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AMERICAN DENTAL ASSOCIATION WWW.ADA.ORG

ADA News

JANUARY 7, 2013 VOLUME 44 NO.1

BRIEFS

Share your GKAS photos with ADA News, Facebook

The 2013 Give Kids A Smile Day is Feb. 1, and program coordinators nationwide should have their digital cameras ready to capture the highlights of the event.

The ADA News welcomes digital photo submissions from GKAS program participants—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.

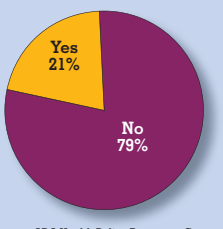
Send high-resolution photos for consideration for use in the ADA News and on

See GKAS, Page 18

JUST THE FACTS

Facebook me?

Only one in five dentists reported having a social media site for their practice in 2010.



Source: ADA Health Policy Resources Center, "survey@ada.org," Ext. 2568

'My life totally changed in Nepal'

Dr. Shinn is 2013 ADA humanitarian awardee

BY STACIE CROZIER

Gig Harbor, Wash.—On the last day of a six-week mountain-climbing vacation in the Himalayas in 1990, Dr. Sherwin R. Shinn was 11,500 feet above sea level when he realized his life's mission was to save lives by providing dental care and education to the less fortunate in his community and worldwide.

Dr. Shinn, a staff dentist at Lindquist Dental Clinic for Children in Tacoma, Wash., and founder of three international dental charities, has received the 2013 ADA Humanitarian Award.

"On the very last day of my trip in Nepal, I heard a little child crying in the lodge I was staying in," remembered Dr. Shinn. "It was the first time in six weeks I'd heard a child in distress. I followed the sound and came to a room where a very young girl was crying and her aunt and uncle were looking in her mouth."

After being in tourist mode for a month and a half, Dr. Shinn said he watched the family and a light

See DR. SHINN, Page 16

Photos courtesy of Dr. Sherwin R. Shinn

Global influence: Dr. Sherwin R. Shinn, above with a young patient and in the operatory with a chimpanzee in an African sanctuary, has spent more than two decades working to improve the oral health of people in some 40 countries worldwide.

Medical device excise tax prompts questions

With a new year comes new taxes, and one in particular on medical devices has drawn questions from dentists nationwide.

A new 2.3 percent federal excise tax went into effect Jan. 1 that applies to the medical devices dentists and physicians use. According to the ADA Division of Legal Affairs, the term "device" can apply to devices, instruments, products, materials and substances.

Dentists are not responsible for assessing or collecting the tax and they are not responsible for reporting it to the government. That's the responsibility of the manufacturers, suppliers or vendors who sell covered items to dentists. However, dentists can expect some modest increase in the cost of covered items because of the tax.

INSIDE
Midlevel provider study in JADA, Page 9

The Internal Revenue Service estimates that there are around 180,000 medical devices and 130 of those are specific to dentistry. These 130 devices appear on the Food and Drug Administration's list of dental devices, which the ADA has made available at www.ada.org/8054.aspx. The ADA also posted more detailed information on the new excise tax at www.ada.org/8053.aspx.

Even if a device appears on the FDA list, it is not subject to the excise tax if it's available at retail. Examples include power or manual toothbrushes, dental floss and teething rings. This retail exemption is the major exception to application of the device tax and applies to all medical devices.

Dentists have asked the ADA whether they will be responsible for

See TAX, Page 19

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Photo by Mary Mininni

Riding in style: Dr. Michael Chalupnik of San Diego shows off the Mercedes-Benz S550 he won for a two-week test drive in November. ADA Business Resources has teamed up with Mercedes-Benz to offer ADA members between $2,000-$4,000 off the purchase or lease of a new vehicle, including the popular C-Class Coupe and the flagship S-Class luxury sedan. Dr. Chalupnik entered a drawing for the free test drive during the ADA Annual Session. "It was a really nice experience and a very smooth ride," Dr. Chalupnik said of the S550. Members can visit ADA.org/mercedes to browse the vehicles and associated incentives.

VIEWPoint

MyView

The new AAOS/ADA clinical practice guidelines on Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures

David S. Jevsevar, M.D., M.B.A.

Elliot Abt, D.D.S.

The American Academy of Orthopaedic Surgeons and the American Dental Association, along with input from the Infectious Disease Society of America, American Association of Oral and Maxillofacial Surgeons, American Association of Neurological Surgeons, American Society of Plastic Surgeons, Musculoskeletal Infection Society, Scoliosis Research Society, American Association of Hip and Knee Surgeons, Society for Healthcare Epidemiology of America, College of American Pathologists and The Knee Society, recently published their collaborative clinical practice guideline (CPG) "Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures."

This evidence-based guideline, with three recommendations, replaces the previous AAOS Information Statement "Antibiotic Prophylaxis for Bacteremia in Patients with Joint Replacements." That information statement contained differences from a previous advisory statement from the AAOS/ADA published in 2003. The 2003 advisory statement concluded: "The risk/benefit and cost/effectiveness ratios fail to justify the administration of routine antibiotic prophylaxis" for patients with total joint replacements. The 2009 AAOS information statement promoted a different position: "Given the potential adverse outcomes and cost of treating an infected joint replacement, the AAOS recommends that clinicians consider antibiotic prophylaxis for all total joint patients prior to any procedure that may cause bacteremia." It is important to note that an AAOS information statement is "an educational tool based on the opinion of the authors." The American Academy of Oral Medicine followed in 2010 highlighting: " … the major points of concern for a future systematic review by multispecialty collaboration. In the meantime, given that the 2009 information statement is more an opinion than official guideline; the AAOM believes that it should not replace the 2003 joint consensus statement prepared by the relevant organizations: the ADA, the AAOS and the IDSA." This collaborative clinical practice guideline addresses the differences in the previous approaches.

The new clinical practice guideline was developed using the published AAOS CPG development process, and meets or exceeds all recommended Institute of Medicine standards for the development of systematic reviews and clinical practice guidelines except for allowing patient input in the selection of topics and questions. Of note, the AAOS CPG program does not allow members with relevant conflicts of interest, and the collaborating societies followed the same conflict of interest rules in selecting

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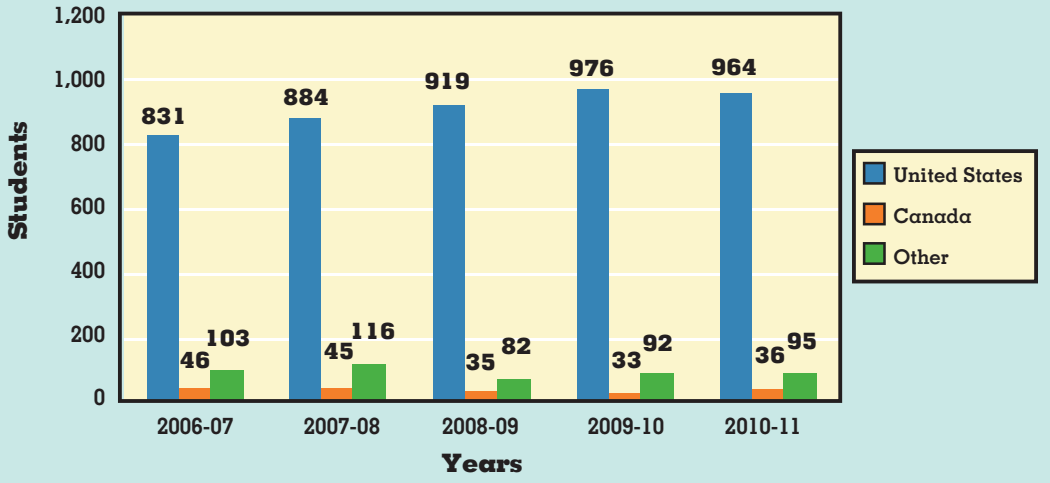
LETTERSPolicy

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; email to ADANews@ada.org.

SNAPSHOTS OF AMERICAN DENTISTRY

General practice residency

Enrollment of U.S. students in general practice residencies increased every year from 2006-07 to 2009-10 before slightly declining in 2010-11.



Source: American Dental Association, Health Policy Resources Center, *2010-11 Survey of Advanced Dental Education.*

Letters

Dr. Brickman

I loved your article "Emory Apologizes For History of Anti-Semitism at Dental School" (Nov. 19, 2012 ADA News). Could you please forward my thanks and appreciation to Dr. Perry Brickman for his dedication in documenting the Emory story?

I want him to know how much I admire his courage and tenacity to research this history, find the others who went through that era and move Emory towards acknowledging injustice. You both have done a wonderful service to our community in sharing this story.

Dan Haberman, D.D.S.
Davis, Calif.

Executive Order 9066

I read with great interest the Nov. 19, 2012 article on dental students of the Jewish faith at Emory University. I would like to remind my colleagues that this same kind of discrimination occurred to Americans of Japanese ancestry in 1942, not only to dental students but to pharmacy and medical students as well.

