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American Dental Association, Publishing Division

YOUR DENTAL ADVOCATE
ADA ADVOCATING FOR DENTISTS AND THEIR PATIENTS

Your Dental Advocate, inside between pages 12-13

AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA NEWS®

JUNE 18, 2007 VOLUME 38 NO. 12

Asking the big questions

Symposium on ethics in education resolves to find out why people cheat, strategies to bolster integrity

Matter of trust: Above, keynote speaker Mark Brennan (left), a clinical ethicist, responds to an inquiry at the ADA symposium June 7, while panelist Dr. Cecile Feldman, dean of the New Jersey Dental School, looks on. At right, Dr. Brooke Loftis describes ways that the American Student Dental Association enhances professionalism.

BY KAREN FOX

Is cheating in dental education prevalent, or are recently reported incidents at several of the nation's dental schools unusual?

Are ethics courses and honor codes enough to prevent academic breaches in dental education?

Who should take the lead when it comes to dealing with this issue—educators, universities, state dental boards, the ADA?

With an eye toward helping the next generation of dentists adhere to important ethical principles, a cadre of ethicists in the health professions, educators and leaders in organized dentistry sought answers to these questions June 7-8 at the Symposium on Integrity and Ethics in Dental Education at ADA Headquarters.

Hosted by the ADA councils on Education and Licensure and Ethics, Bylaws and Judicial Affairs in collaboration with

See ETHICS, page 12

NCDHM: Above, Dr. Reneida Reyes of Brooklyn, N.Y., bestows a gift on Evan Butler. Elsewhere in New York, Dr. Scott Levy (right) poses with an enthusiastic youngster. See story on National Children's Dental Health Month winners on page three.

Web security

National provider identifier posting doesn't make personal data accessible

BY ARLENE FURLONG

Dentists shouldn't be concerned their personal information will become compromised when national provider identifier data is posted on the Web.

"Social Security numbers, individual tax identification numbers and dates of birth will not be accessible," said Dr. John Luther, ADA senior vice president, Dental Practice/Professional Affairs.

Dentists submitted personal and practice information, such as names, business addresses, business phone numbers and fax numbers, license numbers, gender and provider type to the National Plan and Provider Enumeration System when applying for a national provider identifier. The NPI is the 10-digit standard identification number for health care providers required under the Health Insurance Portability and Accountability Act for transmitters of electronic transactions.

All the records, excluding Social Security numbers, individual tax ID numbers and dates of birth, will be accessible to help health plans update

See NPI, page nine

BRIEFS

GKAS growth: An Aug. 27 symposium at ADA Headquarters will help program planners expand their Give Kids A Smile programs, start new GKAS programs in cities or regions that have never hosted one or find new ways to maximize the success of programs.

The Give Kids A Smile "Promising Practices" Symposium will meet Aug. 27 from 9 a.m. to 3:30 p.m.

Cosponsored by the ADA and Dental Trade Alliance Foundation, the symposium seeks to identify and share successful community based program practices that support GKAS.

It's free and open to the first 100 registrants. Registration ends July 13; sign up online at "www.ada.org/goto/gkas".

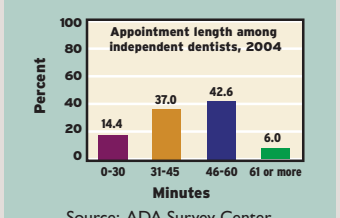
The topics for the "Promising Practices" Symposium cover engaging volunteers and products; managing screenings, triage and treatment; tracking statistics; working with the media; and translating program success to advocacy.

In only five years, Give Kids A Smile has become the ADA's signature charitable event, touching close to 1 million children. In 2006, the ADA Board of Trustees voted to expand GKAS. A national advisory board was appointed and one of its first initiatives is the symposium, which will be held each of the next three years. ■

JUST THE FACTS

Appointment length

General practitioners are most likely to have appointments between 31 and 60 minutes long.



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

ADA Foundation launches Strategic Alliance Grant Program

ADA | FOUNDATION
American Dental Association Foundation

A new ADA Foundation grant program will offer national- or state-level organizations with a project proposal to support dental research, education or access the opportunity to partner with the ADAF and make a greater impact on oral health.

The Strategic Alliance Grant Program will give qualified organizations a chance to work with the Foundation to leverage human and financial resources and to collaborate on a program to enhance oral health for up to three years, said Michael Sudzina, ADA Foundation vice president.

"A successful grant program will highlight the Foundation's and the strategic partner's mutual effort to raise the awareness of the importance of oral health in a unique collaborative manner," said Mr. Sudzina. "The multi-year approach for this grant program will provide for and support ongoing collaboration and communication between the ADAF and the strategic alliance organization."

Qualified organizations and agencies, both within and outside the dental community, include: national associations; federal agencies; dental schools; state associations; state health departments; foundations; national nonprofit organizations; museums; state or national organizations involved in research, education or access initiatives that increase oral health awareness; or other organizations with an interest in improving the oral health of the public.

The ADAF will accept proposal requests of up to $100,000 or less per year, with the opportunity to renew for one to two additional years. Letters of Intent are due to the Foundation by July 16.

The RFP process will require applicants seeking funding for research and/or education projects to provide 100 percent matching funds to qualify for consideration, but access to care projects will not be required to provide matching funds.

For more information about the program and eligibility, evaluation of proposals, submission guidelines and more, log on to "www.adafoundation.org" or call Jane Forsberg Jasek, director of programs, toll free, Ext. 4639. ■

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NYSDA keeps kids smiling

Creativity: Posters like this one were entered in the NYSDA's contest during National Children's Dental Health Month.

BY JENNIFER GARVIN

Albany, N.Y.—Its "Keeping Smiles Brighter" poster contest was just one of the reasons the New York State Dental Association was the first-place recipient in the 2007 Samuel D. Harris National Children's Dental Health Month State Program Award.

From its enhanced Web site to the Sugarless Wednesday promotions encouraging children to become more aware of hidden sugars in their diet, NYSDA succeeded in getting more than 600,000 children to think about their oral health this year.

Additionally, NYSDA involved 20,000 educators and 25,000 parents through school programs, public fairs and promotional events. The association also reached out to food service managers with information about the relationship between nutrition and oral health.

"Despite record snows in New York during February, our programs prospered because of our enthusiastic members, their dental teams and local component staff," said Sandra DiNoto, director of public relations for NYSDA. "By including new partners in 2007, such as food service managers at SchoolFood in New York City, we have opened doors in our outreach to urban schools whose population includes a segment of children from low socioeconomic backgrounds who are at risk for dental disease."

SchoolFood reached more than 500,000 children in 1,240 New York City elementary schools during Sugarless Wednesday. Grassroots participation of NYSDA's 13 component dental societies in New York supported the month-long effort through the involvement of hundreds of member dentists and their staffs.

The creative contest, which was open to children at all grade levels, called for participants to come up with T-shirt designs that shared a message about good oral health care. NYSDA expanded its Web site to include curriculum ideas for teachers who incorporated dental health education in their February lesson plans.

The award comes with $2,000 from Oral Health America. This is NYSDA's 13th national award for its Children's Dental Health Month programs.

Two other dental societies were recognized with 2007 NCDHM merit awards. The Pennsylvania Dental Association and Indiana Dental Association each received $1,000 checks from OHA. For more information about children's oral health, visit ADA.org. ■

Don't miss it

Summer health and wellness conference convenes Aug. 16-18

"I have never missed one before and I don't plan to miss one in the future."

So says Dr. William Kane, a member of the ADA Dentist Well-Being Advisory Committee on the ADA's Dentist Health and Wellness conferences.

This year's meeting–Healthy Dentists, Thriving Practices—will convene Aug. 16-18 at ADA Headquarters in Chicago.

"There's something for everyone, from practicing dentists to significant others to dental board investigators and dental hygiene students," said Dr. Kane. "The scope of these meetings has broadened to include ergonomic issues, chronic pain and personal growth, in addition to addictive disease issues."

For more information about the conference, go to "www.ada.org/prof/prac/wellness/program.asp"; e-mail Linda Keating ("keatingl@ada.org") or call her toll-free, Ext. 2622. ■

ViewPoint

MyView

The more things change

Robert D. Kelsch, D.M.D.

Recently, as a donation to the Department of Dental Medicine at Long Island Jewish Medical Center, I was fortunate to receive some older journals which included several volumes of the Archives of Clinical Oral Pathology from the 1930s and an issue of the Dental Cosmos from 1857.

Being a book lover and dentist, I found these volumes intriguing for many reasons, but two stuck out.

One, on browsing through some of the articles, I noted with great interest, striking similarity between some things we do today and what was done many years ago. Procedures may change in name and materials used but I guess the adage is true—the more things change, the more they remain the same.

The second thing I noted was that, even back then, dentists loved gadgets. Being an oral pathologist, one particular advertisement caught my eye: "The Dentist's Microscope."

Apparently, this microscope of "firm cast iron" with two mirrors and two objectives that came in a "French-polished mahogany case" was designed specifically for dentists' use under the supervision of Samuel S. White (a name with which some of us may be familiar).

This for only $60: a bargain at any price, especially with two objectives.

And this got me to thinking about all the products marketed to us over the years, all theoretically with the implied purpose of making our work lives easier, more efficient and allowing us to better diagnose and treat our patients. As you well know, the marketing of products—good and bad, useful or not—continues to this day. Some products may be more scientifically based or come with more fancy wrapping (although I doubt we'll be getting any mahogany cases any time soon), and they're certainly more expensive. But they may not be particularly efficacious.

To guard against spending our hard-earned dollars on a less than helpful product, common sense may dictate that it's important to be skeptical of the often-fantastic claims put forth by the companies and seek out products that have proven track records or can show legitimate safety and efficacy.

A good place to start is to determine whether a product has the ADA Seal of Acceptance. This implies that there has been some scrutiny and oversight of the product by our profession.

And when the product rep comes to visit, ask for the scientific literature that shows that the product is better than another and not just more expensive. This goes for mechanical products and for medications we may prescribe as well.

For example, I had the opportunity to review a paper comparing two topical antiviral medications for treatment of recurrent herpes labialis. The company wanted to state that their medication healed lesions faster than the generic. While the basic claim was factual, it was not statistically significant and lesions only resolved faster by 8 to 10 hours, not several days which was what hoped might be assumed. In this case the cheaper alternative could be considered just as effective.

