, two issues of Developing Dentistry, six electronic issues of the Ferney Communiqué and a 10 percent discount on items sold at the FDI Pavilion during the FDI World Dental Congress.

At least €8 of your membership fee each month will be donated to the World Dental Development Fund, which contributes to oral health development projects in developing countries and underserved populations. Current projects supported by the fund include programs in northern Pakistan, Namibia, rural India, Rwanda, Latin America and Togo.

For more information or to join, log on to "www.fdiworldental.org/friends/index.html" or contact the FDI USA Section by calling toll-free, Ext. 2727. ■

International exchange

Spanish dentist wins trip to ADA annual session

BY STACIE CROZIER

Montreal—Dr. M. Alfonso Villa-Vigil, of Madrid, Spain—one of 250 international dentists who shared their thoughts on global dentistry with the ADA at the FDI World Dental Congress in August—has won a five-night stay in Las Vegas and free registration for annual session 2006 in Las Vegas for participating in the International Dental Survey.

"We are very pleased that Dr. Villa-Vigil won this trip to Las Vegas," said ADA Executive Director James B. Bramson. "I am sure that this will be an exciting trip for him, because Las Vegas has so much to offer. And, we expect that this meeting will be one of the largest we've conducted in many years."

The survey, completed by about 250 international dentists attending, was designed to help the ADA learn more about global dentistry and to help the ADA collaborate with international dental associations to more effectively contribute to the advancement of oral health care worldwide. The ADA also surveyed international attendees at annual session in Philadelphia last month. The ADA meeting drew some 675 international attendees, including nearly 275 dentists.

The ADA Center for International Development and Affairs offers international dentists attending annual session a variety of benefits, including an international reception, a hospitality lounge, multilingual staff, a certificate of attendance and information on ADA affiliate memberships. CIDA also sends letters of invitation to international registrants who may need verification to obtain travel visas.

In addition to working closely with international attendees, CIDA also presents programs at annual session for U.S. dentists on international volunteer opportunities through Health Volunteers Overseas/Dentistry Overseas, a volunteer program sponsored by the ADA, and information on the FDI World Dental Federation.

Las Vegas bound: Dr. M. Alfonso Villa-Vigil, inset photo at left, president of the Spanish Dental Association (Asociación Española de Endodoncia), is the lucky winner of the International Dental Survey contest. Dr. Robert M. Brandjord, ADA president, above left, and Dr. James B. Bramson, ADA executive director, draw the winning name at ADA Headquarters Sept. 28.

Dr. Villa-Vigil, who is president of the Spanish Dental Association (Asociación Española de Endodoncia), wins a five-night stay in Las Vegas for himself and a companion during ADA annual session Oct. 16-19, 2006, and free registration to the meeting. ■

Rep. Norwood returns to work after lung surgery this month

Washington—Dentist/Rep. Charlie Norwood (R-Ga.) is back at work in his Capitol Hill office and available for votes in the U.S. House of Representatives.

He was released Nov. 10 from Inova Fairfax Hospital in Falls Church, Va., five days after doctors removed a small malignant tumor from his left lung. A non-small cell cancer, "a little spot about the size of a quarter," was discovered during a Nov. 3 checkup of the transplanted right lung Rep. Norwood received just over a year earlier. The cancer did not affect the transplanted lung.

Rep. Norwood's doctors say they were able to cure the malignancy surgically, having found the Stage 1 tumor quickly, and that no follow-up therapy is necessary. They discharged the former private practice, U.S. Army dentist at his request after advising at least several weeks of recuperation before resuming congressional duties.

However, Rep. Norwood said, "As long as I'm up, I might as well stay up."

He intends to seek re-election next year from a newly drawn 10th congressional district in Georgia, said his communications director, John Stone. Rep. Norwood represents the 9th district. ■

Crest, Oral-B combine under new corporation

P&G, Gillette get OK to merge

Cincinnati—Two of the biggest brands in oral health care, Crest and Oral-B, are joining forces following the Oct. 18 announcement that their respective parent companies, Procter & Gamble and Gillette, have decided to merge.

The news comes on the heels of the merger's approval by the Federal Trade Commission, European Commission and shareholders.

"An important part of our vision for the combined business is to design a world-class professional organization to help serve the needs of patients and to advance the science and education of oral health," said Michelle Stacy, vice president and general manager of global professions, oral care, for the combined companies. ■

DICOM

Continued from page six

practical demonstrations within ADA Marketplace exhibits and Technology Day tabletop presentations in 2003, 2004 and 2005.

"There are no DICOM police. But standards are standards and one problem dentists have with digital radiography right now is that they believe they have purchased an interoperable system, only later to find that this is not the case," explained Dr. Farman.

He says dentists sometimes don't realize every component in a system has to work together to achieve interoperability.

"Some digital system manufacturers may be less inclined to promote the idea of DICOM conformance because it keeps dentists purchasing within their line of products," says Dr. Farman.

Digital radiography manufacturer Schick Technologies' John Goyette, Ph.D., contributed to the report as co-chairman with Dr. Farman. He says dentists should get a DICOM conformance statement from their vendors, which specifies what parts of the systems are DICOM conformant.

"One of the goals of manufacturers that participate in the ADA demonstrations is to prove DICOM conformance," said Dr. Goyette. "Dentists may not know how long a vendor will be operating, but they'll know their data will always be able to be read if their systems are DICOM conformant. As we see more people buying digital radiographic equipment, this becomes more and more important."

DICOM files not only carry the digital image, but also imbedded information containing patient identifiers and other data such as who made the image, on what equipment, at what time, on what date. DICOM files also show if the file is original or enhanced to be used with DICOM conformant practice management software.