On Feb. 19, 1942, President Roosevelt issued Executive Order 9066, which resulted in the relocation and imprisonment of over 110,000 Japanese and Japanese-Americans. There were students in professional schools who were kicked out or refused admittance due to their ancestry despite the fact that they were Americans. Many went to camps set up in distant sites by the Department of the Interior, ending their education by this executive order. The University of California sped up the graduation process of their pharmacy students who were soon to be interned in order that these final year students could obtain their diplomas and enter into that profession.

I have knowledge that some displaced dental students were later admitted to Midwestern dental schools like Kansas City, Northwestern, Washington and St. Louis universities, as well as Loyola University in Chicago. I was born in one of those internment camps (Tule Lake Relocation Center in California in 1944) so do not have firsthand knowledge of this experience. I encourage my colleagues who suffered this humiliation to share their stories so that this does not happen again. To our fellow Jewish professionals, we Japanese-Americans can understand what you went through and would like future generations to know that sometimes democracy can be sidetracked but will eventually right itself.

Jerald Satoru Takesono, D.D.S.
Kaneohe, Hawaii

Greatest nation

The story about Dr. Perry Brickman's experiences at Emory reminded me of a colleague of similar age. He's a retired Jewish dentist who played football at University of Tennessee. Since he was a big defensive lineman, his fellow dliners called him a name with a derogatory slur. He told me he never liked that, but tolerated it as part of the South's culture. Many years later, at a class reunion, those same teammates came up to him to offer their sincere apologies.

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MyView

Continued from Page 4

their members. The work group, at its first meeting, developed three recommendations regarding prophylaxis for patients with joint replacements who are undergoing dental procedures. These recommendations formed the basis for systematic reviews of the literature related to dental procedures and periprosthetic joint infection (PJI). The work group also established strict criteria to evaluate the quality of published data and avoid bias.

The AAOS uses predetermined, specific language for its recommendations to avoid bias. The exact wording is governed by the final grade of the recommendation. The three recommendations are accompanied by rationales, with each being graded strong, moderate, limited, inconclusive or consensus. The use of the term limited is definitive; in that it means low levels of evidence exist to support the recommendation. Consensus recommendations can only be proffered by the work group for two reasons: The first is for procedures that have virtually no associated harm, are of relatively low cost and that reflect current, routine clinical practice. The second is when providing (or not providing) a service could result in loss of life or limb. Consensus recommendations are the weakest form of recommendation, and cannot be used to override recommendations derived from higher grades of evidence. Due to the limitations in available evidence, the three recommendations in the current guideline are limited (one), inconclusive (one) and consensus (one). Higher grade recommendations are relatively uncommon within published CPGs.

Recommendation 1 proposes that the practitioner consider changing the longstanding practice of prescribing prophylactic antibiotics for patients who undergo dental procedures.

Recommendation 1 is supported by the highest grade of evidence of the three recommendations, and it proposes that the practitioner consider changing the longstanding practice of prescribing prophylactic antibiotics for patients who undergo dental procedures. The recommendation is founded in evidence that dental procedures are unrelated to PJI and that subsequent antibiotic prophylaxis does not reduce the risk for PJI. There is no conclusive evidence to support otherwise. High strength evidence suggests that antibiotic prophylaxis reduces the incidence of post-dental procedure related bacteremia, but there is no evidence that bacteremia increases the risk of PJI.

Other studies have questioned the use of similar surrogate measures that have not been validated. For example, a study of 4,000 patients assessed the effects of intranasal mupirocin on the incidence of postsurgical infections. Patients who harbor nasal *Staphylococcus aureus* are known to be at risk for surgical site infections and intranasal mupirocin is highly effective in reducing the presence of nasal *S. aureus.* However, no effect on the rate of *S. aureus* infections at surgical sites was noted. This calls into question the use of surrogate measures or outcomes. Dental prophylaxis can be useful in reducing subsequent bacteremia, but bacteremia is a surrogate measure since no direct evidence exists linking bacteremia to PJI.

This is analogous to the differences seen previously between the AAOS clinical practice guideline recommendations on Preventing Venous Thromboembolic Disease in Patients Undergoing Elective Hip and Knee Arthroplasty and those by the American College of Chest Physicians. Previously, the ACCP had used the surrogate measure of deep venous thromboembolism (DVT) as diagnosed by venography or ultrasound in place of pulmonary embolism (PE). Direct evidence of a link between DVT and PE is lacking, so the most recent ACCP Guidelines used direct clinical outcomes as the primary measure of efficacy. To be scientifically and academically consistent, the current dental prophylaxis guideline should use PJI, and not bacteremia, as the primary outcome of interest.

Recommendation 2 addresses the use of oral topical antimicrobials in the prevention of PJI in patients undergoing dental procedures. There is no direct evidence that oral topical antimicrobials prevent PJI following dental procedures. There is conflicting evidence that these agents may decrease the incidence of post-procedure bacteremia. The discussion for this rationale highlights differences between high quality and lower quality studies.

Recommendation 3 is the only consensus recommendation in this clinical practice guideline, and it addresses the maintenance of good oral hygiene. There is no direct evidence for this recommendation. In concordance with consensus recommendations, oral hygiene measures are low cost, provide potential benefit, are consistent with current practice, and are in accordance with good oral health.

The new AAOS/ADA guideline on prevention of orthopaedic implant infection in patients undergoing dental procedures addresses the weaknesses of previous efforts with an exhaustive systematic review of available evidence. Similar to previously published guidelines, the work group identified the need for further research in this area to provide clear evidence regarding the correlation between dental procedures and PJI in patients with orthopaedic implants. Evidence-based practice incorporates three

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Letters

Continued from Page 4

I remember when we arrived in Miami, from Cuba, in 1961. My parents were looking to rent a small room to get started in America. It was not uncommon to see signs that read "No Cubans, No Blacks, No Pets." I've never received any apologies and don't really expect them, but I can see the other side of this and the pain it has to cause exemplary persons like Dr. Brickman, who were born in the U.S. and still treated in that manner. I believe America is the greatest nation and would live nowhere else, but even we are not perfect or infallible.

Carlos A. Sanchez, D.D.S.
Coral Gables, Fla.

Active life members

The ADA website encourages dentists to "Join 70 percent of your colleagues—157,000 member dentists and 16,000 student members." I was able to find out that there are 12,000 of us active life members but I am not sure, with other possible categories, just how many regular dues paying members there are so I used 142,000 for that number.

The dues increase passed for 2013 for the active life membership category (HOD Resolution 51H-2012) is in my view an unconscionable action ("House OKs Changes to Active Life Membership Category," Nov. 5, 2012 ADA News). It is just over a 53 percent increase of the dues structure that has been promulgated for as long as I can remember (once one had 30 consecutive years or a total of 40 years membership in the ADA and attained age 65, the active life category would consist of a 50 percent rate as related to the active membership rate). The new active membership rate increased 2.3 percent for 2013. That is a bit of a disparity (to state it politely). For the active members, their dues represent a $1,420,000 net gain (142,000 members); for the ADA and for the active life members, the ADA gains $1,632,000 (12,000 members).

The total gain for the ADA in dues income would then be $3,052,000. Had each category of membership been assessed 4.03 percent dues increase, the amount would have come very close the same total.

I have come to the conclusion that the active life membership category consists of old guys/gals that have life, disability, office overhead and maybe other forms of ADA-sponsored insurance plans that they simply cannot afford to get or cannot get anywhere else at this time of their lives. They have us where we cannot do anything but pay the dues; never mind that we have been among those that have kept the ADA going over the years as full dues paying members.

Many ADA members cannot afford to have our policies canceled by dropping our ADA membership or retiring. Younger members and the student members may well consider what happens when they become the older members and consider instead belonging only to their specialty group and for certain obtaining their insurance policies outside the ADA-sponsored plans while you still have a choice. I will, with considerable aggravation, pay the dues—I have no choice.

The ADA should rescind HOD Resolution 51H-2012 and live up to its commitments to its life members. It is the right thing to do.

R. P. Lansdowne, D.D.S.
Wichita, Kansas

Editor's note: The Council on Membership appreciates Dr. Lansdowne's perspective on this issue. Active life members are highly valued and integral to the ADA and the dental profession. While all ADA members receive a full range of benefits, in 2012 only 54 percent paid full active dues of $512. The other 46 percent of members received some type of discount. Taking into account all discounts, the average member paid $311 in dues this year, roughly a 39 percent discount from the full dues of $512. The largest contributor to growth in the average discount rate has been rapid growth in the number of members that qualify for active life status. When compared to other membership categories, active life members enjoy a reduction in their dues while receiving the same membership benefits as those paying the full active rate.

MyView

Continued from Page 5

components: scientific evidence, clinician's experience and the patient's values. Therefore, this clinical practice guideline is not meant as a stand-alone document; rather, all three of these elements should be incorporated into the decision-making process in an effort to improve patient care.

