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OFFICIAL MAGAZINE OF THE NEVADA DENTAL ASSOCIATION AND COMPONENT SOCIETIES

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Dear 2012 American Dental Association House of Delegates

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In 1985, the American Dental Society of Anesthesiology (ADSA) Past President and Oral and Maxillofacial Surgeon (OMS) Norman Trieger quoted findings from the National Institute of Dental Research in his paper *The Specialty of Anesthesiology in Dentistry*, "It is one of history's ironies that the dental profession continues to bear the onus of pain in many people's minds when, in fact, it was the dental profession that pioneered the development and use of the first effective anesthetics."[1]

Many dentists are weary of the profession being the genesis of ubiquitous comedy skits. Audiences routinely roar visceral approval about the "funny" aspects of others dealing with the anxiety, pain, and suffering popularly associated with dentistry. As reported in the *Journal of the American Dental Association*, humorists from Mark Twain to W.C. Fields, to Bob Hope and Bill Cosby, to Steve Martin and even an animated Nemo, have dental material ready to go prn.[2] Relatively few practicing dentists avail themselves of advanced techniques that render even the most challenging patient's anxiety, pain, and suffering a nonissue.

One hundred years ago, Edgar "Painless" Parker was the target of organized dentistry's criticism, in part, for his then-controversial advocacy for the routine administration of local anesthesia. According to Parker, a main reason patients avoided the dentist was fear of pain.[3] The Centers for Disease Control and Prevention, the U.S. Surgeon General, the ADA, and others, have confirmed Parker's opinion that millions upon millions of potential patients fearfully avoid dentistry.[4–6] 2012 research continues to document that: "…dental anxiety… should never be downplayed."[7]

In 1983, ADSA founding member and OMS Morgan Allison recalled the work required to establish the ADSA with a "…cautious American Dental Association, disinterested American Association of Dental Schools, an antagonistic American Association of Oral Surgery, and an aloof and condescending American Society of Anesthesiologists (ASA)."[8] Some things never change, and anesthesia in dentistry has not progressed as it has in other professions. With regard to the ADA, certainly at times it is good to proceed cautiously, but does dentistry's gift to the world, enthusiastically accepted and developed elsewhere, really need more scrutiny before dentistry itself fully incorporates it? Even veterinary medicine has a specialty in anesthesiology. We all love our pets, but do animals deserve more anesthesia expertise than humans?

Dentist anesthesiologists have greatly profited all the health professions, even if for only a relatively small number of fortuitous dental patients at the end of the day. Beginning in the 1970s, students at the University of Southern California School of Dentistry learned advanced pain control techniques from new professor and dentist anesthesiologist (DA) Stanley Malamed. We did not realize how fortunate we were to have someone so uniquely qualified to teach

Continues ➲

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control of anxiety and pain. In the decades since, even Malamed's local anesthesia continuing education courses have drawn standing-room only audiences, evidencing that dentists are generally not taught other than the most basic levels of pain control in dental school.

Primary purposes of the nascent ADSA, supported by preeminent OMS members such as future AAOMS Presidents Harry Seldin, Fred Henny, Edward Thompson, Daniel Lynch, Daniel Laskin, and William Wallace, included fostering much greater numbers of quality anesthesia education opportunities at both undergraduate and the graduate levels. Vol. 1, No. 1 of the *ADSA News* emphatically mentioned the establishment of a specialty to advance these purposes…three times in the first three paragraphs. Today, a significant majority of dental schools still do not have dedicated DA professors.

The motivation for the establishment of the ADSA and a specialty in 1953 is informative. Dentistry was then, as it is now, under constant scrutiny, and cyclical attack, with regard to the provision of anesthesia. For instance, in 1983 serious misinformation about anesthesiology in dentistry was promulgated by two *20/20* programs, resulting in a wave of significantly more unwarranted patient anxiety across the country. Dentistry has always needed articulate anesthesiology trained spokespersons to respond to such diatribe. *20/20* investigators and much of the lay public were surprised that anesthesiology was not deemed important enough by the ADA to be a specialty (even the National Institutes of Health had recommended specialty status in 1972).[9] Until 1950, dentists trained in anesthesiology were accepted as unrestricted members of the ASA, thus providing the profession a recognized forum from which to opine.[10, 11] When the ASA affiliation was rescinded, planning for another authoritative society, the ADSA, had to begin immediately so that dentistry's interests were effectively proffered from a bona fide anesthesia entity.

Today, dentistry needs an anesthesia specialty more than ever. For the most part, U.S. dentistry has been fortunate to survive sensational media assaults and, sadly, regular criticism from sister professions. As but two examples, the American Association of Nurse Anesthetists actually questioned dentistry's competence in the administration of N_2O/O_2.[12] Further, the Ohio component of the ASA sponsored legislation that would have prohibited any dentist from administering N_2O/O_2 without a second dentist monitoring the patient.[13]

Since 2000, the not-so surprising growth of groups such as the Dental Organization for Conscious Sedation (DOCS) has clearly demonstrated the overwhelming need and demand for advanced pain control in dentistry.

OMS has effectively developed and defended its own singularly successful office-based team anesthesia model. Anesthesia in OMS is well-founded, safe, and universally appreciated by dentistry's patients. Anesthesia in dentistry, including any future specialty, will stand to a degree on the shoulders of the OMS archetype. For this reason at least, those who practice the OMS paradigm should be qualified as sub-specialists, if you will, without the standard requirement of two or more years of anesthesiology residency training. In 1977, ADSA President and OMS Daniel Laskin's support for the specialty effort was based in part on the logical inclusion of OMS within the specialty's structure.[14]

But, anesthesia in dentistry needs to be much more than the safe administration of local anesthesia, N_2O/O_2, p.o. Rx's, or the OMS office-based niche in order to meet the demands of an ever-more sophisticated and complex patient population.

Dentistry introduced safe, reproducible, anesthesia to the world in 1844. Dentists have provided innumerable anesthetics in even the most challenging circumstances such as the theaters of the Civil War, World Wars I and II, Korea, and Vietnam.[15, 16] Dentists have directed cardiac anesthesia units and chaired anesthesia residencies. When President Grover Cleveland needed surgery, dentist Ferdinand Hasbrouck was chosen to administer the anesthetic.[17]

I vividly recall a day in 1975, while a resident in anesthesiology at the University of Utah, our faculty's excited revelation at rounds that the state now had its first outpatient surgery center. This was a place patients could go to have a procedure done under general anesthesia and then return home the very same day! I also remember being the cause of disillusionment

Dentist Anesthesiologists Wanted in Pediatric Practices

The desire for dentist anesthesiologists in pediatric dental practices is reportedly on the rise, according to a survey published in an issue of *Anesthesia Progress*.

"The purpose of this study is to explore the use of office-based sedation by board-certified pediatric dentists practicing in the United States," the authors wrote.

The research team, from Indiana University in Indianapolis, surveyed active board-certified pediatric dentists who are members of the American Academy of Pediatric Dentistry. Of the 1,927 recipients, a total of 494 practitioners completed and returned the survey, according to the report.

More than 70 percent of board-certified pediatric dentists in the United States report using some form of sedation. Less than 20 percent administer IV sedation, while 20 to 40 percent use a dentist anesthesiologist, and 60 to 70 percent say they would use a dentist anesthesiologist if one were available.

Source: Anesthesia Progress 59(1):12–17, Spring 2012

It is tragically incongruous, in fact inconceivable, that ethical health professionals would argue against increasing the qualitative and quantitative ability to relieve pain and suffering.

throughout the room after sharing that dentistry had been doing the same thing, in private offices, for more than 100 years. Although medicine is now very comfortable with its adoption of part of dentistry's nearly 170 year-old outpatient paradigm, it is just now investigating the concept of nonoperating room-based delivery.[18]

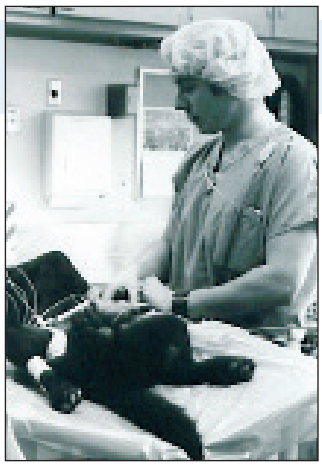
No entity has more expertise in anesthesia for dentistry than dentistry itself. Medical anesthesiology often involves a prolonged general anesthetic in paralyzed patients, while dental anesthesia requires the continuous negotiation of lighter planes of consciousness, an entirely different challenge. All dentists, students, residents, and of course our patients, deserve the considerable advantages a specialty in anesthesiology will bring.[19]

In 1997, the specialty application failed by only five votes in the ADA House of Delegates. In 1999, the House approved four of five criteria but, narrowly, not the requirement of "need and demand." One year later, our patients (and now nearly 20,000 DOCS graduates and millions of doses of DOCS protocol anxiolysis) began to vividly demonstrate their disagreement with the ADA House's determination of no need or demand for more anesthesia options.