Dr. Farman says the origins of DICOM go back 22 years, but dentists' desire for digital radiographic equipment is driving its importance within dentistry today. He estimates that some 20 percent of the dental market is already digital, with the largest practice management companies claiming users of digital systems varying from a high of 40 percent to a low of 17 percent in the United States.

Currently, the International Standards Organization is working with the DICOM Standards Committee to make DICOM an ISO referenced standard for all medical and dental digital images. The ADA represents all of organized dentistry as a voting member of the DICOM Standards Committee. ■

Exam

Continued from page one

adequately prepared for practice.

"This is a great opportunity for the general practitioner who seldom has a chance to provide feedback into this process to be able to contribute," said Dr. Ziemiecki.

Cases are integral to assessing a candidate's knowledge of clinical disciplines and the ability to use that knowledge to solve patient problems. Items are stand-alone questions in multiple-choice format that evaluate knowledge of basic and clinical science.

Cases should present as realistically as possible a situation that includes a patient, a set of conditions and complaint of problems. A good case for the national boards, Dr. Ziemiecki emphasized, involves one with appropriate documentation—including patient history, dental charts, radiographs and clinical photos.

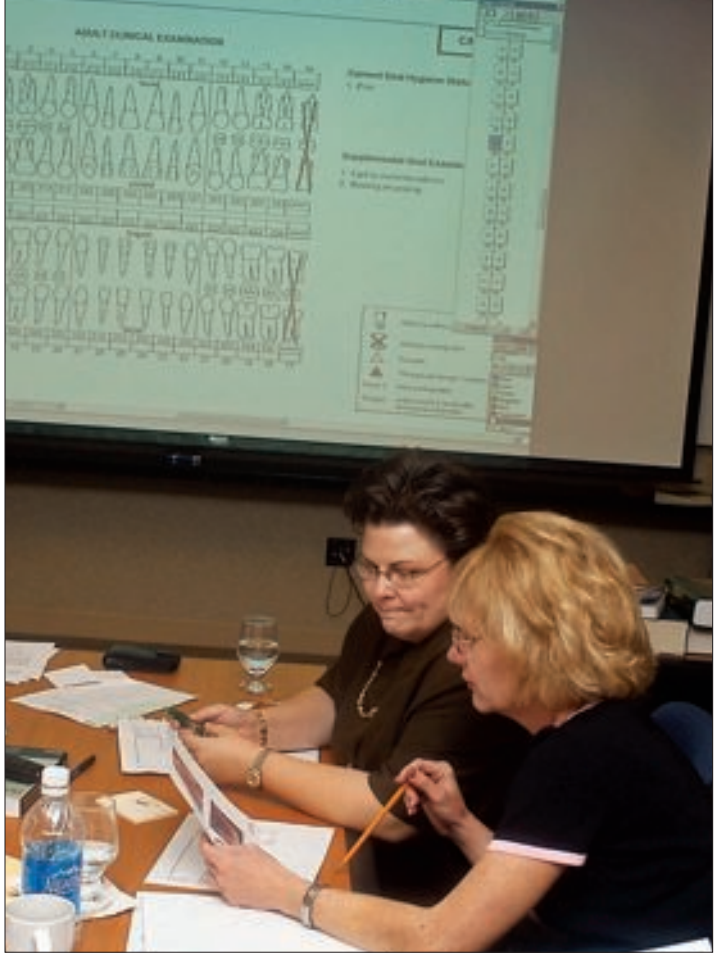
"In addition, we usually like to have at least three disciplines included in one case, for example a case that involves operative dentistry, periodontics and prosthodontics," he said.

Dentists and dental hygienists encounter compelling cases on a regular basis, and many that involve complex biomedical issues.

"We're looking for cases that are not just dental but biomedical," said Dr. Ziemiecki. "Maybe a patient has a caries problem related to medications. Such cases are ones that beginning dentists should know about but don't often get a chance to see."

The National Board Dental Hygiene Examination presents a unique challenge for the test construction committees by requiring a higher volume of cases. The case-based section of the dental exam has 10 cases per test; the hygiene exam includes 150 items based on 12 to 15 cases.

"In dental hygiene, we're dealing with case histories, clinical pictures and radiographs, and that's



Good cases needed: Members of the Component B Test Construction Committee study possible cases for the national boards Sept. 19. Committee members include (far left) Dr. Jacqueline Plemons (left), Baylor College of Dentistry, and Lynn Tolle, Old Dominion University; and above, Diane Bourque (left), Community College of Rhode Island, and Kathy Griffin, Lake Superior College.

all we have to work with," said Dr. Jacqueline Plemons, a member of the Component B Committee and associate clinical professor in the department of periodontics at Baylor University. "This requires more cases to ensure dental hygiene candidates have a good level of knowledge."

What's most important, said Dr. Plemons, are "good clinical photographs, a full-mouth series of radiographs, and case histories that are challenging for students and maybe have interesting case histories that lead to questions that test across a variety of subjects."

Test items do not necessarily constitute completed treatment, added Dr. Ziemiecki.

"A good case could be the first visit before any treatment is done, a case that is in the midst of treatment, even a completed case that presents with a new problem or a problem related to something that was treated before," he said.

Case materials should include intraoral photos and radiographs that are of good technical quality—clear, well-framed and free of artifacts.

All submitted materials are reviewed by a case selection committee. If the committee determines the case is suitable for use on the NBDEs, an honorarium of $200 will be sent to the contributor.