Physicians, dentists and patients should work collaboratively to customize a treatment plan that is based on the evidence, clinical judgment and patient preferences.

Dr. Jevsevar is chair of the AAOS Evidence Based Practice Committee that oversees the development of clinical practice guidelines.

Dr. Abt, a member of the ADA Council on Scientific Affairs, served on the AAOS-ADA work group on behalf of the ADA.

Editor's note: The online version of this commentary contains a list of references. Read the commentary at ADA.org/news/8102.aspx.

For more about the new clinical practice guideline, including a Shared Decision Making Tool, see Page 12.

EDUCATION

Council initiates study of criteria, process for specialty recognition

BY KAREN FOX

San Francisco—Based on a charge from the 2012 House of Delegates, over the next year the Council on Dental Education and Licensure will take another look at the criteria and process for specialty recognition to determine if changes are needed.

Dr. Venezie

In October, the House approved Resolution 185H-2012, which directs CDEL to review the process and criteria for approving interest areas in general dentistry and recognizing dental specialties and report to the 2013 House with appropriate recommendations on how to improve the process and evaluation criteria. In the meantime, the ADA will not accept any application for recognition of a specialty in dentistry.

As a first step, Dr. Ronald Venezie, CDEL chair, assigned his council's Committee on Recognition to begin compiling information based on past studies, procedures followed by other health professions and input from the two districts (9th and 17th) that offered resolutions to the House that ultimately resulted in Res. 185H.

"This is not the first time the criteria and process for specialty recognition have been looked at," said Dr. Venezie. "The ADA last conducted a study in 2000-01, and the Committee on Recognition is now reviewing those past efforts. I have asked committee members to come up with a preliminary analysis by the end of January.

"The committee may conclude that we need an in-depth study with input from a broader group of stakeholders," he continued. "On the other hand, the committee may

See STUDY, Page 9

House OKs completion of student debt study

BY KAREN FOX

San Francisco—The Task Force on Dental Education Economics and Student Debt will continue the work it began last year in studying the impact that escalating levels of educational debt has on students.

The House passed the initial resolution in 2011 calling for a comprehensive analysis of the economics of dental education, including student debt and its impact on new graduates and access to care for vulnerable groups, with short- and long-term recommendations. The task force—which includes members of the Board of Trustees, the Council on Dental Education and Licensure, and the New Dentist Committee—began in 2012 by conducting extensive research using data collected from the American Dental Education Association, the Commission on Dental Accreditation, the American Student Dental Association and the ADA Health Policy Resources Center, but did not spend the funds allocated for 2012.

The 2012 House passed Resolution 113H-2012, Dental Education Economics and Student Debt, which reiterated the call for the study with results to be reported back to the 2013 House. The unused funds originally allocated by the 2011 House are to be used to complete the study.

The issue of student debt is on the docket for the 2013 National Roundtable for Dental Collaboration, an annual event that gives dental associations the opportunity to identify and assess common challenges in the delivery of oral health care and work collaboratively to address those challenges. At press time for this issue of the ADA News, the Task Force on Dental Education Economics and Student Debt was scheduled to meet in conjunction with the Jan. 4-5 roundtable. ■

Requirements for specialty recognition stay the same

BY KAREN FOX

San Francisco—The ADA will take more time to work toward consensus on the requirements for specialty recognition to avoid disenfranchising public health dentists who could have been affected by the changes.

That was the directive from the 2012 House of Delegates, which referred Resolution 17 back to the Council on Dental Education and Licensure for further study.

The decision came as a relief to the American Association of Public Health Dentistry. Changing the requirements would have meant that only specialists in public health dentistry would be able to vote or hold office in AAPHD, the sponsoring organization of public health dentistry. All specialty organizations except the AAPHD require officers and voting members to be specialists in the specialty sponsored by the organization. Over the years, AAPHD has had a handful of nondentist members serve in leadership positions. Currently, however, specialists in public health dentistry comprise only 41 percent of the membership of AAPHD, according to data provided to CDEL in 2011.

"This is an opportunity for us as public health dentists to work with our colleagues in the profession to help them understand why our membership structure is different than other specialties," said Dr. Catherine Hayes, AAPHD president-elect. "Our hope is that by increasing dialogue and sharing information, we'll come to a resolution that will be amenable to all."

In May 2012, CDEL passed a resolution stating that voting or holding office in a sponsoring organization of an ADA-recognized dental specialty should be limited to specialists in that discipline. The move was intended to clarify ambiguities that the council identified in the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, said CDEL Chair Ronald Venezie.

"In 2011, as part of CDEL's periodic review of dental specialties, we learned that there were two sponsoring organizations of recognized specialties that permitted nonspecialists and even nondentists to vote and hold office," said Dr. Venezie. "The requirements were vague on this issue, so we looked for a way to clarify the language."

Since that time, one of the sponsoring organizations—the American Academy of Oral and Maxillofacial Radiology—has revised its bylaws to allow only specialists in oral and maxillofacial radiology to vote or hold office in AAOMR.

The council focused on requirement 1(a), which currently states that specialties should be represented by a sponsoring organization whose membership is reflective of the special area of dental practice. In Res. 17, the council proposed to change that to "membership is reflective of that proposed or recognized dental specialty in which the privileges to vote and hold office are reserved for dentists who have either completed a CODA-accredited residency program in that proposed or recognized specialty or a formal advanced education program" and called for all specialties to come in line with the new requirements by 2015.

During the House of Delegates meeting in October 2012, a number of dentists appeared before the Reference Committee on Dental Education, Science and Related Matters to voice their opinions on Res. 17. The reference committee concluded there would be unintended consequences if the requirements were amended as proposed. In the end, the reference committee recommended that CDEL; the Council on Access, Prevention and Interprofessional Relations; the Board of Trustees; and AAPHD further explore options to define the term "reflective" and arrive at a procedure to bring the sponsoring organization of public health dentistry into alignment with other dental specialty organizations. The House then referred Res. 17 back to CDEL.

Dr. Hayes: Testifies before the reference committee.

Dr. Hayes, who testified before the reference committee, explained that public health dentistry is different from clinical specialties.

"In public health dentistry, we learn to apply all that we learned in dental school to a community setting. We evaluate communities; not just patients. There is a broader scope of practice. In doing that, we bring in other people—economists, sociologists and physicians among them.

"The majority of our dentist members of AAPHD are not board-certified public health dentists," she continued. "Someone who practices in a federally qualified health center or the U.S. Public Health Service may not have pursued training to be board certified so they don't have specialty training. The way the resolution was written, only those who completed specialty training could vote or hold office, and that would disenfranchise many of our members."

"The House directed us to take another look at the requirements, incorporate issues raised in reference committee testimony and come back to the 2013 House with a consensus recommendation that brings public health dentistry back in line with other specialties without excluding dentists with appropriate education and/or experience," said Dr. Venezie. "It's a reasonable directive and we will work to achieve that." ■

—foxk@ada.org

Report: Do midlevel providers improve oral health?

BY CRAIG PALMER

An ADA scientific literature review finds no evidence of disease prevention or cost effectiveness associated with midlevel providers such as dental therapists.

"The expert panel and the ADA can be proud of the work that went into this report," said Dr. Robert A. Faiella, Association president. "It is an unprecedented look at these issues." The report's principal author, Dr. J. Timothy Wright, said that "this analysis shows midlevel providers who provide surgical treatment do not result in reduced rates of dental caries in the population. Oral health disparities exist regardless of the provider workforce model."

The January peer-reviewed Journal of the American Dental Association includes the report (jada.ada.org/content/144/1/75.full) on the systematic review with commentaries by Drs. Faiella (jada.ada.org/content/144/1/95.full) and Wright (jada.ada.org/content/144/1/92.full).

The nearly yearlong systematic review responded to a request by the 2011 ADA House of Delegates and addressed the question of whether the use of midlevel providers to conduct diagnostic, treatment planning or irreversible/surgical dental procedures produces change in disease increment, untreated dental disease or cost-effectiveness of dental care.

The study's authors "felt strongly that the conclusions are evidence-based and fully supported by the analysis of the included studies," the report said. A systematic review is a critical assessment and evaluation of all research studies that address a particular clinical issue.

"The potential function and benefit of oral health care workforce models that incorporate midlevel providers, such as dental therapists or dental nurses, remains a highly controversial and politically charged topic in the United States," the report said.

"A variety of studies indicate that appropriately trained midlevel providers are capable of providing high quality services including irreversible procedures such as restorative care and dental extractions. What is less clear is whether midlevel providers can provide these services in a cost effective manner and if incorporation of these providers into the workforce will result in improved oral health of the population."

The authors said they "cast a broad net to ensure inclusivity of all relevant research" that yielded 7,000 references but ultimately provided 18 studies that addressed the clinical question and presented data that could be reviewed. This was "limited evidence that overall has a high risk of bias," the report said.

"All but one of the studies reviewed were conducted on populations outside the United States and most were on school age children, making it tenuous to generalize the results to populations in the United States."