See MY VIEW, page six

LettersPolicy

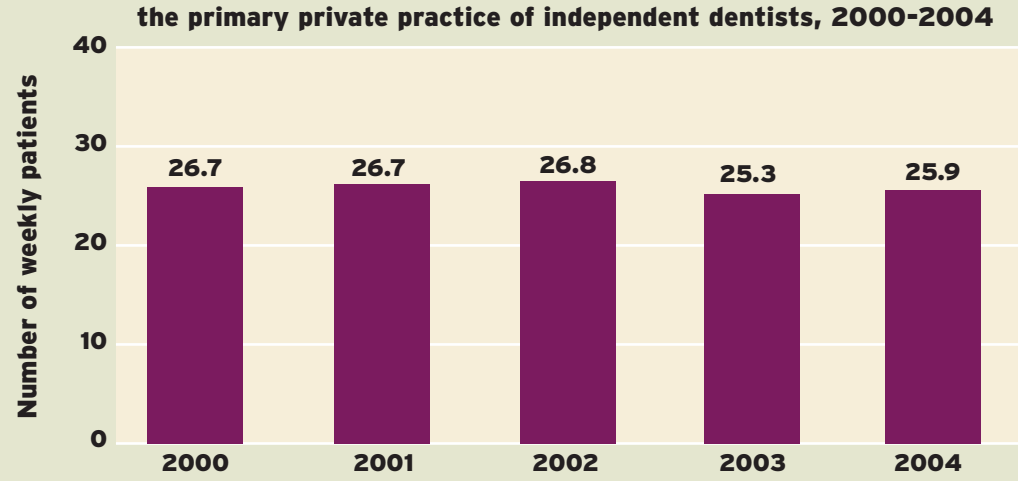
ADA News reserves the right to edit all communications and requires that all letters be signed. The views expressed are those of the letter writer and do not necessarily reflect the opinions or official policies of the Association or its subsidiaries. ADA readers are invited to contribute their views 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 practice

In 2000, the average number of patients seen per dental hygienist on a weekly basis was 26.7. In 2004, the average had decreased slightly to 25.9 patients per week.

Average number of patients seen weekly per dental hygienist in the primary private practice of independent dentists, 2000-2004



Source: American Dental Association, Survey Center, *Surveys of Dental Practice.*

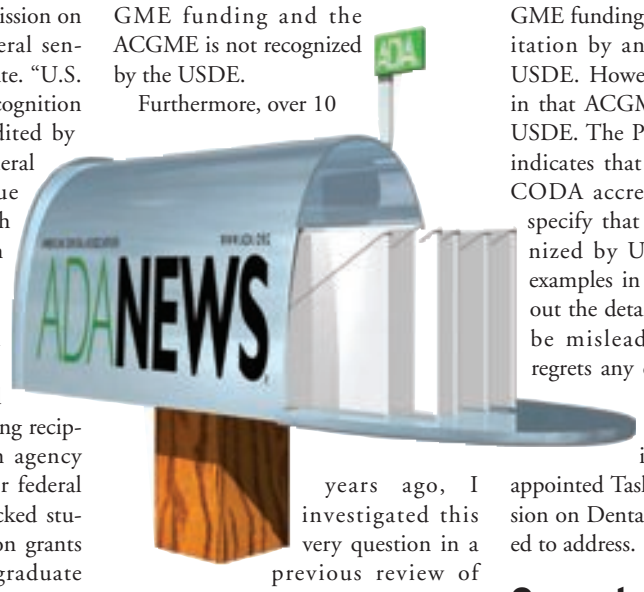
Letters

CODA

I read with great interest the article on the Commission on Dental Accreditation in the May 21 issue of the ADA News ("Panel to Study Commission on Dental Accreditation"). Several sentences on page 12 are inaccurate. "U.S. Department of Education recognition also enables programs accredited by CODA to be eligible for federal funding programs" is a true statement. What follows, "such as graduate medical education funding, funding to support residency programs in pediatric dentistry and advanced general dentistry," is not.

The "eligibility for federal funding" in the statute requiring recipients to be accredited by an agency approved by the USDE is for federal education funds, federally-backed student loans, school construction grants and the like. Funding for graduate medical education comes under the umbrella of the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), and carries with it no requirement for a USDE-recognized accrediting body.

I am sure that Dr. David Whiston's task force would quickly find this out, but ADA News readers should also know that what was printed is inaccurate lest opinions about CODA's direction be formed as a result of misinformation. All graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education receive federal GME funding and the ACGME is not recognized by the USDE.



Furthermore, over 10 years ago, I investigated this very question in a previous review of CODA's structure and I was told directly in a meeting at the USDE that GME funding was not in the purview of the USDE and that USDE-recognized accreditation was not necessary for that type of "federal funds." I hope that this information is helpful.

John P. Kelly, D.M.D., M.D.
Chief, Section of Oral and Maxillofacial Surgery
Hospital of St. Raphael
New Haven, Conn.

Editor's note: According to the ADA Division of Education, funding to support pediatric and general dentistry residency start-ups (primary care residency funding) is different from GME funding and does require accreditation by an agency recognized by USDE. However, Dr. Kelly is correct in that ACGME is not recognized by USDE. The Public Health Service Act indicates that GME funding requires CODA accreditation, but does not specify that CODA must be recognized by USDE. By listing these examples in the May 21 story without the detail, the information could be misleading. The ADA News regrets any confusion caused by the omission.

This is one of many issues that the newly appointed Task Force on the Commission on Dental Accreditation is expected to address.

Organ transplant

I read with interest about Dr. Jack Rigby waiting for a liver transplant ("Ohio Dentist Battles Liver Disease, Awaits Transplant," Jan. 22 ADA News) because I have walked in his shoes and I understand his situation.

I just celebrated the 9th anniversary of liver transplant. I stuck myself with a local anesthetic needle in 1978. The

See LETTERS, page six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Letters

Continued from page four

patient had just received a transfusion of blood tainted with hepatitis C. Is there a dentist who has never had a needlestick?

I practiced dentistry until the day before my transplant. The end of my day was a one-hour nap just to get the energy to go home. I lived on carbohydrates since protein and fats made me deathly ill. I looked like a walking dead guy.

I had my liver transplant in 1998. After that I had to rebuild every muscle in my body, which I did through the martial art of aikido. We started beginner's exercises which helped me rebuild my body that had wasted away for years. An hour on the mat being thrown around is a real test of how alive I am today.

I am still a full-time practicing dentist in Pompano Beach, Fla. We are a technology driven office employing all the goodies including a Cerec. I participated in the International Association of Orthodontics instructors' institute and was certified as a senior instructor in 2006. I take a plethora of drugs to stay alive and deal with all the various side effects. After years of dying a little every day, I am fully involved in living an active life.

I have a few thoughts on dentistry and organ transplant:

• We have a responsibility to ourselves and our families to have a physical each year which should include a test for hepatitis. We are treating people in our practices that may have hep C and don't know it because they have never been tested. Gloves will not prevent a needlestick and there is no hep C vaccine to prevent being infected.

• Our offices are filled with promotional data. If every dental office made available organ donation information we could help change people's perception of organ donation and more lives will be saved.

• Transplant patients are a part of our patient population and they require a different sensibility to their particular needs. Pre-transplant patients will have different requirements for their treatment than the post-transplant patient. Each class of patient will be on a different medication regimen. The purposes and the side effects of each drug require a disciplined knowledge of these drugs and their effects.

• Many transplants, me included, also have a mystical experience. We are alive and a donor family is saying goodbye to their loved one. Personally, that fact changed the context of my life.

• Make a personal decision: sign a donor card, put "donor" on your driver's license and tell your family about your decision.

Today organ transplant is a viable treatment that is extending lives of children and adults. I am 66, and all of my personal possessions will be given away when I die. But my most important assets I carry with me in my body. If my death is untimely, all my vital organs will be donated and other strangers will be given the gift of life that I received.

Edwin C. Delz, D.D.S.
Pompano Beach, Fla.

Editor's note: Dr. Rigby recently contacted the ADA News to deliver good news—he received a new liver May 13. Writes Dr. Rigby: "My call came on Saturday of Mother's Day weekend. A fellow member of my community and parish died of cerebral hemorrhage. I entered surgery at midnight for the eight-hour operation.

"My wife and I consider this blessing a direct result of the prayers and the kindness of one family at their time of unspeakable sorrow," Dr. Rigby adds. "Five people received transplants from a man who was said to be generous his entire life and now continues to be."

According to the ADA Division of Science, hepatitis C virus is a major public health problem and a leading cause of chronic liver disease. Most liver transplant candidates have hepatitis C.

The potential for HCV occupational transmission is low when standard precautions are observed. The Centers for Disease Control and Prevention recommends that all health care, emergency medical and public safety workers be tested after a needlestick injury or mucosal exposure to HCV-positive blood.

The ADA Foundation's 44th Health Screening Program, scheduled for Sept. 27-30 at the ADA annual session in San Francisco, includes screening for hepatitis C virus.

For more information, go to "www.ada.org/prof/events/session/2007_health.asp".

MyView

Continued from page four

I believe that keeping that critical eye will become increasingly more important in the future as companies begin to inundate us with increasingly complex materials and biologicals: growing new bone, or periodontium or teeth! Many of these will be wonderful and we'll still be using them 100 years from now; others may not be used tomorrow.

Hope springs eternal, but I guess what Felix Unger said is also true: we should never assume. And safe does not always mean effective.

Dr. Kelsch is the editor of the Bulletin of the Nassau County Dental Society (N.Y.). His comments, reprinted here with permission, originally appeared in the January/February issue of that publication.

Editor's note: Dr. Kelsch mentioned the ADA Seal of Acceptance Program, which since its inception in 1930 has included both professional and consumer products. The ADA Council on Scientific Affairs voted to terminate the Seal Program for professional products as of Dec. 31 of this year, having transitioned to the Professional Product Review as a more timely method for giving dentists credible, comparative information on professional dental products.

The PPR is mailed quarterly with The Journal of the American Dental Association to members. More information on the PPR can be found online at "www.ada.org/goto/ppr", or by sending an e-mail request to "pprclinical@ada.org".

The ADA Seal Program for consumer products is still regarded as a valuable member and consumer service, and will be maintained. For more information, call the ADA at Ext. 3528.

CONVENTIONAL WISDOM

"... self-etch bonding agents have retained the **problems of incompatibility with dual cured core material** and dual cure composite resin luting cements."
Karl Leinfelder, DDS, MS

"Clinically, (single-step self etchers) may result in the **debonding of core build-ups** with self- or dual-cured composites during impression taking."
Dr. Franklin Tay

"One-step self-etch adhesives are typically **contraindicated for use with chemically- or dual-curing composite resins.**"
USAF Dental Investigation Service

"Self-etching systems are also **contraindicated for use with dual-cure and self-cure** composite resins."
Howard Strassler, DMD, FADM, FAGD

"**Self-adhesive systems** should be used for direct restorations and **not for** indirect restorations involving **self-cure or dual-cure** composite resins."
Prof. Steven Wei

UNCONVENTIONAL BONDING

Brush&Bond is the only self-etch bonding agent in the world documented to create reliable bonds, not only to light-cure composites, but also to dual- and self-cure core resins and cements. In fact, two independent newsletters recently used the same word to describe Brush&Bond's ability to bond to this wide range of composites: "**amazing**."