The ADA Department of Testing Services publishes the "Case Development Guide" with details on criteria for submissions and patient release, copyright, patient history and radiograph forms.

For more information or to receive a Case Development Guide, contact Debra Willis, "willisd@ada.org" or Ext. 2671. ■

Michigan

Continued from page one

But last year, a "clean water" ballot initiative turned off the taps by a narrow voter margin of 52 percent to 48 percent.

Dr. Daniel Kane, a Mt. Pleasant dentist and concerned citizen, said he went to a Ninth District Dental Society meeting after the 2004 ballot measure was passed and raised his hand to ask a question when they were discussing fluoridation ballot strategy, "and they put me in charge," he says. "I told them I was too old, I wasn't experienced in politics or public speaking, but it didn't seem to matter."

So Dr. Kane says he starting working with the Michigan Dental Association to devise strategies to educate local citizens about the confusing wording of the 2004 ballot initiative and about the benefits of fluoridation. He attended the 2005 National Fluoridation Symposium at ADA Headquarters in July, where he learned about political, legal, scientific and mechanical issues related to fluoridation and networked with a variety of speakers and attendees, from water system engineers to people—like him—who had conducted or were planning a profluoridation campaign.

> **"When people know the issues, I think they vote the correct way and it showed tonight."**

"I've been to a lot of continuing education programs," says Dr. Kane, "but I came out of the symposium with so much knowledge. I attended the spokesperson training session and, although I've never been a public speaker, it really prepared me for the work I had ahead of me—to speak before the city commissioners, participate in a League of Women Voters forum and be interviewed several times for local newspapers and a couple of radio shows. Everything was fantastic."

The campaign used direct mail pieces to all registered voters, radio spots, newspaper ads, postcards for dentists to distribute or mail to their patients, letters to the editor and yard signs that borrowed another Fluoridation Symposium attendee's campaign slogan, "Got Teeth? Get Fluoride."

"It was a real grassroots effort," says Tom Kochheiser, director of marketing and public information for the Michigan Dental Association. "Dr. Kane was co-chairman of the ballot proposal committee and the driving force behind the successful campaign. During the September meeting of the NDDS, we gave each member a water fluoridation background kit, complete with sample patient letters and editorials on a disk. They also received a quantity of postcards for distribution to patients."

"Our dental society is small," says Dr. Kane. "About 46 dentists in the three-and-a-half-county area and 16 in Mt. Pleasant. The dentists worked hard in a grassroots effort to reach their patients."

"I'm thrilled. This is a statement," Dr. Kane told the Mt. Pleasant Morning Sun after the victory at the polls. "When people know the issues, I think they vote the correct way and it showed tonight."

The Sun article also included input from the citizen who organized the removal of fluoride from Mt. Pleasant's water supply:

"This is surprising to me. Unbelievable," said Gladys Mitchell, organizer of the 2004 ballot proposal that removed fluoride. "The evidence is so overwhelming what (fluoride) does to the body."

Mitchell said the wide disparity in money between the two groups was probably a large factor in the measure's passage as well as tradition.

"People trust their dentist," Mitchell said. "It's just real sad."

On the West Coast, a hotly contested fluoridation ballot measure in Bellingham, Wash., at press time remained too close to call.

As of Nov. 15, mail ballots rejecting fluoridation had a 341 vote lead and 51.2 percent of the votes over the 48.8 percent tally of profluoridation votes. Officials estimate that some 20,000 ballots are left to count. City officials say ballot counting should be completed and results made official by the end of November.

Watch ADA News Today online ("www.www.ada.org/goto/adanews/") and upcoming issues of ADA News for updates.

Three other communities will remain without community water fluoridation based on election results from Nov. 8. Voters in Xenia, Ohio; Springfield, Ohio; and Tooele City, Utah, rejected community water fluoridation ballot measures. ■

Topical fluoride gets EBD review

BY JENNIFER GARVIN

Work on evidence-based clinical recommendations on professionally applied topical fluoride began Oct. 17 and 18 at a workshop at ADA Headquarters.

Eight scientific experts on fluoride, including Dr. Amid Ismail, chair of the Council on Scientific Affairs and a professor at the University of Michigan School of Dentistry, reviewed and critiqued literature written on professionally applied topical fluoride. Dr. Jeffrey Hutter, chair of the ADA's Evidence-Based Dentistry Advisory Committee and an associate dean at Boston University's School of Dental Medicine, moderated the event.

The panelists analyzed and discussed the collective data available in systematic reviews and recent clinical studies on professionally applied topical fluoride, including fluoride gels and varnish. They will draft a user-friendly report with recommendations to help dentists in their clinical decision-making. The report will contain evidence-based clinical recommendations that are based on a patient's age and caries risk.

"It was a great experience to work with experts in the field of fluoride research and discuss how we should apply fluoride products in the dental office," Dr. Ismail said. "The clinical recommendations will expand the age range that topical fluoride should be used and is tailored to caries risk of the patients. The clinical decision is left in the hands of the dentist in collaboration with his or her patient. This is the ADA's EBD policy."

"This is the first time that the ADA has used an evidence-based process to develop recommendations," said Julie Frantsve-Hawley, Ph.D., assistant director, Division of Science. "The clinical recommendations will provide a useful tool for dentists to use in clinical decision-making. This tool will be an adjunct to be used in combination with the dentist's expertise and judgment as well as patient preferences."

The panel expects to finalize the report in early 2006 and to post it on ADA.org.