An Association media statement issued with publication of the JADA report said that the review found:

- no difference in the overall caries rates between populations treated by therapists and those treated solely by dentists, as measured by diseased, missing and filled teeth scores;
- a greater decrease in untreated caries in the therapist-treated populations than in dentist-only-treated populations;
- no data that addressed cost-effectiveness, defined as the real cost of reducing disease rates or about diseases other than caries.

"The data show that midlevel providers are not helping stem the tide of the caries epidemic nor reducing the population's need for these services," the report said. "They do help manage the sequelae of the disease and could decrease the negative outcomes that are well-known to occur with untreated dental caries."

"To put it simply, the report shows that if more personnel are treating cavities, more cavities get treated," said Dr. Faiella. "But that does nothing to reduce the number of people getting cavities. And it points up the futility of a delivery system based on surgically treating disease that could have been prevented." ■

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Study

Continued from Page 7

conclude that the current specialty recognition process and criteria are appropriate and work as intended. The council will thoroughly review the committee's recommendations and determine how to proceed from there."

There are currently nine ADA-recognized dental specialties. In 1999, oral and maxillofacial radiology became the first new specialty to be recognized in 36 years. In 2012, a specialty application for dental anesthesiology advanced to the House of Delegates but failed to pass.

"We will take a very careful look at specialty recognition as directed by Res. 185H. We intend to be as thorough and comprehensive as we can and come back to the House with a recommendation as to whether the process should continue as is or should be changed," said Dr. Venezie. ■

Peer review a win for dentists and patients

BY KELLY SODERLUND

A dispute with a patient over his or her dental care can prove frustrating to everyone involved.

Tensions are high, fingers are pointed and many times, both parties come to a standstill. The patient's instinct may be to seek legal assistance, but it's important for him or her to be aware of a more economical and helpful path to a resolution.

"From the patient's point of view and the dentist's point of view, it's best to adjudicate the complaint through the peer review process," said Dr. Jeffrey Galler, chair of the Council on Peer Review and Quality Assurance Committee for the New York State Dental Association. "From a patient's perspective, they want the complaint taken seriously, evaluated fairly, impartially and expeditiously and, if justified, have their fee returned. Dentists want their work to be evaluated by unbiased peers and, in the event of an adverse finding, limit their financial liability to only the money paid by the patient. The dentist would also like for the incident to never be recorded in the National Practitioner Data Bank."

Peer review is offered to members through most of the state dental societies. Each state has a unique program and rules that it follows.

"Having peer review available is a wonderful membership benefit," said Dr. Mark Bauman, chair of the ADA Council on Membership. "Electing to go through the peer review process could potentially save a member the difficulties of going through a malpractice lawsuit. It pays for their membership many times over."

Dr. Bauman

In New York, around 200 complaints are submitted each year, Dr. Galler said, and of those, about 50 are rejected. Unacceptable complaints typically focus on a fee dispute instead of the appropriateness or quality of care. The committee also rejects complaints against dentists who are not members of the tripartite.

A patient who's dissatisfied with his or her treatment has several options to remedy the situation. But none are as easy or can provide as many benefits as peer review, Dr. Galler said.

In New York, a patient could file a complaint with the Office of Professional Discipline of the State Education Department, which issues dentists their licenses in New York. Even if the dentist is exonerated, the investigation process is stressful and the patient doesn't benefit because the patient's money is not returned, Dr. Galler said.

The patient could also file a malpractice lawsuit but that's also not necessarily in the best interest of the patient or the dentist, Dr. Galler said. For the dentist, in addition to being time consuming and stressful, the liabilities are greater and he or she could be reported in the national databank.

It's not a better process for patients, Dr. Galler said. Their attempts to redress their grievances depend on a jury of nondentists who will examine evidence provided by expert witnesses and attorneys skilled at defending their clients.

"Plus, most of these complaints don't involve enough money for a lawyer to be interested in taking the case," Dr. Galler said. "Peer review is clearly the best way to go."

The road to peer review typically starts when a patient calls the local or state dental society to complain about a dentist or treatment they received, Dr. Galler said. The dental society will mail the patient information explaining what peer review is and a contract the patient can fill out if he or she is interested in pursuing peer review.

If the patient sends the contract back, the dental society will begin the process to determine whether the case is acceptable for peer review, he said. If it is, a mediator is assigned and that person calls both the dentist and the patient to determine whether the dispute can be resolved without going through the clinical review process, Dr. Galler said.

"Fifty percent of all cases accepted for peer review are resolved through mediation," Dr. Galler said.

If the dispute can't be resolved in mediation, the case is heard by three dentists, who make a final ruling on whether the patient has a meritorious claim. Almost every case is settled within 30-60 days, Dr. Galler said.

"Complaints are handled expeditiously, impartially and confidentially in a calm, considerate and nonconfrontational atmosphere," Dr. Galler said. "After going through our peer review process in New York, there is a definitive, final resolution to the complaint."

The ADA and the state and local dental societies have used peer review as a recruitment tool to attract dentists to join organized dentistry. The ADA suggests that peer review be offered to both members and nonmembers.

"Peer review is a membership benefit of, for and by members," Dr. Bauman said. "Not only would a dentist want a potential patient dispute resolved by peer dentists, but hopefully by tripartite members whom they might know and trust that they are following the ethical guidelines of the ADA."

Dr. Galler plans to have a local member of the Peer Review Council visit every dental residency program in New York this year to present a simulated peer review hearing. He plans to do the same thing at various component dental society meetings. He's also initiating a program where every year, he'll present a simulated hearing to every senior class in every dental school in the state.

"The purpose of these presentations is to teach what the peer review program is all about. It's also to emphasize that this process is only available to members through their state and local dental societies and it's just one of the many benefits of joining organized dentistry," Dr. Galler said. "And it teaches the residents and students how to avoid some of the common pitfalls that dentists commit that leads them to become the subject of a peer review complaint." ■

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Harris Fund grant recipients take on childhood caries

BY JEAN WILLIAMS

The ADA Foundation awarded 2012 Harris Fund for Children's Dental Health grants to 20 programs engaged in the battle to end early childhood caries.

The Foundation awarded more than $94,000 to the nonprofit organizations, which support programs that work to prevent early childhood caries through educating parents, caregivers and pregnant women on adequate oral health care.

The San Luis Obispo Public Health Department was granted $4,200 for its early intervention and education program targeting children from birth to 5 years and their mothers at Women, Infants and Children's program sites.

"We're using the grant to enhance the educational support materials that we provide to families," said Theresa Anselmo, who manages the Oral Health Program for the San Luis Obispo County, Calif., Public Health Department.

"The other unique thing about this program is, while I'm a dental hygienist, a dental professional working in this WIC clinic, these materials are also distributed by nutritional counselors within the program. They are reinforcing the message," Ms. Anselmo said.

Drs. Paul Chu and Dara Rosenberg direct a grant-winning oral health education program in the pediatric dental residency at St. Barnabas Hospital in Bronx, N.Y. Dr. Chu said the program also educates WIC program recipients. "We educate mothers of the importance of proper oral hygiene, a good diet and establishment of a dental home," Dr. Chu said.

Early education: Dr. Mark Macaoay teaches children about good oral health at St. Barnabas Hospital in Bronx, N.Y., which was a recipient of a 2012 Harris Fund for Children's Dental Health grant.

St. Barnabas used its $5,000 Harris grant to pay for teaching aides, including typodonts, puppets and demonstration toothbrushes. "Many times the mothers bring the children to these WIC sessions, and it's been wonderful," Dr. Chu said.

Dr. Chu, program director of the pediatric dental residency, said the dentists also go beyond the WIC program to educate mothers on how to prevent early childhood caries.

"We're not only performing outreach to the mothers in the area, but we're educating pediatricians and local Head Start programs as well," Dr. Chu said. "The dentists will demonstrate the typodonts for patients as well as the pediatricians themselves. The pediatricians enjoy it and request that we visit their offices more often."

The list of 2012 Harris Fund grant recipients includes:

- Baylor College of Dentistry, Texas;
- Brite Smiles Inc., Minnesota;
- Child Health and Disability Prevention Program, California;
- Community Action Partnership of Sonoma County, California;
- Erie Family Health Center, Illinois;
- Hamilton Health Center, Pennsylvania;
- Joseph M. Smith Community Health Center, Massachusetts;
- Kent County Health Department, Michigan;
- Missouri Coalition for Primary Health Care, Missouri;
- New York University College of Dentistry, New York;
- PRASAD Children's Dental Health Program, New York;
- Public Health Authority of Cabarrus County, North Carolina;
- Saipan Seventh-Day Adventist Dental Clinic, Northern Mariana Islands;
- San Luis Obispo Public Health Department, California;
- Santa Barbara County Education Office, California;
- Southern Jersey Family Medical Centers Inc., New Jersey;
- Southern Nevada Public Television, Nevada;
- St. Barnabas Hospital, New York;
- St. Christopher's Foundation for Children, Pennsylvania;
- Tuolumne Me-Wuk Dental Clinic, California.