Since there is an obvious need and demand by our patients, why isn't anesthesiology a specialty in dentistry already? Anesthesia history often graphically demonstrates positive and not-so-positive aspects of basic human nature. At its very inception, Horace Wells felt anesthesia should be as accessible as the air we breathe, while William Morton sought to restrict access to anesthesia, patenting his "invention" (ether fragranced with perfume). I do not wish to offend, but in my opinion anesthesiology is not a dental specialty because of historical selfishness, economic and otherwise, on the part of organized dentistry at several levels.

It is tragically incongruous, in fact inconceivable, that ethical health professionals would argue against increasing the qualitative and quantitative ability to relieve pain and suffering, yet that is exactly what organized dentistry has done for decades.

While comedians mockingly remind the public of the anxiety, pain, and suffering persistently associated with dentistry, perhaps in 2012 the ADA will determine to no longer facilitate the jokes. Dentistry developed as a recognized profession in large part because of its anesthesia pioneers.[20] It is time for dentistry to begin to seriously develop the art it bestowed on mankind two centuries ago by creating a specialty of anesthesiology. ◆



The author in 1976 as a resident in anesthesiology, University of Utah

Dr. Orr is professor and director of OMS and Advanced Pain Control at The University of Nevada Las Vegas School of Dental Medicine. He is a diplomate of The American Board of Oral and Maxillofacial Surgery, The American Dental Board of Anesthesiology, The National Dental Board of Anesthesiology, and The American Board of Legal Medicine. He is editor of the Nevada Dental Association Journal *and vice president of the American Association of Dental Editors.*

Editor's Note: *As this edition of the* NDAJ *was going to press, the NDAJ learned that* ABC Nightline *will be airing a program on dental anesthesia in July.*

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NDA Executive Director's Message

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One of the most important functions of your Nevada Dental Association is advocacy both at the state and federal level. Our relationships with our legislators are invaluable and go a long way in making sure we are heard in Carson City and in Washington D.C. In these efforts we are non-partisan and donate money to "friends of dentistry." Sometimes we find it necessary to support both sides of a particular campaign because we have friends on both sides. I work with our contract lobbyist, Chris Ferrari, your legislative chairman, David White, and the executive and legislative committees to watch for any legislation that might affect our profession. We participate in meetings of the four statewide oral health coalitions to lend a hand where we can on access to care and workforce issues. This collaboration along with others are important in that we need to work together to find common ground on what is best for dentistry and our patients. It is very important to continue to donate your time and skill to the many volunteer oral health programs throughout the state that strive to help the underserved. Our legislators need to know we care about the underserved.

The legislative committee has been hard at work interviewing candidates running for office this year. The number of interviews totals 58 as of June 2012. We have been concentrating on those offices with open seats due to term limits and there are a lot of them. Also we will wait until the primary election is finished in most of these before we have another round of interviews and make decisions on financial contributions from the association. It should be another exciting year in politics.

Our relationships with our legislators are invaluable and go a long way in making sure we are heard in Carson City and in Washington D.C.

We continue to follow the formation of the Silver State Health Insurance Exchange. Our lobbyist testified that dental plans in the exchange should remain "stand alone" as they are now and not be tied into a medical plan. This allows for the maximum flexibility for the patients and will create the least amount of loss of patients from our dentist's practices. The Exchange appears to be an avenue where dentists may be able to find plans to cover their employees if needed. Of course, this all depends on the Supreme Court's decision whether to strike down the Affordable Care Act.

The legislative team met with the Board of Pharmacy a few months ago after some inadvertent comments were made by their staff at an interim health committee meeting. They said they thought dentists had a problem with over prescribing opiates in their practices. Knowing this *not* to be true, I set up the meeting and we had a nice discussion with the board's executive director and they conceded that dentists were not the problem.

Finally, we ask this often but it is really important for me to know if you have a relationship (patient, friend, relative) with a current or prospective legislator in our state. I will promise you we do not abuse this knowledge but it is helpful and we sometimes need to reach out to them on an issue. They listen to their dentists. There also may be some opportunities to help these legislators in their campaigns for office which goes a long way when it comes to putting ourselves in front of them in Carson City. ◆

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I am proud to represent the dentists of our great state as your President. Throughout my journey I have been blessed to have several mentors along the way. These mentors have all displayed a deep passion and sense of commitment for the profession of Dentistry. These qualities will be greatly needed for our profession's future, as there are many forces looming on the horizon that could greatly alter our profession. My predecessors have set the Nevada Dental Association and our local components on a strong course, one I hope to further develop. Drs. Balle, DiGrazia, and Banks have been strong leaders and visionaries for our Association. Drs. Talley, White, and Brooks have been tireless in providing the Nevada Dental Association with guidance and counsel. Our committees are composed of many passionate dentists coming to bat for our profession.

One of the goals of the NDA and local components is to stop the erosion of membership. The only way we can stay strong as a profession, is to keep our membership energized and unified. To this goal, we have continued our payment programs to help during these tough economic times. Our efforts to encourage new dentists to join our wonderful association have been ongoing. We hope that those of you who have not recently attended one of our events do so.

We have hired an energetic and visionary lobbyist, Mr. Chris Ferrari, who has brought forth a wealth of strong ideas that will help raise the stature of the Nevada Dental Association at the legislative level. However, Chris can only do it with our help. I encourage the entire state's dentists to present a united front to ensure that the profession can withstand the potential changes that are being proposed across the nation. Our membership must, as a whole, become more visible in letting the public and legislators know about our philanthropic efforts.

We want to make the NDA a leaner, more efficient organization; one that can make decisions effectively and quickly, should an attempt be made that could affect our patients and profession. Please donate to our PAC fund, become a delegate, attend your local monthly meetings, contact legislators that may be a patient in your office, bring a non-member to a meeting, and attend political events to represent Nevada dentistry.

On a lighter note, we hope to see you at all the local meetings and the Summer Meeting. As you know, these events are for you and your families to share in the camaraderie we have for each other.

Again, I am honored and proud to serve as your President and hope to work with you in shaping our future.

Together we can keep our profession strong and care for our patients at the highest level. Remember, the NDA is the Voice and Advocate for Oral Health Care in Nevada. ◆

NDA Membership Report

By Brad Wilbur, DDS • NDA Membership Chair

Membership-wise, it has not been the best of times. Fortunately, due to the hard work by association staffers, it has not been the worst of times. By the end of May 2012, we were getting closer to the membership level of last year. Since there still may be another spike in totals, hopefully we can exceed last year's membership.

Female dentists were going to be marketed during May. This segment of the dental population is one of our lowest percentage groups, so targeting this sector could provide help to our totals. The ADA was also due to start a program June 1, 2012 calling all non-renewing dentists, and sending them information on re-joining.

On a very positive note, Nevada was the winner of four awards at the latest membership meeting at ADA headquarters in Chicago. They were:

- Greatest net gain in membership
- Greatest net gain in number of new dentists
- Most improved active member retention rate
- Greatest percentage change of non-member to membership

Anthony Ferreri, NDA Director of Member Services and Richard J. Dragon, DMD accept the the ADA membership awards

This was a superb accomplishment! Thanks go to everyone that has helped us keep membership levels stable in a "down" economy. Special thanks to Anthony Ferreri, who has been mostly responsible for the innovation in the membership department strategies. ◆

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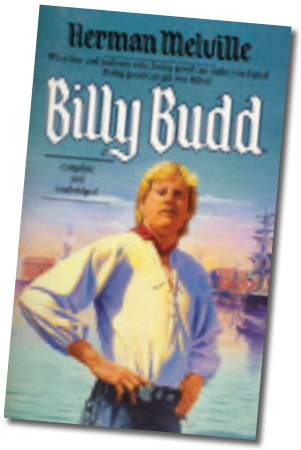

By David W. Chambers, PhD

Omniscience means knowing everything.

Naturally, it would come in handy in the "Who's smartest at the table?" kinds of competitions. But it is generally recognized that the number of truly omniscient individuals is very small and phony know-it-alls are real pains.

Surprisingly, we are slower at recognizing that the same sort of limitations apply in the ethical domain. If a genie offered me the gift of knowing what everybody else should do, I would be sorely tempted to turn it down.

Consider the case of *Billy Budd, Sailor.* This is the title of Herman Melville's posthumously published novella, now a standard text in high school. Budd is a merchant sailor pressed into the British Navy (kidnapped at sea) in 1797.

Described as "beautiful Billy," Melville makes him a Christ-like paragon of virtue: an able seaman, loyal, popular, and even gifted as a peacemaker. His only flaws include a touch of righteous indignation and stammering under emotional pressure. Never in the novella is there even a hint that Budd is anything less than pure virtue. The fact that he is hanged, and even Budd praises the captain who orders it, makes for a nice ethical discussion.

