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ADA News - 04/07/2008

American Dental Association, Publishing Division

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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADANEWS®

APRIL 7, 2008 VOLUME 39 NO. 7

American Indian/Alaska Native outreach grows

BY CRAIG PALMER

Washington—Dentist volunteer efforts are gaining ground in Indian country, the Association told Congress.

Placement of private practice, public, retiree and student volunteers has been "so successful" that expansion is under way in the private sector and recommended on the public side.

■ **Minnesota legislation update, page 16**

"There is no doubt that fully staffing all Indian Health Service and tribal dental clinics with dentists is the best way to meet the oral health concerns of American Indians/Alaska Natives," the Association said in written testimony last month on IHS dental appropriations. "However, the ADA also recognizes that using volunteers can help to fill the gaps until that day comes."

The dental needs are critical, the

See OUTREACH, page nine

Photo by Dr. Marshall L. Wade

Photo by Dr. John T. Frey

Disaster: Debris litters the street outside the Omni Hotel at CNN Center after a tornado hit downtown Atlanta March 14. In inset, what the tornado did to Dr. John T. Frey's hotel room in the south tower of the Omni Hotel.

Perilous night

Hinman shuts one day early due to tornado

BY STACIE CROZIER

Atlanta—A surprise tornado that heavily damaged the Georgia World Congress Center and other structures in downtown Atlanta March 14 forced the Thomas P. Hinman Dental Meeting to close early for only the second time in its nearly century-long history.

Just after 9:30 p.m. on that Friday, the 96th Hinman meeting had completed its second day, logging some 22,600 attendees for the first two days at the GWCC.

Upstairs on the eighth floor in the south tower of the adjacent Omni Hotel at CNN Center, Dr. John T. Frey, a member of the Council on ADA Sessions from Grand Rapids, Mich., was watching an approaching storm through the glass window wall of his room overlooking the CNN Center.

He had just returned from dinner with friend and past CAS Chair Dr. Ken McDougall and his wife Rosemary, and was relaxing in front of the

See TORNADO, page 14

Reading between the lines

Knowing what EBD is (and isn't) is essential for practitioners

BY ARLENE FURLONG

The ADA wants members to know it's questioning the insurance industry's use of the terms "evidence," "evidence-based" and "EBD" and that individual dentists should too.

"Don't make the assumption that because your insurers call their benefits 'evidence-based' that they really are," said Dr. John Luther, ADA senior vice president, dental practice/professional affairs. "Ask why they are."

The Association believes some insurers are using the terms to lend credibility to plan design, dental coverage and cost containment strategies, without employing a truly science-based approach. Efforts to persuade the

See EBD, page 28

BRIEFS

Therapeutics Guide:

The ADA/PDR Guide to Dental Therapeutics, 4th Edition, remains the most authoritative drug reference guide on the market for dentists looking for up-to-the-minute pharmaceutical answers.

The 1,000-plus page book was developed by the ADA in partnership with Thomson PDR and edited by Dr. Sebastian G. Ciancio. It's available to members for $49.95 and $74.95, nonmembers.

Designed for quick searches and referencing so that dentists can make informed therapeutic decisions, the guide also includes comprehensive coverage of more than 2,500 brand-name and 900 generic drugs relevant to dentistry as well as unique, dental specific sections on clinical diagnosis and treatment.

For instance, did you know:

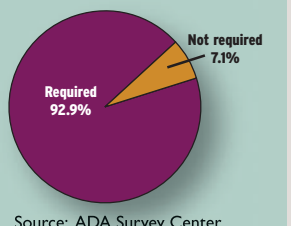
- More than 500 medications can cause xerostomia?
- More than 20 drugs can alter a patient's taste? Some of the biggest offenders are antihypersensitives, glucose elevating medications, muscle relaxants and smoking cessation agents.

To place an order online, visit "www.adacatalog.com" or call 1-800-947-4746. ■

JUST THE FACTS

Dental education

52 of 56 dental schools required community-based clinical experiences as a component of their curriculum in 2006-07.



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Council sponsors ethics contest for dental students

BY JENNIFER GARVIN

The ADA Council on Ethics, Bylaws and Judicial Affairs is sponsoring a Student Ethics Video Contest inviting dental students to create video presentations on common ethical situations.

Participation in the contest, which the American Student Dental Association supports, encourages students to review and study the ADA Principles and Code of Professional Conduct. Students are asked to develop video enactments demonstrating one of the principles, codes or advisory opinions found in the ADA Code.

CEBJA envisions using the videos as part of ADA educational programming and as a seminar at future annual sessions.

The top five videos will be shown at the 2008 annual session in San Antonio, and the winner will receive a $1,000 prize.

All entrants must be ASDA members and deadline for entry is June 1. Videos should not exceed four minutes in length and can be articulated through drama, comedy, documentary, interview, public service or music video. Students may enter multiple times if they wish.

Each applicant must provide two copies of the video on disc and in AVI format.

For more information, contact Earl Sewell at "sewelle@ada.org" or call the ADA toll-free number, Ext. 2499. ■

ViewPoint

MyView

ADHP proposal

A call for more practical solutions

David Lurye, D.D.S.

What doesn't seem to be public knowledge about the proposed Advanced Dental Hygiene Practitioner workforce model in Minnesota is a letter circulating among Minnesota dentists, a copy of which was sent to me—a Colorado dentist—because of my unique background (which includes being a Minnesota native).

The letter describes procedures that this new tier of hygienists would be allowed to perform, including pulpotomies, fillings and extractions of primary and permanent dentition. The letter does assure the dentists up there that even though these irreversible procedures will be on the docket, they won't bleach teeth. Thank heavens for that.

Allow me to share with you a bit of background about myself, so that you will understand why a dentist from a small town in Colorado has such a deep interest in the subject. I will start by telling you that for the past 14 years I have supervised an independently practicing hygienist in my town, Winter Park. Perhaps you have heard of Winter Park or even visited, as it is a thriving resort community.

I serve as the vice president of the Colorado Dental Association, and I have volunteered one day per week for the last five years at the University of Colorado-Denver School of Dental Medicine where I instruct in most phases of clinical dentistry to second-, third- and fourth-year students. I am also on a committee formed of dentists and hygienists to review and rewrite the dental practice act regarding dental hygiene in Colorado. Although I do not represent any of these organizations or institutions as author of this viewpoint article, I do believe that my affiliation with them is relevant.

We—the hygienist I have supervised and I—have collaborated to make what would seem to be an intolerable situation tolerable. Indeed, our collaborative efforts have often been cited in Colorado as "the way independent hygiene is supposed to work." But I can tell you it has not been fun, easy, practical or as efficient as seeing those patients in my own office. Far too many patients slip through the cracks, as in their mind "they have seen a dentist" when in actuality they have seen a very competent hygienist. Some of these patients go years before seeing a dentist, oftentimes with treatment needs that are now far greater than if they had sought a dentist's services years prior to that visit while under the care of a hygienist.

It is stated in the letter from the dean of that community college that these newly trained ADHPs will focus on providing access to underserved communities. That was the intent when the Colorado legislature gave the OK for independent hygiene many years ago. Currently many of the independent hygienists now practice in what are clearly not underserved areas, unless you call the year-round resort towns of Winter Park, Pagosa Springs, Salida and Durango "underserved." One of the first independent practices to open (although it is now closed) was in Crested Butte. These are hardly out in the boonies.

One of my questions when it comes to the health care model they wish to

See MY VIEW, page five

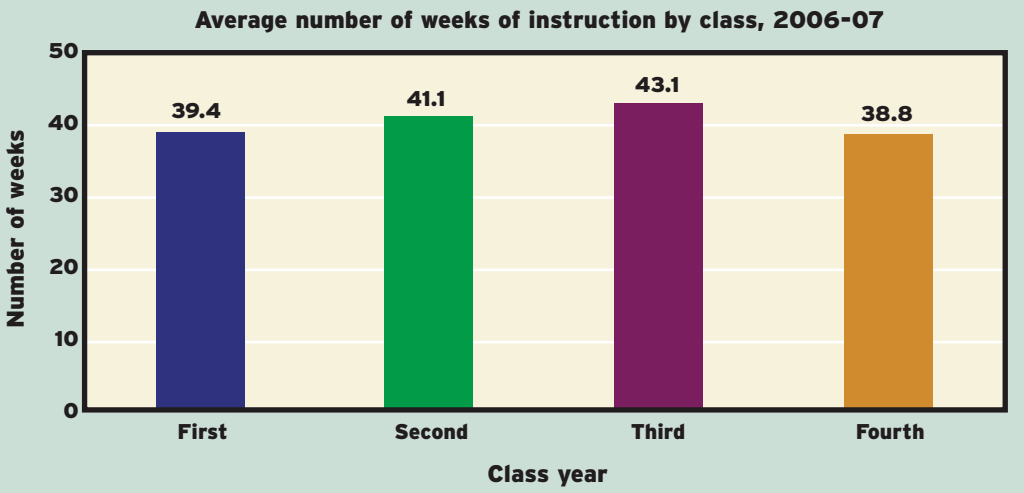
LettersPolicy

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

SNAPSHOTS OF AMERICAN DENTISTRY

Dental education

On average, the number of weeks of instruction increases for each of the first three years, from 39.4 in the first year to 43.1 in the third year, but drops to 38.8 in the fourth year.



Source: American Dental Association, Survey Center, 2006-07 *Survey of Dental Education.*

Letters

ADHPs

I wanted to voice my displeasure with the state of Minnesota proposing to allow dental hygienists to perform dental procedures without the supervision of a licensed dentist ("Minnesota Bill Expands Dental Hygiene Scope: Proposal Would Authorize Surgical Procedures," March 17 ADA News).

I am extremely alarmed that those elected officials have no idea what ramifications could occur if hygienists are given the green light to extract or restore dentition. If they think they can do these procedures, then I believe they should go to an accredited dental school and take a licensure exam just like we DDS/DMDs did.

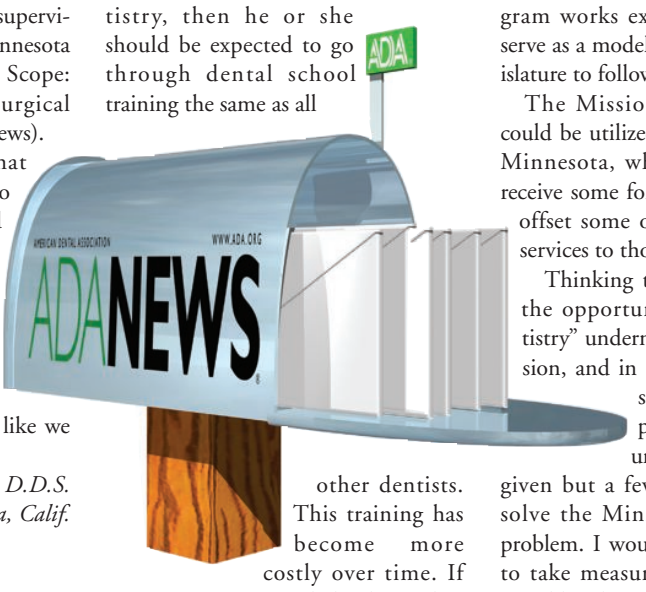
Gilberto G. Garcia, D.D.S.
Placentia, Calif.

Try other options

As a practicing dentist in Colorado which allows dental hygienists to practice without direct dentist supervision, I feel the Minnesota bill is a great travesty.

While I am not opposed to hygienists practicing independently, the original concept of granting this form of hygiene practice is not being followed. The basic tenet was to expand preventive services (such as those provided by hygienist) to "underserved areas." Unfortunately, this has not happened here in Colorado, with the underserved areas still being underserved.

If a hygienist wants to practice dentistry, then he or she should be expected to go through dental school training the same as all other dentists. This training has become more costly over time. If Minnesota wants to help the underserved, they should establish dental facilities in these areas and have a program that will help dental students pay the mounting costs of a proper dental education in exchange for working in these clinics for a protracted period upon graduation. The program could be offered to any dental student throughout the country who is enrolled in an accredited dental school curriculum.



One only need look at the military model of the ROTC scholarship program, where students have their college paid for by the military in exchange for spending time in the service. This program works extremely well and can serve as a model for the Minnesota legislature to follow.

The Mission of Mercy program could be utilized to a greater extent in Minnesota, whereby dentists could receive some form of compensation to offset some of the costs to provide services to those underserved areas.

Thinking that giving nondentists the opportunity to "practice dentistry" undermines the dental profession, and in my estimation will not solve the problem for providing serves in underserved areas. I have given but a few possibilities to help solve the Minnesota "underserved" problem. I would encourage the ADA to take measures to defeat this proposed legislation.

Joel B. Feinberg, D.D.S.
Greeley, Colo.

Access

I am tired of hearing how dentistry is so concerned about Advanced Dental Hygiene Practitioners fighting with dentists over scope of practice, and legislators allowing dental services in rural

See LETTERS, page six

MyView

Continued from page four

establish is who pays for setting up the clinics? Is it the state? Town? County? Is this newly trained ADHP going to set up his or her own clinic? I can tell you from experience that the fees that they charge will be similar or equal to what a dentist charges, as it costs just as much to maintain that hygiene office as it does to maintain a dental office. That is not speculation but fact, as many conversations about overhead with the hygienist that I supervise have demonstrated the fact that procedures will be no less costly if delivered by a stand-alone ADHP or a dentist and his or her staff.