The ADA Foundation established the ADAF Harris Fund for Children's Dental Health in 2000 to honor the legacy and spirit of Dr. Samuel Harris, a distinguished pediatric dentist and philanthropist. Dr. Harris made a generous contribution in 1998 to endow a fund for oral health education and prevention of early childhood dental disease. He challenged the then ADA Health Foundation to match his contribution.

Find more information about ADAF programs at www.adafoundation.org. ■

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SCIENCE

Evidence does not support antibiotics for dental patients with joint replacements

BY JEAN WILLIAMS

Following a collaborative systematic review of scientific evidence, the ADA and the American Academy of Orthopaedic Surgeons last month released a co-developed guideline that does not support routine prescription of antibiotic prophylaxis for joint replacement patients undergoing dental procedures.

In developing "Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures," an AAOS-ADA work group conducted a systematic review of existing clinical research published in peer-reviewed journals to determine the correlation between dental procedures and prosthetic joint infection (PJI).

"This guideline was based primarily on clinical research which examined a large group of patients, all having a prosthetic hip or knee and half with an infected prosthetic joint. The research showed that invasive dental procedures, with or without antibiotics, did not increase the odds of developing a prosthetic joint infection," said Dr. Elliot Abt in a Dec. 18 press release. Dr. Abt, a member of the ADA Council on Scientific Affairs, served on the AAOS-ADA work group on behalf of the ADA.

Said David Jevsevar, M.D., M.B.A., chair of the AAOS Evidence Based Practice Committee that oversees the development of clinical practice guidelines, "As clinicians, we want what is in the best interest of our patients, so this clinical practice guideline is not meant to be a stand-alone document. Instead it should be used as an educational tool to guide clinicians through treatment decisions with their patients in an effort to improve quality and effectiveness of care.

"It has been long debated that patients with orthopaedic implants, primarily hip and knee replacements, are prone to implant infections from routine dental procedures," added Dr. Jevsevar who also is an orthopaedic surgeon in St. George, Utah. "What we found in this analysis is that there is no conclusive evidence that demonstrates a need to routinely administer antibiotics to patients with an orthopaedic implant who undergo dental procedures."

The new ADA and AAOS guideline has three recommendations and replaces the previous AAOS Information Statement "Antibiotic Prophylaxis for Bacteremia in Patients with Joint Replacement."

The full guideline, supporting documentation and work group disclosures are posted on ADA.org. Supporting documentation includes commentary on the guideline development and results as well as a tool on how to balance clinical information and treatment options with patient preferences. (See below.)

(See Page 4 for a commentary on the guideline written by Dr. Abt and Dr. Jevsevar.) ■

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Winner: Daryn Lu attends the University of Oklahoma College of Dentistry.

ASDA member receives Turner scholarship

Daryn Lu, a student from the University of Oklahoma College of Dentistry, is the recipient of the American Student Dental Association's 2013 Ryan Turner Memorial Scholarship.

ASDA's board of trustees selected Mr. Lu for the award. He will receive a $2,500 scholarship with an additional $500 awarded to his school's ASDA chapter during ASDA's Annual Session, March 6-9 in Atlanta.

The annual scholarship honors the memory of Ryan Turner, an ASDA national leader and fourth-year dental student at the University of Michigan when he died in 2007.

"The Ryan Turner Memorial scholarship allows its recipients to inspire others and commit themselves to a passionate, lifelong involvement in organized dentistry," said Mr. Lu. "I'm humbled to be a part of those honored few."

Mr. Lu currently serves as his ASDA chapter president-elect. He is the founder and president of the University of Central Oklahoma Predental Society, a mentor in the Big Brothers Big Sisters of Oklahoma, a member of the OUHSC Crimson Club, and founder of the Student Professionalism and Ethics Association in Dentistry chapter at the Univeristy of Oklahoma. ■

Toolkit for discussing antibiotics with patients who have orthopaedic implants

The following is text from the Shared Decision Making Tool: An Aid to Help Balance Clinical Information and Treatment Options with Patient Preferences, authored by David S. Jevsevar, M.D., M.B.A.

More information about this tool is included online and can be viewed at www.ada.org/2157.aspx?currentTab=2#replace.

Shared Decision Making Tool

A Shared Decision Making Tool promotes the collaborative decision making between patient and clinician for best treatment strategy. It is an additional tool to be used and supplements, but does not replace, informed consent procedures.

As a useful aid to the AAOS/ADA Prevention of Orthopaedic Implant Infection in Patients Undergoing Dental Procedures clinical practice guideline, the Shared Decision Making Tool would engage patients in a decision making process and provide information to further clarify the risks, benefits and alternatives to treatment.

Should I take antibiotics before my dental procedure?

Introduction:

You have an orthopaedic implant (joint replacement, metal plates or rods, etc.) from a previous orthopaedic surgery.

• A potential complication of these implants is bacterial infection, which occurs in approximately 1-3 percent of patients. These infections require more surgery as well as antibiotic usage for an extended period of time. Most infections occur around the time of the procedure (within one year), but some have occurred much later.

• In theory, late implant infections are caused by the spread of the bacteria from the bloodstream to the implant. Unfortunately, there is no clear scientific evidence to support this theory. We know that many patients with orthopaedic implants frequently have bacteria in their blood that does not spread to their implants.

Dental procedures have long been considered a potential cause of implant infections even after the initial orthopedic postoperative period.

This is because dental procedures can introduce bacteria from the mouth into the bloodstream. However, this fact should be considered in the context that eating and performing oral hygiene at home may also introduce oral bacteria into the blood.

• Traditionally, antibiotics have been provided prior to dental procedures in patients with orthopaedic implants to minimize the bacteria that get into the blood.

• Best evidence, however, does not show that antibiotics provided before oral care help prevent infections of orthopaedic implants.

• The routine use of antibiotics in this manner has potential side effects such as increased bacterial resistance, allergic reactions, diarrhea and may even cause death.

Patients who have compromised immune systems might be at greater risk for implant infections.

• Diabetes, rheumatoid arthritis, cancer, chemotherapy and chronic steroid use are examples suggesting immunosuppression. Please discuss your potential for immunosuppression with your physician or dentist.

• Patients who are immune-compromised might wish to consider antibiotics before dental procedures because of their greater risk for infection.

• Decisions with regard to antibiotic premedication should be made by patients, dentists and physicians in a context of open communication and informed consent.

Questions:

1. Patients with orthopaedic implants have which of the following:

a. 0 percent chance of infection
b. 0-1 percent chance of infection
c. 1-3 percent chance of infection
d. >3 percent chance of infection

2. Most implant infections are:

a. Related to dental procedures
b. Occur around the time of surgery
c. Related to skin infections
d. Occur long after surgery

3. Some dental procedures:

a. Routinely cause implant infections
b. Are the primary source of implant infections
c. Never cause implant infections
d. Allow bacteria to enter the bloodstream

4. Routine pre-dental procedure antibiotics are:

a. Not supported by current evidence
b. May be beneficial in certain groups of patients
c. Associated with other unwanted side effects
d. All of the above

Patient Checklist:

1. I have adequate understanding of implant infections associated with dental procedures: __ Yes or __ No
2. My physician/dentist has discussed my specific risk factors with me: Yes or No
3. I need further education and discussion on this issue: __ Yes or __ No
4. I am immunocompromised because I have: *(specify condition)* _____
5. Based on this educational material and discussion, I will: Not take antibiotics before my dental procedure OR take antibiotics before my dental procedure. ■

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1. Study methodology described in: van der Meer WJ, et. al. (2012). Application of Intra-Oral Dental Scanners in the Digital Workflow of Implantology. PLoS ONE 7(8):e43312. doi:10.1371/journal.pone.0043312.
Additional measurements conducted by ACTA (Academic Center for Dentistry Amsterdam); Wicher J. van der Meer, et. al. (2012). Publication pending.

YOUR HEALTH

NIH promotes blood test that can diagnose type 2 diabetes

The National Institutes of Health has released a fact sheet that provides greater awareness on diabetes, which affects 26 million people nationwide.

Around 7 million Americans currently have diabetes but don't realize it, putting them at risk for serious complications that can arise when the disease is left untreated.

The fact sheet describes a blood test called A1C, which can diagnose type 2 diabetes and prediabetes. Prediabetes raises the risk for developing type 2 diabetes.

Diabetes is a chronic disease that affects your body's ability to process sugar.

The resulting high blood sugar can cause problems with your eyes, nerves, kidneys, heart and other parts of your body.

Diabetes can lower your resistance to infection and can slow the healing process.

Taking the test is more convenient than the other glucose tests often used to diagnose diabetes because there's no need to fast. The A1C test can also help patients with type 1 and 2 diabetes monitor their blood sugar levels.