The plot unfolds like this: John Claggart, the master-at-arms (shipboard chief of police), is jealous of Billy Budd and fabricates circumstantial evidence of his being involved in a mutiny plot. Claggart reports Budd to Capt. Vere and the captain calls in Budd to confront his false accuser. In complete disbelief and unable to express himself otherwise, Budd lashes out at Claggart and lands a single, fatal blow.

The moral challenge is what should Capt. Vere do? Budd is guilty of three breaches of the British Articles of War: failure to report the attempts by Claggart to frame him, making a threat to a superior officer, and committing murder. Striking a superior officer (regardless of the effect) normally called for summary execution. There are no doubts about the facts. Vere saw it with his own eyes.

Melville really piles it on Vere. He and Budd were the only witnesses. Budd's ship, with the absolutely inappropriate name *Bellipotent*, had pursued a French warship and become separated from the fleet so that Vere could not appeal to others. The story is set a few years following the well-publicized mutiny on the ship Bounty and several notorious navy uprisings in English ports, creating a climate hypersensitive to organized insubordination.

In his heart, Vere "knows" Budd was set up. He convenes a drum head court of his officers. They hear the testimony and condemn Budd to be hanged the next morning. Just before Budd is raised on a yard arm with a rope around his neck to suffocate, he cried out, "God bless Captain Vere."

Modern readers regard Vere's verdict as wrong-headed, harsh, insensitive, the triumph of a callous system over the virtuous individual, or simple cruelty. They regard Budd's opinion on the matter as mockery or irony.

Such a judgment can only be justified based on omniscience. The reader is sucked into a position of false moral superiority by being given a view of the situation that no one in the novella actually had. That is a common ethical trap. We like easy answers, and are tempted to make up facts that justify the outcome we

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Moral courage means deciding based on everything that is known, not what is imagined. Be humble about what you do not know.

prefer. Knowing only what Vere knew or what the officers who sat at the court martial knew, there is no other judgment that could be reached. Budd is truly prescient in praising Vere: he saw that Vere did what he had to do and that armchair second-guessers would not even have been allowed to give testimony. Melville has pulled a dirty trick on the reader by making him or her seem morally superior by taking a position that no one could actually take.

In years of leading students and practicing dentists through ethics cases involving second opinions and justifiable criticism of colleagues, I am struck by the assumptions that are added to the case by participants. The best way to get out of a dilemma is to assume some additional facts that justify our conclusion: "The patient may just be shopping for a lower price," or "Perhaps this is the kind of patient who is mad at the world in general."

Psychologists such as Nobel laureate Daniel Kahneman and Amos Tversky have studied what people make up in order to make sense of ambiguous situations. A common scenario used in their research is a college professor driving home and diverting his normal route to run an errand for his wife. He is struck by a truck and dies. Virtually, no one is willing to leave the story as told, accepting the facts as random events. Human nature requires that we invent "if onlys" in order to make the story meaningful to us. Here are some of the common characteristics of makeup explanations: Bad things require explanatory stories; there is something that needs fixing in the world if things do not turn out as we would like. Good outcomes are accepted as one's due. The explanations are simple, single changes in the world—the brakes failed—not the truck took the wrong turn, and the professor started late, and the brakes failed. The best fix is that the other guy should have acted otherwise.

The nub: There is no view from nowhere. It is unethical to presume ethical omniscience.

Moral courage means deciding based on everything that is known, not what is imagined.

Be humble about what you do not know. ◆

"That Was a Pithy Presentation"

By John S. Bauer, FACMPE, CPA, CFE, CVA

In decades of working with dental and specialty practices across the country, it still amazes me that in many practices, their business and accounting professional guidance overlooks the optimization of two very important aspects.

The first is the benefit found in a Qualified Retirement Plan. Unlike in past decades, these plans can now be designed to have a major portion of the annual contribution benefit the dentist and to a much lesser extent, the staff.

If a dentist has a Profit Sharing Plan for 2009, the maximum contribution is up to 25% of their 2009 pay up to a maximum of $49,000 per year. Clearly, the first benefit is that the profit sharing contribution is tax deductible and no taxes are currently paid on the contribution. On one hand, if a dentist took the entire $49,000 as pay and was in the 35% tax bracket, the taxes currently due on that income would be $17,150. On the other hand, when making that pension contribution of $49,000, the dentist effectively only pays $31,850 ($49,000–$17,150) for a full $49,000 contribution.

And the story even gets better… the pension money grows tax deferred. If a dentist makes an annual $49,000 deposit in monthly installments for 20 years and averages a five percent return, at the end of 20 years the pension's value will be $1.7 million, and in 30 years it is $3.4 million. Albeit a five percent return over the past decade was difficult. Five percent over several decades and business cycles is still a conservative return. The aforementioned is a very simplistic but accurate approach to the value of having a Qualified Retirement Plan, which typically becomes the dentist's largest asset.

In my opinion—and the majority of financial professionals—this benefit is the best investment a dentist can make, as long as the contribution remains tax deductible and the money continues to grow in a tax deferred status. This benefit should not be overlooked. If you do not have a plan, contact your professional consultant or accountant to review all of the options available. Plans are available from financial institutions, on the web and from attorneys who specialize in Qualified Retirement Plans.

pith·y [pith-ee] *adjective*
Brief, forceful, and meaningful in expression; full of vigor, substance, or meaning; terse.

The second issue applies to dental practices with an underperforming collection cycle. This is where over a dentist's career, significant money is lost due to "controllable losses" or losses in the collection cycle that could have been prevented.

In the practices we encounter, almost all have significant amounts of controllable losses. The collection cycle can be objectively monitored for improvement using analytical procedures to compare collection efforts to prior periods. An example of objective measurements is calculating the average days that it takes to collect payments on the current day's services.

Knowing this is far more accurate than, "I think we are doing okay." As an example, if a practice charges $75,000 per month and *should* collect 90% but only collects 87%, that loss over 20 years earning five percent interest would exceed $562,000. In another example, if the practice only collected 85% instead of the 90%, that difference at five percent interest over 20 years would exceed $900,000. Clearly, having a well managed collection process could fund a good portion of the aforementioned pension plan.

So, how does the word "pithy" come into this article? A few years ago, I presented this information in a live forum to a group of dentists. After discussing the information in much greater detail, a dentist stood up and said, "that is simply pithy and I wish someone had told me that when I was younger." I was taken aback because I did not know what "pithy" meant. Did I hear that correctly? Well, I thanked him for his comment and scurried to get the definition of pithy from an online dictionary. Pithy means, "brief, meaningful and full of substance." I believe that after decades of working with professional practices, he was right on target. ◆

Any comments or questions regarding this article should be directed to John S. Bauer at the Aspen Consulting Group, Ltd., 440-238-7033, ext 122 or by e-mail to jbauer@aspen-ltd.com.

Expectations

By Ken Jones, DDS, JD

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An open letter to the Ohio Dental Association:

I expected some response to my recent dissertation on DHATs, access, Medicaid, and the undertreated, ("Dear Mr. Kellogg," reprinted in the *NDA Journal,* Spring 2012) and I wasn't at all disappointed. The response was hot and heavy. I was awed by your fervor.

In case you've forgotten, I theorized that, not only should dentists help out the poor and underserved, but that it would help if those same poor and underserved would do a lot more to take care of their and their children's oral health, their lifestyles, and their social responsibilities.

I also felt that if more people would make more of an effort to reduce the need for care, perhaps more of us would make more of an effort to provide the care they need, and then we might just have a more successful battle for the "access" they need. In other words, we'll help increase access if they'll help decrease need. It's the old "hand up" vs. "hand out" argument.

I was not surprised that 95 percent of you agreed with me. About three-fourths of you also said you take Medicaid patients in your practice, participate in organized dentistry's programs to give dental care to the needy, or just give away some amount of dental care to those who need it.

Besides poor parent and patient cooperation, those who didn't "take the Card" blamed governmental aggravation more than anything else. Many of you said that you "used to take Medicaid, but quit" because it was such a hassle. Several admitted that you got tired of providing emergency services for children whose parents didn't care enough to bring them back for routine care. You were also the ones who talked about parents handing out candy bars and sodas to keep the kids quiet in the waiting room while they stepped out for a smoke.

"Expect nothing and you'll never be disappointed!"

While I wasn't particularly surprised that some of you disagreed with me, I was a little taken aback at the severity of the attitude adopted by many of those who opposed my view. The most verbal and vitriolic responses came from a listserve of dental professionals, many of whom, as far as I can determine, do not, in reality, practice the patient care they rant about. Of those that actually see patients, many seemed to be government employees who don't have to worry about the overhead.

We working dentists were chastised for wanting our patients to take some responsibility for their actions (or lack thereof). That holier-than-thou viewpoint seems to have little potential to actually increase access or reduce need for those they purport to care so much about. And both things need to happen—soon.

A few dental school administrators told me I was being discriminatory because I wanted my Medicaid patients to floss, just like the ones who pay for my services. They said that EBD studies show that flossing doesn't work. Besides, they said it wasn't up to me to tell them how to behave—it's not politically correct. Just shut up, slick teeth, and fix decay—over and over.