Panel members are:

- Dr. Amid Ismail, chair, ADA Council on Scientific Affairs; professor, Department of Cariology, Restorative Sciences and Endodontics; University of Michigan School of Dentistry.
- James S. Wefel, Ph.D, assistant dean and acting dean for research and the director of the Dows Institute for Dental Research; University of Iowa College of Dentistry.
- Dr. John Stamm, professor, Department of Dental Ecology and Dental Research School of Dentistry; University of North Carolina.
- Albert Kingman, Ph.D., chief, Biostatistics Core; National Institute of Dental and Craniofacial Research.
- Dr. Jarvis T. Chan, Ph.D., D.D.S, professor, Department of Integrative Biology and Pharmacology; University of Texas Health Science Center at Houston Medical Center.
- Dr. Domenick T. Zero, director, Oral Health Research Institute; Indiana University School of Dentistry.
- Dr. Norman Tinanoff, Department of Pediatric Dentistry; University of Maryland Baltimore College of Dental Surgery.
- John D.B. Featherstone, Ph.D., professor and chair, Department of Preventive and Restorative Dental Sciences; University of California, San Francisco.

"The clinical decision is left in the hands of the dentist in collaboration with his or her patient. This is the ADA's EBD policy."

For more information, contact the Division of Science via the ADA toll-free number at Ext. 2878 or e-mail "science@ada.org". ■

JCAHO backs technology, forms patient safety panel

Oak Brook Terrace, Ill.—The Joint Commission on Accreditation of Healthcare Organizations formed a Healthcare Information Technology Advisory Panel to help improve patient safety and clinical processes as new health care information systems develop.

The panel includes some 40 individuals representing the Office of the National Coordinator for Health Information Technology, American Health Information Management Association, Agency for Healthcare Research and Quality, Veterans Health Administration and Healthcare Information and Management Systems Society, as well as researchers, physicians, nurses, chief information officers, educators and health care organization leaders.

The panel will provide recommendations for the Joint Commission's accreditation process to encourage the widespread use of technology to improve patient care, safety, quality and efficiency.

For a list of panelists or more information, log on to "www.jcaho.org". ■

AnnualSession

2005 House actions

Philadelphia—This is the second installment of a summary of resolutions adopted by the 2005 House of Delegates during the ADA annual session last month. Other key actions were summarized in the Nov. 7 issue of ADA News. This report was compiled by Arlene Furlong, Jennifer Garvin and Judy Jakush.

Photo by Lagniappe Studio

Outstanding students: Winners of the ADA/Dentsply 2005 Student Clinician Program include, front row: Aaron James Cregger, Megan Robl, Amy E. Suhr and Scott Joslin; back row: Lee D. Pham, Joseph R. Karam and William R. Allen Jr.

Budget, business and administrative matters

Res. 26H-2005 urges the Board of Trustees to maintain the ADA's liquid reserves at a targeted level of 40 percent of the Association's annual budgeted operating expenses. Liquid reserves are defined as the total uncommitted balance of the Reserve Division Investment Account.

The resolution also urges the Board to use reserve funds in excess of the 40 percent target level in developing the following year's annual operating budget in a manner consistent with a long-term financial strategy of dues stabilization, taking into consideration any known contingent use of reserves.

Finally the resolution rescinds Res. 110H-2002, Association Reserve Levels (Trans.2002: 372).

Res. 28H-2005 approves the 2006 annual budget (as reported in the Oct. 17 ADA News).

Res. 30H-2005 rescinds Res. 139H-1995 (Trans.1995:604), which had requested an annual report summarizing the financial options available for the ADA's Washington, D.C. property.

Res. 61H-2005 urges constituent and component dental societies to develop a network of volunteer dentists to help maintain the practices of dentists who are temporarily activated into military service by practicing in the deployed dentist's office and treating their patients.

Res. 63H-2005 urges the Board of Trustees to develop a plan for the long-term needs of our dental family resulting from disasters and calls for a report to the 2006 House of Delegates on the plan and appropriate recommendations.

Res. 74H-2005 directs the ADA to fund an amount of up to $60,000 for 2006 operating expenses in addition to the amount currently in the 2006 budget to the Alliance of the American Dental Association (AADA).

The resolution also calls for the appropriate ADA agencies to work with the Alliance to evaluate programmatic relationships between ADA and AADA and that the study include an evaluation of opportunities to align ADA and AADA more effectively in terms of structure and function, with a report with recommendations due to the 2006 House of Delegates.

Res. 87H-2005 urges the ADA Foundation Board of Directors to temporarily waive the grant limit of the Disaster Response Fund above $2,500, if excess money is available, for victims of 2005 hurricanes.

Res. 93H-2005 affirms that the Association opposes pilot programs that are in violation of the ADA policy in Res. 24H-2004 that states: "The ADA is opposed to non-dentists making diagnoses, developing treatment plans or performing irreversible procedures."

Res. 95H-2005 directs the ADA Board of Trustees to review current policy concerning financial assistance to constituent societies on issues of national significance, with a report on this review due to the 2006 House of Delegates.

Dental benefits, practice, science and health

Res. 4H-2005 amends the policy, Audits of Private Dental Offices by Third-Party Payers, by revising the second clause to read: "and in the event of an audit, the dentist is encouraged to obtain a written description and scope of the audit procedures and should seek the advice of his or her legal counsel." Res. 4H also adds the following clause to the policy: "that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices." (Look in an upcoming issue of the ADA News for an article detailing what dentists need to know about retrospective claim audits.)

Res. 5H-2005 rescinds Res. 32H-2003, "Insurance Benefits for Posterior Direct Resin Restorations."