What I am getting at is that in the real world, the figures that are being used to sway legislators of being able to treat 4,500 patients with three ADHPs for the same amount as one dentist can treat 1,500 patients is fantasy, pure and simple. They cite research. Whose is it? What are their motivations? As Benjamin Disraeli said so long ago, there are "lies, damn lies and statistics." If someone is motivated to further their agenda, statistics can always be used to support their claims. You just have to manipulate the data carefully and pick the studies that suit your purpose. I know that if the same issue were "researched" in Winter Park you would find that the costs are roughly equal, and that is 14 years of hard data.

The list of what ADHPs will and will not be able to do is a remarkable study in ambiguity. They can prepare and restore primary and permanent teeth but will do atraumatic temporary restorations. What kind of restorations can they do? Amalgam? Composite? Gold? And how many

The figures that are being used to sway legislators of being able to treat 4,500 patients with three ADHPs for the same amount as one dentist can treat 1,500 patients is fantasy, pure and simple.

"nonsurgical" extractions have to be completed surgically? Yet somehow they try to assuage the dental community by telling us, "Hey, they won't be doing any whitening!"

Practicing in a resort community has given me the opportunity to see patients from all over the world. Some work here for the season and some are on holiday. They come to my office because something broke or something hurts. Just in the last month I have seen three patients from New Zealand. All had seen the equivalent to the ADHP in their own country. All had a level of treatment that would be deemed below the standard of care, at least in my community.

My experience working in the clinic with dental students for the last five years has shown me that even the best and brightest can have unexpected outcomes for their patients, which often requires immediate, major revision by the supervising dentist. The list of procedures that they hope to see this new level of practitioner perform seems to make placement of crowns, pulpotomies and extractions as benign as polishing a tooth with pumice. That list includes formulization of treatment plans as though this is a simple task. Most of us know that treatment planning can often be the most vexing and complicated service that we provide to our patients, and is constantly improved and perfected with years of clinical experience as general practitioners.

I feel that the legislation in Minnesota (which can trickle down up or over to any other state) is pushing a model of health care that will be a disservice and detriment to the citizens of Minnesota, using the banner of "underserved" to advance an agenda. Ski towns and resort towns are not underserved, but that is where people, including independent hygienists and soon ADHPs, will flock to. I challenge the notion that costs will be greatly reduced, because that dental chair, rent, utilities, supplies and other overhead cost just as much for a hygienist as for a dentist. We are not going to see these ADHPs running off to practice in rural farming communities because it sounds noble. These men and women have the same likes and dislikes as the general population, and the lack of amenities that some of these outlying areas display are not going to hold an outsider there for very long.

In Colorado, we have a group of dentists and hygienists from their state associations working together to redefine and improve our practice act to help take care of access-to-care issues. We are not opposed to looking at changes in roles and responsibilities in dental care, but in my opinion the legislation on the table in Minnesota is walking down a very slippery slope.

I hope that Minnesota can find a model to help the people in their communities. But history is a great teacher, and if you use Colorado as a model, this plan will not take people into the communities that they hope to see targeted. There will be many people falling through the cracks between the office of an ADHP and a dentist, very often with more extensive work necessary because of the lag between offices.

I suggest they work with their legislature and the dental and dental hygiene communities to look for a more practical solution which can guarantee that a dentist is directly involved in your populations' care.

In addition to being a general dentist in Winter Park, Colo., vice president of the Colorado Dental Association and an associate professor in restorative dentistry at the University of Colorado-Denver School of Dental Medicine, Dr. Lurye is a former U.S. Public Health Service dentist from the Indian Health Service branch.

Editor's note: The Advanced Dental Hygiene Practitioner bill (SF 2895) has been modified since it was introduced in the Minnesota state Senate. The editorial and letters on the ADHP workforce model published here were submitted before SF 2895 included a provision requiring that ADHPs practice in underserved areas. For the most up-to-date news on the bill as of press time for this issue of the ADA News, see story, page 16, and check updates on ADA.org.

Letters

Continued from page four

and underserved areas without the direct supervision of a dentist.

The fact is that if all the dentists in this country did their part, and served some of the underserved or went into these rural areas part time regardless of the financial return, there would be no underserved and no need to expand duties to those not trained to perform such procedures.

The problem is that we all expect someone else to take one for the team, and sacrifice everything to go out and do it. Sure, there have been many student loan repayment programs created that can arrange for a new dentist to serve a rural community for a few years. It helps, but that is not enough to meet the huge need.

Let's face reality. If you/we the dentists are not willing to do the work, then we should get out of the way and let someone else do it. If you/we are concerned about these compromises being a threat to patient care or a threat to our scope of practice, then you/we need to get out there and do our part. Here's an idea, how about "Give Adults A Smile Day," or "National Adult Dental Health Care Month"?

Rick J. Nichols, D.D.S.
Redlands, Calif.

Economically disadvantaged

I would like to expand on the beautifully written letter by Dr. Joe Niamtu ("Letters," March 17 ADA News) regarding physically challenged patients with special care needs.

Special care needs do not only include physical disabilities. The economically disadvantaged among us, who may also be physically and emotionally challenged, also have special care needs. Our profession has an obligation to provide an access of care to our fellow citizens whose physical, emotional and/or economic situations prevent them from obtaining preventive and basic dental care.

The physically and emotionally challenged are not difficult to treat; they just take a little longer and require a little patience. Just like your patient base, most of these patients have the financial and/or insurance resources to pay for their care.

As dentists, we are blessed with the ability to practice the profession we love, provide well for our families and put away money for retirement. Therefore, in my opinion, we have an obligation to give back to society in return for this blessing.

How does a dentist know that the person he is treating pro bono is truly in need of care or just working the system? There is a wonderful national organization called Donated Dental Services that screens patients carefully before they are referred for care. In the past few years I have been able to treat wonderful people who are appreciative and grateful for the care I provide.

On the local level the Suffolk County Dental Society on Long Island, N.Y., has formed a program called the "Save-A-Smile Volunteer Project," that I think can serve as a model for other societies. It is a volunteer program that would be open to all people in our communities who have no way to obtain needed dental care. The program would be run in conjunction with agencies that serve as the link between patients and volunteer dentists. The dentist performs the needed treatment but has no long-term obligations and therefore is protected from abandonment issues.

There are 150,000 dentists in the United States. If we all treat, without charge, one patient a month, 1,800,000 truly needy people will get care that was previously unavailable.

How rewarding would it be to prevent or treat a child from early loss of their teeth? How inspiring would it be to see the restored smile on a young adult's face that had brain damage and lost his front teeth due to a car accident? Why not?

Scott Firestone, D.D.S.
Melville, N.Y.

Editor's note: The ADA Council on Access, Prevention and Interprofessional Relations thanks Dr. Firestone for his comments. In his sense of community responsibility, Dr. Firestone is not alone—dentists across the nation donate millions of dollars in donated dental care every year.

The Donated Dental Services Program of the National Foundation of Dentistry for the Handicapped that Dr. Firestone mentions offers a collaborative way for the dental profession to reach out to individuals with special needs. A DDS coordinator serves as liaison between patients, dentists and dental laboratories, simplifying participation for dentists. The NFDH has been a charitable affiliate of the ADA since 1988.

To get involved with Donated Dental Services, contact the National Foundation of Dentistry for the Handicapped at 1-303-534-5360 or visit "http://nfdh.org".

Amalgam

Yes! Yes! Yes! I agree with you 1 million percent ("Amalgam Safety" letter by Dr. Howard Silbersher, March 17 ADA News). Let's be honest. There's only one disadvantage amalgam has: it isn't white. And, there's only one advantage current posterior composites have: they are white.

The disadvantages of current posterior composites are so numerous that brevity prevents me from listing them all in my letter. But we, the dental "profession," have prostituted ourselves at the altar of esthetics because patients today want "white" fillings in their back teeth. Isn't that really what it comes down to?

I have been practicing since 1978, and also have placed numerous amalgams without any detrimental effects in my patients. If my wife or children need a filling in a posterior tooth I use amalgam. Why? Because I want the best for them. Amalgam is a superior product! Composite in most posterior situations is a vastly inferior product.

Finally, I'm tired of going to dental meetings and the lecturers implying that anyone "still using amalgam" is a Neanderthal. A real professional sometimes has to tell the patient what's best for them, and refuse to do what's not good for them even if they want it. That may be old fashioned, but so be it. I will continue to do amalgams until I quit practicing because amalgam is a superior product that should continue to be available to my patients. I will also refuse to do things that may be popular but bad for my patients.

Peter J. Balogh, D.D.S.
Alamogordo, N.M.

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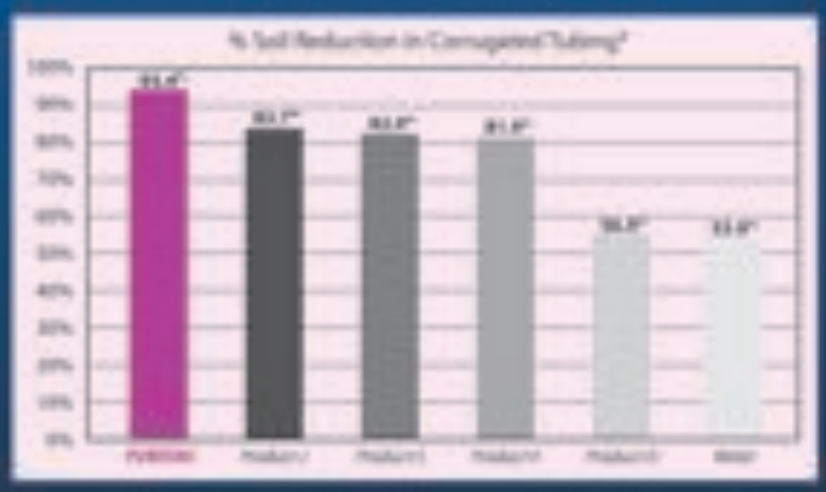

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*Independent laboratory study, 2006.

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Government

AADR urges Congress to boost oral health research

BY CRAIG PALMER

Washington—Dental scientists urged Congress to increase the oral health research budget and to set aside $1 million a year to fight the early childhood caries described as "particularly common" in Native American communities.

Citing "exciting research under way and the potential to improve oral health," Dr. Marc Heft told a House appropriations panel that additional funds for the National Institute of Dental and Craniofacial Research would advance the use of saliva-based diagnostic tests for oral and other cancers, cardiovascular diseases and systemic conditions.

Early diagnosis and treatment are also key to "avoidance of the disfiguring surgery that may occur when malignancy is advanced and spread," Dr. Heft testified March 13. "NIDCR-funded research has produced a saliva test that can detect oral cancer, but further clinical studies are needed to produce and validate a diagnostic test with the accuracy required by the Food and Drug Administration.

"Imagine a world where disease can be detected at its earliest possible moment with quick, painless and non-invasive saliva-based tests," Dr. Heft testified on behalf of the American Association for Dental Research. "Imagine getting results from a test for oral cancer or systemic diseases without a two- or three-day wait, or going to the dentist for a mineral-restoring rinse instead of getting a filling. We would not only improve Americans' quality of life but save lives and better utilize the valuable resources currently burdening our health care system."

The AADR testimony also supported an American Dental Association request for $1 million a year for three years for research and clinical studies on early childhood caries in cooperation with the Indian Health Service.

"Early childhood caries is a painful, costly and severe form of tooth decay—an unfortunate reality for too many preschool children in this country," Dr. Heft testified. "Unfortunately, early childhood caries is particularly common among Alaska Native/American Indian children—with rates up to three times higher than those seen among other 2- to 5-year-olds."

Dr. Heft is professor and director of the Department of Oral and Maxillofacial Surgery and Diagnostic Sciences at the University of Florida. The mission of the 4,000-individual, 100-institutional member AADR is to advance research and increase knowledge for the improvement of oral health. ■

—palmerc@ada.org

CMS prescription pad requirement effective in April

BY CRAIG PALMER

Washington—As of April 1, all written prescriptions for Medicaid patients from dentists and other providers were required to be on tamper-resistant pads. This includes computer-generated prescriptions printed on paper inserted into a printer.

The Association and other professional organizations successfully urged delay of the anti-fraud and abuse requirement that was scheduled to take effect Oct. 1, 2007, to give members time to prepare. When the six-month moratorium expired, all hand-written Medicaid prescriptions were required to have at least one tamper-resistant feature to prevent copying, erasure or counterfeiting.

Some states require tamper-resistant prescriptions but many don't. The impact should be minimal for dentists in states already requiring tamper-resistant pads, the Association says. Dentists in other states must use new pads from their dental supply firms for all Medicaid prescriptions beginning April 1. Your state dental association executive, the state Medicaid directors Web site ("www.nasmd.org/issues/TRPP") and the Centers for Medicare & Medicaid Services ("www.cms.hhs.gov") are among information sources.

A congressional "Dear Colleague" letter alerting members of the House of Representatives to the April 1 effective date said there is no national standard and that CMS deferred to the states the features they will accept for a prescription to be considered tamper-resistant. The letter cited educational materials at the National Council for Prescription Drug Programs ("www.ncpdp.org"), which offer a question and answer format. Two sample Q&As follow:

Q. Does this requirement pertain to prescriptions received by fax, telephone or electronically?

A. No. Since fax, telephone and electronic prescriptions are sent directly to the pharmacy, they are excluded from the new federal requirements. The direct communication from the prescribing doctor to the pharmacist is considered tamper-resistant.

Q. Does the tamper-resistant requirement apply to over-the-counter products?

A. Yes. OTC products that require a prescription for reimbursement under Medicaid must be written on a tamper-resistant prescription paper.