My EBD says that my patients who floss and take care of their oral hygiene need less care than those who don't. My study (unfortunately, unfunded) has been going on since 1968. My study says that if you don't clean it, then it doesn't matter how much remineralization you try and how many sealants you stick in there—dental disease comes back. And, as my buddy says, "If you floss and it bleeds, that means it's unhealthy."

Maybe they can find a way to clean it if they know it's dirty. My question is, what do these educators teach their students about floss and oral hygiene? And do they floss themselves? "What's good for the goose…."

So, with that last thought in mind, here's my challenge to all you who think that the midlevel providers that PEW and Kellogg are so gung ho for will solve all our dental access (and dental needs?) problems. When the first class of 19 year-old DHATs arrives in Ohio, I expect every legislator who voted for them, and everyone who gave me hell for my views, to be part of the first group in line to let them diagnose, anesthetize, restore, and extract in their mouths.

Then I'll expect you to talk to me again. Don't disappoint me. ◆

It's the economy

By Edward Leone Jr., DMD, MBA, RFC

The nature of the economy deserves our attention—given the economic health of our households and businesses. Perhaps we should examine where we have been, where we are now and where we are going.

From 1802 through 2007, yields after inflation on several now popular investments look as follows: gold 0.1%, US bonds 3.5%, equities 6.8%, according to Jeremy Siegel of the University of Pennsylvania's Wharton School of Business. Ibbotson Associates does some excellent research on past economic performance. Looking back to 1926, if you had one dollar, you would need $12 in 2010 to have the same buying power. If you invested one dollar in US Treasury Bills in 1926, you would have $21 in 2010; one dollar in large cap stocks in 1926, you would have $2,982 in 2010; and one dollar in small cap stocks in 1926, you would have $16,055 in 2010. According to Fidelity Management since 1926, there have been 57 rising stock market moves and 20 corrections. The S & P 500 index has gone from 18 prior to WWII to 1,333 this past April. We have also experienced 14 recessions and recoveries (including the Great Depression) during the 84 year period between 1926 and 2010.

The observation has to be that business cycles occur regularly. Expansion of the money supply is integral to the expansion of business opportunities and economic growth. The level of return on investment is related directly to the level of risk. Along with growth in the money supply comes inflation. A key consideration is whether or not inflation is under control. In other words, is there discipline in monetary policy? Along with this dynamic, it is evident that economic growth over the long-term out paces inflation.

Our current status is a matter for concern. In 2010, the average US household income was $49,777. This number is five percent lower than it was in 2000. The economy based on GDP growth has increased 20%, but inflation over that ten year period has been 23.7%. Economic growth is behind the growth in the money supply for this period and we are earning less in compensation for our work. How did this happen? The lessons of history tell us that our monetary and fiscal policy over this past ten-year period has not been synchronized with the business cycle, global-economic and geopolitical events.

Where are we going? Not one of us has a crystal ball, but we are presently on a slow path of recovery. Projected GDP growth for 2011 is between 2.8% and 3.5% depending on the source. The 2010 inflation rate at the consumer level was 3.1%. It is possible that we will experience another year in which growth compared to inflation is stagnant. Liquidity created by the monetary policy of the Federal Reserve is winding down. Fiscal policy as established by the US Congress has not attracted capital to our shores, but rather continues incentives to invest overseas. None of these dynamics are sustainable over an extended number of years. The lessons of history as demonstrated by Ibbotson research tells us that over the past ninety years, there have been only two decades in which investment returns have been flat or negative. The total equity investment return over those ninety years averages 10.6% per year. We are at the door step of the second decade of this century. Will it be one of growth and prosperity? ◆

Dr. Leone is a past President of the Metropolitan Denver Dental Society and a past President of the Colorado Dental Association. He currently serves the profession of dentistry as the Treasurer of the American Dental Association. Dr. Leone is also an Associate with GHP Investment Advisors in Denver, CO.

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Living longer with HIV/AIDS in Nevada

By H. Barry Waldman DDS, MPH, PhD and Steven P. Perlman, DDS, MScD

A recent national survey found that Americans' sense of urgency about HIV/AIDS as a national health problem has fallen dramatically. A review of government and foundation reports is used to emphasize the continuing extent of the epidemic in Nevada and the United States. The emphasis is on the need for dentists to consider modifications for dental services, given the reality that many of the individuals with HIV/AIDS are living for extended periods.

Background

The U.S. Centers for Disease Control and Prevention (CDC) estimated that over one million adults and adolescents are living with HIV in the country, including those not yet diagnosed, and those who have already progressed to AIDS. At the end of 2008, an estimated 682,700 people (including almost 6,700 in Nevada) were living with a diagnosis of HIV infection in the 40 states and 5 U.S. independent areas with confidential name-based reporting. An estimated 490,700 were living with AIDS (including 82,700 in New York, 67,700 in California, 50,800 in Florida, 35,600 in Texas and 3,240 in Nevada).[1] This represents a continual increase over time as people are living longer with the disease.

> "(However) less than a year after the government increased its estimate of new HIV infections each year, (a national 2009) survey finds Americans' sense of urgency about HIV/AIDS as a national health problem has fallen dramatically and their concern about HIV as a personal risk has also declined."[2]

HIV/AIDS is preventable and treatable—early diagnosis and care helps those with the disease live longer and healthier lives. Yet, one in five Americans living with HIV today does not know it. The CDC identifies stigma as a major contributor to the spread of HIV, keeping people from seeking information, speaking openly, using protection, getting tested and treated and otherwise acting to protect themselves and those they love.[3] Could it be that this lack of a "sense of urgency" is a reaction to the fact that worldwide "only" four percent of people living with HIV/AIDS live in the United States, while 67 percent live in Sub-Saharan Africa?[4] Or that "only" 8,400 plus individuals with HIV/AIDS live in Nevada (i.e. "only" one percent of the total number in the United States)?

Given this "diminished concern" regarding HIV/AIDS, it would be appropriate to review the realties of this ongoing epidemic in this country and specifically in Nevada.

Numbers and proportions in the United States

The U.S. Centers for Disease Control and Prevention (CDC) publish HIV statistics for 37 states and five dependent areas with confidential name-based HIV infection reporting. AIDS statistics include all 50 states and the District of Columbia, as well as the five dependent areas.

- Over a half million people diagnosed with AIDS have died.
- About two-thirds of these people did not live to the age of 45.
- Between 2005 and 2008, the number of AIDS diagnoses decreased among those aged 30–44, but increased among those aged 20–29 and 55–64.[5]
- Every 9½ minutes someone in the U.S. is infected with HIV. [2]

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Numbers and proportions in Nevada

While the majority of Nevada residents living with HIV/AIDS reside in Clark County (85%) and Washoe County (10%), there are residents all Nevada counties and Carson City. Clark County has the highest rate (329 individuals living with HIV/AIDS per 100,000 residents). Storey County and Carson City have 200 to 275 individuals living with HIV/AIDS per 100,000 residents. Churchill, Mineral, Nye, Pershing and Washoe Counties have 125 to 200 individuals living with HIV/AIDS per 100,000 residents.[7]

- One in 321 Nevada residents is known to be living with HIV/AIDS.
- Among Nevada residents living with HIV/AIDS, 24% are white, non-Hispanic, 24% are black, non-Hispanic and 20% are Hispanic.
- Males represent 83% of residents living with HIV/AIDS.
- Black females represent 42% of all females diagnosed with HIV/AIDS in 2010.
- The greatest proportion of individuals living with HIV/AIDS (83%) is between 25 and 54 years. Nevertheless, more than a thousand residents are less than 25 years of age, and more than 350 are 55 years and over. (*See Table 1*)

Is the epidemic under control?

The press release headlined in August 2011 by the Centers for Disease Control and Prevention announced, "New multi-year data show annual HIV infections in U.S. relatively stable."[8] Nevertheless, the text specified that "… approximately 50,000 new (HIV) infections (were reported) each year between 2006 and 2009."[8] In addition, it noted that there was an "alarming increase (in HIV infections) among young, black gay and bisexual men…"[8] The annual increase of "only" 200,000 HIV cases in the four year period surely forecasts a continuing increase in the number individuals living with HIV/AIDS in our communities.

What of dentistry?

The writing of this presentation was stimulated by an episode in our school's Dental Care Center. One of the students had just completed a medical history with a middle-aged female patient, who reported that she has been HIV positive for the past 18 years, when he questioned his instructor whether this was possible. Should we be surprised by the student's question, given the national survey findings that "…Americans' sense of urgency about HIV/AIDS as a national health problem has fallen dramatically…"?[2] The fact that hundreds of thousands of men and women survive with HIV and AIDS for an increasing period time has transformed the delivery of dental services from palliative care for a "limited period of time" to the need to provide long term repair and replacement services.