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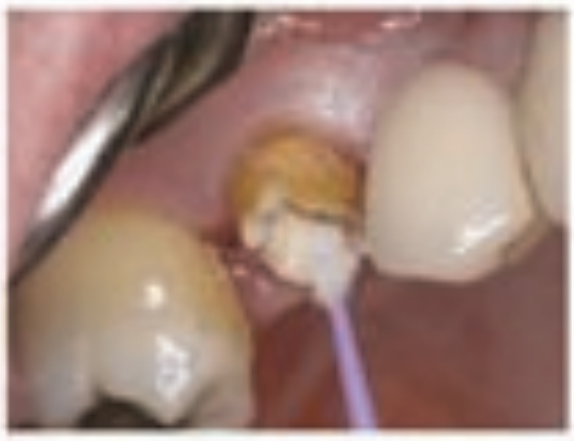
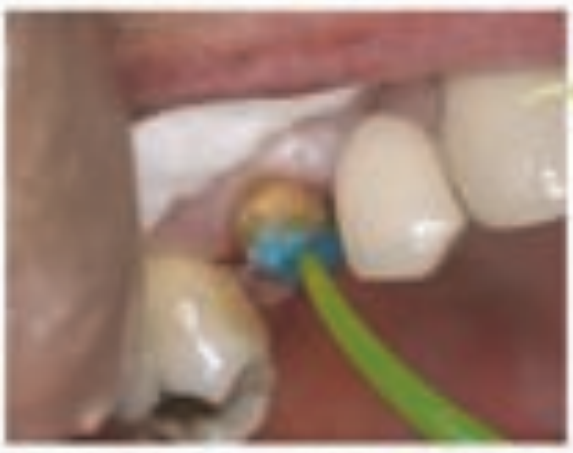
As one new user recently wrote -

"Individually, Brush&Bond and Absolute Dentin are great products. But together? They're amazing!"





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Summer PPR covers impression materials, dental handpieces

BY JENNIFER GARVIN

Dentists can learn more about elastomeric impression materials and high-speed air turbine handpieces in the summer issue of the ADA Professional Product Review, which mails with the July issue of The Journal of the American Dental Association.

Ten brands of impression materials were tested on working time, elastic recovery, stiffness and other common properties. The issue reveals that working time for impression materials can drop 50 percent or more once they are syringed around the teeth and reach mouth temperature.

The issue also features performance evaluations of eight air turbine handpieces and compares traits of those handpieces with their electric counterparts.

Product selection for each review is based on input from members of the ADA Clinical Evaluator Panel, which comprises volunteer member dentists who participate a few hours each month by responding to product evaluation surveys and taking part in panel discussions or interviews. About 1,700 members have joined the ACE Panel.

At this year's annual session in San Francisco, the ADA for the third year will host a user forum. Dentists will test intraoral cameras then fill out a one-page survey for use in the clinical evaluation section of a future PPR.

To join the ACE Panel or get more information about the Professional Product Review, contact the ADA by e-mail at "pprclinical@ada.org", by phone at the toll-free number, Ext. 3528 or visit "www.ada.org/goto/ppr". Nonmembers may contact the ADA by phone at 1-312-440-3528. ■

Toothpaste alerts issued

FDA advises against use of Chinese brands; Colgate warns of counterfeit packaging

BY JENNIFER GARVIN

Rockville, Md.—The Food and Drug Administration advised consumers June 1 to avoid using toothpaste made in China because the products could contain the chemical diethylene glycol.

Separately, two weeks later, Colgate-Palmolive announced that counterfeit toothpaste is being falsely packaged under the Colgate name and may contain DEG.

DEG, which is also known as diglycol and diglycol stearate, is used in automobile antifreeze and as a solvent in the U.S. It also is sometimes used as a thickening agent in food or medicinal products outside the U.S. The FDA does not permit its use for this purpose in this country.

Colgate said there are indications the counterfeit toothpaste does not contain fluoride. The toothpaste was found in dollar-type discount stores in New York, New Jersey, Pennsylvania and Maryland.

In its June 14 press release, Colgate said "it does not use, nor has ever used, diethylene glycol as an ingredient in Colgate toothpaste anywhere in the world."

The FDA said it is not aware of any U.S. reports of adverse health effects from the toothpaste made in China, but said it was concerned about potential risks from chronic exposure and exposure to the chemical in certain populations, such as children and persons with liver and kidney disease.

Colgate said the counterfeit toothpaste is easily recognized because it is labeled as "Manufactured in South Africa" and Colgate does not import any toothpaste into the United States from South Africa.

The counterfeit packages examined so far have several misspellings including: "isclinically," "SOUTH AFRLCA" and "South African Dental Assoxiation."

The FDA has identified the following toothpastes with DEG from China that have either been found at retail outlets in the U.S. or at ports waiting to be unloaded, and included them in its import alert: Cooldent Fluoride, Cooldent Spearmint, Cooldent ICE, Dr. Cool, Everfresh Toothpaste, Superdent Toothpaste, Clean Rite Toothpaste, Oralmax Extreme, Oral Bright Fresh Spearmint Flavor, Bright Max Peppermint Flavor, DentaKleen, DentaKleen Junior, DentaPro and ShiR Fresh Mint Fluoride Paste.

The products typically are sold at low-cost, bargain retail outlets.

Dentists and patients may report incidents to FDA's MedWatch Adverse Events Reporting Program by calling 1-800-332-1088 or visiting "www.fda.gov/medwatch/report.htm".

Colgate said it is working closely with the FDA to help to identify those responsible for the counterfeit product. Consumers who suspect they may have purchased the counterfeit product may call Colgate's toll-free number at 1-800-468-6502. ■

Check NPI data

The ADA is encouraging dentists who have been assigned NPIs to check their information in the National Plan and Provider Enumeration System records to ensure it is current.

"You may wish to delete optional NPPES data that you furnished when applying for your NPIs since the information provided in the optional fields was not required data," says Jean Narcisi, director of the ADA Department of Dental Informatics.

For example, data contained in the "Other Names" and "Other Provider Identifiers" data fields are optional.

To access the NPPES go to "https://nppes.cms.hhs.gov". ■

D.C. dentist avoids scam

BY ARLENE FURLONG

Washington—Call it serendipitous, coincidence or a stroke of luck, but Dr. Eugene Giannini had just finished reading an item in the "District of Columbia Dental Society Newsletter" warning of an alleged credit card scam when he got a call.

"Have you or anybody in your family authorized phone services to Pakistan and China?" the caller asked.

"If it wasn't for having that article on my desk I might not have seen the red flag," said Dr. Giannini, president of the District of Columbia Dental Society. "The caller was very professional. I might have been fooled."

Other D.C. member dentists also report receiving calls from individuals representing themselves as agents of major credit card companies. These callers request confirmation of activity on charge accounts. When the recipient denies making the charges in question, the caller says activity has taken place and a replacement card will be issued. That's when the caller requests personal information, such as Social Security numbers and birthdates.

Dr. Giannini

Dr. Giannini says a big concern is that dental team members may divulge information in an effort to be helpful to the dentist.

The ADA cautions dentists not to release personal information over the telephone or the Internet and to share that advice with dental team members.

"If you have any problems with your credit cards, transactions or statements, communicate directly with the credit card company through the telephone numbers on your credit card or billing statement," advises the ADA Division of Legal Affairs.

For a wealth of updated information on common telemarketing scams and how to protect yourself against them go to "www.ftc.gov/bcp/menus/consumer/phone/scams.shtm".

ADA Member Advantage cardmembers enjoy security features and a toll-free number to call to speak with an identity theft specialist. Visit "www.citibank.com/us/cards/cm/theft04.htm" for additional resources on how to protect yourself against identity theft and what to do in the event you become a victim. ■

NPI

Continued from page one

their databases and match NPIs to legacy identifiers. (Legacy numbers are the identifiers in common use, such as dental plan specific identifiers, license numbers and Social Security numbers that plans use to identify health care providers.)

"The only information that may be accessible through NPPES that isn't already readily available to anyone who might be looking for it is probably the practice fax number," added Dr. Luther.

"There's no question that the information that will be available on the Web is already out there," reiterated Dr. Robert Ahlstrom, a member of both the Council on Dental Practice and the Dental Content Committee. It all falls under the Freedom of Information Act."

NPPES says NPI data will be accessible June 30 by downloadable files from a Web site, a query-only database or through written request.

"Posting NPI information on the Web will prove to be the most efficient and cost-effective way to convey this information," said Dr. Ahlstrom. He acknowledges that there may be a few "squeaks or cracks" in any HIPAA process initially, and that's why the ADA is sponsor and chair of the Dental Content Committee.

The committee was established under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 to cooperate in the maintenance of the standards adopted under HIPAA. The secretary of the Department of Health and Human Services named the content committee a designated standards maintenance organization. The committee addresses standard transaction content on behalf of the dental sector of the health care community.

As it stands right now, the NPPES isn't planning any restrictions or limitations on who can access the NPI data, excluding Social Security numbers, tax ID numbers and dates of birth. Dr. Ahlstrom thinks the federal government will look at a way to limit that capability to the entities that need to have it. He also believes third-party payers and clearinghouses will institute their own methodologies for securing transactions and information.

"Spammers and junkers are everywhere and always will be," commented Dr. Ahlstrom. "Meantime, what dentists should do is pay due diligence to their own security systems."

He recommends changing passwords frequently, having a good firewall system and not opening unknown files from unknown entities.

"The benefits for dentists of using the NPI, a single identifier, will in the long-run, far outweigh any potential negative consequences," he said.

Members with questions, comments or concerns can e-mail "NPI@ada.org" or call the ADA Department of Dental Informatics, Ext. 4608.

To read the Federal Register notice, go to "www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf". ■

Recipe for success

NYU dental students raise funds, awareness through 2nd oral cancer walk

BY STACIE CROZIER

New York—The recipe called for months of planning, hard work by dedicated volunteers and a vision to raise oral cancer awareness.

The pièce de résistance was the 2nd annual Oral Cancer Walk sponsored by the Student National Dental Association at New York University College of Dentistry April 14 in Harlem.

Following a "cookbook" plan developed after its event last year, the SNDA raised nearly $32,000 for the Oral Cancer Foundation and attracted more than 500 walkers—up from $20,000 and 300 walkers last year. But just as important, the SNDA's recipe for success included partnerships among volunteer dental students, faculty, dental hygiene students, cancer survivors and health groups and other partners who all worked together for months to stage the 4-mile walk.

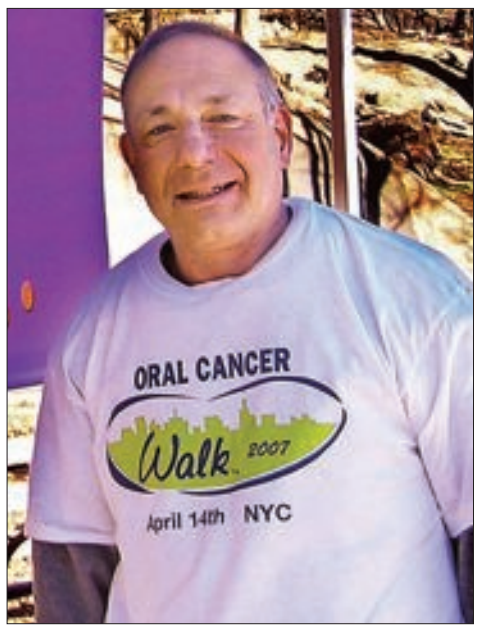
"So many people wanted to get involved and they were so excited about it," said Jocelyn Jeffries, event chair. "Making the event a success is all about the team. The team was fantastic. I was just an incidental player."

One of the event's featured speakers and top fundraisers was Dr. Jerry Wilck, a dentist in Langhorne, Pa., and an oral cancer survivor.

"I was happy to participate and raise money for a cause that is close to my heart," said Dr. Wilck.