The regulations required use of prescription pads with at least one security feature by April 1 and require three by Oct. 1, 2008. ■

Outreach

Continued from page one

ADA said. AI/AN children experience rampant early childhood caries at a rate approximately 50-100 times higher than non-AI/AN children. "This may represent the largest health disparity in the U.S. today." While disease is at epidemic levels, use of dental services among Indian people is declining. Indian Health Service dental vacancies, population growth, medical inflation and flat budgets "are at the heart of this problem," the Association said. There is a need for training additional IHS dental specialists. Within a year, 65 percent of Indian Health Service specialists will be eligible for retirement, a situation described as "approaching a severe crisis."

The Association proposed a $1 million line item increase for dental residencies and urged congressional appropriators to indicate that "it is to continue as part of the base in future budgets of the IHS dental program."

Public-private volunteer efforts provide "an excellent opportunity to improve access to care for AI/AN communities and increase awareness among the dental profession about the tremendous oral health disparities among Native people," the Association told Congress.

The Association under 2006 House of Delegates policy has recruited some 25 dentists to volunteer service for at least two weeks in Indian country and this year will expand the base of recruits and sites. On the public side, some 427 dentists and dental student volunteers have provided 297,653 additional Indian Health Service patient visits and dental services since 2004. "This proved so successful that the IHS could use an additional $250,000 to expand the program," the Association said. The per dentist cost, slightly more than $2,000, "demonstrates the program's cost effectiveness."

The Association also called for additional funding for loan repayment "as the best recruiting tool" for IHS dentists and for school-based sealants, community water fluoridation, dental education and other community-based activities to prevent dental disease. "The ADA believes that this request represents a relatively 'bare bones' approach to rebuilding the IHS dental public health infrastructure and is essential to accomplishing increased access to care throughout Indian country."

In separate testimony, the American Association for Dental Research supported an ADA request for $1 million a year for three years for research and clinical studies on early childhood caries in cooperation with the Indian Health Service. ■

Dentist volunteers report experience rewarding; locations grow in number

BY CRAIG PALMER

The ADA struck collaborative agreements with nine Indian Health Service/tribal clinics in Minnesota, North Dakota and South Dakota in response to a 2006 policy directive from the House of Delegates to improve access to oral health care for American Indians and Alaska Natives.

Some 25 private practice and retired dentists and dental students have volunteered over the 18-month period, said Gary D. Podschun, ADA community outreach and cultural competence manager.

"Dentists who have volunteered have served for at least two weeks at a time and found the experience fulfilling and rewarding," the Association told Congress in March 13 testimony. "This is an excellent opportunity to improve access to care for AI/AN communities and increase awareness among the dental profession about the tremendous oral health disparities among Native people."

The Association this year will expand the program to support dental student externships. The ADA Council on Access, Prevention and Interprofessional Relations will support externship activities at the White Earth Health Care Center in Ogema, Minn., Mr. Podschun said. Additionally, the Hopi Health Care Center in Arizona was added this year as a volunteer placement site. ■

International implant meeting set for Chicago

The International Congress of Oral Implantologists will hold the 11th Annual Implant Prosthetic Symposium, "Practical & Productive Implant Prosthetics," Aug. 22-24 in Chicago.

The symposium features multiple presentations by restorative dentists, laboratory technicians and surgical specialists, as well as prosthetic pre-congress workshops, technical hands-on courses and auxiliary certification programs for hygienists.

For more information, contact the ICOI by phone at 1-888-449-4264, by Web site at "www.icoi.org" or by e-mail at "icoi@dentalimplants.com". ■

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Celebrating membership success

Annual conference fosters new strategies and solutions

BY KAREN FOX

When it comes to educating, persuading or simply connecting with an audience in a meaningful way, there's no better way than storytelling.

Using storytelling to illustrate what the ADA and constituent and component societies do, how the tripartite makes a difference and why it is worthy of support was the kick-off to this year's ADA Conference on Membership Recruitment and Retention.

"We have increased the number of actively licensed dentists by 12,014—boasting a market share of 71 percent."

Drawing 160 tripartite volunteers, staff members and guests to ADA Headquarters March 28-29 with the theme of "Celebrating Membership Successes," the annual conference's goal is to bring forth innovative ideas, strategies and solutions that can contribute to tripartite membership success.

"The Tripartite Grassroots Membership Initiative has been very successful since it started in 2001," Dr. Pamela Z. Baldassarre, chair of the ADA Council on Membership, told the crowd.

"We have increased the number of actively licensed dentists by 12,014—boasting a market share of 71 percent," said Dr. Baldassarre. "Our 2008 membership goal is to achieve a market share of 72 percent by adding 4,200 active licensed dentist members and through achieving a 2.8 percent active licensed dentist nonrenew rate."

Sharing ideas: Clockwise from top left, Drs. Ben Taylor, Terri Baarstad, Hank Moore and Pamela Baldassarre, chair, Council on Membership, share ideas for continued tripartite membership success at the ADA Conference on Membership Recruitment and Retention.

Emphasizing the importance of momentum at all three levels of the tripartite, Dr. Baldassarre spoke out on the continued success of the one-to-one outreach strategy necessary to achieving these goals.

Speaker Colin Rowan of A Goodman Communications led the audience in a session designed to elicit motivational tripartite success stories. Examples included a society that assisted a member who was overcoming drug addiction and another that helped a student prepare for his licensure exam. These are "stories that open the door so facts can be heard," said Mr. Rowan, and are powerful testaments to the strengths and benefits of organized dentistry.

The theme of communicating powerful stories continued throughout the conference, and participants attended sessions that provided insight into dentists' critical professional issues, key challenges to inclusivity and diversity in organized dentistry, and opportunities to energize and educate volunteers. An open forum and table topic discussions encouraged TGMI team sharing and networking. ■

—foxk@ada.org

Tip sheets to help dentists help patients

National Maternal and Child Oral Health Resource Center offers new resources

BY STACIE CROZIER

Washington—The National Maternal and Child Oral Health Resource Center is offering two new free tip sheets and a new electronic guide.

• A Way with Words: Guidelines for Writing Oral Health Materials for Audiences with Limited Literacy—This two-sided tip sheet discusses how to choose words, set an appropriate tone and reach people with limited literacy. Also included are ideas for designing documents, guidelines for presenting unfamiliar terminology and a list of resources.

• Dental Hygienists and Head Start: What You Should Know and How You Can Help—This four-page tip sheet, developed for Head Start program staff who want to share resources with dental hygienists, contains an overview of the Head Start program; oral health status of enrolled children and barriers to care; and oral health services provided by Head Start. It also offers ideas for dental hygienists who want to get involved with Head Start as individuals or as members of their professional association.

These tip sheets can be downloaded at the OHRC Web site: "www.mchoralhealth.org". Single or multiple copies are available at no charge from the Health Resources and Services Administration Information Center, P.O. Box 2910, Merrifield, Va. 22116; phone 1-888-ASK-HRSA; e-mail "ask@hrsa.gov" or online at "www.ask.hrsa.gov".

• Knowledge Path: Oral Health and Pregnant Women, Infants, Children, and Adolescents—This electronic guide links to resources that analyze data, describe effective programs and report on policy and research aimed at improving oral health access and quality. Links to Web sites, electronic publications, journal articles, books reports and other print publications, databases, discussion groups and electronic newsletters are available at "www.mchoralhealth.org/knwpathoralhealth.html". ■

It's in the mail

Look for ADA survey on charitable dental care

The ADA's 2008 Survey of Prepayment Arrangements will be mailed to a random sample of approximately 5,000 dentists starting in early April. The survey will ask dentists about their reimbursements from third party payers and Medicaid/SCHIP programs (State Children's Health Insurance Program), as well as their donation of free and discounted charitable dental care.

Dentists who receive the survey are asked to complete it as quickly as possible to avoid the costs of follow-up mailings. Any questions about the survey can be directed to the Survey Center at 1-312-440-2568 or by e-mail at "survey@ada.org". ■

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The rate of irrigant delivery is digitally controlled and powered by the Integra's built-in pump. Just flip a switch to select the proper reservoir and touch the membrane to adjust the flow rate.

Fill one reservoir with water, the other with chlorhexidine or Listerine®, and you're ready to scale anywhere there's an electrical outlet. You don't need a water hook-up or source of compressed air.

To use an external water source, simply plug in the hose and flip the source control to "EXTERNAL."

The Integra doesn't force you to choose between patient comfort and power.

Some scalers perform comfortably during recall subgingival debridement, but have trouble removing heavy accretions. That's because their circuitry has sacrificed high power in order to expand the low-power range. As a result, for those calculus-blasting new patient appointments you may have to switch to another scaler - or use hand instruments.

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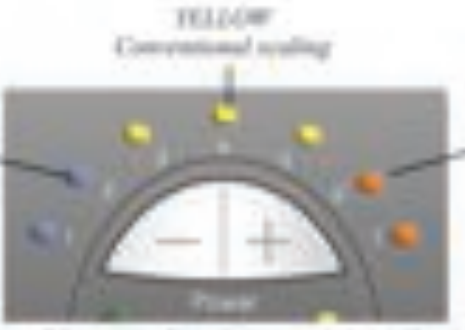

When you adjust the power using either the touch panel or the foot pedal, color-coded lights indicate the operating power. (Red-zone power is best reserved for patients under anesthesia.)

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Tornado

Continued from page one

television. Dr. Frey was attending the Hinman as an official ADA scout.

"Up until Friday at 9:40 p.m., I was very impressed with the meeting," said Dr. Frey. "I was enjoying what I was seeing and taking lots of notes.

"About 9:40 I heard the rain start and it sounded like hail was hitting my window as well. I went closer to the windows—really a floor-to-ceiling glass wall—and I remember thinking how strange it looked. It was a pale green-yellow color and the wind had really ramped up, and there were things mixed in with the rain and wind, like debris. The strangest thing was that the wind was blowing completely horizontally across my windows."

On the 14th floor, Dr. Marshall L. Wade of Woodbury, Minn., a continuing education speaker for the meeting, had just put the finishing touches on his Saturday lecture, ironically titled, "Leadership in Times of Crisis," and joined his wife Terri on their hotel balcony to watch the lightning.

"We tease my wife because she's a natural phenomenon freak," said Dr. Wade. "She had just gotten in from the airport and she was out on the balcony watching the lightning. When I came out to look over her shoulder, I didn't see lightning. I saw house-sized debris coming toward us.

"Then the windows were bowing and started to explode," said Dr. Wade. "My wife and I ran back into the room and headed for the bathtub as the windows and glass doors blew in. We were crouched in the bathtub and the building was shaking so violently that I was worried it would collapse or come apart."

Dr. Frey said when the building started shaking he grabbed his pants and his athletic shoes and ran toward his door.

"When I opened my door, there was a tremendous gush of wind from the hallway into my room," said Dr. Frey. "and I had to struggle to get out. I tried to close my door as if to separate myself from what was happening in my room, but I was unable to close it against the wind. The roar was tremendous. One of the light fixtures in the hallway fell near my feet to the floor."

He heard three women in the darkened hallway screaming, and called to them as he held up his cell phone to light the way to the stairwell and down to ground level.

"I was in survival mode," said Dr. Frey. "At the time, there was no question what to do. I was surviving. When I thought I was safe on the ground at the bottom of the stairwell, that's when I put on my pants. I wasn't worried about it. It wasn't a priority. If I had needed to run away from the building in my boxers and socks to get out, I would have."

Outside the hotel, said Dr. Frey, "It looked like a bomb had gone off. Every car and taxi around the hotel had its windows blown in. There was debris everywhere—most of it broken glass. I wandered around in stunned confusion. I wanted to return to my room, but I didn't have my room key with me and I didn't know how safe the building was."

After several attempts, Dr. Frey reached Dr. McDougall on his cell phone and went to the McDougalls' room in the north tower to watch storm coverage on television.

"About 1 a.m. I went back to the south tower and got another room key at the front desk and made the trek up to my room," said Dr. Frey. "The key was working but the door handle was jammed. Some maintenance workers came by and they used a crowbar to open the door for me."

Dr. Frey said the eight workers and he entered to find the entire glass wall overlooking the convention center was gone.

"It wasn't until I saw the condition of the room that it really hit me what had happened," Dr. Frey said. "I got a little light-headed seeing that open wall where I'd been standing right before I ran out."

"At dinner earlier that same night, I had joked with Ken and Rosemary that I was their third wheel, and then I ended up sleeping in their room for the rest of the night. They were so kind and helpful."

After the tornado had passed, Dr. Wade and his wife climbed out of the bathtub, packed their bags and headed downstairs. They met up with fellow Hinman speaker Dr. Hal Crossley and helped him get his luggage downstairs, too.

"It looked like a war zone outside, said Dr. Wade.

With Dr. Crossley's help, the Wades were able to get a room in a hotel two blocks away and they stayed on in Atlanta until their flight left on Sunday.

"The Hinman people were amazing," said Dr. Wade. "My host called every day and made sure that we got to the airport OK. As a whole, I didn't see anyone freaking out during the crisis. People were calm, helping each other and especially the people in the dental profession. It's how you'd want your peers to react."

His wife, said Dr. Wade, reflected on the experience by expressing a wish to chase a storm some day.

Photos by Dr. John T. Frey

Damage: Dr. Frey's hotel room sustained heavy damage, from shattered window wall glass, at top, to ceiling damage, above.

Photo by Dr. Marshall L. Wade

Shattered: Dr. Wade's hotel room patio door exploded during the tornado.

"But I think this episode took some of the romance out of that idea for me," he said. "I could fee the power of the pressure change, the incredible power when the windows exploded, and I have a deep respect for things that are out of our control."