Seventy-nine million Americans have prediabetes and are at risk for developing type 2 diabetes, according to the American Diabetes Association, which estimates that the total national cost of diagnosed diabetes in the U.S. is $174 billion.

The fact sheet covers a wide range of details about the A1C test, including how the test works, other blood tests for type 2 diabetes and prediabetes, the accuracy of blood tests and more.

The A1C Test and Diabetes fact sheet is available at www.diabetes.niddk.nih.gov/dm/pubs/A1CTest.

Or contact NIH's National Diabetes Information Clearinghouse at 1-800-860-8747 or email ndic@info.niddk.nih.gov.

People with diabetes are at greater risk of developing some oral health problems, including gum disease and fungal infections, according to the American Dental Association.

Good oral hygiene habits, including professional cleanings at the dental office, are important to control the progression of gum disease and other oral health problems, the ADA says.

Regular dental checkups and periodontal screenings are important for evaluating overall dental health and for treating dental problems in their initial stages.

To learn more about what the ADA has to say about diabetes and oral health, visit www.MouthHealthy.org, select A-Z topics and choose "D" to find the listing for diabetes. ■

—Source: National Institutes of Health

Register for opioid prescribing webinars in 2013

ADA continues educating members on how to treat pain

BY KELLY SODERLUND

The ADA will continue educating members on prescribing opioid medications and drug abuse through two webinars scheduled this winter.

"Opioid Prescribing-Spokane County Dentists," will be held at 2 p.m. CST Jan. 23.

Amy Riffe, an epidemiologist in the community health assessment, planning and evaluation area of the Spokane Regional Health District, will discuss a survey that was conducted in Washington's Spokane County that examined dentists' prescribing practices around opioid medication.

"A Statewide Evaluation of Opioid Prescribing Patterns with an Emphasis on Drug Diversion and Substance Abuse" will be presented by Michael O'Neil, professor of pharmacy practice at South College in Knoxville, Tenn., at 2 p.m. CST Feb. 20.

The webinars are part of a sub-award the ADA received from the American Academy of Addictive Psychiatry from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, which received a grant to create webinars and training on treating pain and opioid addiction. The center is paying for the Prescriber's Clinical Support System for the Appropriate Use of Opioids in the Treatment of Pain and Opioid-related Addiction, which is a collaborative effort among a handful of medical associations that will provide training and education on the topic.

Those who participate in the Jan. 23 webinar are eligible to earn one hour of continuing education credit.

To register, contact Alison Siwek, manager of dentist health and wellness for the Council on Dental Practice, at siweka@ada.org or 1-312-440-2622.

The ADA will also host the 2013 Conference on Dentist Health and Wellness at its headquarters Sept. 19-20.

The conference will focus on opioid prescribing and abuse prevention, general health issues, stress, burnout, ergonomics and addiction issues.

For more information, contact Ms. Siwek. ■

—soderlundk@ada.org

ADA launches Dental Symptom Checker

BY KAREN FOX

A patient has a mildly painful blister on the tip of the tongue. What is it?

As dentists know, it could be any number of things.

To provide patients with accurate information about their symptoms and help them make better-informed decisions about their oral health, the ADA has introduced the ADA Dental Symptom Checker on MouthHealthy.org.

After entering their age and gender in the Symptom Checker, patients can identify the location of the symptom they're having and other factors, such as pain or discharge, and read about various conditions that fit that description.

The Symptom Checker is not meant to diagnose or replace the role of the dentist. In fact, many of the conditions emphasize the importance of seeing a dentist or physician.

The ADA Dental Symptom Checker was developed by the Association in conjunction with an ADA member dentist who is a faculty member at an accredited U.S. dental school. Four ADA councils vetted the Symptom Checker.

The ADA launched the award-winning MouthHealthy.org website in June 2012 to reach the 80 percent of Internet users who seek health information online.

Consumers can find oral health concerns organized by life stages, A-Z topics with videos, ADA Seal of Acceptance products, and tips and activities to make oral health care fun for kids.

In developing MouthHealthy.org, a symptom checker tool was identified as the top feature requested by consumers.

The ADA Dental Symptom Checker is now available as an interactive Web platform on MouthHealthy.org, as well as a downloadable app on iTunes and Google Play.

Visit MouthHealthy.org and check out the new tool to help build consumer awareness of the importance of oral health and visiting a dentist regularly. ■

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Evidence-based dentistry

ADA/Forsyth Institute course attracts diverse group of dental professionals

BY JEAN WILLIAMS

Cambridge, Mass.—They were orthodontists, endodontists, prosthodontists and general dentists. They were professors, associate professors, instructors and lecturers. They were chairmen, senior partners, deputy directors and directors.

And they all had one goal: learn the primary aspects of evidence-based dentistry.

All 40 participants made inroads to that end when they attended the ADA/Forsyth Institute's 2012 EBD Course Nov. 5-9. The course is a collaboration of the ADA Center for Evidence-Based Dentistry and the Forsyth Institute, where the interactive program has taken place since 2009.

The weeklong course reaches for a comfortable mean in imparting the basics of EBD to participants with varying frames of reference for practice.

"Roughly half are private practitioners and the other half are in academia," said Dr. Elliot Abt, who has taught biostatistics at the ADA Forsyth course since its inception. "The participants in academia are department chairs, some in public health or epidemiology. They may have a strong background in methodology and statistical analysis, while others would not."

Dr. Abt, who is also a member of the ADA Council on Scientific Affairs, indicated that participants are introduced to the rigors of vetting scientific literature in order to translate research findings into clinical practice.

"When it comes to research design and statistics, the Forsyth course is not really about how to design a research project or run statistical tests," Dr. Abt said. "It's much more focused on how to interpret the methodology and statistics that are used in a paper. So if one reads a randomized trial, a systematic review or an observational study, the questions might be, 'What methods were used? Was this an appropriate study design? Were the statistical tests appropriate? And, how does one interpret and apply the results to my clinical practice or academic environment?' "

Other EBD instructors included course leaders Dr. Richard Niederman, director of the Center for Evidence-Based Dentistry at the Forsyth Institute; Dr. Derek Richards, director of the Centre for Evidence-Based Dentistry at Oxford University; and Julie Frantsve-Hawley, Ph.D., senior director of the ADA Center for Evidence-Based Dentistry. They lectured on EBD topics such as question formulation, critical appraisal of diagnostic tests, MEDLINE searching and citation management, and systematic reviews and meta analysis.

The ADA Center for Evidence-Based Dentistry defines EBD as "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 needs and preferences."

The course was open to all dentists, members of the dental team, educators and researchers from both the United States and the international community.

Dr. Cheng

"EBD is changing our profession, redefining what true informed consent is with current relevant evidence disclosed for each individual patient," said participant Dr. Linda Cheng, an assistant professor in the Department of General Dentistry at Texas A&M University Baylor College of Dentistry.

"The course was an incredible opportunity to meet other colleagues from all different backgrounds, all different regions of the United States, and all over the world. I am grateful to the ADA for making this course possible and that I had an opportunity to take part in it."

The Forsyth Institute, which is affiliated with Harvard University, was founded more than a century ago to provide charitable dental care to children in Boston. Today it is dedicated to promoting oral health through research and education.

Participants earned continuing education credits from the ADA and a certificate in EBD from the Forsyth Institute.

For more information about the 2013 ADA and Forsyth Institute EBD course, set for Oct. 14-18, contact Erica Vassilos, manager of the ADA Center for Evidence-Based Dentistry, at 312-440-2523 or vassilose@ada.org. ■

2013 EBD Champions Conference planned

Take a first step in the journey toward EBD by attending the ADA Evidence-Based Dentistry Champions Conference, April 25-27 at ADA Headquarters.

Participants will be chosen through a competitive selection process. Only 100 dentists may participate in the 2013 conference. Early application is encouraged.

For more details, contact Erica Vassilos, manager of the ADA Center for Evidence-Based Dentistry, at 312-440-2523 or vassilose@ada.org. ■

Dr. Shinn

Continued from Page 1

bulb went off in his head. He suddenly remembered he was a dentist and could help figure out what was wrong.

"She was a 5-year-old girl and was swollen from temple to armpit with a life-threatening, systemic infection caused by abscessed teeth," he said. "She was miserable and would probably die without some help."

Dr. Shinn was planning to spend part of his last day visiting Hillary Hospital in Khunde, founded by mountain climber, explorer and philanthropist Sir Edmund Hillary. The hospital was 2,000 feet up from the lodge. Dr. Shinn convinced the girl's relatives to let him take little Sonam Sherpa to the hospital to see if a doctor could help her.

"I was scared," he said. "She was really sick. I had to climb up 2,000 feet with her and I prayed all the way that nothing bad would happen to her while she was in my care."

When they arrived, Dr. Shinn said the doctor encouraged him to treat the girl himself. After digging around for awhile, the doctor handed Dr. Shinn a shoe box filled with broken dental instruments rusted together and covered with a fuzzy mold.