"Two years ago, I had noticed an ulcer in my mouth and it hadn't been painful. I'm not sure how long it was there before I realized it wasn't going away. I thought maybe it was caused by that new cinnamon flavored toothpaste I had recently started using. So I waited a week or two before asking my oral surgeon to do the biopsy. Neither of us suspected cancer."

Event time: NYU volunteers, including Jocelyn Jeffries (front row, far right) pause for a photo at the oral cancer walk April 14.



Dr. Wilck: "I was happy to participate and raise money for a cause that is close to my heart."

But it was stage I squamous cell carcinoma of the tongue. Dr. Wilck began a whirlwind of tests, surgery and speech rehabilitation.

Since his bout with oral cancer, Dr. Wilck volunteers to bring awareness to the public and the dental profession through local media, the Oral Cancer Foundation and other venues. (See his story online on the Oral Cancer Foundation Web site: "www.oralcancerfoundation.org/news/story.asp?newsId=859".)

Ms. Jeffries worked on the planning team for last year's event and helped develop a poster presentation last year—a cookbook on how to organize an event.

"I cannot tell you how many details, how much red tape can be involved. Permits, police and community details, promotional materials and logistics. I hope our guidelines can help other schools organize a walk in their communities."

"Being aware and mastering skills to prevent oral diseases, and protect and promote oral health are fundamental to our profession," said Dr. Caswell A. Evans, president, American Association of Public Health Dentistry. "The efforts undertaken by the NYU students focused oral cancer awareness activities on a community that experiences a disproportionate burden of disease and could serve as a model for students, faculty and practitioners everywhere."

Also associate dean for prevention and public health sciences at the University of Illinois at Chicago College of Dentistry, Dr. Evans says, "At the University of Illinois great emphasis is placed on Yul Brynner Oral Cancer Awareness Week and students are heavily involved in numerous oral cancer related events. These are important opportunities to inform the public and broaden the focus of the oral health workforce."

Next year, Ms. Jeffries said, the NYU group hopes to get more involved in community outreach in the African American community—since African American men are the population group with the highest rates of oral cancer—by working at health fairs and other community events.

"I'm graduating this year," added Ms. Jeffries, "but I'm staying in the area, doing my residency at Jacobi Hospital in the Bronx, so I will be able to help out again next year."

For more information about the event or the cookbook, contact Ms. Jeffries by e-mailing "jj460@nyu.edu" or Dr. Ross Kerr, faculty mentor for the event, at "ark3@nyu.edu". ■

FDI urges support for smoke-free environments

Geneva—As nations around the globe observed World No Tobacco Day May 31, the FDI World Dental Federation urged dental professionals around the world to support smoke-free environments.

"Smoking in a dental practice or health facility needs to be banned worldwide," said FDI President Michèle Aerden. "The dental team and its working environment are important role models for patients."

The FDI enforces smoke-free policies in its workplace as well as its congresses, continuing education sessions and meetings and promotes oral health professionals taking an active role in tobacco control and smoking cessation.

"Tobacco or Oral Health: An Advocacy Guide for Oral Health Professionals," is a joint FDI/World Health Organization publication available in English, Portuguese and simplified Chinese or traditional Chinese (and will be available in Italian and Vietnamese later this year). It is available at "www.fdiworldental.org/public_health/5_5advocacy.html".

The guide provides tobacco facts, highlights the involvement of the FDI and the WHO in tobacco control initiatives, discusses the role of dentists and other oral health professionals in tobacco control, examines the role of advocacy and more.

ADA policy has called for the Association to educate and inform its members and the public about the health hazards of tobacco products since 1964 and has prohibited smoking at all its meetings and conferences since 1972. Since 1988, the ADA has also urged members, dental societies, dental schools and other dental organizations to adopt antismoking policies for its workplaces and meetings. (For a complete list of ADA positions and statements on tobacco, log on to "www.ada.org/prof/resources/positions/statements/tobac.asp".)

The ADA also offers a comprehensive package of tobacco cessation resources at "www.ada.org/goto/quittobacco". ■

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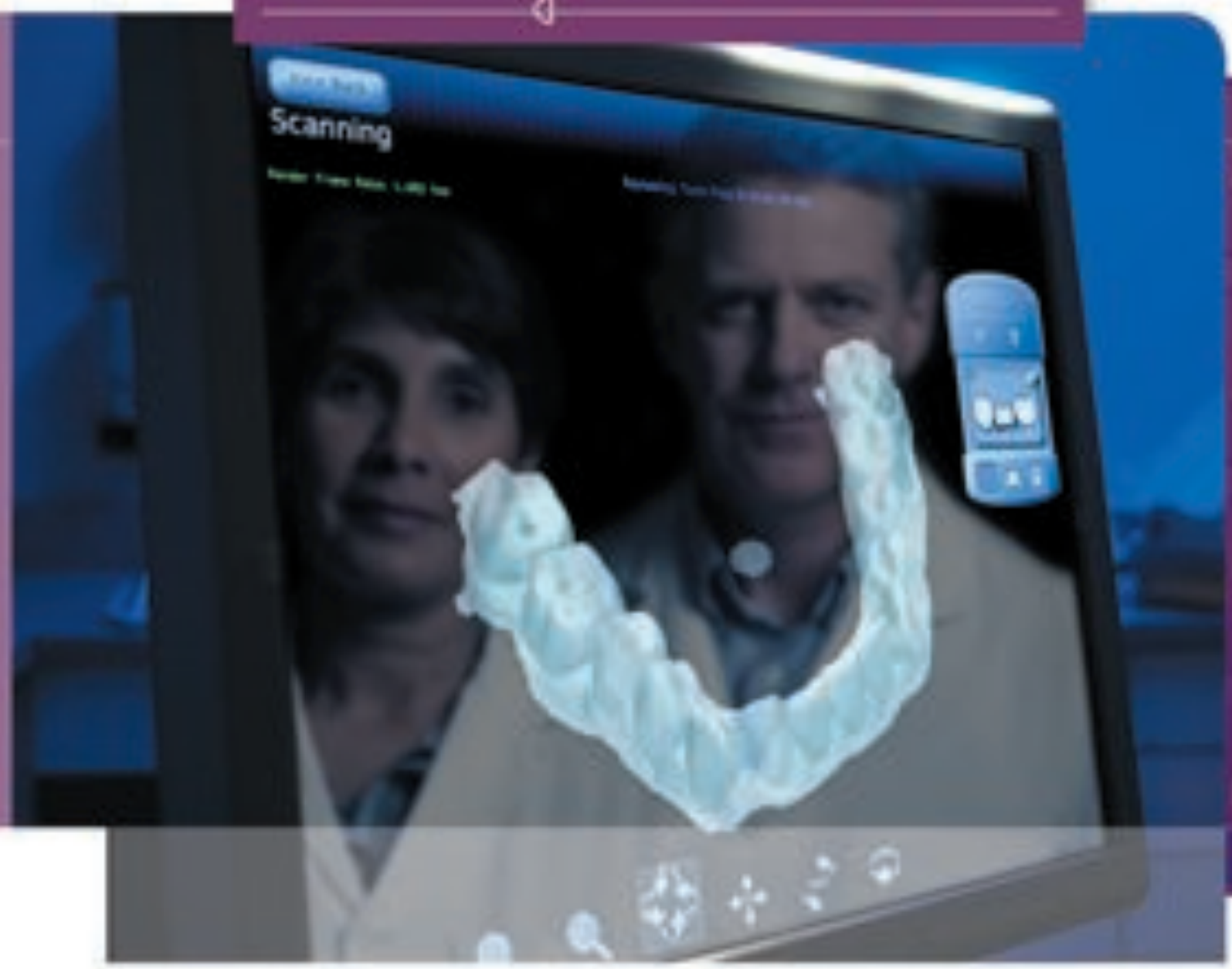


You and 3M ESPE share a common goal. We're both committed to improving dental care. More specifically, we're both committed to finding healthier, safer and better solutions for the people who sit in the chair next to you. New 3M ESPE product developments will help, but this commitment isn't just about products. Our new digital scanning technology will help, but this commitment isn't just about technology either. For our part, this commitment requires the vision to transform the way dental work is done and to support that vision in all we do, from education to research to participation in important industry events to simply listening well. To learn more about what we're doing to help you define the future of dentistry, visit **3Mespe.com.**

3M ESPE

Ethics

Continued from page one

the American Dental Education Association and American College of Dentists, the event included 78 participants who heard from students and experts in higher education, dental education and testing.

Research and observational data indicate an erosion of ethical norms in society as a whole, said speaker Dr. Charles Bertolami. Medicine, science, the military, sports, and the public and private sectors have experience with cheaters, and it's clear dental schools are starting to feel the repercussions.

Deans and faculty from dental schools in Nevada, New Jersey and New York shared their experiences with recent ethical breaches that involved students trading clinical procedures, using a faculty password to approve treatment and sharing unreleased questions and answers from the National Board Dental Exam, and the impact those incidents have had on their institutions.

The cases are disheartening to dental education program faculty who take seriously their role in developing ethical practitioners.

But there is a big difference between teaching about ethics and teaching ethics, said Dr. Bertolami, dean of the University of California at San Francisco School of Dentistry.

In his widely recognized paper from the Journal of Dental Education, "Why Our Ethics Curricula Don't Work," Dr. Bertolami suggests that it's not enough to simply teach students about ethics without demonstrating how they are used in practice. Advancing the ethics curriculum to the next level, he says, requires that we also show how this works in practice. It's difficult to achieve this type of ethics curriculum in didactic courses because "how" can only be accomplished by role-modeling in dental schools.

Others pointed to the competitive nature of dental schools that breeds a "win-at-all costs" mentality as contributing to incidents of cheating.

"Competency systems eat away at students' altruism, and hierarchies and relentless drilling of students can frustrate genuine respect," said speaker Jos V.M. Welie, Ph.D., an expert in medical ethics.

When cheating scandals in dental school involve patient care, Dr. Welie warns of dire consequences for the future of the profession.

"If a student is willing to do something to a patient now because of an educational requirement, what will they do when the bank is paying their loans? There is much greater pressure in the future than waiting another five or six weeks for graduation," he said.

Ethical scandals in medicine and dentistry in the United Kingdom resulted in the erosion of some of the professions' ability to self-regulate, added keynote speaker Mark Brennan, a clinical educator and ethicist from the University of Kent in Canterbury, England.

"The majority of students have a moral compass that was in place before arriving at dental school and have continued to push hard to stay true to those principles," said Bradley Harrelson, immediate past president, American Student Dental Association.

For the students who cheat, Dr. Brooke Loftis, current ASDA president, said it's not clear whether they fear the consequences of their behavior or if they believe the potential benefits outweigh the repercussions.

Do faculty and administrators avoid confronting these problems when breaches are discovered? Threats of litigation are one reason that schools may be timid in cracking down on violators, said Dr. Loftis.

Despite the troubling issues brought to light at the symposium, participants made headway toward finding solutions to bolster academic integrity.

"There is this idea of having 'an ethics conversation' with students now," said Dr. Richard N. Buchanan, dean of the State University of New York at Buffalo School of Dental Medicine. "You demonstrate your own ethics, for example with recordkeeping. You explain this is why accuracy of communication is essential, because patient welfare depends on it. We're starting to have these conversations, and I think that is part of the solution."