Dr. Wade has revised his leadership presentation since the tornado. It is now titled, "Strength for the Journey: Thoughts from Inside the Atlanta Tornado."

"The tornado to me is an appropriate metaphor for the maelstrom that life can become," he said.

Saturday morning Dr. Frey called Experient, the ADA travel agency, which quickly arranged a flight home for him leaving at 10 a.m.

"I was safe at home by noon, but I kind of lost it when my wife Lisa picked me up at the airport. When I unpacked, I found glass in my clothes and dumped glass and bits of insulation and twigs and leaves out of the dress shoes I had worn every day at the meeting.

"I'm a little rattled," he added, "but I didn't get hurt or cut. It's amazing. The hotel was full because of the dental meeting, the [Southeastern Conference men's tournament] basketball games, proms and other events. I saw girls in prom dresses, using sheets as shawls to keep warm after the tornado. We were lucky."

"When I unpacked, I found glass in my clothes and dumped glass and bits of insulation and twigs and leaves out of the dress shoes I had worn every day at the meeting."

Dr. Frey is in his fourth and final year on the Council on ADA Sessions.

"This was my last scouting trip and it was such an awesome meeting," said Dr. Frey. "I'm sorry it ended so quickly, because I was looking forward to observing on Saturday. I'm thrilled to be on this council. I've really enjoyed it."

Near the convention center, the Georgia Dome was filled with about 18,000 fans watching a college basketball game that went into overtime and another 16,000 fans were watching an NBA game in Phillips Arena in the same complex when the tornado hit. According to Associated Press reports, one man was killed and damage estimates are expected to exceed $150 million.

Officials at the Georgia World Congress Center and the Omni Hotel issued statements late Friday night that Saturday's meeting activities could not be held in their facilities due to safety issues.

"It's unfortunate that we had to close the meeting one day early, but with the damage to the facilities and the safety of our attendees and exhibitors our primary concern, we were left with no alternative," said Dr. Dan Dunwody III, general chairman of the 2008 Hinman Dental Meeting. "We are just relieved that there were apparently no serious injuries to our attendees and exhibitors. Given the damage to the infrastructure downtown, it was nothing short of a miracle that there were so few injuries to the thousands and thousands of people in Atlanta."

Hinman Dental Society members and meeting staff worked through the night Friday to alert attendees and exhibitors to the early closing. They manned an information booth in the Omni Hotel south tower and established a hospitality area where attendees could have breakfast and lunch before planning for an early departure from Atlanta. Each of the meeting's 78 speakers had a HDS member host and every host immediately checked on the safety of their speaker and helped them relocate to other hotels if necessary and reschedule flights home. Some Atlanta-area hosts even opened their homes to speakers in need of lodging.

The GWCC was closed over the weekend as the state fire marshal and a team of assessors inspected the building. The walls, ceiling and doors of Exhibit Hall A—where all the meeting's technical exhibits were housed were damaged. Hall A was the area of the convention center hardest hit by the tornado.

Photo courtesy Jim Hill Photo

Dr. Frey

Dr. Wade

"I'm proud of how the Hinman volunteers and staff really pulled together as a team to keep attendees and exhibitors informed, help them make flight arrangements and ensure they had access to lodging and food until they could leave downtown Atlanta," said Dr. Dunwody. "We appreciate the Hinman members' efforts to make this happen and we are grateful for the understanding and support of our attendees and exhibitors."

Attendees who purchased tickets in advance for Saturday courses, including registered attendance lectures, participation courses, videotaping sessions and a homes tour and luncheon will automatically receive refunds within six weeks. They do not need to contact Hinman to receive a refund.

At least 24,000 attendees were expected for the meeting, which scheduled more than 200 courses and 900 technical exhibits.

This is only the second time the meeting has not been conducted in its entirety since it began in 1911. In 1931, the meeting was cancelled when Dr. Thomas P. Hinman died, and renamed for him.

The Hinman Dental Society is a study club comprised of more than 700 dentist members, primarily from the Atlanta-metro area. It is a nonprofit organization that provides more than $250,000 annually in scholarships and gifts to dental education programs. This year, Hinman donated $500,000 each to the University of Alabama and the University of Tennessee dental schools to endow a chair.

For more information, log on to "www.hinman.org". ■

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Minnesota Dental Association, with ADA support, musters opposition to hygiene practitioner bill

BY KAREN FOX

St. Paul, Minn.—The debate over the establishment of the Advanced Dental Hygiene Practitioner continues in Minnesota's state Senate.

The ADHP is loosely modeled on the American Dental Hygienists' Association workforce model that drastically expands the scope of dental hygiene duties to include restorations and extractions.

Since its introduction, proponents have amended the term ADHP to "oral health practitioner" and added a clause that requires OHPs to practice in settings for low-income, uninsured or underserved patients. The Minnesota Dental Association is vigorously opposing the proposal (SF 2895) due to its potential to compromise patient safety.

"The MDA continues to strongly oppose this new dental hygienist position as proposed," said MDA President Jamie Sledd. "Though the bill has recently been amended by the Senate author, there are still significant flaws in the language that potentially compromise patient safety and fail to provide comprehensive solutions to the dental access problem in our state. The MDA is currently supporting an amended version that calls for a collaborative effort among all stakeholders to seek a solution that makes best use of the entire dental team."

MDA has initiated a strong grassroots initiative to help defeat the bill, added Dr. Sledd.

"We are extremely pleased with the response of MDA members throughout the state," she said. "The MDA has sent out dozens of legislative alerts, electronic newsletters and special bulletins to members requesting their assistance in contacting their legislators to oppose this controversial and experimental proposal.

"Hundreds of members have responded by calling or writing their legislators, sending letters to editors of local papers and attending town hall, Chamber of Commerce and other local meetings," said Dr. Sledd. Students from the University of Minnesota School of Dentistry were also active participants in grassroots activities.

"This collective effort has helped influence some key legislators' votes so far and we hope to continue these powerful grassroots efforts throughout the session," said Dr. Sledd.

The ADA is supporting the Minnesota Dental Association in its efforts to oppose the new practitioner. "Rest assured that all is not lost and there are a number of activities being undertaken," said ADA President Mark J. Feldman.

"The ADA is providing significant lobbying and public relations assistance to the Minnesota Dental Association via our State Public Affairs program," said Dr. Feldman. "These efforts include public relations assistance, increased lobbying capacity and coordination of member communications. ADA representatives have worked with the MDA Board and consultants to assess the situation and help them develop their next strategic moves."

A key success for MDA came in persuading the author of the ADHP bill in the state House of Representatives to withdraw the bill from further consideration. The measure is now dead in that chamber. The Senate, however, is an entirely different story.

On March 25, the sponsor of SF 2895 offered the amendment that was adopted in a Senate finance subcommittee that revises the term for ADHP and tacks the bill onto an omnibus Senate supplemental appropriations bill. The amendment included a pilot study for the oral health practitioner but takes a step backward from an earlier amended version that would have required that the new practitioner only perform extractions during the first year of the practice if a supervising dentist was on the premises.

The amendment also moves authority for regulation of this model during the pilot study from the state dental board to the Commission of Health. The intent of the pilot study is to authorize 15 OHPs to enter practice in 2011 and another 15 in 2012. The licensure of additional OHPs would be contingent on additional authorization from the legislature.

However, this action does not sunset those licenses after any period of time so cannot be truly understood to be a pilot project. This would create 30 OHPs without a provision for expiration after a study period, pending further authorization. The MDA has advised grassroots members to let their state senators know this end run around the process is counterproductive and that the proposal still is unacceptable.

On March 13, a Senate finance subcommittee approved SF 2895 in a 5-3 vote. That subcommittee included the sponsor, who severely limited the Minnesota Dental Association's opposition testimony during the hearing.

It was in that hearing that proponents of the bill offered the amendment requiring ADHPs to work on site with a dentist during their first years of practice while performing extractions. The bill's sponsors also sought to mischaracterize the MDA's position during the March 13 hearing—claiming that the MDA had agreed to numerous concessions in discussions regarding the bill, which is untrue. The MDA and ADA have emphasized that they will continue to oppose this bill as long as it includes unsupervised surgical procedures.

The omnibus bill is expected to be heard on the Senate floor in the upcoming weeks. ■

—foxk@ada.org

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Think twice before you speak

Careless comments can have unexpected consequences

BY ARLENE FURLONG

The ADA Council on Members Insurance and Retirement Programs previously surveyed 15 insurance companies—insuring nearly 104,600 dentists—on malpractice claims reported during the five-year period between 1999-2003.

The council believes the survey findings provide useful information and highlight opportunities to improve the quality of patient care.

This is the second installment of an occasional series about those findings. The May 21, 2007, issue included the first—Tracking Malpractice Stats. Subsequent articles will cover topics including various record-keeping errors and patient communication issues, as well as treatments and adverse outcomes most frequently cited in dental malpractice allegations.

Dr. Engar

Ms. Roman

When it comes to communication issues, critical comments made by dentists to patients about another dentist's work are among the most common factors contributing to malpractice allegations.

The issue rates a score of 7.7 on a scale of one to 10, with 10 indicating a very common problem, according to 14 of the insurance companies surveyed in the Council on Members Insurance and Retirement Program's survey of claims filed over five years.

Dental malpractice risk managers say it's easy to make an off-the-cuff comment, but difficult to control its far-reaching consequences. They say the patient, the discredited dentist, even the dental profession and the commenting dentist can all be affected in the long run. Another repercussion dentists don't often consider is that an inappropriate comment can enmesh them in a lawsuit against another dentist.

Dentists are faced with many difficult situations that can prompt thoughtless comments and increase their vulnerability to lawsuits. The good news is legal vulnerability can be minimized, if not avoided entirely, by employing effective communication techniques, insurers say.

They encourage dentists to consult with their risk managers when faced with difficult situations. Most insurers also offer continuing education risk management seminars on a number of key topics, including techniques for effective patient communications. Included below are insurers' examples of the kinds of reactions that can be injurious to dentists and patients, the reasons why, and examples of alternative responses and actions.

Opinionated statements

"Who the heck put in those kinds of fillings?" "Those crowns are bound to have problems." "I wouldn't have done it that way if it were up to me."

Although these comments may jump out on this page as obvious "no-nos," dental malpractice liability insurers say dentists use them more frequently than one would think.

"Sometimes dentists speak without thinking first," said Dr. Richard C. Engar, chief executive officer for the Professional Insurance Exchange, which insures some 90 percent of Utah's dentists. "But careless talk has cost thousands of dollars in settlements, legal fees and hurt reputations, as well as irreparable damage to dentist/patient relationships."

Dentists make careless comments for any number of reasons or no reason at all, insurers say. Sometimes the dentist isn't in a very good mood or has a less than convivial relationship with the previously treating dentist. Sometimes the commenting dentist would've provided different treatment or used different materials. Or maybe the dentist sees what he or she believes is substandard work, has seen it from this dentist before and decides this case is the final straw.

Insurers say that no matter what the reason, thoughtless comments about another dentist or dentist's work can shatter the patient's confidence in the entire profession.

"Even when there aren't any legal consequences, negative comments about a prior dentist come back to the treating dentist in the form of the patient's perceptions about dentistry overall," says Liz Brott, regional vice president for risk management and an attorney for ProAssurance Corp., a national dental and medical malpractice insurer. Ms. Brott has learned that

Talking points: Dr. Frederick Wetzel, member of the Council on Members Insurance and Retirement Program and a director of the Medical Liability Mutual Insurance Co., talks about risk management and critical comments at CMIRP's March 28 meeting.

Collaboration: Council members consult each other about risk management trends at the March meeting at ADA Headquarters in Chicago. Seated from left, are Drs. Kevin Brewer (turned away), Lawrence Browder and Douglas Cassat. Standing from left are Drs. Alan DerKazarian and Edmund Cassella.

Dr. Feinberg: "If you don't know the whole story you will not be giving the patient proper counsel."

dentists of all ages and experience can succumb to the temptation to personalize their reactions.

"Dentists don't even have to go so far as to speak to convey the wrong impression to patients," says Ms. Brott. "Patients can misinterpret an inappropriate facial expression to mean something is wrong with the treatment they received."

Inappropriate reactions by a dentist may indirectly insult a patient by inferring he or she used poor judgment in choosing the previous dentist and/or received poor treatment, insurers say. In addition, knocking another dentist or his work can make a patient question whether he or she may have been harmed.

An unhappy patient

Liability insurers say a common scenario preceding a malpractice claim allegation is a dentist speculating with a patient as to why a former dentist's treatment resulted in a poor outcome. They say a patient's current dentist can't know if the patient's former dentist offered a treatment plan that the patient declined. In addition, patients don't always correctly recall what was said or why the patient and dentist decided upon a particular treatment plan at the time it was implemented.

If the outcome of treatment received by a former dentist isn't what the patient expected, malpractice risk managers recommend dentists tell the patient, "Why don't I give your former dentist a call and find out what happened?"

"Let the patient know that no dental treatment is 100 percent guaranteed," advises Ms. Brott. "Just because the outcome wasn't what the patient expected doesn't mean the previous dentist did something wrong."

Ms. Brott recommends dentists let the patient know that although things may not have progressed as anticipated, what was done may have been the right thing to do at the time. Then the dentist should move on to an outcome-oriented discussion.

Kathleen Roman, risk management education leader for Medical Protective, the nation's oldest liability insurer for dentists and physicians, agrees that dentists should stay in the present when commenting to patients about their treatment.

"A patient may misunderstand the explanation of the history or take what's said out of context when it wasn't stated as a criticism," says Ms. Roman. "Before speaking, dentists have to consider, 'How will my statement benefit the patient?'"