The reality is that HIV has, to some degree, become "a chronic illness" for many youngsters, the middle-aged and older individuals, who live in all parts of Nevada (and other states). Dentists increasingly will be called upon to meet the long term oral health needs of these individuals, many of whom are members of families currently being treated in community practices. ◆

Table 1. Nevada prevalence rates of individuals with HIV/AIDS, 2010[6]

	Living Rate*	Number Living
Total	**306.3**	**8,390**
County at Diagnosis		
Clark County	361.1	7,105
Washoe County	197.5	837
All other counties**	129.0	448
Gender		
Male	502.6	6,990
Female	103.9	1,400
Age		
< 13	10.5	60
13–24	243.9	961
25–34	750.9	3,009
35–44	700.0	2,842
45–54	311.2	1,161
55–64	107.3	305
65 +	17.0	52
Race/ethnicity		
White non-Hispanic	254.6	4,328
Black non-Hispanic	1,066.2	2,017
Hispanic	266.7	1,704
American Ind./Alaska Native	205.9	75
Asian/Hawaiian/Pacific Islander	126.5	220
Multi-race/Other	N/A	46

* Rates per 100,000 total area population is based on 2008 interim population estimates from NV Demographics.

** Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine Counties.

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A clean mouth saves money

By Elizabeth Douglas

Not many nurses would be keen on brushing patients' teeth, but that is exactly what dramatically lowered infections and costs in an intensive care unit (ICU) at a Missouri hospital.

Toothbrushing and an application of antibacterial solution prevented 14 cases of ventilator-associated pneumonia (VAP) in the 24-bed surgical/trauma ICU. The researchers estimated the resulting annual savings to be $375,032. The prospective longitudinal study won the Nursing Specialty Award at the annual meeting of the Society of Critical Care Medicine, where it was presented.

All Category IA and IB Centers for Disease Control and Prevention recommendations for prevention of VAP were already in place in the ICU. "Implementation of an oral care protocol —a Category II recommendation— reaps low-hanging fruit," said Carrie Sona, RN, Clinical Nurse Specialist at Barnes-Jewish Hospital in St. Louis. "It is a low-cost, easy-to-implement strategy."

A simple protocol

VAP is associated with poor outcomes and high cost, Ms. Sona noted. Mortality among ICU patients who have VAP is 50% higher than for those who do not have the condition. Length of both ICU and hospital stay is increased, and cost per infection is estimated at $10,000 to $40,000.

In the year before implementation of the oral care protocol, the VAP rate was 5.2 infections per 1,000 ventilator days. This is lower than the rate of 14.7 infections per 1,000 ventilator days reported for other trauma ICUs. "But we thought we could do better," Ms. Sona said.

She and her colleagues devised an oral care protocol in which the nursing staff would brush patients' teeth, with a toothbrush and toothpaste, for a minimum of one minute every 12 hours while the patient was on mechanical ventilation. The active ingredient in the toothpaste was sodium monofluorophosphate (0.7%). After brushing, 15 mL of a 0.12% chlorhexidine gluconate solution was applied to all oral surfaces.

The year following implementation of the oral care protocol, the VAP rate was 2.4 infections per 1,000 ventilator days. The difference from the previous year's rate was statistically significant (P=0.04; Mann-Whitney test). There were a total 14 fewer VAP cases after the novel intervention was put into practice. Total ventilator days during the two years were not different (4,606 days before vs. 4,158 days afterward).

Low cost, big savings

Cost per patient per day was 62 cents: 7 cents for the toothbrush, 24 cents for the tube of toothpaste and an estimated 31 cents for a multi-use bottle of chlorhexidine gluconate. The total cost of chlorhexidine gluconate during the study period was $1,620.48.

Subtracting cost of materials and using an estimate of $40,000 per VAP infection, Ms. Sona estimated the savings at $26,788 per infection, or a total $375,032.

The researchers noted a decrease in the number of every type of infecting organism, with the exception of Serratia marcescens.

Despite worries about resistance from the nursing staff, compliance with the oral care protocol, monitored biweekly, averaged 81% over the year.

Brushing past the resistance

"There are many studies on oral care for ventilator-dependent patients, and the Europeans have used oral care protocols for years," said Peter J. Papadakos, MD, Director of Critical Care Medicine and Professor of Anesthesiology, Surgery and Neurosurgery at the University of Rochester School of Medicine and Dentistry in Rochester, N.Y. "This study was a good one."

Both Ms. Sona and Dr. Papadakos conceded that there might be considerable resistance from nurses to brushing another person's teeth. Probably because of this resistance, some ICUs use swab-like tooth cleaners. "But brushing more effectively removes plaque," Ms. Sona said.

"It is a good idea to provide good mouth care and not get infected secretions in the mouth," Dr. Papadakos said. "Patients can get all kinds of bacteria built up in the mouth."

At Dr. Papadakos's Rochester facility, ventilator-dependent patients receive oral care with a chlorhexidine gluconate solution (Peridex, Zila Professional Pharmaceuticals). Brushing would be a good addition, Dr. Papadakos said, "if I could talk the nurses into it." ◆

Based on a poster presentation (Abstract 49) at the annual meeting of the Society of Critical Care Medicine, the Centers for Disease Control and Prevention "Guidelines for Preventing Health-Care–Associated Pneumonia" (www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm) and an interview with Peter J. Papadakos, MD.

Reprinted with permission from Anesthesiology News.

Editor's Note: *This article, deemed newsworthy by* Anesthesiology News, *the Society of Critical Care Medicine, the CDC, and others simply documents some benefits of oral health and why hospitals need a dental presence. Nurse expertise ends with basic toothbrushing, which is more treatment than physicians provide.*

Nation's frontline physicians unhappy with Health Care Reform Measures

Troubling new research indicates health care reform will put increased strain on doctors and their patients; amplify national doctor shortage

The Physicians Foundation released the results of a national survey of physicians that finds strong negative feelings towards the new health care reform law and fear that patient care will suffer in the months and years ahead. The survey was intended to gauge physicians' initial reaction to the passage of health reform and to learn the ways in which they plan to respond to it.

Research, conducted by Merritt Hawkins, found growing dissatisfaction among doctors as they struggle with less time for patient care and increased time dealing with non-clinical paperwork, difficulty receiving reimbursement and burdensome government regulations. New research reinforces those findings and shows that the new health care reform could intensify existing problems for doctors and worsen the shortage of primary care doctors, making it more difficult for patients to access quality care.

"Physicians support reform; in fact, we were the ones leading the fight against the status quo. But this new research shows that doctors strongly believe the law is not working like it needs to – for them, or for their patients," said Lou Goodman, PhD, President. "For any health care reform effort to be successful, it must include the viewpoint of our nation's doctors. Their perspective from the front lines of patient care is critical in determining what's broken in our system and how we can fix it."

Notably, physicians also felt that Medicare's Sustainable Growth Rate formula (SGR) had an equally large impact on their practices as health care reform. Proposed cuts have been repeatedly put off by Congress and in January will reach approximately 30% if not addressed. "Despite the high profile nature of the health reform discussion, physicians are equally concerned over the impact of SGR on their practices," said Walker Ray, MD, Research Committee Chair. "The fact that SGR was not addressed as part of this year's reform effort shows that we don't have a comprehensive solution yet, and also that doctors simply didn't have a voice at the table during the reform debate. That needs to change."

Key research findings include:

- The majority of physicians (60%) said health reform will compel them to close or significantly restrict their practices to certain categories of patients. Of these, 93% said they will be forced to close or significantly restrict their practices to Medicaid patients, while 87% said they would be forced to close or significantly restrict their practices to Medicare patients.
- 40% of physicians said they would drop out of patient care in the next one to three years, either by retiring, seeking a non-clinical job within healthcare, or by seeking a non-healthcare related job.
- The majority of physicians (59%) said health reform will cause them to spend less time with patients.
- While over half of physicians said health reform will cause patient volumes in their practices to increase, 69% said they no longer have the time or resources to see additional patients in their practices while still maintaining quality of care.
- 67% of physicians said their initial reaction to passage of the 2010 Patient Protection and Affordable Care Act was either "somewhat negative" or "very negative" and a great majority (86%) believes the viewpoint of physicians was not adequately represented to policy makers during the run-up to passage of the law.
- Physicians are almost evenly divided over the relative importance of SGR (36%) and health reform (34%) to their practices, while 30% are unsure which will have the greatest impact. ◆

The full research report is available as part of "Health Reform and the Decline of Physician Private Practice," an expert analysis of the potential effects of reform on physician practices available at www.physiciansfoundation.org.

Fred H. Hart, A Toothache Cure

The Sazerac Lying Club, 1878

A Toothache Cure

Night before last, a prominent citizen was awakened from his peaceful slumbers by the pain of a raging tooth, and his sympathizing wife told him to go into the pantry and get some cloves, and put three or four of the spices in the hollow of the tooth.