Res. 6H-2005 deletes the following sentence in the Statement on Prosthetic Care and Dental Laboratories, section on regulation of laboratories: "As the dental laboratories do not shoulder the ultimate responsibility for the public's welfare, the Association believes that licensure of dental laboratories is not warranted."

Res. 7H-2005 adopts a new ADA policy that recognizes the growing public awareness of the importance of professional health in the Statement on Dentist Health and Wellness. (See story, page 14.)

Res. 8H-2005 recognizes the extent of problems associated with the abuse of controlled substances, particularly opioids, with an ADA Policy Statement including guidelines for the use of opioids in the treatment of dental pain, which states:

1. The ADA encourages continuing education about the appropriate use of opioid pain medications in order to promote both responsible prescribing practices and limit instances of abuse and diversion.

2. Dentists who prescribe opioids for treatment of dental pain are encouraged to be mindful of and have respect for their inherent abuse potential.

3. Dentists who prescribe opioids for treatment of dental pain are also encouraged to periodically review their compliance with Drug Enforcement Administration recommendations and regulations.

4. Dentists are encouraged to recognize their responsibility for ensuring that prescription pain medications are available to the patients who need them, for preventing these drugs from becoming a source of harm or abuse and for understanding the special issues in pain management for patients already opiate dependent.

5. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for nondental purposes.

Appropriate education in addictive disease and pain management should be provided as part of the core curriculum at all dental schools.

Res. 9H-2005 rescinds Res 64H-1986, "ADA Policy Statement on Chemical Dependency."

Res. 10H-2005 replaces the ADA's policy related to substance use disorders as diseases, using current terminology.

Res. 11H–2005 adopts the following ADA Statement on Substance Abuse Among Dentists:

1. Dentists who use alcohol are urged to do so responsibly. Dentists are also urged to use prescription medications only as prescribed by an appropriate, licensed health care professional and to avoid the use of illegal substances.

2. Colleagues, dental team members and the dentists' family members are urged to seek assistance and intervention when they believe a dentist is impaired.

3. Early intervention is strongly encouraged.

4. Dentists with addictive illness are urged to seek adequate treatment and participate in long-term monitoring protocols to maximize their likelihood of sustained recovery.

5. Impaired dentists who continue to practice, despite reasonable offers of assistance, may be reported to appropriate bodies as required by law and/or ethical obligations.

Dentists in full remission from addictive illness should not be discriminated against in the areas of professional licensure, clinical privileges, or inclusion in dental benefit network and provider panels solely due to the diagnosis and recovery from that illness.

The ADA encourages additional research in the area of dentist impairment and the factors of successful recovery.

Res. 12H-2005 adopts new policy, "Statement on Substance Use Among Dental Students," to reflect awareness of the vulnerability of young people in the natural development of substance use disorders and calls attention to the Association's role in transmitting professional norms and behaviors to its future practitioners.

Res. 13H-2005 rescinds Res. 17H-1989, "ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent."

Res. 14H-2005 adopts ADA policy on the provision of dental treatment for patients with substance use disorders as follows:

1. Dentists are urged to be aware of each patient's substance use history, and to take this into consideration when planning treatment and prescribing medications.

2. Dentists are encouraged to be knowledgeable about substance use disorders—both active and in remission—in order to safely prescribe controlled substances and other medications to patients with these disorders.

3. Dentists should draw upon their professional judgment in advising patients who are heavy drinkers to cut back, or the users of illegal drugs to stop.

4. Dentists may want to be familiar with their community's treatment resources for patients with substance use disorders and be able to make referrals when indicated.

5. Dentists are encouraged to seek consultation with the patient's physician, when the patient has a history of alcoholism or other substance use disorder.

6. Dentists are urged to be current in their

Photo by Lagniappe Studio

Honorary members: The ADA Board of Trustees conferred honorary membership Oct. 10 on individuals pictured above who have made notable contributions to the oral health of the public and the advancement of the art and science of dentistry, including, from left: C. Wayne McMahan, executive director and lobbyist, Alabama Dental Association; Dr. John Clarkson, dean, Dental School and Hospital at Trinity College, Dublin, Ireland; Dr. Martin H. Hobdell, visiting professor, University College London and member, ADA's Health Volunteers Overseas/Dentistry Overseas Steering Committee; David S. Horvat, executive director, Tennessee Dental Association; William E. Zepp, executive director, Oregon Dental Association; Dr. Richard Haught, then-ADA president; A. Jerry Davis, executive director, Idaho State Dental Association; Mary Kay Linn, executive director, Texas Dental Association; Peter F. Taylor, executive director, Vermont State Dental Society; Dennis J. McGuire, executive director, Wisconsin Dental Association; and Daniel J. Buker, executive director, Florida Dental Association.

Photo by Judy Jakush

Service honored: Dr. Bill Lawson, long-time ADA budget watchdog and delegate for 36 years from Alabama, holds the special certificate awarded him Oct. 11 during annual session by Dr. Mark J. Feldman, ADA treasurer. "You have to love a guy like that," said Dr. Feldman in announcing the award.

knowledge of pharmacology, including content related to drugs of abuse; recognition of contraindications to the delivery of epinephrine-containing local anesthetics; safe prescribing practices for patients with substance use disorders—both active and in remission—and management of patient emergencies that may result from unforeseen drug interactions.

7. Dentists are obliged to protect patient confidentiality of substance abuse treatment information, in accordance with applicable state and federal law.

Res. 15H-2005 adopts a new policy, "ADA Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients," as follows:

1. Dentists are encouraged to inquire about pregnant or postpartum patients' history of alcohol and other drug use, including nicotine.