Insurers recommend dentists call the former dentist so the two of them understand the current circumstances and work out a consistent message to deliver to the patient.

Differences of opinion

Differences of opinion should never be communicated in a manner that implies mistreatment, according to dental liability insurers.

"Each dentist has a personal opinion about how a procedure should be done," commented Ms. Brott. "Dentists have to keep in mind that their way isn't the only way. The standard of care allows for variance—'what a reasonable dentist would've done'— and reasonable minds can disagree."

Ms. Brott recommends that dentists avoid casting doubts in a patient's mind, and instead qualify their comments about another dentist's work by saying something along these lines: "Even if that's not how I would've done it many dentists do it that way and it's perfectly acceptable."

Questionable treatment?

Risk managers interviewed by ADA News say many malpractice allegations may not have occurred if there had been a simple phone call from one dentist to the other.

Dr. Maxine Feinberg, council chair, thinks all dentists should be courteous enough to call another practitioner before making comments to a patient.

"If you don't know the whole story you will not be giving the patient proper counsel," says Dr. Feinberg. "It's incumbent upon us to do our homework rather than speak out of turn."

See COMMENTS, page 20

ADA-Aetna meetings prove fruitful

Explanation of benefit language reported as problematic by dental offices was among the issues that the ADA Aetna Advisory Committee sorted out during the past four years.

The committee, comprised of both ADA and Aetna representatives, met twice a year for four years under a 2003 settlement agreement seeking to improve communication and collaboration and lessen complexity in the payment of dental claims.

ADA representative dentists made recommendations to Aetna representatives on the company's policies. The committee was unanimous in its opinion that the meetings were productive for both sides based on the information and ideas exchanged, outcomes over the years, including:

A letter sent from Aetna's Special Investigations Unit about standard auditing procedures that may have alarmed patients was revised. The SIU worked directly with the state dental society on the wording of the patient letter to clearly explain its routine status.

EOB language considered problematic by member dental offices was reviewed. Aetna revised language to make it compatible with what the dental offices were using in most cases.

Aetna formerly bundled the removal of an impacted tooth and an additional removal of a cyst on the same day. Aetna revised the policy as a result of the committee recommendation. Aetna will deny one of the procedures if submitted on the same day and in the same area of the mandible or maxilla; Aetna will allow the cyst removal if it is performed in a different area of the mouth. ■

Communication: Dr. Mary Lee Conicella, dental director at Aetna, and Dr. Lanny Garvar discuss a dental benefit policy issue during the ADA Aetna advisory committee's final meeting March 12 at ADA Headquarters in Chicago.

Learn how to avoid malpractice claims filings from the experts

The 2008 ADA Annual Session in San Antonio will feature a risk management presentation by Liz Brott, regional vice president, risk management, and attorney for ProAssurance Corp., a national medical and dental malpractice insurer. Results of the Council on Members Insurance and Retirement Programs five-year survey of insurance companies will be discussed.

Complete information on all annual session continuing education courses, including topics, speakers, dates and times, will be available at "www.ada.org/goto/session" April 16. Request an annual session preliminary program by calling toll-free, 1-800-232-1432 or e-mailing "annualsession@ada.org". The ADA will mail preliminary programs in May and a PDF version will be available beginning on April 16 on "www.ada.org/goto/session" under "attendee resources."

Medical Protective is conducting a risk management seminar entitled "Risk Management Consult: When Doctors Don't Agree," this spring in St. Louis; Columbus, Ohio; Pittsburgh, Pa.; and Louisville, Ky. The seminar was developed for any dentist interested in learning how to improve quality of care through better communications. Participants will be taught how to formalize ways in which the doctor-patient relationship is initiated and terminated; systematize communication processes with other dentists; develop patient-focused strategies to prevent and resolve professional differences of opinion; and teach members of the dental team to improve communications to patients relating to another dentist's care.

Call Medical Protective at 1-800-463-3776 or e-mail "CRMTeam@MedPro.com" for more information. ■

Comments

Continued from page 19

Although differences of opinion as to preferred treatment should not be communicated to a patient in a manner that implies mistreatment, clinical circumstances may at times require dentists to make comments to patients regarding faulty treatment if there is a reasonable basis to believe the statements to be true.

According to the ADA Principles of Ethics and Code of Professional Conduct, section 3 (Beneficience), dentists are duty bound to treat patients in such a way as to promote the patient's welfare. The ADA Code obligates dentists to inform patients of their current oral health status in a truthful, informed and justified manner without making misleading or disparaging (untruthful or unsupported) comments about prior services.

The ADA Code obligates dentists, under the Principle of Justice, section 4 (Justice), to report any instances of gross or continual faulty treatment by other dentists to the appropriate dental agency. The ADA Code cautions, however, against statements that would "unjustly imply mistreatment." The Code also states that anyone who believes that a member dentist has acted unethically may bring the matter to the attention of the appropriate constituent (state) or component (local) dental society.

For more information on ADA Principles of Ethics and Code of Professional Conduct visit "www.ada.org/prof/prac/law/code/principles.asp". The results of the CMIRP malpractice survey are also available at ADA.org by visiting "www.ada.org/goto/liability". Or, call toll-free, Ext. 2885 or e-mail "insurance@ada.org". ■

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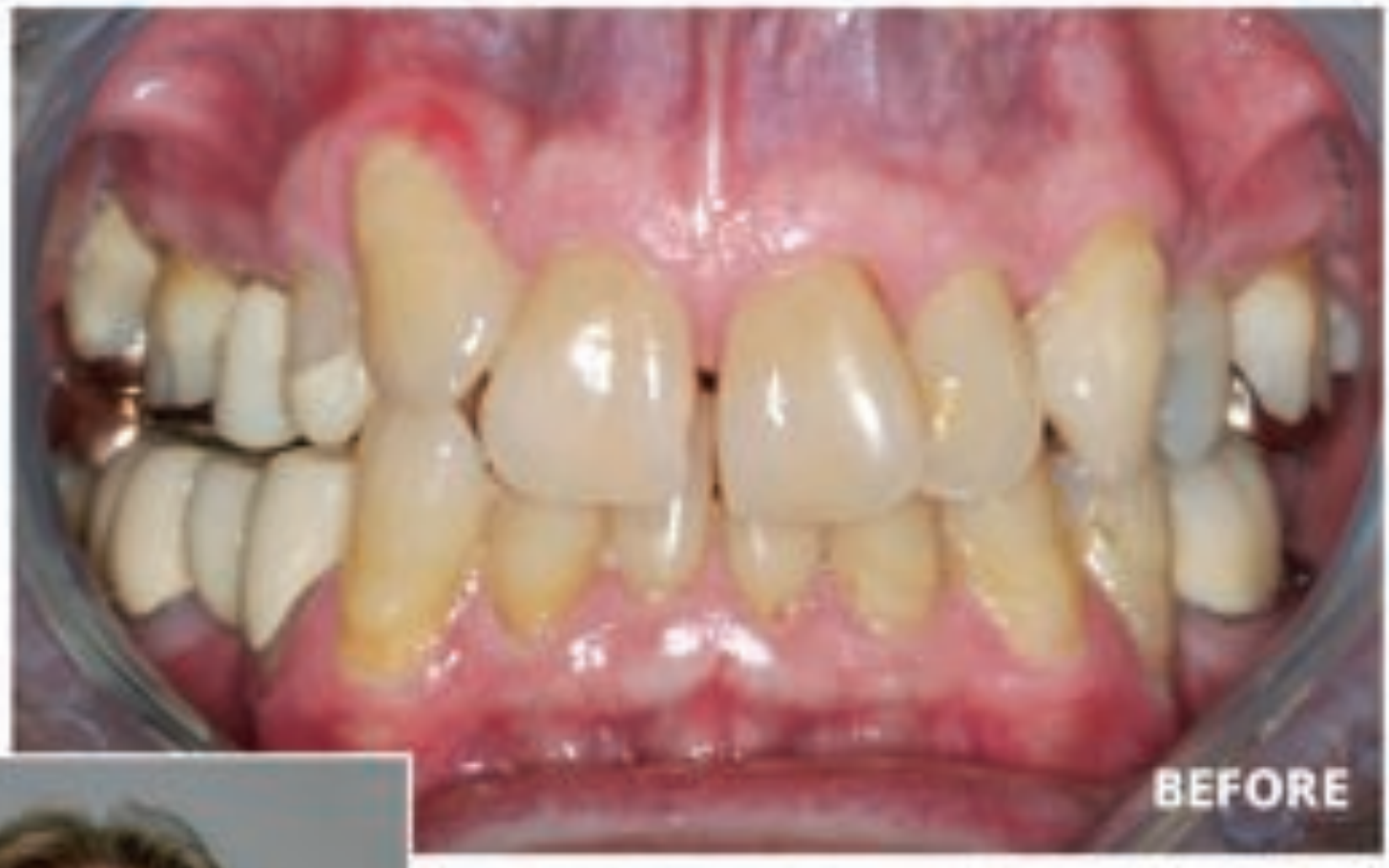

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Atlanta, GA

May 2-3, 2008
Vancouver, CN
Myrtle Beach, SC

May 9-10, 2008
Atlantic City, NJ
Boston, MA
Houston, TX
Miami, FL
Raleigh, NC

May 16-17, 2008
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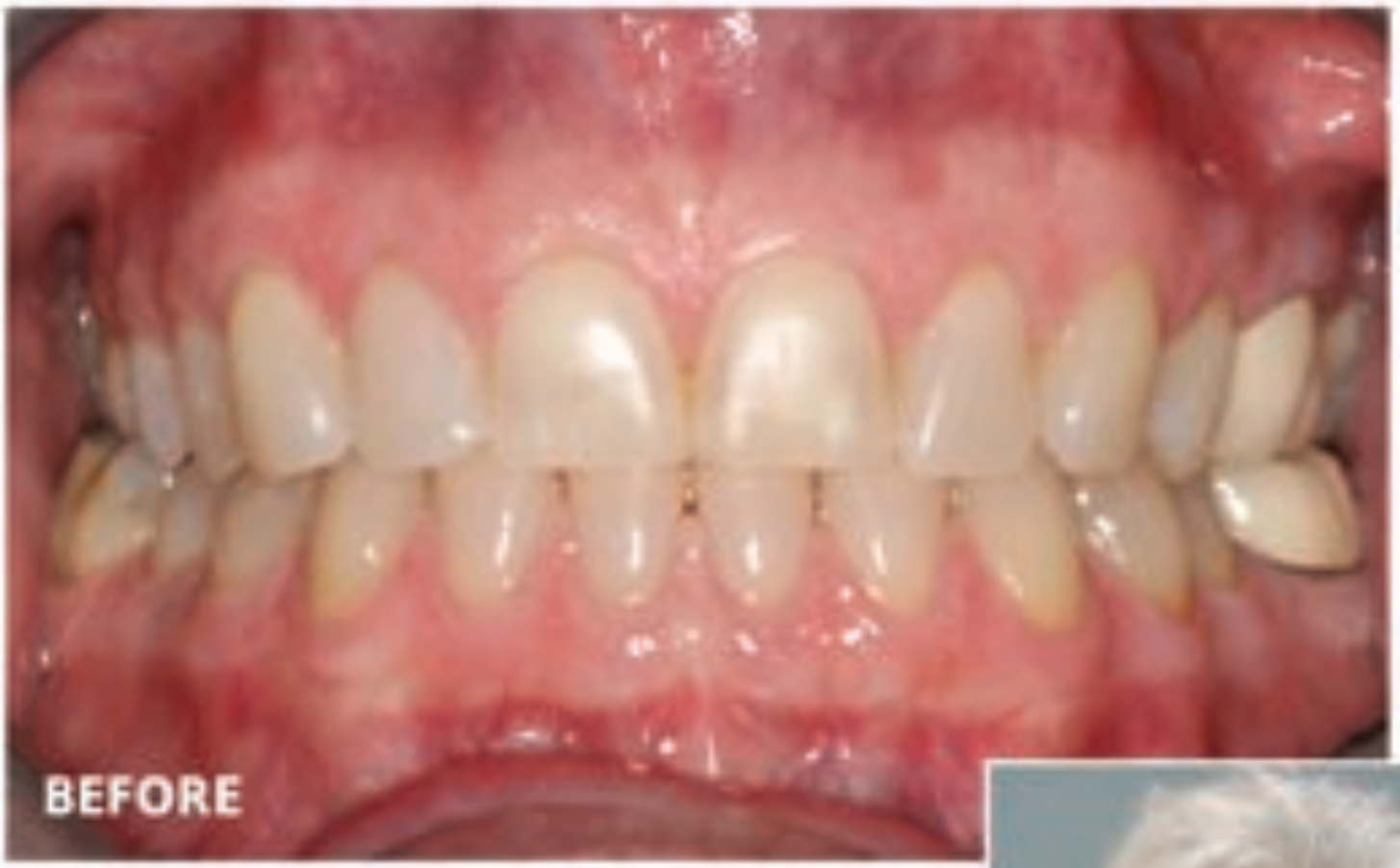

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Santa Barbara, CA
Pittsburgh, PA
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July 16-19, 2008
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Dearborn, MI
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Health&Science

NIDCR slates 60th anniversary events

BY CRAIG PALMER

Dallas—They're highlighting the future of dental research in a year-long celebration of the 60th anniversary of the National Institute of Dental and Craniofacial Research.

Three symposia and a presentation by the NIDCR director were among anniversary activities planned for the April 2-5 annual meeting of the American Association for Dental Research. The celebration also included presentations on practice-based research at the Chicago Mid-Winter Dental Meeting and in the March issue of The Journal of the American Dental Association.