The medical profession doesn't have the answers to these questions but is working very hard to find them, said speaker Patricia Surdyk, Ph.D., executive director of the Accreditation Council of Graduate Medical Education.

One example is the ACGME's outcome project, a long-term initiative to enhance education through outcomes assessment, which includes the concept of professionalism. The point is to help young professionals grow, and teaching and assessment should support that growth.

"Residents must demonstrate a commitment to carrying out professional policies and adherence to ethical principles," said Dr. Surdyk. "In other words, you have to teach it, but have to know that they are really getting it."

One observation of that project reveals a "hidden curriculum," where students and residents learn behaviors that send a different message than what the institution is trying to teach—such as faculty mistreating one another and disrespectful communications from office staff.

"If they don't see the entire environment as respectful, of course we're going to see bad behaviors," said Dr. Surdyk. "We have to treat each other, and groups within the profession have to treat each other, with the kind of respect that we want to see in students."

Strange as it is, students can go through four years of dental school without ever seeing a dentist practice dentistry, notes Dr. Bertolami.

"We have an obligation to role model, to teach and demonstrate morals and ethics to dental students," he said. "It used to be a given that if you were a doctor, society would trust you. It's dangerous to go into practice and society with that expectation. We have to help students realize that. You have to show you are trustworthy first."

One outcome from the incidents at the University of Medicine and Dentistry of New Jersey is that administrators are encouraging students to take the lead when it comes to policing each other, said Dr. Cecile Feldman, dean.

"We are moving from a faculty-driven honor code to one that is more student-driven," said Dr. Feldman. "We want them to know that we have an obligation to self-police as a profession, and hopefully that will make them more apt to take on that responsibility."

Research shows that school honor codes do have an impact on reducing student cheating. Is there more that the ADA could do to bolster its own Principles of Ethics and Code of Professional Conduct?

There is no reference to students in the ADA code, said Dr. Rickland Asai, chair of the Council on Ethics, Bylaws and Judicial Affairs, but the American Student Dental Association promotes its own Student Code of Ethics.

Even so, the most rigorous honor code won't help some students confronting ethical dilemmas. As UMDNJ's Dr. Feldman stated, "The actions we're talking about, the students clearly knew they were wrong but did it anyway. That is what makes this so hard."

The symposium's ultimate goal was to understand the context of ethical conduct in dental schools and explore innovative approaches to furthering ethics in education.

Continuing the discussion is on the agenda for the two hosting councils, both of which will consider recommendations for action at upcoming meetings. It was clear that all stakeholders—the ADA, ADEA, American Association of Dental Examiners, ASDA and ACD—must work together.

"This was an outstanding event that generated a lot of discussion and a list of strategies to maintain and enhance integrity and ethics in dental education," said Dr. Stephen K. Young, chair of the Council on Dental Education and Licensure. "CDEL and CEBJA will now review and prioritize these strategies and develop an action plan." ■

—foxk@ada.org

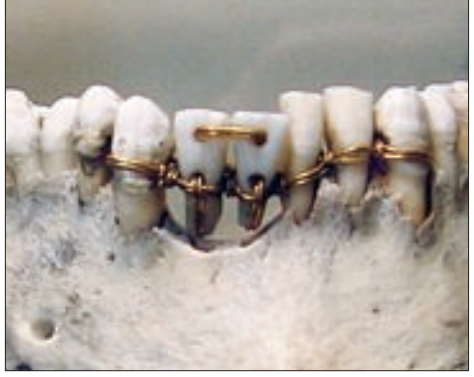
Code: The ADA Code of Ethics contains no reference to students, says Dr. Rickland Asai, CEBJA chair.

Student view: Bradley Harrelson of ASDA says "ethical violations threaten the future of your, and our, profession."

Military: Maj. Matthew Hallgarth of the U.S. Air Force Academy's Center for Character Development serves as a speaker on June 8.

Challenge: "There is a big difference between teaching about ethics and teaching ethics," Dr. Charles Bertolami (right), UCSF dental dean, tells the group. Patricia Surdyk, Ph.D., Accreditation Council for Graduate Medical Education, notes that "residents must demonstrate a commitment to carrying out professional policies and adherence to ethical principles."

Education



Bridging a gap: This ancient Egyptian bridge that used gold wire to attach crowns to intact dentition is part of the Bioengineering: Making a New You exhibit.

National Museum of Dentistry opens new exhibit this summer

BY CRAIG PALMER

Baltimore—The Dr. Samuel D. Harris National Museum of Dentistry offers summer visitors a look at the possibilities of growing new teeth, gene therapeutics for salivary glands and new careers to make it happen.

It's part three of the museum's focus on state-of-the-art research changing the face of dentistry, Bioengineering: Making a New You, that opened June 16. "Explore how the genetic secrets unlocked by the Human Genome Project and the science of bioengineering are making this exciting research possible. Learn how genes introduced through saliva could one day treat disease, and find out more about the specialized careers that could help make this future possible."

The exhibit traces a history from tooth replacement in ancient Egypt through 21st century visions of growing natural teeth from stem cells, inserting genes in salivary glands to treat systemic disorders like diabetes and attracting students to careers that could make it real.

The innovative and interactive three-part exhibition, Your Spitting Image, highlights saliva, forensics and bioengineering. Museum officials credit professional advice and support for the exhibit:

• The National Museum of Dentistry is pleased to have the continued involvement of Dr. Christian Stohler, dean of the Baltimore College of Dental Surgery, University of Maryland Dental School, and Dr. Harold Slavkin, dean of the University of the Southern California School of Dentistry, in an advisory role for the project.

• Special advisors for Bioengineering: Making a New You are Dr. Christopher Fox, executive director of the International and American Associations for Dental Research; Dr. Songtao Shi, University of Southern California School of Dentistry, dental stem cell researcher; Dr. Malcolm L. Snead, USC School of Dentistry, principal investigator of a collaboration to conceptualize a plan to successfully regenerate teeth; and Pamela Yelick, Ph.D., Tufts University School of Dental Medicine, dental stem cell researcher.

• Support for Your Spitting Image is provided by Patterson Dental Foundation, Dr. Constance P. Seldin, Dr. Leslie W. Seldin, Dr. Laurence E. Johns and Dr. Robert J. Wilson. ■

CORRECTION

Two contact updates

• The News Brief on page one of the June 4 ADA News lists an incorrect phone number to obtain your password for access to ADA Member Center discounts. To obtain your password for access to this area on ADA.org, call the ADA member toll-free number, Ext. 3553 or 1-312-440-2500, Ext. 3553.

• Dental societies interested in hosting ADA CELL Seminar Series programs can call the ADA toll-free, Ext. 2908 to schedule all programs; by e-mail at "seminarseries@ada.org" or visit "www.ada.org/goto/seminarseries". ■

Marketing your practice

The ADA joined forces earlier this year with the experts at Intelligent Dental Marketing to provide a comprehensive offering of effective and affordable marketing products and services to help dentists attract and retain patients.

The new venture is called ADA Intelligent Dental Marketing, and the offerings for dentists include:

- Branding and Identity;
- External Marketing;
- Internal Marketing;
- Case Presentation.

One of ADAIDM's areas of expertise is helping dentists learn how to maximize results within their marketing budgets. Most dentists, says ADAIDM, conceptually understand the importance of building a brand and attracting new patients through marketing efforts. However, fewer truly understand the net effect, or their return on investment, and how to use their marketing dollars wisely.

With years of experience helping dental practices grow and retain quality patients, the team at ADA Intelligent Dental Marketing utilizes cutting-edge and innovative tools matched with time-tested marketing strategies. ADAIM will not only help to improve patient perception of a dental practice, but also will increase new patient flow.

To find out more about ADA Intelligent Dental Marketing call toll-free at 1-866-859-1999 or visit "www.adaidm.com". Call before Aug. 1 to receive a free copy of "Breakthrough Dental Marketing." ■

TIMELINE: Proposed revisions to the ADA's anesthesia guidelines documents

October 2005	May 2006	June - September 2006	November 2006	December 2006
ADA House of Delegates passes Res. 42H-2005 supporting the Council on Dental Education and Licensure's Committee on Anesthesiology's comprehensive review of ADA's anesthesia guidelines documents and policies to keep pace with other dental and medical organizations that had recently made significant changes to their documents.	Committee hosts an Invitational Anesthesia Conference to gather information from nationally-recognized experts in the science and clinical practice of sedation and general anesthesia in dentistry.*	Committee on Anesthesiology develops draft documents focused on being consistent with other leading organizations and reorganizing the content from route of administration to level of sedation.	CDEL reviews and forwards proposed documents to the ADA Board of Trustees with a request to circulate the documents to the communities of interest. The Board approves the request in December 2006.	A call for comments is issued to key communities of interest with a Feb. 23, 2007, deadline for written comments.

* Conference attendees represent the American Society of Anesthesiologists, American Society of Dentist Anesthesiologists, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Dental Society of Anesthesiology, American Academy of Pediatric Dentistry, Academy of General Dentistry, American Association of Dental Examiners, American Association of Endodontists, American Association of Hospital Dentists, American College of Prosthodontics, American Dental Education Association, Dental Organization for Conscious Sedation and the National Institutes of Health.

CDEL adopts further changes to proposed anesthesia guidelines

BY KAREN FOX

Since receiving more than 1,400 comments, the Council on Dental Education and Licensure and its Committee on Anesthesiology have made changes and further clarifications to the proposed revisions to the ADA's anesthesia guidelines documents, which are now available for viewing on ADA.org.

"I believe the revisions clarify and address many of the questions and concerns from the communities of interest," said Dr. Stephen K. Young, CDEL chair. "The next step is that the revised proposed guidelines will go to the House of Delegates for discussion and a vote."

Dr. Guy Shampaine, chair of the Committee on Anesthesiology, said the committee carefully considered each of the comments received.

"The process worked," added Dr. Shampaine. "The comments from the communities of interest were excellent, and some very valid criticisms of the original language. We were able to incorporate changes without compromising patient safety."

■ To view the full guidelines, visit "www.ada.org/goto/hodreports"

Revising the documents is a process that has lasted almost two years since the 2005 House of Delegates supported the CDEL Committee on Anesthesiology's comprehensive review of the Association's guidelines and policies. (See timeline above.)

Several dental and medical organizations with policies and guidelines on sedation and anesthesia had recently made significant changes to their documents, and the council believed it was imperative that the ADA update its documents to reflect contemporary terminology, which included a reorganization by level of sedation vs. route of administration.

Feedback received on the revisions proposed earlier this year led the committee and council to take a closer look at a few key areas of concern.

Definitions of minimal & moderate sedation

A significant number of commenters felt the definitions of minimal and moderate sedation in the proposed revisions were too similar, and the council agreed—making clarifying edits to both definitions.

"The differences were subtle enough that we wanted to have a clear delineation between those levels of sedation to make it easier for practitioners to evaluate their patients using the appropriate protocol," said Dr. Shampaine. "Many requested more precise language, and the committee took another look at those definitions. This also resulted in definitions that are closer to those used by the medical community."