2. As health care professionals, dentists are encouraged to advise these patients to avoid the use of these substances and to urge them to disclose any such use to their primary care providers.

3. Dentists who become aware of postpartum patients' resumption of tobacco or illegal drug use or excessive alcohol intake are encouraged to recommend that the patient stop these behaviors. The dentist is encouraged to be prepared to inform the woman of treatment resources, if indicated.

Res. 16H-2005 adopts new policy related to child and adolescent patients in response to dentists' requests to the Dentist Well-Being Program of the Council on Dental Practice for guidance in this area, as well as the societal problem of young peoples' access to a variety of drugs of abuse, as follows:

1. Dentists are urged to be knowledgeable about the oral manifestations of nicotine and drug use in adolescents.

2. Dentists are encouraged to know their state laws related to confidentiality of health services for adolescents and to understand the circumstances that would allow, prevent or obligate the dentist to communicate information regarding substance use to a parent.

3. Dentists are encouraged to take the opportunity to reinforce good health habits by complimenting young patients who refrain from using tobacco, drinking alcohol or using illegal drugs.

4. A dentist who becomes aware of a young patient's tobacco use is encouraged to take the opportunity to ask about it, provide tobacco cessation counseling and to offer information on treatment resources.

5. Dentists may want to consider having age-appropriate anti-tobacco literature available in their offices for their young patients.

6. Dentists who become aware of a young patient's alcohol or illegal drug use (either directly or through a report to a team member) are encouraged to express concern about this behavior and encourage the patient to discontinue the drug or alcohol use.

A dentist who becomes aware that a parent is supplying illegal substances to a young patient may be subject to mandatory reporting under child abuse regulations.

Res. 17H-2005 editorially updates language of the "Guiding Principles for Dentist Well-Being Activities at the State Level" and recognizes changes in the way assistance services are delivered to dentists.

Res. 37H-2005 directs the ADA to encourage manufacturers and distributors to follow the International Organization for Standardization number coding system for diamond-bur instruments. The House also rescinded the ADA policy on the Standardized Numbering System for Diamond Burs.

Res. 52H-2005 directs appropriate agencies, in consultation with marketing and advertising experts, to study the necessity and potential value of developing a brand name for the concept of direct reimbursement, including the variation known as direct assignment, and if deemed appropriate by the agencies develop a plan of action to produce a new brand name for use in the national campaign.

Res. 76H-2005 states that the ADA, in cooperation with the scientific community and drug abuse and public health experts, work together to keep the public and profession aware of the oral health effects of drug abuse.

Res. 83H-2005 directs the ADA to urge the U.S. Food and Drug Administration to require that a subcontracting dental laboratory notify the dentist in advance when prostheses, components or materials indicated in the dentist's prescription are to be manufactured or provided, either partially or entirely, by a foreign dental laboratory or any domestic ancillary dental laboratory.

Dental workforce related issues

59H-2005 calls for appropriate ADA agencies, in consultation with the recognized dental specialties and representatives from general dentistry, to review supervision of dental hygienists in all United States licensing jurisdictions in all work settings, including public health agencies, and report to the 2006 House of Delegates with a definition of public health supervision.

Res. 85H-2005 reaffirms the Association's role as the premier advocate for the oral health of all Americans. (See story, page 14.)

■ **More on workforce, access, dental practice and dental health resolutions, page 14**

Legal and legislative issues

Res. 40H-2005 calls for the ADA to actively lobby for liability reform legislation that should not override state limits on noneconomic damages, to actively communicate the Association's position on medical liability reform in all appropriate policy/decision-making venues and to pursue coalition opportunities with other impacted health care professionals.

Res. 54H-2005 resolves that the ADA work with federal regulatory officials and others to develop a system for addressing complaints between dentists and health centers (funded under section 330 of the Public Health Services Act). This resolution also directs the ADA to find a way to ensure that health center grant reviewers receive accurate and complete information on the dental providers participating in the Medicaid program affecting underserved populations that will be served by facilities under review for section 330 grants.

The resolution also asks that each constituent dental society be encouraged to establish a joint initiative with the primary care association in its state to address oral health care access and be encouraged to help form dental advisory boards with the health centers in their area and report on these efforts to the Council on Government Affairs. Additionally, the resolution calls for the ADA to monitor these outreach initiatives and the Council to include such information in its annual report.

Res. 55H-2005 calls for the ADA, in consultation with constituent dental societies, to implement the 2006 advocacy plan to prevent state bans on dental amalgam.

Recognizing that accommodating the language needs of English-limited patients is a shared responsibility of the profession, **Res. 56H-2005** calls for the ADA to work with the appropriate federal agencies, advocacy groups, trade associations and other stakeholders.

The resolution also calls for the Association to support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff.

In turn, the ADA will oppose any legislation that would unreasonably add to the administrative, financial or legal liability of providing dental services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving state and/or federal benefits.

Constituent and component dental societies are encouraged to support state, local and private sector efforts to address the language needs of English-limited patients. Dental and allied dental programs are encouraged to educate students about the challenges associated with treating these patients. Finally, the resolution calls for Res. 96H-2001, the Federal Guidelines on Limited English Proficiency, to be rescinded.

Res. 57H-2005 directs the ADA president to appoint a presidential task force on improving access to native populations of up to seven members, which will include, at a minimum, the four members of the current Alaska Native Oral Health Care Access Task Force and that this task force report to the House of Delegates in 2006.