Other National Institutes of Health and American Dental Association events are in the planning stage.

Created in 1948 as the National Institute of Dental Research, one of the National Institutes of Health, the NIDCR today is the nation's leading source of oral, dental and craniofacial research funds.

AADR symposia held earlier this month:

- Looking toward the future, a recognition of the growing cadre of new scientists and professionals making an impact in oral health research;
- Dental practice-based research has great potential for answering questions practitioners face daily in routine patient care with a focus on general dental practice;
- Building on our strengths highlights individuals making high-impact contributions to oral health research.

Dr. Lawrence Tabak, NIDCR director, in a presentation entitled "Enhancing Peer Review at NIH," was set to report on recommendations from a recently completed trans-NIH study.

"The AADR has always enjoyed a strong, mutually beneficial relationship with the NIDCR since its inception 60 years ago," said AADR Executive Director Christopher H. Fox. "We are delighted that they have chosen our annual meeting as a natural place to celebrate their anniversary."

AADR annual meeting attendees were given the opportunity to provide initial input for the NIDCR's next strategic plan, an AADR spokeswoman said. ■

—palmerc@ada.org

Spring PPR

ADA Professional Product Review looks at how to choose a CAD/CAM system

BY JENNIFER GARVIN

From chairside computer-aided design/computer-aided manufacturing systems to in-office whitening systems to shade guides, the spring issue of the ADA Professional Product Review is packed with information to help you decide what's best for your practice.

"If you are considering investing in a CAD/CAM system, this issue of PPR will give you a head start on the decision process," said Dr. David Sarrett, PPR editor.

Dr. Sarrett added that the issue also discusses critical factors to consider such as the CAD/CAM's cost effectiveness and the technology learning curve. There are also literature reports cited on clinical performance.

Questions for dentists to ask before purchasing a CAD/CAM include:

- How many single-unit restorations do I prescribe?
- Am I comfortable using software to design restorations?
- Can my staff learn with me?

The spring PPR also includes the 2008 readership survey and evaluates six brands of in-office tooth-whitening products.

The PPR is a quarterly newsletter mailed with The Journal of the American Dental Association. Each issue provides practitioners with clinically relevant information on dental office products. Participants for the surveys were drawn from the ADA Clinical Evaluators panel and from a random sample of other ADA members.

For a complete description of the test methods and for more information on the PPR, visit "www.ada.org/goto/ppr".

For more information about the ADA Clinical Evaluators panel, contact the ACE Panel desk at the ADA toll-free number, Ext. 3528, or e-mail "pprclinical@ada.org".

The PPR is free to ADA members and available by subscription to nonmembers. For nonmember subscription information, call 1-312-440-7735. ■

Large-scale studies make strides in mapping the topography of the mouth

BY CRAIG PALMER

Washington—Dental scientists reported the online launch of the first comprehensive database of microorganisms living in the mouth and the identification of 1,116 unique proteins in saliva in separate announcements March 25.

This genomic and proteomic data mining represents the "big science" oral research described to Congress by Dr. Lawrence Tabak, director of the National Institute of Dental and Craniofacial Research, which supports both projects. "These large-scale projects attempt to assemble a more detailed snapshot of the biological topography of a given tissue or disease process," he said in a budget justification document supporting the administration's request for oral research funds.

The NIDCR, one of the National Institutes of Health, is the nation's leading source of funds for oral, dental and craniofacial research.

"With this more comprehensive view of the biological landscape, scientists can search more systematically for new diagnostic and therapeutic leads and move them more rapidly into clinical testing," Dr. Tabak told Congress. "A good example is a consortium of scientists that recently completed a parts list of the proteins that are at work in the salivary glands. This first-ever catalog, like a Webster's dictionary to a writer, provides an essential resource to design future saliva-based tests for human diseases."

The protein map of human saliva was announced in a Web release by the Journal of Proteome Research ("http://pubs.acs.org") and described by Reuters news service as important in developing saliva-based tests for cancer, heart disease, diabetes and other conditions.

The National Institutes of Health announced the Human Oral Microbiome Database of some 600 distinct microorganisms known to live in the mouth. The Web site is located at "www.homd.org" and overseen by scientists at The Forsyth Institute in Boston and King's College London in England. "The HOMD fills a critical research need," Dr. Tabak said. "The oral microbiome is extremely rich in data, and HOMD becomes the essential search engine for scientists to view and retrieve this information, generate novel hypotheses, make computational discoveries, and ultimately develop more biologically sound therapies to control oral diseases."

Dr. Floyd Dewhirst, a project leader and scientist at The Forsyth Institute, said the HOMD introduces the first comprehensive nomenclature system to bring order to the naming of uncultured or previously unnamed oral microbes. Officially open to scientists, the HOMD is an ongoing project and a potential model for other microbiome studies, he said.

Already under way in "biology's next revolution" is a NIDCR-supported project to compile a full catalog of the complete genomes of all oral microbes.

These studies will define the role of microbes in such common chronic diseases as tooth decay and periodontal disease. The microbiome is a comprehensive listing of bacteria and other microorganisms in dental plaque and the salivary proteome a complete listing of proteins in saliva, a NIDCR spokesman said. ■

Give Kids A Smile Awards Gala May 13 in Washington

The Give Kids A Smile Awards Gala May 13 at the ADA Washington Leadership Conference is fast approaching, and if you haven't purchased tickets or otherwise confirmed your attendance at the Gala, please do so right away.

Not only are tables for the Gala filling quickly but hotel rooms in the city are becoming scarce and will sell out because of a large convention in D.C. at the same time as the Gala. This is going to be a very special event, and those who want to attend should register now on ADA.org at "www.ada.org/prof/events/featured/gkas/2008_content_awards_gala.asp" or contact Janelle Marshall ("marshallja@ada.org", Ext. 2590) for more information. ■

Museum, schools, dental offices custom fit their GKAS programs

BY STACIE CROZIER

From coast to coast in the U.S., volunteers are shaping their Give Kids A Smile programs to showcase their unique talents and meet the needs of local children.

At The Dr. Samuel D. Harris National Museum of Dentistry, nearly 100 Baltimore City schoolchildren received interactive oral health education and screenings to identify dental disease on Feb. 8 in a partnership between the museum, the University of Maryland Dental School and the Maryland State Dental Association.

Maryland Rep. Elijah Cummings kicked off the event, talking to the children about the importance of good oral hygiene. Kids learned how to brush and floss, eat healthy foods and avoid the dangers of tobacco through the museum's hands-on MouthPower program. They all received a free dental screening, fluoride varnish and a Smile Kit with oral care products, MouthPower oral health care tips and a report with suggested follow-up care and recommendations on where to seek dental treatment.

"We are extremely pleased at the success of this first-time Give Kids A Smile event in which the Museum's MouthPower program was the centerpiece, giving children the tools they need to take care of their teeth for a lifetime," said NMD Executive Director Rosemary Fetter.

In Gaithersburg, Md., the office of Dr. Adam Schneider, Dr. Bill Schneider and Dr. Jennifer Matelis treated more than 25 children, ages 4-14, providing more than $12,000 in free dental care for GKAS in February.

"Everything from cleanings, diet discussions, extractions, laser caries removal, restorations to orthodontic needs were addressed during the day, and a few of the kids are scheduled to come back and finish their treatment needs," said Dr. Adam Schneider. "Thanks to our local specialists, these children did not face obstacles to treatment when in need of specialty procedures. It is great to see the generosity in our dental community at work helping worthy recipients get back to school again."

In Indiana, 200 dentists and 770 staff members volunteered statewide to treat more than 2,000 children through GKAS this February. This brings the total in donated treatment to more than $1.1 million for more than 8,600 children in the past four years.

"It's exciting to see how much treatment our volunteers donated, but it's bittersweet," said Dr. Catherine Periolat, Give Kids A Smile chair. "It's unfortunate so many children lack dental coverage and don't make it to a dentist until they have a mouth full of toothaches."

On the West Coast, the University of the Pacific Arthur A. Dugoni School of Dentistry's GKAS programs reached nearly 500 children in

See CUSTOM FIT, page 27

Photo by Kristine Buls, courtesy of The Dr. Samuel D. Harris National Museum of Dentistry

Hands-on learning: Kids discover the power of a healthy smile with the National Museum of Dentistry's MouthPower program.

Ready to roll: Students from the Lincoln Unified School District in Stockton, Calif., arrive at UoP's Pacific Dental Care Clinic to receive free dental screenings for GKAS.

More than 2,800 served in New Jersey Give Kids A Smile programs statewide

BY KAREN FOX

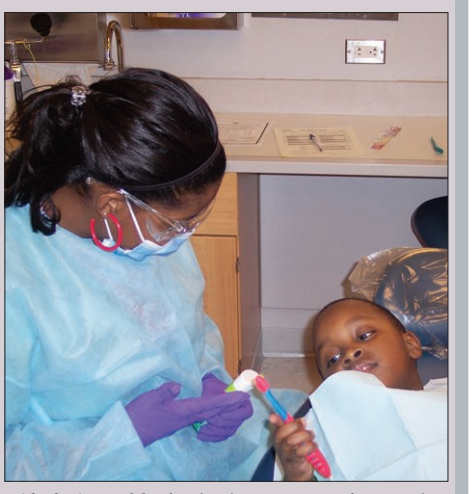
North Brunswick, N.J.—A volunteer corps of 600 fanned out across New Jersey Feb. 1 for the state's 6th annual Give Kids A Smile Day, working in 55 public and private locations to bring needed dental care to more than 2,800 children.

The University of Medicine and Dentistry of New Jersey/New Jersey Dental School in Newark was the state's largest GKAS site, where treatment was provided for 645 children.

"Our spirit of teamwork throughout the dental community in New Jersey is always evident on Give Kids A Smile Day," Dr. Robert Hersh, president of the New Jersey Dental Association, told the Courier News of Bridgewater, N.J. "Dentists perform pro bono work more than people think, and it's never about the publicity; it's about helping people."

New Jersey's program "serves as a shining example of how organized dentistry strives to highlight the importance of providing oral health care to children," added Dr. Cavan Brunsden, statewide chair for GKAS.

"This year demonstrates the greatest success ever" for Give Kids A Smile in the state, said Dr. Brunsden. "Once again, we were privileged to have the combined efforts of the New Jersey Dental Association, New Jersey Dental School, New Jersey Dental Hygiene Association, New Jersey Dental Assistants Association, the School of Health Related Professions of UMDNJ, and many other residencies and clinical health care programs throughout the state." ■



This is how: Marie Jackson, a senior at the University of Medicine and Dentistry of New Jersey/New Jersey Dental School, shows a Newark-area child the proper way to brush.

Photos by Dr. Rebecca Reed

Take a look: Matthew Gialanell, a junior at the University of Medicine and Dentistry of New Jersey/New Jersey Dental School, looks for decay in the mouth of a Newark-area youngster.

Custom fit

Continued from page 26

Stockton and Oakland, Calif., this February.

The university's Student Community Outreach for Public Education organization and faculty partnered with the Alameda County Dental Society Feb. 23 to provide 84 Oakland area children with screenings and fluoride varnish at La Clinica del la Raza. The event also allowed parents to establish a dental home for their children and make appointments for free restorative care.

"This experience was certainly eye-opening in terms of the extensive need for oral health care in Alameda County," said Stephanie Hannon, class of 2009. "Several parents related that their child had missed school during the past few months because of a toothache. After coming to the Give Kids A Smile Day, dozens of kids are now on their way to being pain free."

In Stockton, some 400 school-age children were screened and more than two-dozen received follow up care.

The ADA News encourages GKAS volunteers to continue sending photos and information from programs held throughout the year—including candid pictures of children, dentists and team members interacting and clinical photos (patients in the chair, dental team in gloves, masks and protective eyewear). Be sure to include identification of those pictured and facts about your event.

Send high-resolution photos for consideration for use in the ADA News and on ADA News Today (on ADA.org) to "adanews@ada.org" as soon as possible following your event. ■

Thumbs up: Brandon Farfan flashes a smile during a GKAS event in Gaithersburg, Md. With Brandon are Dr. Adam Schneider and Carmen Jimenez.

Eye on Dental Benefits

EBD

Continued from page one

insurance industry not to underestimate the need for correct methodology when using the term are going unheeded.

The ADA has a formal EBD policy statement, which includes a definition of evidence-based dentistry, as well as four primary steps for the evidence-based review process.

"Dentists should go to their Association to learn what EBD is and to understand its application in clinical practice," said Dr. Luther. "The terminology linked with some benefits defined as 'evidence-based' may be simple sales talk."

Dr. Daniel Meyer, senior vice president, ADA Division of Science, agrees.

"Insurers are developing benefits in their policies and saying they're based on evidence by using proprietary, aggregate data from insurance claims," explained Dr. Meyer. "This is not a transparent and reproducible approach. The ADA believes such a method can't compare to the quality of evidence gathered from randomized, controlled, scientific studies in recognized peer-reviewed professional publications."

The Council on Dental Benefit Programs, the Council on Dental Practice and the Council on Scientific Affairs collaboratively specified ADA concerns in a letter to America's Health Insurance Plans (a national association representing some 1,300 member insurance companies). The ADA included a six-point outline in its remarks explaining key differences in the way the ADA and AHIP view evidence-based dentistry. The letter was drawn up based on AHIP's report to dental plan members entitled "Guiding Principles for the Development of Quality Affordable Dental Coverage Based on Evidence." (To read the entire ADA letter, go to OnlineXtra, Jan. 21, 2008, at ADA.org)

In its response to the ADA letter, AHIP appears to have evaded issues raised rather than addressed them, according to Dr. Deborah Bishop, 2008 EBD Advisory Committee and Council on Dental Benefit Programs member.