Clarifying edits included moving the definition of titration from minimal sedation to moderate sedation, and placing a definition of supplemental dosing in the minimal sedation definition, which the council felt more accurately reflects what occurs when dentists administer oral sedative drugs to achieve minimal sedation.

Monitoring patients post-sedation

Requiring the dentist to remain in the room with a minimally sedated patient who meets the criteria for recovery was also carefully considered in light of feedback from the communities of interest.

"In almost all circumstances, the duration of monitoring in minimal sedation is required until active dental treatment stops, and does not need to extend beyond that for most patients," said Dr. Shampaine. "So for minimal sedation only, we clarified the intent of the original language."

What's new is the addition of language stating that an appropriately trained individual is now allowed to monitor the patient under minimal sedation.

"That is a result of considering the comments from various communities and evaluating the risks exclusive to minimal sedation," said Dr. Shampaine.

The guidelines also note that provisions in states where dental assistants or hygienists are currently authorized to monitor sedation patients would not be affected by the guidelines.

Proposed monitoring requirements for moderate sedation were not changed because the standard of care requires the dentist to monitor the patient until that patient meets the criteria for recovery, however the council has proposed additional language that the dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

Strengthening "grandfather clause"

During the call for comments period, there were several concerns that the revisions would prohibit dentists who have been safely practicing sedation and anesthesia under current state rules and regulations from continuing this practice without further education.

The educational requirements currently state that guidelines should not exclude individuals who would be "grandfathered" by individual state laws, but the council believed it could further strengthen the intent of this language.

"What we did is clarify the language in several portions of the documents so there would be no misunderstanding," said Dr. Shampaine. "We made it absolutely clear that we were 'grandfathering' practitioners who were providing these services in their states and not recommending additional training.

New course on emergency management for dental sedation/anesthesia in the works

As part of its comprehensive review of the ADA anesthesia guidelines documents, the Council on Dental Education and Licensure is working with the ADA Foundation to develop an emergency management course focusing on airway management for dentists administering sedation or general anesthesia.

The council recommended the course specifically for dentists, which concentrates on the emergency management situations faced by dentists administering sedation or general anesthesia in the dental office.

CDEL and its Committee on Anesthesiology believe the course could serve as an alternative to the Advanced Cardiac Life Support training currently recommended in the guidelines. Current ACLS courses involve interventions concentrating on cardiac arrhythmias, which are not the early presentation of the emergencies most commonly faced by dentists administering sedation. ■

January 2007	February 2007	March 2007	April 2007	June 2007	July 2007	September 2007
Proposed revisions are posted on ADA.org and general call for comment is issued.	More than 1,400 letters—supportive and critical—are received from 18 state and national dental-related organizations, 1 constituent society, 3 state dental boards, 1 ADA council, 1 dental sedation CE organization, 313 individual dentists and 33 dental patients. An organization known as Trust for Equal Access Medicine 1500 submitted over 1,000 letters from dentists and patients.	Committee on Anesthesiology holds 11-hour meeting to review each comment and make additional changes to the proposed revisions.	CDEL considers the revised documents, makes further recommendations and presents resolutions that call for the adoption of the revised guidelines and rescind previous guidelines.	Proposed revisions are posted on ADA.org. Academy of General Dentistry is holding a town hall meeting on the guidelines at its annual meeting this month.	Board of Trustees will make comment on the proposed revisions.	ADA and American Association of Dental Examiners will hold sessions on the guidelines during their annual meetings in San Francisco. ADA House of Delegates will then act on the new guidelines.

"That is unchanged from the previous guidelines," said Dr. Shampaine. "However, we now have clearer language than the ADA has ever used."

Number of courses and patient experiences

There were also numerous concerns over the proposed training requirements in the Guidelines for Teaching.

Many felt the training requirements would be difficult to provide and could be cost prohibitive for both course providers and participants. The limited availability of proper facilities could limit a dentist's ability to find the training requirement, and dental phobic patients may have difficulty finding a dentist who can provide sedation services.

"As a result of comments from the communities of interest, we closely examined the training requirements for moderate enteral sedation, which is a unique and prevalent practice modality in dentistry but not medicine," said Dr. Shampaine. "We felt it was important to factor that out for dentistry alone."

After the call for comments period, the Committee on Anesthesiology consulted with a number of educators to determine the number of instructional didactic hours and clinical cases required to teach moderate enteral sedation and proposed a new educational framework separating the didactic instruction from clinical experiences.

The newly proposed guidelines call for moderate enteral sedation training requirements that reflect 24 hours of didactic instruction (down from the previously proposed 60 hours) and the management of at least 10 adult case experiences, which includes at least three live clinical dental experiences managed by participants in groups no larger than five (remaining cases may be simulation and/or video presentations, but must include one experience in returning or rescuing a patient from deep to moderate sedation), and a participant/faculty ratio of 5:1.

"We feel comfortable that as a minimal requirement, this is appropriate," said Dr. Shampaine. "But we also take the opportunity to endorse the ADA lifelong learning philosophy, which encourages additional training throughout a practitioner's lifetime."

The council also agreed that clinical experience in establishing intravenous access for moderate enteral sedation should not be required.

Another change made in the Guidelines for Teaching states that minimal and moderate sedation training could be done in dental school. "For example, nitrous oxide use for minimal sedation could be accomplished in dental school, so we added language stating that training could be achieved as part of the predoctoral dental education," said Dr. Shampaine.

The proposed revisions that will be submitted to the House of Delegates this fall are in the Council on Dental Education and Licensure's annual report, which is now available in members-only content on ADA.org.

To view the documents, visit "www.ada.org/goto/hodreports". If you have problems accessing members-only content, call the ADA toll-free number, Ext. 7700. ■

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Annual session tours showcase the best sights, food and fun

San Francisco—The steep hills, the bay views, mysterious Chinatown, historic and modern architecture, cable cars, astounding bridges, the nearby wine country and more—these are the elements that make San Francisco one of the most unique, beautiful and memorable cities in the world.

During annual session Sept. 27-Oct. 2, explore the wonders of San Francisco: the ADA is offering more than 30 unique tours to help you enjoy the sights, sounds and tastes of your choice.

Discover all there is to see by attending a quick "San Francisco Orientation" at the San Francisco Marriott, where a local expert will offer advice on making the most of your stay.

Three tour options provide an overview of the landmarks and attractions of San Francisco: a land and water tour of "The City & The Bay"; a trip back in time to "Historic San Francisco"; and a well-rounded look at all things San Francisco in the "San Francisco Highlights" tour. Three additional tours offer a more in-depth view of some of San Francisco's largest and most famous landmarks: an excursion to "Alcatraz: 'The Rock'"; an exhilarating walk across the city's icon for a "Golden Gate Bridge Experience"; and a private tour of the San Francisco Giants' home field, AT&T Park on the "Take Me Out To The Ball Park" tour.

Do you have a yearning to explore San Francisco's art and architecture? Indulge your appreciation of antique jewelry, pottery, crafts and furniture when you're "Antiquing Across the Bay." Enjoy an "Emphasis On Art" by touring the California Palace of the Legion of Honor and the de Young Fine Arts museums. If your true love is architecture, explore two of San Francisco's "painted ladies" Victorian homes in the "Splendid Survivors" tour; combine your visit to a Victorian-era home with a trip to the Legion of Honor museum during the "Art & Architecture" tour; or head north of the city to Marin County and explore the grand homes of Tiburon and Belvedere during the "Exclusive Residences of Marin" tour. Unravel the oddities of the "Winchester Mystery House," the Victorian mansion of the Winchester Rifle heiress that features staircases leading to nowhere and doors that open to blank walls.

Landmark neighborhoods: Pier 39 at San Francisco's Fisherman's Wharf, above, features a bustling variety of shopping, dining and entertainment options along the Bay. At left, Chinatown sparkles in the twilight.

San Francisco Convention and Visitors Bureau photos

Fans of stage and screen can relive the "Dynasty" television show by visiting "The Mansion and Gardens of Filoli," set on 16 acres of manicured grounds; or get a backstage glimpse at motion picture shooting locations for famous films including "The Jazz Singer," the "Maltese Falcon," "Vertigo" and more during the "Hollywood By The Bay" tour. You can also attend a matinee performance of San Francisco's most famous show, "Beach Blanket Babylon," or an evening show that includes dinner at a North Beach Italian restaurant ("Beach Blanket Babylon Matinee" or "Beach Blanket Babylon and Italian Dinner" tours).

Satisfy your appetite for tours that combine fabulous sites and fine dining and/or wine. Everyone from occasional wine drinkers to wine connoisseurs will enjoy visiting the Napa and Sonoma Valleys to taste the vintages of two wineries and enjoy a fabulous lunch during "The Best of The Wine Country with Restaurant Luncheon" tour, or tour two Sonoma wineries and historic sites during "Sonoma: Birthplace of California Winemaking." Spend "An Evening in the Wine Country" at the Viansa Winery in Sonoma, including a winery tour, hors d'oeuvres, entertainment, dinner … and of course, locally produced wine.

Back in San Francisco, board a luxurious yacht for a champagne brunch on San Francisco Bay ("Brunch On The Bay"), or test your culinary skills by joining the "California Cooking Adventure," where small teams of participants will work with experienced chefs to make a four-course meal with local organic ingredients. Experience the wonders of Chinatown and its exotic cuisine with a nighttime tour and dinner or a walking tour and lunch ("Chinatown By Night" and "Chinatown Discovery: A Walking Excursion With Lunch"). Dine and dance watching the sunset over the Golden Gate Bridge during "Elegance Afloat: A Dinner-Dance Cruise on the Bay." Or, taste the fantastic cuisine of San Francisco from "Tip of the Pier to the Top of the Town: Progressive Dinner," starting with dinner at Fisherman's Wharf and ending with dessert at the Carnelian Room on the 52nd floor of the Bank of America Building.

Outdoor enthusiasts can stretch their minds and their muscles at the same time with tour options that include the "Cycle & Sail" tour, a bike ride from Fisherman's Wharf along the coast and over the Golden Gate Bridge to Sausalito with lunch and a ferry ride back; a "Kayak Adventure on the Bay" that includes a picnic lunch; or "A Sailing Adventure" on a catamaran with lunch and breathtaking views. Let your feet carry you through San Francisco during the "Wake Up and Walk" exploration of either the Union Square area or the SOMA and Embarcadero neighborhoods; or a brisk 3.8-mile through the heart of the city in "A Walk Along the Barbary Coast Trail," a tour that will help you enjoy 20 of the city's most famous sites on foot, plus a cable car ride back to the hotel.

AnnualSession

Three "Magical Marin" tour options highlight Marin County, including the giant redwoods in Muir Woods and the quaint shops and galleries of Sausalito, with options for a ferry ride return and/or lunch. Travel south of San Francisco to "Monterey, Carmel & The 17-Mile Drive," where you can see Cannery Row, windblown cypress trees and multi-million-dollar mansions along the coastline, or journey to "Yosemite National Park" which offers breathtaking scenery and lunch.

Tour tickets can be purchased through Sept. 7. Reserve your tours in advance online at "www.ada.org/goto/session" or by mail or fax to help ensure you get tickets for the tours of your choice.