"He told me, 'You are a dentist, so you will know what to do.' There was no electricity or sterilization. No sutures. He handed me some glass vials with Chinese writing that I hoped was anesthetic. All I had was my pocket knife. It was an awkward situation. This was a hospital, and they didn't have anything for dental emergencies."

Dr. Shinn said the courageous little girl didn't cry and made it through the extractions with flying colors. Other people at the hospital asked him to look at their teeth, too.

"When it was time to go, I was a little frustrated," he said. "I had planned to take a picture of the sunset on Mount Everest and was running out of time to do that. I thought I would need to carry weakened Sonam back down the steep hill. We walked to the edge of the mountain and could see her village 2,000 feet below. When she recognized her house, she suddenly started running down the rocky switchbacks like an antelope. I was in the best physical shape of my life but there was no way I could have caught up with her. Somehow she knew she'd be OK now and was happily running back home.

"I stood in wonderment watching her and I felt an immense feeling of shame come over me," said Dr. Shinn. "How dare I be selfish enough to worry about taking a photo when kids were dying here every day from abscessed teeth? Tears were streaming down my face. I thought, 'I need to do something about this.'"

Dr. Shinn vowed he would return to Nepal with toothbrushes and educate teachers and families about the importance and the process of preventive oral health care.

"When I got home I started collecting toothbrushes. I went back 18 months later. A simple toothbrush there is a lifesaving tool. It is such a powerful thing to hand out. I saw the value of it and I was hooked. I wanted to do more."

He now averages about four international trips a year with volunteer teams providing dental care, teaching oral hygiene, training and supplying local providers, and improving maternal and infant health by upgrading conditions in rural labor and delivery rooms. He jokingly admits he feels very at home on an airplane. Since 1990, he has volunteered in some 40 countries, including Costa Rica, Bolivia, the Cook Islands, Micronesia, Guatemala, Jamaica and Uganda.

At home in Washington state, he served as the dental director and is now a staff dentist for Lindquist Dental Clinic for Children, a community-based, private nonprofit clinic that sees more than 30,000 patient visits each year by children from low-income families.

"The volume of patients at the clinic speaks to the demand even in the United States," Dr. Shinn said. "We take care of them, give them a positive experience and give their parents a place to bring their children without worrying about how much it will cost. The per capita income in our area is higher than the national average and we still have a tremendous need. I can't imagine what it's like in more depressed areas suffering from the effects of today's economy."

Early on, Dr. Shinn set up a nonprofit foundation to establish dental health education and outreach programs in developing countries. He has trained and mentored hundreds of volunteers and says that many of them have gone on to start their own programs.

"I love to help other people have the same experience. It takes a lot of time to get people ready for their trips, from travel arrangements and accommodations to other details. You want it to be easy and predictable for volunteers, so they can show up and get right to work. Never in my wildest dreams did I think it would have grown into what it's like today. It's humbling to see how people are afflicted and know that you have the capability to fix it. That's what we dentists do."

He tells colleagues that volunteering leads to fulfillment, whether you're ladling out a meal

Mobile clinic: Dr. Shinn's outreach has extended to the Bwindi Impenetrable Forest of southwest Uganda, where he set up a dental clinic in a school.

AMERICAN DENTAL ASSOCIATION
HUMANITARIAN AWARD

Family: Dr. Shinn is surrounded by his wife and children, from left, Shaleena, Yasmeen, Tomar, Jim-Nasser and his wife Faria. Dr. Shinn met Faria while volunteering in Uganda.

African scenery: Dr. Shinn used his camera to document the scenery on his way to and from work during his trips.

Himalayan adventure: A youngster waits in the dental chair for treatment during Dr. Shinn's first outreach trip to Nepal.

in a local soup kitchen, serving as a big brother or big sister or working at a Special Olympics event.

"You don't have to crawl through the jungle to find fulfillment," he said. "It's right outside your door. And volunteering makes life so much more delicious and exciting and worth living. When you work for money, you can have all the things money can buy. When you work unconditionally, you get to have all the things money can't buy."

In 2002 he worked with Great Shape!, a nonprofit organization that provides health care and education in Jamaica, to establish the 1000 Smiles Project—one of the world's largest international humanitarian dental projects that serves 15,000 Jamaicans each year.

"We are in our 10th year with 1000 Smiles, and the model we developed focuses on prevention, training local health care workers, and lobbying with local governments to spend their health care budgets on prevention instead of emergency care. This model should be able to work in other countries and make an impact beyond the level of an individual village," he said. "At first it was exciting to me to go to a remote area and provide dental care. I was an adventurer. Treating Pygmies in Africa was an amazing experience, for instance. But as I get older, I see that having more people get involved in changing the culture of health care delivery in a country has a much more significant impact."

Dr. Shinn's travels also had a significant impact on his personal life. While volunteering in Uganda, he met his wife Faria. The couple have four children, Jim-Nasser, 8; Yasmeen, 6; Shaleena, 5; and Tomar, 2. Dr. Shinn also has two grown children, Josef and Michael, and four grandchildren.

It has been 22 years since Dr. Shinn treated Sonam Sherpa in Nepal. She recovered from her infection and went on to become a national badminton champion in Nepal. A few years ago, she and her parents and her sister moved to Ashford, Wash.—about an hour and a half away from Dr. Shinn. She just graduated from nursing school, and her sister sometimes babysits for Dr. Shinn's children.

"My life changed totally in Nepal that day, and for the better," said Dr. Shinn. "I lived in an upper middle class community where people went to the dentist and had insurance. The vast majority of the world is suffering from a lack of dental care and a lack of understanding about it.

"The best jobs in developing countries are service industry jobs. It doesn't matter how qualified you are, you won't get the job if you don't have a pleasing smile. A nice smile adds to the ability to get a good job and take care of your family. If you teach preventive care to your children, they will have better nutrition and be healthier because they can chew painlessly. They will learn better in school, and have stronger immune systems. The cycle of dental disease impacts a family's success and longevity. But we know how to take care of it. We can change lives."

Dr. Shinn has received many accolades for his work, including the Washington State Dental Association 2003 Citizen of the Year and the 2003 National Jefferson Award, the nation's highest honor for public service. He is the co-founder of "International Smile Power," and the co-founder and current president of "For World Wide Smiles," which is planning trips to Uganda, Jamaica, and Haiti in 2013. He is also the author of "Confessions of a Modern Dentist" and lectures on How To Make Your Dreams Come True, Raising Self-Esteem and Empowering Yourself and Others, and Maximizing The Fulfillment Factor In Dentistry and Life Through Volunteerism.

"I would like to sincerely thank Dr. Shinn for his contributions to the dental profession and congratulate him on being the 2013 recipient of the American Dental Association Humanitarian Award," said Dr. Robert A. Faiella, ADA president. "This prestigious award is designed to recognize an ADA member who has made a lasting impact on the oral health of their fellow human beings. It is clear that Dr. Shinn has changed the lives of individuals and motivated other health care professionals to get involved and to give their time and resources to those in need."

"I can't say how humbled and appreciative I am to receive this award," Dr. Shinn said. "When Dr. Faiella called me, I had tears running down my face. I was so amazed by this huge honor and I so much appreciate it. I will make sure I continue to work to deserve it. I'm really, really blown away by the whole thing."

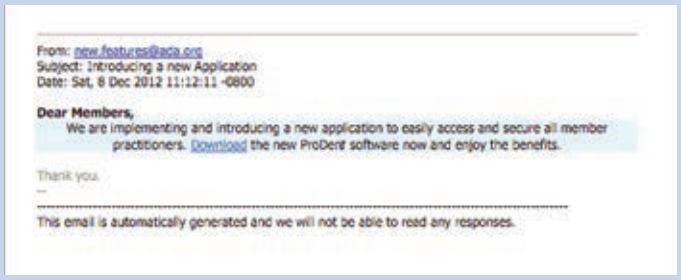
Dr. Shinn will receive a plaque and a $5,000 donation to For World Wide Smiles during the ADA's 154th annual session in New Orleans Oct. 31-Nov. 3.

The ADA Division of Global Affairs is now accepting nominations for the 2014 ADA Humanitarian Award. To download the nomination packet log on to www.ada.org/1477.aspx. ■

—croziers@ada.org

Have you received spam email? Hit delete

BY KAREN FOX


From: new.features@ada.org
Subject: Introducing a new Application
Date: Sat, 8 Dec 2012 11:12:11 -0800

Dear Members,

We are implementing and introducing a new application to easily access and secure all member practitioners. Download the new ProDent software now and enjoy the benefits.

Thank you.

This email is automatically generated and we will not be able to read any responses.

Another spam message appearing to come from the ADA has turned up in members' email boxes.

It's not the first time this has happened and probably won't be the last. The latest spam began popping up around Dec. 8 in the email accounts of an unknown number of members and others in the dental community. The email subject line reads "Introducing a new Application" and states: "Dear Members: We are implementing and introducing a new application to easily access and secure all member practitioners. Download the new ProDent software now and enjoy the benefits."