"It's difficult to believe AHIP didn't understand the points we specified," said Dr. Bishop. "It seems to me that AHIP intentionally skirted the issues because they want to use the term evidence to lend clinical credence to financially based decisions."

AHIP's response, described by the organization as an attempt to provide the ADA with clarification on its concerns, highlights the ADA's key criticisms of the way AHIP views evidence-based dentistry.

AHIP said its guiding principles indicate that evidence-based coverage guidelines are intended "to assist dental benefit plans and purchasers in choosing appropriate coverage to meet the clinical needs of the members while providing an affordable dental benefit package."

The distinction between coverage and clinical guidelines is at the heart of ADA criticisms. The phrases "evidence-based dental coverage" and "evidence-based dental practice" cannot be used interchangeably, according to EBD experts.

"Using sources of evidence appropriate for the purpose of plan development and creating the impression that the recommendations are based on clinical scientific evidence is potentially misleading," said Dr. Luther. "We're not saying that financially weighted evidence isn't appropriate for financial decisions, such as benefit plan development, only that calling it evidence-based gives the wrong impression."

The ADA definition of evidence-based dentistry is:

"An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment need and preferences."

"[EBD] is intended to enable the dentist to exercise his or her professional judgment. ... Aggregate claims data about care that does not address the specific needs of your patient is not consistent with evidence-based dentistry principles—and resulting constraints should not be referred to as evidence-based dentistry."

The ADA policy includes the four primary steps of the evidence-based review process: defining a clinically relevant question; synthesizing the available evidence that is relevant to the clinical question; translating that synthesis to the professional community; and evaluating health outcomes in clinical practice (based on the findings of the previous steps).

"The entire process aims to minimize the influence of individual bias in the systematic review and to develop justified clinical recommendations that address specific questions," said Dr. Meyer.

"Evidence-based dentistry is designed to give dental providers and their patients the most relevant, scientifically based, clinical information to help optimize the care you provide for each patient," continued Dr. Meyer. "It is intended to enable the dentist to exercise his or her professional judgment to ensure that the patient has the opportunity to receive the highest quality care that is based on the individual's clinical treatment needs and preferences. Aggregate claims data about care that does not address the specific needs of your patient is not consistent with evidence-based dentistry principles—and resulting constraints should not be referred to as

See EBD, page 29

Dr. DiPlacido, past AAOMS president, dies; involved with dental accreditation

BY KAREN FOX

Fort Myers, Fla.—Dr. Frank DiPlacido Jr., the 2000-01 president of the American Association of Oral and Maxillofacial Surgeons, died March 14.

Colleagues of Dr. DiPlacido, 73, remember him as a clinician who was passionate about education- and accreditation-related matters.

"Dr. DiPlacido had a genuine interest in advancing academic dentistry through enhancing education, research and accreditation," said Dr. Thomas W. Braun, dean of the University of Pittsburgh School of Dental Medicine.

Dr. Braun was a member of the ADA Commission on Dental Accreditation when Dr. DiPlacido, as an AAOMS officer, attended meetings of CODA's Oral and Maxillofacial Surgery Education Review Committee.

"He was fair and kind to friends and critics alike, and he did what he believed was right, even when that might be the more difficult path to follow," said Dr. Braun.

Dr. DiPlacido

His contributions in the field of accreditation extended beyond dentistry, too. Dr. DiPlacido was an active surveyor who inspected ambulatory health care facilities for the Accreditation Association for Ambulatory Health Care from 1993 until his death. From 2005-06, he served as AAAHC president.

Dr. DiPlacido earned his dental degree from the University of Pennsylvania School of Dental Medicine in 1962, served in the U.S. Army from 1962-65 and completed a residency in oral and maxillofacial surgery at the University of Pennsylvania. Shortly thereafter, he moved to Fort Myers to join his friend Dr. Jerry Laboda in the practice of oral surgery. After nearly 40 years of private practice, he officially retired in 2007.

In recent years, Dr. DiPlacido and his wife of 38 years, Noreen, dedicated themselves to patient care beyond the United States, making many trips to Honduras and founding a project called "New Faces for Honduras," in conjunction with CURE International, the organization that supports disabled children throughout the developing world through advocacy, partnerships and medical care.

In addition to Noreen, Dr. DiPlacido is survived by three children and four grandchildren, three sisters and one brother.

Services were held March 18-19 in Fort Myers. Memorials may be made to the Frank DiPlacido Charitable Fund, c/o the Church of the Resurrection of our Lord, 8121 Cypress Lake Dr., Fort Myers, Fla. 33919. ■

Questions to ask insurers about what they call 'EBD'

The ADA Council on Dental Benefit Programs, in collaboration with the Division of Science, recommends dentists ask their insurers the following questions:

- What is the insurer's definition of "evidence-based"? Is it the ADA definition?
- Is the "evidence" cited actually financial data, not scientific data?
- Has the data gone through an external peer review process and been accepted for publication in a professional journal?
- Are the evidence reviewers EBD experts or financial experts?
- Are the insurers' policies consistent with other existing EBD recommendations and guidelines, including ADA clinical recommendations ("www.ada.org/prof/resources/ebd/clinical.asp")? ■

OnlineXtra
www. ada.org/goto/newsextra

For more information related to this story, visit the ADA's Web site, using the Web address above.

EBD

Continued from page 28

evidence-based dentistry."

The ADA urges dentists to go to their Association to learn about evidence-based dentistry and its application in clinical practice.

For links to tutorials and a wealth of other EBD information go to "www.ada.org/goto/ebd".

For information about the May Evidence-Based Dentistry Champion Conference and 3rd International Conference on Evidence-Based Dentistry visit "www.ada.org/goto/ebdconf", send an e-mail to "ebd@ada.org" or call the ADA Division of Science, Ext. 2878, for information.

The ADA Cell Seminar Series offers "Evidence-Based Dentistry: Practical Science." The course reviews the concept of evidence-based dentistry, how systematic reviews are conducted, analyzes findings from published systematic reviews and demonstrates how scientific studies should be critically analyzed before they are applied in dental practice.

Dental societies interested in hosting this or any ADA Cell Seminar Series program can schedule a program or get more information by calling the ADA toll-free, Ext. 2908; e-mailing "seminarseries@ada.org"; or logging on to "www.ada.org/goto/seminarseries". ■

—furlonga@ada.org

Understanding Associations

ADA CE Online offers new course

BY KAREN FOX

Are you looking for a new way to hone your leadership skills?

ADA CE Online has launched a leadership development series that provides new dentists and established dentists who are new to association volunteerism with basic information on how associations function.

"Understanding Associations" describes the nature, structure and functions of professional associations in general, and the ADA specifically. Each self-guided module offers comprehensive information and objectives—from identifying your leadership style and conducting effective meetings to setting goals and understanding dentistry's role in the political process.

The series is free but available to ADA members only.

"Many times, people finish dental school and want to become involved in the profession but don't know how to make connections or have a clear understanding of how associations function," said Dr. Jennifer Barrington, chair of the ADA Committee on the New Dentist, which proposed the Understanding Associations course several years ago.

Dr. Swilling: "The modules are well organized and give you a sense of what associations do for their members."

Dr. Barrington: "Anything that supports and cultivates volunteerism will ultimately strengthen the tripartite."

"This is a perfect way to obtain background information on association structure for future leadership opportunities," she added. "It's great to see this series finally come to fruition. Anything that supports and cultivates volunteerism will ultimately strengthen the tripartite."

The series has nine modules that can be taken individually or as a series, and once the course is selected, users can start and stop the program at their own pace. You have up to a year to finish the course.

Module topics include: associations 101; effective leadership; strategic planning; association committees, formation and procedure; recruitment and retention; finances and budgeting; communications; diversity; and political action.

Participants who select and successfully complete the series of nine modules will earn three continuing education units. To find out if the credits are accepted by your licensing jurisdiction, contact your state dental board.

"Many times, people finish dental school and want to become involved in the profession but don't know how to make connections or have a clear understanding of how associations function."

Dr. Stacey E. Swilling, a member of the Committee on the New Dentist from Sheridan, Ark., recently completed the entire series.

"The modules are well organized and give you a sense of what associations do for their members," said Dr. Swilling. "Not just the services they offer, but advocacy, communicating with the public and so on.

"If you're a member of the ADA you may not realize what all is going on and how many volunteer dentists are giving their time to make the association work," Dr. Swilling added. "It really opened my eyes. All of us can and should be involved on some level."

Dentists currently active in their associations and those looking to get involved are encouraged to register for Understanding Associations, one of many leadership opportunities offered by the ADA.

To learn more about CE courses, check out the 130 clinical and practice management courses on ADA CE Online at "www.ada.org/goto/ceonline". All courses can be bookmarked so participants can start and finish courses during multiple visits. Some courses, like Understanding Associations, are offered at no charge.

For more information about Understanding Associations and other Committee on the New Dentist leadership development offerings, including web seminars and workshops, contact the CND at Ext. 2779 or "newdentist@ada.org", or visit "www.ada.org/goto/newdent". ■

—foxk@ada.org

Dr. Jay Eshleman, past ADA leader, dies at 97

BY JAMES BERRY

Philadelphia—Dr. Jay H. Eshleman, a past ADA trustee and vice president, died March 10. He was 97 years old.

Dr. Eshleman served as ADA vice president in 1961-62 and represented the Association's Third Trustee District (Pennsylvania) from 1965-71. He was also a past president of the Pennsylvania Dental Association and served as general chair of the ADA Annual Session when it was held in Philadelphia in 1960.

"He loved dentistry, loved his profession, loved organized dentistry," Dr. Eshleman's widow, Martha, said of her husband. "He was a tireless worker at the local, state and national levels of the profession."

Born in 1910 on a farm in rural Lancaster County, Pa., Dr. Eshleman was the eldest of eight children. He received his elementary education in a one-room schoolhouse and walked five miles a day, round trip, to high school.

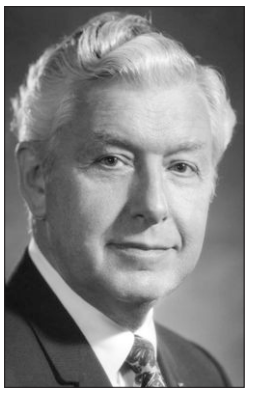
He attended Elizabethtown College and received his dental degree from what is now the Kornberg School of Dentistry at Philadelphia's Temple University.

"I opened a practice, but no one came," he recalled in a 1998 interview. "I was living on one meal a day and passed out cards to local businesses."

Then one snowy night, Dr. Eshleman encountered a man who was suffering from toothache. The young dentist took that man back to his dental office where he treated the tooth and relieved the man's pain. Word of this encounter got around the neighborhood, and Dr. Eshleman's practice took off.

Dr. Thomas W. Gamba, president-elect of the Pennsylvania Dental Association and a lifelong friend of Dr. Eshleman's, was the major source of information for this report.

"Dr. Eshleman was passionate about organized dentistry," Dr. Gamba wrote in an obituary sent to the ADA. "He was a man of devout faith and unwavering ethics who prayed on his knees every day and was an active member of his church."



Dr. Eshleman

Dr. Eshleman joined the Navy in 1944 and rose to the rank of lieutenant commander. He began teaching practice administration and ethics at Temple in 1949.

"He spoke frequently across the country and in Canada on public health, ethics, community dentistry and dental insurance," recalled Dr. Gamba. "He participated in White House conferences on health and aging in the 1980s. He was an advisor to the U.S. Department of Health and Human Services and the National Institutes of Health."

In addition to his wife Martha, Dr. Eshleman is survived by three daughters, three grandchildren, three brothers and a sister. Memorial contributions can be sent to the Jay H. Eshleman Endowment Scholarship Fund at the Temple University Kornberg School of Dentistry, office of the dean, 3223 No. Broad St., Philadelphia, Pa. 19140. ■

Dr. Jerry Larson, past trustee, dies

BY JENNIFER GARVIN

Brookfield, Wis.—Former ADA Trustee Gerald "Jerry" Larson died unexpectedly Feb. 20. He was 78.

A 1958 graduate of the Marquette University School of Dentistry, Dr. Larson was a general dentist who served the ADA as 9th District trustee from 1983-1989.

He practiced in New Berlin, Wis., and Brookfield, Wis., for 41 years before retiring in 1999.

Dr. Larson

He was a past president of both the Wisconsin Dental Association and Waukesha County Dental Society. In 1972 he received the WDA's Distinguished Service Award and in 1987 was awarded the 1987 Distinguished Alumnus in Dentistry Award from Marquette.

According to his daughter, Jill Larson Nugent, Dr. Larson found dentistry to be very rewarding. He was proud of his family and enjoyed doing things with his grandchildren. He was also very proud to be the first of three generations of Eagle Scouts.

"He loved that my brothers and his grandsons followed in his footsteps and became Eagle Scouts," she said of the tradition her dad started.

Dr. Larson was also very proud to have served with the U.S. Army 1st Calvary Division in the Korean conflict.

He is survived by his wife of 55 years, Audrey, and five children. ■

PRODUCT news

The 17th Annual Meeting for the American Academy of Dental Sleep Medicine will be held from June 6 – June 8, 2008 in Baltimore, Maryland. This year's meeting will include educational courses designed for practitioners of all levels, an exhibit hall displaying oral appliances and other dental sleep medicine products and services, oral presentations and poster viewing of abstracts and new this year are Meet-the-Professor luncheons with recognized experts in dental sleep medicine. To view the annual meeting program, register and for more information, please visit www.aadsm.org or call 708-273-9366.