A complete list of tours with descriptions, dates, times and prices, is available online or in the Annual Session Preliminary Program. ■

Register now for a chance to win

San Francisco—The June issue of the Journal of the American Dental Association is coming soon to your mailbox—complete with 72 pages of annual session information.

Register today for annual session Sept. 27-30 for a chance to win great prizes. Log on to "www.ada.org/goto/session" and register and book your hotel reservation by July 13 and you'll be entered into a drawing for:

- Two free round-trip airline tickets to anywhere in the continental U.S.;
- Tickets to "An Evening with Billy Crystal" Sept. 29 at the Moscone Center;
- One of two free dinners for two at one of San Francisco's Real restaurants—Betelnut, Bix or Fog City Diner.

See page 13 of the 2007 preliminary program or visit "www.ada.org/goto/session" for complete rules. ■

Special registration rate helps dentists try the benefits of ADA membership at session

San Francisco—Experience some of the benefits of ADA membership that 155,000 ADA members already enjoy by attending the American Dental Association's 148th Annual Session and World Marketplace Exhibition Sept. 27-30.

The ADA is offering dentists who are not yet members of the ADA an opportunity to attend the annual session at a reduced rate of $75. The regular nonmember registration rate is $750. Dentists can only take advantage of this offer one time, so those who attended the 2005 or 2006 annual session at the reduced rate are not eligible.

For more information or to register, log on to ADA.org or call the Council on ADA Sessions at 1-312-440-2388 to receive an annual session preliminary program, including registration materials. ■

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1. Federal Register. Vol 57. No 91. May 11, 1992: 20114-20115. 2. Joiste MT, et al. Comparison of enamel fluoride uptake and fluoride release from liquid and paste dentifrices. J Dent Res. 2005;84(Sp. Issue): Abstract 1353. 3. Baysan A, et al. Reversal of primary root caries using dentifrices containing 5,000 ppm and 1,100 ppm fluoride. Caries Res. 2001;35:41-46.
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Communities receive honors for fluoridation

Denver—A dozen communities in nine states were recognized at the National Oral Health Conference in Denver May 1 for reaffirming community water fluoridation in response to challenges to their existing fluoridation programs in 2006.

"This is the first time that more awards were given to those communities who fought to retain fluoridation programs than to initiate them," said Dr. Lewis Lampiris, director, ADA Council on Access, Prevention and Interprofessional Relations. "The trend we're seeing is that there are a growing number of challenges in communities that have had fluoridation for many years. Fighting these challenges takes a coalition of stakeholders to work together so their citizens don't lose this important public health option."

Photo by Dr. Eugenio D. Beltran

Honored: Dr. Lewis Lampiris, left, director, ADA Council on Access, Prevention and Interprofessional Relations and a former president of the Association of State and Territorial Dental Directors, receives the ASTDD's Distinguished Service Award May 1 in Denver from ASTDD President and Utah State Dental Director Dr. Steve Steed.

Communities receiving reaffirmation awards include: Arcata, Calif.; Boulder, Colo.; Palm Beach, Fla.; Hampton, Iowa; Jackman and Moose River, Maine; Stockton, Mo.; Del Rio, Texas; Burlington, Montpelier and Bellows Falls, Vt.; and Antigo, Wis.

Eleven communities were also recognized for initiating fluoridation in 2006, including: Arcata and West Sacramento, Cal.; New Bedford, Mass.; Grand Lodge, Mich.; Guntown, Lebanon Water Association, Puckett and Quincy Water Association, Miss.; Keytesville, Mo.; Corning, N.Y. and Skagit County, Wash.

More than 90 other community water systems nationwide received community water fluoridation awards in additional categories. CAPIR, in conjunction with the Association of State and Territorial Dental Directors and the Centers for Disease Control and Prevention presented the awards.

A total of 83 water systems in 29 states and Puerto Rico celebrated their golden anniversary of continuous water fluoridation in 2006, receiving Fifty Year Awards.

For more information on community water fluoridation awards or a complete list of this year's winners, log on to "www.ada.org/goto/fluoride". ■

CDC fluoridation engineer recognized for achievements

BY CRAIG PALMER

Atlanta—Citing fluoridation as one of "10 great public health achievements of the 20th century," the Centers for Disease Control and Prevention honored environmental engineer Kip Duchon at an employee awards ceremony for outstanding customer service in working to promote safe, effective water fluoridation practices. The CDC provides training and technical assistance for community water fluoridation.

Recognition: Mr. Duchon pauses for a photo at the CDC employee awards ceremony with (from left) Kathleen Toomey, M.D., director, CDC Coordinating Center for Health Promotion, and Julie Gerberding, M.D., CDC director.

"Mr. Duchon's ability to bring together agencies, organizations and other stakeholders has been vital to the progress in improving the oral health of the nation and toward meeting the Healthy People 2010 community water fluoridation objective," the CDC said.

"The essence of my job is to assist state water fluoridation programs to have the information to do their jobs better and more effectively," said Mr. Duchon, national fluoridation engineer with the CDC's division of oral health. "Our goal is for states to have the best quality water fluoridation for the citizens of their states."

Mr. Duchon was cited for "responsiveness to CDC customers' needs" and for "customer-centric" relationships with state and local oral health programs, professional organizations including the ADA and Association of State and Territorial Dental Directors, and federal and international agencies including the Environmental Protection Agency and Pan American Health Organization. ■

ADA CE Online offers free OSHA course

BY ARLENE FURLONG

The first in a series of five U.S. Occupational Safety and Health Administration courses will be available without charge to ADA members until Sept. 1 on ADA CE Online.

"I encourage all of our members to take the OSHA course that is being offered for free so they can experience the quality and ease of use that make ADA CE Online so popular," said Dr. Richard F. Hunt III, a member of the advisory committee for ADA CE Online and the Council on Dental Practice. "ADA continuing education online is evidence of the ADA's commitment to its mission of professional advancement through education."

"OSHA Series No. 1: Introduction to the Bloodborne Pathogens Standard" is being provided at no cost to participants, through the generosity of 1-800-DENTIST.

"The loyalty of the ADA membership paired with the convenience of their easy-to-use Web site ensures that ADA CE Online will become the leader in electronic continuing education for dentists," commented Fred Joyal, chief executive officer and cofounder of 1-800-DENTIST. "We are proud to be partnering with the ADA and to further our common goal of enabling dentists to get the ongoing training they need to practice dentistry at the highest level."

OSHA's Bloodborne Pathogens Standard requires all employers with occupational exposure in the dental office to provide a training program at the time of initial assignment of tasks where occupational exposure may take place and at least annually thereafter, according to Dr. Roger J. Adams, editor in chief, ADA CE Online. "ADA CE Online's OSHA series courses have proven to be an excellent resource for dentists and dental team members to meet this requirement."

Dr. Hunt: "ADA continuing education online is evidence of the ADA's commitment to its mission of professional advancement through education."

The online CE library currently has 81 courses in categories ranging from pharmacology to sports dentistry.

To take ADA CE Online courses and learn about other special offerings go to "ada.org/goto/ceonline." ■

CELL partners with state dental societies on dental CE

ADA CE Online is helping ADA members and state societies at the same time.

As part of its online education member service, the Center for Continuing Education and Lifelong Learning is partnering with state societies to make ADA CE Online the first place members go to look for online continuing education on the Web.

As part of the program the ADA will relax exclusivity requirements with constituent dental societies to allow them to share their online continuing education programs with many more dental team members through ADA CE Online. In addition, state dental societies can earn royalties when its members take ADA CE Online courses.

Dental societies interested in learning more about ways to collaborate with the ADA on continuing education for members should contact Marsha P. Stiegel, director, CELL, Ext. 2830 or e-mail "stiegelm@ada.org". ■

That's Italian

Medical musical group plans fall tour in Italy

Washington—From the Rockies to the Alps, medical musicians and vocalists can reach new performance heights by joining the VA-National Medical Musical Group for its fall season.

The MMG will perform its National Veteran's Day Concert Nov. 2 in Denver before embarking on a nine- or 12-day tour of Italy, including performing in two concerts.

The Italian tour will include stops in Rome and Venice plus optional visits to Verona, Milan, Lake Como and more.

The MMG is especially in need of tenors and strings at this time. For more information on the group or the upcoming concerts and tour, write to 1700 17th Street, NW, Suite 508, Washington, D.C. 20009, call 1-202-797-0700, e-mail "vanmmg@hotmail.com" or visit: "www.medicalmusical.com". ■

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Receive your ADA CERP CE in this interactive, multi-media learning environment.

TO REQUEST YOUR 2007 ADA ANNUAL SESSION INFORMATION:
Copy and fax this panel to 312-440-2707, or e-mail your request to annualsession@ada.org. The Preliminary Program is available online at www.ada.org/goto/session.

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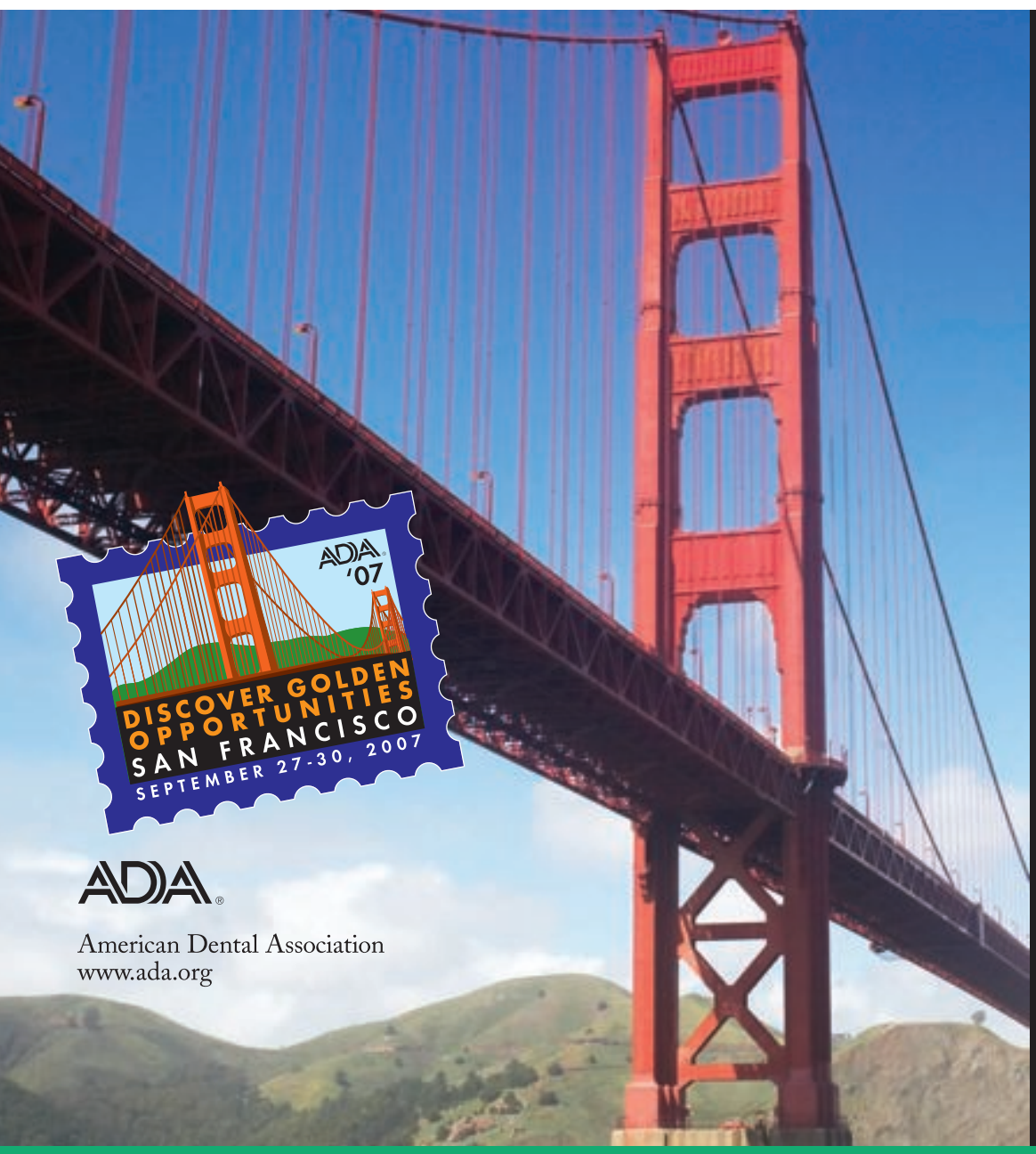

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Dental Benefits

ADA/NADP share views on bundling and downcoding

This is the fifth installment of a series of ADA News articles on dentists' "Top 10" concerns submitted to the ADA about dental claims. These articles include perspectives from ADA members, National Association of Dental Plans members and the Council on Dental Benefit Programs.