Res. 79 was referred to the appropriate agencies for study and report to the 2006 House. It calls for the ADA and its constituents and components to make lobbying for adequate funds to provide oral health care to the Medicaid and other indigent care populations the highest priority and for the organizations to carry out an intensive educational program to enlighten the public and government agencies of the value of oral health care and consequences of untreated oral health disease to the overall health of citizens and the health care system. ■

Workforce issues under study

BY ARLENE FURLONG

Philadelphia—Reaffirming dentistry's role as the premier advocate for the oral health of all Americans, the 2005 House of Delegates last month adopted Resolution 85H-2005 to further explore dental workforce models.

The resolution calls for a presidentially appointed task force to gather and analyze sufficient data about availability of dental care to underserved groups and recommend any needed changes.

Its work will build upon the foundation of knowledge constructed by last year's task force, which was charged with identifying the best way to utilize the dental workforce to meet access needs of the underserved.

The breadth of research the new objectives entail will require the task force to call upon ADA councils, interested parties, experts, staff and state dental societies to provide research and information to the ADA Health Policy Resource Center for analysis.

"I'm impressed with the tremendous accomplishments of last year's task force,"said Dr. T. Howard Jones. The 2002-2003 ADA past president will serve as nonvoting chair when the 2005 task force convenes for its first meeting Dec. 5-6 at ADA Headquarters. "Our charge has been expanded and our first step will be to gather and compile additional information as directed by the House."

ADA data shows an adequate supply of dentists to meet demand for dental services during the next decade and beyond. However, the Association also recognizes dentist distribution and other issues can prevent access to care in some areas.

"Adequacy of workforce is often the connection between access issues and scope of practice," said ADA President Robert M. Brandjord, ex-officio member of the 2005 task force. "The new task force brings together a diverse group from which to build a consensus on workforce needs now and in the future."

Res. 85H-2005 calls for the formation of a 19-member task force, consisting of one member from each trustee district and two ADA trustees appointed by the ADA president, with members of the Council on Access, Prevention and Interprofessional Relations and Council on Dental Practice represented as full voting members.

It directs the Association to support:

• the study of possible new types of allied dental personnel and realignment of roles for existing personnel to perform their duties;

• community-based oral health provider programs without including alternative restorative treatment and local anesthesia, as a viable alternative to the dental health aide therapist.

The resolution also directs the task force to collect and review existing data to develop additional information, if needed, and report to the 2006 ADA House of Delegates on the following issues:

• the adequacy of the current workforce to serve the population groups with unmet oral health care needs, and the oral health of the general population;

• the rationale and feasibility of additional duties for allied dental personnel and the possible realignment of roles, including the analysis of existing programs where additional duties are in place;

• the impact on access to care in states where expanded duties or independent practice of dental auxiliaries have been granted to members of the dental team;

• the disparity between need and demand for oral health care and the real and perceived causes of any unmet needs;

• the development of strategies to increase oral health literacy and utilization;

• economic factors including, but not limited to, development of business models and financial incentives that would attract and retain dental practitioners to underserved areas.

The 19-person group includes Drs. Robert E. Barsley, Pouchatoula, La.; Cynthia A. Bolton, Reedsville, N.C.; Vincent Filanova, Amsterdam, N.Y.; Debra S. Finney, Folsom, Calif.; Edward J. Green, Albany, Ga.; Harold J. Haering, Labelle, Fla.; Roger L. Kiesling, Helena, Mont.; Timothy R. Kinzel, Madison, Wis.; John T. Mooney, Pocatello, Idaho; Theodore R. Pope, Englewood, Ohio; William K. Rich, Dry Ridge, Ky.; John A. Maletta, Des Moines, Iowa; Philip T. Siegel, Fort Washington, Pa.; Larry W. Spradley, Bedford, Texas; Keith W. Suchy, Westchester, Ill.; Robert H. Talley, Las Vegas; Carol Turner, Vienna, Va. The task force also includes ADA 16th District Trustee Ronald L. Tankersley, Newport News, Va., and 8th District Trustee Perry K. Tuneberg, Rockford, Ill. ■

New ADA policy on dentist health and wellness

Philadelphia—Delegates took action last month to focus on the health of the dentist.

Recognizing growing public awareness of the importance of professional health, Resolution 7H-2005 addresses the dentist's role in personal health and protection of the practice, as well as ways organized dentistry can assist its members in this area.

"The single most important asset of any dental practice is really a healthy dentist—not the equipment, not the location, not the patient base," explained Dr. Wade Winker, chairman of the Dentist Well-Being Advisory Committee. "This new policy on Dentist Health and Wellness is intended to be a guide to dentists about the importance of maintaining their own health and also having adequate protections in place, for practice coverage and insurance protection, to protect their practices in the event of an illness or injury."

The ADA Statement on Dentist Health and Wellness reads as follows:

"To preserve the quality of their performance" and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired."

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are encouraged to participate in the ADA's Health Screening Program when they attend annual session, both to assist them in monitoring key indicators of personal health and to contribute to the body of knowledge about dentist health and well-being.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

• promoting health and wellness among dentists:

• supporting peers in identifying dentists in need of help;

• intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program; encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness;

• establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness;

• establishing mechanisms to assure that impaired dentists promptly cease practice;

• reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations; supporting recovered colleagues when they resume patient care. ■

House answers questions on access, quality of care

BY STACIE CROZIER

Philadelphia—The 2005 ADA House of Delegates spelled out definitions for "oral health literacy" and the "dental home" and ADA positions on patient safety and quality of care and oral health assessment for schoolchildren at annual session last month by passing four resolutions.