The American Academy of Dental Sleep Medicine
708-273-9366
www.aadsm.org

Dentalcompare Learning Centers are your destination for focused, in-depth content. As the latest addition to Dentalcompare, Learning Centers feature easy access to focused articles and interviews, technique videos, webinars, new product news, Q&A and more. Learning Centers are continually updated with breaking news, product announcements, and articles from leading clinicians. In addition, you can quickly search and compare over 6,000 products. For more information visit our website at www.dentalcompare.com or visit us at the CDA Anaheim Meeting.

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With the Hertz Green Collection, you can reserve fuel efficient, environmentally-friendly cars that are both easy on the wallet and suitable for families and small groups traveling together. Now you can reserve the Toyota Prius Hybrid, the newest vehicle in the Green Collection. We have nearly 35,000 cars in the Green Collection fleet and all vehicles are reservable by specific make and model, EPA Highway Fuel Efficiency rating of 28 Miles or more per gallon, available at 50 major airport locations in the U.S. Be sure and mention your ADA Discount CDP# 42371 to receive special discounts.

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A magnetostrictive scaling system with electronic controls for easier, more precise adjustments, the smartly designed Integra features a self-contained fluid supply with two removable reservoirs. The rate of irrigant delivery is digitally controlled and powered by a built-in pump. The Integra automatically adjusts to any 25KHz or 30KHz insert, and you can control power from the Smart Foot Pedal, or power and water from the touch controls. The Integra includes an expanded low-power range, an easy-to-clean waterproof membrane control panel, autoclavable handpiece sheaths, a built-in safety turn-off feature and a 5-year warranty.

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N'Durance Nano Dimer Composite system from Septodont simplifies aesthetic composite placement with the offering of two technique oriented composite kits geared to those who prefer the Self Etch system and for those who rely on a Total Etch Technique. N'Durance is the latest breakthrough in composite technology in over 30 years. Using a proprietary chemical formulation of Dimer Acid with Nano technology, N'Durance demonstrates greater polymerization with significantly lower shrinkage than the most popular composites on the market. Endurance can be used with confidence in all classes of anterior and posterior direct dental restorations.

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Ozinga is a color-changing universal bond for use in a dry or wet environment. The self-etching primer may be used as an initial bond coat for an orthodontic adhesive or for enamel and dentin bonding. Ozinga changes to a pink color upon mixing, allowing for increased visibility of the applied area and verifying coverage, but returns to clear after air-drying on the tooth. Ozinga will form a colorless, strong, cohesive bonding layer.

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Handler Manufacturing is the first to design and combine two proven technologies in the dust collection industry for the dental lab. Announcing the 62-IIUV SUPER SANITIZER II Dust Collector with UV germicidal bulb technology. This unit filters dust during use in the lab, while helping to purify the air that flows through the unit. Handler has incorporated a UV germicidal low pressure mercury arc lamp, which emits optimal spectral radiation peaking at 253.7 Nanometer. This output is highly effective to inactivate microorganisms such as bacteria and virus. The UV germicidal bulb has a tested lifespan of 3,000 hours.

Handler Manufacturing Co.
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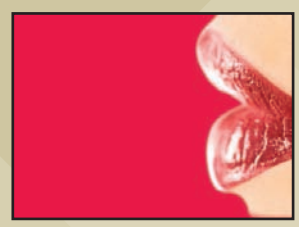

Designed with versatility in mind, IPS e.max presents the ultimate in metal-free ceramics, high-strength and esthetics. With five major components, IPS e.max enables multiple fabrication techniques and offers patented lithium disilicate—a state of the art material that demonstrates the highest strength in glass ceramics today.

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Pola Office+ is the world's fastest in-office tooth whitening system. Absolute minimal chair time is required: the total treatment time will take less than 30 minutes. Less chair time means increased patient comfort and satisfaction. Pola Office+, the world's fastest bleach is the answer for those patients living busy lifestyles. Pola Office+ can be used with or without a bleaching light as it does not require light activation. Any heat emitting curing light can be used thus eliminating the need for special and expensive lights. The neutral pH bleaching of Pola Office+ ensures maximum comfort during and after treatment.

SDI Limited
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Opalescence Boost now includes Ultradent's patented and scientifically proven PF technology for stronger enamel, decreased sensitivity and caries prevention. Recent studies have shown that the best in-office whitening results do not require the use of a light. Opalescence Boost has maintained its time-tested and chemically activated 38% hydrogen peroxide solution now with the added benefit of PF technology. The unique syringe-to-syringe mixing system ensures freshness in application while the distinct red color makes the gel easy to apply and remove. Because Opalescence Boost formula is so powerful, a full treatment can be completed within a one-hour appointment.

Ultradent Products Inc.
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The D.T. LIGHT-POST Illusion from BISCO is the most advanced and aesthetically appealing quartz fiber post on the market. When placed in the tooth, the intrinsic color of the post disappears allowing it to blend in with the natural dentition and the restoration. Yet the post color will reappear on command under cool water spray making it easier to locate if retreatment is required. Take 25% OFF your order when you purchase the D.T. LIGHT-POST Illusion and see for yourself why this revolutionary technology is the best option for your practice.

Bisco Dental
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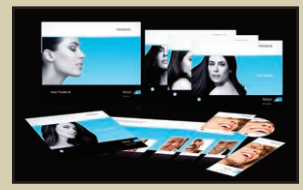

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Heraeus Kulzer
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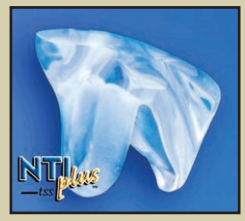

Keller Laboratories' NTI-tss Plus is the superior alternative to full coverage bite guards. Doctors report that it is easier to seat and more effective at preventing damage from bruxing and clenching. Patients find it more comfortable so they actually use it. NTI-tss suppresses parafunctional muscle contraction by nearly 70% and is FDA approved for the prevention of medically diagnosed migraine pain associated with tension type headache and bruxism. NTI-tss Plus is made from Keller's Crystal Clear, a clinically unbreakable thermoplastic that won't absorb stains or odors.

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Ready for San Antonio?

Registration for the annual session opens April 16 on ADA.org

San Antonio—Have you marked your calendar? Registration and housing for the ADA's 149th annual session opens April 16 on ADA.org.

Secure your choice of hotel as well as continuing education course tickets when you register in advance for the annual session in San Antonio, Oct. 16-19.

Register by Sept. 12 to save on registration and course fees and to receive your meeting materials via U.S. mail in advance of the meeting. Hotel reservations at discounted rates within the ADA's official hotel block can be made until Sept. 26.

The 2008 annual session will convene at the Henry B. Gonzalez Convention Center. ADA pre-session activities begin Oct. 15, continuing education will be held Oct. 16-19, the World Marketplace Exhibition will be open Oct. 16-18 and the House of Delegates meets Oct. 17-21.

Watch for the April 21 issue of the ADA News, featuring an overview of the annual session. Highlights include the Distinguished Speaker Series sponsored by Johnson & Johnson Oral Healthcare Products, special events, new continuing education opportunities unique to the ADA, World Marketplace Exhibition information, San Antonio facts plus a special two-page bonus guide to San Antonio hotels to help you choose the amenities, location and price that meet your needs.

Choose a San Antonio hotel starting April 16

San Antonio—Reservations in ADA official hotels for the 2008 annual session may be made beginning April 16 at "www.ada.org/goto/session". Book early for the best variety of hotels and discounted rates. ■

If you already know your annual session schedule, you may book your air travel now by calling Experient's travel desk at 1-800-621-1083 toll-free in U.S. and Canada only, or at 1-847-940-1176.

Request an annual session preliminary program by calling toll-free, 1-800-232-1432 or e-mailing "annualsession@ada.org". Preliminary programs will be mailed in May and a PDF version will be available on ADA.org April 16. ■

New Jersey dental meeting will feature CE, exhibits and luncheon with Ivana Trump

Atlantic City, N.J.—The New Jersey Dental Association will hold its annual convention here June 4-6.

The meeting is open to all dental professionals and takes place at the Trump Taj Mahal Casino & Resort. It is cohosted by the New Jersey Dental Hygienists' Association and the New Jersey Dental Assistants' Association.

This year's convention features more than 150 exhibit booths, a two-day silent auction, continuing education and an elegant president's dinner dance. There will also be a celebrity luncheon with Ivana Trump.

For more information, contact the NJDA by phone at 1-732-821-9400 or visit "www.njda.org". ■

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Matsco provides practice financing based primarily on the income of the practice rather than personal assets such as a home. This allows dentists to preserve the equity of those assets for future use, while enabling new graduates and others with fewer accumulated assets to more easily make the leap to ownership.

"We truly understand the business of being a dentist, and we know what it takes to create a thriving practice," said Allison Farey, Matsco president. "Traditional lenders require a down payment and secure the loan on personal assets. We don't ask for that. We provide financing based on the projected revenues of the practice, and we manage the details of the financing program so that the dentists can stay focused on producing dentistry."

When Dr. Ashish Patel of Marietta, Ga., was seeking funding for a new practice, he didn't realize he could obtain a loan based on the projections for his new business.

"I always figured I'd have to use a house as an asset for my loan," said Dr. Patel. "But with Matsco, that wasn't true. They trusted my track record and they believed in my vision, and they were able to financially support me based on those two things."

All Matsco clients are enrolled in the Practice Success program, which provides professional support and business planning tools along with personalized service. Matsco's team of industry experts is dedicated to ensuring that clients' projects are completed on time and on budget. For Dr. Patel's new practice, Matsco representatives provided counsel every step of the way, such as selecting the right office equipment and software, getting a business license and developing a marketing strategy.

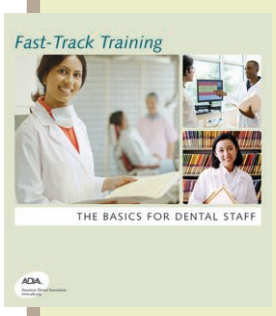
"I didn't even have a mortgage at the time, and I was still in debt from dental school," said Dr. Patel. "I had a lot of fears and anxiety about the process. But it was so easy with Matsco. I didn't even look anywhere else."

ADA members are eligible for preferred interest rates and free business planning tools through Matsco. If you're interested in owning a practice or looking to expand, find out more at "www.matsco.com" or call 1-888-937-2321. ■

Shop and save on ADA products at CDA meeting

Anaheim, Calif—Visit the ADA booth at the California Dental Association Meeting May 2-4 to check out the latest ADA products and brochures.

Located at Booth No. 1550, feel free to peruse the Practice Management titles available including Fast-Track Training: The Basics for Dental Staff, the ADA Regulatory Compliance Manual, OSHA Training for Dental Professionals, The Power of Customer Service and Transitions.



There will also be samples of the ADA's personalized products line: ADA brochures, magnets, sticker appointment cards, recall cards and tote bags.

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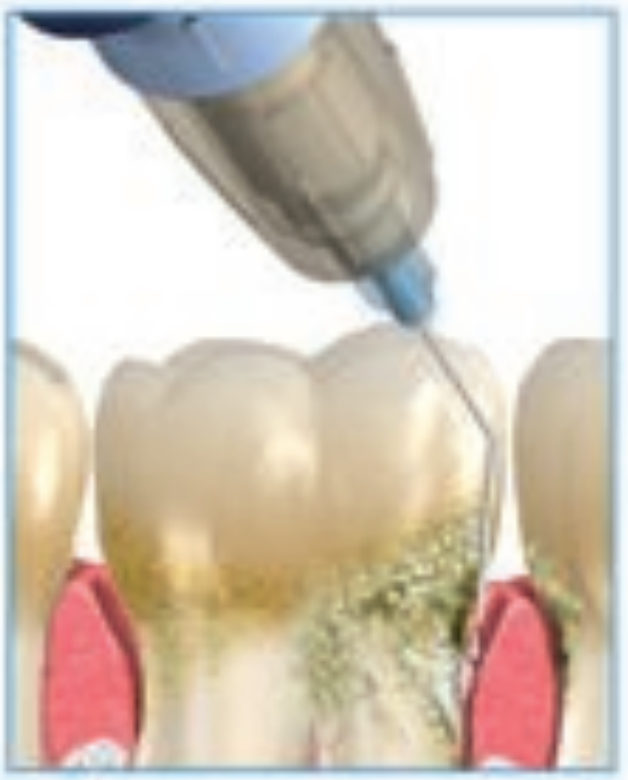

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- In clinical studies, 70% of patients preferred Oraqix® vs. an injectable.†
- 40% of patients stated that they would be more likely to return if Oraqix® was offered.†

Needle-free Oraqix® can enable greater compliance and enhance your ability to implement full-mouth scaling. This can make the procedure—and the entire appointment—run more smoothly. When you think scaling and/or root planing, think Needle-free Oraqix®. It's the easy way to achieve enhanced comfort for you and your patients.

- **Do not inject.**
- For adults who require localized anesthesia in periodontal pockets during scaling and/or root planing.
- Can be used for a single tooth, quadrant, or the entire mouth.
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- Oraqix® should not be used in those patients with congenital or idiopathic methemoglobinemia.
- Can be reapplied if needed to a maximum of 5 cartridges.

† submissions on file at Pierrel evaluation of a novel non-injectable anesthetic gel: a multicenter crossover study comparing the gel to infiltration anesthesia during scaling and/or root planing. J Periodontol 2005; 76(11): 1411-1418.

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