He tried to find the cloves in the dark, but the attempt was attended with unfortunate consequences. He knocked over a pan of dough which had been placed on a chair in the kitchen, and after he got his feet out of the sticky mass and was proceeding to the pantry, he suddenly sat down in a bucket of slops. He is a good-tempered man, but this circumstance ruffled him and wet the nether portion of his night garment. But he was determined to have those cloves.

He got to the pantry, and, following his wife's directions, reached for the little crock in the right-hand corner of the third shelf. He was not discouraged because he pulled down a pitcher of yeast and a keg of brine. It is true, these liquids wet his hair and ran down his spinal column; but he didn't mind that—he had the crock. Then he reached down into it for those cloves, and his hand went into something soft; he didn't know whether it was preserves, or mustard, or tar, or jelly, or mud, but it was something very sticky and soft; and he called in a voice of suppressed emotion for his wife to bring a light. He called pretty loud, as he thought his wife was asleep; but she answered the call promptly, and when she reached him with the lamp, her remarks were to the effect that he was a nice-looking object. She had not complimented him in many years of their married life, and her words touched him. "Yes," he said sadly, "I'm in a hell-of-a-fix."

After getting some of the jelly out of his hair, and the dough scraped off his legs, and the brine washed out of his eyes, she said she guessed she'd just look for those cloves herself—"a man couldn't be trusted to do anything." There was not a clove in the house, and when she went back into the bedroom to tell him he had better go to a dentist and have that grinder snaked out. He said the bitter experience of that night had cured his toothache. ◆

Editor's Note: *The NDAJ thanks Dr. John DiGrazia for his historical contribution.*

NDA Past Presidents

1922	George H. Marvin	1967	William D. Berry
1923	John V. Ducey	1968	James F. Archer
1924	Thomas H. Suffol	1969	Philip J. Youngblood
1925	George A. Carr	1970	Carl M. Hererra
1926	Samuel T. Spann	1971	George P. Rasqui
1927	Bruce Saulter	1972	William H. Schaefer
1928	Frederick H. Phillips	1973	Robert L. Morrison
1929	Frederick J. Rulison	1974	John S. McCulloch
1930	William H. Cavell	1975	James M. Jones
1931	Harold E. Cafferata	1976	Harry P. Massoth
1932	Louis M. Nelson	1977	Leeland M. Lovaas
1933	Carlton E. Rhodes	1978	Blaine R. Dunn
1934	Pliney H. Phillips	1979	Louis J. Hendrickson
1935	Harold R. McNeil	1980	Duane E. Christian
1936	Lawrence D. Sullivan	1981	Dwight Meierhenry
1937	Alexander A. Cozzalio	1982	Clair F. Earl
1938	Charles A. Cozzalio	1983	R. D. Hargrave
1939	George A. Carr	1984	James L. Davis
1940	George A. Steinmiller	1985	N. Richard Frei
1941	George A. Steinmiller	1986	Lloyd Diedrichsen
1942	Omar M. Seifert	1987	Gerald Hanson
1943	Stephen W. Comish	1988	Gerald C. Jackson
1944	Quannah S. McCall	1989	James C. Evans
1945	Oliver M. Wallace	1990	Whit B. Hackstaff
1946	Gilbert Eklund	1991	William E. Ursick
1947	Robert H. Gatewood	1992	Dennis J. Arch
1948	E. Ross Whitehead	1993	A. Ted Twesme
1949	Howard W. Woodbury	1994	Bruce Pendelton
1950	Roy P. Rheuben	1995	J. Gordon Kinard
1951	Leonard G. Jacob	1996	Joel F. Glover
1952	Clifford A. Paice	1997	Rick Thiriot
1953	Walter R. Bell	1998	Jade Miller
1954	Raymond J. LaFond	1999	Patricia Craddock
1955	Jack E. Ahlstrom	2000	William C. McCalla
1956	J. D. Smith	2001	Robert H. Talley
1957	Kern S. Karrash	2002	Susan Jancar
1958	Vincent J. Sanner	2003	Dwyte Brooks
1959	Wallaxe S. Calder	2004	Peter DiGrazia
1960	John B. Hirsh	2005	Robert Thalgott
1961	David W. Melarkey	2006	Arnie Pitts
1962	David W. Melarkey	2007	George Rosenbaum
1963	Fae T. Ahlstrom	2008	Joel T. Glover
1964	Morris F. Gallagher	2009	Peter Balle
1965	Wayne L. Zeiger	2010	John C. DiGrazia
1966	Mario E. Gildone	2011	Michael Banks

SNDS President's Message

Brendan Johnson, DDS
docbgj@cox.net

As I present my report, I must preface by thanking my predecessor, Dr. Joel Casar for his diligent work over the last year, and also to Dr. Lydia Wyatt in her capacity as Chief Delegate. She has worked hard to pioneer this new position, and I am happy to welcome her as our new Secretary-Treasurer. We are all the beneficiaries of her efforts. Dr. Tina Brandon has generously volunteered to be our new Chief Delegate and deserves our support in this important role.

I am happy to report that the SNDS is doing well. After a tough couple of years due to the economy in Las Vegas, we are seeing a turn around and can be cautiously optimistic. Most significantly, our membership numbers rose by about 7% last year, especially appreciated after two years of decreasing numbers. This year, the numbers look optimistic, with dues revenue matching last year, but with more members on the payment plans than before.

Our committees are functioning well, with Peer Review, under the leadership of Dr. Pamela Caggiano, handling 29 cases over the last 12 months. Our Dentist Health and Wellness Committee, with Dr. Richard Walker as Chair, will be receiving specialized training this summer through the annual conference on addiction and dependency at the University of Utah. We thank the NDA, and Dr. Michael Day, for the funding that allows the committee to have access to this very important training.

Our Give Kids A Smile event in February of this year saw treatment worth $150,000 delivered to 220 underprivileged children who had no access to oral health care. Amazingly, our superb volunteers accomplished this in just five hours. Give Kids A Smile is the only event that involves every oral health organization and education program in southern Nevada. This year, we once again documented the event in a DVD which the Nevada Dental Squadron is sending to every state Assemblyman and state Senator, as well as the Governor's office, to show what the dentists of southern Nevada give back to the community. The DVD makes the point that over the 10 years of the event, about 1,500 children have received over $1,000,000 worth of care. We're happy to demonstrate the long term commitment of organized dentistry to our community.

Our continuing education programs continue to be met with very positive reviews. We just concluded a great series of four, all day seminars, and have the next series already in place. Our CE Café series was expanded to six evening seminars, at no cost to the society or to members, and has become very popular with participants, and we are now planning the coming year's topics and speakers. When you consider that each of the six seminars provides 2 CEUs and the members can receive 1 CEU for each dinner meeting they attend, this means that SNDS members can acquire 20 CEUs as part of their dues, with no fees. They also have the choice of attending our all-day seminars with nationally recognized speakers for a very reasonable fee. In fact, we have hosted dentists from Alaska, Canada, Kansas, Texas, California, and many other states who see the value provided by our series.

We also have recorded select seminars, creating our "CE On Demand" program. Members or visiting dentists can visit our office during regular office hours and catch a seminar they missed or choose from those in our library. This last year has seen this program grow in popularity as well.

Thanks to our dues and non-dues revenue, and continued trimming of expenses, we were able over the last year to add to our financial reserves, while still not increasing our dues or fees for our members. A big thanks for this goes to our corporate partners, who continue to demonstrate their commitment as members of the dental community.

Looking forward, our delegates are informed and active, taking seriously their charge to represent the interests of our membership. We are looking at different methods of involving our members, and increasing communication between the members and the delegates and officers.

We are hoping to formalize our Continuing Education Committee, to provide more resources and great choices for our CE programs, from our main series to our dinner meeting speakers. If we hope to continue to recruit world class speakers, we need to plan further ahead, and spread the work among more of our members. Of course, this is a process, but one we are committed to beginning this coming year.

The other area of importance, socially and politically, is to expand our community outreach. By this fall, our 1DAY program will be back up and running in a leaner, more effective

Continues ➲

As much as we all look forward to summer, with vacations, family outings, spending time at the lake, it sure does go by quickly!

Though the SNDS doesn't have any meetings during the summer, it's actually our busiest time of the year. We're finalizing arrangements for our CE Seminar series, the CE Café, as well as our dinner meetings. We're working on the Member Directory, Community Night, the Mentor Program, re-vamping the website and laying the groundwork for next February's Give Kids A Smile. All of these things come back, directly or indirectly, to you, as benefits of membership.

While things are still being confirmed, I can share that our main CE Series should be a great one, with some nationally-recognized speakers. We're also committed to keeping the CE Café at six sessions over the year.

Speaking of continuing education, we're also tying down the speakers for our dinner meetings well in advance, and adding one extra dinner meeting for next May. With with dinner meetings (1 CEU for each), and six CE Cafés (a total of 12 CEUs), members will be able to score 20 continuing education units at no charge. Even our mainline series of seminars will be offered with no fee increase for members.