Bundling and downcoding are among the most frequent concerns ADA members complained about to the ADA during 2005. Lost radiographs, claim forms and attachments were covered in the May 7 ADA News. Claims processing delays was covered in the March 5 ADA News. Dental claims denials were featured in the Nov. 20, 2006, and Jan. 8 ADA News.

Subsequent articles will feature the remaining "Top 10" concerns which include post utilization review, assignments to participating doctors only, provider contract issues and others. ■

Captive audience: CDBP 2006 members (from left) Drs. Mark Kampfe, Steve Hogg (back), Pat Boyle and Steve Simpson consider NADP input on industry perspectives last year.

Bundling and downcoding

Dentist perspective

Bundling is defined by the ADA as "The systematic combining of distinct dental procedures by third-party payers that results in a reduced benefit for the patient/beneficiary."

Many dentists want to know what the purpose of developing a procedure coding system with separate codes for distinct dental procedures is when third-party payers simply ignore it. Although there are some instances of bundling due to improper filing of the claim, the instances of concern to dentists are when procedures which are legitimately separate are bundled either inappropriately, or due to contract provisions without explanation.

Dr. Alan Friedel

Dr. Robert Faiella

One of the most common complaints the ADA receives concerning bundling issues pertains to radiographs. Several radiographs will be combined and recoded as a full mouth series and are then subjected to dental benefit plan frequency limitations. Usually the number or type of radiographs taken would not constitute a full mouth series.

Another area of confusion is the practice of some third party payers to combine a panoramic radiograph together with bitewings for payment as a full mouth radiographic examination (FMX). While a panoramic radiograph has many diagnostic uses, its inherent distortion does not permit the clinical differentiation required for many dental procedures.

Downcoding is defined by the ADA as "A practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements."

When a third-party payer downcodes a procedure, it may be understood by the patient that the payer is making a determination that a lower level of care was needed or should have been provided. Dentists feel that the determination of the level of care necessary for the treatment of their patients should be made by them, not the insurance company. Unless the purely business reason for the payer decision is explained, this may wrongfully interfere with the doctor-patient relationship.

Many carriers typically do not disclose their bundling or downcoding policies, even during the contract negotiation process. Dentists and patients have no way of knowing what the reimbursement will be until the explanation of benefits is received. When the dentist has a contractual arrangement with the carrier, and procedures are bundled or downcoded, a greater dollar amount than what was anticipated may have to be written off. If the dentist is not contracted with the carrier, the patient's coinsurance may also be greater than what they had expected.

There is no disagreement about the right of a plan purchaser and the payer to decide what will be covered and what will not be covered. In some cases limits on coverage are an industry response to what payers believe is abuse of the system by some dentists. The concern often goes back to explanation of benefits language. If payers would clearly explain that these are economic decisions between the plan purchaser and the payer in a manner that does not impact the doctor-patient relationship, it would help clear the air. Patients still might not be happy with how the benefits are administered but the dentist would not be held to blame. In the present climate, it is incumbent upon dentists and their staff to explain to patients in advance of treatment that a treatment plan should be dictated by what the doctor and patient determine is clinically appropriate, not by plan compensation.

In addition, carrier coding methodologies should be made readily available to both patients and providers. ■

Dental benefits industry perspective

Payers agree that both they and dentists have the responsibility to utilize the Code on Dental Procedures and Nomenclature as the designated standard for the reporting of dental services. Through the review and revision process, the Code has evolved to clearly define the scope of dental procedures, at times clarifying component services that may be considered part of another procedure code. One of the most common problems that payers have with claims is the use of outdated versions of CDT. Under the Health Insurance Portability and Accountability Act, payers must utilize the most current version of CDT and claims submitted with outdated procedure codes will be updated to the current codes in CDT.

Bundling:

What is often described as bundling is the effort of payers to follow guidelines established in the Code. For example, payers commonly see claims submitted with the following combinations of services that are not consistent with the Code:

- Pins reported as a separate service from a core buildup (the D2950 buildup code includes pins);
- Adhesives, bases or liners as a separate service from the restorations (the Code defines these to be included as part of the restoration);
- Occlusal adjustments and minor adjustments to prostheses as a separate service, when the prosthetic service includes routine post-delivery care;
- Suture removal, as a separate service from the extractions, which include suturing and postoperative care; and
- X-rays taken during the course of root canal therapy as a separate service from the root canal, which by definition, includes intra-operative X-rays.

For the examples above, payers will often consider these component services as part of the main procedure in accordance with the Code and pay benefits accordingly.

Regarding X-rays, payers can understand dentists' confusion regarding the coding for a complete radiographic series. The D0210 code for an intraoral complete series (including bitewings) does not specify the number of intraoral films that would compose a full mouth set of radiographs. The FDA provides some guidance by defining a full mouth radiographic examination (FMX) as "a set of intraoral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone crest." However, because radiographs are individualized, it is understood that the number of films to adequately view what is defined in a complete series will vary from patient to patient. Thus, payers may establish benefit guidelines that multiple intraoral films on the same date of service will be considered a complete series of intraoral radiographs or will be limited to the maximum reimbursement of an FMX. These guidelines should be available to both dentists and patients.

It is a fairly common occurrence for insurers to receive a panoramic film and bitewings from pediatric dentists and general dentists as their full mouth series. Payers recognize that panorex films alone are not considered sufficient for the diagnosis of decay, and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. The combination of a set of bitewings and a panoramic film is particularly useful for those patients who are to be referred for orthodontic consult and for extraction of wisdom teeth. The practice of combining these and providing a benefit equal to the full mouth series is a result of requests from the dental community, and not the creation of payers. When a single panoramic film is taken and submitted for orthodontic records, third molar evaluation and similar cases, they are often benefited separately from a full mouth series depending on the employer group.

Downcoding:

Most often employers contract for group dental benefits and contribute to the premiums which pay for the dental services provided to their employees. Payers have a responsibility to the employer-

See INDUSTRY, page 23

Industry

Continued from page 22

purchasers and their employees to assure that appropriate procedure codes are applied to the reported dental services and to make payments under the terms of the contract for those procedure codes. Payers' downcode or recode submitted procedure code(s) to a less complex or lower cost procedure(s) to apply the appropriate procedure codes for dental services based upon professional review of the information submitted by dentists and current CDT descriptors and nomenclature.

An example is a claim received with the reporting of three sites of D4263 (bone replacement graft–first site in quadrant) within the same quadrant. In this situation, payers will recode the two additional D4263 codes to D4264 (bone replacement graft– each additional site in quadrant) in accordance with the Code. Another example is the submission of code D4341 when only one to three teeth are treated in a quadrant. A payer may change the code to D4342 to accurately reflect the procedure being performed.

Payers may also pay benefits for procedures as a result of applying an allowance for benefits in the cases where dental benefit plans have a least expensive alternative treatment provision. In such cases, what may appear as downcoding is a reflection of the insured's specific allowance under their dental benefit plan for benefit determination only. This application of a dental benefit policy provision is not intended to dictate the level of care reported by the dentist, only to provide some benefit to the patient under the policy. The application of a LEAT provision should be clearly noted in the explanation of benefits. Some dental benefit plans allow the dentist to additionally bill the patient for services to which an "alternate benefit or LEAT" provision is applied—those services that the patient and dentist chose as the best option for treatment.

It is important to note that some employer groups may elect to have claims paid exactly as submitted by dentists, but there is obviously a cost to the employer for doing so. Others may set their own guidelines for administration which the payer must follow for that employer group. Again, payers are responsible to administer the benefit allowance for the reporting of dental services in accordance with the contract established with the employer.

Coverage determination guidelines:

Most payers establish utilization review programs that address both coverage determination guidelines and covered procedures. Appropriately trained staff or licensed professionals are responsible for code adjustment decisions in accordance with these program descriptions as well as compliance with state regulations. Payers vary with respect to their communication of such guidelines to dentists, but most make them available through some means for their insured plans. Since payers often administer plans for self-funded employers that may determine their own reimbursement guidelines, the payer's guidelines may not apply to some employer groups.

Tips:

- Verify procedure codes are appropriately reported in accordance with the current CDT descriptors and nomenclature.
- Contact payers directly for clarification of concerns related to coding of dental services.
- Explain to the patient in advance of treatment by use of pretreatment estimates that a treatment plan should be decided by what the doctor and patient determine is clinically appropriate, not by plan compensation. ■

—Compiled by Arlene Furlong

Executive management

Register today for ADA/Kellogg program set to begin next month

There are still openings in the ADA/Kellogg Executive Management Program for dentists, set to begin next month.

If you're interested in participating in this unique learning opportunity, give us a call and plan to submit a registration form as soon as possible.

The Executive Management Program is specially designed for dentists seeking to broaden their management knowledge from one of the nation's premier business schools.

Kellogg School of Management

Content is based on the core curriculum of Kellogg MBA students. Study areas include business strategy, organizational leadership, marketing, finance, accounting, economics, quantitative methods and information systems.

The program consists of three sessions conducted at Northwestern University's Chicago campus. Separated by seven-week intervals, the sessions are set for July 20-25, Sept. 15-20 and Nov. 1-5.

Upon completion, participants receive a Northwestern University Kellogg School of Management certificate and continuing education hours.

Registrations will be accepted on a first-come, first-served basis. Class size is limited to 45.

Application materials and program details are available for viewing and downloading at "www.ada.org/goto/kellogg". Fees must accompany the registration form, and registration includes all books and meals.

If you have questions, contact Connie Paslaski at Ext. 3541 or "paslaskic@ada.org". ■


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