Res. 2H-2005 says "it is the ADA's position that health care should be:

• safe—avoiding injuries to patients from the care that is intended to help them;

• effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively);

• patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions;

• timely—reducing waits and sometimes harmful delays for both those who receive and those who give care;

• efficient—avoiding waste, including waste of equipment, supplies, ideas and energy;

• equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status."

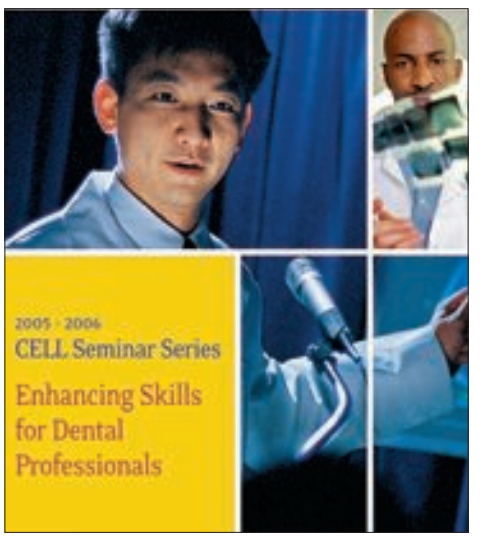
Res. 3H-2005 says "oral health literacy indicates that individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions."

Res. 41H-2005 says Association policy supports oral health assessments for schoolchildren "intended to gather data, detect clinically apparent pathologic conditions and allow for triage and referral to a dentist for a comprehensive dental examination."

The resolution also urges state dental associations to sponsor legislation to provide oral health assessments for schoolchildren and that children and parents/caregivers be informed that an oral health assessment does not take the place of a comprehensive oral examination conducted by a licensed dentist.

The resolution also calls on the ADA to take steps to educate policymakers and the public that oral health is an integral part of overall health, making oral health assessments as important as other health assessments and encourages state and local dental societies to take similar action.

Res. 53H-2005 makes this definition of the dental home ADA policy: "Dental Home. The ongoing relationship between the dentist who is the primary dental care provider and the patient, which includes comprehensive oral health care, beginning no later than age 1, pursuant to ADA policy." ■



Enhancing skills: It's the theme behind 12 new course offerings from the 2005-2006 Seminar Series catalog, pictured above. The ADA Seminar Series, produced by the Association, is partially underwritten by grants from Sullivan-Schein, a Henry Schein Co., and Patterson Dental Supply. Call the ADA toll-free, Ext. 2908, to schedule all programs.

CORRECTION

The figures in the Just The Facts graph on page one of the Nov. 7 issue of the ADA News were transposed.

The number of male U.S. dental school graduates was 2,688 in 2003, up from 2,445 in 1993. The number of female dental school graduates was 1,755 in 2003, up from 1,333 in 1993. ■

Dr. Bentley, past ADA president, dies at 85

Dr. Donald E. Bentley: A general practitioner, Dr. Bentley was a member of the ADA House of Delegates for 12 years and a member of the Board of Trustees for six years.

BY JOE HOYLE

Hawley, Minn.—Dr. Donald E. Bentley, a Minnesota dentist who served as ADA president in 1983-84 as well as in numerous other posts in organized dentistry, died Nov. 5 at the age of 85.

Dr. Bentley was active in organized dentistry at the local level, holding several offices in the Minnesota Dental Association including trustee for three years and treasurer for six years. He was president of Minnesota's Northwestern District Dental Society and served by appointment of the governor on the Comprehensive Health Planning Council of Minnesota.

Dr. Bentley is survived by his wife of 57 years, Dorothy, as well as one son, three daughters and 12 grandchildren.

In lieu of flowers, the Bentley family requests that memorial gifts be made in the name of Donald E. Bentley to one of two organizations: the National Parkinson Foundation, c/o Mary Ann Sprinkle, director of development, 1501 N.W. Ninth Ave., Bob Hope Rd., Miami, FL 33136-1494 or Hospice of the Red River Valley, Development Office, 1701 38th St. S.W., Suite 201, Fargo, ND 58103-4499. ■

Nine dental schools to receive funding for summer programs for undergraduates

BY KAREN FOX

Washington—Nine dental schools are among the 12 recipients of Robert Wood Johnson Foundation funding for a new enrichment program aimed at college students interested in dental and medical careers.

The American Dental Education Association and Association of American Medical Colleges are administering the "Summer Medical and Dental Education Program" in an effort to create a more diverse dental and medical workforce.

Dental schools selected include:

- Case Western Reserve University;
- Columbia University;
- University of California-Los Angeles;
- Howard University;
- University of Texas at Houston;
- University of Medicine and Dentistry of New Jersey/New Jersey Dental School;
- University of Louisville;
- University of Nebraska Medical Center;
- University of Washington.

The schools will receive $300,000 a year for four years from the RWJF, along with matching support from their own institutions.

The SMDEP allows institutions to develop and implement six-week academic enrichment programs for qualified undergraduate college students from diverse population groups underrepresented in dentistry and medicine.

Applicants may come from economically disadvantaged backgrounds, racial and ethnic groups that historically have been underrepresented, or parts of the country (such as rural areas) where residents historically have been underrepresented.

"We look forward to collaborating with AAMC and the Robert Wood Johnson Foundation to help prepare students from diverse backgrounds for success in dental and medical schools," said Dr. Richard W. Valachovic, ADEA executive director.

The RWJF is also funding the "Pipeline, Profession, and Practice: Community-Based Dental Education" program to help dental schools develop a quality workforce with an emphasis on diversity and leadership development. ■

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