Our new website will be more versatile, easier to keep updated, and most importantly, will provide realtime information to track SNDS seminars, dinner meetings and other events. It will also be integrated with our new Facebook page, so that you have access to information through various media.

We want to hear from you, so we're making it easier for you to feel connected and share your input. Along those lines, we'll be updating our database for those who want to receive the *Prezfax* electronically rather than by fax (in fact, you can call the SNDS office anytime to switch).

You may also be hearing more about opportunities to get involved. We are working to reorganize our community service opportunities, including the 1DAY Program. Watch for more information about becoming a mentor by coaching one or two UNLV dental students. And of course there are always opportunities to work with our standing committees.

Robert Anderson
s_nds@hotmail.com

Most importantly, we hope you'll share the SNDS with colleagues who haven't joined or who have let their membership lapse. With no dues increases, new benefits, and no fee increases, membership is a better value than ever.

So while we may be busy this summer, by the time Fall rolls around you'll see new initiatives, improvements, and upgrades. Watch for the *Prezfax* and Facebook for details and announcements, and save the date for Community Night on Tuesday, September 11, 2012, at the Gold Coast Hotel! ◆

SNDS President's Message, *continued*

business model, supplementing the annual Give Kids A Smile. We are also meeting with community leaders to discuss varying needs and possibilities, as well as to acquire funding to support UNLV's clinics, to perhaps expand Give Kids A Smile to multiple events over the course of the year, and build stronger relationships with community organizations. Not only is this appropriate for us as professionals, and as members of our community, but it is essential in supporting the NDA's legislative efforts. We all know that dentists are very generous in charitable work for the needy, but frankly, we don't blow our own horn as loudly as we probably should. Organized dentistry provides the perfect medium for delivering and tracking the impact that we make as a profession.

What form this outreach will take is still being determined as I deliver this report, but make no mistake that this is a major priority for the SNDS this year.

I look forward to working with my fellow leaders, officers, delegates, committee chairs and colleagues to make membership in the Southern Nevada Dental Society not only the best value it can be, but a very real point of pride. I also look forward to reporting to you on our progress as we work together to make a difference, and, as we say, put a smile on southern Nevada. ◆

NNDS Executive Director's Message

Lori Benvin
nnds@nndental.org

Spring in Nevada means reminds me of a quote by Amelia Earhart: "No kind action ever stops with itself. One kind action leads to another. Good example is followed. A single act of kindness throws out roots in all directions, and the roots spring up and make new trees. The greatest work that kindness does to others is that it makes them kind themselves."

On May 2, we recognized those individuals who give selfless acts of kindness by generously providing pro-bono dental treatment to this community. The Northern Nevada Dental Health Program hosted its Inaugural Pro-Bono Provider Appreciation reception to recognize *all* dentists and dental labs that provide pro-bono dental care. More than 120 dentists and representatives from northern Nevada were in attendance. They were praised by Nevada legislators. Senator Don Gustavson; Assemblymen Pat Hickey, Randy Kirner, David Bobzien; Assemblywoman Teresa Benitez-Thompson and Debbie Smith presented a Proclamation from the State of Nevada signed by 10 of our local legislators. The office of Congressmen Mark Amodei presented Certificates of Appreciation for each program honored. Senator Harry Reid and Senator Dean Heller's offices presented Certificates of Appreciation to each dental provider and dental lab. Proclamations were also made by both Reno Mayor Bob Cashell and Sparks Mayor Geno Martini.

The event provided an opportunity to spotlight NNDHP, Give Kids A Smile, Donated Dental Services, Adopt a Veteran Dental Program, and Dentistry from the Heart—each an incredible program and we honored their volunteer service including many dental laboratories who without them, these acts of kindness would not be possible. We also had information available for charity events that support these non-profit programs such as the 10th Annual Northern NV Dental Health Program Charity Golf Tournament scheduled for Friday, September 21, at LakeRidge Golf Club, the 2nd Annual Joel Bowl to support the Joel F. Glover, DDS Memorial Foundation (www.gloverfoundation.org), and the Jason Eberle Memorial Fund that supports NNDHP. Thank you to those who attended but more importantly, thank *you* for all that you give back and support.

Our 2012–13 continuing education lineup will be something to check out and we are priding ourselves with some top-notch speakers. You are all still facing challenging economic times in your practice and *we* want to offer quality continuing education in Reno to save you travel costs. Our past Chair, Dr. Maggie Heinen, along with our incoming Chair, Dr. Mike Almaraz have scheduled Dr. Charles Blair on June 29, Robert London, DDS from the Department of Periodontics University of Washington School of Dentistry on November 8–9, and Dr. Jose-Luis Ruiz to join us in March 2013. Contact the NNDS at 775-337-0296 or visit our website www.nndental.org for details.

Lastly, thank you to all who renewed their 2012 tripartite membership dues. Advocacy is our #1 priority and you are the reason for our strong society and association for the betterment of your profession. If you want to get more involved and be heard or have a concern, please contact me and I will certainly tell you about becoming a Delegate or part of the NNDS Executive Board or on one of our outstanding committees. ◆

Welcome New NNDS MEMBERS

Christopher Comfort, DDS – General
Cody McElroy, DDS – General
Troy Savant, DDS – Oral Surgery
Welcome back to Nevada!
Tara VanOrden, DMD – General

The Northern Nevada Dental Society is in a mourning process as we send our recent past president, Quincy L. Gibbs, DDS, to the University of California, San Francisco. We wish him well during the next 36 months of study in postgraduate dental prosthodontics.

The incoming NNDS Executive Board is looking forward to building on the successful past few years of our society. I will step in as President, working with Frank Beglin, DDS as Vice President; Perry Francis, DDS as Secretary/Treasurer; and Members at Large: Brandi Dupont, DMD; Maggie Heinen, DMD; and Richard J. Dragon, DMD. We are also thankful to retain Lori Benvin as our Executive Director. The incoming board is committed to serving the membership to the highest standard possible and is excited to announce some new benefits for members.

The NNDS monthly dinner meetings provide a social setting with continuing education (CE) that members can enjoy this year for a 46% savings. The reduction in price is possible due to the ongoing support of the membership. The NNDS board committee members are now in a position to attract well-known names, such as the past February CE meeting with Dr. Stanley Malamed and continue to do so, beginning on June 29, 2012.

In addition to classes, membership also provides the opportunity to come together strictly to socialize. July brings the annual NNDS Barbecue at Barley Ranch Park, a Reno Aces game in August, and to send out the year, a formal Christmas party in December. You as members provide the access and benefits, but family, friends, and staff is always welcome at all events and meetings.

Northern Nevada dentists continue to support both the underserved youth in need of dental treatment through the Northern Nevada Dental Health Program (NNDHP) and our northern Nevada Veterans through the Adopt a Veteran Dental Program. NNDHP and all of the Saint Mary's Healthcare mission outreach programs are merging with Health Access Washoe County (HAWC) under a new name. NNDHP will continue to operate with no interruption in benefits to the children it serves. Dulce, Lori, and the NNDHP Advisory Board will also continue to operate NNDHP as we have come to know it and we thank all of our generous providers who have donated over $750,000 in pro-bono dentistry since 2011.

Support and membership of the NNDS is important for our profession. The organization enables our ability to communicate and take swift action on pressing matters, whether it is to provide a voice on legislative issues or to provide support of a colleague, such as through the Temporary Dentist Network. This past spring, Dr. Rick Dragon attended an American Dental Association conference in Chicago

Jason Ferguson, DDS
jasferg@hotmail.com

and returned with a four award sweep in recruitment and retention for Nevada's dental organizations. This illustrates that the membership of the Northern Nevada Dental Society continues to educate and support one another in multiple capacities.

I would like to thank all who participate and give of their time to make the NNDS what it has become to so many. I feel strongly that we will continue to provide for the needs of our community and for the needs of the family, friends, and membership of our society. Together, we do make a difference. ◆

Karen P. West, DMD
UNLV SDM Dean

Greetings from the SDM!

Faculty grants/awards

Dr. Christina Demopoulos received an award from the American Academy of Public Health Dentist for $5000. This is a grant award made to only one person in the US and supports community outreach and public health initiatives focused on oral health. She received the 2012 award.

Community service

Our students continue to be busy within the community providing services to the various underserved populations with the Las Vegas, Mesquite and Pahrump communities. During the past few months, SDM students, residents, faculty and staff along with UNLV pre-dental students and CSN dental assistant students have treated over 250 patients within our student sponsored clinics. Student sponsored clinics such as the John Ferrin Memorial Clinic, Saturday Children Clinic, Shade Tree Clinic, Shannon West Clinic, and the Huntridge Homeless and Teen Clinic have provided over $45,000.00 worth of free dental services since the first of the year to low income veterans, children with no dental insurance, homeless Shade Tree women, and homeless teens. The SDM hopes to continue to be the one of the major sources for access to care for these population groups.