Recipients of the message (pictured above) are encouraged to delete it. Don't open the message or attempt to access the link contained within it. This is an attempt to trick you into clicking on the link to "download" software, which may result in an attempt to infect your computer with a virus or to trick you into providing personal information.

The email is not a communication from the ADA and the ADA is not the source of the member email addresses to which the spam was sent. The ADA does not sell, rent or publish in any way the email addresses of current or former member dentists in our database. Legitimate emails from the Association are distributed in one of the standard ADA email formats, as members are accustomed to receiving.

Members should alert their dental team to the spam email and contact the ADA Member Service Center at 1-312-440-2500 with questions or concerns. ■

QuickTakes

Summaries of ADA News stories published online

ADA Standards Committees to meet in February and March

The ADA Standards Committees and the U.S. Technical Advisory Group for the International Organization for Standardization Technical Committee 106 Dentistry will meet in February and March.

The ADA Standards Committee on Dental Informatics will meet in Chicago, Feb. 18-20 at ADA Headquarters. For more information on the ADA SCDI meeting, contact Paul Bralower at 1-312-440-2500, Ext. 4129 or email bralowerp@ada.org.

The ADA Standards Committee on Dental Products and the U.S. TAG for ISO/TC 106 Dentistry will meet March 18-20 in Seattle at the Washington State Convention Center, 800 Convention Place, Seattle, WA, 98101.

Although there is no charge, registration is required to attend Standards Committee on Dental Products/U.S. Technical Advisory Group meetings and events. Call 1-312-440-2500, Ext. 2533 or email medick@ada.org for registration information.

To read the full story, visit ADA.org/news/8098.aspx. ■

AAE Foundation seeks applicants for $2.5 million research fund

The American Association of Endodontists and its AAE Foundation are seeking applications for up to $2.5 million in funding to support one or more research projects to investigate regenerative endodontic treatment.

Applications are due Aug. 1. Download guidelines and application from www.aae.org. To read the full story, visit ADA.org/news/8063.aspx. ■

Penn research offers new way to halt periodontal disease

Scientists at the University of Pennsylvania have demonstrated an ability in mouse model to prevent periodontitis from developing and stymie the progression of the disease once it's already occurred.

The new strategy works by blocking a molecular receptor that bacteria normally target to cause the disease. Published in the Journal of Immunology, the study was led by postdoctoral researcher Dr. Toshiharu Abe and expands on previous research by Penn professors Dr. George Hajishengallis and John D. Lambris, Ph.D. They are now working to replicate their success in mice in other animal models, an important step toward extending this kind of treatment to humans with gum disease.

"The complement inhibitors, some of which are in clinical trials, developed by my group are now tested in various periodontal disease animal models," Dr. Lambris said, "and we hope soon to initiate clinical trials in human patients."

To read the full story, visit ADA.org/news/8095.aspx. ■

Oral health abstracts sought for 2013 public health meeting

The American Public Health Association Oral Health Section is accepting abstract submissions for individual paper presentations and posters for its 141st annual meeting in Boston, Nov. 2-6.

Deadline for submissions is the week of Feb. 4-8. Presenters must be individual members of APHA and register for the meeting.

See the complete article at www.ada.org/news/8082.aspx. ■

Cancer publishes letter on controversial dental X-rays study

Cancer, the journal of the American Cancer Society, has published a letter by Dr. William Calnon, immediate past ADA president, titled "Shortcomings of Study on Dental X-rays and Risk of Meningioma."

The letter has been published online in Cancer. It also will be published in its Jan. 15 print edition. In his letter, Dr. Calnon addresses "Dental X-rays and Risk of Meningioma," a controversial study published in the online version of Cancer in April 2012. ■

GKAS

Continued from Page 1

ADA News (on ADA.org) to adanews@ada.org as soon as possible following your event.

Program coordinators can also post photos on the new ADA GKAS Facebook page (www.facebook.com/GiveKidsASmile). Clinical photos submitted for the site should also show dental professionals using universal precautions.

With GKAS Day just a few weeks away, a total of 1,668 GKAS events have registered, and estimate they will treat nearly 393,000 children on or around Feb. 1. Nearly 9,400 dentists and almost 31,000 other dental team members and lay volunteers will be providing care to kids in need through GKAS programs.

Programs are encouraged to register if they haven't done so yet—either before or after their events, and all program coordinators/dentist participants are asked to report their actual program totals following their events. Log on to www.givekidsasmile.ada.org.

GKAS corporate sponsors continue to generously support the program. Henry Schein Dental will provide professional dental kits containing gloves, patient bibs and bib holders, masks, plastic cups, tongue depressors, gauze pads, dental floss, prophy angles and paste, fluoride varnish and chair sleeves. Colgate Palmolive Co. has donated toothbrushes and toothpaste. DEXIS Digital X-ray Systems will donate the use of their X-ray units and the expertise of their staff to U.S. dental schools requesting assistance, state associations and large group practices during GKAS. ■

Photo by Steve Horne

Kellogg graduates: Seated from left are Dr. Tami Schwartzman; Dr. Elizabeth Demichelis; Siraj Haque; Dr. Dawn Harvey; Dr. Amerian Sones; Virginia Moore; Jody Arrowsmith; Dr. Nihal Bicakci; and Marianne Sturtevant. Standing are Dr. Yogi Chen; Dr. Vageesh Sabharwal; Dr. Sukhminder Pannu; Dr. Todd McGovern; Dr. James Reichle; Dr. Michael Mundenar; Dr. Gurjit Randhawa; Sean O'Donnell; Dr. Michael McDill; Dr. Thomas McNeely; Dr. Joshua Jeon; Dr. Tony Lee; Dr. Allen Huang; Dr. Edward Finnigan; Dr. Michael Glick; and Dr. Grace Thomas. Not pictured is Dr. Dorothy Anasinski.

2012 Kellogg Executive Management Program graduates complete studies

Twenty-six graduates completed their studies in the 2012 ADA Kellogg Executive Management Program, earning certificates in ceremonies Dec. 4, 2012.

ADAKEMP is an intensive business education program at the Northwestern University Kellogg School of Management designed for dentists to learn the core principles of an MBA program that gives participants an opportunity to expand their business and management experience. Topics include business strategy, organizational leadership, marketing, finance, accounting, economics, statistics and operations.

Twenty-one of this year's graduates were dentists; the remainder consultants and practice managers. For more information about the program, visit ADA.org/kellogg. ■

ADA's MouthHealthy.org named among 'most creative communication vehicles'

BY KAREN FOX

The ADA's MouthHealthy.org consumer website has garnered an award in an annual contest for association media.

MouthHealthy.org won the bronze award in the website category in the Association TRENDS 2012 All-Media Contest. Award winners were announced Dec. 12. MouthHealthy.org was one of more than 420 entries in 22 categories of association communications.

Held annually, the competition recognizes the most creative and effective communication vehicles developed in the industry over the prior year. It's sponsored by Association Trends, a news publication for association professionals.

The ADA launched MouthHealthy.org in June 2012 to provide the latest information to help patients make informed decisions about their oral health. MouthHealthy.org—available in Spanish translation as well—includes timely and credible information on prevention, care and treatment with in-depth content, videos and a highly engaging presentation.

Topping the All-Media Contest website category were the websites ThisWayToCPA.com (gold award) from the American Institute of CPAs, and AssociationsNow.com (silver award) from ASAE: The Center for Association Leadership.

Along with other winners, MouthHealthy.org will be honored at the 34th Annual Salute to Association Excellence Feb. 15 at the Capital Hilton in Washington, D.C. ■

Tax

Continued from Page 1

assessing the tax on bridges or customized crowns they make in their dental offices. Since neither bridges nor customized crowns appear on the FDA list, the answer is no, according to the Association's legal division.

If any components that the dentist uses to fabricate the customized devices are on the FDA list, however, the manufacturer or supplier will add the tax and the dentist will pay it at the time of purchase. As another example, a restoration is not subject to the tax but the material used for the restoration—gold or amalgam, for example—will be subject to the tax and collected by the manufacturer or supplier from the dentist, since both materials appear on the FDA list.

The ADA is communicating with labs concerning the importance of applying the tax correctly.

This also means that if a dentist purchases, for example, a finished bridge from a domestic dental lab, the excise tax should not be applied to the item. Instead, any price increase in the product should only reflect the amount of excise tax the manufacturer paid when it purchased the materials it used to make the bridge or finished crown. The IRS has not yet determined how it will treat such finished items when they are purchased from offshore labs.

The examples given here are not meant to represent the whole scope of the law, but to bring to dentists' attention some of the possible real-life applications of the tax.

Some dental labs have sent the dentists they work with letters explaining their interpretation of how the tax works. At this point, there may be some differences of opinion among various stakeholders as to how the tax is to be applied. The ADA is communicating with labs concerning the importance of applying the tax correctly.

The ADA continues to urge Congress to repeal this tax. The Association will continue to track developments and relay information to members as it receives it. ■

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