Students and residents continue to provide preventive services in community-based, underserved settings in Clark County and Nye County. Services are offered at health fairs, career fairs, back to school events, boys and girls clubs, and Family Resource Centers (FRC). As of July 1, 2011, UNLV SDM secured funding from Oral Health America to implement the Clark County Dental Health Initiative in Title 1 schools in metropolitan and rural aspects of Clark County. The funding enabled Seal Nevada South to be fully implemented in elementary schools and provided a subaward to Future Smiles. Seal Nevada South and Future Smiles are school-based programs that provide oral health education, oral hygiene workshops, oral health screenings, sealants and fluoride varnish to at-risk children. Seal Nevada South will be expanding to 15 schools next year while Future Smiles will expand into some middle schools.

In the spring semester of 2012, UNLV first-year dental students presented oral hygiene and nutrition education information to over 10,000 at-risk kindergarten through fifth grade elementary school students in the Clark County School District. The dental students also handed out tooth-brushes, toothpaste and instructions on how to properly brush and floss.

Second year dental students visit assisted living centers in Nevada where they perform oral cancer screenings on residents. The students present information on oral hygiene, oral cancer and denture care. Residents are also given toothbrushes, toothpaste or denture kits.

The UNLV SDM also secured funding from the AAPHD Foundation to provide a community-based program to assess the oral health risk of youth exposed to tobacco smoke in rural Clark County (tentative sites: Searchlight, Mesquite, Moapa Valley, and Boulder City). It is estimated that the project will be fully implemented by August 2012.

Funding obtained through the Southern Nevada Immunization and Health Coalition; children identified in need of restorative dental care were able to receive $6,678 in restorative dental treatment at the UNLV SDM Pediatric Clinic. Currently, the UNLV SDM is completing an affiliation agreement with St. Rose Dominican Hospitals to provide restorative dental treatment to at-risk children in Henderson, Nevada.

Dean's Symposium and Research Day

The first Dean's Symposium and Research Day was held March 5. Dr. Charles Goodacre, Dean, and Dr. Patrick Naylor, Associate Dean of Graduate Programs at Loma Linda University, School of Dentistry were gracious in attending and being our keynote speakers for the event. The symposium was a wonderful event and we look forward to next year and hope all will be interested in attending. CE credits were available and will also be available next year as well.

Volunteer faculty

As always, we are looking for those among you who would like to become an instructor or just volunteer to be at one of our many outreach clinics here at SDM. Please contact Dr. Michael Sanders or Dr. Rick Thiriot for more information.

Budget update

We are entering the second year of our biennium budget and have been able to meet the 2011–13 budget cuts by increasing tuition and cutting unfilled administrative positions as originally planned. No one has lost their job due to budget cuts this past year. Any teaching faculty that have left during the past year have been/will be replaced and we currently have advertisements out for these positions. In looking at our total budget for the school after these cuts occurred and student tuition was increased, the school will have a total budget of approximately $30 million of which 21% comes from state funding, 24% from student tuition and the remainder, 55% from clinical income, grants and contracts or donations.

In addition, in spite of the news of the increased tuition, the number of applications continue to be well above our peer institutions. Our four-year cost of a dental education at UNLV continues to be in the middle or just slightly above that of our peers as all dental schools are anticipating a tuition increase and we remain only slightly above the average in student debt.

Admissions and student affairs

The Class of 2012 has graduated and is dispersed throughout the country. A total of six students each will be starting Orthodontic and Pediatric residencies; three will begin Oral & Maxillofacial Surgery residencies; and two will be in Periodontic residencies. There are 20 students that will be starting General Practice Residencies, as well as Advanced Education in General Dentistry programs in July. Sixteen students will be going into the military and will be representing the Army, Air Force, Navy and Army National Guard branches.

The remainder of the class will be working in Nevada, North and South Carolina, Ohio, Colorado, Utah, California, Georgia, Oregon, Oklahoma, Virginia, Rhode Island, Missouri, Nebraska, Texas, Wisconsin, Florida, Idaho, Connecticut, Illinois, Arizona, and Louisiana. We wish them the best! We also want to thank those graduates who stayed at the school a bit longer to assist in laboratory instruction. They were a great help and we hope that they consider a career in full time academics someday.

With the graduation of the Class of 2012, dawns the introduction of the Class of 2016. The Office of Admissions and Student Affairs is nearing the end of the selection process for the incoming class. There were 2,180 applicants for the 2011–12 application cycle. Currently, there are 77 students that will be matriculating this fall with 34% being female and 8% from underrepresented minority backgrounds. This entering class consists of 40 in-state students and 37 out-of-state students. The entering cumulative GPA is 3.44 and the science GPA is 3.31. The average DAT scores are in the 19–20 range. Historically, we have experienced attrition as late as the week before orientation. A ranked alternate list will be used to replace the students that withdraw. Orientation week is August 27–31. Classes begin September 4. We are excited to welcome these students to the UNLV School of Dental Medicine family.

June 4 marked the beginning of the next application cycle for the recruitment of the Class of 2017. In the first week since accepting applications, AADSAS is processing 519 applications for UNLV SDM. Interviews will begin in mid-September. Dr. Jonathan Rothbart will be chairing the Admissions Committee next year.

In January 2012, **Dr. Marshall P. Brownstein** announced his retirement from his position of eight years as Associate Dean for Student Affairs and an impressive 40 years in academia. **Dr. Christine Ancajas** is now the Assistant Dean for Admissions and Student Affairs. Assisting her with Admissions is **Dr. Antonina Capurro** who will be half-time in the office and half-time with the Clinical Sciences department.

Las Vegas, Nevada—Tianjin, China dental school exchange

In spring of 2012, three administrators from The Stomatological Hospital of Nankai University visited the UNLV SDM to learn more about the United States system of dental education to consider establishing university exchanges. Soon the Chinese representatives extended a reciprocal invitation for a delegation from UNLV SDM to learn about the Chinese system of education and establish a formal working relationship.

This culminated in the signature and exchange of documents to establish the relationship between the UNLV SDM and the Stomatological Hospital of Nankai University.

Continuing education

The Dental School CE Division is pleased to report there are over 30 CE courses scheduled this year. Through an educational support grant, UNLV can offer approximately 25% of the CE courses in the evenings at no cost to NDA members or their staffs. Of particular interest to NDA Members, are specific monthly study clubs for both dentists and hygienists.

Additionally, the breadth and scope of CE courses have been expanded to include areas as diverse as Endodontics, CBCT technology, Digital Dentures, Surgical Bone Grafting utilizing Cadavers, Composite Esthetics, Advanced Orthodontics, and Implant Courses. Future courses are planned in Periodontics, Oral Surgery, and Oral Pathology. Of particular interest to NDA Members will be a partnership between UNLV and Delta Dental to offer free CE Courses which will be announced shortly. Please bookmark the UNLV CE Website for the updates. The direct UNLV CE website address is *www.unlvdentalce.com*, or call 702-774-2822. ◆

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Calendar of Events

JULY–OCTOBER 2012

JULY

WED 18	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
THU 19	NNDS Open House BBQ	5 pm	Bartley Ranch Park, Reno

AUGUST

2–4	Western States President's Conference		Sedona, AZ
TUE 14	NNDS Executive Committee Meeting	6 pm	161 Country Estates Cir, #1B, Reno
WED 15	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
FRI 24	NNDS Spouses/Guest Night at the Reno Aces Game	5 pm	Reno Aces Ballpark, Reno
TUE 28	SNDS Executive Committee Meeting	6 pm	SNDS Office

SEPTEMBER

7–9	Caucus I		Denver, CO
TUE 11	SNDS Community Night		
TUE 11	NNDS Executive Committee Meeting	5:30 pm	161 Country Estates Cir, #1B, Reno
THU 13	NDA Executive Committee Meeting	7 pm	*Videoconference*
WED 19	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
FRI 21	NNDHP/Joel F. Glover 10th Annual Golf Tourney	12:15 pm	Lakeridge Country Club, Reno

OCTOBER

TUE 2	NNDS Executive Committee Meeting	6 pm	161 Country Estates Cir, #1B, Reno
FRI 5	*SNDS presents:* CE Seminar	9 am – 4 pm	Gold Coast Hotel, Las Vegas
TUE 9	SNDS Monthly Member Dinner Meeting		Gold Coast Hotel, Las Vegas
THU 11	NNDS General Membership Dinner Meeting— Dr. Thomas Flynn	6 pm	The Grove at SouthCreek, Reno
WED 17	SNDS Peer Review Committee Meeting		*Contact SNDS at 702-733-8700*
THU 18	AGD General Membership Dinner Meeting	6 pm	location: tbd
18–23	ADA Annual Session. Register online at www.ADA.org/session *Events:* THU 18: Opening General Session and Distinguished Speaker Series FRI 19: New Dentist Reception SAT 20: Closing Reception in the Exhibit Hall MON 22: ADA Foundation Give Kids A Smile® 10th Anniversary Gala		
TUE 23	SNDS Executive Committee Meeting	6 pm	SNDS Office

Classified Ads

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